ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672
10747 HOUSE HEATH EDUCATION & SOCIAL SERVICES

There are two basic categories of services and supplies covered by health insurance policies.

- **Hospital Benefits** include expenses associated with stays at hospitals and other covered facilities, such as skilled nursing facilities, nursing homes and outpatient surgery centers. Benefits for hospital services often require that the individual or their physician contact the insurer or the employer to obtain prior approval for the number of days of hospital stay. Without this approval the benefits may be reduced.
- **Physician or Provider Benefits** include services provided by licensed physicians and other medical providers.

There are a number of other charges and services generally excluded from coverage under most health insurance plans. Following are examples of common exclusions:

- Services determined by the insurer to be medically unnecessary
- Services considered experimental by an accepted medical authority
- Services related to cosmetic surgery
- Services for mental or nervous disorders, vision, hearing
- Services that are provided without charge
- Services provided due to war
- Services provided as a result of a work-related injury
- Services provided by a relative
- Services related to normal pregnancy and routine well-baby care (these are generally excluded from individual policies and included in group policies).

Alaska law mandates that the following specific charges or services be covered in health insurance plans sold in Alaska. These requirements do not apply to employers with self-insured health plans.

- Coverage for newly born or adopted children for at least 30 days, if coverage includes dependents
- Coverage for treatment of alcoholism or drug abuse
- Low-dose mammography screening if the contract covers mastectomies and prosthetic devices and reconstructive surgery
- Treatment of phenylketonuria
- Coverage for not less than 48 hours after vaginal birth and 96 hours after a cesarean birth, if the contract covers the costs of childbirth
- Coverage for prostate cancer screening and cervical cancer screening

Coordination of Benefits

This provision applies to the situation where an individual is covered under two different health insurance plans. It is included in almost all group insurance plans. It requires that payments made under the two plans be coordinated so that the individual does not receive duplicate payments for a service, thereby being reimbursed more than what was spent. Duplicate coverage frequently occurs when an individual is covered under both their own and their spouse's insurance plans. Most coordination of benefits provisions require that the individual's own plan pay first on a claim, and the other plan only pay the amounts not covered by the first plan. It is important that this provision be reviewed so that misunderstandings can be avoided regarding the benefit payments each insurer will make.

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Alaska Insurance Consumer Guide

Federal Laws Affecting Health Insurance

COBRA

COBRA is the federal law that requires employers to continue to provide their health insurance coverage to employees who have been laid off or terminated. The coverage may extend from 18 to 36 months. To obtain coverage under COBRA, the employee or their dependent must apply to the employer within 60 days of termination of their employment. The U.S. Department of Labor handles all inquiries regarding COBRA coverage. Inquiries should be sent to:

Office of Program Services
Pension and Welfare
Benefits Administration
U.S. Department of Labor
200 Constitution Ave., N.W.
Washington, DC 20210
(202) 219-8776

ERISA (Employee Retirement Income Security Act)

Many people who believe that they have a health insurance policy through their employer are actually covered under what is called a self-insured health plan. A **self-insured health plan** exists when an employer chooses to pay for medical bills directly, instead of purchasing insurance for that purpose. Most self-insured plans are regulated by the federal government through the Department of Labor under the authority of ERISA and are exempt from state regulation. Most large employers have self-insured health plans. The State of Alaska changed to a self-insured health plan for employees and retirees effective July 1, 1997.

Employers choosing to self-insure their health plans are not subject to state insurance laws such as benefit mandates, state premium taxes, capital and surplus requirements, and reserve requirements. They are also able to gain more control over their cash flow and have more freedom in determining benefits to be provided to their employees. Most employers with self-insured health plans purchase stop-loss insurance from insurance companies to protect themselves against large losses.

Employees who receive health coverage under a self-insured plan are not afforded the protections of state insurance laws and regulations. These protections include financial solvency requirements as well as requirements applying to the payment of claims. If a self-insured plan fails, Alaska benefits and managed care protections, such as standards for grievance procedures, fair disclosure of plan provisions, fair claims settlement practices and consumer services, are not available to employees. The federal laws governing these self-insured plans limit damages to actual costs and may not even cover attorney fees. Individuals covered under a self-insured plan must assume responsibility for all claims if the plan fails. Also, individual employees are required to obtain their own legal counsel to settle disputes, since the U.S. Department of Labor will not become involved in individual disputes over coverage. One other important consideration is that a self-insured employer may make material changes to the health plan (such as reducing or eliminating benefits) without providing advance notice.

HIPAA (Health Insurance Portability and Accountability Act of 1996)

This Act establishes federal standards for group and individual health insurance plans. The Act sets minimum standards for guaranteed renewability, preexisting condition waiting periods, and crediting for prior health insurance coverage. Alaska has enacted into law these federal standards which are

discussed in the health insurance sections of this guide.

Medical Savings Accounts

Under this federal law a bank, insurance company, or other federally approved entity may set up an individual savings account called a Medical Savings Account (MSA) where you can set money aside to pay for qualified medical expenses. The deposits (called contributions) in the account are tax deductible. Qualified medical expenses are those expenses paid by you for medical care including any deductible and coinsurance payments. Medical Savings Accounts are regulated by the federal government, not the Alaska Division of Insurance. One advantage to establishing an MSA is that contributions are not subject to tax and qualified medical expenses paid out of the account are not included in gross income for federal income tax purposes.

In order for a savings account to qualify as an MSA, you must be covered by a high deductible health plan offered by a small employer (2-50 employees) or be self-employed and have purchased a high deductible health plan. A high deductible health plan is an individual health insurance policy with deductibles between $1,500 and $2,250 and out-of-pocket limit of $3,000, or a family health insurance policy with deductibles between $3,000 and $4,500 and out-of-pocket limit of $5,500. These high deductible health plans are regulated by the Division of Insurance in the same manner as other health insurance policies.

If you are seeking information on setting up an MSA account, the best place to start is by contacting your financial advisor or producers selling health insurance in Alaska. Producers should have knowledge of the high deductible plans that are available in Alaska and any MSAs that may be offered in conjunction with those plans.

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5-18-02

ALASKAALMANAC

Got health insurance? You're lucky

116,000 – Estimated number of Alaskans without health coverage

19 – Percentage of Alaskans without health coverage

3 – Number of states that have a higher percentage of uninsured residents than Alaska does

$9,076 – Amount a typical 45-year-old Alaskan will pay each year for an individual health policy covering his family with a $1,000 deductible

184 – Percentage increase in Alaska medical care costs since 1983

3:1 – Ratio by which the increase in Alaska medical costs has exceeded overall inflation since 1983

$297,500 – Minimum amount state health insurance will pay toward the $300,000 of medical bills recently incurred by a state legislator (assuming no dispute over the price or necessity of the treatment)

Unknown – Number of Alaskans who will be able to afford health coverage if Alaska creates an unsubsidized insurance-buying pool for small businesses and nonprofit groups

Source: Daily News files; state division of retirement and benefits.

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In Alaska, health insurance depends on job

Falling Through the Cracks

ALASKA'S HEALTH INSURANCE CRISIS

■ **HEALTH INSURANCE:** This story and others in the Life section look at the health insurance problems facing Alaskans. The series continues Tuesdays in Life & Health through May.

■ **WITHOUT:** Small-business employees, self-employed, young can seldom afford it.

By ANN POTEMPA
Anchorage Daily News 5/7/02

Studies show that the 116,000 Alaskans without health insurance aren't always whom you expect.

They're working people. They're self-employed. They're twenty-somethings who assume youthful good health will see them through. Often they work for small businesses that cannot afford to offer benefits.

They're your neighbors.

People like Steven Small. He has repaired cars in Anchorage for almost 20 years and has never had health insurance, even since he opened his own shop.

Doctors diagnosed liver cancer last fall. Small has been paying his medical bills out of pocket and with the help of donations. With a family to support and employees who need work, Small can't stop. After his chemotherapy infusion last week, he worked an eight-hour-plus day.

Rep. Sharon Cissna, D-Anchorage, has met many families like the Smalls.

"It's not like they made all the wrong choices in life," she said. "It's not like they weren't hard workers."

See Back Page, **INSURANCE**

INSURANCE: *116,000 are not covered*

Continued from A-1

Cissna has opened her office and invited the public in to talk about solutions to rising health care and insurance. She's not the only one paying attention. Local and state agencies have spent the past few years studying the problem and publishing data. They have discovered a disparity in who gets health insurance and who doesn't, and that difference often centers on one thing: where Alaskans work.

"Some folks get a Cadillac (plan)," Cissna said. "Some folks get bare bones."

And some folks get nothing at all. Well over 00,000 Alaskans, 19 percent of the state, lack health insurance. About 26,000 live in Anchorage.

Nancy Cornwell, the state's health policy analyst, said this total reflects Alaska's population in the late 1990s, but more recent data suggest that number is rising.

The U.S. Census Bureau and the Henry J. Kaiser Family Foundation, an independent agency tracking national health issues, have ranked all 50 states according to uninsured residents. In both studies, Alaska falls in the bottom five states.

New Mexico ranks lowest, with almost 24 percent uninsured; Rhode Island has the best performance, with only about 6 percent uninsured. The United States as a whole is almost in the middle, with 14 percent of Americans lacking health insurance.

Cornwell said some people wonder whether Alaska really has 116,000 residents without health insurance. They question whether Alaska Natives might have responded that they have no insurance, even though they receive health care through tribal programs like Indian Health Services, she said.

That issue aside, the deciding factor for whether Alaskans have benefits often comes down to whom they work for. The smaller the company, the less likely its workers are to have health insurance, studies show.

Fewer than half of Anchorage companies offer health insurance to full-time employees, according to data collected by the Anchorage Access to Health Care Coalition. Companies with more than 250 employees are most likely to offer it. But the local marketplace is filled with companies of fewer than 10 employees. Only 35 percent of those offer health insurance to full-time workers.

Compare that to the nation, and Alaska falls short. Coast to coast, almost 60 percent of small businesses offer employees health insurance, according to the coalition.

Expensive premiums are the main reason employers give for not offering the benefit. Premiums escalate for many reasons, including rising health care costs.

Studies show Alaskans pay more for medical services than people in the Lower 48.

Last year, the state Department of Labor concluded that health care costs for Alaskans are increasing at a faster rate than any other cost-of-living category, including housing, food and transportation. The state Division of Medical Assistance studied the 300 most common dental, medical and surgical procedures performed nationwide. It reported that health care costs Alaskans 25 percent more than the average for all states.

As premiums climb, businesses make choices. They shop for a cheaper insurance provider, cut positions or ask employees to pick up more of the tab.

Jan MacClarence faced this choice just a few months ago. The executive director for Abused Women's Aid in Crisis learned that her health insurance provider would no longer serve the nonprofit organization in 2002. The best option she found more than doubled her premiums, jumping, per employee, from about $300 to $765 a month.

AWAIC pays all its employees' full premiums, but continuing to do so has meant sacrifices. MacClarence has had to leave positions unfilled to cover the expense.

For the self-employed, the story is even more grim. They buy their own policies and pay all costs. Premera Blue Cross writes about 90 percent of all individual health insurance policies in Alaska, said Bob Lohr, director of the Division of Insurance. The average annual premium for a 35-year-old Alaskan with a $1,000 deductible is $2,484, Lohr said. The family rate is $6,828.

And numbers climb with age. A 45-year-old will pay $3,768 in premiums, $9,096 if the whole family is covered, Lohr said.

People who cannot afford that kind of coverage often go without health care.

"I think there's a perception that not having health insurance is not a big deal," said Catherine Schumacher, chairwoman for the steering committee of the Anchorage Access to Health Care Coalition. "That people can just go to the emergency room and get the care they need."

The coalition's data show otherwise. Almost half of uninsured Anchorage residents couldn't see a doctor during the past year because of cost. Many have chronic conditions like high blood pressure but aren't able to pay for medications needed to manage them, Schumacher said. And forget about preventive checkups.

"They don't get their mammograms, their pap smears," she said. "They don't get their cholesterol checked."

So when they do end up in an emergency room, their conditions are often more serious — and more expensive.

■ Reporter Ann Potempa can be reached at apotempa@adn.com or 257-4581.

How states rank

Percent of state population without health insurance, 1999-2000

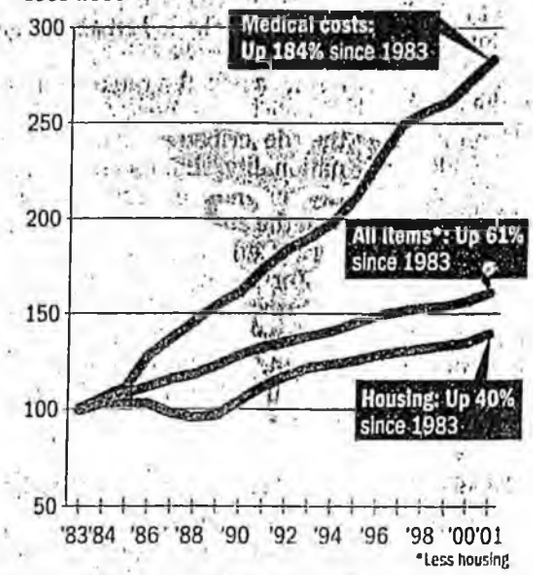
Most Insured Rank	State	Percent not insured
1	Rhode Island	6%
2	Pennsylvania	8%
2	New Hampshire	8%
2	Minnesota	8%
2	Iowa	8%
2	Connecticut	8%
	U.S. average	14%
Least Insured		
46	California	19%
47	Alaska	19%
48	Louisiana	21%
49	Texas	22%
50	New Mexico	24%

Source: Henry J. Kaiser Family Foundation

RON ENGSTROM / Anchorage Daily News

Medical costs have soared

Anchorage Consumer Price Index for selected costs; 1983-2001



Source: U.S. Bureau of Labor Statistics, Alaska Department of Labor

RON ENGSTROM / Anchorage Daily News

—C|F|O—

CFO GROWTH SOLUTIONS

April 9, 2003

Norman Rokeberg
State Capital, Room 214
Juneau, AK 99801-1182

RE: HB10 – Group Health Insurance

Dear Mr. Rokeburg:

We are a CPA/Consulting firm that provides business advice aimed at helping sm n businesses succeed. Based upon our twenty year business history we know that the cost of nce is a major impediment to furthering Alaskan business development. At this time there are fe r options, in an affordable way, for businesses to secure adequate health care coverage for their e .

We are strongly in support of the state of Alaska pooling small business owners tog er for the purpose of obtaining health care coverage. We strongly believe that this will significantly improv e the ability of owners to invest in Alaska.

Sincerely,

Robert Doughty
Founder/President

P.O. Box 243306 • Anchorage, AK 99524 • (907) 770-3772 • Fax (907) 770-3760

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Jack C. McRae
Senior Vice President

April 11, 2003

Representative Norman Rokeberg
House of Representatives
State Capitol, Room 24
Juneau, AK 99801-1182

Re: Alaska House Bill 195

Dear Representative Rokeberg:

Blue Cross Blue Shield of Alaska is pleased to support the proposed Committee Substitute for House Bill 195 (version "Q"). We believe this bill represents an important step forward for Alaska in addressing increasing costs of health care coverage and the problem of the uninsured.

HB 195 gives health insurers the flexibility of offering a benefit plan to individuals that is not subject to state mandated health insurance benefits. We strongly believe that Alaska consumers should have choice in the insurance products available for purchase. The product allowed under HB 195 will be welcomed by many individual consumers looking for an alternate to plans currently available in the marketplace.

We are also pleased to see that version "Q" of HB 195 recognizes important new options available through the Federal Trade Act of 2002. The Trade Act contains important provisions for workers whose health coverage could be affected because of unemployment related to foreign trade agreements. Given that the Alaska Comprehensive Health Association is already a federally qualified HIPAA high-risk pool, the ACHIA amendments made by HB 195 are a fiscally responsible way to leverage federal dollars to assist in covering workers eligible under the Trade Act.

Blue Cross Blue Shield of Alaska congratulates Representative Rokeberg for introducing a bill that will benefit Alaskans seeking new alternatives for health insurance. We urge the committee to advance the bill to the next step in the legislative process.

Respectfully,

Jack C. McRae

Cc: Jerry Reinwand
Jeff Davis

P.O. Box 327
Seattle, WA 98111

tel 425.918.5757
fax 425.918.5635
jack.mcrae@premera.com

www.premera.com

HB

197

Alaska State Legislature

Session Contact:
State Capitol, Rm. 420
Juneau, AK 99801
(907) 465-3875
(907) 465-4588 fax

Interim Contact:
716 W. 4th Ave., Ste. 360
Anchorage, AK 99517
(907) 269-0190
(907) 269-0193 fax

Representative Sharon Cissna

District 22

Sponsor Statement: HB 197

"An Act relating to intensive family preservation services; and providing for an effective date."

HB 197 provides the Department of Health and Social Services funds to conduct an evaluation of the need and effectiveness of 'intensive family preservation' services in Alaska, and explore long term funding sources for ongoing intensive family preservation programs.

The Intensive Family Preservation program keeps families together and children safe. In the many states that have adopted this model, there has been demonstrated prevention of inappropriate and costly placements of children into state custody and care. This would reduce costs to the juvenile justice, child welfare and mental health systems.

Based on Washington state's proven *Homebuilders* program, HB 197 provides immediate intensive, family-focused, in-home crisis intervention. These services have been effective in changing abusive or neglectful behavior and have prevented family crises likely to result in child placement. Consequently, many children are now able to remain safely in their homes and communities, instead of being placed in costly foster care and/or state institutions.

- *Homebuilders* in Washington State has been successful and in 1999 published and 84% success rate among participants in the project.
- The average cost of family preservation services is approximately $4,000 per family per year in Alaska, whereas the average cost of out-of-home placement is $13,200 per child per year, in addition to the cost of possible institutional care.
  Homebuilder's success is built on the following program characteristics:
- Immediate response (within 24 hours) by a caseworker team;
- 24-hour-a-day availability of the same family assigned caseworker for up to six weeks;
- Service delivery by a family assigned caseworker with small caseloads (two families per worker or 6 families per team; and
- Approximately 15 hours of intensive home service provided by the same family assigned caseworker each week.

I urge you to give this legislation your full consideration.

CHILD WELFARE LEAGUE OF AMERICA

STANDARDS FOR SERVICES TO STRENGTHEN AND PRESERVE FAMILIES WITH CHILDREN

Child Welfare League of America
Washington, DC

*Intensive Family-Centered Crisis (IFC) Services**

IFC services are valuable for families in crisis, particularly at a time when removal of a child from the home is imminent, or the return of a child from out-of-home care is being considered. These intensive crisis services share the same philosophical orientation and characteristics as the FC services described in the previous section. In summary, they embody the following characteristics:

- Family-centered
- Promote family empowerment
- Accessible

**The services described in this section are referred to in the field by a variety of different terms, including intensive family services, intensive home-based services, or family preservation services. This volume of standards uses the generic inclusionary term intensive family-centered crisis intervention services to describe these services.*

- Flexibile in relation to family needs
- Home-based
- Build on family strengths

What is different is the intensity of the service (including time frame and caseload size) intended to help a family concentrate on resolving a crisis that places children at imminent risk of placement in out-of-home care, or on the critical period when a child is being reunited with the other family members.

Also different from FC services is the immediate situation facing the families receiving the IFC services. Families benefiting most from these services may be experiencing any of the problems described for the target population appropriate for receiving FC services, but due to precipitating factors, they no longer are able to cope with them.

This section describes distinguishing aspects of IFC services.

2.34 Definition

IFC services should be used to provide intensive counseling, education, and supportive services to families in serious crisis, with the goal of protecting the child, strengthening and preserving the family, and preventing what would be an unnecessary out-of-home placement of children, or promoting the return home of children temporarily in out-of-home care.

2.35 Target population

IFC services are appropriate for families in serious crisis, including families no longer able to cope with problems that threaten family stability, families in which a decision has been made by an authorized public social service agency to place a child outside the home, and families whose children are in temporary out-of-home care and are being reunited.

This service is appropriate for families being served by social service, juvenile justice, or mental health systems. Adoptive or foster families facing potential disruption should also be targeted for this service.

The service has been found effective with families of varying income levels, racial or ethnic backgrounds, and living environments (rural, urban, suburban).

2.36 Goals

The primary goals of IFC services are to ensure the safety of children and family; to preserve the family unit, if possible; to improve family functioning for those families whose children are at imminent risk of placement; to prepare the family for an out-of-home placement, if appropriate; or to facilitate the early return of children in out-of-home placement.

The goal of preserving or reunifying a family unit can be best accomplished by:

- *Empowering families.* IFC services should be used to help families obtain and manage the resources necessary to sustain them, cope with crises, and achieve their service goals. Social workers should respect the authority of the parents in the family unit. They should help the family identify problems, set realistic goals, and develop plans for their achievement.
- *Improving family functioning.* IFC services should be used to provide parents with the information and skills necessary to help them become better parents. The parents often have not had adequate parental role models themselves, and have lacked opportunities to learn good parenting. Through the use of IFC services, parents should be provided opportunities to learn basic child development information and child care skills, communication skills, and ways to discipline their children without resorting to physical violence—the information and skills necessary to nurture, teach, and discipline their children within a safe environment.
- *Reducing isolation of the family.* IFC services should be used to help families connect with support networks that may include the extended family, neighbors, and other community resources. Families are often unaware of the resources available to them. Social workers should inform families of existing community services and

help families learn how to access them. Social workers should also help families to strengthen their relationships with extended family members, neighbors, and friends; and to ask for help when it is needed.

2.37 Considerations for the use of this service

Child welfare agencies should consider the safety of the child, other family members, the safety of the community, and the safety of the staff in determining whether IFC services should be used.

Whether the family can be preserved depends on the parents' ability to provide adequate care for their children, and the ability of the IFC service staff to help the family reduce or eliminate the conditions associated with risk to the child.

Cases in which IFC services can be particularly effective are those in which the intensity of service and the ability to mobilize resources can reduce risk to the child. IFC services can, for example, provide daily supervision of parent-child interaction in cases of failure-to-thrive babies and provide parents with the needed parenting skills. IFC services can also mobilize extended family members, friends, or community agencies to assist and support parents in caring for their child.

The safety of the staff and the community must also be considered in determining whether IFC services are appropriate for a particular family. The agency should consider employing safety measures that will reduce the risk to staff members. Before an initial visit, if there is an indication of potential violence or a safety risk, workers should gather more information and develop a plan with their supervisor. Workers should also learn strategies for preventing violence during visits. Agencies should also consider the use of teams for initial home visits in these circumstances.

Characteristics

IFC services share the same characteristics as FC services; they are family-centered; they promote family empowerment; they are accessible, flexible in relation to family need, comprehensive, and home-based; they rely on strengths; and they use

an array of services. IFC services also include other distinguishing characteristics, as discussed below.

2.38 Imminent risk

Agencies should develop criteria for determining the imminent risk of placement of the child.

In assessing the risk of placement, agencies should consider factors related to the child and the parents; their functioning within the context of community norms; and the availability of social supports and community resources.

Among the criteria to be considered are the following:

- A representative of an agency legally authorized to make placements has filed a petition for the removal of the child from the home
- A representative of an agency legally authorized to make placements has made a determination that the child should be removed from home
- An agency-designated review panel has determined that the child should be placed within a specified time frame—within seven days—if intensive family-centered crisis services are not provided
- There is a likelihood of immediate and/or severe harm to the child

2.39 Twenty-four hour availability

IFC services should be available to families 24 hours a day if they are to avert or manage a crisis situation.

2.40 Intensity

IFC service caseloads should be kept low to allow for the necessary intense level of interaction of the services, most of which should be spent in direct contact with families. Services should be most intensive at the time of a crisis. (2.41)

2.41 Caseloads

IFC service caseload size should range from two to six families. (2.40)

The addition of other team members, level of complexity of the case, severity of problems, and the duration of the service should determine what is a reasonable caseload for this service within the two to six family limitation.

The greater the risk of harm, such as active suicide, severe neglect, or failure-to-thrive cases, the more appropriate is a lower caseload, to facilitate greater accessibility of the staff to the family and greater intensity of service.

Using a team approach in staffing IFC service cases adds service hours, since team members sometimes work separately with families. For example, a parent-aide team member may meet separately with a family to teach parenting skills. The additional service time allows for more flexibility in determining an appropriate caseload within the six-family limitation.

2.42 Time spent directly with families

IFC service families should be seen on an average of eight to ten hours per week, with workers expending a minimum of 60% of their time in direct, face-to-face contact with families.

The caseload should be phased in so that there is a balance of cases just beginning, in the middle of treatment, and terminating. Depending on the severity of problems and degree of risk of harm, some cases may require considerably more time than the average, particularly in the beginning stages of working with the family. Cases moving toward termination should require lesser intensity, unless a new crisis arises.

2.43 Time-limited or brief duration

IFC services should be provided from four to a maximum of 12 weeks. The short-term nature of the service should be used to focus time, energy, and resources on the priority concerns that place the family at greatest risk of dissolution.

The addition of other team members, complexities of the family situation, and service goals should be the determinants of the length of service required within the 12-week limitation.

The crisis should be viewed by the staff as an opportunity for leverage and for the family members to evaluate their situation and determine how they must change in order to resolve the crisis and remain intact.

The crisis should be used to provide the staff with an opportunity for teaching at a time when the family is most amenable to change. Services should be massed at the point of crisis for a brief time to provide the family with all the resources necessary to help them manage the crisis. The worker should be able to teach the family the skills they need to handle a crisis that may recur in the future. After the crisis is resolved the worker should assure the family that arrangements will be made for them to receive follow-up services, as needed. Some families will not require follow-up services; others may need family-centered casework or family support and education services.

2.44 Time frame for initial contact and determination of acceptance

After the initial screening of information regarding the family, the social worker should make contact with the family and schedule a home visit within 24 hours of the referral, but no later than 48 hours. Immediate contact (within one hour) should be made for emergency cases. A determination of the acceptability of the case for the IFC service program should be made within 72 hours of the referral.

Staffing Family-Centered Services

Staff members for both types of family-centered service should be qualified and prepared to work with diverse families who are under varying degrees of stress.

2.45 Staff qualifications for family-centered service programs

Staff members of family-centered service programs should possess

EIGHT WAYS to do CHILD WELFARE RIGHT

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Eight Ways to do Child Welfare Right

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About This Site

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Successful Alternatives to Taking Children from their Parents

At the **National Coalition for Child Protection Reform**, we often are asked what can be done to prevent the trauma of foster care by safely keeping children with their own families. There are many options, and we've listed some of them below.

None of the alternatives described below will work in every case or should be tried in every case. Contrary to the way advocates of placement prevention often are stereotyped, we do not believe in "family preservation at all costs" or that "every family can be saved." But these alternatives can keep many children, now needlessly taken from their parents, safely in their own homes.

1. Doing nothing. There are, in fact, cases in which the investigated family is entirely innocent and perfectly capable of taking good care of their children without any "help" from a child welfare agency. In such cases, the best thing the child protective services worker can do is apologize, shut the door, and go away.

2. Basic, concrete help. Sometimes it may take something as simple as emergency cash for a security deposit, a rent subsidy, or a place in a day care center (to avoid a "lack of supervision" charge) to keep a family together. Indeed, the federal Department of Housing and Urban Development has a special program, called the Family Unification Program, in which Section 8 vouchers are reserved for families where housing is the issue keeping a family apart or threatening its breakup. Localities must apply for these subsidies. By doing so, they effectively acknowledge what they typically deny: that they do, in fact, tear apart families due to lack of housing.

3. Intensive Family Preservation Services programs. The first such program, Homebuilders, in Washington State, was established in the mid-1970s. The very term "family preservation" was invented specifically to apply to this type of program, and only this type of program, which has a better track record for safety than foster care. The basics concerning how these programs work - and what must be included for a program to be a real "family preservation" program -- are in NCCPR Issue Papers 9 and 10. Issue Paper10 lists studies proving the programs' effectiveness.

The largest replication of the program is in Michigan. The first director of the program, called Families First, was Susan Kelly. She now works for the Center for the Study of Social Policy. Families First has in press a book describing the program's history and outcomes and including several success stories.

CONTACTS:

Charlotte Booth, executive director, Homebuilders (253) 874-3630, cbooth@bsihomebuilders.org.

Susan Kelly, former director, Families First (734) 483-6671.

4. The Alabama "System of Care." This is the single most successful child welfare reform in the country. The Alabama reforms actually have reduced the foster care population while making children safer. The reforms are the result of a consent decree growing out of a lawsuit brought by the Bazelon Center for Mental Health Law. The consent decree requires the state to rebuild its entire system from the bottom up, with an emphasis on keeping families together. Twenty-one counties have completed this conversion so far. Their foster care population is down by 33 percent, and an independent monitor appointed by the court has found that children are safer now than before the changes.

CONTACTS:

Ira Burnim, Legal Director, Bazelon Center for Mental Health Law (202) 467-5730, ext. 29. Mr. Burnim also is a member of the NCCPR Board of Directors. The Bazelon Center also has published a book about the Alabama reforms.

Paul Vincent, Child Welfare Policy and Practice Group, Montgomery, Ala. (334) 264-8300. Mr. Vincent ran the child protection system in Alabama when the lawsuit was filed. He worked closely with the plaintiffs to develop and implement the reform plan.

Ivor Groves, independent, court-appointed monitor (850) 422-8900.

5. Family to Family. This is a multi-faceted program developed by the **Annie E. Casey Foundation** (which also helps to fund **NCCPR**). One small element of the program, **Team Decisionmaking** (sometimes called family group conferencing) often is confused with the entire program, which has many more elements. The program is described at the Casey website http://www.aecf.org/familytofamily. Also on the website is a comprehensive outside evaluation of the program.

CONTACT:

Lisa Paine-Wells, Annie E. Casey Foundation (410) 2 23-2962.

6. Community Partnerships for Child Protection. These partnerships, sponsored by the Edna McConnell Clark Foundation, are similar to the Family to Family projects. Among their key elements is an approach called "differential response," sometimes also known as "two-tiered response." This is an approach that both widens and narrows the net of

intervention. Families considered relatively low risk are offered voluntary help. Previously, some of these cases would have been ignored entirely, while others would have subjected families to traumatic, coercive investigations and the threat of having their children taken away. Since Iowa switched to this approach, child abuse deaths have decreased.

CONTACT:

Marno Batterson (641) 792-5918.

7. The turnaround in Pittsburgh. In the mid-1990s, the child welfare system in Pittsburgh and surrounding Allegheny County, Pa. was typically mediocre, or worse. Foster care placements were soaring and those in charge insisted every one of those placements was necessary. New leadership changed all that. Since 1997, the foster care population has been cut by 20 percent. When children must be placed, half stay with relatives and siblings are kept together 82 percent of the time.

They've done it by tripling the budget for primary prevention, more than doubling the budget for family preservation, embracing innovations like Family to Family and adding elements of their own, such as housing counselors in every child welfare office so families aren't destroyed because of housing problems. And as in Alabama, children are safer. Reabuse of children left in their own homes has declined. And since January, 1997, there has been only one child abuse fatality in a family previously known to the agency.

CONTACT:

Karen Blumen, Allegheny County Department of Human Services, Office of Community Relations (412) 350-5707.

8. Changing financial incentives. While not a program per se, making this change spurs private child welfare agencies to come up with all sorts of innovations they previously had claimed were impossible.

This is clear from the experience in Illinois. Until recently, Illinois reimbursed private child welfare agencies the way all other states typically do: Though the agencies were told to seek permanence for children, they were paid for each day they kept a child in foster care. Thus, agencies were rewarded for letting children languish in foster care and punished for achieving permanence.

Now those incentives have been reversed, in part because of pressure from the Illinois Branch of the ACLU, which won a lawsuit against the state child welfare system. Today, private agencies in Illinois are paid for permanence. They are rewarded both for adoptions (which, in fact are often conversions of kinship placements to subsidized guardianships) and for returning children safely to their own homes. They are penalized for prolonged stays in foster care. As soon as the incentives changed, the

"intractable" became tractable, the "dysfunctional" became functional, and the foster care population plummeted. The University of Illinois is monitoring the changes and has found no compromise of safety

CONTACT:

Ben Wolf, Illinois Branch, ACLU, (312) 201-9760, ext. 420.

Cost Comparison: Intensive Family Preservation Services vs. Out-of-Home Care

"One of the most unusual and exciting things about family preservation is that it is largely self-financing. One reason states can expand and institutionalize the program is that a good portion of it can be funded with money states are already spending on out-of-home care." - Frank Farrow, Director of Children's Services Policy at the Center for the Study of Social Policy

	IFPS Cost	Foster Care	Residential Treatment	Psychiatric Hospital
Alaska		$8000-17,520 per child per year	$25,285-84,680 per child per year	$100,000+ per child per year
Washington[1]	$2556 per child	$8000-36,000 per child per year	$48,000-120,000 per child per year	$110,000+ per child per year
Missouri[2]	$3200 per family	$8000 per child per year	$40,000+ per child per year	
Michigan	$4500 per family	$12,000 per child per year		$100,000+ per child per year
New York City	$8000 per family	$20,000 per child per year		
North Carolina[3]	$5284 per family	$7055 average per child per placement	$20,862 average per child per placement	$28,862 per child placed in Youth Corrections facilities

Federal funding sources for IFPS:

- PL96-272 Adoption Assistance and Child Welfare Act
- Title IV-A Emergency Assistance
- Title IV-B of the Social Security Act
- Title IV-C of the Social Security Act
- Title IV-E of the Social Security Act
- Title XX of the Social Security Act
- National Child Abuse and Neglect state grants
- Medicaid, Title XIX of the Social Security Act

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[1] Washington figures from the Behavioral Sciences Institute, Federal Way, WA (2001)

[2] Figures for Missouri, Michigan and New York City found in: Barthel, Joan, For Children's Sake: The Promise of Family Preservation, The Winchell Company, Philadelphia, PA: 1992.

[3] These figures are from a study done in FY '97 in North Carolina (see attached documents)

Cost-effectiveness and cost/benefit statistics for the IFPS program during SFY '97:

- 967 children were at imminent risk of removal, at a total potential placement cost of $11,423,195;
- 71 children were actually placed in various, known placements at an estimated cost of $923,113;
- IFPS diverted an estimated maximum of $10,500,082 from placement costs; a cost savings of 92%;
- if the cost of operating the IFPS program ($3,059,494) are subtracted from the gross savings ($10,500,082), a net savings of $7,440,588 results;
- the cost/benefit ratio of IFPS for SFY '97 is $3.43; that is, for every dollar spent providing IFPS, $3.43 is not being spent on placement services for imminent risk children;
- the cost of delivering IFPS in SFY '97 was $3,164 per imminent risk child, and $5,284 per family;
- had all 967 children been placed as originally indicated, the placement cost per child would have been $11,813, and the families would not have received any services as part of these expenditures.

Raymond S. Kirk, Ph.D. April 10, 1999
Jordan Institute for Families, University of North Carolina at Chapel Hill
Phone: (919)962-6510 email: rskirk@email.unc.edu

Children At Risk of Out-Of-Home Placement at Intake.

Potential Placement Type	Number of Children At Risk	Number of Children Placed
DSS Foster Care	697	45
Juvenile Justice	110	8
Mental Health	93	11
Developmental Disabilities	5	0
Substance Abuse Services	27	1
Private Placement	35	6
Totals	967	74

Estimated Potential and Actual Costs of Placements, SFY '97

Estimated Potential Placement Costs					Estimated Actual Placement Costs		
Placement Type	Number of Children At Risk	Placement Costs	Total		Number of Children Placed	Costs	Total
DSS FC	697	$7,055	$4,917,335		45	$7,055	$317,475
MH/DD/ SAS	160	20,819	3,331,040		18	20,819	374,742
Juv. Just.	110	28,862	3,174,820		8	28,862	230,896
Column Totals	**967**		**$11,423,195**		**71***		**$923,113**

* This number is less than 74 because 3 children who had been "placed" were "on runaway".

Raymond S. Kirk, Ph.D. April 10, 1999
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Determining the Fiscal Break-Even Point of the IFPS Program: Cost and Cost-Savings Resulting from Different Levels of Placement Prevention

Placement Prevention Rates	Cost of Providing IFPS in SFY '97	Placement Costs Avoided	Net Additional Cost or Cost Savings
100%	$3,059,494	$11,423,195	$8.363,701 savings
92%	3,059,494	10,500,082	7,440,588 savings
90%	3,059,494	10,280,875	7,221,381 savings
80%	3,059,494	9,138,556	6,079,062 savings
70%	3,059,494	7,996,237	4,936,743 savings
60%	3,059,494	6,853,917	3,794,423 savings
50%	3,059,494	5,711,598	2,652,104 savings
40%	3,059,494	4,569,278	1,509,784 savings
30%	3,059,494	3,426,959	367,465 savings
26.7832%	3,059,494	3,059,497	3 savings
20%	3,059,494	2,284,639	<774,855> add'l cost
10%	3,059,494	1,142,320	<1,917,174> add'l cost
0%	3,059,494	0	<3,059,494> add'l cost

This table is adapted from a method developed by the Center for the Study of Social Policy (CSSP, Working Paper FP-6, 1989).

The two shaded rows of data from the Table illustrate that the "fiscal break-even point" for IFPS occurs at about the 27% (26.7832%) placement prevention rate, whereas the IFPS program actually performed at a 92% placement prevention rate. This yields a range of more than 60% within which program critics can argue about the cost-effectiveness of the program and the cost/benefit produced. However, the data clearly demonstrate that the program is *very cost-effective*, and results in a very high cost/benefit ratio.

Raymond S. Kirk, Ph.D. April 10, 1999
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Reasons to Retain Intensive Family Preservation Service (IFPS).

GOOD PUBLIC POLICY:

Intensive Family Preservation Services (IFPS), set in statute by the Washington State Legislature in 1992, provides intensive in-home counseling and support services for families whose children are at imminent risk of out-of-home placement. IFPS keeps children safe, reduces the need for costly out-of-home care, enhances permanency for children, and keeps children in the most culturally relevant home, their own.

SAFETY:

IFPS keeps children safe in their own homes. There have been no child fatalities during an IFPS intervention in the 24 years that the service has been available in the State of Washington.

PROGRAM EFFECTIVENESS:

Service providers have exceeded the outcome criteria set in state law: prevention of out-of-home placement in at least 70% of cases for no less than six months following termination of services. The current statewide average success rate is 78%.

COST EFFECTIVENESS:

Eliminating IFPS will not save the state money. Although the initial cost of IFPS services is high, **placement alternatives are more costly.** Average placement costs are computed based on the daily rate times the average length of stay in care.

IFPS costs:

- $2556 per child

Placement costs, based on average length of stay: [1]

- $12,270 for 18 months of regular foster care
- $30,000 for 10 months of therapeutic foster care
- $72,000 to $108,000 for 18 months of group care
- $29,700 for 3 months of residential treatment
- $9,000 for one month of psychiatric hospitalization

IMPLICATIONS OF ELIMINATING IFPS:

In other states, when IFPS was cut, the number of out-of-home placements increased, and more children died. For example, when Illinois abandoned IFPS-type services in 1993, child abuse deaths soared by 22% in the following two years. Foster care placements increased by 30% in 14 months, overwhelming the system. Child abuse deaths in foster care went from zero to five in the first year afterwards – an all-time record. There was a backlog of 5,000 uncompleted investigations. A Child Welfare Institute review found that 1/3 of the children in foster care could be immediately returned home. Similar results occurred in Connecticut and New York City when IFPS was cut.

[1] Region 5 Child Welfare Provider Agencies

11/09/98

North Carolina

INTENSIVE FAMILY PRESERVATION SERVICES

2000 ANNUAL REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBY

Executive Summary

This report presents data and findings on North Carolina's Intensive Family Preservation (IFPS) Program from State Fiscal Year 1999-00, and on the complete seven-year history of the program since the implementation of the automated, statewide management information system in January 1994. The findings from the analyses of seven-year trend data remain very positive, both in terms of achieving legislative intent, and in terms of achieving a variety of positive outcomes for children and families-at-risk in North Carolina.

During SFY '00, 22 IFPS programs offered services in 34 counties, serving 523 families in which 862 children were at imminent risk of being removed from the home. After IFPS services, 57 of those children (7%) were not living at home. This represents a placement prevention rate of 92% with respect to families, and 93% with respect to individual children. Changes in family functioning that enabled children and families to remain together safely included improvements in environmental factors, parental capabilities, family interactions, family safety and child well-being. SFY '00 was the first year that the North Carolina Family Assessment Scale, Version 2.0, was used by IFPS programs. The NCFAS V2.0 data are discussed in detail elsewhere in this report.

During the past year, the number of African American children served by IFPS programs remained the same, at 33% of all imminent risk children served, statewide. However, children

served from "other" non-white populations decreased from 8% in SFY'99 to 7% in SFY'00. The proportion of white children in the service population increased one percent to 60%.

Among the important findings of the 7-year trend analyses are that the IFPS program continues to show stability with regard to:

- sources of referral to services,
- the age and sex distribution of imminent risk children,
- the major presenting problems that these children and families face, and
- a very high degree of success in preventing placements, averaging about 90% per year with respect to families, and 91% with respect to individual children.

Other important 7-year findings are that the IFPS program appears to have a significant effect on determining the level of service need for children who are ultimately placed in out-of-home care. Data indicate that children at risk of placement in correctional or psychiatric care at the time of intake often are able to be served in less costly, less restrictive alternative placements. Further, a small number of children at risk of placement into foster care have service needs identified that result in their receiving mental health services or more restrictive care.

Analyses of data from the North Carolina Family Assessment Scale reveals statistically significant relationships between "strengths" on several domains and placement prevention, and between "problems" on several domains and out-of-home placement. Further, the data indicate convincingly that IFPS interventions are capable of improving family functioning across all the measured domains, albeit incrementally, and that these improvements in family functioning are statistically associated with placement prevention.

The findings from the client tracking study reveal that 77% of families (representing 81% of children) remained "intact" one year after IFPS, with 80% of imminent risk children living at

home or living with a relative, and 1% living with a family friend. The large majority of children (86%) were in "good to very good" general health, although nearly one quarter (23%) were reported to have moderate emotional/mental health difficulties, and almost an additional quarter (23%) were reported to have "poor to very poor" emotional/mental health during the previous year. However, about one half of the children accessed mental health services or other services and these reported difficulties did not result in family dissolution in the large majority of cases. Caretakers reported that there are still significant stressors in their families' lives. However, they also reported that they are fairing quite well, particularly when compared to their circumstances at the time that they began IFPS services.

Results of a retrospective study of the effectiveness of IFPS that was conducted during SFY '00 indicate that IFPS is effective in preventing or delaying out-of-home placement among the target population of high-risk families when compared to the same types of families receiving traditional child welfare services. Results also indicate that the higher the risk evident in families, the larger the difference is between IFPS and traditional services.

Taken as a whole, the evaluation results for the Intensive Family Preservation Services program in North Carolina reveal that:

- IFPS is more effective than traditional child welfare services in preventing or delaying the out-of-home placement of children from high-risk families;
- there are significant shifts in family functioning that occur during IFPS that are associated with positive treatment outcomes;
- placement prevention rates have been very steady, ranging between 88% and 92% of families, and 89% to 93% of children each year since SFY '94;
- IFPS is a very cost effective program, and yields a very favorable cost/benefit ratio;

- benefits appear to accrue for families that have received the service (measured by living arrangements of families, service utilization by families and their apparent abilities to handle family stress).

Introduction

This is the seventh Annual Report on North Carolina's Intensive Family Preservation Services (IFPS) program that presents data and information about families and children that have participated in the program. It is the fourth annual report in which data from more than one year are presented, including seven-year trend data on the service population and client tracking data that now spans more than four years. Information about the IFPS program's activities and performance relating specifically to SFY'00 are also presented, but are brief when compared to past years. Brevity is permitted because most demographic and program performance variables have been quite stable for the past several years.

Data that are presented graphically or in tables represent the most interesting findings from the current year, or from past years. There are also sections on Family Functioning, based upon the use of the North Carolina Family Assessment Scale, and long-term client tracking data that indicate how well families fare after having participated in the IFPS program.

Data from the IFPS statewide information system are presented that:

- examine this year's performance of the program,
- describe the historical trends of the program since its beginning,
- describe research and evaluation findings that help explain the program's data,
- examine the long term outcomes of families that have received the services, and
- discuss the cost effectiveness and cost/benefit of the program.

Review of Program Goals

The goal of North Carolina's Intensive Family Preservation Services Program is to prevent the unnecessary placement of children away from their families by providing intensive, in-home services that result in long term improvements in parents' abilities to care for and protect their children.

The services provided by IFPS programs are intended to meet the following objectives:

- to stabilize the crisis that places the child at imminent risk of placement;
- to keep the child, family and community safe by reducing the potential for violence (physical, sexual, emotional/verbal);
- to keep the child safe from the consequences of neglect;
- to help families develop skills and resources needed to face and resolve future crises; and,
- to improve family functioning so that the family's quality of life is improved.

Cost-Effectiveness, Cost/Benefit Analysis

The following analysis is based upon true costs of operating the IFPS program during SFY'00, and estimated placement costs provided by the Division of Social Services, the Division of Mental Health/Developmental Disabilities/Substance Abuse Services, and the Division of Youth Services.

During SFY '00 there were 862 children identified as being at imminent risk of placement into one of the state's child serving systems (DSS foster care, MH/DD/SAS facilities, Juvenile Justice facilities). Table 4 presents a breakdown of the number of children at risk of placement, and the number of children actually placed in care or not living at home.

Table 4. Children At Risk of Out-Of-Home Placement at Intake.

Potential Placement Type	Number of Children At Risk of Out-Of-Home Placement	Number of Children Placed or Not Living At Home
DSS Foster Care	647	26
Juvenile Justice	120	5
Mental Health	64	8
Developmental Disabilities	1	0
Substance Abuse Services	0	0
Private Placement	30	13
Other	NA	5
Totals	**862**	**57**

For purposes of the analysis, MH/DD/SAS and Private Placements (which are almost always psychiatric placements) are combined to determine the potential costs and cost savings of the IFPS program. Table 5 presents those estimated potential costs and estimated actual costs of placements.

Table 5. Estimated Potential and Estimated Actual Costs of Placements for SFY '00

Estimated Potential Placement Costs				Estimated Actual Placement Costs		
Placement Type	# of Children At Risk	Placement Costs	Total	# of Children Placed	Placement Costs	Total
DSS FC	647	4,382	2,835,154	26	4,382	113,932
MH/DD/SAS	95	21,433	2,036,135	21	21,433	450,093
Juv. Justice	120	53,785	6,454,200	5	53,785	268,925
Column Total	**862**		**11,325,489**	**52***		**832,950**

* This number is less than 57 because 5 children were either "on runaway", emancipated, married, in college, or were homeless.

Following are the cost-effectiveness and cost/benefit statistics for the IFPS program during SFY '00:

- 862 children were at imminent risk of removal, at a total potential placement cost of $11,325,489;
- 52 children were actually placed in various, known placements at an estimated cost of $832,950;
- IFPS diverted an estimated maximum of $10,492,539 from placement costs; a cost savings of 92.65%;
- if the cost of operating the IFPS program ($3,716,945) is subtracted from the gross savings ($10,492,539), a net savings of $6,775,594 results;
- the cost/benefit ratio of IFPS for SFY '00 is $1.82; that is, for every $1.00 spent providing IFPS, $1.82 is not being spent on placement services for imminent risk children who would otherwise be assumed to be placed in out-of-home care;
- the cost of delivering IFPS in SFY '00 was $4,312 per imminent risk child, and $7,107 per family;
- had all 862 children been placed as originally indicated, the placement cost per child would have been $13,139, and the families would not have received any services as part of these expenditures.

Table 6 presents a way of analyzing the costs and cost savings of IFPS that addresses the "fiscal break-even point" of operating the program. This is a useful analysis because some program critics contend that not all children who are identified as being at imminent risk would

eventually go into placement, even if they did not receive IFPS. They contend that traditional methods of presenting cost savings are misleading. Table 6 presents costs and cost savings at different levels of placement prevention, and demonstrates that the IFPS program is cost effective and results in a very high cost/benefit ratio.

The left-most column presents different levels of placement prevention; the other columns present the true costs of the program, the estimated placement costs avoided, and the net cost or cost saving of operating the IFPS program.

Table 6. Determining the Fiscal Break-Even Point of the IFPS Program: Cost and Cost-Savings Resulting from Different Levels of Child Placement Prevention

Placement Prevention Rates	Cost of Providing IFPS in SFY '00	Placement Costs Avoided	Net Additional Cost or Cost Savings
100%	$3,716,945	$11,325,489	$7,608,544 savings
SFY'00 @ 92.65%	3,716,945	10,492,539	6,708,594 savings
90%	3,716,945	10,192,940	6,475,995 savings
80%	3,716,945	9,060,391	5,343,446 savings
70%	3,716,945	7,927,842	4,210,897 savings
60%	3,716,945	6,795,293	3,078,348 savings
50%	3,716,945	5,662,745	1,945,800 savings
40%	3,716,945	4,530,196	813,251 savings
33% (32.8193%)	3,716,945	3,716,945	0 break even point
30%	3,716,945	3,397,647	<319,298> add'l. cost
20%	3,716,945	2,265,098	<1,451,847> add'l. cost
10%	3,716,945	1,132,549	<2,584,396> add'l. cost
0%	3,716,945	0	<3,716,945> add'l. cost

This table is adapted from a method developed by the Center for the Study of Social Policy (CSSP, Working Paper FP-6, 1989).

The two shaded rows of data from Table 6 illustrate that the "fiscal break-even point" for IFPS occurs at about the 33% (32.8193%) placement prevention rate, whereas the IFPS program actually performed at a 93% (92.6%) placement prevention rate. This yields a range of 60% of children served within which program critics can argue about the cost effectiveness of the program and the cost/benefit produced. However, the data clearly demonstrate that the program is very cost effective.

Summary of Major Findings and Conclusions of Outcome-Focused Evaluation of North Carolina's Intensive Family Preservation Services Program

- The North Carolina Family Assessment Scale, Version 2.0 (NCFAS V2.0) has been demonstrated to be a reliable and valid tool for measuring family functioning.
- Intensive Family Preservation Services are able to improve family functioning, albeit incrementally, in all areas measured by the NCFAS.
- Some areas of family functioning (e.g., Parental Capabilities, Family Interactions, Child Well-Being) are more amenable to change during a brief intervention than other areas (e.g., Environment).
- Family functioning scores, as measured on the NCFAS, are statistically significantly associated with placement and non-placement at the end of IFPS.
- Overall, placement prevention rates have been between 88% and 92% each year, since SFY '94.
- In addition to placement prevention, IFPS services are statistically significantly associated with reductions in the "level or care" needed among those children *who are placed* at the end of IFPS services.
- IFPS program cost analysis indicates that IFPS is a very cost-effective program. It also revealed a very favorable cost/benefit ratio.
- Long-term client tracking revealed durability of IFPS services one year after service, as measured by: living arrangements of families, service utilization by families and their apparent abilities to handle family stress, and caretakers attitudes about IFPS and other services.

COMPREHENSIVE MENTAL HEALTH SERVICES

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January 25, 2001

Rep. Sharon Cissna
State Capitol
Juneau, AK 99801

Dear Rep. Cissna,

I am writing on behalf of the Board of Directors and staff at Life Quest, the comprehensive mental health services provider in the Matanuska Susitna Borough. I have had an opportunity to review HB 23 and wish to offer my unqualified support.

During the past several years, we have been increasingly frustrated at our agency with the child welfare policy shift from family preservation to out of home (and out of community) placement for at risk kids. It appears as though most resources are now being used to place children and adolescents in emergency shelters, foster care, residential treatment and psychiatric centers while few dollars are being spent to keep kids with their own families.

HB 413 clearly stipulates that intensive family preservation services need to be provided before out of home, more restrictive placements can be considered. I have no doubt this will significantly reduce the number of out of home placements in and outside of Alaska.

Let me also offer my support of the Homebuilder's program as the model to be used for these intensive family preservation services. As you may or may not know, Life Quest has provided Home-Based therapy for the past 5 years. We have had some successful outcomes as result of this treatment strategy but have been searching for an intervention model that would improve our performance. As a result, we have determined, through our own research efforts, that the Homebuilder's program appears to make the most sense for our community, for the families we serve and for our staff. I, personally, participated in the Homebuilder's training program in the early 90's and had the opportunity to supervise in home children's services in mental health centers in other states that used this model. It can have a dramatic impact on families and is cost effective as well.

Life Quest wishes to offer our agency and our community as a demonstration site for the implementation of intensive family preservation services using the Homebuilder's model. We have over 15 years of experience providing mental health services to kids and families. We also have an array of programs that can serve to supplement and augment the proposed intensive family preservation efforts.

We would be happy to work with you and your staff, as well as the Department of Health and Social Services (DMHDD and DFYS) to bring this to fruition. Additionally, we might consider assistance from the Mental Health Trust Authority to support this endeavor.

Please let me know if you wish further information or clarification or if I can be of further assistance. Thanks again for allowing me to help support your efforts.

Sincerely,

William H. Hogan

William H. Hogan, CEO P.W.S.

SHELLEY LEAVITT, Ph.D.

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Education

	Washington State University, Pullman, Washington University of Madrid, Madrid, Spain
B.A.	in Sociology: Washington State University, Pullman, Washington.
M.A.	in Sociology: Boston University, Boston, Massachusetts. Thesis Title: Training Parents of Severely Deviant Children: Some Program and Follow-Up Findings. (M.A. Kozloff, Thesis Chairman)
Ph.D.	in Developmental Child Psychology: University of Kansas, Lawrence, Kansas. Dissertation Title: The Development and Evaluation of a Parent Training Program for Single Parents. (M.M. Wolf and D.L. Fixsen, Dissertation Chairmen)

Professional Experience

1998 to Present. **Associate Director,** Institute for Family Development (formerly Behavioral Sciences Institute), Federal Way, Washington.

1984 to 1998. **Assistant Director/Director of Training,** Behavioral Sciences Institute, Federal Way, Washington.

1979 to 1983. **Research Associate and Program Development Specialist**, Boys Town Center for the Study of Youth Development, Girls and Boys Town, Nebraska.

Publications

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Leavitt, S. and Robison, S. Intensive Family Preservation Services Implementation Guide and Tools Book. Federal Way, WA: Institute for Family Development, in press.

Professional Presentations

1980 - Present — Numerous presentations delivered at national and state meetings and conferences, including the American Psychological Association, Association for the Advancement of Behavior Therapy, National PTA, National Association of Family Based Services, Children's Defense Fund, Child Welfare League of America, National Council of Juvenile Court Judges, The International Children's Conference, and the Family Resource Coalition. Topics include, parent education and training; prevention/intervention programs for children and families; in-home services for children, youth and families; program evaluation, and critical thinking and decision-making. Specific references are available on request.

Training and Consultation

1980 - Present — Training, consultation and technical assistance provided to over 300 public and private organizations in the U.S., Puerto Rico, Canada, The Netherlands, Belgium, England, Germany, Finland, Lithuania, Portugal, Romania and Australia. Areas of expertise include: Program and Policy Development; Outcomes-based Evaluation; Child Welfare and Mental Health Services/Treatment for Children and Families; Organizational Development; Critical Thinking and Staff Training and Education. Specific references are available on request.

Professional Associations

American Psychological Association
National Family Preservation Network

Journal Affiliations

Editorial Board, Family Preservation Journal
Guest Reviewer, Journal of Applied Behavior Analysis

Board Affiliations

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February 24, 2004

House Health and Social Services Committee

Dear Committee members,

I would like to express my support for Bill 197, Family Preservation Services. As a Masters level practitioner providing mental health services for children and families in the State of Alaska, I believe it is imperative to move services closer to families. Intensive case management, smaller case loads and the ability for social workers to be family centered and deliver both hard and soft services will give reunification efforts a solid chance.

As a student intern, I had the opportunity to work in child protection services here in the State and learned that social workers are often relegated large case loads, enforcing legal mandates and department policies while families were often alienated throughout this process.

Family preservation and similar programs such as Homebuilders programs have shown to be successful in reducing the amount of children in foster care, unfortunately, these programs are often deemed as preventative strategies requiring additional resources despite the cost effectiveness and objective of reducing the number of children in the foster care system.

Please support this important legislation and allow our communities to provide intensive family preservation services and to help support the State's commitment towards reunification and supporting the best interests of children.

Sincerely,

James B. Gallanos MSW

James B. Gallanos, MSW

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HB

211

Alaska State Legislature

Representative Peggy Wilson
Putting Alaska's Families First

SPONSOR STATEMENT – CSHB 211 (HESS)
Alaska Nurse Recruitment Loan Repayment Program

Alaska and the nation are experiencing a severe shortage of nurses. HB 211, which establishes the Alaska Nurse Recruitment Loan Repayment Program, could help to change that. The program would offer up to $2,000 per year, not to exceed $10,000 total for nurses to repay nursing loans. Hopefully this incentive will attract new nurses to the state and encourage Alaskans to pursue their nursing vocations here in Alaska.

In 2002, the Alaska Colleagues in Caring, in collaboration with the Alaska Hospital and Nursing Home Association, surveyed facilities in Alaska regarding nursing workforce needs. Results showed that vacancy rates for RNs had increased from 5.7% in 2000 to 11.5% in 2002, with increasing vacancy rates projected into the future. Facilities in western and northern Alaska reported a vacancy rate of over 20% and, according to information from other sources; the vacancy rate in some remote areas of Alaska is as high as 35 percent.

To qualify for loan reimbursement, an individual must be hired as a nurse in Alaska on or after July 1, 2003, be licensed to practice as a nurse in Alaska, work as a nurse in the state throughout the loan repayment period, and have outstanding educational loans from a recognized lending institution.

Additional eligibility criteria and guidelines for the loan program will be set in regulations adopted by the Board of Nursing, in consultation with the Alaska Commission on Postsecondary Education. These may include guidelines on establishing priorities for participation in the loan repayment program if funding for the program is not adequate to meet need. The guidelines may include determinations based on areas of the state and nursing specialties affected by shortages,

Funding for the program may be appropriated from the Student Loan Corporation dividend (the return of contributed capital authorized in AS 14.42.295(a)) or alternate state, federal, or other sources. The executive director of the Alaska Commission on Postsecondary Education will administer the program.

Representative Peggy Wilson
April 4, 2003

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Alaska State Legislature

Representative Peggy Wilson
Putting Alaska's Families First

SECTIONAL ANALYSIS – CSHB 211 (HESS)

ALASKA NURSE RECRUITMENT LOAN REPAYMENT PROGRAM

Section 1: Findings and purpose.

Section 2: Adds responsibility for establishing standards and eligibility criteria for the Alaska Nurse Recruitment Loan Repayment Program, including the adoption of necessary regulations and determination of areas of the state and specialties that have a shortage of nurses, to the Alaska Board of Nursing, in consultation with the Alaska Commission on Postsecondary Education.

Section 3: Adds responsibility to perform duties relating to the Alaska Nurse Recruitment Loan Repayment Program to the list of responsibilities of the Alaska Commission on Postsecondary Education (ACPE).

Section 4: Directs the executive director of ACPE to administer the Alaska Nurse Recruitment Loan Repayment Program.

Section 5: Establishes that the money made available to the state from the dividend of the Student Loan Corporation may be appropriated for the Alaska Nurse Recruitment Loan Repayment Program.

Section 6: Establishes the Alaska Nurse Recruitment Loan Repayment Program.

Sec. 14.43.530 – Establishes the loan repayment program to provide financial incentives for qualified registered nurses to work in the state through the repayment of education loans.

Sec. 14.43.540 – Establishes the Alaska Nurse Recruitment Loan Repayment Program account in the general fund. The account shall be used to provide financial awards for the repayment of education loans and to pay for the costs of administering the program. The account includes money appropriated by the legislature from the dividend paid to the state by the Alaska Student Loan Corporation or other sources.

Sec. 14.43.550 –Establishes that the Alaska Nurse Recruitment Loan

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Representative_Peggy_Wilson@l.legis.state.ak.us • http://www.akrep.state.ak.us • 1-888-525-4221

Repayment Program shall be administered by the executive director of the ACPE using standards and eligibility criteria established by the Board of Nursing and financial management standards established by the commission. Gives the commission authority to adopt regulations to carry out the duties involved with administering the program, after consultation with the Board of Nursing.

Sec. 14.43.560 – Establishes these eligibility criteria:

- Applicant was hired as a nurse in Alaska on or after July 1, 2003.
- Applicant is employed as a nurse in Alaska during the loan repayment period.
- Applicant is licensed to practice as a nurse in Alaska.
- Applicant must agree to fulfill any requirement of the program.
- Applicant must have outstanding education loans from a recognized lending institution..

Sec. 14.43.570 – Establishes conditions and limitations on loan payments. The total repayment amount to any individual is limited to $10,000. An annual loan repayment to an individual may be the lesser of $2,000 or 20 percent of the total loan and interest owed by the person.

Financial awards under the program will be conditioned on the availability of funds. If adequate funds are not available to meet all needs, the executive director of ACPE may prorate available funds and suspend the acceptance of new applications or award funds available for new or pending applicants according to criteria approved by the Board of Nursing.

A loan is not eligible for repayment under the program if it is eligible for repayment or forgiveness under any other program

Sec. 14.43.590 – Definitions of terms.

Section 7: Allows the Board of Nursing and ACPE to adopt necessary regulations immediately upon passage of the Act.

Section 8: Establishes an immediate effective date for Section 7.

Section 9: Establishes an effective date of July 1, 2003, for the remainder of the Act.

23-LS0861\D
Ford
3/29/03

CS FOR HOUSE BILL NO. 211(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVE WILSON

A BILL

FOR AN ACT ENTITLED

"An Act relating to a student loan repayment program for nurses, and amending the duties of the Board of Nursing that relate to this program; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

FINDINGS; PURPOSE. (a) The legislature finds that a shortage of qualified nurses exists in this state.

(b) The purpose of this Act is to establish the Alaska nurse recruitment loan repayment program to provide financial incentives through the repayment, in whole or part, by the state of education loans for nurses upon the nurse's completing a term of employment as a nurse in the state.

*** Sec. 2.** AS 08.68.100(a) is amended by adding a new paragraph to read:

(10) in consultation with the Alaska Commission on Postsecondary

Education, establish standards and eligibility criteria for the Alaska nurse recruitment loan repayment program under AS 14.43.530 - 14.43.590, including the adoption of necessary regulations and determination of areas of the state that have a shortage of nurses.

*** Sec. 3.** AS 14.42.030(b) is amended to read:

(b) The commission shall

(1) administer the financial aid and interstate education compact programs under AS 14.43.091 - 14.43.920 and 14.43.990, and AS 14.44;

(2) administer the provisions of AS 14.48 concerning regulation of postsecondary educational institutions;

(3) resolve disputes under a consortium or other cooperative agreement between institutions of public and private higher education in the state; [AND]

(4) serve as the state agency required under 20 U.S.C. 1001 - 1155; **and**

(5) perform duties assigned under AS 14.43.530 - 14.43.590 (Alaska nurse recruitment loan repayment program).

*** Sec. 4.** AS 14.42.040 is amended by adding a new subsection to read:

(c) The executive director of the commission shall administer the Alaska nurse recruitment loan repayment program under AS 14.43.530 - 14.43.590 in accordance with standards and eligibility criteria set by the Board of Nursing under AS 08.68.100.

*** Sec. 5.** AS 14.42.295(a) is amended to read:

(a) The board may elect to pay the state a return of contributed capital, or a dividend, for each base fiscal year that the corporation's net income equals or exceeds $2,000,000. The payment may not be less than 10 percent nor more than 35 percent, as approved by the board, of the corporation's net income for the base fiscal year, and is subject to the provisions of any applicable bond indentures of the corporation. If a payment is authorized under this section, payment must be made available by the corporation before the end of the fiscal year in which payment has been authorized. The corporation shall notify the commissioner of revenue when the amount of the payment authorized under this section is available for appropriation. **The money made available under this subsection may be appropriated for the Alaska nurse**

recruitment loan repayment program under AS 14.43.530 - 14.43.590.

* **Sec. 6.** AS 14.43 is amended by adding new sections to read:

Article 9A. Alaska Nurse Recruitment Loan Repayment Program.

Sec. 14.43.530. Program established. (a) There is established the Alaska nurse recruitment loan repayment program to provide financial incentives for qualified nurses to work in this state through the repayment of education loans.

(b) The program is not a financial obligation of the corporation.

Sec. 14.43.540. Alaska nurse recruitment loan repayment program account. (a) The Alaska nurse recruitment loan repayment program account is created in the general fund. The account shall be used to provide financial awards for the repayment of education loans under the program and to pay for the costs of administering the program.

(b) The account includes money that the legislature appropriates from the corporation's dividend to the state under AS 14.42.295, the interest and earnings on money that are appropriated to the account, and funds contributed from federal or other sources. If money available is inadequate to finance the requests from eligible nurses under this program for a fiscal year, additional money may be requested from the general fund and appropriated to the account for the program.

Sec. 14.43.550. Administration. (a) The Alaska nurse recruitment loan repayment program shall be administered by the executive director using

(1) the standards and eligibility criteria of the program established by the Board of Nursing under AS 08.68.100 and the eligibility criteria established under AS 14.43.560; and

(2) the financial management standards for proper administration of the Alaska nurse recruitment loan repayment program account as established by the commission.

(b) After consultation with the Board of Nursing, the commission may adopt regulations to carry out its duties and the executive director's duties under the program.

Sec. 14.43.560. Eligibility criteria. In addition to program standards and eligibility criteria established under AS 08.68.100, an applicant must meet the

following criteria:

(1) the applicant was hired as a nurse in this state on or after July 1, 2003;

(2) the applicant is employed as a nurse in this state during the loan repayment period;

(3) the applicant has the required license to practice as a nurse in this state;

(4) the applicant shall agree to fulfill any requirement of the program;

(5) the applicant has outstanding education loans from a lending institution to be repaid under the program.

Sec. 14.43.570. Conditions and limitations on loan payments. (a) The total amount of education loans and interest on loans repaid for an individual may not exceed $10,000 in a lifetime for a nurse. An award under this section shall be paid on an annual basis over a period of at least five years. The maximum annual award under this section is the lesser of

(1) $2,000; or

(2) 20 percent of the total loan and interest amount owed by the program participant.

(b) An award must be conditioned on the availability of money for the program. The executive director shall monitor the outstanding financial awards made under the program to ensure the adequacy of the balance of the account to meet program needs. If the executive director finds that the balance of the account is

(1) insufficient to pay for existing awards, the executive director shall prorate the money available in the account among all existing award recipients and shall suspend the acceptance of new applications and the processing of pending applications under the program; and

(2) sufficient for existing awards but insufficient for new or pending applicants, the executive director shall pay existing awards and shall award the money available for new or pending applicants according to criteria approved by the Board of Nursing.

(c) An educational loan or interest on a loan is not eligible for repayment

under the program if the loan or interest is eligible for repayment under another source, including another loan repayment or forgiveness program.

Sec. 14.43.590. Definitions. In AS 14.43.530 - 14.43.590, unless the context otherwise requires,

(1) "account" means the Alaska nurse recruitment loan repayment program account established in AS 14.43.540;

(2) "executive director" means the executive director of the commission;

(3) "nurse" means a person licensed as a registered or practical nurse under AS 08.68.170;

(4) "program" means the Alaska nurse recruitment loan repayment program.

*** Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. Notwithstanding sec. 9 of this Act, the state Board of Nursing and the Alaska Commission on Postsecondary Education may immediately proceed to adopt regulations necessary to implement their respective duties under this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before July 1, 2003.

*** Sec. 8.** Section 7 of this Act takes effect immediately under AS 01.10.070(c)

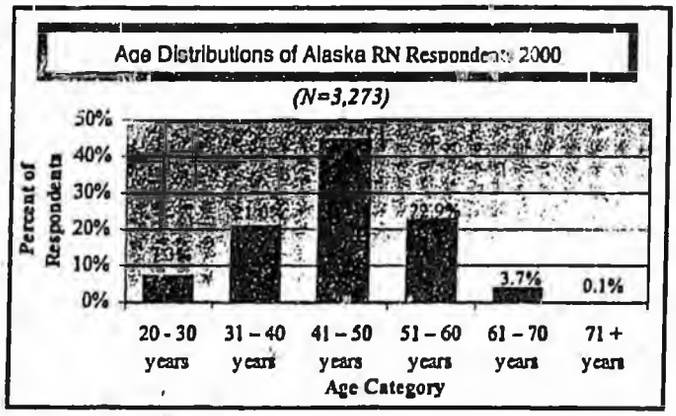
*** Sec. 9.** Except as provided in sec. 8 of this Act, this Act takes effect July 1, 2003.

AkNA
Alaska
Nurses
Association

Background On the Nursing Shortage in Alaska

There are currently about 5,200 RNs living in Alaska. Since the late 1990's there has been an increasing shortage of Registered Nurses in Alaska and the US as a whole. This has led to an 11.5% vacancy rate for nursing positions in the State. Contributing factors for this shortage include:

- The aging of the workforce. In 2000 the average age of a RN in Alaska 45.1 years compared to 43.3 years nationally. 72% of the RNs in Alaska are over the age of 40 years old. Data from the 2002 license renewal is currently being evaluated, but it is expected that the average age has only increased.[i]



- Hospital and nursing home nursing is very physically demanding. Because of this most nurses working in these settings retire in their 50s. Nationally it is projected that half the nursing workforce will retire in the next five years.

- Fewer young people have gone into the profession. This is graphically illustrated by the above figure.[ii] Formerly, the two primary occupations available to women were teaching and nursing. Now there are a larger number of options available. Many women who previously would have become nurses are now becoming doctors.

- Increased complexity of patient care. In order to reduce health care costs more procedures are being done on an outpatient basis, and hospital stays have been shortened. This means that the patients in hospitals are much sicker than 15 years ago, requiring more skilled care.

- In order to reduce costs, hospitals in the 90's increased the number of patients nurses were required to care for at the same time that the patients became sicker. This lead many nurses to leave the workforce because of concern about patient and nurse safety.

- A decrease in job satisfaction, as inadequate staffing is preventing RNs from providing high quality care to patients. One of the single most important factors in nurses being satisfied with their working conditions is the RN having ample time to provide quality care to their patients. This is usually directly tied the number and the acuity of the patients they are required to care for.

- Increased work-acquired injury and illness. This is addressed in detail elsewhere, but between the increased number of HIV and hepatitis infected patients and the increased weight of the population, many nurses have suffered career ending injuries or illnesses. It is not unusual for nurses to be asked to care for 300-500 lb patients.

Importance of RNs to Patient Health and Safety

The nursing shortage effects patient care in two main ways. Studies tie RNs to positive patient outcomes and poor staffing causes experienced RNs to leave the profession due to job dissatisfaction.

- A 2000 study[iii] looked at hospital and Medicare data from hospitals in nine states in five categories of adverse outcomes: length of hospital stay, pneumonia contracted in the hospital, postoperative infection, bed sores, and urinary tract infections contracted while in the hospital. All five measures are markedly decreased with higher levels of RN involvement in patient care.

- A study published in the October 2002 Journal of the American Medical Association[iv], found the risk of patient mortality increased by 7% for every additional patient in the average nurse's workload in the hospital;

- The study suggests that RNs contribute importantly to surveillance, early detection, and timely interventions that save lives;

- The benefits of improved RN staffing also extend to larger numbers of hospitalized patients who are not at risk for mortality but nevertheless are vulnerable to a wide range of unfavorable outcomes;

- Higher emotional exhaustion and greater job dissatisfaction in nurses were strongly and significantly associated with patient-to-nurse ratios;

- Improving nurse staffing levels may reduce alarming turnover rates in hospitals by reducing burnout and job dissatisfaction, major precursors of job resignation;

- Improving staffing may not only save patient lives and decrease nurse turnover but also reduce hospital costs, if recently published estimates of the costs of replacing a hospital medical and surgical general unit and a specialty nurse ($42,000 to $64,000) are correct.

Health and Safety Issues Related to the Nursing Shortage

Health care is rapidly becoming the most hazardous industry in America, as well as Alaska. RNs report that health and safety concerns play a major role in their decisions to remain in the profession. Nurses and other health care workers are exposed to the following hazards:

- Biological hazards: HIV, hepatitis B and C and more than 20 other infectious agents have caused infections in nurses caring for patients with these infections.
- Ergonomic Injuries – Ergonomics hazards of manual lifting and transfer of patients cause back injuries to over 1/3 of all nurses. Nurses are more prone to back injuries than construction laborer, truck loader, or warehouse worker.[v] Nurses accounted for more than 10% of the total for all occupations combined for neck, back and muscle injuries. [vi]
- Chemical hazards: latex allergy and disinfectants cause occupational asthma, and laser smoke, exposure to carcinogenic chemotherapeutic agents result in illness.

The Shortage Will Grow

Alaska Department of Labor and Workforce Development[vii] provided the below statistics related to the current and growing nursing shortage.

- Employment demand for RNs is projected to grow nearly 40% between 1998 – 2008, faster than the all-occupational average (16.6%)
- The number of RNs needed to fill the new jobs resulting from industry growth will increase by nearly 1,600.
- If 2008 projections hold true, RNs will be the largest single healthcare occupation and the seventh largest occupation in the state.
- Nursing shortage is nationwide and Alaska must compete for RNs, or grow more of our own, to keep up with demand caused by the aging of society, as well as the aging of the RNs.

Alaska Nursing Employer Survey Results[viii]

In 2002, the Alaska Colleagues in Caring, in collaboration with the Alaska Hospital and Nursing Home Association, surveyed facilities in Alaska regarding their nursing workforce needs.

- Vacancy rates for RNs increased on average from 5.7% in 2000 to 11.5% in 2002 with the West and North respondents reporting a 20.8% vacancy rate in 2002.

- Rate of Turnover reported for RNs in 2002 was 24% indicating difficulties with retaining RNs

- Employers identified the most successful retention incentives included
  - Decreased workload and greater scheduling choices
  - Educational Options
  - Management education and involvement
  - Positive work environment

- The percentage of facilities that actively recruit RNs from other states increased from 47.6% of facilities in 2000 to 83.3% of facilities in 2002.

- Employers identified the following anticipated changes in demand for nurses in the next two years
  1. Aging population/increased number of nurses retiring
  2. Increase in medical services used and number of patients
  3. Increased need for nurses, especially RNs
  4. Possible closure of facilities
  5. New facilities built/facility expansion
  6. An increased difficulty in recruiting and retaining nurses

Current Nursing Education in Alaska

The University of Alaska is the primary educator of nurses in the state. Weber State has had a small LPN program in the state for many years, but they will soon be leaving the state. Nursing education is very expensive to provide due to the cost of labs and clinical rotations. This cost is why there are not more providers of nursing education, and why nationally there has been a decrease in nursing education programs.

Current RN Programs Provided by UAA (110 RN graduates per year)

- 2 year RN – Anchorage 32 students admitted per year; Fairbanks16 students, Kodiak 9 students (every 2 years)
- 4 year RN – Anchorage 80 students admitted per year, with an additional 40 being added this summer
- 1 year LPN – Anchorage 16 students admitted per year, Bethel 7, Fairbanks 8(rotates), Ketchikan 6 (rotates)

Projected Locations and Numbers of Nursing Students 2006 (220 RN graduates per year)

- 2 year RN – Anchorage 32 students admitted per year, Fairbanks 16, and about 40 students admitted per year in Juneau, Bethel, Kodiak, Kenai, Ketchikan, or Sitka on a rotating basis. Other sites are also being investigated.
- 4 year RN – Anchorage 120 students admitted per year.

Articulation Programs
The University already has an RN to BSN program in place that can be completed through distance learning. UAA is in the process of refining the LPN to RN program to make mobility within the profession easier.

Current Demand for Nursing Education Exceeds Slots
The UAA four-year BSN program has only a minimal waiting list, which should be eliminated with this year's planned expansion. This year the 2-year (AAS) RN program had 2 applicants for every position. Initial interest meetings in expansion sites such as Kenai have shown a tremendous interest from persons in the community.

AkNA Alaska Nurses Association

SOLUTIONS

The Alaska Nurses Association suggests the following solutions to the Alaska nursing shortage, which come under three main categories:

- Recruitment and education of new RNs
- Retention of experienced RNs
- Adapting the work environment to prolong the careers of aging RNs

RECRUITMENT AND EDUCATION

- State funding support of UAA and Industry Consortium's effort to double the number of RN graduates by 2006. This requires the State to match the industries commitment of 2.4 million over the next three years.

- Continue Federal funding of the Recruitment and Retention of Alaska Natives into Nursing (RRANN Program) at UAA.

- Support legislation for tuition loan reimbursement of nurses who work in Alaska. Currently several legislators are working to draft such legislation.

- Support an increase to competitive salaries for nursing professors. RNs can currently make more practicing in a hospital than teaching at the University, making the recruitment of qualified instructors very difficult.

- The Alaska Nurses Association is working to develop a recruitment program aimed at grade school children to show them the variety of careers available in the nursing profession.

- The Alaska Nurses Association, hopefully with the support of the Alaska Department of Labor and the University, is planning to work with high schools in developing a pre-nursing preparation program to ensure a successful foundation is created in math and science, especially for rural and non-traditional students.

- With the help of industry, identify and develop training for post-graduate RNs in high-need specialty areas, such as OR and ICU.

- Encourage employers to provide financial incentives for nurses working in facilities to mentor nursing students and new graduates.

RETENTION OF EXPERIENCED RNS

Workplace Conditions

- Support creation and adoption of legislation and/or standards for an appropriate nurse to patient acuity system that creates a safe and satisfying work environment. Several states have passed or are considering similar legislation.

- Create financial incentives for facilities to apply for Nursing Magnet Status with American Nurses Credentialing Center. Magnet status ensures RN participation in workplace design, and promotes quality patient care, highly increasing job satisfaction.

- Encourage employers to make nursing attractive as a long-term career by increasing retirement and medical benefits.

- Encourage Employers to be responsive to RN needs, such as providing daycare that is available during the hours that nurses work and providing flexible scheduling options.

- Create legislation to prohibit mandatory overtime as a staffing solution to the nursing shortage. Other states have successfully passed such legislation.

Health and Safety Solutions

- Provide legislative or administrative incentives for facilities to purchasing latex free products in order to limit latex injuries to RNs and patients, as well as decrease related costs.

- Support the revision and passage of Alaska's existing Needlestick Legislation[ix] to meet federal standards, to protect patients and healthcare workers from HIV, Hepatitis, and other infectious diseases.

- Department of Labor's development of Regulations aimed at reducing injuries, and related costs, acquired from lifting and transferring patients in facilities, such as lift teams and assistive devices. Alaska Native Medical Center has had significant success in this area.

ADAPTING THE WORK ENVIRONMENT TO PROLONG THE CAREERS OF AGING RNS

- Encourage institutions to be flexible about working hours and patient loads to allow aging nurses to physically prolong their careers. Many facilities demand 12-hour shifts, which are physically demanding and difficult for aging RNs.

- Fund a study to explore what measures need to be adopted to keep RNs who are over 50 in the workforce.

- Find creative ways to utilize experienced nurses to educate, mentor and recruit new nurses into the profession.

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[i] "Alaska Colleagues in Caring, Alaska Re-Licensure Survey for RNs, 1996, 1998, and 2000", October 2001
[ii] Id.
[iii] ANA's Nurse Staffing and Patient Outcomes in the Inpatient Hospital Setting released in May of 2000.
[iv] "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," by Linda Aiken, PhD. RN, et. al., is in the October 23/30, 2002, issue of JAMA. The study looked at 232,342 patients between the ages of 20 and 85 who underwent general surgical, orthopedic, or vascular procedures in 168 Pennsylvania hospitals from April 1, 1998 to November 30, 1999.
[v] Labor Department's Bureau of Labor Statistics, in 1998.
[vi] Id.
[vii] Alaska Department of Labor and Workforce Development, Research and Analysis Section (April 9, 2002)
[viii] Alaska Colleagues in Caring Nursing Employer Survey, 1998, 200, & 2002.
[ix] Sec. 18.60.880. Needlestick and sharps injury protections for health care workers.

Alaska Nurses Association

APR - 4 2003

April 2, 2003

Honorable Peggy Wilson
State Capitol
Juneau, AK 99801-1182

Dear Representative Wilson;

On behalf of Alaska's 6,000 RNs I would like to thank you for taking the leadership in drafting HB 211, "An Act relating relating to a student loan repayment program for nurses."

Alaska is already facing a nursing shortage with health care facilities reporting average vacancy rates of 11%, with some rural facilities reporting vacancies as high as 35%. This shortage is only going to get worse over the next five years since the average age of nurses in the state is 47, and many hospital nurses retire in their mid-fifties.

The nursing shortage is contributing to the rise in health care costs because it is forcing health care institutions to staff with traveling and agency nurses who are more expensive to institutions than their regular staff. It is also leading to an increase in overtime, which is expensive to institutions and has be shown to contribute to nursing errors and injury.

The University of Alaska is responding to this shortage by doubling the number of nursing students they teach each year by the year 2006. SB 154 is an excellent companion to this effort by the University. It will provide an incentive for Alaskans to enter the profession, and remain in the state to practice.

With the armed conflict in the middle east, the threat of bioterrorism, and the emergence of fatal illnesses such as West Nile virus and SARS, now more than ever we need to take action to insure we have an adequate number of nurses to serve Alaskans in the coming years.

Sincerely,

Patricia K. Senner, MS, RN, ANP
President

2207 East Tudor, Suite 34, Anchorage, AK 99507-1069
907/274-0827 ▪ Fax 907/272-0292 ▪ www.aknurse.org

Subject: SB 154 & HB 211
Date: Sun, 30 Mar 2003 00:15:20 -0900
From: Karen Decker-Brown RN <karenrn@alaska.net>
To: representative_peggy_wilson@legis.state.ak.us

Dear Peggy Wilson:

What a great bill! It was needed five to ten years ago. I have been a nurse for over 20 years, born here and love being a nurse. I am currently finishing up graduate school, (MSN) and have incurred about 30-40 K costs for grad school between courses, books, travel, mailings misc. and so forth. It will take years of employment for me to be on the plus side of the equation when other day to day living expenses are factored. My husband and I took out a home equity loan to pay for school. I should be graduating this summer. Unfortunately, UAA would not admit me to their program although every other grad nursing program I applied to in the lower 48 accepted me. This forced me to incurr additional expenses for travel that I would not have otherwise have. I attribute this to predjudice and that they get more money from out of state stincur. But that is old history. I am excited about this as my daughter who was born here has alprejudice for nursing school, although obviously not in the State of Alaska. I have been encouraging young people to go into the profession as it has been good for me and I would like to see other native students go this route. Karen Decker-Brown RN FNPS.

HB

231

ALASKA STATE LEGISLATURE
REPRESENTATIVE JOHN HARRIS
STATE CAPITOL 507 JUNEAU ,ALASKA 99801-1182 (907)465-4859

MEMORANDUM

April 14, 2003

To: Representative Peggy Wilson, Chair
House: Health, Education and Social Services

From: Representative John Harris

Subject: Hearing request for HB 231

Please schedule a Health, Education and Social Services committee hearing on HB231 as soon as your committee calendar will allow. This bill would allow the court to terminate the parental rights of a noncustodial parent if requested by the custodial parent, and the court finds substantial child support arrearages.

Attached are background materials for the bill. If you have questions or need additional information, please contact Pete Fellman of my staff at 465 4859. Thank you for your consideration of this request to hear HB 231

Alaska State Legislature

REPRESENTATIVE JOHN HARRIS

District 35 - Valdez, Cordova, Whittier, Glennallen, Delta Junction, Tatitlek, Kenny Lake, Paxson, Gakona, Chenega Bay

SPONSOR STATEMENT

House Bill 231: *"An Act relating to termination of the parental rights of a person who owes substantial child support arrearages."*

House Bill 231 is an effort to solve problems single custodial parents have with non-custodial parents who refuse to pay their share of child support. Many custodial parents go for years with no financial support, yet the non-custodial parent maintains parental rights as if they helped provide for the child. Under current law, these non-custodial parents maintain whatever parental jurisdiction the courts allow. However, the custodial parent holds all the financial responsibility.

House Bill 231 would allow custodial parents to petition the court to have the non-custodial parents rights removed. If the court finds that the removal of parental rights is in the best interest of the child, those rights can be removed. This frees the custodial parent from the burden of consulting and involving a deadbeat parent.

This legislation will provide a tool to a parent from having to share parental decisions with non-custodial parents who don't pay their fair share. In addition, this legislation could alleviate the non-custodial parent from having to pay support in the future.

Co-Chair: Community and Regional Affairs Committee; Member: Resources, Labor and Commerce, Oil and Gas, Fisheries and Regulation Review

Session: State Capitol, Juneau, Alaska 99801-1182 • Phone: (907) 465-4859 Fax: (907) 465-3799

Interim: P.O. Box 1245, Valdez, Alaska 99686 • Phone (907) 835-2836 Fax: (907) 835-3732

Chapter 25.20. PARENT AND CHILD

Sec. 25.20.010. Age of majority.

A person is considered to have arrived at majority at the age of 18, and thereafter has control of the person's own actions and business and has all the rights and is subject to all the liabilities of citizens of full age, except as otherwise provided by statute.

Sec. 25.20.020. Arrival at majority upon marriage.

A person arrives at the age of majority upon being married according to law, unless the person is under the marriageable age of consent as defined in AS 25.05.171 (a), in which case the person reaches majority upon reaching the marriageable age of consent.

Sec. 25.20.025. Examination and treatment of minors.

(a) Except as prohibited under AS 18.16.010 (a)(3),

(1) a minor who is living apart from the minor's parents or legal guardian and who is managing the minor's own financial affairs, regardless of the source or extent of income, may give consent for medical and dental services for the minor;

(2) a minor may give consent for medical and dental services if the parent or legal guardian of the minor cannot be contacted or, if contacted, is unwilling either to grant or withhold consent; however, where the parent or legal guardian cannot be contacted or, if contacted, is unwilling either to grant or to withhold consent, the provider of medical or dental services shall counsel the minor keeping in mind not only the valid interests of the minor but also the valid interests of the parent or guardian and the family unit as best the provider presumes them;

(3) a minor who is the parent of a child may give consent to medical and dental services for the minor or the child;

(4) a minor may give consent for diagnosis, prevention or treatment of pregnancy, and for diagnosis and treatment of venereal disease;

(5) the parent or guardian of the minor is relieved of all financial obligation to the provider of the service under this section.

(b) The consent of a minor who represents that the minor may give consent under this section is considered valid if the person rendering the medical or dental service relied in good faith upon the representations of the minor.

(c) Nothing in this section may be construed to remove liability of the person performing the examination or treatment for failure to meet the standards of care common throughout the health professions in the state or for intentional misconduct.

Sec. 25.20.030. Duty of parent and child to maintain each other.

Each parent is bound to maintain the parent's children when poor and unable to work to maintain themselves. Each child is bound to maintain the child's parents in like circumstances.

Sec. 25.20.040. Maintenance and education of minor out of income of the minor's property.

If a minor who has a parent living has property from which income is sufficient for maintenance and education in a manner more expensive than the parent can reasonably afford, considering the situation of the parent's family and all the circumstances of the case, the expenses of the minor's maintenance and education may be defrayed out of the income of the property, in whole or in part, as judged reasonable by the court. The expenses may be allowed accordingly in the settlement of the accounts of the minor's guardian.

Sec. 25.20.045. Legitimacy of children conceived by artificial insemination.

A child, born to a married woman by means of artificial insemination performed by a licensed physician and consented to in writing by both spouses, is considered for all purposes the natural and legitimate child of both spouses.

Sec. 25.20.050. Legitimation by subsequent marriage, acknowledgment in writing or adjudication.

(a) A child born out of wedlock is legitimated and considered the heir of the putative parent when (1) the putative parent subsequently marries the undisputed parent of the child; (2) for acknowledgments made before July 1, 1997, the putative parent acknowledges, in writing, being a parent of the child; (3) for acknowledgments made on or after July 1, 1997, the putative father and the mother both sign a form for acknowledging paternity under AS 18.50.165 ; or (4) the putative parent is determined by a superior court without jury or by another tribunal, upon sufficient evidence, to be a parent of the child. Acceptable evidence includes evidence that the putative parent's conduct and bearing toward the child, either by word or act, indicates that the child is the child of the putative parent. That conduct may be construed by the tribunal to constitute evidence of parentage. When indefinite, ambiguous, or uncertain terms are used, the tribunal may use extrinsic evidence to show the putative parent's intent.

(b) The Bureau of Vital Statistics, as custodian of the original certificates of birth of all persons born in the state, is designated as the depository for such acknowledgment and adjudication. The acknowledgment or adjudication shall be forwarded to the bureau in accordance with appropriate regulations of the bureau, and shall be noted on and filed with the corresponding original certificate of birth.

(c) In case of the birth in this state of a child out of wedlock and the legitimation of the child in accordance with this section, at the written request of the parents, or either of them or of the legal guardian, or of the person when of legal age, the Bureau of Vital Statistics shall prepare and place on file a substitute birth certificate, in accordance with the laws and regulations of the bureau pertaining to new certificates of this type.

(d) The results of a genetic test that is of a type generally acknowledged as reliable by an accreditation body designated by the Secretary of Health and Human Services and performed by a laboratory approved by such an accreditation body shall be admitted and weighed in conjunction with other evidence in determining the statistical probability that the putative parent is a legal parent of the child in question. However, a genetic test described in this subsection that establishes a probability of parentage at 95 percent or higher creates a presumption of parentage that may be rebutted only by clear and convincing

evidence.

(e) Except as provided in (i) of this section, in proceedings in which paternity is contested, the tribunal shall order the parties, including the child, to submit to testing as described in (d) of this section upon request of

(1) the child support enforcement agency created in AS 25.27.010 or the child support enforcement agency of another state; or

(2) a party, including a sworn statement

(A) alleging the paternity of an individual and setting out facts that show a reasonable possibility that the mother and that individual had sexual contact that could have resulted in the conception of the child; or

(B) denying the paternity of an individual and setting out facts that show a reasonable possibility that the mother and that individual did not have sexual contact that could have resulted in the conception of the child.

(f) The child support enforcement agency may recover the costs of testing ordered under (e) of this section from the alleged father unless the testing establishes that the individual is not the father, except that costs may not be recovered from a person who is a recipient of cash assistance or self-sufficiency services under AS 47.27 (Alaska temporary assistance program). For purposes of this subsection, a person who receives a diversion payment and self-sufficiency services under AS 47.27.026 is not considered to be a recipient of cash assistance or self-sufficiency services under AS 47.27.

(g) A default judgment shall be entered against the defendant in an action where paternity is contested upon

(1) a showing that process was served on the defendant as required under applicable state law and court rules;

(2) a showing that the defendant has failed to appear at a hearing in the action or has failed to respond within a reasonable period of time as specified in court rules; and

(3) any additional showing determined necessary by the court.

(h) The tribunal in a paternity action shall give full faith and credit to a determination of paternity made by another state, whether established through voluntary acknowledgment or through administrative or judicial procedures.

(i) If a tribunal finds that good cause exists not to order genetic testing after considering the best interests of the child, the tribunal may not order testing under (e) of this section.

(j) Invoices, bills, or other standard documents showing charges for medical and related costs of pregnancy, childbirth, or genetic testing are admissible in an action to establish paternity without testimony or other evidence from the medical or other provider or third-party payor to provide the foundation for admissibility of the documents. The documents shall constitute prima facie evidence of the amounts incurred for such charges.

(k) Upon the motion of the child support enforcement agency or another party in the action to

establish paternity, the tribunal shall issue a temporary order for support of the child whose paternity is being determined. The order may require periodic payments of support, health care coverage, or both. The order shall be effective until the tribunal issues a final order on paternity and a permanent order for support is issued or the tribunal dismisses the action. The temporary order may only be issued if the tribunal finds clear and convincing evidence of the paternity of the putative father on the basis of the results of the genetic tests and other evidence admitted in the proceeding.

(l) The tribunal shall consider a completed and signed form for acknowledging paternity that meets the requirements of AS 18.50.165 (a) as a legal finding of paternity for a child born out of wedlock. For an acknowledgment signed on or after July 1, 1997, the acknowledgment may only be withdrawn by the earlier of the following dates: (1) 60 days after the date that the person signed it, or (2) the date on which judicial or administrative procedures are initiated to establish child support in the form of periodic payments or health care coverage for, or to determine paternity of, the child who is the subject of the acknowledgement. After this time period has passed, the acknowledgment may only be contested in superior court on the basis of fraud, duress, or material mistake. The parent wishing to contest the acknowledgment carries the burden of proof by a preponderance of the evidence. Unless good cause is shown, the court may not stay child support or other legal responsibilities while the action to contest the acknowledgment is pending.

(m) If a parent signs an acknowledgment of paternity under (a) of this section and does not successfully challenge the acknowledgment under (l) of this section, the child born out of wedlock is considered legitimated and the heir of the parent without further action of the tribunal to ratify the acknowledgment of paternity.

(n) Each paternity order or acknowledgment made under this section must include in the records relating to the matter the social security numbers, if ascertainable, of the following persons:

(1) the father;

(2) the mother;

(3) the child.

(o) In this section, unless the context requires otherwise, "tribunal" means a court, administrative agency, or quasi-judicial entity authorized by state law to determine parentage.

Sec. 25.20.055. Early acknowledgement of paternity program.

(a) When a birth occurs to an unmarried woman in a hospital or en route to a hospital to which the woman is later admitted, the hospital shall ensure that a staff member

(1) meets with the woman before release from the hospital;

(2) attempts to meet with the father of the unmarried woman's child, if possible;

(3) presents to the mother and, if possible, the father, a pamphlet or statement regarding the rights and responsibilities of a natural parent; the Department of Health and Social Services shall prepare this pamphlet and distribute copies of it to each hospital in the state, to each physician in the state whose practice includes attendance at births, to each nurse-midwife and direct-entry midwife in the state, and to other interested persons in the state who request copies;

(4) provides to the mother and, if possible, the father, all forms, statements, or agreements necessary to voluntarily establish a parent and child relationship, including an acknowledgement of paternity form prepared under AS 18.50.165 ;

(5) on request of the mother and father, assists the father in completing specific forms, statements, or agreements necessary to establish a parent and child relationship between the father and the child; and

(6) on request of the mother and father, mails a completed voluntary acknowledgement of paternity form to the state registrar for filing under AS 18.50.165 .

(b) When a birth occurs to an unmarried woman who is not in a hospital for the birth nor admitted to a hospital immediately after the birth, and the birth is attended by a physician, nurse-midwife, or direct-entry midwife, the physician, nurse-midwife, or direct-entry midwife shall perform the duties described in (a)(2) - (6) of this section or ensure that an agent performs those duties.

(c) When a birth occurs in a situation that is not covered by either (a) or (b) of this section, any adult may, upon request of the father and mother, assist them in filing a voluntary acknowledgement of paternity form with the state registrar under AS 18.50.165 .

(d) Notwithstanding (a) of this section, the Department of Health and Social Services may adopt regulations to establish exceptions for good cause that identify circumstances under which a hospital is not required to comply with (a) of this section. A hospital may be excused from complying with (a) of this section if the hospital meets those regulatory requirements.

Sec. 25.20.060. Petition for award of child custody.

(a) If there is a dispute over child custody, either parent may petition the superior court for resolution of the matter under AS 25.20.060 - 25.20.130. The court shall award custody on the basis of the best interests of the child. In determining the best interests of the child, the court shall consider all relevant factors including those factors enumerated in AS 25.24.150 (c). In a custody determination under this section, the court shall provide for visitation by a grandparent or other person if that is in the best interests of the child.

(b) Neither parent, regardless of the question of the child's legitimacy, is entitled to preference in the awarding of custody.

(c) The court may award shared custody to both parents if shared custody is determined by the court to be in the best interests of the child. An award of shared custody shall assure that the child has frequent and continuing contact with each parent to the maximum extent possible.

(d) If the court finds that a parent or child is a victim of domestic violence, the court may order that the address and telephone number of the parent or child be kept confidential in the proceedings.

Sec. 25.20.061. Visitation in proceedings involving domestic violence.

If visitation is awarded to a parent who has committed a crime involving domestic violence, against the other parent or a child of the two parents, within the five years preceding the award of visitation, the court may set conditions for the visitation, including

(1) the transfer of the child for visitation must occur in a protected setting;

(2) visitation shall be supervised by another person or agency and under specified conditions as ordered by the court;

(3) the perpetrator shall attend and complete, to the satisfaction of the court, a program for the rehabilitation of perpetrators of domestic violence that meets the standards set by the Department of Corrections under AS 44.28.020 (b), or other counseling; the perpetrator shall be required to pay the costs of the program or other counseling;

(4) the perpetrator shall abstain from possession or consumption of alcohol or controlled substances during the visitation and for 24 hours before visitation;

(5) the perpetrator shall pay costs of supervised visitation as set by the court;

(6) the prohibition of overnight visitation;

(7) the perpetrator shall post a bond to the court for the return and safety of the child; and

(8) any other condition necessary for the safety of the child, the other parent, or other household member.

Sec. 25.20.065. Visitation rights of grandparent.

(a) Except as provided in (b) of this section, a child's grandparent may petition the superior court for an order establishing reasonable rights of visitation between the grandparent and child if

(1) the grandparent has established or attempted to establish ongoing personal contact with the child; and

(2) visitation by the grandparent is in the child's best interest.

(b) After a decree or final order relating to child custody is entered under AS 25.20.060 or AS 25.24.150 or relating to an adoption under AS 25.23, a grandparent may petition under this section only if

(1) the grandparent did not request the court to grant visitation rights during the pendency of proceedings under AS 25.20.060 , AS 25.23, or AS 25.24; or

(2) there has been a change in circumstances relating to the custodial parent or the minor child that justifies reconsideration of the grandparent's visitation rights.

(c) When determining whether to grant rights of visitation between a grandparent and grandchild under this section, AS 25.20.060 , or AS 25.24, and when determining the terms and conditions to be attached to a right of grandparent visitation, the court shall consider whether there is a history of child abuse or domestic violence attributable to the grandparent's son or daughter who is a parent of the grandchild.

Sec. 25.20.070. Temporary custody of the child.

Unless it is shown to be detrimental to the welfare of the child, the child shall have, to the greatest degree

practical, equal access to both parents during the time that the court considers an award of custody under AS 25.20.060 - 25.20.130.

Sec. 25.20.080. Mediation of child custody matter.

(a) Except as provided in (f) and (g) of this section, at any time within 30 days after a petition for child custody is filed under AS 25.20.060 the court may order the parties to submit to mediation. Each party has the right to challenge peremptorily one mediator appointed.

(b) Mediation shall be conducted informally as a conference, or by telephone, or series of conferences, as determined by the mediator. The parties to the action and a court-appointed representative of the minor children shall attend.

(c) If the mediator determines that mediation efforts are unsuccessful, the mediator shall terminate mediation and notify the court that mediation efforts have failed. The custody proceeding shall proceed in the usual manner.

(d) Upon submission of the parties to mediation under this section a pending child custody proceeding shall be stayed for a period of 30 days or until the court is notified that mediation efforts have failed. All court orders made during the pending custody proceeding remain in effect during the period of mediation.

(e) Costs of mediation shall be paid as ordered by the court by one party, by both parties, or by the state if both parties are indigent.

(f) The court may not order or refer parties to mediation in a proceeding concerning custody or visitation of a child if a protective order issued or filed under AS 18.66.100 - 18.66.180 is in effect. The court may not order or refer parties to mediation if a party objects on the grounds that domestic violence has occurred between the parties unless the court finds that the conditions of (g)(1) - (3) of this section are met. If the court proposes or suggests mediation under this subsection,

(1) mediation may not occur unless the victim of the alleged domestic violence agrees to the mediation; and

(2) the court shall advise the parties that each party has the right to not agree to mediation and that the decision of each party will not bias other decisions of the court.

(g) A mediator who receives a referral or order from a court to conduct mediation under (a) of this section shall evaluate whether domestic violence has occurred between the parties. A mediator may not engage in mediation when either party has committed a crime involving domestic violence unless

(1) mediation is requested by the victim of the alleged domestic violence, or proposed by the court and agreed to by the victim;

(2) mediation is provided by a mediator who is trained in domestic violence in a manner that protects the safety of the victim and any household member, taking into account the results of an assessment of the potential danger posed by the perpetrator and the risk of harm to the victim; and

(3) the victim is permitted to have in attendance a person of the victim's choice, including an attorney.

Sec. 25.20.090. Factors for consideration in awarding shared child custody.

In determining whether to award shared custody of a child the court shall consider

(1) the child's preference if the child is of sufficient age and capacity to form a preference;

(2) the needs of the child;

(3) the stability of the home environment likely to be offered by each parent;

(4) the education of the child;

(5) the advantages of keeping the child in the community where the child presently resides;

(6) the optimal time for the child to spend with each parent considering

(A) the actual time spent with each parent;

(B) the proximity of each parent to the other and to the school in which the child is enrolled;

(C) the feasibility of travel between the parents;

(D) special needs unique to the child that may be better met by one parent than the other;

(E) which parent is more likely to encourage frequent and continuing contact with the other parent;

(7) any findings and recommendations of a neutral mediator;

(8) any evidence of domestic violence, child abuse, or child neglect in the proposed custodial household or a history of violence between the parents;

(9) evidence that substance abuse by either parent or other members of the household directly affects the emotional or physical well-being of the child;

(10) other factors the court considers pertinent.

Sec. 25.20.100. Reasons for denial to be set out.

If a parent or the guardian ad litem requests shared custody of a child and the court denies the request, the reasons for the denial shall be stated on the record.

Sec. 25.20.110. Modification of child custody or visitation.

(a) An award of custody of a child or visitation with the child may be modified if the court determines that a change in circumstances requires the modification of the award and the modification is in the best interests of the child. If a parent opposes the modification of the award of custody or visitation with the child and the modification is granted, the court shall enter on the record its reason for the modification.

(b) When making a determination relating to child custody under (a) of this section, the court shall consider the past history of the parents with respect to their compliance with the child support payment

provisions of temporary or permanent support orders or agreements relating to the child or to other children. Under this subsection, the court may consider a parent's failure to pay child support only if the parent had actual knowledge of the amount of the child support obligation and had funds available for payment of support or could have obtained those funds through reasonable efforts, as determined by the court.

(c) In a proceeding involving the modification of an award for custody of a child or visitation with a child, a finding that a crime involving domestic violence has occurred since the last custody or visitation determination is a finding of change of circumstances under (a) of this section.

Sec. 25.20.115. Attorney fee awards in custody and visitation matters.

In an action to modify, vacate, or enforce that part of an order providing for custody of a child or visitation with a child, the court may, upon request of a party, award attorney fees and costs of the action. In awarding attorney fees and costs under this section, the court shall consider the relative financial resources of the parties and whether the parties have acted in good faith.

Sec. 25.20.120. Closure of custody proceedings and records.

At any stage of a proceeding involving custody of a child the court may, if it is in the best interests of the child, close the proceeding to the public or order the court records closed to the public temporarily or permanently. The court may modify or vacate an order under this section at any time.

Sec. 25.20.130. Access to records of the child.

A parent who is not granted custody under AS 25.20.060 - 25.20.130 has the same access to the medical, dental, school, and other records of the child as the custodial parent.

KANSAS LEGISLATIVE RESEARCH DEPARTMENT
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July 7, 1999

To: SRS Transition Oversight Committee

From: Emalene Correll, Research Associate

Re: Guardians *Ad Litem*

Background

The most notable procedural difference between adults and minors as litigants is representation. Because of legal incapacity, minors cannot initiate or defend lawsuits without adult assistance. Historically, a minor as plaintiff sued through his "next friend," and when the minor was a defendant, was represented by a guardian *ad litem*. This distinction has been blurred over time and the terms are used almost interchangeably in a majority of the states. Some states use other terminology to refer to the guardian *ad litem*. New York is an example, using the term "law guardians" to refer to those who in other jurisdictions are known as guardians *ad litem*.

In a 1967 case, *In re Gault*, the U.S. Supreme Court ruled for the first time that children involved in juvenile delinquency proceedings are entitled to representation by counsel at state expense. It is this case that has generated activity in most states over the past three decades to attempt to define when children are entitled to representation by counsel or guardians *ad litem* in actions in the state courts. In 1974, Congress enacted the Child Abuse Prevention and Treatment Act which requires that a guardian *ad litem* be appointed "in every case involving an abused or neglected child which results in a judicial proceeding." Since the federal language creates a prerequisite for states to receive federal funds for child abuse and neglect prevention and treatment, the appointment of a guardian *ad litem* in child abuse and neglect cases is almost universal. However, the federal law does not provide any guidance about who should serve as guardians *ad litem*, what their duties or responsibilities are to be, at what stage they are to be appointed, and other issues that states have been wrestling with over the past several decades. Many of the states have followed the federal action in requiring the appointment of a guardian *ad litem* in specific circumstances and in specific types of cases.

It is generally agreed the courts have the inherent power to appoint guardians *ad litem* for minors involved in litigation and have the duty to insure a minor's best interests are adequately represented. It is also generally agreed the appointment of a guardian *ad litem* is to benefit the child, not other parties.

According to *Legal Rights of Children*, while the appointment of a guardian *ad litem* is generally considered to be within the discretionary power of the courts, such appointments are most frequently made in adoption, child custody, child support, paternity, visitation rights, and child abuse cases. Some states have adopted the federal rule, others do not have discretionary appointment provisions, and others have more comprehensive requirements that cover such topics as the ability of a child of a specified age to nominate his own guardian *ad litem* and the financial responsibility of the guardian *ad litem* for litigation-related costs. Some states require such appointments in every instance in certain types of cases. Missouri, for example, requires the appointment of a guardian *ad*

litem in all child custody proceedings that involve allegations of child abuse or neglect, in cases where custody, visitation, or child support is contested, and in contested paternity cases. The Missouri statute (Mo Civ P 507, 190 *et seq.*) is considered to be an example of a broad guardian *ad litem* statute. California requires determinations regarding appointments to be made on a case-by-case basis, but requires the appointment of a guardian *ad litem* if a conflict exists between a minor and a state agency. According to one source, no reported case has ever held that a U.S. district court abused its discretion by appointing a guardian *ad litem*, but it has been held to be a reversible error for a trial court to fail to determine whether a guardian *ad litem* is necessary.

Guardians *ad litem* are usually considered officers of the court, subject to court supervision, and charged with representing the child's best interest. For the past several decades states have been wrestling with what constitutes protecting the child's best interests. It is generally agreed, for example, the guardian *ad litem* should be aggressive in protecting the interests of the child, particularly in custody cases, but how this is to be done is not yet subject to universal agreement.

State Cases and Laws

In an Alaska case, the court directed that the guardian *ad litem* should normally conduct home visits and private interviews with the child when custody is an issue. Since the child's best interest and the child's wishes may be in conflict, the guardian in some states is expected to advocate the child's best interests, while in others the guardian is to present what he or she considers the child's best interest, but make it clear to the court what the child's wishes are (*Hawaii Revised Statutes*, Sec. 587.34(c)). In Wisconsin, if the child is 12 or older, the guardian must present the child's wishes to the court, but if the child is under 12, the guardian is required only to represent the best interests of the child (*Wisconsin Statutes*, Sec. 48.23(3)).

It is not always clear to a guardian *ad litem* exactly what the court may desire in protecting the child's best interest. In a Maryland case (*Leary v. Leary*), the court suggested the appointing judge make it clear whether the guardian is expected primarily to act as a traditional guardian, as an investigator, as an advocate for the child, or in some other protective role.

Payment of fees and expenses is generally decided by the court making the appointment of a guardian *ad litem*. However, fees and expenses for the court appointed guardian is an issue that has been the subject of much study and is generally considered to be a key issue in improving the system. (See recommendations in the *Technical Assistance Bulletin* of the National Council of Juvenile and Family Court Judges supplied to the Committee.)

There is some dispute to whether the guardian *ad litem* is responsible for negligence in representing a minor. Some courts have held that a guardian who is negligent may be held liable for damages. In a recent federal case (*Kohl v. Murphy*), the court held that guardians *ad litem* are not always entitled to absolute immunity for their actions. Most state courts have held the guardian *ad litem* is absolutely immune for his or her actions. This is another issue under study in some states.

Recent State Legislation

A 1997 Arkansas law requires the appointment of an attorney *ad litem* to represent the best interests of juveniles in dependency-neglect proceedings, authorizes court appointment of special advocates who meet specified training requirements, creates a Division of Dependency-Neglect

Representation, and authorizes creation of a statewide court appointed special advocate program within the court system.

A 1997 Connecticut law requires the release of records to attorneys and guardians *ad litem* in any proceedings affecting the best interests of the child.

A 1997 Florida act allows a juror to donate his or her compensation for jury duty to the guardian *ad litem* program or a domestic violence shelter.

1997 Illinois Laws, P.A. 90-28, Sec. 10-20 requires the court appointed guardian *ad litem* in counties of fewer than 3,000,000 people to remain with the same child throughout the entire juvenile trial court process, including permanency and termination of parental rights hearings. The 1997 act also requires a training program for guardians *ad litem*.

Maine, in a 1997 law, requires the appointment of guardian *ad litem* or a "visitor" within two days of appointment of a temporary guardian. The visitor or guardian *ad litem* must visit the child and report to the court within ten days of the appointment. Another 1997 Maine act requires the guardian *ad litem* to have a face-to-face interview with the child.

Chapter 239, *1997 Minnesota Laws* requires the appointment of a guardian *ad litem* in all child protection cases and allows the court to appoint separate counsel for the guardian if necessary. Any waiver of rights by an unrepresented minor must be made by a guardian *ad litem*, not a parent. The law mandates access to records on the part of counsel representing a child, parent, or guardian *ad litem* in child protection proceedings.

A Nevada statute enacted in 1997 authorizes the appointment of a special master to identify the person most qualified to serve as a guardian for a child determined to be in need of a guardian and requires that a petition for the appointment of a guardian state whether the guardianship is sought as a result of abuse or neglect. The 1997 act also allows for testimony from certain interested persons at hearings to identify a guardian.

A 1997 New Hampshire act requires a guardian *ad litem* appointed in certain child custody proceedings to be subject to the same rules as those in divorce proceedings. The act requires all guardian *ad litem* fees to be paid from a special fund. Another New Hampshire statute enacted in 1997 makes it clear that legal representation of abused or neglected children may include investigative, expert, and other services.

A 1997 Ohio law permits a guardian *ad litem* to bring a civil action against any mandatory reporter of child abuse who fails to report an incident of abuse if the child suffers any injury or harm as a result of the abuse or neglect. The same act eliminated a $400 compensation limit for guardians *ad litem*.

1997 Texas General Laws, Chapter 650, requires an attorney *ad litem* for a child to conduct appropriate investigations, obtain certain records, and interview all parties in a case. Chapter 1294 requires the appointment of a guardian *ad litem* to represent a child in a suit by a governmental entity requesting termination of parental rights or the appointment of the state as a conservator for a child, specifies the powers and duties of a guardian *ad litem*, and requires the Attorney General to adopt standards for local volunteer advocate programs.

In 1997, the Utah Legislature created a special account to fund recruiting and training of CASA volunteers and to fund the Office of the Guardian *Ad Litem* Director. The 1997 act allows the expenses of a guardian *ad litem* to be assessed against the minor's parents.

1998 Arizona legislation specifies that juveniles in dependency or termination of parental rights proceedings have a right to be represented by counsel.

A 1998 Florida act requires the State Attorney or the Office of the Attorney General to provide child welfare legal services in specified counties.

The Georgia Legislature in 1998 enacted legislation requiring the appointment of a guardian *ad litem* for a child's interests if the child's interests conflict with those of the child's parent, guardian, or custodian. The act allows an attorney or court-appointed special advocate, or both, to be appointed as a child's guardian *ad litem*.

1998 Massachusetts Acts, Chapter 40, directs the committee for public counsel to continue a pilot program serving specified counties that use attorneys to represent children in need of service cases and requires a report to the legislature.

1998 Mississippi Laws, Chapter 516, clarifies the role of a guardian *ad litem*, requires the appointment of an attorney for a child when a layman has been appointed as the guardian *ad litem*, and provides for the payment of fees.

In 1998, the Oklahoma Legislature enacted Chapter 421, *1998 Oklahoma Session Laws*, to clarify the rights and duties of court appointed special advocates and guardians *ad litem* for children. A separate act (Chapter 415) clarifies the role of the guardian *ad litem* for the child and the child's attorney in adoption actions.

The 1998 Wyoming Legislature specified the duties and reporting requirements for guardians *ad litem* in Chapter 114, *1998 Wyoming Session Laws*.

Recommendations for Improving the Guardian *Ad Litem* System

See excerpt from the Technical Assistance Bulletin: *Child Abuse and Neglect Cases: Representation as a Critical Component of Effective Practice*, prepared as a part of the Permanency Planning for Children Project of the National Council of Juvenile and Family Court Judges, March 1998 distributed to the Committee.

October 22, 1999 99-R-1087

TERMINATION OF PARENTAL RIGHTS IN ABANDONMENT CASES

By: Lawrence K. Furbish, Assistant Director

You asked if a woman could initiate a termination of parental rights (TPR) action against her ex-husband because (1) he does not pay child support and (2) despite being granted supervised visitation by the court, never visits the child.

The woman in the situation you describe can certainly pursue a termination in the courts, whether it will be granted depends on the court's findings and its determination of the child's best interest. She should go to the probate court for the town or district where she lives. She does not need an attorney, and usually the probate court is very "user friendly."

A TPR action must be initiated by a petition to the court, and the mother is one of the parties allowed by statute to initiate such a petition (CGS § 45a-715). The court will schedule and hold a hearing on the petition. If the father's whereabouts are known, he must be served with notice concerning the petition and hearing. Notice will be served personally by the sheriff if he resides in Connecticut and by certified mail if he resides out of state. If his whereabouts are unknown, he will be served by newspaper notice.

The father has the right to appear at the hearing and to be represented by counsel (CGS § 45a-716). If he cannot afford counsel, the court will provide it. He can contest the termination, if he wishes. In some cases when parties contest a termination, the probate court will transfer the case to Superior Court, which is more able to deal with complex and vigorously contested cases.

In order to terminate parental rights the court must find by clear and convincing evidence that (1) the termination is in the child's best interest and (2) one or more of the statutory grounds for termination exists (CGS § 45a-717). There are several grounds for termination in the situation you describe. Probably the most likely is abandonment, which is described in statute as failing to maintain a reasonable degree of interest, concern, or responsibility for the child's welfare. Another would be parental acts of commission or omission that deny the child the care, guidance, or control necessary for his well being.

According to Linda Dow, chief counsel to the Probate Court Administrator, one possible problem might arise concerning child support. In the case you describe the father has not been paying support. If the mother has been supporting the child herself, the court would probably not be concerned about this issue. If, however, she is or has been receiving state public assistance, the Attorney General's Office, which represents the

state in termination cases, might object. Even though the father has not been paying, circumstances might change and he might be able or be forced to pay in the future. If he comes into any money, the state has a lien against it for the amount of past support provided. Once his parental rights are terminated he has no obligation to provide financial support to the child. According to Dow, in such cases the judges will look at this issue in the context of the child's best interest, which they are statutorily required to consider.

LKF:pa

TOP

Child Abuse and Neglect

STATUTES

AT-A-GLANCE

Grounds for Termination of Parental Rights

Every State and the District of Columbia have statutes providing for the termination of parental rights. Termination of parental rights ends the legal parent-child relationship. Once the relationship has been terminated, the child is legally free to be placed for adoption with the objective of securing a more stable, permanent family environment that can meet the child's long-term parenting needs.

Grounds

Some States spell out factors that constitute grounds for termination of parental rights. Other States use general language. The most common statutory grounds for involuntary termination of parental rights include:

- Severe or chronic abuse or neglect.
- Abuse or neglect of other children in the household;
- Abandonment.
- Long-term mental illness or deficiency of the parent(s).
- Long-term alcohol or drug-induced incapacity of the parent(s).
- Failure to support or maintain contact with the child.

Another common ground for termination is a felony conviction of the parent(s) for a crime of violence against the child or other family member, or a conviction for any felony when the term of conviction is such a length as to have a negative impact on the child and the only available provision of care for the child is foster care.

The Adoption and Safe Families Act (ASFA)[1] also requires State agencies to seek termination of the parent-child relationship when:

- A child has been in foster care for 15 of the most recent 22 months.
- A court has determined:
  - A child to be an abandoned infant.
  - That the parent has committed murder of another child of the parent, committed voluntary manslaughter of another child of the parent, aided or abetted, attempted, conspired, or solicited to commit such a murder or such a voluntary manslaughter,[2] or committed a felony assault that has resulted in serious bodily injury to the child or to another child of the parent.[3]

In response to ASFA, many States have adopted limits to the maximum amount of time a child can spend in foster care before termination proceedings must be initiated.

Typically, States have adopted the ASFA standard of 15 out of the most recent 22 months in care. Some States, however, specify shorter time limits, particularly for very young children. Most States have also complied with the other termination grounds required under ASFA.

Reasonable Efforts

The above factors become grounds for terminating parental rights when reasonable efforts by the State to prevent out-of-home placement or to achieve reunification of the family after placement have failed to ameliorate the conditions and/or parental behaviors that led to State intervention.

continues

This summary is a product of the **Child Abuse and Neglect State Statutes Series**, which is produced by the National Clearinghouse on Child Abuse and Neglect Information. The Clearinghouse is a service of the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

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