



- South Carolina;
- Utah;
- Virginia;
- Washington;
- West Virginia;
- Wisconsin; and
- Wyoming.

Eighteen of the states require testing of those arrested or indicted for an offense:

- Alaska;
- Arizona;
- Colorado;
- Delaware;
- Florida;
- Idaho;
- Kansas;
- Louisiana;
- Michigan;
- Nevada;
- New Jersey;
- North Carolina;
- North Dakota;
- Ohio;
- Oklahoma;
- Tennessee;
- Virginia; and
- Wisconsin.

Some states require testing both upon arrest and upon conviction, or make testing at one point discretionary and the other mandatory. South Dakota and Texas do not require testing at any stage, but give courts discretion to order testing at the pre-conviction stage.

In most states, the victim must request that the offender be tested. In some states the victim petitions the court directly; in others, the prosecutor files a petition at the request of the victim. Most of the laws mandating the testing of offenders before conviction require a finding of probable cause that the defendant committed the offense, and that the circumstances of the offense resulted in significant exposure of the victim to the semen or other bodily fluids of the offender, placing the victim at risk of transmission of HIV/AIDS.

Even where a state does not have a law specifically relating to the testing of sex offenders, it may have a law that permits any person to seek a court order for disclosure of another person's *confidential* HIV/AIDS information. The individual seeking the information must be able to demonstrate a compelling need for access to the information.

In nearly every state that allows disclosure of the test results to the victim, where the victim is a minor the information is disclosed to the parents or guardian. Often, in cases where the victim is incompetent, the law specifies that the results shall be disclosed to the victim's guardian. The law may permit the victim to disclose the matter to his or her spouse or sexual partner, or to his or her physician or counselor. Alaska states that the information shall be confidential, but may be used by the victim in any subsequent civil action. Mississippi requires that the victim and the victim's spouse be notified of the test results.

Laws may provide for counseling of the victim, but these vary. For instance, in California and Iowa, victims are to be counseled regarding the transmission of HIV/AIDS and the nature and reliability of the test prior to requesting a hearing on testing or prior to requesting the test results. Such a requirement lessens the possibility that a victim will have unrealistic expectations about the nature of the test results. States may require that test results only be disclosed to a victim by a trained health professional or counselor. In other states, a victim is to be notified of the results of the test by a criminal justice official, and then may be referred to counseling on request. Counseling generally also includes referral to health care and support services, as appropriate.

Many of the laws specify the agency that is required to pay for HIV/AIDS testing and counseling, which may include HIV/AIDS testing of the victim. This is often the public health department, but may be the state victim compensation board, or another governmental branch. In several states, the defendant, upon conviction, may be required to reimburse the state for the costs of testing and counseling.

A 1990 Federal law provides that a state will lose a portion of its grant funds if it does not have a law that requires testing of convicted adult or juvenile sex offenders at the request of the victim, as well as counseling and testing of victims.<sup>(4)</sup>

At the Federal level, a victim may petition the court for an order requiring pre-conviction HIV testing of a defendant. The law includes provisions for follow-up testing and for confidentiality of the test results.<sup>(5)</sup>

It should be emphasized that victims who believe there may have been a transfer of bodily fluids to them by the perpetrator of the crime -- whether by sexual assault or another crime -- should not wait for the offender to be tested, and should not rely solely upon any test of the offender. Instead, victims should be tested themselves at the earliest possible time, and periodically thereafter.

For more information on the laws in your state, please contact the rape crisis center in your area, your local law enforcement or prosecutor's office, your state legislator or Attorney General. You may also want to contact the Centers for Disease Control's **National HIV/AIDS Hotline** and/or the CDC **National AIDS Clearinghouse** for more information, assistance, and referrals. Additional information can also be found in the **INFOLINK** bulletins entitled, *Sexual Assault and HIV/AIDS and Victim Services*.

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## FACTORS IN AGGRAVATION AND MITIGATION

Sec. 12.55.155. Factors in aggravation and mitigation.

(a) Except as provided in (e) of this section, if a defendant is convicted of an offense and is subject to sentencing under AS 12.55.125(c), (d), (e), or (i) and

(1) the low end of the presumptive range is four years or less, the court may impose any sentence below the presumptive range for factors in mitigation or may increase the active term of imprisonment up to the maximum term of imprisonment for factors in aggravation;

(2) the low end of the presumptive range is more than four years, the court may impose a sentence below the presumptive range as long as the active term of imprisonment is not less than 50 percent of the low end of the presumptive range for factors in mitigation or may increase the active term of imprisonment up to the maximum term of imprisonment for factors in aggravation.

(b) Sentences under this section that are outside of the presumptive ranges set out in AS 12.55.125 shall be based on the totality of the aggravating and mitigating factors set out in (c) and (d) of this section.

(c) The following factors shall be considered by the sentencing court if proven in accordance with this section, and may allow imposition of a sentence above the presumptive range set out in AS 12.55.125 :

(1) a person, other than an accomplice, sustained physical injury as a direct result of the defendant's conduct;

(2) the defendant's conduct during the commission of the offense manifested deliberate cruelty to another person;

(3) the defendant was the leader of a group of three or more persons who participated in the offense;

(4) the defendant employed a dangerous instrument in furtherance of the offense;

(5) the defendant knew or reasonably should have known that the victim of the offense was particularly vulnerable or incapable of resistance due to advanced age, disability, ill health, or extreme youth or was for any other reason substantially incapable of exercising normal physical or mental powers of resistance;

## SENTENCING AND PROBATION FOR SEXUAL OFFENSES

Sec. 12.55.125. Sentences of imprisonment for felonies.

(a) A defendant convicted of murder in the first degree shall be sentenced to a definite term of imprisonment of at least 20 years but not more than 99 years. A defendant convicted of murder in the first degree shall be sentenced to a mandatory term of imprisonment of 99 years when

(1) the defendant is convicted of the murder of a uniformed or otherwise clearly identified peace officer, fire fighter, or correctional employee who was engaged in the performance of official duties at the time of the murder;

(2) the defendant has been previously convicted of

(A) murder in the first degree under AS 11.41.100 or former AS 11.15.010 or 11.15.020;

(B) murder in the second degree under AS 11.41.110 or former AS 11.15.030; or

(C) homicide under the laws of another jurisdiction when the offense of which the defendant was convicted contains elements similar to first degree murder under AS 11.41.100 or second degree murder under AS 11.41.110;

(3) the court finds by clear and convincing evidence that the defendant subjected the murder victim to substantial physical torture; or

(4) the defendant is convicted of the murder of and personally caused the death of a person, other than a participant, during a robbery.

(b) A defendant convicted of attempted murder in the first degree, solicitation to commit murder in the first degree, conspiracy to commit murder in the first degree, kidnapping, or misconduct involving a controlled substance in the first degree shall be sentenced to a definite term of imprisonment of at least five years but not more than 99 years. A defendant convicted of murder in the second degree shall be sentenced to a definite term of imprisonment of at least 10 years but not more than 99 years. A defendant convicted of murder in the second degree shall be sentenced to a definite term of imprisonment of at least 20 years but not more than 99 years when the defendant is convicted of the murder of a child under 16 years of age and the court finds by clear and convincing evidence that the defendant (1) was a natural parent, a stepparent, an

adopted parent, a legal guardian, or a person occupying a position of authority in relation to the child; or (2) caused the death of the child by committing a crime against a person under AS 11.41.200 - 11.41.530. In this subsection, "legal guardian" and "position of authority" have the meanings given in AS 11.41.470.

(c) Except as provided in (i) of this section, a defendant convicted of a class A felony may be sentenced to a definite term of imprisonment of not more than 20 years, and shall be sentenced to a definite term within the following presumptive ranges, subject to adjustment as provided in AS 12.55.155 - 12.55.175:

(1) if the offense is a first felony conviction and does not involve circumstances described in (2) of this subsection, five to eight years;

(2) if the offense is a first felony conviction and the defendant possessed a firearm, used a dangerous instrument, or caused serious physical injury or death during the commission of the offense, or knowingly directed the conduct constituting the offense at a uniformed or otherwise clearly identified peace officer, fire fighter, correctional employee, emergency medical technician, paramedic, ambulance attendant, or other emergency responder who was engaged in the performance of official duties at the time of the offense, seven to 11 years;

(3) if the offense is a second felony conviction, 10 to 14 years;

(4) if the offense is a third felony conviction and the defendant is not subject to sentencing under (1) of this section, 15 to 20 years.

(d) Except as provided in (i) of this section, a defendant convicted of a class B felony may be sentenced to a definite term of imprisonment of not more than 10 years, and shall be sentenced to a definite term within the following presumptive ranges, subject to adjustment as provided in AS 12.55.155 - 12.55.175:

(1) if the offense is a first felony conviction and does not involve circumstances described in (2) of this subsection, one to three years; a defendant sentenced under this paragraph may, if the court finds it appropriate, be granted a suspended imposition of sentence under AS 12.55.085 if, as a condition of probation under AS 12.55.086, the defendant is required to serve an active term of imprisonment within the range specified in this paragraph, unless the court finds that a mitigation factor under AS 12.55.155 applies;

(2) if the offense is a first felony conviction, the defendant violated AS 11.41.130, and the victim was a child under 16 years of age, two to four years;

(3) if the offense is a second felony conviction, four to seven years;

(4) if the offense is a third felony conviction, six to 10 years.

(e) Except as provided in (i) of this section, a defendant convicted of a class C felony may be sentenced to a definite term of imprisonment of not more than five years, and shall be sentenced to a definite term within the following presumptive ranges, subject to adjustment as provided in AS 12.55.155 - 12.55.175:

(1) if the offense is a first felony conviction and does not involve circumstances described in (4) of this subsection, zero to two years; a defendant sentenced under this paragraph may, if the court finds it appropriate, be granted a suspended imposition of sentence under AS 12.55.085, and the court may, as a condition of probation under AS 12.55.086, require the defendant to serve an active term of imprisonment within the range specified in this paragraph:

(2) if the offense is a second felony conviction, two to four years;

(3) if the offense is a third felony conviction, three to five years;

(4) if the offense is a first felony conviction, and the defendant violated AS 08.54.720 (a)(15), one to two years.

(f) If a defendant is sentenced under (a) or (b) of this section,

(1) imprisonment for the prescribed minimum or mandatory term may not be suspended under AS 12.55.080;

(2) imposition of sentence may not be suspended under AS 12.55.085

(3) imprisonment for the prescribed minimum or mandatory term may not be reduced, except as provided in (j) of this section.

(g) If a defendant is sentenced under (c), (d), (e), or (i) of this section, except to the extent permitted under AS 12.55.155 - 12.55.175,

(1) imprisonment may not be suspended under AS 12.55.080 below the low end of the presumptive range;

(2) and except as provided in (d)(1) or (e)(1) of this section, imposition of sentence may not be suspended under AS 12.55.085;

(3) terms of imprisonment may not be otherwise reduced.

(h) Nothing in this section or AS 12.55.135 limits the discretion of the sentencing judge except as specifically provided. Nothing in (a) of this section limits the court's discretion to impose a sentence of 99 years imprisonment, or to limit parole eligibility, for a person convicted of murder in the first or second degree in circumstances other than those enumerated in (a).

(i) A defendant convicted of

(1) sexual assault in the first degree or sexual abuse of a minor in the first degree may be sentenced to a definite term of imprisonment of not more than 99 years and shall be sentenced to a definite term within the following presumptive ranges, subject to adjustment as provided in AS 12.55.155 - 12.55.175:

(A) if the offense is a first felony conviction and does not involve circumstances described in (B) of this paragraph, eight to 12 years;

(B) if the offense is a first felony conviction and the defendant possessed a firearm, used a dangerous instrument, or caused serious physical injury during the commission of the offense, 12 to 16 years;

(C) if the offense is a second felony conviction and does not involve circumstances described in (D) of this paragraph, 15 to 20 years;

(D) if the offense is a second felony conviction and the defendant has a prior conviction for a sexual felony, 20 to 30 years;

(E) if the offense is a third felony conviction and the defendant is not subject to sentencing under (F) of this paragraph or (l) of this section, 25 to 35 years;

(F) if the offense is a third felony conviction, the defendant is not subject to sentencing under (l) of this section, and the defendant has two prior convictions for sexual felonies, 30 to 40 years;

(2) attempt, conspiracy, or solicitation to commit sexual assault in the first degree or sexual abuse of a minor in the first degree may be sentenced to a definite term of imprisonment of not more than 30 years and shall be sentenced to a definite term within the following

presumptive ranges, subject to adjustment as provided in AS 12.55.155 - 12.55.175:

(A) if the offense is a first felony conviction and does not involve circumstances described in (B) of this paragraph, five to eight years;

(B) if the offense is a first felony conviction, and the defendant possessed a firearm, used a dangerous instrument, or caused serious physical injury during the commission of the offense, 10 to 14 years;

(C) if the offense is a second felony conviction and does not involve circumstances described in (D) of this paragraph, 12 to 16 years;

(D) if the offense is a second felony conviction and the defendant has a prior conviction for a sexual felony, 15 to 20 years;

(E) if the offense is a third felony conviction, does not involve circumstances described in (F) of this paragraph, and the defendant is not subject to sentencing under (I) of this section, 15 to 25 years;

(F) if the offense is a third felony conviction, the defendant is not subject to sentencing under (I) of this section, and the defendant has two prior convictions for sexual felonies, 20 to 30 years;

(3) sexual assault in the second degree, sexual abuse of a minor in the second degree, unlawful exploitation of a minor, or distribution of child pornography may be sentenced to a definite term of imprisonment of not more than 20 years and shall be sentenced to a definite term within the following presumptive ranges, subject to adjustment as provided in AS 12.55.155 - 12.55.175:

(A) if the offense is a first felony conviction, two to four years;

(B) if the offense is a second felony conviction and does not involve circumstances described in (C) of this paragraph, five to eight years;

(C) if the offense is a second felony conviction and the defendant has a prior conviction for a sexual felony, 10 to 14 years;

(D) if the offense is a third felony conviction and does not involve circumstances described in (E) of this paragraph, 10 to 14 years;

(E) if the offense is a third felony conviction and the defendant has two prior convictions for sexual felonies, 15 to 20 years;

(4) sexual assault in the third degree, incest, indecent exposure in the first degree, possession of child pornography, or attempt, conspiracy, or solicitation to commit sexual assault in the second degree, sexual abuse of a minor in the second degree, unlawful exploitation of a minor, or distribution of child pornography, may be sentenced to a definite term of imprisonment of not more than 10 years and shall be sentenced to a definite term within the following presumptive ranges, subject to adjustment as provided in AS 12.55.155 - 12.55.175:

(A) if the offense is a first felony conviction, one to two years;

(B) if the offense is a second felony conviction and does not involve circumstances described in (C) of this paragraph, two to five years;

(C) if the offense is a second felony conviction and the defendant has a prior conviction for a sexual felony, three to six years;

(D) if the offense is a third felony conviction and does not involve circumstances described in (E) of this paragraph, three to six years;

(E) if the offense is a third felony conviction and the defendant has two prior convictions for sexual felonies, six to 10 years.

(j) A defendant sentenced to a (1) mandatory term of imprisonment of 99 years under (a) of this section may apply once for a modification or reduction of sentence under the Alaska Rules of Criminal Procedure after serving one-half of the mandatory term without consideration of good time earned under AS 33.20.010, or (2) definite term of imprisonment under (l) of this section may apply once for a modification or reduction of sentence under the Alaska Rules of Criminal Procedure after serving the greater of (A) one-half of the definite term or (B) 30 years. A defendant may not file and a court may not entertain more than one motion for modification or reduction of a sentence subject to this subsection, regardless of whether or not the court granted or denied a previous motion.

(k) *[Repealed, Sec. 32 ch 2 SLA 2005].*

(l) Notwithstanding any other provision of law, a defendant convicted of an unclassified or class A felony offense, and not subject to a mandatory 99-year sentence under (a) of this section, shall be sentenced to a definite term of imprisonment of at least 40 years but not more than 99 years when the defendant has been previously convicted of two or more most serious felonies and the prosecuting attorney has filed a notice of intent to seek a definite sentence under this subsection at the

time the defendant was arraigned in superior court. If a defendant is sentenced to a definite term under this subsection.

(1) imprisonment for the prescribed definite term may not be suspended under AS 12.55.080 ;

(2) imposition of sentence may not be suspended under AS 12.55.085

(3) imprisonment for the prescribed definite term may not be reduced, except as provided in (j) of this section.

(m) Notwithstanding (a)(4) and (l) of this section, if a court finds that imposition of a mandatory term of imprisonment of 99 years on a defendant subject to sentencing under (a)(4) of this section would be manifestly unjust, the court may sentence the defendant to a definite term of imprisonment otherwise permissible under (a) of this section.

(n) In imposing a sentence within a presumptive range under (c), (d), (e), or (i) of this section, the total term, made up of the active term of imprisonment plus any suspended term of imprisonment, must fall within the presumptive range, and the active term of imprisonment may not fall below the lower end of the presumptive range.

## SEXUAL OFFENSES IN ALASKA STATUTES

Sec. 11.41.410. Sexual assault in the first degree.

(a) An offender commits the crime of sexual assault in the first degree if

(1) the offender engages in sexual penetration with another person without consent of that person;

(2) the offender attempts to engage in sexual penetration with another person without consent of that person and causes serious physical injury to that person;

(3) the offender engages in sexual penetration with another person

(A) who the offender knows is mentally incapable; and

(B) who is in the offender's care

(i) by authority of law; or

(ii) in a facility or program that is required by law to be licensed by the state; or

(4) the offender engages in sexual penetration with a person who the offender knows is unaware that a sexual act is being committed and

(A) the offender is a health care worker; and

(B) the offense takes place during the course of professional treatment of the victim.

(b) Sexual assault in the first degree is an unclassified felony and is punishable as provided in AS 12.55.

Sec. 11.41.420. Sexual assault in the second degree.

(a) An offender commits the crime of sexual assault in the second degree if

(1) the offender engages in sexual contact with another person without consent of that person;

(2) the offender engages in sexual contact with a person

(A) who the offender knows is mentally incapable; and

(B) who is in the offender's care

(i) by authority of law; or

(ii) in a facility or program that is required by law to be licensed by the state;

(3) the offender engages in sexual penetration with a person who the offender knows is

(A) mentally incapable;

(B) incapacitated; or

(C) unaware that a sexual act is being committed; or

(4) the offender engages in sexual contact with a person who the offender knows is unaware that a sexual act is being committed and

(A) the offender is a health care worker; and

(B) the offense takes place during the course of professional treatment of the victim.

(b) Sexual assault in the second degree is a class B felony.

Sec. 11.41.425. Sexual assault in the third degree.

(a) An offender commits the crime of sexual assault in the third degree if the offender

(1) engages in sexual contact with a person who the offender knows is

(A) mentally incapable;

(B) incapacitated; or

(C) unaware that a sexual act is being committed;

(2) while employed in a state correctional facility or other placement designated by the commissioner of corrections for the custody and care of prisoners, engages in sexual penetration with a person who the offender knows is committed to the custody of the Department of

Corrections to serve a term of imprisonment or period of temporary commitment; or

(3) engages in sexual penetration with a person 18 or 19 years of age who the offender knows is committed to the custody of the Department of Health and Social Services under AS 47.10 or AS 47.12 and the offender is the legal guardian of the person.

(b) Sexual assault in the third degree is a class C felony.

Sec. 11.41.427. Sexual assault in the fourth degree.

(a) An offender commits the crime of sexual assault in the fourth degree if

(1) while employed in a state correctional facility or other placement designated by the commissioner of corrections for the custody and care of prisoners, the offender engages in sexual contact with a person who the offender knows is committed to the custody of the Department of Corrections to serve a term of imprisonment or period of temporary commitment; or

(2) the offender engages in sexual contact with a person 18 or 19 years of age who the offender knows is committed to the custody of the Department of Health and Social Services under AS 47.10 or AS 47.12 and the offender is the legal guardian of the person.

(b) Sexual assault in the fourth degree is a class A misdemeanor.

*Sec. 11.41.430. Sexual assault in the third degree. [Repealed, Sec. 10 ch 78 SLA 1983. For current law, see AS 11.41.420 (a)(2)].*

Repealed or Renumbered

Sec. 11.41.432. Defenses.

(a) It is a defense to a crime charged under AS 11.41.410 (a)(3), 11.41.420(a)(2), 11.41.420(a)(3), or 11.41.425 that the offender is

(1) mentally incapable; or

(2) married to the person and neither party has filed with the court for a separation, divorce, or dissolution of the marriage.

(b) Except as provided in (a) of this section, in a prosecution under AS 11.41.410 or 11.41.420, it is not a defense that the victim was, at the time of the alleged offense, the legal spouse of the defendant.

Sec. 11.41.434. Sexual abuse of a minor in the first degree.

(a) An offender commits the crime of sexual abuse of a minor in the first degree if

(1) being 16 years of age or older, the offender engages in sexual penetration with a person who is under 13 years of age or aids, induces, causes, or encourages a person who is under 13 years of age to engage in sexual penetration with another person;

(2) being 18 years of age or older, the offender engages in sexual penetration with a person who is under 18 years of age, and the offender is the victim's natural parent, stepparent, adopted parent, or legal guardian; or

(3) being 18 years of age or older, the offender engages in sexual penetration with a person who is under 16 years of age, and

(A) the victim at the time of the offense is residing in the same household as the offender and the offender has authority over the victim; or

(B) the offender occupies a position of authority in relation to the victim.

(b) Sexual abuse of a minor in the first degree is an unclassified felony and is punishable as provided in AS 12.55.

Sec. 11.41.436. Sexual abuse of a minor in the second degree.

(a) An offender commits the crime of sexual abuse of a minor in the second degree if

(1) being 16 years of age or older, the offender engages in sexual penetration with a person who is 13, 14, or 15 years of age and at least three years younger than the offender, or aids, induces, causes or encourages a person who is 13, 14, or 15 years of age and at least three years younger than the offender to engage in sexual penetration with another person;

(2) being 16 years of age or older, the offender engages in sexual contact with a person who is under 13 years of age or aids, induces,

causes, or encourages a person under 13 years of age to engage in sexual contact with another person;

(3) being 18 years of age or older, the offender engages in sexual contact with a person who is under 18 years of age, and the offender is the victim's natural parent, stepparent, adopted parent, or legal guardian;

(4) being 16 years of age or older, the offender aids, induces, causes, or encourages a person who is under 16 years of age to engage in conduct described in AS 11.41.455 (a)(2) - (6); or

(5) being 18 years of age or older, the offender engages in sexual contact with a person who is under 16 years of age, and

(A) the victim at the time of the offense is residing in the same household as the offender and the offender has authority over the victim; or

(B) the offender occupies a position of authority in relation to the victim.

(b) Sexual abuse of a minor in the second degree is a class B felony.

Sec. 11.41.438. Sexual abuse of a minor in the third degree.

(a) An offender commits the crime of sexual abuse of a minor in the third degree if

(1) being 16 years of age or older, the offender engages in sexual contact with a person who is 13, 14, or 15 years of age and at least three years younger than the offender;

(2) being 18 years of age or older, the offender engages in sexual penetration with a person who is 16 or 17 years of age and at least three years younger than the offender, and the offender occupies a position of authority in relation to the victim; or

(3) being under 16 years of age, the offender engages in sexual penetration with a person who is under 13 years of age and at least three years younger than the offender

(b) Sexual abuse of a minor in the third degree is a class C felony.

Sec. 11.41.440. Sexual abuse of a minor in the fourth degree.

(a) An offender commits the crime of sexual abuse of a minor in the fourth degree if

(1) being under 16 years of age, the offender engages in sexual contact with a person who is under 13 years of age and at least three years younger than the offender; or

(2) being 18 years of age or older, the offender engages in sexual contact with a person who is 16 or 17 years of age and at least three years younger than the offender, and the offender occupies a position of authority in relation to the victim.

(b) Sexual abuse of a minor in the fourth degree is a class A misdemeanor.

*Sec. 11.41.443. Spousal relationship no defense. [Repealed, Sec. 61 ch 50 SLA 1989. For current law, see AS 11.41.432 (b)].*

Repealed or Renumbered

Sec. 11.41.445. General provisions.

(a) In a prosecution under AS 11.41.434 - 11.41.440 it is an affirmative defense that, at the time of the alleged offense, the victim was the legal spouse of the defendant unless the offense was committed without the consent of the victim.

(b) In a prosecution under AS 11.41.410 - 11.41.440, whenever a provision of law defining an offense depends upon a victim's being under a certain age, it is an affirmative defense that, at the time of the alleged offense, the defendant

(1) reasonably believed the victim to be that age or older; and

(2) undertook reasonable measures to verify that the victim was that age or older.

Sec. 11.41.450. Incest.

(a) A person commits the crime of incest if, being 18 years of age or older, that person engages in sexual penetration with another who is related, either legitimately or illegitimately, as

(1) an ancestor or descendant of the whole or half blood;

(2) a brother or sister of the whole or half blood; or

(3) an uncle, aunt, nephew, or niece by blood.

(b) Incest is a class C felony.

Sec. 11.41.452. Online enticement of a minor.

(a) A person commits the crime of online enticement of a minor if the person, being 18 years of age or older, knowingly uses a computer to communicate with another person to entice, solicit, or encourage the person to engage in an act described in AS 11.41.455 (a)(1) - (7) and

(1) the other person is a child under 16 years of age; or

(2) the person believes that the other person is a child under 16 years of age.

(b) In a prosecution under (a)(2) of this section, it is not a defense that the person enticed, solicited, or encouraged was not actually a child under 16 years of age.

(c) In a prosecution under this section, it is not necessary for the prosecution to show that the act described in AS 11.41.455 (a)(1) - (7) was actually committed.

(d) Except as provided in (e) of this section, online enticement is a class C felony.

(e) Online enticement is a class B felony if the defendant was, at the time of the offense, required to register as a sex offender or child kidnapper under AS 12.63 or a similar law of another jurisdiction.

Sec. 11.41.455. Unlawful exploitation of a minor.

(a) A person commits the crime of unlawful exploitation of a minor if, in the state and with the intent of producing a live performance, film, audio, video, electronic, or electromagnetic recording, photograph, negative, slide, book, newspaper, magazine, or other material that visually or aurally depicts the conduct listed in (1) - (7) of this subsection, the person knowingly induces or employs a child under 18 years of age to engage in, or photographs, films, records, or televises a child under 18 years of age engaged in, the following actual or simulated conduct:

(1) sexual penetration;

(2) the lewd touching of another person's genitals, anus, or breast;

(3) the lewd touching by another person of the child's genitals, anus, or breast;

(4) masturbation;

(5) bestiality;

(6) the lewd exhibition of the child's genitals; or

(7) sexual masochism or sadism.

(b) A parent, legal guardian, or person having custody or control of a child under 18 years of age commits the crime of unlawful exploitation of a minor if, in the state, the person permits the child to engage in conduct described in (a) of this section knowing that the conduct is intended to be used in producing a live performance, film, audio, video, electronic, or electromagnetic recording, photograph, negative, slide, book, newspaper, magazine, or other material that visually or aurally depicts the conduct.

(c) Unlawful exploitation of a minor is a

(1) class B felony; or

(2) class A felony if the person has been previously convicted of unlawful exploitation of a minor in this jurisdiction or a similar crime in this or another jurisdiction.

(d) In this section, "audio recording" means a nonbook prerecorded item without a visual component, and includes a record, tape, cassette, and compact disc.

## **Testing, Disclosure of Results, Definitions of HIV and AIDS**

Sec. 18.15.300. Order for blood test; disclosure of results.

(a) A defendant charged in a criminal complaint, indictment, presentment, or information filed with a magistrate or court with a violation of AS 11.41.410 - 11.41.450 that includes sexual penetration as an element of the offense, or a minor with respect to whom a petition has been filed in a juvenile court alleging a violation of AS 11.41.410 - 11.41.450 that includes sexual penetration as an element of the offense, may be ordered by a court having jurisdiction of the complaint, indictment, information, presentment, or juvenile petition to submit to testing as provided in AS 18.15.300 - 18.15.320.

(b) An alleged victim listed in the complaint, indictment, information, presentment, or juvenile petition, the parent or guardian of an alleged victim who is a minor or incompetent, or the prosecuting attorney on the behalf of an alleged victim, may petition the court for an order authorized under this section.

(c) Upon receipt of a petition filed under (b) of this section, the court shall determine if (1) probable cause exists to believe that a crime for which a test may be ordered under (a) of this section has been committed, and (2) probable cause exists to believe that sexual penetration took place between the defendant or minor and the alleged victim in an act for which the defendant or minor is charged under (a) of this section. In making the determination, the court may rely exclusively on the evidence presented at a grand jury proceeding or preliminary hearing.

(d) If the court finds probable cause exists to believe that (1) a crime for which a test may be ordered under (a) of this section has been committed, and (2) sexual penetration described in (c)(2) of this section took place, the court shall order that the defendant or minor provide two specimens of blood for testing as provided in AS 18.15.300 - 18.15.320.

(e) Copies of the blood test results shall be provided to the defendant or minor, each requesting victim, the victim's designee or, if the victim is a minor or incompetent, the victim's parents or legal guardian. If the defendant or minor is being incarcerated or detained at the time of the blood test or thereafter, the blood test results shall be provided to the officer in charge and the chief medical officer of the facility in which the defendant or minor is incarcerated or detained, including an incarceration or detention ordered as a result of conviction or judgment of delinquency or child in need of aid for an act for which the defendant or minor is charged under (a) of this section.

(f) A court may not order a test under this section

(1) before seven days after the defendant or minor's arrest;

(2) after the entry of a disposition favorable to a defendant; or

(3) if the defendant is convicted or adjudicated delinquent or in need of aid, after 90 days after the issuance of the judgment and sentence or of the judgment in a juvenile action.

(g) In this section,

(1) "disposition favorable to the defendant" means an adjudication by a court other than a conviction, or if the defendant is a minor not being prosecuted as an adult, that the minor is not adjudicated delinquent or a child in need of aid, for an offense for which a blood test could be ordered under this section;

(2) "sexual penetration" has the meaning given in AS 11.81.900 (b).

Sec. 18.15.310. Testing; test results.

(a) The withdrawal of blood for a test under AS 18.15.300 - 18.15.320 shall be performed in a medically approved manner. Only a physician or physician assistant licensed under AS 08.64, registered nurse, licensed practical nurse, or certified emergency medical technician may withdraw blood specimens for the purposes of AS 18.15.300 - 18.15.320.

(b) The court shall order that the blood specimens withdrawn under AS 18.15.300 - 18.15.320 be transmitted to a licensed medical laboratory and that tests be conducted on them for medically accepted indications of exposure to or infection by the human immunodeficiency virus (HIV) and other sexually transmitted diseases for which medically approved testing is readily and economically available as determined by the court.

(c) Copies of test results that indicate exposure to or infection by HIV or other sexually transmitted diseases shall also be transmitted to the department.

(d) The test results shall be provided to the designated recipients with the following disclaimer:

The tests were conducted in a medically approved manner but tests cannot determine exposure to or infection by HIV or other sexually transmitted diseases with absolute accuracy. Persons receiving this test

result should continue to monitor their own health and should consult a physician as appropriate."

(e) The court shall order all persons, other than the test subject, who receive test results under AS 18.15.300 - 18.15.320 to maintain the confidentiality of personal identifying data relating to the test results except for disclosures by the victim, or if the victim is a minor or incompetent by the victim's parents or legal guardian, as

(1) is necessary to obtain medical or psychological care or advice or to ensure the health of the victim's spouse, immediate family, persons occupying the same household as the victim, or a person in a dating, courtship, or engagement relationship with the victim;

(2) is necessary to pursue civil remedies against the test subject; or

(3) otherwise permitted by the court.

(f) The specimens and the results of tests ordered under AS 18.15.300 - 18.15.320 are not admissible evidence in a criminal or juvenile proceeding.

(g) A person performing testing, transmitting test results, or disclosing information under AS 18.15.300 - 18.15.320 is immune from civil liability for an act or omission under authority of AS 18.15.300 - 18.15.320. However, this subsection does not preclude liability for a grossly negligent or intentional violation of a provision of AS 18.15.300 - 18.15.320.

(h) If the results of a blood test conducted under AS 18.15.300 indicate exposure to or infection by HIV or other sexually transmitted diseases for which testing was conducted, the department shall provide (1) free counseling and free testing to a victim for HIV and other sexually transmitted diseases reasonably communicable through the offense; and (2) counseling to the alleged perpetrator or defendant upon request of the alleged perpetrator or defendant. The department shall provide referral to appropriate health care facilities and support services at the request of the victim.

(i) In this section,

(1) "AIDS" means acquired immunodeficiency syndrome or HIV symptomatic disease;

(2) "counseling" means providing a person with information and explanations relating to AIDS and HIV that are medically appropriate for that person, including all or part of the following:

(A) accurate information regarding AIDS and HIV;

(B) an explanation of behaviors that reduce the risk of transmitting AIDS and HIV;

(C) an explanation of the confidentiality of information relating to AIDS diagnoses and HIV tests;

(D) an explanation of information regarding both social and medical implications of HIV tests;

(E) disclosure of commonly recognized treatment or treatments of AIDS and HIV;

(3) "HIV" means the human immunodeficiency virus.

Sec. 18.15.320. Cost of performing test; reimbursement.

(a) The cost of performing a blood test under AS 18.15.300 shall be paid by the department.

(b) If a defendant for whom a blood test has been ordered under AS 18.15.300 is convicted of an offense for which the defendant was charged, and for which a blood test could be ordered under AS 18.15.300, the court shall order the defendant to reimburse the department for the cost of the test and may order the Department of Corrections to deduct the amount of the test from any pay the inmate receives under AS 33.30.201.

Brenda K Stanfill  
PO Box 81012  
Fairbanks, AK 99708

February 17, 2006

Alaska State Legislature  
Juneau, AK 99811

Dear Members of the House and Senate,

I am writing this letter as both an individual and a professional who works in the field of assisting sexual assault victims.

In my personal life I have experienced the pain of watching a friend and a family member attempt to reclaim their life after experiencing a sexual assault, one from a stranger, one from another family member. In both situations there was a concern over whether the perpetrator had been exposed to or was HIV positive. Both had HIV tests done and continued to have them done for six months after the RAPE.

Each time they went in for the HIV test they relived the horror of the sexual assault. They could not begin the healing process during this time, due to the devastating thought that not only had this man taken something from them that was not his but he may have left a disease that would impact them for the remainder of their lives. Once again, a continual reminder of a horrible life-changing event.

As the Executive Director of the Interior Alaska Center for Non-Violent Living in Fairbanks, I have also experienced this situation many times in working with victims of sexual assault at the agency. I have known of two cases where the victim did contract AIDS as a result of the sexual assault. In both cases the perpetrator knew he had AIDS. I feel strongly that this fact should have been considered as an aggravator in sentencing and a longer prison sentence given.

It is one crime to RAPE someone and it is another crime to knowingly expose someone to a disease that has the potential to cause their death. Please support using this fact as an aggravator at sentencing by supporting HB258.

Thank you for your focus on the issue of sexual assault.

Sincerely,

Brenda K. Stanfill  
Alaska Resident, Fairbanks  
Executive Director, Interior Alaska Center for Non-Violent Living

February 18, 2006

Representative Bob Lynn  
Alaska House of Representatives  
Capitol Room 415  
Juneau, Alaska 99801-1182

Dear Representative Lynn:

I am writing in support of House Bill 258, which would make sexual assault by defendants knowingly infected with HIV an aggravating factor at sentencing.

In my 19 years of experience as a family therapist, I have worked almost exclusively with people who have either been diagnosed or feared they have been infected with the HIV virus. During that time, I have seen the isolation as well as emotional trauma that individuals and patients go through fearing they have the disease. Family members, friends and associates tend to avoid and even shun people who have either contracted the virus or are in the process of being tested for infection.

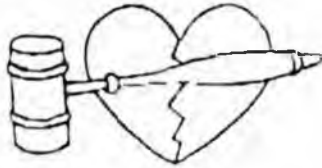
I have seen the toll on individuals dealing with the burden of uncertainty for months while waiting for test results. For the victims of rape and sexual assault, this is especially cruel and unfair. Exposure to HIV by a sexual predator makes a terrible crime even more devastating and should be punished with an enhanced sentence.

Sincerely yours,



Robert A. Bassett, Jr.  
Masters in Family Therapy (MFT)  
Certified HIV/AIDS counselor and educator, State of Connecticut

VICTIMS



For Justice, Inc. 1057 W. Fireweed Lane, Suite 101 • Anchorage, AK 99503  
(907) 278-0977 • Fax: (907) 258-0740 • e-mail: vff@alaskalife.net

February 16, 2006

Representative Bob Lynn  
House of Representatives  
Juneau, Alaska

Dear Representative Lynn

We are writing in support of your bill, HB 258, making a known positive HIV-AIDS status an aggravating factor in sentencing for rape

We agree that adding months of terror, and possibly years of illness and a shortened life, to the horror of a rape, makes an attack by an HIV-AIDS positive rapist a horrendous assault. An assailant who knowingly adds potential murder to the crime of rape should receive a sentence that reflects the seriousness of the offence, and one that will separate the perpetrator from society for a very long time.

Thank you for your work on this issue.

A handwritten signature in cursive script that reads "Susan Sullivan".

Susan Sullivan  
Executive Director  
Victims for Justice



# Municipality of Anchorage

4501 Brigaw Street • Anchorage, Alaska 99507-1599 • Telephone (907) 786-8500 • <http://www.muni.org>



Mayor Mark Begich

Anchorage Police Department

February 23, 2006

Representative Bob Lynn  
House of Representatives  
Alaska State Legislature

Re Letter of Support for HB 258

Representative Lynn,

I wish to add my support for this valuable piece of legislation. We in law enforcement are adept in training ourselves in confronting suspects armed with guns, knives, clubs, and a host of other weapons. Through training and experience, we enter such confrontations confident that we will likely prevail and secure the suspect without the necessity of actually using deadly force. Meaning that usually no one is harmed, victims are rescued, the suspects are taken into custody, and the officer goes home to his or her family and survives to fight another day.

What can be insidious with some of those unfortunates who knowingly have been diagnosed with the "HIV" and "AIDS" virus is that they, for reasons of their own, can utilize their disease as a weapon to again strike out with the intent to harm. It would not be the handgun or edged weapon that police and others would recognize as the threat and react appropriately, but rather a silent and inconspicuous assault that undetected and/or untreated threatens not only the victim, but also the victim's loved ones.

So until there is a cure for these viruses, such assaults must be met with the same level as the threat it presents.

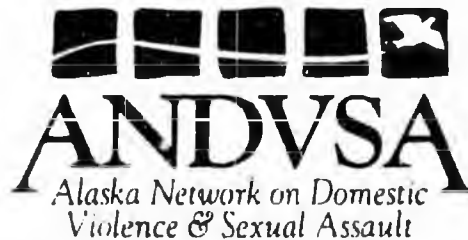
I again state my support for this legislation, both for those who are tasked to protect and for those whom we protect

Respectfully submitted,

Walt Monegan  
Chief of Police  
Anchorage Police Department

*Community. Security. Prosperity*

Juneau Office  
130 Seward St #209  
Juneau, Alaska 99801  
Phone: (907) 586-3650  
Fax: (907) 463-4493  
www.andvsa.org



Sitka Office  
PO Box 6631  
Sitka, Alaska 99835  
Phone: (907) 747-7545  
Fax: (907) 747-7547

February 14, 2006

The Honorable Representative Lynn  
State House of Representatives  
Alaska State Capitol  
Juneau, AK 99801-1182

Dear Representative Lynn:

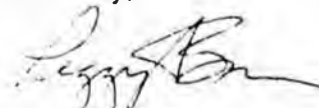
The Alaska Network on Domestic Violence & Sexual Assault is a statewide coalition of member shelter and community based programs that provide direct services and advocacy for victims of domestic violence and sexual assault. We would like to thank you for introducing House Bill 258, "An Act relating to aggravating factors at sentencing", and offer our support.

Sexual assault alone is a heinous crime for which perpetrators much be held fully accountable. When a sexual predator who is knowingly infected with HIV or AIDS commits an assault that could transmit the virus, it puts a victim at even greater risk and emotional distress. In order to hold the perpetrator fully accountable, the sentences of these sexual predators should be enhanced. We fully support your legislation to add these circumstances to AS 12.55.155 Factors in Aggravation and Mitigation.

Thank you for your leadership in addressing this issue.

Please let me know if I can offer other support for this legislation.

Sincerely,



Peggy Brown  
Executive Director

---

Member Programs

Anchorage AWAIC, AWRC, STAR Barrow AWIC Bethel TWC Cordova CFRC Dillingham SAFE Fairbanks IAC  
Homer SPIII Juneau AWARE Kenai LeeShore Center Ketchikan WISH Kodiak KWRCC Kotzebue MFCC  
Nome BSWG Palmer AFS Seward SCS Sitka SAFV Unalaska USAFV Valdez AVV



# State of Alaska

Department of Public Safety

## Council on Domestic Violence & Sexual Assault

Frank H. Murkowski, Governor  
William Tandeske, Commissioner

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February 23, 2006

The Honorable Representative Bob Lynn  
State Capitol  
Room 415  
Juneau, AK 99801-1182

Dear Representative Bob Lynn:

The Council on Domestic Violence and Sexual Assault would like thank you for sponsoring HB 258.

As you know, sexual assault is one of the most personal violations that a person can experience. Repercussions of that crime may last throughout a victim's lifetime, with damaging consequences to their relationships, families, friends and communities. Many victims of violence may end up divorced or unable to maintain intimate relationships. Because sexual assault is such an invasive crime, many victims end up feeling that the world is a very threatening place and thus are unable to live their lives in a way that many of us take for granted. Working, attending community events, marriage, friendships, and socializing may all become activities that a victim may no longer be willing to risk.

The only way to make this already destructive crime even more difficult is to add the complications and fears of HIV and AIDS. Because of this additional threat the victim now also has to worry about a potentially life threatening disease and how this effects their personal relationships. Holding the offender accountable by making this an aggravator in the crime of sexual assault is very appropriate, and is supported by the Council on Domestic Violence and Sexual Assault.

Sincerely,

Barbara E. Mason  
Executive Director  
(907) 465-5504 Phone  
(907) 465-3627 Fax

Council on Domestic Violence & Sexual Assault  
P.O. Box 111200 - Juneau, AK 99811 - Voice (907) 465-4356 - Fax (907) 465-3627



# Alaska Association of Chiefs of Police

February 21, 2006

Representative Bob Lynn  
State Capitol, Room 415  
Juneau, AK 99801-1182

Reference: House Bill 258

Dear Representative Lynn,

I would like to take this opportunity to voice my support of HB 258.

Sexual Assault causes untold pain to the victim. However, for the victim to later learn that the assailant is infected with HIV or AIDS and to face the possibility of transmission, would be crippling.

An individual who knows they are infected with HIV or AIDS and commits sexual assault, should face additional punishment for this crime. It is reasonable that this should be considered as an aggravating factor at sentencing.

If I can be of further assistance to you in getting this bill passed please don't hesitate to contact me. Your introduction of this house bill demonstrates your commitment to the citizens of Alaska.

Sincerely,

Chief Thomas Clemons  
President  
Alaska Association of Chiefs of Police



## ALASKA CORRECTIONAL OFFICERS ASSOCIATION

*"Walking Alaska's toughest beat"*

### **Alaska Correctional Officers Association supports HB 258.**

**Prepared by: Alaska Correctional Officers Association  
February 21, 2006**

As Correctional Officers, we are exposed to bodily fluids during the course of our duties and at times are assaulted by prisoners with bodily fluids. It is one thing to be in an environment in which the chance of being assaulted is an inherited risk and something we train for, but being the innocent victim of an assault by a person with HIV or AIDS is hard to fathom! Not only does the victim have to deal with being assaulted they now have to face the uncertainty of being infected with a deadly virus. Persons who commit a crime like this needs to be prosecuted to the fullest extent of the law. ACOA applauds Representative Lynn and his staff for protecting Alaskan citizens from assaults of this nature and we ask that you join them in their efforts!

P.O. Box 210290 • Anchorage, Alaska 99521  
Phone: 1 (907) 646-2262 • Fax: 1 (907) 646-2286  
Website: [www.acoa.us](http://www.acoa.us)

# STATE OF ALASKA

## DEPARTMENT OF ADMINISTRATION

### VIOLENT CRIMES COMPENSATION BOARD

FRANK H. MURKOWSKI, GOVERNOR

PO BOX 110230  
JUNEAU, ALASKA 99811-0230  
PHONE (907) 465-3040  
TOLL FREE 1-800-764-3040  
FAX (907) 465-2379

February 27, 2006

The Honorable Representative Lynn  
State Capitol, Room 415  
Juneau, AK 99801-1182

RE: HB 258  
An act relating to aggravated factors  
at sentencing

Dear Representative Lynn:

The Violent Crimes Compensation Board supports HB 258 and agrees with its provisions. This bill provides for an additional consideration by the court when sentencing certain felonious offenders. Victims of sexual assault without these additional aggravating circumstances are traumatized enough. Trying to deal with the additional heartache of a HIV or AIDS diagnosis makes it unthinkable.

We encourage passage of this bill as a sign of respect, compassion, and understanding of the trauma experienced by victims of serious sexual offenses. Please contact Board Administrator, Susan Browne, at 465-5525 if we can provide any additional information. The Board wishes to thank the bill sponsors and for their hard word work on behalf of Alaska crime victims.

Respectfully,

*Susan Z. Browne*

*SZ*  
Susan Z. Browne  
Chair

**HB**

**271**



# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB 271  
 ( ) Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): \_\_\_\_\_ Dept. Affected: Commerce  
 Title Limit Overtime for RDU Corps, Bus & Prof Licensing (117)  
Registered Nurses Component Corps, Bus & Prof Licensing  
 Sponsor Wilson  
 Requester Health, Education & Social Services Component No. 2360

**Expenditures/Revenues** (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES ( )</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
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**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1156 Receipt Supported Services						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2006) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

HB 271 establishes limitations on overtime for registered nurses in health care facilities. New funds are not required to implement the provision of this bill.

Prepared by: Jennifer Strickler, Chief  
 Division: Corporations, Business & Professional Licensing  
 Approved by: William C. Noll, Commissioner  
 Agency: Commerce, Community and Economic Development

Phone 907.465.2144  
 Date/Time 1/24/06 9:14 AM  
 Date 1/24/2006

# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB271CS(HES)-DHSS-DAPH-02-27-06  
 ( ) Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): \_\_\_\_\_

Dept. Affected: Health & Social Services

Title LIMITATIONS ON OVERTIME FOR REGISTERED NURSES

RDU Alaskan Pioneer Homes

Component Pioneers Homes

Sponsor WILSON

Requester HOUSE (HES)

Component No. 2671

**Expenditures/Revenues** (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES (0)</b>						
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**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2006) cost: \_\_\_\_\_

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

CS HB 271 (HES) establishes limitations on overtime for Registered Nurses (RNs) in health care facilities and requires reporting of any overtime, with the overtime designated as voluntary or mandatory by the RN. The intent of HB 271 is to eliminate mandatory overtime for RNs unless the overtime is due to a grave and unforeseen event. Under the bill, use of mandatory overtime in excess of the bill's limitations will result in a report to the Department of Labor.

"Overtime" (OT) means the hours worked in excess of a predetermined and regularly scheduled shift that is agreed on by a nurse and a health care facility. Mandatory OT to address an unforeseen emergencies is not subject to the limitations or penalties under the bill.

Prepared by: Virginia Smiley, Director  
 Division: Alaska Pioneer Homes  
 Approved by: Karleen Jackson, Commissioner  
 Agency: Department of Health and Social Services

Phone 465-5736  
 Date/Time 02/21/2006  
 Date 02/27/2006

# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB271CS(HES)-DHSS-DBH-02-27-06

( ) Publish Date: \_\_\_\_\_  
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction): \_\_\_\_\_  
 Title: LIMITATIONS ON OVERTIME FOR REGISTERED NURSES

RDU: Behavioral Health  
 Component: Alaska Psychiatric Institute

Sponsor: WILSON  
 Requester: HOUSE (HES)

Component No.: 311

**Expenditures/Revenues** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
<b>CAPITAL EXPENDITURES</b>						
<b>CHANGE IN REVENUES (0)</b>						

**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2006) cost: \_\_\_\_\_  
 Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

CS HB 271 establishes limitations on overtime for Registered Nurses (RNs) in health care facilities. The intent of CS HB 271 is to eliminate mandatory overtime for RNs unless the overtime is due to a grave and unforeseen event.

The division has determined that passage of this bill will have zero fiscal impact.

Prepared by: Cristy Willer, Director Phone: 269-3410  
 Division: Behavioral Health Date/Time: 02/22/2006  
 Approved by: Karleen Jackson, Commissioner Date: 02/27/2006  
 Agency: Department of Health and Social Services

# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB271CS(HES)-DHSS-FMS-02-27-06  
 ( ) Publish Date: \_\_\_\_\_  
 Dept. Affected: Health & Social Services  
 RDU Health Care Services  
 Component Medicaid Services

Revision Date/Time (Note if correction): \_\_\_\_\_

Title LIMITATIONS ON OVERTIME FOR REGISTERED NURSES

Sponsor WILSON  
 Requester HOUSE (HES)

Component No. 2077

**Expenditures/Revenues** (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	0.0	0.0	0.0	0.0	0.0	0.0
<b>CAPITAL EXPENDITURES</b>						
<b>CHANGE IN REVENUES (0)</b>						

**IND SOURCE** (Thousands of Dollars)

IND SOURCE	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
<b>TOTAL</b>	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost: \_\_\_\_\_

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

Alaska statutes (AS 47.07.070) require Medicaid hospital and nursing facility rates to be based on reasonable costs related to patient care. This proposed statute could require hospitals to hire more higher cost contract nurse staff because of the shortage of nurses in Alaska, and pay more for overtime nursing services. The additional costs would push Medicaid hospital and nursing facility rates upward. Generally speaking Medicaid pays it's share of new hospital (Approx 20-30%) and nursing facility (Approx 80-85%) costs eventually. The DHSS does not have data on how many nurses could currently be working illegal overtime under this proposed statute. There could well be an impact on Medicaid hospital and nursing facility payment rates, however the amount of such impact is indeterminate at this time. Fines and penalties are not factors considered in establishing Medicaid payment rates, so decreasing the amount of the penalty in CS HB271 (HES) does not affect the fiscal note.

Prepared by: Jack Nielson Phone 334-2447  
 Division Commissioner's Office/Office of Rate Review Date/Time 02/03/2006  
 Approved by: Karleen Jackson, Commissioner Date 02/27/2006  
 Agency Department of Health and Social Services



# *Alaska State Legislature*

Representative Peggy Wilson

House District 2

Putting Alaska's Families First

## **SPONSOR STATEMENT**

### **HB 271**

**" An Act relating to limitations on overtime for registered nurses in health care facilities and providing for an effective date."**

---

This bill will prohibit an employer from assigning mandatory overtime and from threatening or retaliating against a nurse who refuses overtime. It will also give the nurse the latitude to make the judgment call about whether they are safe to practice (work overtime) or not. The bill assigns the administration of implementation and enforcement to the Commissioner of Department of Labor.

Mandatory overtime hours are those hours above an agreed upon, predetermined, regularly scheduled shift, which the employer makes compulsory (as opposed to voluntary). The threat of reprisals includes but is not limited to discharge, discipline, demotion or assignment to unattractive tasks or work shifts or in some cases licensure removal, retaliatory reporting, and charges of "patient abandonment".

Mandatory overtime contributes to poor quality patient care because fatigue and loss of concentration, which results from excessive overtime, increases the likelihood of errors. According to a study by the National Institute for Occupational Safety and Health (NIOSH), when staff plans to work additional shifts on a volunteer basis, they are more likely to be prepared and get plenty of rest immediately prior to working the extended shift. However, when an employer mandates overtime, this occurs with little or no prior notice. The result is high levels of fatigue and thus increased errors.

For nurses, these errors or mistakes may cause life-threatening situations for both the patient and the nurse. These situations run the gamut from back injuries for the nurse to patient medication errors to even death. The evidence is very strong that prolonged work hours and fatigue affect worker performance.

Emergency situations and Critical Access Hospitals are exempt from this bill.

24-LS0838C  
Bullock  
2/20/06

**CS FOR HOUSE BILL NO. 271(HES)**  
**IN THE LEGISLATURE OF THE STATE OF ALASKA**  
**TWENTY-FOURTH LEGISLATURE - SECOND SESSION**

**BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE**

**Offered:**  
**Referred:**

**Sponsor(s): REPRESENTATIVE WILSON**

**A BILL**  
**FOR AN ACT ENTITLED**

1 **"An Act relating to limitations on overtime for registered nurses and licensed practical**  
2 **nurses in health care facilities; and providing for an effective date."**

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

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

6 **LEGISLATIVE FINDINGS AND INTENT.** The legislature finds that

7 (1) it is essential that registered nurses and licensed practical nurses providing  
8 direct patient care be available to meet the needs of patients;

9 (2) quality patient care is jeopardized by registered nurses and licensed  
10 practical nurses who work unnecessarily long hours in health care facilities;

11 (3) registered nurses and licensed practical nurses are leaving their profession  
12 because of workplace stresses, long work hours, and depreciation of their essential role in the  
13 delivery of quality and direct patient care;

14 (4) it is necessary to safeguard the efficiency, health, and general well-being

1 of registered nurses and licensed practical nurses, and the health and general well-being of the  
2 persons receiving care from registered nurses and licensed practical nurses in health care  
3 facilities;

4 (5) it is necessary that registered nurses and licensed practical nurses be made  
5 aware of their rights, duties, and remedies concerning hours worked and patient safety; and

6 (6) health care facilities should provide adequate and safe nurse staffing  
7 without the need for or use of mandatory overtime.

8 \* **Sec. 2.** AS 18 is amended by adding a new chapter to read:

9 **Chapter 09. Overtime Limitations for Nurses.**

10 **Sec. 18.09.010. Limitations on nursing overtime.** (a) Except as provided in  
11 (b) of this section, a nurse in a health care facility may not be required or coerced,  
12 either directly or indirectly, to accept an assignment of overtime if, in the judgment of  
13 the nurse, the overtime would jeopardize patient or employee safety.

14 (b) This section does not apply to

15 (1) a nurse on duty in overtime status because of an unforeseen  
16 emergency situation that could otherwise jeopardize patient safety;

17 (2) a nurse fulfilling prescheduled on-call time;

18 (3) a nurse voluntarily working overtime;

19 (4) the first hour on overtime status when the health care facility is  
20 obtaining another nurse to work in place of the nurse in overtime status.

21 (c) After working 12 or more consecutive hours, a nurse shall be allowed not  
22 less than eight consecutive hours of off-duty time immediately following the end of  
23 that period of duty.

24 (d) A health care facility shall provide for an anonymous process for patients  
25 and nurses to make complaints related to staffing levels and patient safety.

26 (e) In this section, "unforeseen emergency situation" means an unusual,  
27 unpredictable, or unforeseen situation caused by an act of terrorism, disease outbreak,  
28 natural disaster, or other act of God, but does not include a situation in which a health  
29 care facility has reasonable knowledge of increased patient volume or inadequate  
30 staffing because of staff scheduling, vacations, medical leave, or other foreseeable  
31 cause.

1           **Sec. 18.09.020. Prohibition of retaliation.** A health care facility may not  
2 discharge, discipline, threaten, discriminate against, penalize, or file a report with the  
3 Board of Nursing against a nurse for exercising rights under this chapter or for the  
4 good faith reporting of an alleged violation of this chapter.

5           **Sec. 18.09.030. Regulations.** The commissioner shall administer this chapter  
6 and adopt regulations for implementing and enforcing this chapter. In this section,  
7 "commissioner" means the commissioner of labor and workforce development.

8           **Sec. 18.09.040. Report requirements.** (a) A health care facility subject to the  
9 limitations on nursing overtime in AS 18.09.010 shall establish a procedure requiring  
10 each nurse to report overtime hours worked and for the nurse to designate the reported  
11 hours as either voluntary or mandatory.

12           (b) The health care facility shall file a semiannual report with the section in  
13 the Department of Labor and Workforce Development responsible for research and  
14 analysis. The report for the six month period ending June 30 must be filed before the  
15 following August 1, and the report for the six month period ending December 31 must  
16 be filed before the following February 1. The report must include the number of  
17 overtime hours worked, the number of overtime hours that were mandatory, the  
18 number of overtime hours that were voluntary, the number of on-call hours, the  
19 number of on-call hours that were mandatory, and the number of on-call hours that  
20 were voluntary for nurses employed by the health care facility. The report must also  
21 state the number of hours worked in each month by nurses under contract with the  
22 health care facility.

23           (c) The report under this section shall be available for public inspection.

24           **Sec. 18.09.900. Definitions.** In this chapter,

25           (1) "health care facility" means a private, municipal, state, or federal  
26 hospital; psychiatric hospital; independent diagnostic testing facility; residential  
27 psychiatric treatment center; skilled nursing facility; kidney disease treatment center  
28 (including freestanding hemodialysis units); intermediate care facility; ambulatory  
29 surgical facility; Alaska Pioneers' Home or Alaska Veterans' Home administered by  
30 the Department of Health and Social Services under AS 47.55; correctional facility  
31 administered by the Department of Corrections or the Department of Health and

1 Social Services; private, municipal, state, or federal facility employing one or more  
2 public health nurses; long-term care facility; or primary care outpatient facility;

3 (2) "nurse" means an individual licensed to practice registered nursing  
4 or practical nursing under AS 08.68 who provides nursing services through direct  
5 patient care or clinical services and includes a nurse manager when delivering in-  
6 hospital patient care;

7 (3) "on-call" means a status in which a nurse must be ready to report to  
8 the health care facility and may be called to work by the health care facility;

9 (4) "overtime" means the hours worked in excess of a predetermined  
10 and regularly scheduled shift that is agreed upon by a nurse and a health care facility.

11 \* **Sec. 3.** AS 18.09.040, enacted in sec. 2 of this Act, takes effect July 1, 2006.

12 \* **Sec. 4.** Except as provided in sec. 3 of this Act, this Act takes effect January 1, 2007.

A M E N D M E N T

OFFERED IN THE HOUSE

BY REPRESENTATIVE WILSON

TO: CSHB 271(HES), Draft Version "Y"

1 Page 3, following line 26:

2 Insert a new subsection to read:

3 "(d) A health care facility shall establish a procedure requiring each nurse to  
4 report overtime hours worked and for the nurse to designate the reported hours as  
5 either voluntary or mandatory. For each calendar month, the health care facility shall  
6 report to the division of labor standards and safety in the Department of Labor and  
7 Workforce Development the name, number of overtime hours worked, and amount of  
8 overtime compensation paid for each nurse. The health care facility shall determine  
9 the amount of any penalty due under (c) of this section and pay the amount at the time  
10 the report is filed. The report filed by the health care facility under this subsection  
11 shall be available for public inspection."  
12

13 Reletter the following subsection accordingly.

**LEGAL SERVICES**

DIVISION OF LEGAL AND RESEARCH SERVICES  
LEGISLATIVE AFFAIRS AGENCY  
STATE OF ALASKA

(907) 465-3867 or 465-2450  
FAX (907) 465-2029  
Mail Stop 3101

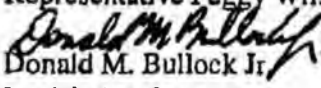
State Capitol  
Juneau, Alaska 99801-1182  
Deliveries to: 129 8th St., Rm. 329

**MEMORANDUM**

September 21, 2005

**SUBJECT:** Draft CS for HB 271 (Draft CSHB 271(HES))

**TO:** Representative Peggy Wilson

**FROM:**   
Donald M. Bullock Jr.  
Legislative Counsel

Enclosed with this memorandum is a draft HESS committee substitute for HB 271. This draft differs from HB 271 by rewriting the proposed sec. 18.09.030(c) on page 3 of HB 271.

HB 271 provided for civil penalties that included "[paying] a nurse required to work in violation of this chapter three times the nurse's hourly compensation for each hour worked in violation of this chapter." The proposed CSHB 271(HES) deletes the triple payment to the nurse as a civil penalty and increases each of the remaining penalties by "the amount of compensation paid to a nurse for each hour worked in violation of this chapter." This change does not affect the compensation the nurse is entitled to for working the overtime hours, but increases the amount of the penalty that must be paid to the state by the amount of compensation paid.

Also, the present draft has a January 1, 2006 effective date, which will make the bill retroactive. Do you want the effective date changed to a date after the second season, such as January 1, 2007 or earlier?

If I may be of further assistance, please advise.

DMB:med  
05-449.med

Enclosure

24-LS0838\Y  
Bullock  
9/21/05

**CS FOR HOUSE BILL NO. 271(HES)**

**IN THE LEGISLATURE OF THE STATE OF ALASKA**

**TWENTY-FOURTH LEGISLATURE - SECOND SESSION**

**BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE**

**Offered:  
Referred:**

**Sponsor(s): REPRESENTATIVE WILSON**

**A BILL**

**FOR AN ACT ENTITLED**

1 **"An Act relating to limitations on overtime for registered nurses in health care facilities;**  
2 **and providing for an effective date."**

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

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

6 **LEGISLATIVE FINDINGS AND INTENT.** The legislature finds that

7 (1) it is essential that registered nurses providing direct patient care be  
8 available to meet the needs of patients;

9 (2) quality patient care is jeopardized by registered nurses who work  
10 unnecessarily long hours in health care facilities;

11 (3) registered nurses are leaving their profession because of workpl.  
12 stresses, long work hours, and depreciation of their essential role in the delivery of quality and  
13 direct patient care;

14 (4) it is necessary to safeguard the efficiency, health, and general well-being

1 of registered nurses and the health and general well-being of the persons receiving care from  
2 registered nurses in health care facilities;

3 (5) it is necessary that registered nurses be made aware of their rights, duties,  
4 and remedies concerning hours worked and patient safety; and

5 (6) health care facilities should provide adequate and safe nursing staffing  
6 without the need for or use of mandatory overtime.

7 \* **Sec. 2.** AS 18 is amended by adding a new chapter to read:

8 **Chapter 09. Overtime Limitations for Registered Nurses.**

9 **Sec. 18.09.010. Limitations on nursing overtime.** (a) Except as provided in  
10 (b) of this section, a nurse in a health care facility may not be required or coerced,  
11 either directly or indirectly, to accept an assignment of overtime if, in the judgment of  
12 the nurse, the overtime would jeopardize patient or employee safety.

13 (b) This section does not apply to

14 (1) a nurse on duty in overtime status because of an unforeseen  
15 emergency situation that could otherwise jeopardize patient safety;

16 (2) a nurse fulfilling prescheduled on-call time;

17 (3) a nurse voluntarily working overtime;

18 (4) the first hour on overtime status when the health care facility is  
19 obtaining another nurse to work in place of the nurse in overtime status;

20 (5) a critical access hospital.

21 (c) After working 12 or more consecutive hours, a nurse shall be allowed not  
22 less than eight consecutive hours of off-duty time immediately following the end of  
23 that period of duty.

24 (d) A health care facility shall provide for an anonymous process for patients  
25 and nurses to make complaints related to staffing levels and patient safety.

26 (e) In this section,

27 (1) "critical access hospital" has the meaning in 42 U.S.C.  
28 1395x(mm)(1);

29 (2) "unforeseen emergency situation" means an unusual, unpredictable,  
30 or unforeseen situation caused by an act of terrorism, disease outbreak, natural  
31 disaster, or other act of God, but does not include a situation in which a health care

1 facility has reasonable knowledge of increased patient volume or inadequate staffing  
2 because of staff scheduling, vacations, medical leave, or other foreseeable cause.

3 **Sec. 18.09.020. Prohibition of retaliation.** A health care facility may not  
4 discharge, discipline, threaten, discriminate against, penalize, or file a report with the  
5 Board of Nursing against a nurse for exercising rights under this chapter or for the  
6 good faith reporting of an alleged violation of this chapter.

7 **Sec. 18.09.030. Enforcement, offenses, and penalties.** (a) The commissioner  
8 shall administer this chapter and adopt regulations for implementing and enforcing this  
9 chapter.

10 (b) A complaint alleging a violation of this chapter must be filed with the  
11 commissioner within 30 days following the date of the alleged violation. The  
12 commissioner shall provide a copy of the complaint to the health care facility named  
13 in the filing within three business days after receiving the complaint.

14 (c) Upon a finding by the commissioner that a health care facility has violated  
15 a provision of this chapter, the following civil penalties shall apply:

16 (1) for a first violation of this chapter, the health care facility shall  
17 receive a reprimand and be assessed a penalty equal to the amount of overtime  
18 compensation paid to a nurse for each hour worked in violation of this chapter;

19 (2) for a second violation of this chapter within 12 months, the health  
20 care facility shall receive a reprimand and be assessed a penalty equal to the amount of  
21 overtime compensation paid to a nurse for each hour worked in violation of this  
22 chapter plus \$500;

23 (3) for a third or subsequent violation of this chapter within 12 months,  
24 the health care facility shall be assessed a penalty equal to the amount of overtime  
25 compensation paid to a nurse for each hour worked in violation of this chapter plus an  
26 additional amount of not less than \$2,500 but not more than \$5,000 for each violation.

27 (d) In this section, "commissioner" means the commissioner of labor and  
28 workforce development.

29 **Sec. 18.09.900. Definitions.** In this chapter,

30 (1) "health care facility" means a private, municipal, state, or federal  
31 hospital; psychiatric hospital; independent diagnostic testing facility; residential

1 psychiatric treatment center; skilled nursing facility; kidney disease treatment center  
2 (including freestanding hemodialysis units); intermediate care facility; ambulatory  
3 surgical facility; Alaska Pioneers' Home or Alaska Veterans' Home administered by  
4 the Department of Health and Social Services under AS 47.55; correctional facility  
5 administered by the Department of Corrections or the Department of Health and  
6 Social Services; private, municipal, state, or federal facility employing one or more  
7 public health nurses; long-term care facility; or primary care outpatient facility;

8 (2) "nurse" means an individual licensed to practice registered nursing  
9 under AS 08.68 who provides nursing services through direct patient care or clinical  
10 services and includes a nurse manager when delivering in-hospital patient care;

11 (3) "overtime" means the hours worked in excess of a predetermined  
12 and regularly scheduled shift that is agreed upon by a nurse and a health care facility.

13 \* Sec. 3. This Act takes effect January 1, 2006.

# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB271-DHSS-DHCS-01-23-06  
 ( ) Publish Date: \_\_\_\_\_  
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction): \_\_\_\_\_

Title LIMITATIONS ON OVERTIME FOR REGISTERED NURSES

RDU Health Care Services

Component Medicaid Services

Sponsor WILSON

Requester HOUSE (L&C)

Component No. 2077

**Expenditures/Revenues**

(Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
------------------------	--	--	--	--	--	--

**FUND SOURCE**

(Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type do not abbreviate)						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY 2006) cost: \_\_\_\_\_

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

Alaska statutes (AS 47.07.070) require Medicaid hospital and nursing facility rates to be based on reasonable costs related to patient care. This proposed statute could require hospitals to hire more higher cost contract nurse staff because of the shortage of nurses in Alaska, and pay more for overtime nursing services. The additional costs would push Medicaid hospital and nursing facility rates upward. Generally speaking Medicaid pays it's share of new hospital (Approx 20-30%) and nursing facility (Approx 80-85%) costs eventually. The DHSS does not have data on how many nurses could currently be working illegal overtime under this proposed statute. There could well be an impact on Medicaid hospital and nursing facility payment rates, however the amount of such impact is indeterminate at this time.

Prepared by: Jack Nielson  
 Division: Commissioner's Office/Office of Rate Review  
 Approved by: Karleen Jackson, Commissioner  
 Agency: Department of Health and Social Services

Phone 334-2447  
 Date/Time 01/19/2006  
 Date 01/23/2006

# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB271-DHSS-DAPH-01-24-06  
 ( ) Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): 01-24-06  
 Title LIMITATIONS ON OVERTIME FOR REGISTERED NURSES

Dept. Affected: Health & Social Services  
 RDU Alaskan Pioneer Homes  
 Component Pioneers Homes

Sponsor WILSON  
 Requester HOUSE (L&C)

Component No. 2671

**Expenditures/Revenues** (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual	134.4	134.4	134.4	134.4	134.4	134.4
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>134.4</b>	<b>134.4</b>	<b>134.4</b>	<b>134.4</b>	<b>134.4</b>	<b>134.4</b>

<b>CAPITAL EXPENDITURES</b>						
<b>CHANGE IN REVENUES (0)</b>						

**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	134.4	134.4	134.4	134.4	134.4	134.4
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
<b>TOTAL</b>	<b>134.4</b>	<b>134.4</b>	<b>134.4</b>	<b>134.4</b>	<b>134.4</b>	<b>134.4</b>

Estimate of any current year (FY2006) cost: \_\_\_\_\_

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

HB 271 establishes limitations on overtime for Registered Nurses (RNs) in health care facilities and penalties for violations. The intent of HB 271 is to eliminate mandatory overtime for RNs unless the overtime is due to a grave and unforeseen event. Under the bill, use of mandatory overtime in excess of the bill's limitations will result in a penalty payment to the RN of 3 times the normal rate of pay. "Overtime" (OT) means the hours worked in excess of a predetermined and regularly scheduled shift that is agreed on by a nurse and a health care facility. Mandatory OT to address an unforeseen emergency is not subject to the limitations or penalties under the bill.

Prepared by: Dave Williams  
 Division: Alaskan Pioneer Homes  
 Approved by: Karleen Jackson, Commissioner  
 Agency: Department of Health and Social Services

Phone: 465-5737  
 Date/Time: 01/18/2006  
 Date: 01/24/2006

FISCAL NOTE  
FN #

STATE OF ALASKA  
2006 LEGISLATIVE SESSION

BILL NO. HB271-DHSS-DAPH 01-24-06

ANALYSIS CONTINUATION

The level of care provided to Pioneer Home residents necessitates at least one RN in each major area of each facility around the clock. More are scheduled depending on the number of floors in the facility and the level of resident health care needs. Emergent situations such as staff illness and fluctuating resident needs are addressed by requesting voluntary OT in excess of the regularly scheduled hours. Staff vacancies are also addressed with voluntary OT until management is able to fill the positions. Certified Nurse Assistants and on-call RNs are used as much as feasible to offset the use of additional RN time. Facility management find this to be more cost-effective than scheduling staffing at high levels year-round to assure no OT occurs. On occasions when there are no volunteers to work needed hours, mandatory OT is assigned. In situations where there is a vacant RN position that results in OT, RNs may be assigned OT or on-call RNs may be called in to address the staffing requirement.

The Pioneer Home system averages 463 hours of RN OT per month.\* Of that amount, we estimate that 200 hours would become mandatory OT under the bill. To reduce the use of mandatory OT and minimize the penalties under the bill, the division would request ability to hire more nurses, increase use of on-call nurses and otherwise rely upon use of contracted RNs. At present, potential for an increase of RNs appears to be primarily through RN contracting agencies. Use of contracted RNs would result in an annual increase of approximately \$134.4 in contractual cost for the division. That estimate is based upon an average hourly rate of \$56 for 200 hours per month ( $\$56 \times 200 \times 12 = \$134.4$ ) and is used in this fiscal note as the impact of the bill. If the division is not able to secure contract hours and has to pay the HB 271 treble cost penalty for all OT the added personal services cost will be \$188.7. The reality of the fiscal impact is probably somewhere in between \$134.4 contractual and \$188.7 personal services cost depending on the available number of contracted RNs hours.

There is a shortage of RNs nationwide that limits the ability of the division to interview and hire RNs. In this regard, the University of Alaska School of Nursing acted to increase its enrollment about two years ago. In December, the School of Nursing graduated 98 RNs who will be available to the workforce, but require about two years of experience to become independently functional and effective in reducing mandatory OT. A similar number of graduates from the school is expected in May of 2006.

The division's ability to hire RNs is hampered by the differential between state wages for RNs and non-state wages. During calendar year 2005 state wages for RNs were approximately \$3.00 to \$4.00 per hour less than those of the non-state hospitals in Anchorage. To address the wage differential, the Governor's budget includes funds to raise salaries of nurses by one range (or 7.5%). That change and other benefits of working for the state should reduce turnover, improve recruitment, and reduce the need for OT.

The effective date of HB 271 is January 1, 2006. For this fiscal note we assume that the effective date will be changed to July 1, 2006.

-----  
\* Source is calendar year 2004 unaudited overtime hours, Division of Personnel, prem.am pay for hours worked on a holiday, straight overtime, overtime pay at time and a half, swing shift overtime, and grave shift overtime.

# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB271-DHSS-DBH-01-23-06  
 ( ) Publish Date: \_\_\_\_\_  
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction): 01-23-06  
 Title: LIMITATIONS ON OVERTIME FOR REGISTERED NURSES

RDU: Behavioral Health  
 Component: Alaska Psychiatric Institute

Sponsor: WILSON  
 Requester: HOUSE (L&C)

Component No.: 311

**Expenditures/Revenues** (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual	161.3	161.3	161.3	161.3	161.3	161.3
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>
<b>CAPITAL EXPENDITURES</b>						
<b>CHANGE IN REVENUES (0)</b>						

**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health	161.3	161.3	161.3	161.3	161.3	161.3
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
<b>TOTAL</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>

Estimate of any current year (FY2006) cost: \_\_\_\_\_  
 Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if ssary)

The intent of HB 271 is to eliminate mandatory overtime for Registered Nurses unless a grave unforeseen event drives the need for mandatory overtime. API averages 337 hours of voluntary overtime and 40 hours of mandatory overtime each month. API estimates that at least half the Registered Nurses volunteer for overtime to avoid being assigned mandatory overtime. If these nurses did not volunteer to work overtime, API estimates that 200 hours each month of mandatory overtime would be assigned. The calculation below is based upon current mandatory overtime of 40 hours per month plus the estimated 200 hours that would be assigned. To eliminate the need for mandatory overtime, API would have to hire contractual nurses. This would result in approximately \$161.3 of increased contractual cost for API annually based upon an average hourly rate of \$56 for 1.5 FTE Registered Nurse locum tenens (1.5 FTE x 40 = 60hrs/wk x 4 = 240hr/months x 12 = 2,880hrs x \$56 = \$161.3).

Prepared by: Cristy Willer, Director  
 Division: Behavioral Health  
 Approved by: Karleen Jackson, Commissioner  
 Agency: Department of Health and Social Services

Phone: 269-3410  
 Date/Time: 01/20/2006  
 Date: 01/23/2006

# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB 271  
 ( ) Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): \_\_\_\_\_

Dept. Affected: Commerce

Title Limit Overtime for  
Registered Nurses

RDU Corps. Bus & Prof Licensing (117)  
 Component Corps. Bus & Prof Licensing

Sponsor Wilson

Requester Health, Education & Social Services

Component No 2360

**Expenditures/Revenues** (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>CAPITAL EXPENDITURES</b>						
-----------------------------	--	--	--	--	--	--

<b>CHANGE IN REVENUES ( )</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
-------------------------------	------------	------------	------------	------------	------------	------------

**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1156 Receipt Supported Services						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2006) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

HB 271 establishes limitations on overtime for registered nurses in health care facilities. New funds are not required to implement the provision of this bill.

Prepared by: Jennifer Strickler, Chief  
 Division: Corporations, Business & Professional Licensing  
 Approved by: William C. Noll, Commissioner  
 Agency: Commerce, Community and Economic Development

Phone 907.465.2144  
 Date/Time 1/24/06 9:14 AM  
 Date 1/24/2006

# FISCAL NOTE

**STATE OF ALASKA**  
**2005 LEGISLATIVE SESSION**

Fiscal Note Number: 1  
 Bill Version: HB 271  
 (H) Publish Date: 5/2/05

Revision Date/Time (Note if correction):  
 Title Limit Overtime for Registered Nurses  
 Dept. Affected: Commerce  
 RDU Occupational Licensing (117)  
 Component Occupational Licensing  
 Sponsor Wilson  
 Requester House Labor & Commerce  
 Component No. 2360

**Expenditures/Revenues** (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>CAPITAL EXPENDITURES</b>						
-----------------------------	--	--	--	--	--	--

<b>CHANGE IN REVENUES ( )</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
-------------------------------	------------	------------	------------	------------	------------	------------

**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1156 - Receipt Supported Services						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2005) cost: 0.0  
 Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (*Attach a separate page if necessary*)

HB 271 establishes limitations on overtime for registered nurses in health care facilities. New funds are not required to implement the provision of this bill.

Prepared by: Jennifer Strickler, Administrative Manager Phone (907) 465-2144  
 Division Occupational Licensing Date/Time 4/30/05 11:52 AM  
 Approved by: Edgar Blatchford, Commissioner Date 4/30/2005  
 Agency Commerce, Community, and Economic Development

# FISCAL NOTE

**STATE OF ALASKA**  
**2005 LEGISLATIVE SESSION**

Fiscal Note Number: 2  
 Bill Version: HB 271  
 ( H ) Publish Date: 5/2/05  
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title LIMITATIONS ON OVERTIME FOR REGISTERED NURSES

RDU Behavioral Health

Component Alaska Psychiatric Institute

Sponsor WILSON

Requester HOUSE (L&C)

Component No. 311

**Expenditures/Revenues** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual	161.3	161.3	161.3	161.3	161.3	161.3
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>

<b>CAPITAL EXPENDITURES</b>						
-----------------------------	--	--	--	--	--	--

<b>CHANGE IN REVENUES (0)</b>						
-------------------------------	--	--	--	--	--	--

**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health	161.3	161.3	161.3	161.3	161.3	161.3
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
<b>TOTAL</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>	<b>161.3</b>

Estimate of any current year (FY2005) cost: \_\_\_\_\_

Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

The intent of HB 271 is to eliminate mandatory overtime for Registered Nurses unless a grave unforeseen event drives the need for mandatory overtime. API averages 337 hours of voluntary overtime and 40 hours of mandatory overtime each month. API estimates that at least half the Registered Nurses volunteer for overtime to avoid being assigned mandatory overtime. If these nurses did not volunteer to work overtime, API estimates that 200 hours each month of mandatory overtime would be assigned. The calculation below is based upon current mandatory overtime of 40 hours per month plus the estimated 200 hours that would be assigned. To eliminate the need for mandatory overtime, API would have to hire contractual nurses. This would result in approximately \$161.3 of increased contractual cost for API annually based upon an hourly rate of \$50 for 1.5 FTE Registered Nurse locum tenens (1.5FTE x 40 = 60hrs/wk x 4 = 240hr/months x 12 = 2,880hrs x \$56 = \$161.3).

Prepared by: Bill Hogan, Director  
 Division Behavioral Health  
 Approved by: Joel S. Gilbertson, Commissioner  
 Agency Department of Health and Social Services

Phone 465-3166  
 Date/Time 04/28/2005  
 Date 04/29/2005

# LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES  
LEGISLATIVE AFFAIRS AGENCY  
STATE OF ALASKA

(907) 465-3867 or 465-2450  
FAX (907) 465-2029  
Mail Stop 3101


State Capitol  
Juneau, Alaska 99801-1182  
Deliveries to: 129 6th St. Rm. 329

## MEMORANDUM

April 30, 2005

**SUBJECT:** Sectional Analysis for HB 271 (Work Order No. 24-LS0838\F)

**TO:** Representative Peggy Wilson  
Attn: Becky Rooney

**FROM:**   
Donald M. Bullock Jr.  
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

**Section 1.** States legislative findings and intent relating to limiting overtime for registered nurses for the benefit of persons receiving care from registered nurses; states that health care facilities should provide adequate and safe nurse staffing without the need for mandatory overtime.

**Section 2.** Adds a new chapter, AS 18.09 to AS 18 that includes the following sections:

**Sec. 18.09.110.** Provides that a nurse in a health care facility may not be required or coerced to accept an assignment of overtime, with certain exceptions, if, in the judgment of the nurse, the overtime would jeopardize patient or employee safety; lists five situations in which a nurse may be required to work overtime; provides for a minimum of eight consecutive hours of off-duty time after working 12 or more consecutive hours; requires a health care facility to provide an anonymous process for nurses and staff to make complaints related to staffing levels and patient safety; adds definitions for the section.

**Sec. 18.09.020.** Prohibits retaliation, including filing a report with the Board of Nursing, against a nurse for exercising rights under AS 18.09.

**Sec. 18.09.030.** Provides for enforcement of the chapter by the commissioner of labor and workforce development; sets the time period for filing a complaint alleging a violation of the chapter; provides increasing penalties for a violation of the chapter by a health care facility that range from a reprimand for a first violation to a penalty between \$2,500 and \$5,000 for a third violation within a 12-month period; requires the health care facility to pay a nurse three times the nurse's hourly rate for each hour worked in violation of the chapter.

Representative Peggy Wilson  
April 30, 2005  
Page 2

**Sec. 18.09.900.** Defines "health care facility," "nurse" (to mean a licensed registered nurse), and overtime.

**Section 3.** Makes the Act effective January 1, 2006, and will require a 2/3 vote in both houses.

If I may be of further assistance, please advise.

DMB:med  
05-324.med

Carol Goss Widman  
8461 Brookridge Drive  
Anchorage, Alaska 99504  
907-333-8797

Rep. Peggy Wilson  
State Capitol  
Room 108  
Juneau, Alaska 99801

April 28, 2005

To Whom It May Concern:

I am writing this letter in support of House Bill 271 "an act relating to limitations on overtime for registered nurses in health care facilities; and providing for an effective date". I am a registered nurse who works for the state of Alaska and is subject to mandatory overtime. I have been mandated to work 16 hour shifts so many times I have lost count. During these times I have had to give medications to 20-30 patients. I personally would not like to have a nurse give me medications who has worked 16 hours. Numerous transcription errors, medication errors, and judgment errors are caused by this unfortunate practice used to staff hospitals. If a nurse refuses to work mandatory overtime they are subject to disciplinary action.

Many states have passed bills outlawing this practice due to it being unsafe and very dangerous to patients. Nurses who work night shift 11pm - 7 am are forced to work till 3 pm -- then they are required to return to work again that night. This practice is very dangerous to patients and staff. I feel this bill is very important for the welfare of patients and citizens of the state of Alaska. Mandatory overtime is a practice that needs to be stopped.

Sincerely,

*Carol Goss Widman RN*  
Carol Goss Widman, RN



t/ 907-274-0827  
f/ 907-272-0292

2207 East Tudor Rd, Suite 34  
Anchorage, AK 99507-1069  
www.aknurse.org  
aknurse@aknurse.org

April 27, 2005

Representative Peggy Wilson  
State Capitol  
Room 108  
Juneau, AK 99801

Dear Representative Wilson,

Let me take this opportunity to thank you on behalf of the Alaska Nurses Association and its labor program for your sponsorship of House Bill 271, "an act relating to limitations on overtime for registered nurses in health care facilities..."

I have been an RN for 26 years and have tried to work within the health care system to improve patient care. We really need to provide a safe environment for patients as well as to address the needs of the professional trying to deliver this quality care. Unfortunately, our voices as nurses often seem to go unheard. To have you, a registered nurse, in the Alaska House of Representatives, a person who both understands these issues and is able to vocalize them on our behalf, is quite a step and we are quite pleased.

As you know, hospitals and health care facilities in this country are using mandatory overtime to staff hospitals everyday. Here in Alaska, the problem is currently most acute at the Alaska Psychiatric Institute but that does not mean that with the growing nursing shortage, the problem could not become much larger affecting patient care in all of our major hospitals if it is not addressed now.

It is appropriate for the state to notify hospital administrations today that whatever staffing problems loom on the horizon, involuntary, mandatory overtime will not be tolerated as a long term solution. There is no better way than imposing mandatory overtime to drive the nurses we still have out of the profession for good.

The Alaska Nurses Association and the Providence Registered Nurses Bargaining Unit are proud to stand up for their nursing colleagues at the Alaska Psychiatric Institute and elsewhere who are being forced to work multiple additional shifts in a given week. This practice is unsafe for patients and unsafe for nurses. Ultimately, it is unsafe for our community.

Again, we want to thank you for your support and indicate our strong support for House Bill 271.

Sincerely,

A handwritten signature in cursive script that reads "Donna Phillips".

Donna Phillips, RN, BSN  
Member, Alaska Nurses Association Board of Directors  
Chair, AaNA Labor Council  
Treasurer and Membership Chair,  
Providence Registered Nurses Bargaining Unit

MICHELLE MURPHY, RN

3425 Patterson Street  
Anchorage, Alaska 99504  
(907) 240-2980  
mlmrn@acsalaska.net

April 28, 2005

Rep. Peggy Wilson  
State Capitol  
Room 108  
Juneau, AK 99801

Dear Representative Wilson,

I am writing this letter to express my enthusiastic and sincere support for HB 271. This bill is very important because it would ensure the safety of Alaskans by banning the use of mandatory overtime as a means for hospitals and other healthcare institutions to provide nursing staff during the nursing shortage.

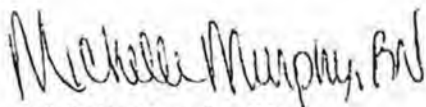
As both a full-time working RN and the Health and Safety officer for the Providence Registered Nurses union, banning mandatory overtime is a critical step for ensuring the health and safety of both the patients and the nurses caring for them. Numerous studies and statistics have shown how this practice has very adverse affects on both nurses and patients and therefore it should be banned.

Why should Alaska make this a law? Because if hospitals and other health care institutions could be trusted not to practice the unsafe use of mandatory overtime to staff their nursing shortage they would have already been doing it.

I have included an article written by Sara Markle – Elder from the United American Nurses that outlines the negative impacts on both the patients and the nurses.

*Please enact this bill in Alaska and make us a leader in participating in the regulation of the dangerous use of mandatory overtime for nurses.*

Sincerely,



Michelle Murphy, RN

**MEMORANDUM**

May 3, 2005

TO: HESS Committee Members  
FROM: Rep. Peggy Wilson  
SUBJECT: Critical Care Hospital Definition

Critical access hospitals (CAH) are recognized by CMS for cost-based reimbursement purposes. To obtain eligibility as a CAH, the facility must be a Medicare hospital, a hospital that stopped operating on or after November 29, 1989, or a health clinic or health center that was a hospital before it was downsized.

The geographic location of the facility plays a role in its designation as a CAH as well.

The facility must be located in a rural area of a State that has established a Medicare rural flexibility program, or within a Metropolitan Statistical Area (MSA) of such a State.

The CAH must be located more than a 35-mile drive from another hospital or CAH (15 miles in mountainous terrain, or areas with only secondary roads) unless it was designated by the state to be a 'necessary provider' before January 1, 2006.

The facility must offer round-the-clock emergency care services, provide not more than 25 beds (acute and/or swing with SNF level care if the CAH has a swing bed agreement) and maintain an average length of stay of no more than 96 hours.

# STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Frank H. Murkowski, GOVERNOR

P.O. BOX 110601  
JUNEAU, ALASKA 99811-0601  
PHONE: (907) 465-3228  
FAX (907) 465-3068

March 25, 2005

Representative Peggy Wilson  
Alaska House of Representatives  
Capitol Building Room 108  
Juneau, Alaska 99801

Representative Wilson:

On March 25, 2005 your staff requested a list of critical access hospitals in Alaska. I am providing that information to you below for your reference.

<p><b><u>Cordova Community Medical Center</u></b> P.O. Box 160 Cordova, Alaska 99574 Phone: 907-424-8000</p>	<p><b><u>Providence Seward Medical Ctr./Wesley Care Ctr.</u></b> P.O. Box 365 Seward, Alaska 99664 Phone: 907-224-5205</p>
<p><b><u>Kanakanak Hospital</u></b> P.O. Box 130 Dillingham, Alaska 99576 Phone: 907-842-5201</p>	<p><b><u>Sitka Community Hospital</u></b> 209 Moller Avenue Sitka, Alaska 99835 Phone: 907-747-3241</p>
<p><b><u>Manillaq Health Center</u></b> P.O. Box 43 Kotzebue, Alaska 99752 Phone: 907-442-3321</p>	<p><b><u>Valdez Regional Health Authority</u></b> P.O. Box 550 Valdez, Alaska 99686 Phone: 907-835-2249</p>
<p><b><u>Petersburg Medical Center</u></b> P.O. Box 589 Petersburg, Alaska 99833 Phone: 907-772-4291</p>	<p><b><u>Wrangell Medical Center</u></b> P.O. Box 1081 Wrangell, Alaska 99929 Phone: 907-874-7000</p>
<p><b><u>Providence Kodiak Island Medical Center</u></b> 1915 E. Rezanof Drive Kodiak, Alaska 99615 Phone: 907-486-3281</p>	<p><b><u>Norton Sound Health Corporation</u></b> P.O. Box 966 Nome, Alaska 99762 Phone: 907-443-3311 - Website</p>

Please let us know if you have any questions or need additional information.

Sincerely,



Robert Buttane  
Project Coordinator

cc: Sherry Hill; Janet Clarke

## **State of Alaska Median Wage as of January 2005**

Nurse I 20.51/hr (A Step)

Nurse II 26.20/hr (F Step)

### **Pay Systems:**

#### **Ketchikan General**

One step increase for every year or 1,248 compensated hours, whichever comes later.

Maximum 2 steps per year.

20 steps total.

#### **Central Peninsula General Hospital:**

One step increase for every 1,872 hours worked.

30 steps total.

#### **Providence Alaska Medical Center:**

Unavailable

#### **State of Alaska:**

One step increase per year for the first 7 steps.

Longevity increases based on length of service after first 7 steps.

11 steps total.

#### **Bartlett Regional Hospital:**

One step every 2,080 hours worked.

12 steps total.

## Overtime Paid in FY 2005 to Nurses by Facility

Organizational Unit	Number of Positions	# of EEs who worked OT	FY 05 Total Amt	FY 05 Total Hrs	Ave Hrs/ Position
Ak Psychiatric Institute	73	55	\$ 205,057.41	9,585.25	131.30
Amya	1	1	\$ 224.59	15.00	15.00
Amya - Challenge	2	2	\$ 7,854.42	211.50	105.75
Anchorage Pioneers Home	39	33	\$ 32,536.63	2,053.25	52.65
Children's Svc - Family Services Juneau	1	1	\$ 275.76	6.00	6.00
Fairbanks Health Center	20	1	\$ 135.90	4.00	0.20
Fairbanks Pioneers Home	19	11	\$ 42,927.66	2,055.50	108.18
Juneau Pioneers Home	17	11	\$ 5,053.57	383.25	22.54
Juv Just - Bethel Youth Facility	1	1	\$ 990.18	16.75	16.75
Juv Just - Fairbanks Youth Facility	2	1	\$ 379.90	9.00	4.50
Juv Just - Johnson Youth Center	2	2	\$ 1,022.35	36.75	18.38
Juv Just - Mat Su Youth Facility	1	1	\$ 2,728.80	73.75	73.75
Juv Just - McLaughlin Youth Center	3	3	\$ 1,460.18	259.75	86.58
Ketchikan Pioneers Home	12	6	\$ 12,926.85	913.75	76.15
Military Youth Corps	2	1	\$ 147.02	4.50	2.25
Mt Edgecumbe High School	2	1	\$ 660.76	19.50	9.75
Palmer Pioneers Home	18	13	\$ 11,621.94	583.00	32.67
Sitka Pioneers Home	23	15	\$ 25,690.29	1,257.00	54.65
Inmate Health Care-Anchorage	54	34	\$ 318,669.21	14,751.25	273.17
Inmate Health Care-Bethel	4	2	\$ 35,004.85	763.50	190.88
Inmate Health Care-Eagle River	14	8	\$ 55,119.93	2,532.50	180.89
Inmate Health Care-Fairbanks	10	7	\$ 15,408.09	786.75	78.68
Inmate Health Care-Juneau	4	3	\$ 9,524.18	326.75	81.69
Inmate Health Care-Kenai	10	5	\$ 28,070.81	920.50	92.05
Inmate Health Care-Ketchikan	4	1	\$ 4,920.22	122.00	30.50
Inmate Health Care-MacKenzie Pt	2	1	\$ 146.94	4.00	2.00
Inmate Health Care-Nome	3	3	\$ 18,079.59	317.00	105.67
Inmate Health Care-Palmer	11	6	\$ 37,474.35	1,301.00	118.27
Inmate Health Care-Seward	10	10	\$ 31,202.01	1,439.50	143.95
<b>Grand Total</b>	<b>238</b>	<b>239</b>	<b>\$ 910,314.39</b>	<b>40,757.25</b>	<b>171.25</b>

Overtime Codes are 251(overtime), 252 (double), 254 (holiday), 260 (swing OT), 261 (grave OT)

x: Projects/Nurse OT/Nurse (only) Overtime by Org Unit

Prepared by C. Preece, Human Resource Specialist, Division of Personnel

### Nursing Employee Movement between Departments and Out of the Executive Branch in 2004

Job Class Title	Education			Health & Social Services			Commerce, Comm & ED			Military & VA			Corrections			Job Class Totals			
	EE Movement	Position Count	Percent	EE Movement	Position Count	Percent	EE Movement	Position Count	Percent	EE Movement	Position Count	Percent	EE Movement	Position Count	Percent	EE Movement	Position Count	Percent	
Assistant Chief, Public Health Nursing					1	0%											1	0%	
Assistant Nursing Director					1	0%											1	0%	
Chief, Public Health Nursing					1	0%											1	0%	
Licensed Practical Nurse				4	21	19%							3	27	11%		7	48	15%
Nurse Consultant I				2	11	18%		1	0%								2	12	17%
Nurse Consultant II				5	16	31%											5	16	31%
Nurse I				5	10	50%					1	0%		3	4	75%	8	15	53%
Nurse II		1	0%	8	36	22%					1	0%		4	35	11%	12	73	16%
Nurse II (Psychiatric)				10	37	27%							2	7	29%		12	44	27%
Nurse III				3	20	15%					1	0%		3	9	33%	6	30	20%
Nurse III (Psychiatric)					11	0%									1	0%		12	0%
Nurse IV					2	0%												2	0%
Nurse IV (Psychiatric)				1	6	17%									1	0%	1	7	14%
Nursing Director					1	0%												1	0%
Public Health Nurse I					5	0%												5	0%
Public Health Nurse II				4	41	10%											4	41	10%
Public Health Nurse III				5	46	11%											5	46	11%
Public Health Nurse IV					8	0%												8	0%
Public Health Nurse V					5	0%												5	0%
Quality Assurance And Utilization Review Nurse														1	0%			1	0%
<b>Departmental Totals</b>	<b>0</b>	<b>1</b>	<b>0%</b>	<b>47</b>	<b>279</b>	<b>17%</b>	<b>0</b>	<b>1</b>	<b>0%</b>	<b>0</b>	<b>3</b>	<b>0%</b>	<b>15</b>	<b>85</b>	<b>18%</b>	<b>62</b>	<b>369</b>	<b>17%</b>	


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## Nurses say working long hours is dangerous

**OVERTIME: Workers seek to limit number of double shifts.**

By TIMOTHY INKLEBARGER  
The Associated Press

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JUNEAU -- Nurses in Alaska are joining a movement in states across the nation to limit forced overtime at hospitals, a practice they contend is dangerous both for them and their patients.

Nurses at state-run health care facilities, such as the Alaska Psychiatric Institute in Anchorage and the state's six Pioneer Homes for seniors, and at health clinics in rural areas often work 12- or 16-hour shifts to help fill holes in round-the-clock schedules.

Dianne O'Connell of the Alaska Nurses Association said nurses sometimes are called in two or three times a week to work double shifts.

They feel obligated to fill the empty shifts over fear of retribution or the possibility of losing their nursing license for abandoning their patients, O'Connell said.

API nursing director Jane Barnes said nurses who leave their posts irresponsibly without alerting other staff could be reported to the Alaska Board of Nursing.

"But we haven't had nurses do that irresponsibly," she said.

Barnes said it is unlikely that nurses would be reported or have their licenses revoked for declining a mandatory overtime shift because of fatigue. She said API takes the circumstances of each situation into account and has tried to work with nurses to accommodate their needs.

Nurses who refuse mandatory overtime shifts without good reason, though, would be subject to disciplinary action, Barnes said. She said any potential disciplinary action would be made known up front before a nurse decides whether to work the shift.

O'Connell said the mandatory overtime issue has been a problem at the Psychiatric Institute for years because the facility does not have enough nurses on staff.

"If somebody calls in sick, they don't have a pool of people to call upon," she said.

There are 8,670 licensed nurses in Alaska. According to a 2000 nationwide survey, Alaska had 782.9 registered nurses per 100,000 residents, close to the national average. But it lagged in licensed practical nurses.

The Alaska State Employees Association, which represents about 90 nurses statewide, and the



Nurses at the Alaska Psychiatric Institute in Anchorage and other state-run health care facilities in Alaska are joining a movement to limit mandatory overtime at hospitals. Nurses often work 12- to 16-hour shifts to fill holes in schedules. (Photo by AL GRILLO / The Associated Press)

Alaska Nurses Association are pushing Alaska lawmakers to pass a bill that would prevent hospitals from requiring nurses to accept overtime hours if they believe it would jeopardize their safety or the safety of their patients. The bill, by Rep. Peggy Wilson, R-Wrangell, would not apply in emergencies.

Nurses would not be allowed to work more than 12 hours without an eight-hour break. Health care facilities that violate the law would have to pay nurses three times their regular pay for the mandatory overtime hours worked. A second offense within 12 months would result in a fine of \$500, and a third violation within a year would mean a fine of \$2,500 to \$5,000.

J.W. Pound, a nurse who has worked at API for 14 years, said nurses at the hospital are attacked by patients on a regular basis. Many of the patients admitted to the institute are straight out of jail, Pound said.

"You have to be on your guard all the time," he said. "You have people who are pretty paranoid. A lot of them are angry and delusional."

Pound, 55, said he works the night shift when attacks are more common.

He said nurses at API often sign up for scheduled overtime shifts to get their names removed from a list of mandatory overtime shifts that can be required if other nurses are sick or unable to work.

He said some of the overtime shifts can make for 16-hour days at the hospital.

ASEA business agent Doug Carson said the assaults can become more of a safety issue for nurses after they've worked double shifts.

"If you're tired, you make yourself more vulnerable," he said.

API director and chief executive officer Ron Adler said the hospital does not compromise its workers' or patients' safety.

"There is a noted incongruence between the data and staff perceptions," Adler said.

Adler said the quality improvement program at API monitors staff safety, which he said is showing a trend of fewer employee and patient injuries.

He said mandatory overtime is a "lightning-rod issue" and the hospital is implementing a nursing management software program that will help identify peak times of the year when mandatory overtime shifts increase.

"It really gives us data and information to staff the hospital in a more precise way than we're doing," he said. "I think we can staff up with seasonal, part-time and on-call employees."

He said the hospital wants to accommodate employees and give them the time off to spend with their families.

Carson said ASEA filed a grievance against the hospital earlier this year, arguing that API cannot call nurses in on their days off. He said the grievance is pending.

Adler declined to comment on the grievance, directing questions to state labor negotiator Art Chance. Chance did not return phone calls requesting an interview.

The Legislature does not meet again until January, but Wilson, who also serves as chairman of the House Health, Education and Social Services Committee, said she plans to hold hearings sometime later this year.

Wilson, who has worked as a nurse for 32 years, said she has never had to work mandatory overtime shifts but wants to give those who have a chance to discuss the issue in a public forum.

She said the issue also is a problem for nurses at state corrections facilities.

"I think what hospitals are going to have to do is start paying nurses more," she said, noting that state health care facilities pay nurses significantly less than private facilities, which makes it difficult to retain employees.

Carol Cooke, a spokeswoman for the American Nurses Association, said the move to establish laws limiting mandatory overtime is playing out in many states as well as in Congress.

She said nine states have passed laws limiting the practice and another 23 have introduced legislation.

A bill by U.S. Rep. Pete Stark, D-California, and U.S. Rep. Steven LaTourette, R-Ohio, would limit mandatory overtime to emergency situations and give the U.S. Department of Health and Human Services the authority to issue \$10,000 fines to facilities that are in violation. A companion bill in the U.S. Senate has been introduced by Sen. Ted Kennedy, D-Mass.

Adler acknowledged the trend and said API is hoping to move away from mandatory overtime with its new scheduling system and seasonal and part-time employees.

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# The Working Hours Of Hospital Staff Nurses And Patient Safety

Both errors and near errors are more likely to occur when hospital staff nurses work twelve or more hours at a stretch.

by Ann E. Rogers, Wei-Ting Hwang, Linda D. Scott, Linda H. Aiken, and David F. Dinges

**ABSTRACT:** The use of extended work shifts and overtime has escalated as hospitals cope with a shortage of registered nurses (RNs). Little is known, however, about the prevalence of these extended work periods and their effects on patient safety. Logbooks completed by 393 hospital staff nurses revealed that participants usually worked longer than scheduled and that approximately 40 percent of the 5,317 work shifts they logged exceeded twelve hours. The risks of making an error were significantly increased when work shifts were longer than twelve hours, when nurses worked overtime, or when they worked more than forty hours per week.

SEVERAL TRENDS IN HOSPITAL USE and staffing patterns have converged to create potentially hazardous conditions for patient safety. High patient acuity levels, coupled with rapid admission and discharge cycles and a shortage of nurses, pose serious challenges for the delivery of safe and effective nursing care for hospitalized patients.<sup>1</sup> While systematic national data on trends in the number of hours worked per day by nurses are lacking, anecdotal reports suggest that hospital staff nurses are working longer hours with few breaks and often little time for recovery between shifts.<sup>2</sup> Scheduled shifts may be eight, twelve, or even sixteen hours long and may not follow the traditional pattern of day, evening, and night shifts. Although twelve-hour shifts usually start at 7 p.m. and end at 7 a.m., some start at 3 a.m. and end at 3 p.m. Nurses working on specialized units such as

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surgery, dialysis, and intensive care are often required to be available to work extra hours (on call), in addition to working their regularly scheduled shifts. Twenty-four-hour shifts are becoming more common, particularly in emergency rooms and on units where nurses self-schedule.

No state or federal regulations restrict the number of hours a nurse may voluntarily work in twenty-four hours or in a seven-day period.<sup>3</sup> Even though state legislatures in approximately nineteen states have considered bans on mandatory overtime for nurses and other health care professionals, bills prohibiting mandatory overtime for nurses have passed only in California, Maine, New Jersey, and Oregon. No measure, either proposed or enacted, addresses how long nurses may work voluntarily.<sup>4</sup> The recent Institute of Medicine (IOM) report, *Keeping Patients Safe*, explicitly recommends that voluntary overtime also be limited.<sup>5</sup>

The well-documented hazards associated with sleep-deprived resident physicians have influenced changes in house staff rotation policies.<sup>6</sup> In contrast, although shift-working nurses have been the focus of numerous studies, it is not known if the long hours they work have an adverse effect on patient safety in hospitals.<sup>7</sup> The purpose of this paper is to examine the work patterns of hospital staff nurses and to determine if there is a relationship between hours worked and the frequency of errors.

### Study Data And Methods

■ **Sample.** A cover letter explaining the study and eligibility criteria was mailed to a random nationwide sample of 4,320 members of the American Nurses Association (ANA) during the winter of 2002; 1,725 nurses expressed interest by returning their completed demographic questionnaire to the Survey Research Institute at Temple University in Philadelphia. Two logbooks covering a two-week period each, instructions for completing the logbooks, and postage-paid envelopes were mailed to 391 eligible subjects (unit-based hospital staff nurses working full time). Three hundred sixty-two subjects returned both logbooks, and thirty-one completed only one of the two logbooks, for a return rate of approximately 40 percent. The Institutional Review Board at the University of Pennsylvania approved this study, and subjects were paid \$140 for their participation.

■ **Subjects.** The sample of 393 registered nurses (RNs) was predominantly female (92 percent), Caucasian (79 percent), middle-aged (mean age 44.8 ± 8.8 years, range 22–66), and experienced (mean 17.2 ± 10.0 years). Only 26.3 percent of the participants reported less than ten years' experience, while 41.9 percent reported twenty or more years. All participants worked full time (at least thirty-six hours per week) as hospital staff nurses. Half reported working in hospitals with more than 300 beds; only 11 percent reported working in a hospital with less than 100 beds. The majority of participants were employed at hospitals located in urban (56 percent) or suburban (19 percent) areas. The remaining participants worked in hospitals located in small towns (18 percent) or rural areas (7 percent). The characteristics of

nurses in the study sample did not differ significantly from those of nurses in the 2000 National Sample Survey of Registered Nurses (NSSRN) in terms of sex, age, marital status, and work environment (hospital size, urban/rural location, and type of hospital unit).<sup>8</sup> Our sample has slightly more nurses who identified their ethnicity as Asian (10.7 percent) than among participants in the NSSRN (3.8 percent).

■ **Instruments.** Spiral-bound logbooks were used to collect information about hours worked (both scheduled and actual hours), time of day worked, overtime, days off, and sleep/wake patterns. Subjects completed seventeen to forty items per day; all forty questions were completed only on days the nurses worked. Questions regarding errors and near errors were included, and space was provided for nurses to describe any errors or near errors that might have occurred during their work periods. On days off, nurses were asked to complete the first seventeen questions about their sleep/wake patterns, mood, and caffeine intake. All items in the logbook and the logbook format itself were pilot-tested before this study began.

Logbooks (both paper and electronic) have been used to collect data during field studies of pilots' cockpit alertness for more than ten years, and from various other groups of subjects including air traffic controllers, flight controllers during space shuttle missions, and emergency room physicians.<sup>9</sup> Data recorded about sleep patterns in these logbooks compare well with data recorded using objective measures such as wrist actigraphy or ambulatory polysomnography.<sup>10</sup>

Although logbooks are not often used to collect information about medical errors, there is some evidence that daily, anonymous, end-of-shift reporting of errors in a logbook is a valid approach to ascertaining the nature and prevalence of nursing errors. During a one-month study period of medication errors at a large military hospital, nurses completed formal incident reports on only 6 percent of the medication errors and 15 percent of the near errors that they reported using daily, anonymous coupons.<sup>11</sup> Another study found that resident physicians also were more likely to report potential injuries to patients using a confidential e-mail system with daily prompts about reporting than they were to complete traditional incident reports.<sup>12</sup>

■ **Analysis.** Data from demographic questionnaires and logbooks were summarized using descriptive statistics and frequency tables. The duration of scheduled and actual work hours per shift was calculated and aggregated per nurse and per week. Cutpoints for classifying shift durations were chosen as 8.5 hours and 12.5 hours because "eight-hour" and "twelve-hour" shifts are usually scheduled to allow for a half-hour handover period at the end of the shift. A work shift was classified as an overtime shift if the actual work hours were longer than the scheduled hours or if the nurse reported that the shift was "scheduled overtime."

A binary response for making an error during a worked shift was used as the primary outcome in analyses. When a nurse caught him/herself before making an error during a shift, a binary near-error variable was reported and treated as the secondary outcome. Errors and near errors were codified into categories by study

investigators, based on the descriptions provided in logbooks (for example, medication administration, procedural, transcription). The univariate associations between the risk of making an error or a near error and (1) the actual duration of the shift, and (2) overtime were estimated separately using logistic regression models. The effect of overtime was also examined by stratifying shifts by their expected duration. Since multiple work shifts from the same nurse contributed to this analysis, procedures based on Generalized Estimating Equation (GEE) were used to determine the odds ratio (OR) while accounting for the nonindependence between repeated measurements.<sup>13</sup> Significance tests were two-sided with  $\alpha = .05$ . Multivariate analyses also were conducted to evaluate the adjusted associations between errors (or near errors), work hours, and overtime, while controlling for other variables including age, hospital size, and type of hospital unit. For the week-level data, logistic regression models were performed to assess if working more than forty hours or fifty hours would increase the probability of making one or more errors (or near errors) in a week.

### Study Results

Data collected on 5,317 work shifts revealed that hospital staff nurses worked longer than scheduled daily, and generally worked more than forty hours per week. Half of the shifts worked exceeded ten and a half hours. Although 31 percent of the scheduled shifts were scheduled for durations greater than or equal to 12.5 hours, there were 2,057 shifts (39 percent) where nurses worked at least 12.5 consecutive hours (Exhibit 1). Fourteen percent of the respondents reported working sixteen or more consecutive hours at least once during the four-week pe-

**EXHIBIT 1**  
**Description Of Work Patterns Of Full-Time Hospital Staff Nurses, 2002**

Variable	Number of shifts	Percent
Number of shifts	5,317	100.0
Scheduled shifts <sup>a</sup>		
Up to 8.5 hours	2,452	46.6
8.5-12.5 hours	1,183	22.5
12.5 or more hours	1,623	30.9
Actual shifts <sup>b</sup>		
Up to 8.5 hours	771	14.5
8.5-12.5 hours	2,484	46.8
12.5 or more hours	2,057	38.7
Number of overtime shifts	4,292	81.4
Number of mandatory overtime shifts	360	6.8

**SOURCE:** Authors' analysis of survey results

<sup>a</sup>Scheduled shift hours were missing from 59 shifts. Mean length (hours): 10.3 (standard deviation,  $\pm 2.3$ ); range: 1.0-22.5 hours.

<sup>b</sup>Actual work hours were missing from 5 shifts. Mean length (hours): 10.8 (SD,  $\pm 2.5$ ); range: 1.2-23.7 hours.

riod. The longest shift worked was twenty-three hours, forty minutes.

Nurses reported leaving work at the end of their scheduled shift less than 20 percent of the time during the study period. Although overtime was reported at the end of all types of shifts, the proportion of shifts involving overtime was significantly higher ( $p = .0001$ ) when eight-hour shifts (85 percent) were compared to shifts scheduled for eight to twelve hours (79 percent) and twelve hours or longer (78 percent). Overall, our participants worked, on average, fifty-five minutes longer than scheduled each day, and all participants worked beyond their scheduled work shift (overtime), at least once during the twenty-eight-day data-gathering period. Almost two-thirds of the nurses worked overtime ten or more times during that period, and a third reported working overtime each day they worked during that period. There were 360 shifts where nurses reported being mandated to work overtime and another 143 shifts where they described being "coerced" to work voluntary overtime. Even though nurses worked approximately four days per week, averaging 40.2 ( $\pm 12.9$ ) hours per week (range 8–97.2 hours per week), one-quarter worked more than fifty hours per week for two or more weeks of the four-week period.

There were 199 errors and 213 near errors reported during the data gathering period. More than half of the errors (58 percent) and near errors (56 percent) involved medication administration. Other errors included procedural errors (18 percent), charting errors (12 percent), and transcription errors (7 percent). Approximately 6 percent of the errors and 29 percent of the near errors reported lacked sufficient information for categorization. Thirty percent of the nurses reported making at least one error, and 32 percent reported at least one near error. One nurse reported eight errors, while another nurse reported nine near errors.

Our analysis showed that work duration, overtime, and number of hours worked per week had significant effects on errors. The likelihood of making an error increased with longer work hours and was three times higher when nurses worked shifts lasting of 12.5 hours or more (odds ratio = 3.29,  $p = .001$ ) (Exhibit 2). Working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled (OR = 2.06,  $p = .0005$ ). Our data also

**EXHIBIT 2**  
**Association Of Errors Or Near Errors With Nurses' Work Duration, 2002**

Work duration (hours)	Number of shifts	Shifts with one or more errors			Shifts with one or more near errors		
		Number	Percent	OR (p value)	Number	Percent	OR (p value)
Up to 6.5	771	12	1.6	1.00	20	2.6	1.00
8.5–12.5	2,484	77	3.1	1.85 (.06)	94	3.8	1.44 (.18)
12.5 or more	2,057	103	5.0	3.29 (.001)	97	4.7	1.80 (.04)
Total	5,312	192	3.5		211	4.0	

**SOURCE:** Authors' analysis of survey results.

**NOTES:** Five shifts with four errors cannot be classified because of missing work durations. OR is odds ratio.

suggest that there is a trend for increasing risks when nurses work overtime after longer shifts (OR = 1.34, 1.53, and 3.26 for scheduled eight-hour, eight-to-twelve-hour, and twelve-hour shifts, respectively), with the risks being significantly elevated for overtime following a twelve-hour shift ( $p = .005$ ) (Exhibit 3). Although the effects of working prolonged shifts were clearly associated with errors, there was no interaction between scheduled shift duration and overtime ( $p = .17$ ). Finally, working more than forty hours per week and more than fifty hours per week significantly increased the risk of making an error (Exhibit 4). Results were somewhat similar for near errors (Exhibits 2-4).

Nurse and employment characteristics were also examined as potential confounders in the multivariate models. Our results suggest that the relationships of errors or near errors and work hours and overtime were not affected by age, hospital size, or type of hospital unit.

### Discussion

This study represents one of the first nationwide efforts to quantify hospital staff nurse work hours and work patterns, and to determine whether extended staff nurse work hours contribute to errors and near errors. Our findings confirm that the work schedules of hospital staff nurses are unpredictably prolonged. All nurses reported working longer than scheduled at least once, and the majority reported working longer than scheduled ten times or more in a twenty-eight-day period, as well as working more than forty hours per week. Almost one-sixth of the sample reported working sixteen or more consecutive hours at least once during the period, which suggests that double shifts (or longer) are not confined to rare emergencies. Mean daily overtime durations were slightly higher than those

**EXHIBIT 3**  
**Association Of Errors Or Near Errors With Nurses' Scheduled Work Duration And Overtime, 2002**

Scheduled work duration (hours)	Number of shifts	Shifts with one or more errors			Shifts with one or more near errors		
		Number	Percent	OR (p value)	Number	Percent	OR (p value)
<b>Up to 8.5</b>							
No OT	377	8	2.1	1.00	15	4.0	1.00
OT	2,075	65	3.1	1.34 (.42)	76	3.7	0.90 (.74)
<b>8.5-12.5</b>							
No OT	246	6	2.4	1.00	5	1.2	1.00
OT	937	36	3.8	1.53 (.36)	42	4.5	2.32 (.08)
<b>12.5 or more</b>							
No OT	360	6	1.7	1.00	8	2.2	1.00
OT	1,263	70	5.5	3.26 (.005)	67	5.3	2.34 (.03)
<b>Total</b>	<b>5,258</b>	<b>191</b>	<b>3.6</b>		<b>211</b>	<b>4.0</b>	

**SOURCE:** Authors' analysis of survey results.

**NOTES:** Fifty-nine shifts with five errors and two near errors cannot be classified because of missing scheduled work durations. OR is odds ratio. OT is overtime.

**EXHIBIT 4**  
**Association Of Errors Or Near Errors With The Number Of Hours Worked Per Week By Nurses, 2002**

Hours worked	Number of weeks	Weeks with one or more errors			Weeks with one or more near errors		
		Number	Percent	OR (p value)	Number	Percent	OR (p value)
<b>More than 40</b>							
No	743	64	8.6	1.00	75	10.1	1.00
Yes	681	101	14.8	1.96 (<.0001)	92	13.5	1.42 (.03)
Total	1,424	165	11.6		167	11.7	
<b>More than 50</b>							
No	1,110	112	10.1	1.00	120	10.8	1.00
Yes	314	53	16.9	1.92 (.0001)	47	15.0	1.46 (.03)
Total	1,424	165	11.6		167	11.7	

**SOURCE:** Authors' analysis of survey results.

**NOTE:** OR is odds ratio.

reported in two small observational studies (fifty-five minutes, compared with forty-two and forty-five minutes, respectively).<sup>14</sup>

Although the occurrence of errors did not increase significantly until shift durations exceeded 12.5 hours per day, risks began to increase when shift durations exceeded 8.5 hours. Since errors are relatively rare, it is possible that this study lacked sufficient power to detect the effects of work hours or overtime on errors when nurses were scheduled to work shorter shifts (less than 12.5 hours). Certainly the trend toward increasing errors with longer work durations is consistent with other studies that have demonstrated that extended work periods are associated with increased accidents and neuropsychological deficits among nurses and have contributed to at least two hospitalwide epidemics of *Staphylococcus aureus*.<sup>15</sup> Investigations of these epidemics showed that nurses, who were fatigued and stressed by high patient caseloads and understaffing, made frequent mistakes and procedural errors. Despite the lack of information about accident rates involving nurses, probed performance tests reveal that nurses working twelve-hour simulated shifts make more frequent errors on grammatical reasoning tasks and medical record reviewing.<sup>16</sup>

There are already hints that the fatigue associated with working twelve-hour shifts is contributing to absenteeism and job dissatisfaction among RNs. Fatigue related to length of shift or the potential of overtime at end of shift, or both, was identified as the cause of approximately 12 percent of the absences reported by a random sample of Canadian hospital staff nurses. Not only did RNs report an unusually high number of sick days year (7.4 days, compared with 3.2 for other workers), but also nurses working twelve-hour shifts reported significantly higher absenteeism rates than nurses working traditional eight-hour shifts. Nurses who worked twelve-hour shifts also expressed lower levels of job satisfaction than nurses working eight-hour shifts.<sup>17</sup>

Inasmuch as the probability of making an error because of long work hours or

*“The long and unpredictable hours documented here suggest a link between poor working conditions and threats to patient safety.”*

overtime was not altered significantly by the age or experience of the nurses, or by the type of unit or hospital size, other factors may be important. More specifically, physiological factors such as fatigue, system variables such as increased work intensity, or a combination of fatigue and increased work intensity may contribute to the errors and near errors we observed. It is also possible that heavy workloads themselves may increase the risk of making an error.

The use of mandatory overtime to cover staffing vacancies is a controversial and potentially dangerous practice.<sup>18</sup> More than one-quarter of nurse participants (28.7 percent) reported working mandatory overtime at least once during the data-gathering period, a percentage that is quite similar to that reported in two surveys of more than 47,000 nurses and in a “Quick Poll” posted on the American Association of Critical Care Nurses Web site.<sup>19</sup>

*Mandatory overtime* is generally defined as nurses’ being told that they could be fired, be subjected to disciplinary proceedings, or lose their nursing license if they refused to stay beyond their regularly scheduled shift or come in to work on their day off.<sup>20</sup> Although not actually threatened with job loss or disciplinary proceedings, many nurses also report feeling that there will be repercussions if they refuse to work extra hours or that overtime “is voluntary but feels like it is required.”<sup>21</sup> Perhaps that is why approximately 60 percent of the participants in the American Nurses Association Staffing Survey (N = 4,258) reported being “forced to work voluntary overtime.”<sup>22</sup>

Our data are derived from the self-reports of a relatively small number of hospital staff nurses and may not be representative of the work schedules and clinical practices of other U.S. hospital nurses. However, the demographic characteristics of our nurse sample and our findings about hours worked are consistent with data reported by hospital staff nurses in the NSSRN, a probability-based sample.<sup>23</sup> In addition, the percentage of staff nurses who identified twelve-hour shifts as their usual shift pattern (60.6 percent) is quite similar to Marlene Kramer and Claudia Schmalenberg’s report that almost two-thirds of the 279 staff nurses they interviewed worked twelve-hour shifts.<sup>24</sup>

Although our response rate was lower than that usually reported for surveys of nurses, this study required more effort than the usual survey; subjects were asked to respond to between seventeen and forty items every day for twenty-eight days.<sup>25</sup> Given the subject burden, it is possible that responders were more invested than nonresponders were in documenting a relationship between the hours they worked and effects on patient safety. However, the amounts of overtime reported varied, with some nurses indicating minimal overtime and others reporting extremely long shift durations or working more than fifty hours per week, or both.

Perhaps more important, the major unit of analysis for this study was the actual work shift ( $N = 5,317$ ) rather than the nurse ( $N = 393$ ).

The definition of *error* was not specified in the survey instrument. Nevertheless, all incidents described by participants were obvious deviations from current standards of practice. Reported medication errors clearly fell into the categories familiar to all nurses: wrong patient, wrong medication, wrong dose, wrong route (such as intravenous, oral), wrong time, and errors of omission.<sup>26</sup> Nurses were asked whether they made an error, not to assess whether it led to harm.

By not collecting data that could identify where participants worked, we reduced the fears usually associated with reporting errors. Studies have shown that nurses typically underreport errors because they fear repercussions, including disciplinary action by employers and regulatory agencies. As a result, only those errors considered potentially life-threatening, or approximately 5 percent of significant errors, are usually reported.<sup>27</sup> Errors that are considered "minor" or are intercepted before reaching the patient are almost never reported.<sup>28</sup> In fact, near errors are now considered nonreportable events by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).<sup>29</sup>

The errors nurses reported in this study occurred in the context of well-documented deficiencies in nurses' practice conditions in U.S. hospitals, deficiencies that nurses have been reporting for well over a decade.<sup>30</sup> The long and unpredictable hours documented here suggest a link between poor working conditions and threats to patient safety. As advocated by the IOM report on medical errors, safer patient care is more likely to result from changes in the environment in which health care is provided than from blaming health care professionals, who may be providing the best care possible under poor circumstances.<sup>31</sup>

Hospital staff nurses' long hours may have adverse effects on patient care; we found that both errors and near errors are more likely to occur when hospital staff nurses work twelve or more hours. Because more than three-fourths of the shifts scheduled for twelve hours exceeded that time frame, routine use of twelve-hour shifts should be curtailed, and overtime—especially that associated with twelve-hour shifts—should be eliminated. Additional research with larger samples, inclusion of other variables such as workload and patient acuity, and more precise measurements of error is suggested.

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## ANA Calls for Action on Legislation to Limit Mandatory Overtime

### *Cites New Study that Shows Link between Patient Safety and Nurses' Work Hours*

**Washington, DC** - The American Nurses Association (ANA) praised a new study released yesterday that shows a strong link between medical errors and the long work hours of nurses and called on Congress to take action on the Safe Nursing and Patient Care Act (H.R. 745, S. 373), which would strictly limit the use of mandatory overtime for nurses.

The study, published in the July/August issue of *Health Affairs*, found that the risk of making an error greatly increased when nurses had to work shifts that were longer than 12 hours, when they worked significant overtime or when they worked more than 40 hours per week. It reinforced findings of the 2003 Institute of Medicine Report, "Keeping Patients Safe: Transforming the Work Environment of Nurses," which said that nurses' long working hours pose a serious threat to patient safety.

"This study is more evidence that patient safety is closely linked to nurses' working conditions," said ANA President Barbara Blakeney, MS, APRN, BC, ANP. "The growing trend of mandatory overtime for nurses is one of the greatest threats to patients' and nurses' safety. We call on Congress to protect the public by taking action to limit mandatory overtime for nurses. Doing so will help protect patients from preventable errors and retain nurses in the workforce."

To date, 10 states have taken action to limit mandatory overtime for nurses, and similar measures have been proposed in 20 other states.

The study, "The Working Hours of Hospital Staff Nurses and Patient Safety," by Ann Rogers, PhD, RN, and colleagues at the University of