ALASKA STATE LEGISLATURE
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
February 6, 2025
3:30 p.m.

MEMBERS PRESENT

Senator Forrest Dunbar, Chair
Senator Cathy Giessel, Vice Chair
Senator Matt Claman

MEMBERS ABSENT

Senator Löki Tobin
Senator Shelley Hughes

COMMITTEE CALENDAR

PRESENTATION(S): ECONNECT ALASKA'S HEALTH INFORMATION EXCHANGE (HIE)

- HEARD

SENATE BILL NO. 76
"An Act relating to complex care residential homes; and providing for an effective date."

- HEARD & HELD

SENATE BILL NO. 44
"An Act relating to the rights of minors undergoing evaluation or inpatient treatment at psychiatric hospitals; relating to the use of seclusion or restraint of minors at psychiatric hospitals; relating to a report published by the Department of Health; relating to inspections by the Department of Health of certain psychiatric hospitals; and providing for an effective date."

- MOVED CSSB 44(HSS) OUT OF COMMITTEE

PREVIOUS COMMITTEE ACTION

BILL: SB 76
SHORT TITLE: COMPLEX CARE RESIDENTIAL HOMES
SPONSOR(s): RULES BY REQUEST OF THE GOVERNOR

01/27/25	(S)	READ THE FIRST TIME - REFERRALS
01/27/25	(S)	HSS, FIN
02/06/25	(S)	HSS AT 3:30 PM BUTROVICH 205

BILL: SB 44
SHORT TITLE: MINORS & PSYCHIATRIC HOSPITALS
SPONSOR(s): CLAMAN

01/17/25	(S)	PREFILE RELEASED 1/17/25
01/22/25	(S)	READ THE FIRST TIME - REFERRALS
01/22/25	(S)	HSS, FIN
01/28/25	(S)	HSS AT 3:30 PM BUTROVICH 205
01/28/25	(S)	Heard & Held
01/28/25	(S)	MINUTE(HSS)
01/30/25	(S)	HSS AT 3:30 PM BUTROVICH 205
01/30/25	(S)	Heard & Held
01/30/25	(S)	MINUTE(HSS)
02/06/25	(S)	HSS AT 3:30 PM BUTROVICH 205

WITNESS REGISTER

KENDRA STICKA, Executive Director
HealthEConnect Alaska
Anchorage, Alaska
POSITION STATEMENT: Gave a presentation on Alaska's Health Information Exchange (HIE).

HEIDI HEDBERG, Commissioner
Department of Health
Anchorage, Alaska
POSITION STATEMENT: Provided an opening statement on SB 76 on behalf of the administration.

EMILY RICCI, Deputy Commissioner
Department of Health
Anchorage, Alaska
POSITION STATEMENT: Co-presented an introduction on SB 76 and provided the sectional analysis on behalf of the administration.

CLINTON LASLEY, Deputy Commissioner
Department of Family and Community Services
Juneau, Alaska
POSITION STATEMENT: Co-presented an introduction on SB 76 on behalf of the administration.

ROBERT LAWRENCE, MD, Chief Medical Officer
Department of Health

Anchorage, Alaska
POSITION STATEMENT: Co-presented an introduction on SB 76 on behalf of the administration.

ARIELLE WIGGIN, Staff
Senator Forrest Dunbar
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Provided a Summary of Changes for SB 44.

ACTION NARRATIVE

3:30:27 PM
CHAIR DUNBAR called the Senate Health and Social Services Standing Committee meeting to order at 3:30 p.m. Present at the call to order were Senators Giessel, Claman, and Chair Dunbar.

PRESENTATION(S):
ALASKA'S HEALTH INFORMATION EXCHANGE (HIE)

3:31:25 PM
CHAIR DUNBAR announced a presentation Alaska's Health Information Exchange (HIE).

3:31:43 PM
KENDRA STICKA, Executive Director, HealthEConnect Alaska, Anchorage, Alaska, presented Alaska's Health information Exchange (HIE). She moved to slide 1 and provided a brief work history. She stated that the Health Information Exchange (HIE) was established through legislation in 2009 to improve the safety and cost-effectiveness of health care in Alaska. She explained that HealthEConnect, a nonprofit organization, administers the HIE as a neutral steward of health data, maintaining separation from both state agencies and private industry.

3:33:11 PM
MS. STICKA moved to slide 3 and stated that the board of directors and governance structure of the Health Information Exchange (HIE) is defined by statute. She noted that although HIE emerged during the Affordable Care Act era, its development was driven by the health care community's recognition of its value. She added that the board includes statutorily designated representatives from various health sectors, all of whom actively contribute to guiding the direction of health care in the state:

[Original punctuation provided.]

Governance: Board of Directors

- Commissioner, DOH/Designee
- Hospitals and Nursing Home Facilities
- Private Medical Care Providers
- Community-Based Providers
- Federal Health Care Providers
- Alaska Tribal Health Organizations
- Health Insurers
- Health Care Consumers
- Employers or Businesses
- Non-voting liaison member for the University of Alaska

3:34:10 PM
MS. STICKA moved to slide 8 and said she would share a video on HIE. She explained that the Health Information Exchange (HIE) serves as a secure data repository for protected health information, compliant with Health Insurance Portability and Accountability Act (HIPAA) standards. She stated that health data flows directly from an organization's electronic medical record into the HIE, allowing other authorized providers to access it immediately without the need for records requests. She illustrated the practical value of the HIE with a scenario where a patient in Juneau receives emergency care but cannot communicate medical history—access to the HIE would allow providers at Bartlett Hospital or, if needed, Providence in Anchorage to make informed treatment decisions and avoid redundant, costly testing. She emphasized that the HIE helps reduce health care costs by enabling safer, more efficient care and noted that board member Dr. Quinn of the Alaska Heart Institute has observed the financial impact when critical health information is unavailable during cardiovascular emergencies.

3:36:08 PM
MS. STICKA played the video which illustrated the value of HIE by sharing the stories of four Alaskans navigating different challenges within the healthcare system. A link to the video was provided - https://youtu.be/r5JbQBSbsU4. The video mentioned the inefficiency of phone calls, faxes, and paper. It also mentioned the various types of information available through HIE's real-time online portal to assist patients.

3:44:51 PM

MS. STICKA moved to slide 9, a list of HealthEConnect data contributors, and addressed a common question about participation in the Health Information Exchange (HIE) and emphasized that its effectiveness depends on both the quantity and quality of the data it receives. She explained that the most robust and valuable method of participation is when organizations send data directly from their electronic medical records into the HIE, which allows for more meaningful use, including analysis related to social determinants of health. She stated that data submitted to the repository is then organized into usable and actionable formats. She shared that several organizations currently send data directly, while others connect through national networks with more limited information. She noted that the HIE continues to expand its list of direct data contributors and that a full list of participating organizations is available on the HIE website.

3:46:23 PM
SENATOR CLAMAN noted that the list of providers connected to the Health Information Exchange (HIE) includes many familiar names but asked about smaller practices that may not participate. He asked whether it's reasonable for consumers to ask their physician if they are part of the HIE and, if not, why not. He emphasized that the core benefit—having complete medical records available in an emergency—is compelling and worth encouraging broader participation.

MS. STICKA agreed that having access to complete medical records, rather than partial information, is ideal and confirmed it is appropriate for patients to ask their providers whether they participate in the Health Information Exchange (HIE). She explained that some organizations may not have joined due to past disengagement or technical limitations, particularly smaller practices with less robust electronic medical records. However, she noted that the HIE has undergone a strong reset in recent years and is actively re-engaging with providers. She added that in most cases, if a practice has an electronic medical record system, there are ways to work toward participation.

3:47:34 PM
SENATOR CLAMAN asked if there is a fee to participate in HIE.

MS. STICKA stated that currently there is no cost for providers to connect to the Health Information Exchange (HIE), though some may incur fees from their electronic medical record vendors, which the HIE does not control. She explained that 90 percent of

the HIE's funding comes from a contract with the Department of Health. She acknowledged past challenges when hospitals and healthcare organizations were required to pay to participate, which limited involvement due to a lack of clear business justification. She credited the Department of Health's funding support for eliminating participation fees, which has significantly increased provider engagement with the HIE.

3:48:33 PM
MS. STICKA stated that the Health Information Exchange (HIE) has secured funding through Fiscal Year 2026 via its partnership with the Department of Health and expressed appreciation for the collaboration. She noted that the department's funding for the HIE contract is currently supported in part by federal Medicaid match dollars. Given the uncertainties surrounding future federal funding, she emphasized the importance of considering how the state can sustainably support the HIE in the long term, independent of federal sources. She clarified that no funding request is being submitted this year.

3:49:20 PM
MS. STICKA moved to slide 11, a graph showing years 2022 - 2024 and amount of usage by clinics and hospital in network, HIE portal users, and portal logins:

Year	2022	2023	2024
Number of Clinics & Hospitals in Network	94	133	198
Number of HIE Portal	195	432	705
Number of Portal Logins	1005	2366	4592

MS. STICKA stated that not charging providers to participate over the past several years led to a significant increase in utilization. She noted excitement in seeing the growing numbers and creative uses of the exchange, including addressing social determinants of health.

3:50:11 PM
MS. STICKA moved to slide 12 Health Data Utility (HDU), and said health information exchanges nationally are maturing into health

data utilities (HDU), which she described as "collect, connect, deliver." She explained that an HDU requires gathering all data in one place, connecting sources to make the information manageable and actionable, and delivering it to those who can use it. She contrasted this with traditional records requests that produce large, unhelpful stacks of paper. She stated the goal is to format data differently for specialists such as cardiologists, primary care physicians, or allergy and immunology providers to make the information more actionable for each user.

3:51:24 PM
MS. STICKA moved to slide 13, Care Coordination / Social Determinates of Health (SDOH) Project, and described a pilot project with Matsu Health Services focused on addressing social determinants of health (SDOH) such as housing security, food security, and economic stability, which account for roughly 80 percent of overall health factors outside traditional care. She noted that the Centers for Medicare and Medicaid Services (CMS) now requires hospitals to screen for some SDOH factors, recorded in medical records as Z codes, which are sent to the data repository. She explained that the project used Z code information for Matsu Health Services' patient panel to identify individuals with social care needs and conduct proactive outreach, connecting them with resources. She said the pilot demonstrated how early, holistic intervention can improve patient health outcomes while reducing costs.

3:53:45 PM
MS. STICKA moved to slide 14, Alaska's Health Information Exchange, and stated that the Health Information Exchange in Alaska was created by healthcare organizations and professionals as a public good for Alaskans. She shared that she transitioned from working at the university to this role because she believed in its mission and the need to strengthen the state's healthcare infrastructure. She emphasized the importance of making healthcare organizations operate more cost-effectively while delivering high-quality care. She expressed appreciation for the partnership with the Department of Health in finding efficient ways to leverage the technology for multiple purposes.

3:55:00 PM
CHAIR DUNBAR said most Alaskans in his generation are accustomed to using digital records and completing forms online, and many assume providers can already access their health records anywhere. He noted participation in the Health Information Exchange is voluntary in Alaska and observed that some large

providers, such as Alaska Regional and Alaska Native Medical Center (AMC), appear to be missing. He asked if other states require participation and what it would look like if such a requirement were implemented.

3:55:48 PM
MS. STICKA said larger organizations such as Alaska Regional are in the process of onboarding and are enthusiastic, but must complete technical, corporate, privacy, and security requirements. She noted ongoing collaboration with tribal health to ensure participation aligns with data security and privacy concerns specific to their system. She stated that some states, including Connecticut, mandate participation, though mandates have pros and cons, with voluntary collaboration often producing better results. She added that challenges include cost and compatibility issues with electronic medical records, and she mentioned emerging federal regulations on data sharing that could influence future participation.

CHAIR DUNBAR said many Alaskans assume health data sharing already occurs and may not realize the Health Information Exchange is part of the state's healthcare infrastructure. He noted funding is secured through 2026, which implies no funding is in place beyond that year. He stated this is an important consideration for the committee and the legislature.

3:58:04 PM
At ease.

SB 76-COMPLEX CARE RESIDENTIAL HOMES

3:58:51 PM
CHAIR DUNBAR reconvened the meeting and announced the consideration of SENATE BILL NO. 76 "An Act relating to complex care residential homes; and providing for an effective date."

3:59:24 PM
HEIDI HEDBERG, Commissioner, Department of Health, Anchorage, Alaska, provided an opening statement on SB 76 on behalf of the administration. She expressed appreciation to the committee for hearing SB 76, introduced at the governor's request. She said the bill resulted from collaboration between the Department of Family and Community Services and the Department of Health to address gaps in Alaska's system of care for individuals with complex behavioral health and co-occurring needs. She stated Alaska lacks an appropriate setting for these individuals to receive care in a home-like, community-based environment. She

said the proposed new license type will fill this critical gap and improve health outcomes for Alaskans.

4:00:36 PM

EMILY RICCI, Deputy Commissioner, Department of Health, Anchorage, Alaska, co-presented an introduction on SB 76 and provided the sectional analysis on behalf of the administration. She moved to slide 2 and said the bill will help address and identify gaps in the system of care for individuals with complex needs. She recalled that strengthening the behavioral health system, with a focus on complex care, was one of the department's four key priorities. She emphasized the importance of addressing needs at both the individual and systems levels. She stated the bill reflects the outcome of that effort and the department's collaboration with the Department of Family and Community Services.

4:01:20 PM

CLINTON LASLEY, Deputy Commissioner, Department of Family and Community Services, Juneau, Alaska, co-presented an introduction on SB 76 on behalf of the administration. He moved to slide 3 and said the bill resulted from collaboration between the Department of Health and the Department of Family and Community Services, demonstrating that cooperation continued after the departments split two and a half years ago. He stated the Department of Family and Community Services prioritized individuals with complex and co-occurring needs, creating a Coordinated Health and Complex Care Team. He explained that work included forming a case response team to address placement challenges for youth and adults after treatment and holding quarterly complex care committee meetings with the Department of Health to address system-level gaps. He said this bill emerged from those combined efforts.

4:03:16 PM

MR. LASLEY stated that complex care involves individuals with complex needs who require a multidisciplinary team to determine diagnoses, develop treatment outcomes, and identify necessary resources. He explained that these individuals often have behavioral challenges and need specialized care settings. He emphasized that the goal is to improve their quality of life and support independent living.

4:04:00 PM

MR. LASLEY moved to slide 4 and explained that the team previously presented the complexity of individuals receiving care, emphasizing a person-centered approach. He stated that

these individuals often require a multidisciplinary team because they interact with multiple systems, including mental health care, substance use treatment, social services, public safety, and medical care. He noted that although this population is relatively small, they demand a significant share of time and resources due to frequent cycling through systems. He concluded that current care settings, such as assisted living homes, often lack the capacity to meet these individuals' needs, highlighting the need for more specialized, long-term care options.

MR. LASLEY stated that many individuals requiring complex care have histories of out-of-state treatment and display disruptive or aggressive behaviors, often linked to co-occurring medical conditions or dementia-related symptoms. He noted that such behaviors, including advanced or sexualized conduct, are difficult to manage in large facilities like Pioneer Homes operated by the Department of Family and Community Services. He emphasized that smaller, home-like settings could better provide the specialized care needed while also protecting other residents. He concluded that creating a complex care residential home license type is essential to strengthening the continuum of care in Alaska and supporting individuals in the least restrictive environment possible.

4:06:52 PM

MS. RICCI moved to slide 5, What Does SB 76 Do, and stated that SB 76 establishes the statutory framework needed for the Department of Health to license and regulate a new type of facility called complex care residential homes. She explained that the goal is to create small, home-like community settings designed to meet the complex needs of individuals through multidisciplinary support. These homes would offer appropriate staffing levels and specialized services tailored to the population served. She added that various complex care residential homes could be designed to address different needs within this population

4:07:56 PM

MS. RICCI moved to slide 6, CCRHs Fill a Gap in the Care Continuum, and explained the current continuum of care and how complex care residential homes would fill a gap between acute inpatient settings and lower-level community-based care. She described the right side of the continuum as including inpatient psychiatric hospitals, general acute hospitals, residential psychiatric treatment centers for youth, and skilled nursing facilities. The left side includes foster homes, private residences, and assisted living homes, primarily supported

through Medicaid's home and community-based waiver services. She noted that individuals with complex needs who do not qualify for an intellectual and developmental disability diagnosis often fall between these levels of care, making it difficult to access appropriate services. She emphasized that complex care residential homes are intended to bridge this gap by providing a long-term, home-like setting tailored to these individuals' needs.

4:09:41 PM
MS. RICCI moved to slide 7, Establishing a New Residential Setting, and outlined a four-step approach used to develop a new care model. The steps include identifying individual needs, determining appropriate care settings, defining the services required, and establishing funding mechanisms. She stated that SB 76 addresses the second step: creating a setting where individuals with complex needs can receive care. She clarified that while the Department of Health already has the statutory authority to develop services and funding, it lacks the authority to create a new facility type, which SB 76 aims to establish. She added that work on the remaining steps is ongoing, but the bill is specifically focused on authorizing a new license type for complex care residential homes.

4:11:13 PM
ROBERT LAWRENCE, MD, Chief Medical Officer, Department of Health, Anchorage, Alaska, co-presented an introduction on SB 76 on behalf of the administration. He moved to slide 8, Who Would Benefit from CCRHs, and stated that the slide emphasizes the need to broaden the understanding of who could benefit from the proposed facility type, noting that the goal is to design a license that applies across a range of ages and mental health conditions. He described the gap in care for youth, particularly ages eight to twelve, who complete inpatient treatment but lack safe or appropriate placement options, such as foster care or assisted living. He also described older adults, including those with dementia who end up in hospitals or even correctional facilities, as another group lacking appropriate residential care settings. He stressed the need for a community-based facility that can serve various individuals with complex behavioral health needs in a least restrictive environment.

4:13:12 PM
DR. LAWRENCE moved to slide 9, Key Features of a CCRH, and explained that SB 76 is designed to be flexible and apply to diverse age groups and needs. He noted that the proposed legislation allows for licensing of facilities with fewer than

15 residents, with the expectation that youth homes would house far fewer—typically five or six. He added that the facilities would operate with 24/7 staff support from a multidisciplinary team tailored to the specific needs of the residents. He emphasized that these homes would offer a higher level of support than assisted living but remain less restrictive than inpatient psychiatric settings. Each home would be defined by its residents' individualized treatment plans, including specialized monitoring and interventions.

4:14:35 PM
DR. LAWRENCE moved to slide 10, Benefits of a CCRH, and stated that the benefits of establishing these home-like settings include improving care for Alaskans with complex needs without relying on overly restrictive environments. He explained that the bill adds a new license type for clinically appropriate residential settings and enables the development of specialized services through regulation. He concluded by emphasizing that this model enhances community safety in a compassionate, cost-effective manner by providing tailored care in the least restrictive environment.

4:15:40 PM
CHAIR DUNBAR stated that he had heard strong support for the concept, noting that many see it as a valuable step-down option to transition individuals out of inappropriate facilities. He commented that the model echoes aspects of de-institutionalization policies from decades ago, with a focus on much smaller residential settings. He then asked whether the proposed license type is intended to be flexible enough to serve a wide range of individuals—from children placed out of state to seniors exiting the correctional system—or if it would allow for specialized facilities within that license type to serve distinct populations.

4:16:50 PM
MS. RICCI responded that the Department envisions specialized homes rather than mixed-population facilities, noting that although the term "complex care population" is used broadly, there are clearly distinct subgroups with differing needs. She gave the example of seniors with dementia and co-occurring conditions like schizophrenia or aggressive behavior, whose care needs differ significantly from youth returning from out-of-state treatment. She explained that the intention is to create separate homes tailored to specific populations. She added that aligning building regulations with existing facility types provides the state flexibility to adapt over time, allowing

requirements to be updated through regulation as population needs evolve.

4:18:35 PM
MS. RICCI moved to slides 11 -13 and reviewed the sectional analysis for SB 76:

[Original punctuation provided.]

SECTIONAL ANALYSIS
Senate Bill 76: Complex Care Residential Homes

Section 1. Amends AS 47.32.010(b) to add "complex care residential homes" to the list of entities regulated by the Department of Health.

Section 2. Amends AS 47.32.900(2) to update the definition of "assisted living home" to exclude complex care residential homes.

4:19:15 PM
MS. RICCI stated that the department is trying to delineate in statute the difference between assisted living homes and complex care residential homes. Assisted living homes are not meant to serve individuals under the age of 18 and do not have the multidisciplinary focus that is envisioned for complex care residential homes.

Section 3. Adds AS 47.32.900(11) to modify the definition of "hospital" to clarify that it does not include complex care residential homes.

4:19:30 PM
MS. RICCI said this ensures that hospital or facility requirements are not applied to complex care residential homes and emphasizes the focus on a home-like setting.

Section 4. Adds AS 47.32.900(22) to introduce a new definition for “complex care residential home.” It is defined as a residential setting that provides 24-hour multi-disciplinary care on a continuing basis for up to 15 individuals with mental, behavioral, medical, or disability-related needs requiring specialized care, services and monitoring.

4:20:17 PM

MS. RICCI noted that the 15-bed limit aligns with a federal requirement. She explained that the Department is mindful of current and potential future federal rules as services and funding mechanisms are developed. At the federal level, she highlighted a prohibition on Medicaid coverage for institutions of mental disease, with an exemption available for facilities with 15 beds or fewer.

Section 5. Amends the uncodified law by adding a new section that requires the Department of Health to submit for approval by the United States Department of Health and Human Services amendments to the state Medicaid plan or apply for waivers necessary to implement the provisions of Sections 1-4.

Section 6. Amends the uncodified law by adding a new section specifying that sections 1-4 of the bill will only take effect if the United States Department of Health and Human Services approves the required Medicaid waivers or amendments by July 1, 2031. The commissioner of health is required to notify the revisor of statutes within 30 days once the necessary approvals are received.

Section 7. Provides that sections 1-4 take effect the day after the United States Department of Health and Human Services approves amendments to the state plan or waivers submitted under Section 5.

4:21:51 PM
MS. RICCI concluded the presentation.

4:22:05 PM
SENATOR GIESSEL asked where the Department would find staff for the complex care residential homes.

4:22:15 PM
MS. RICCI responded that workforce challenges exist across nearly all healthcare settings in the state and acknowledged that the Department does not yet have all the answers. She explained that many individuals with complex needs are already receiving care in various settings—such as assisted living homes, inpatient facilities, or through the general relief program—but without the appropriate alignment of services,

settings, and payment structures. She emphasized that staffing difficulties are closely tied to inadequate funding models that fail to reflect the intensity and acuity of care required. She stated that aligning payment with the severity of need, service complexity, and necessary staffing ratios is essential to supporting and sustaining an appropriate workforce for complex care residential homes.

4:24:08 PM
SENATOR GIESSEL stated that she is aware personnel costs will be 50 percent federally funded, as noted in the fiscal notes. She expressed interest in the timeline for revising behavioral health reimbursement rates and emphasized the importance of completing that process before staffing begins. She noted that staff in complex care residential homes will likely require competitive compensation, given the intensity of care, and stressed the need for an appropriate pay scale.

4:24:47 PM
MS. RICCI stated that rebasing for community behavioral health rates took effect earlier this year. She added that the Department is currently conducting a rate methodology review to evaluate whether behavioral health payment rates and rules align with service needs. She emphasized that the Department is actively responding to concerns from the behavioral health community about significant gaps between service demands and the payment structures available to support them.

4:25:38 PM
CHAIR DUNBAR held SB 76 in committee.
4:26:17 PM
At ease.

SB 44-MINORS & PSYCHIATRIC HOSPITALS

4:28:11 PM
CHAIR DUNBAR reconvened the meeting announced the consideration of SENATE BILL NO. 44 "An Act relating to the rights of minors undergoing evaluation or inpatient treatment at psychiatric hospitals; relating to the use of seclusion or restraint of minors at psychiatric hospitals; relating to a report published by the Department of Health; relating to inspections by the Department of Health of certain psychiatric hospitals; and providing for an effective date."

4:28:17 PM

CHAIR DUNBAR stated a committee substitute was developed for SB 44.

4:28:27 PM
CHAIR DUNBAR solicited a motion.

4:28:32 PM
SENATOR GIESSEL moved to adopt the Committee Substitute (CS) for SB 44, work order 34-LS0126\N, as the working document.

4:28:44 PM
CHAIR DUNBAR objected for purposes of discussion.

4:28:55 PM
ARIELLE WIGGIN, Staff, Senator Forrest Dunbar, Alaska State Legislature, Juneau, Alaska, provided a summary of changes for SB 44. She stated there were nine changes requested by members of the committee and the of Family and Community Services (DFCS):

[Original punctuation provided.]

SUMMARY OF CHANGES

CS(SHSS) SB 44: RIGHTS OF MINORS IN PSYCHIATRIC HOSPITALS
Version A to Version N
February 5th, 2025

Section 1

Page 1, line 11 and Page 2, line 1: Inserts "professional person in charge" as a replacement for "overseeing physician" which is deleted.

Page 1, line 13: Deletes "over not more than four occasions,"
Page 2, line 2: Inserts "and may place reasonable limits on the number of calls permitted"

Section 2

Page 2, line 12 following "treatment": Inserts "and the type of psychotropic medication used, if any, to carry out each chemical restraint;"

Page 2, line 15 following "data": Inserts "on the number of minors who received residential care at psychiatric hospitals, including information"

Page 2, line 16 and 19 following "minors": Inserts "in state custody"

Section 3
Page 3, line 16 after "restraint": Inserts "The notification provided by a psychiatric hospital regarding the use of a chemical restraint must include the type of psychotropic medication used to carry out the chemical restraint

4:30:54 PM
SENATOR CLAMAN noted that the committee and the Department of Family and Community Services (DFCS) collaborated on the changes, particularly regarding the role of the professional person in charge. He explained that the concern involved situations where limiting family contact could infringe on an individual's right to communicate. He stated that the intention was to require a higher level of review—beyond the treatment team—by involving the professional person.

4:31:31 PM
CHAIR DUNBAR removed his objection; found no further objection and CSSB 44 was adopted as the working document.

4:31:55 PM
SENATOR CLAMAN stated he appreciates the questions that were asked and the time committee members and other gave to working on SB 44.

4:32:06 PM
SENATOR DUNBAR solicited the will of the committee.

4:32:11 PM
SENATOR GIESSEL moved to report CSSB 44, work order 34-LS0126\N, from committee with individual recommendations and attached fiscal note(s).

4:32:23 PM
CHAIR DUNBAR found no objection and CSSB 44(HSS) was reported from Senate Health and Social Services Committee.

4:32:43 PM
There being no further business to come before the committee, Chair Dunbar adjourned the Senate Health and Social Services Standing Committee meeting at 4:32 p.m.