

ALASKA LEGISLATURE

1913

HOUSE and SENATE FINANCE COMMITTEE FILES, 1999 - 2000

Please feel free to call me if you have any questions or concerns.

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Special Assistant to the Commissioner
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Public Safety Employees Association, Inc.
"Representing Alaska's Finest"

February 16, 1999

Honorable Representative Tom Brice
State Capitol
Juneau, AK 99801-1182

Re: House Bill 3

Dear Representative Brice:

Thank you for sponsoring House Bill 3. This legislation establishes a felony crime for those who possess certain chemicals with the intent to manufacture schedule IA, IIA, IIIA, IVA or VA drugs.

The Public Safety Employees Association fully supports this bill and advocates its quick passage so that Alaska's law enforcement officers can charge people who are using these dangerous chemicals to make methamphetamine and other illegal drugs.

This important tool will allow officers to apprehend and deter methamphetamine traffickers and ensure our neighborhoods are safer places to live.

Please call us if you need any assistance in passing this bill. We have members who are involved with drug enforcement and who, on behalf of PSEA, would gladly testify as to the importance of this legislation.

Sincerely,



Keith Perrin
Business Manager

FAIRBANKS
Daily News - Miner

Saturday, January 22, 2000

Suspected drug lab raided

By SEAN COCKERHAM
Staff Writer

Local drug investigators raided a suspected methamphetamine lab on Friday, the second discovered in North Pole this month.

Agents of the Statewide Drug Enforcement Unit served a search warrant on a house at 3135 Old Richardson Highway.

Alaska State Trooper Sgt. J.R. Roberts said it is the home of 34-year-old Mac Anthony Payne. Payne was present at the time of the raid, Roberts said, but did not admit any culpability.

The suspected lab was located near a junkyard where investigators had discovered a methamphetamine lab in 1998, only the second one that law enforcement officers had ever found in the Interior.

Roberts said the lab discovered Friday appears to be a small methamphetamine operation. No arrests have been made, and charges will not be filed until the chemicals are sent to a laboratory for positive identification.

Methamphetamine is created from a potpourri of chemicals, and the labs can consist of 20 to 150 different items. The evidence analysis is time-consuming.

Investigators raided another suspected methamphetamine lab in North Pole less than three weeks ago. In that case they were serving an arrest warrant based upon the lab results of a raid from six months earlier and reportedly discovered that the wanted man had begun cooking the drug again.

Meth lab suspect released

Loophole in law halts charges

By JOLIE LEWIS
Staff Writer

Highly explosive materials stored near exposed live wires; hazardous chemicals left uncapped in a trailer where two people lived. Authorities characterized the methamphetamine lab as unusually dangerous.

To their disappointment, the 42-year-old Oklahoma transplant and the lab's alleged drug cook is now back on the streets three months after his arrest.

Oklahoma failed to produce a governor's warrant for Raymond C. Anderson's extradition before a 90-day window expired Sept. 21, and Alaska never filed drug charges.

Methamphetamine labs—described as extremely dangerous operations by Alaska State Troopers Statewide Drug Enforcement Unit investigators—are a new enough



Sam Herald/News-Miner

METH LAB—In this summer file photo, an investigator enters an Atco building suspected to be a methamphetamine lab Wednesday in a junk yard off the Old Richardson Highway south of North Pole.

criminal trend in Alaska that prosecutors are just now discovering a possible loophole in state statute.

The chemical process Anderson allegedly used to cook the drug may not be illegal.

"Somewhere, the system has failed," said Jeff Deutch, the North Pole police officer who first sought a warrant for Anderson's arrest on a traffic charge. "Now it becomes a community problem again."

But Sgt. J.R. Roberts, chief of the local drug enforcement unit, said the setback should almost have been expected.

"It's something that's new to Alaska," Roberts said of meth labs. "It's new to the system. It's new to us. We're all novices when it comes to this."

North Pole police and drug investigators in mid-June converged on the junkyard Atco unit where Anderson apparently lived with his teen-age son. They had a warrant al-

leging Anderson had provided a false name during a traffic stop—his own license was suspended—and had fled from justice in Oklahoma.

Authorities didn't find Anderson that day, but they did discover hazardous chemicals and drug-manufacturing apparatus in a "poor man's" set-up that spooked even experienced methamphetamine lab investigators. There were no drugs, however.

Anderson was arrested a week later in a Fairbanks apartment on the warrant.

Oklahoma authorities said they would extradite. Though Anderson was wanted in two counties in southeastern Oklahoma, prosecutors from one took charge of extradition.

In this case, it was Bryan County, where Anderson was wanted for failing to show up in court in January on charges of possessing methamphetamine and marijuana after a felony conviction. Further, drugs

charges are pending in other cases, said assistant district attorney Greg Jenkins.

In neighboring Choctaw County, Anderson missed court dates in cases alleging he delivered drugs and conspired to manufacture them. Assistant District Attorney Maria Blakely said Anderson has a "whole slew" of prior drugs convictions.

Oklahoma bondsman Wayne Holder, an agent for a company that posted more than \$30,000 of bonds on Anderson's behalf in Choctaw County, searched for Anderson for approximately six months. He tracked Anderson to Fairbanks and provided information to local investigators.

"It was just a long, hard deal," said Holder, who ultimately salvaged the company's bond. "We did our job. We got him incarcerated up there. As bondsmen, we're exonerated."

See METH Page A-4



RAYMOND ANDERSON

METH: Suspected methamphetamine cook released; loophole found in law

Continued from Page A-1

To extradite, the Bryan County district attorney needed to submit a warrant request to the Oklahoma governor, who in turn would sign it and send it to Alaska Gov. Tony Knowles for approval. Local authorities could then send Anderson back to Oklahoma.

They had 90 days. Bryan County officials, however, didn't begin the process until early September, more than 70 days after Anderson's arrest in Fairbanks.

Beverly Jackson, an extradition secretary in Bryan County, said she waited because Anderson at first said he would return willingly and because she thought Alaska would file felony drug charges.

The documents were still in the governor's office in Oklahoma when time ran out Sept. 21. Blakely said it was "absolutely" disappointing Anderson slipped through their fingers.

Anderson walked out of jail in Fairbanks on Sept. 22.

Meanwhile, the district attorney's office in Fairbanks had reached a plea agreement with Anderson. He pleaded no contest to driving with a suspended li-

Despite provisions in Alaska statutes that say manufacturing methamphetamine constitutes third-degree drugs misconduct, a felony, charges were never filed.

"We don't have a statute which makes it illegal to possess precursor drugs," said District Attorney Harry Davis, adding that the state may yet consider pinning other charges on Anderson.

State law says it is illegal to manufacture "any amount" of a controlled substance—suggesting that some amount of finished product must be recovered for the charge to apply, Davis said. It's also a felony to be in possession of certain illegal substances with the intent of using them to make drugs—but many precursors and chemicals used to make methamphetamine apparently are not defined as illegal.

Yet some of those same chemicals are so toxic or volatile that investigators say methamphetamine cooks may be putting an entire neighborhood at risk.

State Rep. Tom Brice, D-Fairbanks, wants to make Alaska's methamphetamine law more clear by defining other precursors as illegal substances. He said he was approached by investigators

"If (investigators) see the boxes of all the precursors going into a house, it will allow them to crack that house before it goes into production," Brice said. "There's nothing else you can do with all that stuff except blow up the block."

Brice's legislation also would require stores to notify authorities when someone buys extremely large quantities of legal, over-the-counter drugs that can be used to make methamphetamine.

Phil Moberly, chief of the Statewide Narcotics Unit based at the district attorney's office in Anchorage, said his team is researching interpretations of stat-

utes applying to methamphetamine labs. He didn't want to comment definitively until after attending a "clandestine lab" class in Anchorage this week.

"Prosecution of (labs) is an evolving thing up here. We don't have a lot of experience with it," Moberly said. "I think we're going to see more."

Moberly has been involved with three methamphetamine lab cases in Anchorage; two of which were prosecuted federally. In the third case, a defunct lab was found in someone's house; the defendant was charged with possession of methamphetamine and maintaining a dwelling con-

taining drug-producing apparatus.

In Fairbanks, two methamphetamine labs have been raided. Crist A. Bigler, the alleged cook at a lab found four days before authorities discovered one in Anderson's trailer, has been charged in federal court.

Assistant U.S. Attorney Stephen Cooper declined to comment Thursday on the possibility of prosecuting the Anderson case, but Roberts said it isn't likely.

Anderson's public defender speculated something must have gone awry in the investigation. If it were simply a loophole in state law, Jim Cannon said federal prosecutors would have just picked up the case.

"The feds have made a bleeding chemical under (illegal)," Cannon said. "I guess they found you couldn't use the evidence. Anderson never came up with a warrant, and the guy sat in jail for 90 days."

Roberts countered the investigators had done everything by the book—and if they had, attorneys would have told about it.

He pledged Saturday to sleuthing out meth labs.

"Regardless of what the limitations are, it's not going to stop our efforts to investigate and bring them down," he said. "It's still illegal."

Go shopping where the reindeer play



5 cited in meth busts

December 03, 1999

By SEAN COCKERHAM
Staff Writer

A Fairbanks grand jury has handed down the first criminal charges from this summer's string of local methamphetamine lab raids.

Indictments were filed Thursday against five people linked to two alleged labs discovered a week apart in late June, one in South Fairbanks and one in North Pole.

Four of those charged remain at large, while the fifth is in custody on a probation violation.

The delay in bringing the charges is due to the wait for results to come back from the state crime lab in Anchorage. Methamphetamine is created from a potpourri of chemicals. The labs can contain 20 to 150 different items.

"With meth labs, unlike any other (drug operation), there is so much evidence to submit," said Alaska State Trooper Sgt. J.R. Roberts, head of the local multi-agency drug enforcement team. "So many items have to be identified to make a solid manufacturing case, and you have to go through each one."

The grand jury determined this week that a sufficient case has been made to indict Richard M. Dickman, 31, and Heather C. Szmyd, 33, on felony drug manufacturing charges. They were allegedly cooking the drug in a Laurene Street Apartment—the first methamphetamine lab ever discovered inside Fairbanks city limits.

Drug investigators raided the lab on the morning of June 24 and reportedly found the drug stew simmering while Dickman and Szmyd slept.

The grand jury also indicted three people in connection with a June 24 bust of an alleged methamphetamine lab in the basement of a Plato Way house in North Pole.

Vincent T. Haugen, 35, and Lara C. Johnson, 29, were charged with felony charges of drug manufacturing and possession. William R. Baxter, 48, was charged only with methamphetamine possession.

During the raid Haugen was arrested on a probation violation for a 1998 drug case and is still in custody.

Three other local methamphetamine labs also were busted this summer. Lab results from two of those raids are back, and charges are possible once the district

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attorney's office completes its review of the evidence.

Roberts said it appears that the methamphetamine labs are not affiliated with one another, but "I would venture to say that the parties involved are probably familiar with one another."

Methamphetamine, also known as crystal, crank, or speed, is an addictive stimulant that is cheaper than cocaine. In the summer of 1998 drug investigators first found methamphetamine labs in the larger Fairbanks area.

Laboratories designed to cook the drug are dangerous because of the toxicity and explosiveness of chemicals used, investigators say.



Two meth lab suspects arrested, two still at large

December 11, 1999

By Staff report

Authorities have arrested two people since last week's methamphetamine lab indictments, but two others also implicated in the summertime drug raids remain free.

Richard M. Dickman, 31, and Heather C. Szmyd, 33, were arrested after an anonymous tip. They were arraigned on felony drug manufacturing charges Friday in Fairbanks Superior Court and both pleaded innocent.

They were allegedly manufacturing the drug in a Laurene Street Apartment.

Drug investigators raided the South Fairbanks apartment in late June, and the couple reportedly was found sleeping while the drug cooked.

Investigators say it was the first methamphetamine lab found within city limits. But authorities first discovered such labs in the borough the previous summer.

Dickman and Szmyd were indicted by a grand jury last week, as were people allegedly connected with a North Pole methamphetamine lab also raided in June.

Vincent T. Haugen, 35, and Lara C. Johnson, 29, were charged with felony charges of drug manufacturing and possession. William R. Baxter, 48, was charged only with methamphetamine possession.

Haugen was already in custody on a probation violation. But Johnson and Baxter, who were also scheduled to be arraigned on Friday, remain at large.

No charges have been filed yet in connection with three other alleged local methamphetamine labs raided this summer. Methamphetamine labs consist of numerous components that must be analyzed by the state crime lab before charges can be filed.



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Suspected meth lab busted

December 15, 1999

By JOLIE LEWIS
Staff Writer

Two people could face felony drug-manufacturing charges after investigators found equipment in a Badger Road area house Tuesday morning that appeared to be part of a methamphetamine lab.

Francis Peron, 36, and Nancy Weatter, 40, were at home when authorities showed up at 10:30 a.m. with a search warrant. Neither has been arrested, said Alaska State Troopers Sgt. J.R. Roberts, supervisor of the local Statewide Drug Enforcement Unit.

Investigators reportedly found drug-manufacturing paraphernalia in a bathtub and small closet in the upstairs of the two-story wood house on Hartzog Loop.

Dressed in protective gear, the investigators carried out containers of sludge and crusty substances, unidentified solvents and cans that apparently held toluene, a colorless hydrocarbon, used in making explosives and as a solvent. Investigators also found residue that may have come from finished product.

"Typical. A bunch of unknowns," Roberts said. "Obviously, it all needs to be analyzed."

Peron and Weatter could be charged with third-degree drug misconduct following testing of chemicals found on scene.

This is the seventh suspected methamphetamine lab to be found this year and the first to be dismantled in the sub-zero temperatures of winter, Roberts said. Investigators from troopers, Fairbanks police and the Drug Enforcement Administration set up a heated workstation under a tarp outside the residence and were still cleaning up 10 hours after they arrived.

Roberts said authorities heard about the suspected lab through an anonymous tip and investigated for two to three weeks. He believes the lab's output would have been comparable to others found this year.

Methamphetamine is an addictive stimulant that is made using toxic or explosive chemicals, investigators say.



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Another meth lab located

Suspect charged in similar case

January 08, 2000

By JOLIE LEWIS
Staff Writer

More than six months elapsed between the discovery of a suspected methamphetamine lab in a cargo van in North Pole and the indictment of the man suspected of running it.

Drug investigators say it was long enough for James Hughes to start cooking again.

While arresting Hughes on a warrant from the first lab, they found a new lab in his bedroom Friday, Alaska State Troopers Sgt. J.R. Roberts said.

Hughes is being held at Fairbanks Correctional Center on \$25,000 bail on a charge of third-degree drug misconduct. He could face another such charge after chemicals found Friday are processed and analyzed, Roberts said.

Investigators went to an Outside Boulevard home near North Pole about 9:30 a.m. to arrest Hughes on the warrant.

They announced themselves when they arrived but reportedly pushed into the place about 45 minutes later because no one answered. Inside, they found Hughes, who may have been preparing to synthesize methamphetamine when investigators showed up, Roberts said.

"How many people are washing out Mason jars at 9:30 in the morning in the bathtub?" asked Roberts, supervisor of the local, multi-agency Statewide Drug Enforcement Unit.

Like several other drug labs found in 1999, the cargo van lab was dismantled by investigators after they found it. Charges have been filed in some of the 1999 cases and are still pending in others.

Roberts classified both of Hughes' suspected labs as relatively small operations. He believes Hughes probably isn't alone in his quick return to manufacturing methamphetamine.

"They're not going to stop," Roberts said. "Look at Hughes. We bust him in a lab this summer, he's back doing the same thing."



Bauer, the DEC's site remediation project manager.

"It has all the appearances of being a surface spill," Bauer said. "Whether it was pure (TCE) or used solvent, it is difficult to

nave to snip this to a hazardous waste landfill in Washington or Oregon. That drives the cost up."

The main goal of any cleanup, Bauer said, would be to bring contamination levels to below drinking water standards.

TCE and benzene are the two major contaminants identified in the area ground water. Benzene is a known carcinogen. Many area residents, in response to the contamination, have resorted to hauling water or have installed

Meth package delivered; man arrested

By JOLIE LEWIS
Staff Writer

Like a boy anxious for Christmas, Ryan Everson kept asking about a package he was expecting.

When it finally came, Everson wasn't home and family members didn't recognize it as the one he was waiting for: It was addressed to somebody else. They turned it over to authorities.

That is how, local investigators say, Everson landed in jail Tuesday on a felony drug trafficking charge, according to a criminal complaint filed in Fairbanks District Court. The package allegedly contained nearly half a kilogram of methamphetamine.

Fairbanks police, Drug Enforcement Administration agents and Alaska State Trooper investigators from the Statewide Drug Enforcement Unit removed 400 of the 454 grams of methamphetamine, resealed the package and with the help of postal workers, again delivered it to the Baranof Avenue address.

This time, the 19-year-old was there to accept it, investigators wrote in the criminal complaint. He left the house within a few minutes in a 1988 Nissan pickup truck.

Police stopped him on Trainor Gate Road and found the package and the drugs behind the seat, according to court records.

Everson was arrested about 2:15 p.m. and charged with third-degree misconduct involving a controlled substance and driving with a revoked license.

The state has since dropped those charges to allow federal authorities to take over the case. Everson is being held without bail at Fairbanks Correctional Center, jail staff said Thursday evening.



PARK FUTURE—Sue Deyoe, right, of Denali Park, looks at a map of Denali with South District Park Ranger J.D. Swed Thursday afternoon in the Noe Park Service was holding an open house meeting to share information on issues and options.

Assembly sets hearing on rifle

Job hunting

The Meth Monster

Combatting the homemade drug methamphetamine is proving to be a difficult and costly job for law enforcement agencies in many states.

BY ELLEN PERLMAN

Bill Hardin, drug director in the Arkansas governor's office, doesn't mince words. "We're in an epidemic condition with this," he says. "It's devastating local law enforcement budgets." Hardin isn't referring to heroin or cocaine or marijuana. The main drug of choice these days in Arkansas is methamphetamine.

The manufacture and use of "meth" or "crank," as the synthetic drug is known on the street, has skyrocketed in Arkansas during the past five years. In 1994, law enforcement officers there got about 25 reports about the existence of methamphetamine labs where people "cook" the drug. In 1997, there were 444 such reports. By mid-November of last year, more than 500. "It is our main criminal activity in

Arkansas at this time," Hardin says.

The problem is hardly confined to Arkansas. Since meth first came on the scene in California more than a decade ago, it has been spreading inexorably eastward. Prior to 1997, Illinois had no record of meth lab seizures; there weren't enough to warrant keeping track. Since then, however, the state has taken action against more than 100. Missouri state police raided 524 clandestine labs between January and October of last year. "We're second only to California," says Tom Taylor, a lieutenant with the Missouri State Highway Patrol.

While the drug is not yet commonly found in the East, the White House Office of National Drug Control Policy sees indications that it's headed that way. Realizing that they are facing a drug trade with

dangers like no other, many states are strengthening laws and lengthening punishments in order to fight back.

ALTHOUGH A PURE FORM of meth comes from Mexico, users don't have to wait on a foreign connection. Anyone with a recipe, which is not difficult to find on the Internet, can produce it. "It's like making a cake," says Walter Allen III, special agent in charge at the Bureau of Narcotic Enforcement in California's Department of Justice. "It's really simple." For less than \$100, a manufacturer can produce about \$2,000 worth of meth.

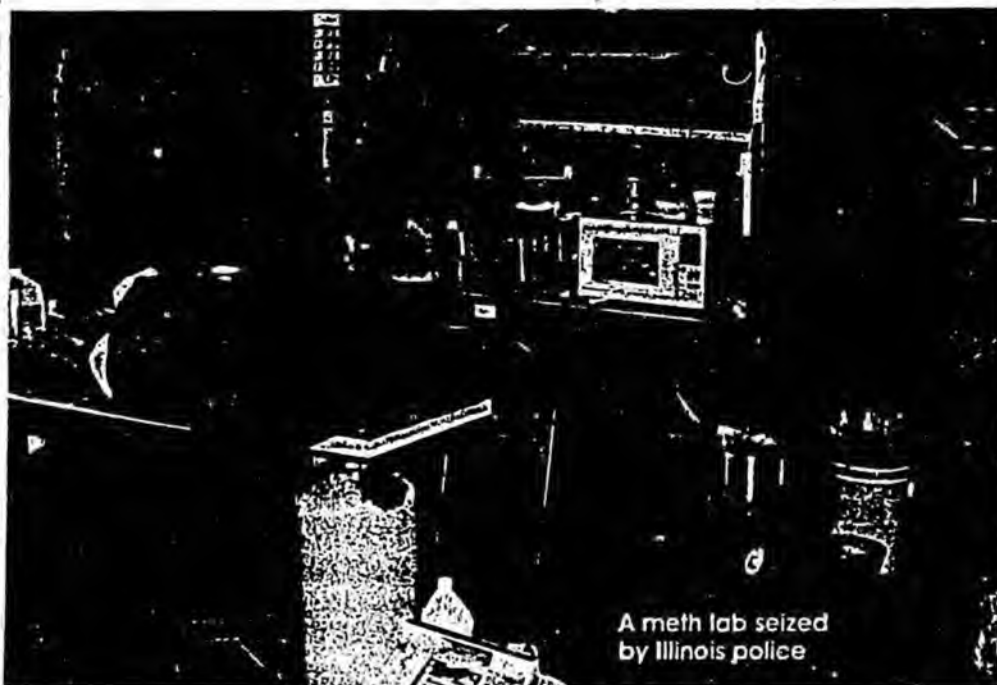
Meth is concocted from a variety of legal ingredients that are easy to obtain, including battery acid, drain cleaner, lye, lantern fuel, antifreeze, hydrochloric acid, sulfuric acid, ethyl ether or red phosphorus, which can be found in matchstick tips. The high comes from the essential ingredient, ephedrine, a substance that can be extracted from over-the-counter cold medicines.

Another key component is typically found on Midwestern farms. Meth makers have been caught sneaking up to the nozzles on large tanks that hold anhydrous ammonia, a fertilizer, to transfer the chemical into small butane bottles or emptied fire extinguishers. If done carelessly, the hazardous substance can spill or the tank can blow up, releasing deadly fumes.

Usually meth is cooked up crudely in kitchens, garages, motels, trailers or trucks, generally somewhere out in the sticks. In more densely populated places, meth makers are at much greater risk of being discovered because the cooking process has a strong and awful smell, similar to cat urine or nail polish remover.

All of these factors have facilitated meth manufacturing and use throughout rural areas that don't typically get bowled over by "urban" drugs. Crack cocaine can, of course, be found in a few pockets in Little Rock. But methamphetamine has spread to 75 counties in Arkansas.

For law enforcement, it's trouble from start to finish. Not surprisingly, meth labs are much easier for manufacturers to set up than they are for state officials to close down. In fact, cleaning up a lab is similar to responding to a hazardous chemical spill.



A meth lab seized by Illinois police

Each pound of meth generates five to six pounds of toxic waste. State workers need training and equipment to do a proper clean-up. And they must find a place to dispose of the hazardous materials. It usually costs from \$5,000 to \$10,000 each time, but there have been much more expensive clean-ups, too. Although that

readily stock up on certain types of cold medicine. Governor Gray Davis signed a statewide measure last fall that limits the amount of these drugs that can be purchased to two packages per buyer per day.

Law enforcement officers know it won't stop the lawbreakers but it is likely to slow them down. "We're able to ride herd on

cers to make more meth arrests, meth makers near state borders moved into Illinois, Kentucky and Tennessee.

Last year, in response, Illinois increased prison time for manufacturing, delivering or possessing meth with intent to distribute it. The state also made it a misdemeanor to tamper with anhydrous ammonia equipment, containers or storage facilities.

Although the increasing number of meth lab seizures makes it seem as though the problem has been getting worse and worse, it may be that the problem has been bad for quite awhile but states did not recognize it. If a state finds 10 labs one year and 50 labs the next, it doesn't necessarily mean the problem has gotten five times

worse, explains Missouri's Taylor. "They were probably out there before, but since we weren't focusing on them we didn't find them," he says.

In addition to dealing with the labs, states also must grapple with the consequences of thousands of people who are hooked on meth. Used predominantly by white teens and young adults, meth is known as the "poor man's cocaine" since it is more accessible and less expensive than cocaine. Sold in pill, capsule, powder or chunk form, meth can be smoked, snorted, injected or swallowed and provides a longer-lasting high than other drugs.

Because meth alleviates fatigue and produces feelings of mental alertness, some people use it to work longer hours. It's also popular among women, who take it as an appetite suppressant.

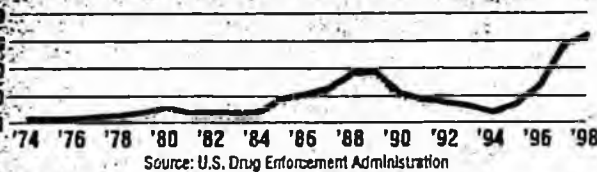
Meth is the most addictive of all drugs. Users get a rush when they take it but quickly develop a tolerance. Then they have to up the ante, taking more for it to work. The stimulation from meth leads to sleep difficulty and psychological problems for users. Nerve endings die, creating sensations like bugs crawling under the skin. Users can become violent or paranoid and commit serious crimes.

Yet in a five-city study of meth users, only 28 percent ever tried to get treatment for their addiction. Most said they didn't bother because they perceived that they had control over their drug use. "We're only beginning to see the impact of the meth monster," says Hardin. "What in the world are we going to do with all these people?"



Tip of the Iceberg

The number of meth lab seizures by the federal Drug Enforcement Administration shown below tell only part of the story. They do not account for seizures made solely by state and local law enforcement agencies.



money comes from the federal Drug Enforcement Administration, state crime lab personnel do the work. They're the same people who must also respond to homicides, rapes and other serious crimes.

With some 500 meth labs uncovered last year in Arkansas, "it's completely overwhelmed the state crime lab," says Hardin. Because the state is short of money and manpower to attack the problem, it has turned for help to the 20 local drug task forces made up of local law enforcement personnel. Still, it's not enough.

The Midwest is now experiencing what California has been dealing with since the late 1980s, when meth manufacture and use started to proliferate with outlaw biker gangs. "Southern California is basically known as the meth capital of the world," Allen says. "The jailhouse recipe has flourished to the point where everyone and his mother makes it."

Of the more than 3,200 labs found nationwide in 1998, 55 percent were in California. Of those, 71 percent were in the four Southern California counties of Orange, Los Angeles, Riverside and San Bernardino. "In the last seven years, it has almost gotten out of hand," Allen says.

States are trying to clamp down on its spread by tightening laws and toughening penalties, educating the public about the dangers, training social workers, educators and other professionals to identify users, and expanding treatment availability.

On the surface, some laws can seem odd. In California, no matter how bad their sniffles or congestion, residents cannot

individuals who buy bulk quantities of cold medicine, so we won't have the typical Beavis and Butt-Head labs popping up in communities," says Allen. Although pleased with the passage of the cold medicine law, he would like to see the state pass much stiffer punishments for meth cooks. "I'd like to see all these people get hammered for all the devastation they create," he adds.

Arkansas has been cracking down with harsher penalties. Last year, the state not only made possessing the ingredients for meth with the intent to "manufacture" the drug a felony, it also required that a person convicted for the offense must serve at least 70 percent of his sentence. The 70-percent rule was created for crimes such as murder, rape and aggravated robbery. Meth is the only drug that falls under the requirement.

Other provisions prohibit possession of anhydrous ammonia in containers that don't comply with federal regulations and authorize Arkansas counties to form multi-jurisdictional drug enforcement groups with county agencies in neighboring states. "We can move freely across state lines, just as freely as the drug manufacturers do," says Hardin. Arkansas also is directing federal money for the next two years to train drug task force officers and provide symposiums around the state on methamphetamine use.

States without stringent laws have found that when adjoining states crack down, meth manufacturers scurry like rats across state lines. When Missouri got tough in 1998, passing laws enabling offi-

Meth Links

Long Term Eff

Slang Name

Meth Labs

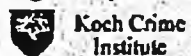
Meth Facts

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High Intensity Drug Trafficking Area

STOP

Methamphetamine Frequently Asked Questions

Q: What is Methamphetamine?

A: Methamphetamine is a powerful central nervous system stimulant. A synthetic drug, methamphetamine has a high potential for abuse and dependence. It is illegally produced and sold in pill form, capsules, powder and chunks. Methamphetamine was developed early in this century from its parent drug amphetamine and was originally used in nasal decongestants, bronchial inhalers, and in the treatment of narcolepsy and obesity. In the 1970s methamphetamine became a Schedule II drug - a drug with little medical use and a high potential for abuse.

Q: What are the street names for methamphetamine?

A: The drug is referred to by many names including "meth," "speed .. crank," "chalk," "go-fast," "zip," and "cristy." Pure methamphetamine hydrochloride, the smokeable form of the drug, is called "L.A." or - because of its clear, chunky crystals which resemble frozen water - "ice," "crystal," "64glass," or "quartz." Since the 1980s, ice has been smuggled from Taiwan and South Korea into Hawaii, where use became widespread by 1988. By 1990, distribution of ice had spread to the U.S. mainland.

Q: Where is meth manufactured and distributed?

A. Methamphetamine is both domestically produced and imported into the U.S. in already processed form. Once dominated by motorcycle gangs and other local producers in remote areas of California and the Pacific Northwest, the market now includes both local producers and Mexican sources providing finished product to stateside distributors.

Q: Is methamphetamine use in the Midwest increasing?

A. Methamphetamine has become the drug of choice in the Midwest. Within the last five years, meth use has increased in some communities by as much as 300 percent, accounting for up to 90 percent of the drug cases in many areas.

Q: Why is meth use so prevalent in the Midwest?

A: The region's methamphetamine epidemic stems from two problems:

- steadily increasing importation of methamphetamine into the region by organized trafficking groups; and
- clandestine manufacturing of methamphetamine by hundreds of users/dealers in small "mom and pop" labs.

Seizures of clandestine labs in the Midwest have increased from 44 in 1995 to more than 500 in 1997. In fact, the state of Missouri led the nation in 1997 in the number of meth labs seized.

Twenty Mexican methamphetamine trafficking organizations have been identified by DEA as being involved in the Midwest, which is connected via major interstate highways, rail and air to the West and Southwest border areas that serve as importation, manufacturing and staffing areas for the Mexican operations.

Q. How is meth made?

A. The processing required to make methamphetamine from precursor substances is easier and more accessible than ever. There are literally thousands of recipes and information about making meth on the Internet. An investment of a few hundred dollars in over-the-counter medications and chemicals can produce thousands of dollars worth of methamphetamine. The drug can be made in a makeshift "lab" that can fit into a suit case. The average meth "cook" annually teaches ten other people how to make the drug.

Q. Where are these labs found?

A. Clandestine labs known as "mom and pop" labs are found in rural, city and suburban residences; barns, garages and other outbuildings; back rooms of businesses; apartments; hotel and motel rooms; storage facilities; vacant buildings; and vehicles.

Q. What ingredients are used to make meth?

A. Over-the-counter cold and asthma medications containing ephedrine or pseudoephedrine, red phosphorous, hydrochloric acid, drain cleaner, battery acid, lye, lantern fuel, and antifreeze are among the ingredients most commonly used.

Q. What are precursor substances?

A: Precursors are substances that, in nature, might be inactive. However, when combined with another chemical the result is a new product. Methamphetamine starts with an inactive or marginally-inactive compound (ephedrine or pseudoephedrine) and other chemicals are added to produce the drug.

Q. How much does meth cost on the street?

A. The cost varies according to several factors, including purity of the drug, the region in which it is sold, the source of the drug (local product vs. imported) and availability of the drug. The approximate prices are:

\$25 per 1/4 gram
\$ 100 per gram
\$1700 per ounce

Experts estimate that one ounce of meth equals about 110 meth "hits."

The following prices were provided by a dealer on June 29, 1998.	The following prices are provided by a dealer on January 31, 1999.
1/32 of an ounce \$50.00	1/32 of an ounce \$30.00
1/16 of an ounce \$80.00-\$100.00	1/16 of an ounce \$50.00
1/8 of an ounce approx \$150.00	1/8 of an ounce approx \$65-80.00
1/4 of an ounce approx \$250.00	1/4 of an ounce approx \$125.00
1/2 of an ounce approx \$400.00-450.00	1/2 of an ounce approx \$225-300
1 ounce approx \$650.00-\$800.00 depending on quality	

Q. Who is using methamphetamine?

A. There are two basic profiles of users reported by law enforcement and treatment providers:

- students, both high school and college age; and
- white, blue-collar workers and unemployed persons in their 20s and 30s.

Use is widely prevalent in both urban and rural areas and equally divided among males and females. Women are more likely to use methamphetamine than cocaine. Some areas of the Midwest are seeing an increase in the number of Hispanic and Native American meth users, though whites are still the most dominant users of the drug.

Q. Are teenagers using the drug?

A. The drug is becoming more popular among persons 18 years and younger, as studies show teenagers perceive methamphetamine as safer, longer lasting and easier to buy than cocaine. The "Monitoring the Future" survey, which measures the extent of drug use among U.S. adolescents, found methamphetamine use among high school seniors more than doubled between 1990 and 1996. In addition, law enforcement officials have caught teens as young as 14- and 15-year-olds using and selling the drug.

Q. Why should I talk to my child about meth?

A. Teens whose parents talk to them about drugs are half as likely to use drugs as those whose parents do not speak to them on this topic.

Q: Why do people start using methamphetamine?

A: Athletes and students sometimes begin using meth because of the initial heightened physical and mental performance the drug produces. Blue collar and service workers may use the drug to work extra shifts, while young women often begin using meth to lose weight. Others use meth recreationally to stay energized at "rave" parties or other social activities. In addition, meth is less expensive and more accessible than cocaine and users often have the misconception that methamphetamine is not really a drug.

Q: Is meth used in combination with other drugs?

A: Methamphetamine users are likely also to be users of alcohol, marijuana and cocaine rather than users of drugs like heroin.

Q. Are there any legitimate uses for methamphetamine?

~~A: In some cases, doctors prescribe low doses of methamphetamine for narcolepsy and attention deficit disorder.~~

Q: How is methamphetamine administered?

A: It can be smoked, taken intranasally (snorted), injected intravenously or ingested orally. The practice of "eating" meth by putting it on paper or food and chewing it also has been reported.

Q: What happens immediately after a person takes methamphetamine?

A: The drug alters mood in different ways, depending on how it is taken. Immediately after smoking or intravenous injection, the user experiences an intense "rush" or "flash" that lasts only a few minutes and is described as extremely pleasurable. Smoking or injecting produces effects fastest, within five to ten seconds. Snorting or ingesting orally produces euphoria - a high but not an intense rush. Snorting produces effects within three to five minutes, and ingesting orally produces effects within 15 to 20 minutes.

Q: How does the drug effect users overall?

A: In all forms, the drug stimulates the central nervous system, with effects lasting anywhere from four to 24 hours. Methamphetamine use can not only modify behavior in an acute state, but after taking it for a long time, the drug literally changes the brain in fundamental and long-lasting ways. It kills by causing heart failure (myocardial infarction), brain damage, and stroke and it induces extreme, acute psychiatric and psychological symptoms that may lead to suicide or murder.

Q: What are the short-term effects?

A: Central Nervous System Side Effects

Even small amounts of methamphetamine can produce euphoria, increased alertness, paranoia, decreased appetite and increased physical activity. Other central nervous system effects include athetosis (writhing jerky, or flailing movements), irritability, extreme nervousness, insomnia, confusion, tremors, anxiety, aggression, incessant talking, hyperthermia, and convulsions. Hyperthermia (extreme rise in body temperature as high as 108 degrees) and convulsions sometimes can result in death.

Cardiovascular Side Effects

Use can produce chest pain and hypertension which can result in cardiovascular collapse and death. In addition, methamphetamine causes accelerated heartbeat, elevated blood pressure and can cause irreversible damage to blood vessels in the brain.

Other Physical Effects

Pupil dilation, respiratory disorders, dizziness, tooth grinding, impaired speech, dry or itchy skin, loss of appetite, acne, sores, numbness, and sweating.

Psychological Effects

Symptoms of prolonged meth abuse can resemble those of

schizophrenia and are characterized by anger, panic, paranoia, auditory and visual hallucinations, repetitive behavior patterns, and ~~formication (delusions of parasites or insects on the skin)~~

Methamphetamine-induced paranoia can result in homicidal or suicidal thoughts.

Q: What other long-term effects can result?

A: Fatal kidney and lung disorders, brain damage, liver damage, blood clots, chronic depression, hallucinations, violent and aggressive behavior, malnutrition, disturbed personality development, deficient immune system, and methamphetamine psychosis, a mental disorder that may be paranoid psychosis or may mimic schizophrenia.

Q: How much of the drug can cause an overdose?

A: A toxic reaction (or overdose) can occur at relatively low levels, 50 milligrams of pure drug for a non-tolerant user. Metabolic rates vary from person to person, and the strength of the illegal form of the drug varies from batch to batch, so there is no way of stating a "safe" level of use. In overdose, high fever, convulsions and cardiovascular collapse may precede death. Because stimulants effect the body's cardiovascular and temperature-regulating systems, physical exertion increases the hazards of meth use.

Q: What effect does methamphetamine use have on pregnancy?

A: Babies can be born methamphetamine addicted and suffer birth defects, low birth weight, tremors, excessive crying, attention deficit disorder, and behavior disorders. There is also an increased risk of child abuse (including "shaken baby syndrome") and neglect of children born to parents who use methamphetamine.

Q: What are some signs that a person may be using the drug?

A: The person may exhibit anxiousness; nervousness; incessant talking; extreme moodiness and irritability; purposeless, repetitious behavior, such as picking at skin or pulling out hair; sleep disturbances; false sense of confidence and power; aggressive or violent behavior; disinterest in previously enjoyed activities; and severe depression.

Q: If methamphetamine is so dangerous, why can physicians prescribe the drug to patients?

A: The key is the dosage. Methamphetamine abusers use much higher dosages of the drug than a physician would routinely prescribe when treating a patient.

Q: Why is methamphetamine addictive?

A: All addictive drugs have two things in common: they produce an initial pleasurable effect, followed by a rebound unpleasant effect. Methamphetamine, through its stimulant effects, produces a positive feeling, but later leaves a person feeling depressed. This is because it suppresses the normal production of dopamine, creating a chemical imbalance. The user physically demands more of the drug to return to normal. This pleasure/tension cycle leads to loss of control over the drug and addiction.

Q: How does methamphetamine take over one's life?

A: Methamphetamine short-circuits a person's survival system by

artificially stimulating the reward center, or pleasure areas in the brain. This leads to increased confidence in meth and less confidence in the normal rewards of life. This happens on a physical level at first, then it affects the user psychologically. The result is decreased interest in other aspects of life while reliance and interest in meth increases. In one study, laboratory animals pressed levers to release methamphetamine into their blood stream rather than eat, mate, or satisfy other natural drives. The animals died of starvation while giving themselves methamphetamine even though food was available.

Q: Is there methamphetamine withdrawal?

A: Yes. The severity and length of symptoms vary with the amount of damage done to the normal reward system through methamphetamine use. The most common symptoms are: drug craving, extreme irritability, loss of energy, depression, fearfulness, excessive drowsiness or difficulty in sleeping, shaking, nausea, palpitations, sweating, hyperventilation, and increased appetite.

Q: Is methamphetamine addiction difficult to treat?

A: Several treatment providers describe methamphetamine abusers as "the hardest to treat" of all drug users. They are often overly excitable and "extremely resistant to any form of intervention once the acute effects of meth use have gone away." Meth addicts get over the acute effects of withdrawal fairly quickly. However, the "wall" period lasts 6-8 months. This is a period of prolonged abstinence during which the brain recovers from the changes resulting from meth use. During this period, recovering addicts feel depressed, fuzzyheaded, and think life isn't as pleasurable without the drug. Because prolonged use causes changes in the brain, willpower alone will not cure meth addicts.

Q: Is relapse common?

A: Yes. Because there are psychiatric, social, and biological components to meth dependence, there is a high likelihood of relapse. Key relapse issues are similar to that of cocaine use and include other substance abuse and being around drug-using friends.

Q: What prompts methamphetamine users to enter treatment?

A: Methamphetamine causes a variety of mental, physical, and social problems which may prompt entry into treatment. Though not as expensive as heroin and cocaine, its cost might also produce financial problems for users and prompt them to seek help. However, the most commonly reported reason why methamphetamine users enter treatment is trouble with the law. These legal problems include aggressive or bizarre behaviors which prompt others to call police. Other reasons for entry include mental or emotional problems and problems at work or at school.

Q: How does the cost of treating meth users compare to incarceration?

A: Treatment is a highly cost-effective alternative; it is about one-tenth of the cost to treat a person rather than putting him or her in jail.

Q: What other problems does methamphetamine pose to society?

A: Automobile accidents; explosions and fires triggered by the illegal manufacture of methamphetamine; environmental contamination; increased criminal activity, including domestic violence; emergency room and other medical costs; spread of infectious disease, including

HIV, AIDS and hepatitis; and lost worker productivity. Economic costs also fall on governments, which must allocate additional resources for social services and law enforcement.

Q: How is the production of meth more dangerous than other drugs?

A: Meth trafficking and production are different than other drugs because they are dangerous from start to finish. The reckless practices of the untrained people who manufacture it in clandestine labs result in explosions and fires that injure or kill not only the people and families involved, but also law enforcement or fireman who respond. Any number of solvents, precursors and hazardous agents are found in unmarked containers at these sites. These potent chemicals can enter the central nervous system and cause neural damage, effect the liver and kidneys, and burn or irritate the skin, eyes and nose. Environmental damage is another consequence of these reckless actions, and violence is often a part of the process as well.

Q. What are the most serious environmental consequences of meth labs?

A: Each pound of meth produced leaves behind five or six pounds of toxic waste. Meth cooks often pour leftover chemicals and byproduct sludge down drains in nearby plumbing, storm drains, or directly onto the ground. Chlorinated solvents and other toxic byproducts used to make meth pose long-term hazards because they can persist in soil and groundwater for years. Clean-up costs are exorbitant because solvent contaminated soil usually must be incinerated.

Q: What is the cost of a cleaning up a clandestine meth lab site?

A: Cleanups of labs are extremely resource-intensive and beyond the financial capabilities of most jurisdictions. The average cost of a cleanup is about \$5,000 but some cost as much as \$150,000.

Q: What are the federal penalties for methamphetamine trafficking?

A: The basic, mandatory minimum sentences under federal law are:

- 10 grams (pure) = 5 years in prison
- 100 grams (pure) = 10 years in prison.

Q: What is the Comprehensive Methamphetamine Control Act of 1996?

A: This federal legislation takes significant steps toward preventing meth from becoming the next crisis in drug abuse. The bill:

- Permits the domestic seizure and forfeiture of methamphetamine precursor chemicals.
- Directs the Attorney General to coordinate international drug enforcement efforts to interdict such chemicals.
- Increases penalties for the possession of equipment used to make controlled substances, and for trafficking in certain precursor chemicals.
- Requires an interagency task force to develop and implement prevention, education and meth treatment strategies.

Q: What is Midwest HIDTA?

A: High Intensity Drug Trafficking Areas (HIDTAs) are areas identified

by the Office of National Drug Control Policy (ONDCP) as having the most critical drug trafficking problems adversely impacting the U.S. The Midwest HIDTA, which includes Iowa, Kansas, Missouri, Nebraska and South Dakota, was created specifically to fight the spread of meth in the Midwest. It promotes a comprehensive, cooperative strategy by law enforcement at the federal, state and local levels to reduce drug trafficking.

Q: What do I look for if I suspect a meth lab in my neighborhood?

A: Unusual, strong odors similar to the that of fingernail polish remover or cat urine; renters who pay cash; large amounts of products such as cold medicines, antifreeze, drain cleaner, lantern fuel, coffee filters, batteries, duct tape, clear glass beakers and containers; and residences with windows blacked out and lots of nighttime traffic.

Q: How do I report a suspected methamphetamine lab or find help for someone who is using meth?

A: Call the Crank Hotline at 1-888-664-4673. (This number is only good for residents of Nebraska, Iowa, Kansas, South Dakota and Missouri)

This Methamphetamine FAQ was written by:

MIDWEST

HIDTA

Nebraska - Iowa - Kansas - South Dakota - Missouri

High Intensity Drug Trafficking Area

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MEMORANDUM ALASKA PUBLIC DEFENDER AGENCY

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TO: Representative Tom Brice
Alaska House of Representatives

Senator Robin Taylor
Chairman Senate Judiciary Committee
Alaska State Senate

FROM: Blair McCune, Deputy Public Defender

RE: HB 3 – Precursor chemicals
Senate Judiciary – Friday, January 21st.

DATE: January 20, 2000

=====

The Public Defender Agency commented on this bill in the House last year. We still feel the bill has problems, especially in the level of the offenses it creates.

We believe that Section 1 of the bill, which makes the conduct a class A felony, is out of synch with other Alaska drug laws. Presently, manufacture of methamphetamines is a class B felony. The bill makes it a class A felony. It also makes possession of any amount of an "immediate precursor" of methamphetamine a class A felony. Finally, possession of any amount of "listed chemicals" is a class A felony.

Although the desire to increase penalties for setting up a large-scale "meth lab" is understandable, this bill makes possession of any amount of the chemicals a class A felony. There should be some recognition that possessing a large quantity of these chemicals is more serious than possessing only a small amount. If provisions on quantities were added, the bill would differentiate between defendants who are preparing for or engaging in a large-scale drug manufacturing operation and misguided individuals who possess small quantities of listed substances with the intent of trying to make a small amounts of drugs.

It would be better to follow the Federal Sentencing Guidelines, which make the offense more serious depending on the amount of the substances possessed. The Guidelines have a detailed table setting out quantities of substances and recommending different sentences based on quantities possessed. The Federal Sentencing Guidelines can be found at <http://www.ussc.gov/1998guid/tabcon98.htm>.



Teleconference Participants

TCN: 10690

Participant Lists

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 Bill:

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 Bill: HB 272: MUNICIPAL TAX: LOW INCOME HOUSING

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 Bill: HJR 56: CONST. AM: WILDLIFE INITIATIVES

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GLENNALLEN (GLN)

1 ✓ Name:Mr. Joseph Hart Phone:

Message

Date: Friday Apr 07, 2000

Time: 9:03 AM

To: JUNEAU

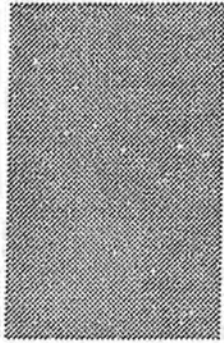
From: JEAN MILLER

TC Number: 10690

Message: Ben Hopson Jr./Barrow is on line to testify on HJR 56. Janice Adair/DEC/Anchorage is on line to testify on SB 271. Jean/Bridge

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HB

10

HFIN

FILE

HOUSE COMMITTEE REPORT

(11)

Date Referred to Committee: February 10, 1999

FURTHER REFERRALS:

Date of Committee Action: 2/10/99

The FINANCE Committee considered:

HB 10

HOUSE BILL NO. 10

EXTEND CERTIFIED DIRECT-ENTRY MIDWIVES BD

"An Act extending the termination date of the Board of Certified Direct-Entry Midwives; and providing for an effective date."

recommends it be replaced the same title
 with the following committee substitute _____ a new title

additional referral to _____ Committee
 attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) _____ APPROVES PREVIOUS: (Dept/Date) _____
 fiscal note(s) _____ fiscal note(s) _____
 zero fiscal note(s) _____ zero fiscal note(s) DCED 2/10/99

SIGNING WITH RECOMMENDATIONS	DP	DNF	NR	AM
<i>Care Theriault</i> Theriault	X			
<i>John Mulder</i> Mulder	/	/		
<i>Tom Bunde</i> Bunde	/			
<i>Vic Kohring</i> Kohring	X			
<i>J. Davies</i> J. Davies	X			
<i>grussindorf</i> grussindorf	X			
<i>J. Davis</i> J. Davis	X			
<i>Williams</i> Williams	X			

CHAIR'S SIGNATURE *Care Theriault* *John Mulder*
Theriault mulder

FISCAL NOTE

Bill Version: HB 10

(H) Publish Date: 2/10/99

**STATE OF ALASKA
1999 LEGISLATIVE SESSION**

Revision Date/Time (Note if correction) _____ Dept. Affected Commerce & Econ Dev.
 Title An Act extending the termination of the BRU Occupational Licensing
Board of Certified Direct-Entry Midwives Component Occupational Licensing
 Sponsor Representative Hudson
 Requester House Health, Education and Social Services Component Serial No. 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ()	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY99) cost: 12.6

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

HB 10 extends the Board of Certified Direct-Entry Midwives to June 30, 2003. Funding for continuation of the board in the amount of \$12.6 is included in the department's FY 2000 operating budget request; therefore, new funds are not needed. The program is required to cover its costs with licensing fees under AS 08.01.065, and revenue generated by board fees are anticipated to cover its full operating costs.

Prepared by Jennifer Strickler, Administrative Manager Phone 465-2144
 Division Occupational Licensing Date/Time 2/3/99 1:46 PM
 Approved by Commissioner Deborah B. Sedwick Date 2/3/99
 Agency Commerce & Economic Development

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BOARD COSTS
INFORMATION

HB 10				
DIRECT COSTS			Total	AVG
FY:	97	98	DIRECT	ANNUAL
				COSTS
Personal Services	11.3	6.7	18.0	9.0
Travel;	0.7	2.6	3.3	1.7
Contractual Services	1.6	2.3	3.9	2.0
Commodities	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0
	13.6	11.6	25.2	12.6

House Bill 10: Extending the Termination Date of the Board of Direct-Entry Midwives 1999-2003

In spite of some current confusion about the intricacies of "economy of scale" in licensing Certified Direct-Entry Midwives (CDM's), Alaska remains, remarkably, among the forerunners in a worldwide movement to establish the Midwifery Model of Care as a safe and economical alternative choice to the medical model.

If you are familiar with this subject, you know that:

Alaska's infant mortality rate is even higher than the national average which ranks 22nd among developed nations.

Increasing the use of midwifery services improves birth outcomes considerably.

The five nations with the lowest infant mortality use midwives for 70% of their births, while midwives in the US attend only 5% of our births.

Immediate savings to the existing Medicaid program will result from using a birthing alternative that costs less than half of the medical model.

Alaska loves its midwives; the legislature has overwhelmingly supported the establishment of a CDM licensing board (1992), the intention to provide Medicaid funding to CDM services (1993) and the funding of Medicaid Reimbursement to CDMs.

Last year during the review of Senate Bill 238, the "Sunset Bill" for the CDM board, there was discussion over the high cost of licensing fees, currently \$1550 for a two-year period. The auditors were concerned that higher fees might serve as a barrier to those trying to enter the profession and that no one seemed to have any suggestions for remedying the situation.

One obvious remedy was the passing of last year's HB 459 which moved CDM's into a position to receive third party reimbursement in the form of Medicaid funding, accomplishing the following:

Begin the process of saving Medicaid funds for the state – an estimated 57% or more per birth. Each year there are 4500 pregnant women eligible for Medicaid who currently have access *only* to the medical model.

Improve birth outcomes by lowering infant mortality.

Provide economic incentive for more midwives seeking licensure – thus removing the current restraint of trade situation.

With growing numbers of CDM's, the price per license will drop.

Public awareness of the profession will make it more difficult for unlicensed practitioners to find work, thereby cutting down on enforcement costs.

The nations noted above with the most successful maternal and child health care programs have the following in common:

Early and continuous pre-natal care. (In AK, the Midwifery Model of Care)

Universal health coverage. (In AK, Medicaid for low income families)

Reciprocity between the midwifery and medical communities. (In AK, two of the five CDM Board members are medical professionals.)

Passing House Bill 10 will go a long way toward ensuring these conditions for Alaskan families. Fostering a population of healthy infants born to healthy mothers is a win-win situation for everyone. The Midwifery Model of Care promotes family bonding as well as individual responsibility. Statistically, midwifery saves lives and will continue to save the State of Alaska increasing amounts of money. CDM's have willingly borne the high costs of licensure in order to sustain their regulated status and allow their profession to grow. Extending the termination date of the Board of Certified Direct-Entry Midwives until June 30th, 2003 will ensure the continued growth of this valued profession in Alaska.

Prepared by: Marilyn Holmes, Citizens for Midwifery and Secretary of the Board of Direct-Entry Midwives.

Alaska State Legislature



Representative Bill Hudson

State Capitol
Juneau, Alaska
99801-1182
Phone: (907) 465-3744
Fax: (907) 465-2273

Committees:
Chair
Fisheries
Utilities Restructuring
Member
Transportation
State Affairs

SPONSOR STATEMENT

HB 10: BOARD OF CERTIFIED DIRECT-ENTRY MIDWIVES

Ch. 130, SLA 1992 established the Board of Certified Direct Entry Midwives (CDM's). HB 10, if enacted, would extend the board operation for another 4 years to June 30, 2003.

The duties of this regulating board include; examining applicants and issuing certificates to qualified applicants, issuing permits to apprentice direct entry midwives, reporting annually to the Governor and the Department, and approving curricula and adopting standards for basic education, training and apprentice programs.

Alaska's infant mortality rate is even higher than the national average which ranks 22nd among developed nations. Increasing the use of midwifery services has been shown to improve birth outcomes considerably. The legislature, in a strong move of support last session, moved midwifery services up on the Medicaid eligibility list. This new listing will insure that these important services, which cost less than half of the Medical Model, will be funded.

Alaska is currently among the forerunners in the worldwide movement to establish a Midwifery Model of Care as an alternative choice to the Medical Model. The board is currently in its wind down year, so if this board is to continue its work, HB 10 must pass this session.

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. HB 10

Revision Date/Time (Note if correction) _____	Dept. Affected <u>Commerce & Econ Dev.</u>
Title <u>An Act extending the termination of the</u>	BRU <u>Occupational Licensing</u>
<u>Board of Certified Direct-Entry Midwives</u>	Component <u>Occupational Licensing</u>
Sponsor <u>Representative Hudson</u>	
Requester <u>House Health, Education and Social Services</u>	Component Serial No. <u>2360</u>

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()	0.0	0.0	0.0	0.0	0.0	0.0
-------------------------------	------------	------------	------------	------------	------------	------------

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY99) cost: 12.6

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)
 HB 10 extends the Board of Certified Direct-Entry Midwives to June 30, 2003. Funding for continuation of the board in the amount of \$12.6 is included in the department's FY 2000 operating budget request; therefore, new funds are not needed. The program is required to cover its costs with licensing fees under AS 08.01.065, and revenue generated by board fees are anticipated to cover its full operating costs.

Prepared by <u>Jennifer Strickler, Administrative Manager</u>	Phone <u>465-2144</u>
Division <u>Occupational Licensing</u>	Date/Time <u>2/3/99 1:46 PM</u>
Approved by Commissioner <u>Deborah B. Sedwick</u>	Date <u>2/3/99</u>
Agency <u>Commerce & Economic Development</u>	

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**BOARD COSTS
INFORMATION**

HB 10				
DIRECT COSTS			Total	AVG
FY:	97	98	DIRECT	ANNUAL
				COSTS
Personal Services	11.3	6.7	18.0	9.0
Trave;	0.7	2.6	3.3	1.7
Contractual Services	1.6	2.3	3.9	2.0
Commodities	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0
	13.6	11.6	25.2	12.6

Midwifery in the United States

Midwives are recognized throughout the world as the most appropriate maternity care provider for most women. Midwifery licensure and scope of practice in the United States is regulated by individual state laws. The following three categories of professional midwives are recognized in the United States:

Direct-Entry Midwives

"Direct-entry" midwives, who are licensed in some states, are not required to become nurses before training to be midwives. The Midwifery Education and Accreditation Council (MEAC) is currently accrediting direct-entry midwifery educational programs and apprenticeships in the United States. Direct-entry midwives' legal status varies according to state, and they practice most often in birth centers and in homes.

Certified Professional Midwives

Certified Professional Midwives (CPMs) may gain their midwifery education through a variety of routes. They must have their midwifery skills and experience evaluated through the North American Registry of Midwives (NARM) certification process and pass the NARM Written Examination and Skills Assessment. The legal status of these nationally credentialled direct-entry midwives varies from state to state. In some of the states where they are also individually licensed, midwives' services are reimbursable through Medicaid and private insurance carriers.

Certified Nurse-Midwives

Certified Nurse-Midwives (CNMs) are educated in both nursing and midwifery. After attending an educational program accredited by the American College of Nurse-Midwives Certification Council (ACC), they must pass the ACC examination and can be licensed in the individual states in which they practice. Certified nurse midwives practice most often in hospitals



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For more information contact:

Midwives' Alliance of North America
PO Box 175 • Newton, KS 67114
316-283-4543

North American Registry of Midwives
PO Box 41705 • Nashville, TN 37204
615-964-3996

Midwifery Education
and Accreditation Council
Drawer SSS • Taos, NM 87571
505-758-1216

American College of Nurse-Midwives
1522 K Street • Suite 1000
Washington, DC 20005
202-298-0171

Kaye Kanne, CDM
PO Box 22707
Juneau, AK 99802
(907)586-1203

What Is A Midwife?



© Ina May Gaskin

*A Midwife is
recognized throughout
the world as the most
appropriate maternity
care provider for
most women.*

A Midwife is . . .

. . . a trained professional who offers expert care, education, counseling and support to a woman and her newborn during the childbearing cycle. The midwife works with each woman and her family to identify their unique physical, social, and emotional needs. In addition, many midwives provide well-woman gynecological care and family planning services. Midwives know how to watch for and identify potential or actual complications, and they can provide emergency treatment until additional assistance is available.

What do Midwives do?

Midwives offer:

- prenatal care that promotes informed decision-making;
- choice of birth place;
- education and counseling;
- labor support, birth and postpartum care;
- support for bonding;
- examination and evaluation of the newborn;
- breastfeeding support;
- counseling in early parenting; and
- well-woman care.

Midwifery Care: Division of Expertise

Midwives are experts on normal birth; obstetricians are experts on difficult or surgical births. This division of responsibility between two strong and respected professions creates the best conditions for optimal birth care.

Midwifery care is cost-effective

Midwifery fees are typically one-third less than fees for comparable services provided by physicians; midwifery care saves money without sacrificing quality or safety.

Midwives provide personalized care

Women want more than technological care during pregnancy and birth. Midwives encourage participation by family members and provide continuous support during labor and birth. Midwives trust the birth process and affirm each individual woman's ability to give birth.

Midwives encourage informed choices

Midwives encourage women and their families to take an active part in their own health care. Pregnancy is an ideal time to educate mothers about nutrition, healthful birth practices, breastfeeding, and infant care.



© Sarah Chester McKusick



© Sarah Chester McKusick

Midwifery care offers choice of birth places

Midwives practice in homes, birth centers and hospitals. Midwives support the right of parents to choose the birthplace that best suits their needs.

Midwifery care makes a difference

Midwives worldwide have an excellent record of safety with numerous studies associating midwifery care with excellent outcomes. The five nations with the world's lowest infant mortality and lowest rates of technological intervention have midwives attending 70 percent of all births without a physician in the birth room.

*Permission to reprint granted.
Printed on recycled paper with soy-based ink.*

• On May 28 Florida's four gubernatorial candidates took part in a forum on meeting the needs of Baby Boomers and their aging parents and of patients and families facing terminal illness. Sponsored by the Tallahassee-based Commission on Aging with Dignity, the session focused on four key issues: meeting and financing long-term care needs of the early 21st Century; improving the system of care for the seriously ill (hospice, palliative care, pain management, advance directives); helping families care for the elderly at home; and addressing the legalization of assisted suicide or euthanasia. For details, call (850) 681-2010.

Behavioral Health

.08 "Carrot"

Congressional conferees have scrapped a provision of the \$211 billion highway bill that would have required states to adopt a .08 percent blood alcohol content standard or lose a share of federal highway funds. Reflecting NCSL's argument against using sanctions to exact compliance with a national standard, the compromise agreed to on May 18 instead offers states with the .08 standard (15 already have such laws) a "carrot," in the form of a share of a \$500 million pot for highway construction.

Taking on Hollywood

Arizona's Department of Health Services will take its antismoking message into theaters, with six different "cinema spots" intended "to counter Hollywood's glamorization of tobacco." One spot promotes a tobacco-cessation hotline, while another targets pregnant women; others focus on spit tobacco and cigars. By June, according to a DHS release, the spots will be shown on 401 screens at 50 theaters statewide. Citing research documenting a larger role for tobacco in the movies in the 1990s, particularly among lead actors and actresses, DHS director James Allen said "the silver screen has become a smokescreen, with tobacco users frequently portrayed as powerful, in control, exciting and rebellious." That image is "particularly dangerous," he said, "because of the enormous impact of popular culture on our children."

Psychiatric Patients & Violence

Discharged mental patients who do not show signs of alcohol or drug abuse are about as safe as their nonpatient neighbors, concluded the *MacArthur Violence Risk Assessment Study*. Using data collected from police, psychiatric hospitals, patients themselves and family members, investigators followed 951 patients from Pittsburgh, Pennsylvania; Kansas City, Missouri; and Worcester, Massachusetts for a year following their hospital discharge. "There is a strong tendency for the general public to treat all people discharged from psychiatric facilities as if they were the same," study director Henry Steadman of New York-based Policy Research Associates said in a release. But, he added, important distinctions can be made among the patients—including whether they are abusing alcohol or illegal drugs—and can be "very useful in assessing which patients are at an increased risk of committing violent acts against others." For details, call (518) 439-7415.

Study on Health Benefits

The cost of behavioral health care benefits has been slashed 670 percent compared to costs for general health benefits over the past ten years, according to *Health Care Plan Design and Cost Trends: 1988 Through 1997* by the Hay Group, a Washington, D.C.-based benefits consulting firm. Commissioned by groups including the National Alliance for the Mentally Ill, the study also found that the value of behavioral health benefits has declined by 54 percent, compared to 7 percent for general care. According to Clarke Ross, executive director of the American Managed Behavioral Healthcare Association, however, more than 20 studies contradict the Hay Group findings. In the Nov. 12, 1997 issue of the *Journal of the American Medical Association*, for example, the California-based RAND Corp. concluded that costs for 24 carve out plans "are lower [due to] reduced hospitalization rates, a relative shift to outpatient care and reduced payments per service ... [while] access to mental health specialty care increased" to 7 percent of enrollees, compared with 6.5 percent under fee-for-service plans.

Primary Care

Overworked Residents

Physicians-in-training in New York hospitals work hours that far exceed the limits set by the state Health Department, according to survey results released by the department on May 18. Despite regulations limiting working hours to no more than 80 hours per week over a four-week period, unannounced inspections of 12 teaching hospitals found that 37 percent of all residents exceeded the regulatory limits. Among surgical residents, 77 percent in New York City hospitals and 32 percent upstate worked more than 95 hours per week. "We have sent a copy of our findings to all hospitals in the state and put them on notice that unannounced state inspections will continue," Health Commissioner Barbara DeBuono said in a release. "Prompt action will be taken against any hospital found out of compliance," she promised. For more, call (518) 474-7354.

Midwives & Birth Outcomes

Certified nurse midwives have an "excellent" track record for birth outcomes—even better than physicians—and "provide a safe and viability alternative to maternity care, particularly for low- and moderate-risk women," according to a study published in the *May Journal of Epidemiology and Community Health*. After adjusting for a variety of social and medical risk factors, the study—conducted by the National Center for Health Statistics—found that the risk of infant death was 19 percent lower when a certified nurse midwife attended the birth than when a doctor was in attendance; in addition, neonatal mortality (deaths occurring during the first 28 days of life) was 33 percent lower and the risk of delivering a low birthweight infant was 31 percent lower when a midwife attended the delivery. The study looked at 3.9 million single vaginal births at 35 to 43 weeks gestation; higher-risk Caesarian deliveries and multiple births were not included. Overall, 94.7 percent of births in the U.S. in 1991 (the study year) were attended by physicians, compared with 4.1 percent by certified nurse midwives.

CERTIFIED DIRECT ENTRY MIDWIVES
FINANCIAL OVERVIEW
FY 96 - FY 99

Midfees.xls/08/98
Last Printed: 1/29/99
CURR1

Certified Direct Entry Midwives		(PJ:28009/LC:08000153/154/155)					
Based on CURRENT FEES							
COST OVERVIEW:		FY 97	FY 98	FY 97/98 Total	FY 98/99 PROJECTION	FY 98/99 Projection	
OCCUPATION Direct Expenses		4,194	2,596	6,792	Total FY 97 + FY 98	6,792	
PROGRAM Direct Expenses		9,470	8,797	18,267	Total FY 97 + FY 98	18,267	
DIVISION Indirect Expenses		1,222	938	2,160	FY 98 x 2 years	1,876	
Sub-Total Expenses:		14,886	12,333	27,219		26,935	
Cost Savings Adjustments		(See below for explanation)				-262	
Expense Adjustments		ASCO Misc. Costs (\$66.0) x 2 years			133,200	0.06%	80
Direct Program Increment Expenses	FY 96-FY 98				0	0	0
TOTAL EXPENSES:		14,886	12,333	27,219	Projected Expenses:	26,753	
TOTAL REVENUE:		22,790	5,025	27,815	Projected Revenue:	30,550	
EXPENSES Less REVENUE:		7,904	-7,308	596	Projected Exp less Rev:	3,797	
Roll-Forward Tracking:	0	7,904	-7,308	596	0% Roll Forward Applied:	0	
					PROJECTED BALANCE:	3,797	
					PROJECTED ROLL FORWARD:	3,797	
A) Cost Savings Adjustments consists of:							
- Reduce One-time Computer Equipment Purchase							
\$185,479.65 x program percentage 0.06%, x 2 yrs	222.58	111.29	yr.				
- INDIRECT CLEAR Registration fees (FY 97)							
\$8,100 x pgm percentage 0.06%, x 2 yrs	9.72	4.86	yr.				
- Hearing Examiner cost savings (FY 96/97)							
\$50,263.00 x program percentage 0.06%	30.16						
	\$ 262.46						

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
OCCUPATIONAL LICENSING

BUDGET REPORT FOR THE BOARD OF DIRECT ENTRY MIDWIVES

As of December 4, 1998

Direct Entry Midwives (In Thousands)		FISCAL YEAR 1995	FISCAL YEAR 1996	FISCAL YEAR 1997	FISCAL YEAR 1998
PERSONAL SERVICES EXPENSES (71000)	Direct	16.7	16.5	11.0	6.7
	Indirect	0.5	0.5	0.7	0.7
	Total:	\$17.2	\$16.0	\$11.7	\$7.4
Personal service expenses are employee salaries and benefits. In Fiscal Year 1994 the Division began using detailed time sheets to record actual time spent on the various licensing areas.					
TRAVEL EXPENSES (72000)	Direct	1.4	2.3	0.7	2.0
	Indirect	0.0	0.0	0.0	0.0
	Total:	\$1.4	\$2.3	\$0.7	\$2.6
Travel expenses include transportation, food and lodging for board meetings, complaint investigations, disciplinary hearings and national meetings.					
CONTRACTUAL SERVICES EXPENSES (73000)	Direct	19.4	1.1	1.1	2.0
	Indirect	0.2	0.1	0.3	0.2
	Total:	\$19.6	\$1.2	\$1.4	\$2.5
Contractual services are services purchased from sources outside the Division and include telephone calls, postage, expert witnesses and Department of Law legal work, and other costs.					
SUPPLIES EXPENSES (74000)	Direct	0.3	0.0	0.0	0.0
	Indirect	0.0	0.0	0.0	0.0
	Total:	\$0.3	\$0.0	\$0.0	\$0.0
Supply expenses include paper, envelopes, cassette tapes, and other office supplies.					
EQUIPMENT EXPENSES(75000)	Direct	0.0	0.0	0.0	0.0
	Indirect	0.0	0.0	0.1	0.0
	Total:	\$0.0	\$0.0	\$0.1	\$0.1
Equipment expenses include purchase and repair of computers, software, copy machines, telephones and other office equipment.					
Total Direct:		\$37.8	\$18.9	\$12.8	\$11.6
Total Indirect:		\$0.7	\$0.6	\$1.1	\$1.0
TOTAL EXPENSES:		\$38.5	\$19.5	\$13.9	\$12.6
TOTAL REVENUE:		12.0	4.2	22.8	5.0
BALANCE (Revenue - Expense) :		(\$26.5)	(\$15.3)	\$8.9	(\$7.6)

This chart shows the figures in the state accounting system on the day the chart was prepared.

Some bills are not received and entered in the system for several months after the expense occurs.

Direct costs are expenditures which can be specifically attributed to distinct occupations. Indirect costs are collective expenses which are shared equally by all division license holders on a per capita basis.

Fiscal Years for Alaska's state government begin July 1 and end June 30.

Figures are in thousands of dollars and are rounded to the nearest hundred. For example, \$1.3 means \$1,300.00.

Date: February 2 1999

Total Pages: 1

▶ **PLEASE DELIVER IMMEDIATELY**

TO All Legislators

FAX 465 2273 PHONE 3

FAX

Dear legislators

I support the Bill 10 to retain the midwifery board. They are a necessary representation for direct entry midwives. I support our licensing fees so we can have a board that is unbiased.

Thank you,
 Deborah M. Davis DM

FROM _____

FAX _____ PHONE _____

FAX

FEB 03 1999

Mat-Su Midwifery

2650 Broadview Ave., Wasilla, AK 99654
907-373-3420 fax 907-376-7847

February 2, 1999

Dear Representative Hudson:

I support continuing the Midwifery Licensing Board. I am a licensed midwife and believe midwifery is profession that is growing. I believe the Board is a viable and-effective means of governing the profession. Even though our licensing fees are high the Board is self supporting.

Please support our efforts to extend the Licensing Board. Please support House Bill 10, not only in behalf of the profession, but for the sake of the families choosing to use midwives for their pregnancy and childbearing care.

Sincerely,

Melissa A. Mayo, CDM

FEB 03 1999

Sharon K. Evans
PO Box 140028, Anchorage, AK 99514
907-373-3420

February 2, 1999

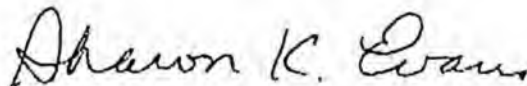
Dear Representative Hudson:

I am writing in support of the continuance of the Midwifery Licensing Board. As a licensed midwife, I believe having a Licensing Board is a viable, cost-effective means of governing our profession. Even though our licensing fees are high, I feel it is worth it to have a Board that is self-supporting.

As a parent and grandmother, I see the importance of midwives continuing to be held accountable to the Licensing Board as well as to one another. This is extremely important for the protection of the Alaskan public.

Please support our efforts to extend the Licensing Board. Please support House Bill 10, not only in behalf of the profession, but for the sake of the families choosing to use midwives for their pregnancy and childbearing care.

Sincerely,



Sharon K. Evans
Midwife

FEB 03 1999

POB 671427
Chugiak, Alaska 99567

February 2, 1999

Dear Representative Hudson,

Thank you on behalf of the Alaska Certified Direct-entry Midwives (CDMs) for introducing HB 10. We sincerely appreciate your efforts and those of your staff.

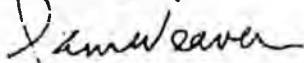
As a practicing midwife, I surely hope the board continues to govern the profession. As a member of the licensing board since its inception, I would like to point to the auditors' report which recommends that the board be extended for 6 years.

I also serve as a member of the North American Registry of Midwives (the national certification board), as liaison to state agencies and legislatures around the country. From this position, it's easy to compare Alaska's regulation of direct-entry with other states. The states with licensing boards with composition comparable to ours are the states where midwifery flourishes as a mainstream, cost-effective healthcare alternative for thousands of low risk women. The Midwifery Model of Care in out-of-hospital settings is a rising trend nationally as well as here in Alaska. The best means of addressing the issue of public safety for birth centers and homebirth is for the profession to continue to be governed by the licensing board established by AS 08.65 010.

There is concern by some for the CDM licensure fees. While the fees are high, the midwives understand that the board must be selfsufficient and are willing to pay the price as the cost of sustaining the profession, understanding that the fees will drop as the number of midwives increases. Further, I understand from discussions with Catherine Reardon, Director of Occupational Licensing, that eliminating the board would have little impact on reducing the licensure fees.

Again, thank you for your efforts with HB 10. I would welcome a call from you or your staff if I can be of any assistance.

Most sincerely,



Pam Weaver, CDM
907-688-2000

Date: 2/3/99

Total Pages: _____

▶ **PLEASE DELIVER IMMEDIATELY**

FEB 03 1999

TO All Legislators

FAX 465 2273 PHONE _____

FAX

Dear Legislators,

I support H.S. Bill 10 to retain the midwifery board. This representation of midwives, by midwives, is important. They are aware of the unique issues that face midwives in Alaska.

Thank You

Suzanne C. Hickey

FROM _____

FAX _____ PHONE _____

FAX

Date: 2/3/99

Total Pages: 1

▶ **PLEASE DELIVER IMMEDIATELY**

FEB 03 1999

TO All Legislators

FAX 465-2273 PHONE _____

FAX

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Dear Legislators

*I support HS Bill 10 to retain the
midwifery board. This representation of midwives
by midwives, is important. They are aware of the
unique issues that face midwives in Alaska.*

Thanks,

Kuoten Hensick, MD

FROM _____

FAX _____ PHONE _____

FAX

Date: 2/3/99

Total Pages: _____

▶ **PLEASE DELIVER IMMEDIATELY**

TO All Legislators FEB 03 1999

FAX 465 - 2273 PHONE _____

FAX

M
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Dear legislators,

I strongly support HS Bill #10 to retain the midwifery board. This board is a necessary & important representation for Direct Entry Midwives. I think its important for Direct Entry Midwives to be licenced & to be represented by midwives that understand the issues facing Alaskan Midwives. AK is a very unique place in terms of midwifery & this board is extremely important.

Thanks,
Holly Fair
(Holly FAIR)

FROM _____

FAX _____ PHONE _____

FAX

Date: 2/3/99

Total Pages: _____

▶ PLEASE DELIVER IMMEDIATELY

TO all Legislators FEB 03 1999

FAX 465 2273 PHONE _____

FAX

Dear Legislators:

M I support H5 Bill 10 to retain
 E the midwifery board. I think
 S representation of and by midwives
 is important because they are
 S aware of the special and unique
 issues that face midwives in
 Alaska.

Thank you,

Rudence J. Brown

FROM _____

FAX _____ PHONE _____

FAX

Date: _____

Total Pages: _____

▶ **PLEASE DELIVER IMMEDIATELY**

TO All legislators FEB 03 1999

FAX 465 2273 PHONE _____

FAX

Dear Legislators,

I strongly support H's Bill #10 to return the midwifery board. This board is a necessary & important representation for Direct Entry Midwives. It is important for direct entry midwives to be licensed & to be represented by midwives who understand the issues they face. This board is extremely important.

Thanks,
Melissa Jamgo

FROM _____

FAX _____ PHONE _____

FAX

Date: 2/3/99

Total Pages: _____

▶ **PLEASE DELIVER IMMEDIATELY**

TO All Legislators FEB 03 1999

FAX 465-2273 PHONE _____

FAX

Dear Legislators:

I strongly support H.A #10 and urge you support it also this bill will retain the midwifery board which is a necessary representation of midwives.

Thank you.
Sincerely,
Lucy Davis

FROM _____

FAX _____ PHONE _____

FAX



J U N E A U
F A M I L Y B I R T H
C E N T E R

Juneau Family Birth Center

3225 Hospital Drive, Suite 106, Juneau, AK 99801 (907)586-1203

Dear Legislator,

I am asking for your support in passing HB 10, the continuation of the Certified Direct-Entry Midwifery Board.

I am an Alaska Certified Direct-Entry Midwife (CDM) practicing here in Juneau. I have served on the CDM licensing board since it was created in 1992. I have practiced midwifery in Juneau for 15 years and last April opened a free standing, non-profit birth center in Juneau.

I am proud of the Certified Direct-Entry Midwives in Alaska. They have accomplished so much for the women and babies in the state. We now have three CDM run birth centers in the state and continue to provide safe home births. Statistics show that our outcomes have been excellent for moms and babies. We continue to work to help pregnant women and babies have the healthiest experience possible and to provide quality midwifery care to low risk women who choose this option.

I am available to answer questions and would be glad to provide information to you about midwifery care.

Sincerely,


Kaye Karne, CDM

ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit



P.O. Box 113300
Juneau, AK 99811-3300
(907) 465-3830
FAX (907) 465-2347
Internet e-mail address:
legaudit@legis.state.ak.us

January 9, 1998

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
BOARD OF CERTIFIED DIRECT-ENTRY MIDWIVES

January 9, 1998

Audit Control Number
08-1454-98

The objective of the audit was to determine whether the Board of Certified Direct-Entry Midwives should continue its existence. Currently Alaska Statute 08.03.010(c)(8) has the board scheduled for termination on June 30, 1998. If no action is taken by the legislature, the board has one year in which to conclude its affairs and will be dissolved on June 30, 1999. We recommend that the legislature extend the board's termination date to June 30, 2004.

This report does not include a response from the state agency responsible for the program's administration. This is an exception to generally accepted government auditing standards.

With the exception noted in the previous paragraph, the audit was conducted in accordance with generally accepted government auditing standards. Fieldwork procedures utilized in the course of developing the findings and recommendations presented in this report are discussed in the Objectives, Scope, and Methodology section of this report.

Handwritten signature of Pat Davidson in cursive.

Pat Davidson, CPA
Acting Legislative Auditor

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OBJECTIVES, SCOPE AND METHODOLOGY

In accordance with the intent of Titles 24 and 44 of the Alaska Statutes (sunset legislation), we have reviewed the activities of the Board of Certified Direct-Entry Midwives to determine if it should continue in existence.

As required by statute, the legislative committee of reference is to consider this report as part of the oversight process in determining whether the board should be reestablished. The law currently specifies that the board will terminate on June 30, 1998 and will have one year from that date to conclude its affairs.

The major areas of our review were board proceedings, examination, licensing, investigations, and licensing/fee structure as it relates to financial self-sufficiency of the board. We reviewed and evaluated the following:

1. Applicable statutes and proposed regulations.
2. Tests of files and documents of licensees.
3. Interviews with employees of the Department of Commerce and Economic Development, Division of Occupational Licensing.
4. Interviews with research staff at the Division of Medical Assistance, Department of Health and Social Services.
5. Minutes of board meetings, annual reports, and budget documents.
6. Complaints filed with the Division of Occupational Licensing, the Ombudsman's Office closed case files, and the Department of Law.
7. Discussions with board members and licensees.

ORGANIZATION AND FUNCTION

Chapter 130, SLA 1992 established the Board of Certified Direct-Entry Midwives effective June 26, 1992. While there was no intent statement attached to the legislation, the prime sponsor of the bill testified during committee meetings as to his intention in sponsoring the legislation. He stated the legislation was intended to protect the health and safety of the public by separating midwives who choose to take training and become licensed from those who choose not to meet the stricter qualifications.

According to the sponsor, insurance companies will pay for midwife services only if they are properly licensed and certified. He testified that a board is needed to "*develop strict regulations and monitor professional practice by peer review and education. Certified, licensed, high-quality care would be available to Alaskans who either prefer home births or are denied financial or geographic access to physicians' care.*" The sponsor also identified midwife care as one way to reduce health care costs and related health insurance premiums.

The board promotes the public's health, safety, and welfare by establishing educational, experience, and continuing education requirements for licensed midwives. These requirements are intended to provide assurance that licensed individuals provide a minimum standard of care. However, the statutes allow for midwife services to be provided by unlicensed individuals. As stated in AS 08.65.150 the differentiation is that those not certified under Chapter 65 (Direct-Entry Midwives) "*may not practice midwifery for compensation.*"

Membership on board

As set out in AS 08.65.010, the board is composed of five members (see inset at right). By statute, board membership consists of two direct-entry midwives certified in Alaska, one physician who has an obstetrical practice or has specialized training in obstetrics and is licensed by the State Medical Board in Alaska, one certified nurse midwife licensed by the Board of Nursing in Alaska, and one public member. The members are appointed by the governor subject to confirmation by the legislature in joint session. Once appointed, the members serve staggered terms of four years.

Board of Certified Direct-Entry Midwives Members

Pam Weaver, Certified Direct-Entry Midwife,
Chairperson
Marilyn Holmes, Secretary, Public Member
Kaye Kanne, Certified Direct-Entry Midwife
Martha J. Linden, Certified Nurse Midwife
Dr. Mark E. Richey, Physician

REPORT CONCLUSION

As set out in AS 08.03.010(c)(8), the Board of Certified Direct-Entry Midwives is presently scheduled for termination on June 30, 1998. The board has one year in which to conclude its affairs if the legislature does not enact legislation for the continuance of the board.

The regulation and licensing of qualified professionals is necessary to promote the public's health, safety, and welfare. The board provides this service by establishing minimum educational, experience, and continuing education requirements that provide reasonable assurance that licensed individuals provide a minimum standard of care. Active investigation of complaints and revocation or suspension of licenses assure licensed professionals act in a competent manner.

Creation of the board has served as a means to make people practicing midwifery aware of the level of experience and education expected of them. Also, by having a board, individuals in the midwifery practice can now be held accountable to an established standard of care. Elimination of the board would likely result in the same lack of oversight that existed prior to the creation of the board in 1992. The board has displayed an ability to conduct its business in a professional, competent, and efficient manner. The board continues to propose changes to statute and regulation to improve its effectiveness.

In our view, the Board of Certified Direct-Entry Midwives is operating in an efficient and effective manner and should continue. We believe the board is safeguarding the public interest by promoting the competence and integrity of those who hold themselves out as licensed midwives or midwife apprentices. We recommend that the legislature extend the board's termination until June 30, 2004.

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION



Rev. 6/98

Central Microfilm Services
Department of Education & Early Development
State of Alaska

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Duties of the board

The board responsibilities under AS 08.65.030 include:

1. Examining applicants and issuing certificates to those applicants it finds qualified;
2. Adopting regulations establishing certification and certificate renewal requirements;
3. Issuing permits to apprentice direct-entry midwives;
4. Holding hearings and ordering the disciplinary sanction of a person who violates statute or regulation regarding direct-entry midwives;
5. Supplying forms for applications, licenses, permits, certificates, and other papers and records;
6. Reporting annually to the governor and the Department of Commerce and Economic Development (DCED) on the board's proceedings during the year;
7. Approving curricula and adopting standards for basic education, training, and apprentice programs; and
8. Approving education, training, and apprentice programs that meet the requirements of statute and the board, and denying, revoking, or suspending approval of programs that fail to meet the requirements.

Duties of the Department of Commerce and Economic Development

DCED provides administrative and investigative assistance to the board (AS 08.01.050). This assistance is funded by licensing and application fees as appropriated by the legislature. Administrative assistance includes budgetary services and functions such as: collecting fees, maintaining files, receiving and issuing application forms, and publishing notice of examinations and meetings. On its own initiative, or in response to a complaint, DCED may conduct an investigation if it appears a person has engaged in or is about to engage in a practice over which DCED has authority. DCED can issue an order that the person stop the practice, bring an action in Superior Court to enjoin the act, examine the books and records of a person, and issue subpoenas for the attendance of witnesses and records.

REPORT CONCLUSION

As set out in AS 08.03.010(c)(8), the Board of Certified Direct-Entry Midwives is presently scheduled for termination on June 30, 1998. The board has one year in which to conclude its affairs if the legislature does not enact legislation for the continuance of the board.

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In our view, the Board of Certified Direct-Entry Midwives is operating in an efficient and effective manner and should continue. We believe the board is safeguarding the public interest by promoting the competence and integrity of those who hold themselves out as licensed midwives or midwife apprentices. We recommend that the legislature extend the board's termination until June 30, 2004.

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AUDITORS COMMENTS

High fees a barrier to entry

Due to the fees charged for licensure, continued licensing of Direct-Entry midwives is problematic over the long term. The licensing fees required of midwives are higher than those of any other licensed profession, except one.¹ Licensure costs have increased from an original two-year fee of \$350 to \$1,550 for the current biennial period. Additionally, prospective license fees due at the end of 1998 for the next biennial licensing period, will probably be even higher since the number of new midwife applicants to date have been less than expected. The fees are relatively higher because of the limited number of licensed midwives, and the statutory requirement that licensing fees be set at a level sufficient to cover the regulatory costs for the occupation.

As of July 1997, there were only 15 licensed Certified Direct-Entry Midwives (CDMs), and 5 apprentice midwives. These 20 licensed individuals were required to cover estimated biennial operating costs of almost \$31,000 — a relatively modest operational cost for a licensing board. AS 08.01.065 requires the licensed CDMs, like all professions, to cover these operational costs.

There is some concern given the market situation for many CDMs, that high licensing fees serve as a barrier to entry into the profession. The fees may be required to be set so high, that they prove to be a significant disincentive for qualified individuals to seek licensure as a CDM. As a result, the public policy benefits that were attributed to developing a licensure process for midwives when the board was created in 1992, may be compromised in total or in part if the already high fees continue to increase.

In July 1997 the director of the Division of Occupational Licensing wrote all licensed midwives soliciting their perspective on alternatives to the high fee structure faced by CDMs. These options, presented in full in the inset on the following page, ranged from disbanding the board altogether, to seeking a general fund appropriation to subsidize the operations of the board. From our review of the options, we could not identify any particular choice that we believe more advantageous than the other. Further, no preference or other suggestions were expressed or offered in discussions with selected board members nor were written comments received from licensees.

¹ The Board of Marine Pilots charges \$4,500 for a biennial license, and had 84 license holders at the end of FY 97. The board has a full time licensing supervisor to support its activities. Because of the structure of the market for marine pilot services, this large fee has not appeared to be too onerous of a charge for most marine pilots. By way of further comparison, biennial renewal fees for physicians and dentists are \$180 and \$250 respectively.

DIRECTOR'S LETTER SETS OUT EIGHT OPTIONS FOR CONSIDERATION OF THE BOARD AND ALL LICENSED CDMs

In a July 7, 1997 letter to all licensed Certified Direct-Entry Midwives (CDMs), the director of Occupational Licensing set out eight options for consideration and discussion. Presented below is an excerpt of the letter. The director, before presenting the following discussion did write, "I am not advocating any of these changes, but am simply setting them out for discussion."

1. Eliminate state licensing of CDM's by repealing the licensing law. All licenses fees would be eliminated . The results could be danger to public health from untrained midwives, elimination of insurance coverage for midwifery services, or the determination that lay midwifery for compensation is an illegal practice of medicine.
2. Eliminate the board and transfer all responsibility for regulation to the Division of Occupational Licensing. The cost of travel to board meetings (\$1,500—\$2,500/year) and staff work-related to meetings would be eliminated. Department staff would write regulations instead of experienced CDM's. . . . Overall savings may be minimal.
3. Create a board which licenses several health care professions to increase the number of board licensees. The medical and nursing boards may not be comfortable locations for CDM's. Professions such as naturopathy and acupuncture do not currently have boards, so their fees would increase if they shared board meeting costs with CDM's. CDM's could see a slight decline in fees related to board meeting travel and meeting staff work as these costs would be spread among all board license holders. An increase in the membership, number, or length of board meetings could offset that savings. . . .
4. Base fees on the number of babies delivered by a specific midwife instead of charging all midwives the same license fee. Overall expenses and revenue would remains the same, but fees would vary substantially depending on the amount of activity/income of each CDM. Since the number of births was known, the Division and Board would face the challenge of dealing with CDM's who fail to pay.
5. Pay some costs of regulating midwives with General Fund money from the state treasury instead of license fees. The Governor and the Legislature would have to cut other state programs or increase the state budget deficit. This is very difficult in a time of oil revenue decline and budget reduction.
6. License CDM's annually instead of biennially. This would increase the amount of staff time spent on license renewal, but would all CDM's to pay half the fee each year.
7. Reduce employee costs. The CDM program is staffed by a licensing examiner and investigator who bill midwives only for those hours they spend on regulation [of] your profession. Division salaries and benefits are set in union contracts. If staff duties remain the same, personnel costs will not decrease
8. Increase the number of Certified Direct-Entry Midwives. While the Division cannot contribute a great deal to this goal, license fees would be lower if there were more people to split the costs of regulation.

Medicaid eligibility and reimbursement was a factor behind creating the board — however, services continue to be nonreimbursable

Prior to establishment of a CDM board, midwives registered with the Department of Health and Social Services (DHSS). This registration function did not satisfy the federal regulatory requirements requiring licensure of practice in accord within a "scope of practice." Creation of the board, and subsequent adoption of licensing regulations satisfied this requirement. As such, midwife services could now be covered under the Medicaid program, which was part of the motivation for originally establishing the board.

Circumstances brought on by funding decisions by the legislature have served to deny Medicaid reimbursement for midwife services.² An estimated 40% of the births in the State are covered by Medicaid. This excludes independently operating CDMs from providing services for payment to a significant number of individuals. In the view of board members we interviewed, this exclusion from Medicaid reimbursement is a central factor in limiting the number of individuals seeking licensure as CDMs.

At the request of DHSS Commissioner Perdue, Division of Medical Assistance personnel and representatives from the Midwives Association of Alaska met to discuss the options and obstacles in obtaining Medicaid reimbursement for midwives. Five Medicaid coverage options and the estimated cost of each were discussed. A synopsis of this analysis may be obtained from DHSS.

Concluding observations and comment

In 1992, the legislature approved establishment of the Board of Certified Direct-Entry Midwives without a dissenting vote. Such a vote suggests the legislature accepted and was in full agreement regarding the prospective public policy benefits that such a board licensing structure would provide. However, since the board was established, circumstances have developed that have limited realization of those perceived public policy benefits.

In order to better accomplish the public policy benefits of the board or licensure of midwives, the legislature should consider the various policy options related to both license fee costs and Medicaid reimbursement. Such consideration may require a reevaluation of the established self-sufficiency policy for occupational boards in addition to developing an avenue to allow Medicaid reimbursement for midwifery services. While each of these options has a varying fiscal impact, such actions may be necessary in order to provide greater opportunity and incentive for individuals to become a member of the direct-entry midwife profession.

² Under federal regulations a state can offer reimbursement under Medicaid for medical or other remedial care provided by licensed practitioners within the scope of practice defined under state law. In Alaska, the legislature retains control over what optional groups of people and services are covered under Medicaid. The legislature has chosen to prioritize optional groups of people and services within state law so that the Department of Health and Social Services is given specific guidance over what groups and services are to be excluded from coverage when Medicaid funding is insufficient to cover the full program costs. In 1993 CDM services were made eligible for Medicaid reimbursement.

The legislature added the services to the optional service provider list set out in AS 47.07.030 for the Medicaid program. Because of federal requirements, midwives were delayed in fully qualifying for Medicaid reimbursement until May 1994. However, for the FY 95 budget, midwives through legislative intent, were eliminated from receiving Medicaid reimbursement. In FY 98, the legislature provided funding for a limited number of optional services, however, midwifery services remain unfunded.

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ANALYSIS OF PUBLIC NEED

Limited Analysis

The following analyses of board activities relate to the public need factors defined in the "sunset" law, Alaska Statute (AS) 44.66.050. These analyses are not intended to be comprehensive, but address those areas we were able to cover within the scope of our review.

The extent to which the board, commission, or program has operated in the public interest.

The Board of Certified Direct-Entry Midwives (CDM) has served the public by examining and licensing qualified applicants, and by proposing changes to statute and regulation in order to enhance the quality of midwifery care in Alaska.

The board developed regulations to establish a peer review committee to review birth summaries and other required medical records to determine if the midwife acted in accordance with regulations and statutes governing CDMs.

The board is currently developing a handbook for applicants, licensees, new board members, and other interested individuals. The handbook will outline the functions of the board as well as clarify licensing requirements, costs and deadlines of the review, and licensing process.

The extent to which the operation of the board, commission, or agency program has been impeded or enhanced by existing statutes, procedures, and practices which it has adopted, and any other matter, including budgetary, resource, and personnel matters.

General licensing statutes require that the Department of Commerce and Economic Development adopt regulations that establish the amount of fees to be charged to licensees of an occupation. The department must adopt fees that provide for financial self-sufficiency. Additionally, the department must perform an annual review to determine whether the financial self-sufficiency requirement has been met.

The licensing fees for the midwifery profession have increased twice since the inception of the board and it is facing another potential increase. The biennial licensing fee has increased from \$350 to \$850 to \$1,550 over the course of four years. The current number of licensed midwives is fifteen. The most recent budget documents were based on optimistic estimates that a small increase in licensees would occur; however, to date this increase has not materialized.

Appointment of the physician board member was not made in a timely manner. This seat was vacant from April 1995 through February 1997. The original physician appointed board member was absent from three meetings immediately preceding his resignation. The newly appointed physician board member was unable to attend the first meeting after his appointment. These circumstances resulted in eight consecutive board meetings being conducted, over a four year period, without benefit of physician representation on the board, as required by statute.

The board failed to meet twice annually as required by AS 08.65.020. In FY 96 the board cancelled their second regularly scheduled meeting due to a lack of pressing business and in an effort to be financially prudent. This cancellation had no significant impact to the board.

Submission of the FY 95 annual report was untimely. The board is required to submit their annual report to the department by August 1; however, the department did not receive the FY 95 annual report until mid-November. Due to the untimely submission, the report was excluded from the department's *Boards, Commissions, and Licensing Programs Annual Performance Reports* publication.

The extent to which the board, commission, or agency has recommended statutory changes that are generally of benefit to the public interest.

The board has proposed that CDMs be added to the definition of "health care provider" as used at AS 18.23.070(3). This statute assures the confidentiality of client records reviewed in the course of a professional peer review process. Currently, peer review regulation does not provide for confidentiality of client records. Alaska Statute 18.23.070(3) defines "health care provider" and applies to confidentiality of records of review organizations. Inclusion of CDMs to the definition of "health care provider" under AS 18.23.070(3) will ensure the necessary confidentiality of client records.

The extent to which the board, commission, or agency has encouraged interested persons to report to it concerning the effect of its regulations and decisions on the effectiveness of service, economy of service, and availability of service that it has provided.

The location, date and time of board meetings and examinations are published in Anchorage, Fairbanks, and Juneau newspapers so that interested public members can attend or make written comment. The department has established a policy and procedure regarding public notices that defines adequate public notice for each specific event such as regularly scheduled meetings, examinations, and unplanned teleconferences. We reviewed advertising orders for the period under review and determined that two exam dates failed to be published timely in any of the three newspapers.

As discussed in the Auditor Comments section of the report, the Director of Occupational Licensing wrote all licensed CDMs in July 1997 to solicit feedback regarding the various options for addressing concerns over the relatively high CDM license fees. The letter, presented in part on page 8 discussed eight prospective options for consideration and discussion by licensees.

The extent to which the board, commission, or agency has encouraged public participation in the making of its regulations and decisions.

Public notices of proposed regulations are published in major newspapers. As previously mentioned, regularly scheduled meetings and exams were adequately advertised except as noted above, and time was set aside for public testimony.

The efficiency with which public inquiries or complaints regarding the activities of the board, commission, or agency filed with it, with the department to which a board or commission is administratively assigned, or with the Office of the Ombudsman have been processed and resolved.

Overall, the investigation of complaints against licensees received by the Division of Occupational Licensing is effective; however, timeliness is a concern. Factors contributing to lengthy closure times include case load and priority assignment. For the period under review, three investigative cases were opened. Two cases involved allegations of unprofessional conduct: one involved allegations of practicing without a license. Two cases were closed without a formal hearing and without license action. One case remains open as of the date of this report.

There were no complaints filed with the Office of the Ombudsman for the period under review.

The extent to which the board or commission which regulates entry into an occupation or profession has presented qualified applicants to serve the public.

Overall, the application process for certified direct-entry midwife licensure appears reasonable and appropriate. The licensing process is neither unduly restrictive nor too lax.

At the end of FY 97, the board had issued a total of 23 CDM licenses (currently 15 active) and 15 CDM-Apprentice permits (currently 5 active). We reviewed twelve license applications; seven CDM and five CDM-Apprentice. We found no errors during our review. We believe that the licensing criteria established by the board is reasonable and appropriate.

The extent to which state personnel practices, including affirmative action requirements, have been complied with by the board, commission, or agency to its own activities and the area of activity or interest.

We found no evidence that the board was not complying with state personnel practices, including affirmative action, in qualifying applicants. The application for CDM licensure requires a photograph of the applicant. We determined that the photograph is not available for viewing when the board review an application for licensure. Each time the board has denied an applicant a license the reason has been based on experience requirements and not personal attributes of the applicant.

The extent to which statutory, regulatory, budgeting, or other changes are necessary to enable the agency, board, or commission to better serve the interests of the public and to comply with the factors enumerated in this subsection.

See Auditor Comments section of this report.

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APPENDIX A
Department of Commerce and Economic Development
Board of Certified Direct-Entry Midwives
Application, License, and Other Fees³

Application and Other Fees⁴

Type of Fee	Amount
Application	\$400
Examination fee	\$300

License Fees

License Category	Initial and Biennial Renewal Fee ⁵
Direct-Entry Midwife Certification	\$1,550
Apprentice Direct-Entry Midwife Permit	\$300

³The licensing fees charged by the Division of Occupational Licensing for the Board of Certified Direct-Entry Midwives are set out in the Alaska Administrative Code at § 12 AAC 02.145. The current fees for this licensing board became effective November 15, 1996.

⁴The Division of Occupational Licensing is also authorized to charge administrative fees (12 AAC 02.105). Administrative fees include: duplicate license fee, photocopying fee, and penalty for reinstatement of a registration, license, permit or certificate which remains lapsed for more than 60 days.

⁵The biennial renewal period for the Board of Certified Direct-Entry Midwives is December 31, 1998.

Love Letters

Kaye empowered me with knowledge and confidence for birthing at home in peace and comfort. It was such a natural flow to have people come to our house; to be fed my food; to lay in my own bed; and to ever so gently, in soft light and quiet, celebrate the appearance of our child.

Birthing is my all-time, number-one high and personal best in effort, and I owe much of the beauty and goodness of the experience to my husband and our midwife, Kaye Kanne.

---Leslie Bennett, mother of two children

I felt safest with a midwife because a midwife specializes in keeping the process of pregnancy, labor and delivery natural. My midwife spent a full hour with me during prenatal visits, educating me, monitoring my health and discussing my diet. This extra attention throughout the pregnancy prepared me for a healthy and natural labor and birth.

---Maureen Riley, mother of two children

We chose to have our son and daughter at home, attended by midwives. While I was in labor, my midwives waited with us and encouraged the process to unfold naturally. They inspired confidence in me by their very presence and wealth of knowledge. When our children's birth days arrived, I knew that my midwives would patiently guide me through labor and birth, give me privacy, respect my wishes, and trust me to find my own way.

---Diana Rossmille, mother of two children



Maurice Sendak



Juneau Family Birth Center
3225 Hospital Drive, Suite 106
Juneau, Alaska 99801
(907) 586-1203

JUNE
AU
FAMILY BIRTH
CENTER



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FAMILY BIRTH
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Where Love Grows



Naturally

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3225 Hospital Drive, Suite 106
Juneau, Alaska 99801
(907) 586-1203

Our Midwives

Kaye Kanne, C.D.M., C.P.M.

is a Certified Professional Midwife and a licensed, Certified Direct-Entry Midwife. She trained in Oregon and became a licensed midwife in New Mexico. She moved to Juneau in 1984 where she established Southeast Maternity Services. Kaye currently serves on the State Board of Licensing for Certified Direct-Entry Midwives in Alaska which she was instrumental in establishing. Kaye founded the Juneau Family Birth Center as part of her long-standing commitment to provide midwifery care to women and families in our community. Kaye is married and the mother of three children, two born at home.

Bev Skaggs, M.S., C.D.M.

is a licensed, Certified Direct-Entry Midwife. She obtained her license in 1998 after completing an apprenticeship with Kaye Kanne, C.D.M. She received her midwifery degree from the National College of Midwifery. Bev also holds a Master's of Science degree in seismology from Cornell University. She became interested in midwifery as a result of her own positive experiences working with a midwife. Bev has lived in Juneau since 1985 and is the mother of four children, all born at home.



Kaye Kanne and Bev Skaggs (L.-R.) with newborn baby Erik Nalan, work as midwives at the Juneau Family Birth Center.

Our Services

Complete Prenatal Care

Free initial consultation and pregnancy testing

Full hour scheduled for each prenatal visit

Free pregnancy and childbirth-education classes, exercise and nutrition classes

All-natural vitamins and supplements available

Management of Labor and Birth

Your choice of midwife-attended birth in your home or at the Juneau Family Birth Center

Assistance and monitoring during labor and birth with emotional support and coaching

Physician referrals as needed

After Your Baby is Born

Complete postpartum care, including home visits, for the first six weeks

New Mom's Support Group meets weekly

Breastfeeding counseling and support

Resources Available to You

A complete lending library of books, videotapes, periodicals, and cassettes relating to all aspects of pregnancy, nutrition, childbirth, breastfeeding, parenting, and holistic health

Visit our Website

<http://www.juneau.com/birthcenter>

**Services are insurance reimbursable.
Medicaid is accepted.**

Our Center

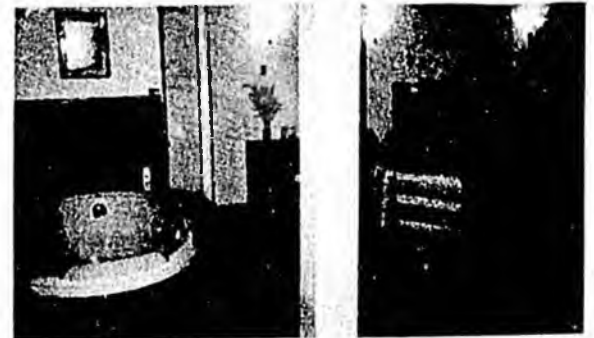
The Juneau Family Birth Center is a new facility located near the hospital. We offer you a home-like environment with two private birthing rooms, jacuzzi tubs, a family room complete with kitchen, a lending library, and a prenatal clinic.

The Juneau Family Birth Center is a non-profit organization dedicated to providing women and their families access to safe and affordable midwifery care.

We view birth as a normal, healthy event, understanding that birth is a complex and empowering life experience for women and their families.

We welcome families and friends to actively participate in pregnancy, labor and birth.

The Juneau Family Birth Center strives to affirm the sacredness of birth, the spiritual, emotional, familial, and communal dimensions of birth. We honor women's wisdom and knowledge of their own bodies, and we trust the rightness of the birth process.



Our family friendly birth rooms offer women jacuzzi tubs and soft lighting in a relaxed and private atmosphere.

Passing House Bill 10 as a means of reducing health care costs to the State and improving birth outcomes:

Background:

The 1992 legislature unanimously established a licensing and regulatory board for non-medical midwives called Certified Direct-Entry Midwives (CDMs).

The 1993 legislature unanimously added CDMs to the Medicaid options list with the intention of reducing health care costs for normal (90%) pregnant women by providing a low cost alternative to the already funded medical model of birth.

The Division of Legislative Audit has recommended in its January 1998 audit of the CDM board that "In order to better accomplish the public policy benefits of the board... the legislature should consider various policy options related to... Medicaid reimbursement."

The 1998 legislature voted overwhelmingly to provide Medicaid funding to Direct-Entry Midwives. On the 12th of this month, this legislation will go into effect.

Advantages to the State of Maintaining Direct-Entry Midwives:

Alaska's infant mortality rate is even higher than the national average which ranks 22nd among developed nations. The five nations with the lowest infant mortality use midwives for 70% of their births, while midwives in the U.S. attend only 5% of our births. Increasing the use of midwifery services improves birth outcomes significantly.

Immediate cost savings to the existing Medicaid program will result from using a birthing alternative that is less than half the cost for normal low-risk deliveries. Currently, hospital births are averaging \$6785 – CDM care for the complete childbearing cycle costs \$2574 and includes postpartum newborn care.

Further cost savings will be realized by the reduction in technological intervention – especially unnecessary Cesarean sections which cost at least an additional \$10,000. The C-section rate in this country is the third highest in the world, around 30%. In Japan it's 7% and midwives deliver 90% of the babies. Bassett Army Hospital in Fairbanks saved the U.S. Military over \$1 million the first year two midwives were introduced into their obstetrics practice.

Restructuring Medicaid spending by funding CDMs demonstrates to Congress and President Clinton that FMAP funds are being used as intended and should therefore be continued.

The Goose That Laid the Golden Egg:

More than 4800 pregnant women are eligible to receive Medicaid coverage in Alaska each year. If only 100 chose the midwifery model of care this year (2%), the total saving in Medicaid dollars would exceed \$300,000. When the program is encouraged to grow by passing House Bill 10, the State will continue to reap increasing benefits while improving maternity and infant care.

House Bill 10: Extending the Termination Date of the Board of Direct-Entry Midwives 1999-2003

In spite of some current confusion about the intricacies of "economy of scale" in licensing Certified Direct-Entry Midwives (CDM's), Alaska remains, remarkably, among the forerunners in a worldwide movement to establish the Midwifery Model of Care as a safe and economical alternative choice to the medical model.

If you are familiar with this subject, you know that:

Alaska's infant mortality rate is even higher than the national average which ranks 22nd among developed nations.

Increasing the use of midwifery services improves birth outcomes considerably.

The five nations with the lowest infant mortality use midwives for 70% of their births, while midwives in the US attend only 5% of our births.

Immediate savings to the existing Medicaid program will result from using a birthing alternative that costs less than half of the medical model.

Alaska loves its midwives; the legislature has overwhelmingly supported the establishment of a CDM licensing board (1992), the intention to provide Medicaid funding to CDM services (1993) and the funding of Medicaid Reimbursement to CDMs.

Last year during the review of Senate Bill 238, "a Sunset Bill" for the CDM board, there was discussion over the high cost of licensing fees, currently \$1550 for a two-year period. The auditors were concerned that higher fees might serve as a barrier to those trying to enter the profession and that no one seemed to have any suggestions for remedying the situation.

One obvious remedy was the passing of last year's HB 459 which moved CDM's into a position to receive third party reimbursement in the form of Medicaid funding, accomplishing the following:

Begin the process of saving Medicaid funds for the state – an estimated 57% or more per birth. Each year there are 4500 pregnant women eligible for Medicaid who currently have access *only* to the medical model.



Alaska Family Health & Birth Clinic

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February 8, 1999

Dear Representative Hudson:

I am writing to communicate my concerns regarding HB 10 and the sunset clause on the State Midwifery Board. Since the Board's inception in 1992 it has made a significant contribution to midwifery care resulting in high standards in the profession. We don't want to lose the representation of the State Licensing Board.

We realize the licensing fees are high but we are not complaining. We need our board and are willing to continue paying these fees; it is worth it to the midwives and our profession. The midwifery profession is growing in the State of Alaska and the demand for midwifery care is increasing. Because we are now able to bill for Medicaid we can reach even more people.

It is the desire of the Midwives Association of Alaska that the State Midwifery Board continue.

Sincerely,

Dana Brown, President
Midwives Association of Alaska