AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, January 14, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
	IDAPA 27 - BOARD OF PHARMACY	
Docket No. 27-0101-1502	Institutional Pharmacy Dispensing (Pending Rule)	**Alex Adams** Executive Director, Idaho State Board of Pharmacy
Docket No. 27-0101-1503	Compounding Definitions (Pending Rule)	**Alex Adams**
Docket No. 27-0101-1504	Emergency Preparedness (Pending Rule)	**Alex Adams**
Docket No. 27-0101-1505	Definition Updates (Pending Rule)	**Alex Adams**
Docket No. 27-0101-1501	Retail Non-pharmacy Outlet Registration (Pending Fee Rule)	**Alex Adams**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, January 14, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting to order at 3:01 p.m. and welcomed everyone to the first meeting of the Senate Health and Welfare Committee (Committee). **Chairman Heider** stated that the members of the Committee were excited to begin the session and voiced appreciation for the public's participation.

INTRODUCTIONS: **Chairman Heider** introduced the new committee secretary, Karen Westbrook, and thanked her for her capable and efficient assistance. Next, Chairman Heider introduced the new page, Jared Kelly, and asked him to tell the Committee about himself. **Jared Kelly** informed the Committee that he lives just outside of Blackfoot, Idaho, attends Snake River High School and enjoys both playing and watching many different sports. After high school, Jared plans to serve a Latter-day Saints mission, attend college and study law. **Chairman Heider** thanked Jared for assisting the Committee.

PASSED THE GAVEL: **Chairman Heider** announced that the Committee would review rules from the Board of Pharmacy and passed the gavel to Vice Chairman Nuxoll to conduct the rules review.

Vice Chairman Nuxoll requested that Alex Adams introduce himself and present the rules of the Board of Pharmacy.

DOCKET NO. 27-0101-1502 **Rules of the Idaho State Board of Pharmacy Related to Institutional Pharmacy Dispensing.** **Alex Adams**, Executive Director of the Idaho State Board of Pharmacy (Board), introduced himself and stated that he would be presenting four pending rule dockets and one pending fee rule docket for the Committee's approval.

Mr. Adams stated that for each docket, the Board held (i) an open conference call on July 27, 2015; (ii) an open negotiated rulemaking session on August 12-13, 2015; and (iii) open proposed rulemaking session on October 28-29, 2015. **Mr. Adams** then informed the Committee that more than 25 diverse stakeholders participated in those sessions.

Senator Martin requested that Mr. Adams provide the Committee with a summary of his professional background. **Mr. Adams** stated that he has lived in Idaho and has served as Executive Director of the Board for approximately four months. Prior to accepting his current position, **Mr. Adams** explained that he lived in Washington, D.C., where he served as the Vice President of the National Association of Chain Drug Stores.

Returning to **Docket No. 27-0101-1502**, **Mr. Adams** explained that the basis for this change comes from the 1976 Supreme Court case *Abbott Laboratories v. Portland Retail Druggists Association, Inc.* In this case, the retail druggists argued that medications were being sold to nonprofit hospitals at a favorable rate unavailable to retail pharmacies, which resulted in unfair competition by the nonprofit hospitals. In its decision for the retail pharmacists, the Supreme Court detailed what is and is not permissible dispensing by a hospital pharmacy. To alleviate confusion among pharmacists in Idaho, this proposed change would make Idaho rules consistent with the Supreme Court's *Abbott Laboratories* decision. This rule, which defines permissible and impermissible hospital dispensing, would prevent hospitals from unfairly competing with retail pharmacists in Idaho.

Vice Chairman Nuxoll called for questions.

Senator Hagedorn inquired what comments and opposition, if any, the Board received during negotiated rulemaking. **Mr. Adams** reported that the Board received no comments in opposition of this proposed rule. Further, **Mr. Adams** reported that the Board received strong support from the Idaho Society of Health-System Pharmacists.

Senator Schmidt noted that there was significant latitude in the rule that would allow certain hospital pharmacies to dispense medication when retail pharmacies are open or when retail pharmacies are not open. In response, **Mr. Adams** stated that another rule addressed emergency room dispensing when community pharmacies are open. The rule before the Committee would not change that additional rule. **Senator Schmidt** asked whether the additional emergency room rule would be in conflict with the "in limited quantities and reasonable time duration" language in the rule currently before the Committee. **Mr. Adams** acknowledged Senator Schmidt's concern and indicated that the Board should address the issue in 2017 rulemaking.

MOTION: There being no more questions, **Senator Martin** moved to approve **Docket No. 27-0101-1502**. **Chairman Heider** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 27-0101-1503 **Rules of the Idaho State Board of Pharmacy Clarifying the Practice of Compounding. Mr. Adams** informed the Committee that this rule clarifies a previously adopted rule that was based on the federal Drug Quality and Security Act. The rule currently before the Committee proposes definitions for terms that were used, but undefined, in the previously adopted rule. Specifically, this rule defines (i) "hazardous drugs" to align with recommendations from the National Institute for Occupational Safety and Health; (ii) "USP 795" and "USP 797" to relate back to the United States Pharmacopeia; and (iii) "compounding" to carve out certain low-risk product and procedures such as reconstitution. **Mr. Adams** then reviewed certain provisions that were ultimately omitted from the current rule due to comments received during the public comment period.

Vice Chairman Nuxoll called for questions.

MOTION: There being no questions, **Senator Hagedorn** moved to approve **Docket No. 27-0101-1503**. **Senator Harris** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 27-0101-1504

Rules of the Idaho State Board of Pharmacy Related to Emergency Preparedness. Mr. Adams informed the Committee that this rule incorporates National Association of Boards of Pharmacy model language that recognizes the important role of pharmacy in mitigating public health emergencies. First, this rule would allow license reciprocity for pharmacists during an emergency declared by the President of the United States or the Governor of Idaho. Second, this rule would allow the transfer of a pharmacy license to a mobile or temporary pharmacy during an emergency. Third, this rule would allow pharmacists to refill certain medications for patients during an emergency when a primary care provider is not available. Finally, this rule would authorize protocol agreements among state agencies.

Vice Chairman Nuxoll called for questions.

Senator Jordan noted that rule related to mobile or temporary pharmacies requires that the provision of these services must cease "with the termination of the declared emergency; or as otherwise authorized by the Board." **Senator Jordan** asked if there were specific criteria for the Board to follow when authorizing continuing services. **Mr. Adams** responded that emergency declarations typically cover a short period of time, and this language gives the Board flexibility to continue services if, in the Board's judgment, the community still needs the services. **Senator Jordan** asked if the Board has established policies that dictate the criteria under which a continuation of services could be authorized by the Board. **Mr. Adams** responded that policies were not yet in place due to the newness of the emergency preparedness rules but indicated that he expects the Board to adopt more detailed emergency preparedness policies in the future.

MOTION: There being no more questions, **Senator Lee** moved to approve **Docket No. 27-0101-1504**. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 27-0101-1505

Rules of the Idaho State Board of Pharmacy Updating Certain Definitions. Mr. Adams informed the Committee that this rule modifies the definition of "pharmaceutical care services" to include ordering and interpreting laboratory tests. **Mr. Adams** noted that pharmacies are now the fourth leading provider of laboratory tests. He added that 37 percent of all pharmacies in Idaho are now providing basic laboratory tests, and the Idaho Bureau of Labs currently provides certificates of registration to pharmacies that provide laboratory tests. **Mr. Adams** stated that the Board has updated the regulation to be consistent with the practice of pharmacy as it continues to grow. In addition, this rule provides a general definition of "reconstitution" as the process of adding water to a powered medication. **Mr. Adams** reminded the Board that the practice of reconstitution was carved out of the definition of compounding in a previous rule.

Vice Chairman Nuxoll called for questions.

Senator Jordan stated that Idaho Code § 54-1704 does not articulate the "ordering and interpreting of laboratory tests" as an acceptable practice of pharmacy. On behalf of Senator Schmidt, **Senator Jordan** then asked Mr. Adams to speak to that apparent conflict. Noting that Senator Schmidt submitted this question to the Board prior to this meeting, **Mr. Adams** stated that he requested the Attorney General identify the statutory authority for this rule when it was originally promulgated. **Mr. Adams** then informed the Committee that Idaho Code § 54-1705(29) provides a broad definition of "pharmaceutical care" that may be further defined by the rules of the Board. Therefore, as authorized by Idaho Code § 54-1705(29), the Board has, from time to time, updated the definition of "pharmaceutical care services" as the practice of pharmacy continues to evolve. Citing an example of the evolving practice of pharmacy, **Mr. Adams** noted all schools of pharmacy in the U.S. are accredited by the Accreditation Council for

Pharmacy Education, which has set a national standard requiring all graduating pharmacy students to be able to order and interpret laboratory tests.

MOTION: There being no more questions, **Senator Harris** moved to approve **Docket No. 27-0101-1505**. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 27-0101-1501 **Rules of the Idaho State Board of Pharmacy Related to Retail Non-pharmacy Outlet Registration. Mr. Adams** reported that Idaho currently has two different classes of registrations for non-pharmacy outlets that stock over-the-counter medications based upon the number of medications the non-pharmacy retail outlet stocks: (i) Class A non-pharmacy retail outlets, which stock more than 50 medications, and (ii) Class B non-pharmacy retail outlets, which stock 50 or fewer medications. Currently Idaho has registered 299 Class A outlets, each paying a $60 registration fee, and 814 Class B outlets, each paying a $25 registration fee. Registration fees cover administrative costs including inspections to confirm products are not expired, adulterated or misbranded. To improve administrative efficiency, **Mr. Adams** stated that the Board has proposed to combine these two classes of registrations into one class, regardless of the number of medications stocked, with all non-pharmacy retail outlets paying a $35 registration fee. **Mr. Adams** noted that the budget impact of this modification will be de minimis. Additionally, **Mr. Adams** reviewed other "housekeeping" changes with the Committee, drawing particular attention to (i) an increase in experiential hours required for foreign-trained pharmacists to be consistent with requirements for pharmacists trained in the U.S. to obtain a license and (ii) updated requirements for controlled substances storage to be consistent with federal law.

Vice Chairman Nuxoll called for questions.

Senator Hagedorn asked Mr. Adams to clarify the delta change in the fees to be received. **Mr. Adams** responded that Idaho currently receives $38,290 in fees under this rule, and that under the proposed rule Idaho would receive $38,955 in fees.

Chairman Heider noted that controlled substances must be stored in "substantially constructed cabinets" and asked whether that term was particularly defined. **Mr. Adams** responded that the term comes from the federal Controlled Substances Act and the term is not specifically defined in that Act. However, **Mr. Adams** noted that Board inspectors have asked for clarity regarding that term, and the Board is working to post pictures of both appropriate and inappropriate storage cabinets. **Chairman Heider** requested that the Board work to revise the rules in the future to include a definition of "substantially constructed cabinet."

Vice Chairman Nuxoll inquired whether there was negotiated rulemaking for this rule and asked what comments were received. **Mr. Adams** confirmed that an open public comment session was held and that negotiated rulemaking was conducted for this rule. **Mr. Adams** confirmed that the Board received zero comments on this rule, but he noted that anecdotally the Board had received positive feedback. **Vice Chairman Nuxoll** also asked for clarification regarding the rulemaking process, and **Mr. Adams** responded that the Board follows the process of the Office of the Administrative Rules Coordinator and provided details of that process. Following up, **Vice Chairman Nuxoll** asked if public comment was held collectively for all dockets or individually for each docket. **Mr. Adams** responded that public comment sessions were held collectively, but noted that the sessions could be conducted individually in the future. **Vice Chairman Nuxoll** then asked why the controlled substances storage requirements were not previously in the Idaho rules. **Mr. Adams** noted that all pharmacies that stock controlled substances must be registered with the federal Drug Enforcement Administration and must comply with the federal Controlled Substances Act,

including the storage of medications. Therefore, Idaho pharmacies have previously been held to this requirement, and now Idaho law is consistent with the federal requirement.

MOTION: There being no more questions, **Chairman Heider** moved to approve **Docket No. 27-0101-1501**. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

PASSED THE GAVEL: Vice Chairman Nuxoll passed the gavel back to Chairman Heider.

ADJOURNED: **Chairman Heider** thanked Mr. Adams for is presentation. There being no further business, **Chairman Heider** adjourned the meeting at 3:40 p.m.

Senator Heider
Chair

Karen Westbrook
Secretary

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, January 18, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
	IDAPA 23 - BOARD OF NURSING	
Docket No. 23-0101-1501	Licensed Nurses Standards (Pending Rule)	**Sandra Evans** Board of Nursing
Docket No. 23-0101-1503	Specialized Practice Update (Pending Rule)	**Sandra Evans**
	IDAPA 16 - DEPT. OF HEALTH AND WELFARE	
Docket No. 16-0107-1501	Emergency Medical Services (EMS) Personnel Licensing Requirements (Temporary Rule)	**Bruce Cheeseman** Div. of Public Health
Docket No. 16-0101-1501	EMS Advisory Committee (Pending Rule)	**Bruce Cheeseman**
Docket No. 16-0102-1501	EMS Rule Definitions (Pending Rule)	**Bruce Cheeseman**
Docket No. 16-0103-1501	EMS Agency Licensing Requirements (Pending Rule)	**Bruce Cheeseman**
Docket No. 16-0105-1501	EMS Education, Instructor, and Examination Requirements (Pending Rule)	**Bruce Cheeseman**
Docket No. 16-0107-1502	EMS Personnel Licensing Requirements (Pending Rule)	**Bruce Cheeseman**
Docket No. 16-0112-1501	EMS Complaints, Investigations, and Disciplinary Actions (Pending Rule)	**Bruce Cheeseman**
Docket No. 16-0203-1501	Chapter Repeal (Pending Rule)	**Bruce Cheeseman**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
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Sen Martin

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Monday, January 18, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting to order at 3:05 p.m. and welcomed everyone to this meeting of the Senate Health and Welfare Committee (Committee).
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Nuxoll to conduct the rules review.
DOCKET NO. 23-0101-1501	**Rules of the Idaho Board of Nursing Related to Licensed Nurses Standards.** **Sandra Evans**, Executive Director of the Idaho State Board of Nursing (Board), presented this docket. **Ms. Evans** informed the Committee that Idaho Code § 54-1404 authorizes the Board to develop standards and criteria to evaluate the continued competency of licensed nurses. She then summarized the current practice of the Board to assess the competence of all nurses at the time of initial and reinstatement licensure. The competence of advanced-practice registered nurses is also assessed at the time of each license renewal, although the Board does not currently assess the competence of licensed practical nurses and registered nurses at the time of license renewal.

Ms. Evans stated that, although there is no empirical evidence that Idaho's nurses lack competence, the Board believed all nurses should be periodically required to demonstrate professional competence. To ensure competence among nurses, the proposed rule (i) requires that registered nurses and licensed practical nurses demonstrate professional learning by completing at least two "learning activities" for biennial license renewal and (ii) sets forth the "learning activities" that will satisfy the professional learning requirements. Additionally, **Ms. Evans** stated that the proposed rule (i) provides exceptions from the professional learning requirements for advanced-practice professional nurses and new graduates receiving their initial nursing license and (ii) provides for an extension of time for good cause to complete the professional learning requirements. She noted that the proposed rule also establishes the effective dates for implementation and clarifies the required proof of compliance.

Ms. Evans reported that notice of rulemaking was published on June 3, 2015. Written and oral comments, received during a public meeting held on July 16, 2015, and during the prescribed comment period, were overwhelmingly in support of the rules as proposed. Specifically, nurses felt that the requirements were achievable, suitable to a variety of clinical and functional settings and were not overly burdensome to Idaho's nurses. **Ms. Evans** reported that implementation of the proposed rule is expected to cost less than $10,000 and she stated that the Board's current fund balance is sufficient to absorb these anticipated implementation costs without increasing licensure fees.

Vice Chairman Nuxoll called for questions.

Senator Martin asked for clarification regarding the current renewal requirements for registered nurses. **Ms. Evans** responded that currently the Board only requires completion of a renewal application and payment of a fee. **Senator Martin** then asked Ms. Evans to confirm that the new rule proposes three categories of requirements, and renewal applicants must comply with two of those three categories. To clarify, **Ms. Evans** stated that the proposed rule provides three categories of "learning activities" and requires renewal applicants to complete two separate activities, which may be from the same category.

Referencing the Nurse Licensing Compact, **Senator Schmidt** asked how these new training requirements would interact with a nurse's ability to be licensed in other states. **Ms. Evans** responded that the Nurse Licensing Compact requires a nurse to comply with all licensing requirements in the nurse's state of residency. However, there was a national conversation that all states should require some form of continued competency assessment, and this conversation compelled the Idaho Board to move forward with this proposed rule. **Senator Schmidt** then asked Ms. Evans to compare these proposed requirements with the requirements of surrounding states. **Ms. Evans** responded that the requirements in the proposed rule were consistent with requirements in other states. Specifically, the Board modeled the proposed rule after a similar rule promulgated by the Virginia Board of Nursing.

Vice Chairman Nuxoll asked how many nurses participated in the rulemaking process, what parts of Idaho did those present represent and why did these nurses support this proposed rule. **Ms. Evans** responded that nursing organizations from all over the state participated in the rulemaking process, including the Idaho Nurses Association, and organizations representing community nurses, faith-based community nurses and school nurses.

Senator Lee observed that many of the "learning activities" that would satisfy the requirements of the proposed rule seem to be many activities that nurses are already completing for the Joint Commission or other accreditation organizations. **Senator Lee** asked Ms. Evans if her observation was correct. **Ms. Evans** confirmed that the observation was correct.

MOTION: There being no more questions, **Senator Martin** moved to approve **Docket No. 23-0101-1501**. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 23-0101-1503 **Rules of the Idaho Board of Nursing Related to Specialized Practice Updates.** **Sandra Evans**, Executive Director of the Board, presented this docket. **Ms. Evans** provided a brief description of "nursing specialties" and informed the Committee that the current nursing specialty rules are no longer sufficient to address the complexities of existing and emerging specialty practices. **Ms. Evans** reported that concerns from both specialty nurses and their employers compelled the Board to amend existing rules to provide for greater clarity and relevance.

Ms. Evans then stated that the proposed rules clarify that (i) nurses may perform functions defined within the parameters of recognized nursing specialties that are approved by either one of the two national accrediting bodies specifically for nursing and (ii) nurses functioning in a specialty must complete an organized program of study specific to the specialty followed by demonstrated competence in the specialty. Further, the proposed rule requires nurses functioning in a specialty to conform to established practice parameters, characters and standards of that specialty. **Ms. Evans** then stated that previous references to Flight/Transport and Surgical First Assisting were deleted because the revised language addresses all recognized specialties.

Ms. Evans reported that notice of rulemaking was published on June 3, 2015. She next informed the Committee that written and oral comments, received during a public meeting held on July 16, 2015, and during the prescribed comment period, were generally supportive. **Ms. Evans** specifically noted that the rules, as proposed, are in alignment with national standards for specialty nursing practice and hold the nurse accountable to perform within parameters of his/her specialty. There was no fiscal impact resulting from implementation of the proposed rules.

Vice Chairman Nuxoll called for questions.

Senator Martin expressed concern and asked why Idaho rules would move from state standards to national standards. **Ms. Evans** clarified the two accrediting bodies referenced in the proposed rule are organizations that will accredit the specialty organizations that ultimately set specialty standards. Moving to the national standards would allow Idaho rules to stay current and relevant.

Senator Harris inquired about the comments in opposition of this proposed rule. **Ms. Evans** noted that the Board received very few comments regarding this proposed rule, but one employer did express concern that the national standards were not as stringent as the standards set by the employer. The Board addressed the employer's concern by noting that the employer's standards could be more stringent but not less stringent than the requirements set by the Board.

Senator Schmidt asked whether nurse midwives were included in "nursing specialties." **Ms. Evans** responded that "certified nurse midwives" are advanced-practice registered nurses (APRN) and therefore the specialty beyond APRN would be addressed by these proposed rules.

Vice Chairman Nuxoll asked whether APRNs practicing a specialty commented on this proposed rule. **Ms. Evans** confirmed that the Board did not receive comments from APRNs practicing a specialty, but noted that these nurses were present at the relevant public meeting.

MOTION: There being no more questions, **Chairman Heider** moved to approve **Docket No. 23-0101-1503**. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0107-1501 **Temporary Rules of the Department of Health and Welfare Related to Emergency Medical Services Personnel Licensing Requirements. Bruce Cheeseman**, EMS Section Manager of the Bureau of Emergency Medical Services and Preparedness (Bureau), presented this docket. After reminding the Committee that temporary rules related to revised continuing education requirements for EMS personnel went into effect in the previous year, **Mr. Cheeseman** requested that these temporary rules remain in effect until July 2016.

Vice Chairman Nuxoll requested further explanation of these temporary rules. **Mr. Cheeseman** responded that the temporary rules addressed the Bureau's concerns about the loss of EMS providers in rural areas as a result of existing EMS continuing education requirements. He stated that, due to time restraints during the previous legislative session, the temporary rules reflected only limited changes to the EMS continuing education requirements. More detailed modifications to the EMS personnel licensure rules will be presented later in the agenda.

Vice Chairman Nuxoll and **Senator Hagedorn** requested clarification regarding the purpose of this temporary rule. **Mr. Cheeseman** stated that the Bureau Chief, Mr. Wayne Denny, could better respond to the Senator's question. **Vice Chairman Nuxoll** invited Mr. Denny to respond. **Mr. Denny** clarified that the Bureau has prepared pending rules related to EMS personnel licensure and, if approved, those rules would go into effect July 1, 2016. Therefore, **Mr. Denny** requested that the Committee approve the temporary rules to remain in effect until July 1, 2016.

MOTION: There being no more questions, **Senator Hagedorn** moved to approve **Docket No. 16-0107-1501** as a temporary rule to be in effect until July 1, 2016. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0101-1501 **Rules of the Department of Health and Welfare Related to Emergency Medical Services Advisory Committee. Bruce Cheeseman**, EMS Section Manager of the Bureau, presented this docket. **Mr. Cheeseman** informed the Committee that the Emergency Medical Services Advisory Committee (EMSAC) provides counsel to the Bureau in administering the Idaho EMS Act. He stated that the proposed rules add one representative from one of Idaho's seven public health districts to serve as a member of EMSAC. He said that a public health district representative was added to EMSAC because the public health districts work closely with local EMS agencies and other emergency response organizations throughout the state.

Vice Chairman Nuxoll called for questions.

Senator Lodge asked why the police or sheriff's departments were not represented on EMSAC while fire chiefs were represented. **Mr. Cheeseman** responded that the county has representation from the sheriff's department.

Following up on Senator Lodge's question, **Senator Jordan** asked Mr. Cheeseman to confirm that the fire chiefs were involved with EMSAC because fire departments provide EMS services. **Mr. Cheeseman** confirmed that Senator Jordan's understanding was correct.

Senator Schmidt asked Mr. Cheeseman to confirm that the Director of Health and Welfare makes these appointments. **Mr. Cheeseman** confirmed that Director Armstrong does make these appointments.

MOTION: There being no more questions, **Senator Schmidt** moved to approve **Docket No. 16-0101-1501**. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0102-1501 **Rules of the Department of Health and Welfare Related to Emergency Medical Services Definitions. Bruce Cheeseman**, EMS Section Manager of the Bureau, presented this docket. **Mr. Cheeseman** stated that a majority of the definition changes were related to education, instructor and examination requirements. After summarizing these changes, **Mr. Cheeseman** also reported that the rules created a new definition for "consolidated emergency communications system" and clarified the definition of "prehospital."

Vice Chairman Nuxoll called for questions.

Senator Lee acknowledged the multiple opportunities that the Bureau gave stakeholders to comment on these rules and asked Mr. Cheeseman to summarize the review process for this rule and the comments received. **Mr. Cheeseman** reported that the Bureau held 22 town hall meetings statewide for the education rules and receive no negative opposition.

Regarding the definition of "prehospital," **Senator Schmidt** asked if the term "emergency medical care" was defined within the rule. **Mr. Cheeseman** confirmed that "emergency medical care" was defined in Section 011.22 of the rule. Related to Senator Schmidt's question, **Senator Martin** asked what level of care EMS personnel may provide in route to the hospital. **Mr. Cheeseman** responded that authorized levels of care are set in accordance with education, personnel licensure and agency licensure rules.

Vice Chairman Nuxoll inquired about the level of involvement of rural EMS providers in the rulemaking process. **Mr. Cheeseman** responded that most of the town halls were held in rural areas.

MOTION: There being no more questions, **Senator Schmidt** moved to approve **Docket No. 16-0102-1501**. **Senator Jordan** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0103-1501 **Rules of the Department of Health and Welfare Related to Emergency Medical Services Agency Licensing Requirements. Bruce Cheeseman**, EMS Section Manager of the Bureau, presented this docket. **Mr. Cheeseman** noted that the majority of changes made in these rules were clarification changes. First, he reviewed the operation declaration changes related to prehospital, prehospital support and air medical support. Second, he stated that the language regarding ambulance-based clinicians was modified to reflect the Bureau's intent to allow ambulance-based clinicians to perform advanced life support transfers between advanced life support facilities without a paramedic present. Third, he noted that the additions made to section 535 were rules moved from IDAPA § 16.02.03. Finally, **Mr. Cheeseman** reviewed changes related to the scheduling of EMS agency annual inspections and noted that the Bureau had deleted certain obsolete provisions of the rule.

Vice Chairman Nuxoll called for questions.

MOTION: There being no questions, **Senator Schmidt** moved to approve **Docket No. 16-0103-1501**. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

Chairman Heider noted that in previous years there had been concern regarding who specifically could provide prehospital services and inquired whether ambulance-based clinicians could perform prehospital services. **Mr. Cheeseman** responded that an ambulance-based clinician may be used up to the intermediate level in prehospital services.

DOCKET NO. 16-0105-1501 **Rules of the Department of Health and Welfare Related to Emergency Medical Services Education, Instructor and Examination Requirements. Bruce Cheeseman**, EMS Section Manager of the Bureau, presented this docket. **Mr. Cheeseman** informed the Committee that this docket proposes a new chapter of rules related to the education, instructor and examination requirements for EMS providers. He said this new chapter and the incorporated "Idaho EMS Education Standards" manual (see attachment 1) provide clear and enforceable standards. The Bureau worked with EMS personnel and educators to develop these new rules and, once drafted, the Bureau held 22 town hall meetings throughout the state to receive additional stakeholder comments. **Mr. Cheeseman** then highlighted select provisions of the rule, including (i) the standards of professional conduct for EMS education program and exam personnel, (ii) the administrative requirements for EMS educational programs, (iii) the Idaho-specific criteria for EMS education, (iv) the EMS education personnel requirements, qualifications and responsibilities and (v) the EMS examination requirements.

Vice Chairman Nuxoll called for questions.

Senator Harris asked what response the Bureau received from town hall meeting participants. **Mr. Cheeseman** described the collaborative drafting process for the rules and noted that comments received were all positive.

Senator Hagedorn asked vwhat response the Bureau received from rural EMS providers regarding these new rules. **Mr. Cheeseman** stated that portions of rural EMS provider training could be provided online and rural providers have responded positively.

MOTION: There being no more questions, **Chairman Heider** moved to approve **Docket No. 16-0105-1501**. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0107-1502 **Rules of the Department of Health and Welfare Related to Emergency Medical Services Personnel Licensing Requirements. Bruce Cheeseman**, EMS Section Manager of the Bureau, presented this docket. **Mr. Cheeseman** informed the Committee that the Bureau has been working for several years to update the personnel licensure rules. He stated that the proposed rules (i) consolidate standards of conduct previously separated in the personnel and the investigation rules and (ii) remove language specific to obsolete scope of practice transition requirements. These proposed rules would also allow the Bureau to (i) waive specific duplicated continuing educational requirements for licensees who maintain a national EMS certification and (ii) grant limited recognition in Idaho to licensees from another state. Finally, in an effort to create flexibility in the continuing education requirements and based upon comments received in open forums across the state, **Mr. Cheeseman** stated that the proposed rules restructured the continuing education categories and added additional acceptable venues of continuing education.

Vice Chairman Nuxoll called for questions.

Senator Lodge inquired whether many high school students have participated in EMR/EMT licensing programs to provide services in rural areas. **Mr. Cheeseman** responded that many rural high schools have conducted classes that allow participants to first obtain an EMR license and then obtain an EMT license the following year. He noted that such programs have increased the number of EMS providers in rural areas. **Senator Lodge** then stated that there has been concern in her local area regarding the lack of adult EMS volunteers. **Senator Lodge** then inquired whether the Bureau had incentives such as PERSI or other retirement-type benefits that may encourage adult volunteers. **Mr. Cheeseman** reported that the Bureau currently does not have monetary incentives, but he noted that the Bureau did purchase software and books for training.

Senator Harris asked Mr. Cheeseman to detail the requirements for an out-of-state provider to obtain limited recognition. **Mr. Cheeseman** stated limited recognition would more often be utilized in connection with wildland fires when Idaho needs additional resources to address medical aspects of these fires. Further, **Mr. Cheeseman** noted that the Bureau will also be bringing legislation allowing Idaho to join an interstate compact for the provision of EMS services by out-of-state providers.

Senator Schmidt referred to the advance do-not-resuscitate (DNR) directives in the standard of professional conduct and inquired whether the "protocol established by the Department" was available for review. **Mr. Cheeseman** responded that there is a statewide DNR protocol developed by the EMS Physician Commission.

MOTION: There being no more questions, **Senator Lee** moved to approve **Docket No. 16-0107-1502**. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0112-1501 **Rules of the Department of Health and Welfare Related to Emergency Medical Services Complaints, Investigations and Disciplinary Actions. Bruce Cheeseman**, EMS Section Manager of the Bureau, presented this docket. **Mr. Cheeseman** stated that the proposed rule clarified but did not make substantive changes to the existing rules. Specifically, **Mr. Cheeseman** reported that these proposed rules would (i) simplify violation language, (ii) align the existing rule with updated education rules and (ii) clarify the negotiated resolution and administrative action provisions of the existing rule.

Vice Chairman Nuxoll called for questions.

MOTION: There being no questions, **Senator Harris** moved to approve **Docket No. 16-0112-1501**. **Chairman Heider** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0203-1501 **Rules of the Department of Health and Welfare Related to Chapter Repeal.** **Bruce Cheeseman**, EMS Section Manager of the Bureau, presented this docket. **Mr. Cheeseman** reported that the Bureau has been working to update the EMS rules during the past several years and stated that the proposed rule would repeal the remaining obsolete emergency medical services rules in IDAPA 16.02.03 that were not otherwise updated or relocated to other relevant IDAPA chapters.

Vice Chairman Nuxoll called for questions.

MOTION: There being no more questions, **Senator Martin** moved to approve **Docket No. 16-0203-1501**. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.

Senator Schmidt inquired whether Mr. Cheeseman would be reporting on **Docket No. 16-0202-1501**. The **Committee Secretary** confirmed that this proposed rule would be heard in a later meeting.

PASSED THE GAVEL: Vice Chairman Nuxoll passed the gavel back to Chairman Heider.

ADJOURNED: There being no further business, **Chairman Heider** thanked the members for their participation and adjourned the meeting at 4:10 p.m.

Senator Heider
Chair

Karen Westbrook
Secretary

Idaho EMS Education Standards

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Version 2016-1

Effective July 1, 2016

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From the National EMS Scope of Practice Model: EMS Personnel Licensure Levels

Emergency Medical Responder

The primary focus of the Emergency Medical Responder is to initiate immediate lifesaving care to critical patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide lifesaving interventions while awaiting additional EMS response and to assist higher level personnel at the scene and during transport. Emergency Medical Responders function as part of a comprehensive EMS response, under medical oversight. Emergency Medical Responders perform basic interventions with minimal equipment.

Emergency Medical Technician

The primary focus of the Emergency Medical Technician is to provide basic emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight. Emergency Medical Technicians perform interventions with the basic equipment typically found on an ambulance. The Emergency Medical Technician is a link from the scene to the emergency health care system.

Advanced Emergency Medical Technician

The primary focus of the Advanced Emergency Medical Technician is to provide basic and limited advanced emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Advanced Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight.

Advanced Emergency Medical Technicians perform interventions with the basic and advanced equipment typically found on an ambulance. The Advanced Emergency Medical Technician is a link from the scene to the emergency health care system.

Paramedic

The Paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system. This individual possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive EMS response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found on an ambulance. The Paramedic is a link from the scene into the health care system.

Each educational level assumes mastery of previously stated competencies. Each individual must demonstrate each competency within his or her scope of practice and for patients of all ages.

	EMR	EMT	AEMT	Paramedic
Preparatory	**Uses simple knowledge of the EMS system, safety/well-being of the EMR, medical/legal issues at the scene of an emergency while awaiting a higher level of care.**	**Applies fundamental knowledge of the EMS system, safety/well-being of the EMT, medical/legal and ethical issues to the provision of emergency care.**	**Applies fundamental knowledge of the EMS system, safety/well-being of the AEMT, medical/legal and ethical issues to the provision of emergency care.**	**Integrates comprehensive knowledge of EMS systems, the safety/well-being of the paramedic, and medical/legal and ethical issues which is intended to improve the health of EMS personnel, patients, and the community.**
EMS Systems	Simple depth, simple breadth • EMS systems • Roles/ responsibilities/ professionalism of EMS personnel • Quality improvement	**EMR Material PLUS:** Simple depth, foundational breadth • EMS systems • History of EMS • Roles/ responsibilities/ professionalism of EMS personnel • Quality improvement • Patient safety	**EMT Material PLUS:** Fundamental depth, foundational breadth • Quality improvement • Patient safety	**AEMT Material PLUS:** Fundamental depth, foundational breadth • History of EMS Complex depth, comprehensive breadth • EMS systems • Roles/ responsibilities/ professionalism of EMS personnel • Quality improvement • Patient safety
Research	Simple depth, simple breadth • Impact of research on EMR care • Data collection	**EMR Material PLUS:** Simple depth, simple breadth • Evidence-based decision making	**Same as Previous Level**	**AEMT Material PLUS:** Fundamental depth, foundational breadth • Research principles to interpret literature and advocate evidence-based practice

	EMR	EMT	AEMT	Paramedic

Workforce Safety and Wellness	Simple depth, simple breadth
	
	• Standard safety precautions
	• Personal protective equipment
	• Stress management
	  ○ Dealing with death and dying
	• Prevention of response- related injuries
	• Lifting and moving patients
		EMR Material PLUS:
		
		Fundamental depth, foundational breadth
		
		• Standard safety precautions
		• Personal protective equipment
		• Stress management
		  ○ Dealing with death and dying
		• Prevention of work related injuries
		• Lifting and moving patients
		• Disease transmission
		• Wellness principles
			Same as Previous Level	**AEMT Material PLUS:**
				
				Complex depth, comprehensive breadth
				
				• Provider safety and well- being
				• Standard safety precautions
				• Personal protective equipment
				• Stress management
				  ○ Dealing with death and dying
				• Prevention of work related injuries
				• Lifting and moving patients
				• Disease transmission
				• Wellness principles

Documentation	Simple depth, simple breadth • Recording patient findings	**EMR Material PLUS:** Fundamental depth, foundational breadth • Principles of medical documentation and report writing	**EMT Material PLUS:** Complex depth, foundational breadth • Principles of medical documentation and report writing	**AEMT Material PLUS:** Complex depth, comprehensive breadth • Principles of medical documentation and report writing
EMS System Communication	Simple depth, simple breadth Communication needed to • Call for Resources • Transfer care of	**EMR Material PLUS:** Simple depth, simple breadth • EMS communication system	**EMT Material PLUS:** Fundamental depth, foundational breadth • EMS communication system	**AEMT Material PLUS:** Complex depth, comprehensive breadth • EMS communication

	EMR	EMT	AEMT	Paramedic
EMS System Communication (continued)	the patient • Interact within the team structure	• Communication with other health care professionals • Team communication and dynamics	• Communication with other health care professionals • Team communication and dynamics	system • Communication with other health care professionals • Team communication and dynamics
Therapeutic Communication	Simple depth, simple breadth Principles of communicating with patients in a manner that achieves a positive relationship • Interviewing techniques	**EMR Material PLUS:** Simple depth, simple breadth Principles of communicating with patients in a manner that achieves a positive relationship • Adjusting communication strategies for age, stage of development, patients with special needs, and differing cultures Fundamental depth, foundational breadth • Interviewing techniques • Verbal defusing strategies • Family presence issues	**EMT Material PLUS:** Simple depth, simple breadth Principles of communicating with patients in a manner that achieves a positive relationship • Dealing with difficult patients	**AEMT Material PLUS:** Complex depth, comprehensive breadth Principles of communicating with patients in a manner that achieves a positive relationship • Factors that affect communication • Interviewing techniques • Dealing with difficult patients • Adjusting communication strategies for age, stage of development, patients with special needs, and differing cultures
Medical/Legal and Ethics	Simple depth, simple breadth • Consent/refusal of care • Confidentiality • Advanced directives • Tort and criminal actions • Evidence preservation • Statutory responsibilities • Mandatory	**EMR Material PLUS:** Fundamental depth, foundational breadth • Consent/refusal of care • Confidentiality • Advanced directives • Tort and criminal actions • Evidence preservation	**Same as Previous Level**	**AEMT Material PLUS:** Complex depth, comprehensive breadth • Consent/refusal of care • Confidentiality • Advanced directives • Tort and criminal actions • Statutory

	EMR	EMT	AEMT	Paramedic
Medical/Legal and Ethics	reporting • Ethical principles/moral obligations • End-of-life issues	• Statutory responsibilities • Mandatory reporting • Ethical principles/moral obligations		responsibilities • Mandatory reporting • Health care regulation • Patient rights/advocacy • End-of-life Issues • Ethical principles/moral obligations • Ethical tests and decision making
Anatomy and Physiology	**Uses simple knowledge of the anatomy and function of the upper airway, heart, vessels, blood, lungs, skin, muscles, and bones as the foundation of emergency care.**	**Applies fundamental knowledge of the anatomy and function of all human systems to the practice of EMS.**	**Integrates complex knowledge of the anatomy and physiology of the airway, respiratory and circulatory systems to the practice of EMS.**	**Integrates a complex depth and comprehensive breadth of knowledge of the anatomy and physiology of all human systems**
Medical Terminology	**Uses simple medical and anatomical terms.**	**Uses foundational anatomical and medical terms and abbreviations in written and oral communication with colleagues and other health care professionals.**	**Same as Previous Level**	**Integrates comprehensive anatomical and medical terminology and abbreviations into the written and oral communication with colleagues and other health care professionals.**
Pathophysiology	**Uses simple knowledge of shock and respiratory compromise to respond to life threats.**	**Applies fundamental knowledge of the pathophysiology of respiration and perfusion to patient assessment and management.**	**Applies comprehensive knowledge of the pathophysiology of respiration and perfusion to patient assessment and management.**	**Integrates comprehensive knowledge of pathophysiology of major human systems.**
Life Span Development	**Uses simple knowledge of age-related differences to assess and care for patients.**	**Applies fundamental knowledge of life span development to patient assessment and management.**	**Same as Previous Level**	**Integrates comprehensive knowledge of life span development.**

	EMR	EMT	AEMT	Paramedic
Public Health	**Have an awareness of local public health resources and the role EMS personnel play in public health emergencies.**	**Uses simple knowledge of the principles of illness and injury prevention in emergency care.**	**Uses simple knowledge of the principles of the role of EMS during public health emergencies.**	**Applies fundamental knowledge of principles of public health and epidemiology including public health emergencies, health promotion, and illness and injury prevention.**
Pharmacology	**Uses simple knowledge of the medications that the EMR may self-administer or administer to a peer in an emergency.**	**Applies fundamental knowledge of the medications that the EMT may assist/administer to a patient during an emergency.**	**Applies to patient assessment and management fundamental knowledge of the medications carried by AEMTs that may be administered to a patient during an emergency.**	**Integrates comprehensive knowledge of pharmacology to formulate a treatment plan intended to mitigate emergencies and improve the overall health of the patient.**
Principles of Pharmacology	**No knowledge related to this competency is applicable at this level.**	Simple depth, simple breadth • Medication safety • Kinds of medications used during an emergency	**EMT Material PLUS:** Fundamental depth, foundation breadth • Medication safety • Medication legislation • Naming • Classifications • Storage and security • Autonomic pharmacology • Metabolism and excretion • Mechanism of action • Medication response relationships • Medication interactions • Toxicity	**AEMT Material PLUS:** Complex depth, comprehensive breadth • Medication safety • Medication legislation • Naming • Classifications • Schedules • Pharmacokinetics • Storage and security • Autonomic pharmacology • Metabolism and excretion • Mechanism of action • Phases of medication activity • Medication response relationships • Medication interactions • Toxicity

	EMR	EMT	AEMT	Paramedic
Medication Administration	Simple depth, simple breadth Within the scope of practice of the EMR, how to: • Self-administer medication • Peer-administer medication	**EMR Material PLUS:** Fundamental depth, foundational breadth Within the scope of practice of the EMT how to: • Assist / administer medications to a patient	**EMT Material PLUS:** Fundamental depth, foundational breadth • Routes of administration • Within the scope of practice of the AEMT, administer medications to a patient	**AEMT Material PLUS:** Complex depth, comprehensive breadth • Routes of administration • Within the scope of practice of the paramedic, administer medications to a patient
Emergency Medications	Simple depth, simple breadth Within the scope of practice of the EMR • Names • Effects • Indications • Routes of administration • Dosages for the medications administered	**EMR Material PLUS:** Fundamental depth, simple breadth Within the scope of practice of the EMT • Names • Actions • Indications • Contraindications • Complications • Routes of administration • Side effects • Interactions • Dosages for the medications administered	**EMT Material PLUS:** Fundamental depth, foundational breadth Within the scope of practice of the AEMT • Names • Actions • Indications • Contraindications • Complications • Routes of administration • Side effects • Interactions • Dosages for the medications administered	**AEMT Material PLUS:** Complex depth, comprehensive breadth Within the scope of practice of the paramedic • Names • Actions • Indications • Contraindications • Complications • Routes of administration • Side effects • Interactions • Dosages for the medications administered

	EMR	EMT	AEMT	Paramedic
Airway Management, Respiration and Artificial Ventilation	**Applies knowledge (fundamental depth, foundational breadth) of general anatomy and physiology to assure a patent airway, adequate mechanical ventilation, and respiration while awaiting additional EMS response for patients of all ages.**	**Applies knowledge (fundamental depth, foundational breadth) of general anatomy and physiology to patient assessment and management in order to assure a patent airway, adequate mechanical ventilation, and respiration for patients of all ages.**	**Applies knowledge (fundamental depth, foundational breadth) of additional upper airway anatomy and physiology to patient assessment and management in order to assure a patent airway, adequate mechanical ventilation, and respiration for patients of all ages.**	**Integrates complex knowledge of anatomy, physiology, and pathophysiology into the assessment to develop and implement a treatment plan with the goal of assuring a patent airway, adequate mechanical ventilation, and respiration for patients of all ages.**
Airway Management	Fundamental depth, simple breadth Within the scope of practice of the EMR • Airway anatomy • Airway assessment • Techniques of assuring a patent airway	**EMR Material PLUS:** Fundamental depth, foundational breadth Within the scope of practice of the EMT • Airway anatomy • Airway assessment • Techniques of assuring a patent airway	**EMT Material PLUS:** Fundamental depth, foundational breadth Within the scope of practice of the AEMT • Airway anatomy • Airway assessment • Techniques of assuring a patent airway	**AEMT Material PLUS:** Complex depth, comprehensive breadth Within the scope of practice of the paramedic • Airway anatomy • Airway assessment • Techniques of assuring a patent airway

Respiration	Fundamental depth, simple breadth
	
	• Anatomy of the respiratory system
	• Physiology and pathophysiology of respiration
	  ○ Pulmonary ventilation
	  ○ Oxygenation
	  ○ Respiration
	  ▪ External
	  ▪ Internal
	  ▪ Cellular
	• Assessment and management of adequate and
		EMR Material PLUS:
		
		Fundamental depth, foundational breadth
		
		• Anatomy of the respiratory system
		• Physiology and pathophysiology of respiration
		  ○ Pulmonary ventilation
		  ○ Oxygenation
		  ○ Respiration
		  ▪ External
		  ▪ Internal
		  ▪ Cellular
			EMT Material PLUS:
			
			Complex depth, foundational breadth
			
			• Anatomy of the respiratory system
			
			Fundamental depth, comprehensive breadth
			
			• Physiology and pathophysiology of respiration
			  ○ Pulmonary ventilation
				AEMT Material PLUS:
				
				Complex depth, comprehensive breadth
				
				• Anatomy of the respiratory system
				• Physiology, and pathophysiology of respiration
				• Pulmonary ventilation
				• Oxygenation
				• Respiration
				• External
				• Internal

	EMR	EMT	AEMT	Paramedic
Respiration (continued)	inadequate respiration • Supplemental oxygen therapy	• Assessment and management of adequate and inadequate respiration • Supplemental oxygen therapy	○ Oxygenation ○ Respiration ▪ External ▪ Internal ▪ Cellular • Assessment and management of adequate and inadequate respiration • Supplemental oxygen therapy	• Cellular • Assessment and management of adequate and inadequate respiration • Supplemental oxygen therapy
Artificial Ventilation	Fundamental depth, simple breadth Assessment and management of adequate and inadequate ventilation • Artificial ventilation • Minute ventilation • Alveolar ventilation • Effect of artificial ventilation on cardiac output	**EMR Material PLUS:** Fundamental depth, foundational breadth Assessment and management of adequate and inadequate ventilation • Artificial ventilation • Minute ventilation • Alveolar ventilation • Effect of artificial ventilation on cardiac output	**EMT Material PLUS:** Complex depth, foundational breadth Assessment and management of adequate and inadequate ventilation • Artificial ventilation • Minute ventilation • Alveolar ventilation • Effect of artificial ventilation on cardiac output	**AEMT Material PLUS:** Complex depth, comprehensive breadth Assessment and management of adequate and inadequate ventilation • Artificial ventilation • Minute ventilation • Alveolar ventilation • Effect of artificial ventilation on cardiac output
Assessment	**Use scene information and simple patient assessment findings to identify and manage immediate life threats and injuries within the scope of practice of the EMR.**	**Applies scene information and patient assessment findings (scene size up, primary and secondary assessment, patient history, and reassessment) to guide emergency management.**	**Same as Previous Level**	**Integrate scene and patient assessment findings with knowledge of epidemiology and pathophysiology to form a field impression. This includes developing a list of differential diagnoses through clinical reasoning to modify the assessment and formulate a treatment plan.**

	EMR	EMT	AEMT	Paramedic

Scene Size-Up	Complex depth, comprehensive breadth
	
	• Scene safety
	
	Fundamental depth, foundational breadth
	
	• Scene management
	  ○ Impact of the environment on patient care
	  ○ Addressing hazards
	  ○ Violence
	  ○ Need for additional or specialized resources
	  ○ Standard precautions
		EMR Material PLUS:
		
		Fundamental depth, foundational breadth
		
		• Scene management
		  ○ Multiple patient situations
			Same as Previous Level	**AEMT Material PLUS:**
				
				Complex depth, comprehensive breadth
				
				• Scene management
				  ○ Impact of the environment on patient care
				  ○ Addressing hazards
				  ○ Violence
				  ○ Multiple patient situations

Primary Assessment	Simple depth, simple breadth
	
	• Primary assessment for all patient situations
	  ○ Level of consciousness
	  ○ ABCs
	  ○ Identifying life threats
	  ○ Assessment of vital functions
	• Begin interventions needed to preserve life
		EMR Material PLUS:
		
		Fundamental depth, simple breadth
		
		• Primary assessment for all patient situations
		  ○ Initial general impression
		  ○ Level of consciousness
		  ○ ABCs
		  ○ Identifying life threats
		  ○ Assessment of vital functions
		• Integration of treatment/ procedures needed to preserve life
			EMT Material PLUS:
			
			Fundamental depth, foundational breadth
			
			• Primary assessment for all patient situations
			  ○ Initial general impression
			  ○ Level of consciousness
			  ○ ABCs
			  ○ Identifying life threats
			  ○ Assessment of vital functions
			• Integration of treatment/ procedures needed to preserve life
				AEMT Material PLUS:
				
				Complex depth, comprehensive breadth
				
				• Primary assessment for all patient situations
				  ○ Initial general impression
				  ○ Level of consciousness
				  ○ ABCs
				  ○ Identifying life threats
				  ○ Assessment of vital functions
				• Integration of treatment/ procedures needed to preserve life

	EMR	EMT	AEMT	Paramedic
History Taking	Simple depth, simple breadth • Determining the chief complaint • Mechanism of injury/nature of illness • Associated signs and symptoms	**EMR Material PLUS:** Fundamental depth, foundational breadth • Investigation of the chief complaint • Mechanism of injury/nature of illness • Past medical history • Associated signs and symptoms • Pertinent negatives	**Same as Previous Level**	**AEMT Material PLUS:** Complex depth, comprehensive breadth • Components of the patient history • Interviewing techniques • How to integrate therapeutic communication techniques and adapt the line of inquiry based on findings and presentation
Secondary Assessment	Simple depth, simple breadth • Performing a rapid full body scan • Focused assessment of pain • Assessment of vital signs	**EMR Material PLUS:** Fundamental depth, foundational breadth Techniques of physical examination • Respiratory system ○ Presence of breath sounds • Cardiovascular system • Neurological system • Musculoskeletal system • All anatomical regions	**EMT Material PLUS:** Complex depth, foundational breadth Assessment of: • Lung sounds	**AEMT Material PLUS:** Complex depth, comprehensive breadth Techniques of physical examination for all major: • Body systems • Anatomical regions

	EMR	EMT	AEMT	Paramedic

Monitoring Devices	**No knowledge related to this competency is applicable at this level.**	Simple depth, simple breadth
		
		Within the scope of practice of the EMT
		
		• Obtaining and using information from patient monitoring devices including (but not limited to):
		  ○ Pulse oximetry
		  ○ Non-invasive blood pressure
			EMT Material PLUS:
			
			Within the scope of practice of the AEMT
			
			Simple depth, simple breadth
			
			• Obtaining and using information from patient monitoring devices including (but not limited to):
			  ○ Blood glucose determination
				AEMT Material PLUS:
				
				Fundamental depth, foundational breadth
				
				Within the scope of practice of the paramedic
				
				• Obtaining and using information from patient monitoring devices including (but not limited to):
				  ○ Continuous ECG monitoring
				  ○ 12 lead ECG interpretation
				  ○ Carbon dioxide monitoring
				  ○ Basic blood chemistry

Reassessment	Simple depth, simple breadth • How and when to reassess patients	**EMR Material PLUS:** Fundamental depth, foundational breadth • How and when to perform a reassessment for all patient situations	**Same as Previous Levels**	**AEMT Material PLUS:** Complex depth, comprehensive breadth • How and when to perform a reassessment for all patient situations
Medicine	**Recognizes and manages life threats based on assessment findings of a patient with a medical emergency while awaiting additional emergency response.**	**Applies fundamental knowledge to provide basic emergency care and transportation based on assessment findings for an acutely ill patient.**	**Applies fundamental knowledge to provide basic and selected advanced emergency care and transportation based on assessment findings for an acutely ill patient.**	**Integrates assessment findings with principles of epidemiology and pathophysiology to formulate a field impression and implement a comprehensive treatment/dispositio n plan for a patient with a medical complaint.**

	EMR	EMT	AEMT	Paramedic
Medical Overview	Simple depth, simple breadth Assessment and management of a: • Medical complaint	**EMR Material PLUS:** Simple depth, foundational breadth Pathophysiology, assessment, and management of a medical complaints to include: • Transport mode • Destination decisions	**EMT Material PLUS:** Fundamental depth, foundational breadth Pathophysiology, assessment, and management of a medical complaints to include: • Transport mode • Destination decisions	**AEMT Material PLUS:** Complex depth, comprehensive breadth Pathophysiology, assessment, and management of medical complaints to include: • Transport mode • Destination decisions
Neurology	Simple depth, simple breadth Anatomy, presentations, and management of: • Decreased level of responsiveness • Seizure • Stroke	**EMR Material PLUS:** Fundamental depth, foundational breadth Anatomy, physiology, pathophysiology, assessment and management of: • Stroke / transient ischemic attack • Seizure • Status epilepticus • Headache	**EMT Material PLUS:** Complex depth, foundational breadth Anatomy, physiology, pathophysiology, assessment and management of: • Seizure	**AEMT Material PLUS:** Anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, and management of: Complex depth, comprehensive breadth • Stroke / intracranial hemorrhage / transient ischemic attack • Seizure • Status epilepticus • Headache Fundamental depth, foundational breadth • Dementia • Neoplasms • Demyelinating disorders • Parkinson's disease • Cranial nerve

	EMR	EMT	AEMT	Paramedic
Neurology (continued)				disorders • Movement disorders • Neurologic inflammation/ infection • Spinal cord compression • Hydrocephalus • Wernicke's encephalopathy
Abdominal and Gastrointestinal Disorders	Simple depth, simple breadth Anatomy, presentations and management of shock associated with abdominal emergencies • Gastrointestinal bleeding	**EMR Material PLUS:** Fundamental depth, foundational breadth Anatomy, physiology, pathophysiology, assessment, and management of: • Acute and chronic gastrointestinal hemorrhage Simple depth, simple breadth • Peritonitis • Ulcerative diseases	**Same as Previous Level**	**AEMT Material PLUS:** Anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, and management of: Complex depth, comprehensive breadth • Acute and chronic gastrointestinal hemorrhage • Liver disorders • Peritonitis • Ulcerative diseases Fundamental depth, foundational breadth • Irritable bowel syndrome • Inflammatory disorders • Pancreatitis • Bowel obstruction • Hernias • Infectious disorders • Gall bladder and

	EMR	EMT	AEMT	Paramedic
Abdominal and Gastrointestinal Disorders (continued)				biliary tract disorders Simple depth, simple breadth • Rectal abscess • Rectal foreign body obstruction • Mesenteric ischemia
Immunology	Simple depth, simple breadth Recognition and management of shock and difficulty breathing related to: • Anaphylactic reactions	**EMR Material PLUS:** Fundamental depth, foundational breadth Anatomy, physiology, pathophysiology, assessment, and management of hypersensitivity disorders and/or emergencies • Anaphylactic reactions	**EMT Material PLUS:** Complex depth, comprehensive breadth Anatomy, physiology, pathophysiology, assessment, and management of hypersensitivity disorders and/or emergencies • Allergic and anaphylactic reactions	**AEMT Material PLUS:** Anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, and management of common or major immune system disorders and/or emergencies Complex depth, comprehensive breadth • Hypersensitivity • Allergic and anaphylactic reactions • Anaphylactoid reactions Fundamental depth, foundational breadth • Collagen vascular disease • Transplant related problems

Infectious Diseases	Simple depth, simple breadth
	
	Awareness of:
	
	• A patient who may have an infectious disease
	• How to decontaminate equipment after treating a patient
		EMR Material PLUS:
		
		Simple depth, simple breadth
		
		Assessment and management of:
		
		• A patient who may have an infectious disease
		• How to decontaminate the ambulance and equipment after treating a patient
			AEMT Material PLUS:
			
			Fundamental depth, foundational breadth
			
			Assessment and management of:
			
			• A patient who may be infected with a bloodborne pathogen
			  ○ HIV
			  ○ Hepatitis B
			• Antibiotic resistant infections
			• Current infectious diseases prevalent in the community
				AEMT Material PLUS:
				
				Anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, reporting requirements, prognosis, and management of:
				
				Complex depth, comprehensive breadth
				
				• HIV-related disease
				• Hepatitis
				• Pneumonia
				• Meningococcal meningitis
				
				Fundamental depth, foundational breadth
				
				• Tuberculosis
				• Tetanus
				• Viral diseases
				• Sexually transmitted disease
				• Gastroenteritis
				• Fungal infections
				• Rabies
				• Scabies and lice
				• Lyme disease
				• Rocky Mountain Spotted Fever
				• Antibiotic resistant infections

Endocrine Disorders	Simple depth, simple breadth Awareness that: • Diabetic emergencies cause altered mental status	**EMR Material PLUS:** Fundamental depth, foundational breadth Anatomy, physiology, pathophysiology, assessment and management of: • Acute diabetic emergencies	**EMT Material PLUS:** Complex depth, foundational breadth Anatomy, physiology, pathophysiology, assessment and management of: • Acute diabetic emergencies	**AEMT Material PLUS:** Anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, and management of: Complex depth, comprehensive

Endocrine Disorders (continued)				breadth • Acute diabetic emergencies • Diabetes Fundamental depth, foundational breadth • Adrenal disease • Pituitary and thyroid disorders
Psychiatric	Simple depth, simple breadth Recognition of: • Behaviors that pose a risk to the EMR, patient or others	**EMR Material PLUS:** Simple depth, simple breadth • Basic principles of the mental health system Fundamental depth, foundational breadth Assessment and management of: • Acute psychosis • Suicidal/risk • Agitated delirium	**Same as Previous Level**	**AEMT Material PLUS:** Anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, and management of: Complex depth, comprehensive breadth • Acute psychosis • Agitated delirium Fundamental depth, foundational breadth • Cognitive disorders • Thought disorders • Mood disorders • Neurotic disorders • Substance-related disorders / addictive behavior • Somatoform disorders • Factitious disorders • Personality disorders • Patterns of violence/ abuse/neglect • Organic psychoses

Cardiovascular	Simple depth, simple breadth
	
	Anatomy, signs, symptoms and management
	
	• Chest pain
	• Cardiac arrest
		EMR Material PLUS:
		
		Anatomy, physiology, pathophysiology, assessment, and management of:
		
		Fundamental depth, foundational breadth
		
		• Acute coronary syndrome
		  ○ Angina pectoris
		  ○ Myocardial infarction
		• Aortic aneurysm / dissection
		• Thromboembolism
		
		Simple depth, simple breadth
		
		• Heart failure
		• Hypertensive emergencies
			EMT Material PLUS:
			
			Anatomy, physiology, pathophysiology, assessment, and management of:
			
			Complex depth, foundational breadth
			
			• Acute coronary syndrome
			  ○ Angina pectoris
			  ○ Myocardial infarction
			
			Fundamental depth, simple breadth
			
			• Heart failure
			• Hypertensive emergencies
				AEMT Material PLUS:
				
				Anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, and management of:
				
				Complex depth, comprehensive breadth
				
				• Acute coronary syndrome
				  ○ Angina pectoris
				  ○ Myocardial infarction
				• Heart failure
				• Non-traumatic cardiac tamponade
				• Hypertensive emergencies
				• Cardiogenic shock
				• Vascular disorders
				  ○ Abdominal aortic aneurysm
				  ○ Arterial occlusion
				  ○ Venous thrombosis
				• Aortic aneurysm / dissection,
				• Thromboembolism
				• Cardiac rhythm disturbances
				
				Fundamental depth, foundational breadth
				
				• Infectious diseases of the heart
				  ○ Endocarditis
				  ○ Pericarditis
				• Congenital abnormalities

Toxicology	Simple depth, simple breadth
	
	• Recognition and management of:
	  ○ Carbon monoxide poisoning
	  ○ Nerve agent poisoning
	• How and when to contact a poison control center
		EMR Material PLUS:
		
		Fundamental depth, foundational breadth
		
		Anatomy, physiology, pathophysiology, assessment, and management of:
		
		• Inhaled poisons
		• Ingested poisons
		• Injected poisons
		• Absorbed poisons
		• Alcohol intoxication and withdrawal
			EMT Material PLUS:
			
			Fundamental depth, foundational breadth
			
			• Opiate toxidrome
				AEMT Material PLUS:
				
				Complex depth, comprehensive breadth
				
				Anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, and management of the following toxidromes and poisonings:
				
				• Cholinergics
				• Anticholinergics
				• Sympathomimetics
				• Sedative / hypnotics
				• Opiates
				• Alcohol intoxication and withdrawal
				• Over-the-counter and prescription medications
				• Carbon monoxide
				• Illegal drugs
				• Herbal preparations

Respiratory	Simple depth, simple breadth Anatomy, signs, symptoms and management of respiratory emergencies including those that affect the: • Upper airway • Lower airway	**EMR Material PLUS:** Anatomy, physiology, pathophysiology, assessment, and management of: Fundamental depth, foundational breadth • Epiglottitis • Spontaneous pneumothorax • Pulmonary edema • Asthma • Chronic obstructive pulmonary	**EMT Material PLUS:** Complex depth, foundational breadth Anatomy, physiology, pathophysiology, assessment, and management of: • Asthma • Obstructive / restrictive disease • Pneumonia	**AEMT Material PLUS:** Anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, management of: Complex depth, comprehensive breadth • Acute upper airway infections • Spontaneous pneumothorax

		disease • Environmental / industrial exposure • Toxic gas Simple depth, simple breadth • Pertussis • Cystic fibrosis • Pulmonary embolism • Pneumonia • Viral respiratory infections		• Obstructive / restrictive lung diseases • Pulmonary infections Fundamental depth, foundational breadth • Neoplasm • Pertussis • Cystic fibrosis
Hematology	**No knowledge related to this competency is applicable at this level.**	Simple depth, simple breadth Anatomy, physiology, pathophysiology, assessment, and management of: • Sickle cell crisis • Clotting disorders	**EMT Material PLUS:** Fundamental depth, foundational breadth Anatomy, physiology, pathophysiology, assessment and management of: • Sickle cell crisis	**AEMT Material PLUS:** Anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, and management of common or major hematological diseases and/or emergencies Complex depth, foundational breadth • Sickle cell disease Fundamental depth, foundational breadth • Blood transfusion complications • Hemostatic disorders • Lymphomas • Red blood cell disorders • White blood cell disorders • Coagulopathies

Genitourinary/Renal	Simple depth, simple breadth
	
	• Blood pressure assessment in hemodialysis patients
		EMR Material PLUS:
		
		Simple depth, simple breadth
		
		Anatomy, physiology, pathophysiology, assessment, and management of:
		
		• Complications related to:
		  ○ Renal dialysis
		  ○ Urinary catheter management (not insertion)
		• Kidney stones
			EMT Material PLUS:
			
			Fundamental depth, simple breadth
			
			Anatomy, physiology, pathophysiology, assessment, and management of:
			
			• Complications related to renal dialysis
			• Kidney stones
				AEMT Material Plus:
				
				Anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, and management of:
				
				Complex depth, comprehensive breadth
				
				• Complications of:
				  ○ Acute renal failure
				  ○ Chronic renal failure
				  ○ Dialysis
				• Renal calculi
				
				Fundamental depth, foundational breadth
				
				• Acid base disturbances
				• Fluid and electrolyte
				• Infection
				• Male genital tract conditions

Gynecology	Simple depth, simple breadth Recognition and management of shock associated with: • Vaginal bleeding	**EMR Material Plus:** Anatomy, physiology, assessment findings, and management of: Fundamental depth, foundational breadth • Vaginal bleeding • Sexual assault (to include appropriate emotional support) Simple depth, simple breadth • Infections	**Same as Previous Level**	**AEMT Material Plus:** Anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, and management of common or major gynecological diseases and/or emergencies Complex depth, comprehensive breadth • Vaginal bleeding • Sexual assault Fundamental depth, foundational breadth • Infections • Pelvic Inflammatory Disease • Ovarian cysts • Dysfunctional uterine bleeding • Vaginal foreign body
Non-Traumatic Musculoskeletal Disorders	**No knowledge related to this competency is applicable at this level.**	Fundamental depth, foundational breadth Anatomy, physiology, pathophysiology, assessment and management of: • Non-traumatic fractures	**Same as Previous Level**	**AEMT Material Plus:** Fundamental depth, foundation breadth Anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, and management of common or major non-traumatic musculoskeletal disorders • Disorders of the spine

Non-Traumatic Musculoskeletal Disorders (continued)				• Joint abnormalities • Muscle abnormalities • Overuse syndromes
Diseases of the Eyes, Ears, Nose, and Throat	Simple depth, simple breadth Recognition and management of • Nose bleed	**Same as Previous Level**	**Same as Previous Level**	**AEMT Material Plus:** Fundamental depth, foundational breadth Knowledge of anatomy, physiology, epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, management of • Common or major diseases of the eyes, ears, nose, and throat, including nose bleed
Shock and Resuscitation	**Uses assessment information to recognize shock, respiratory failure or arrest, and cardiac arrest based on assessment findings and manages the emergency while awaiting additional emergency response.**	**Applies fundamental knowledge of the causes, pathophysiology, and management of shock, respiratory failure or arrest, cardiac failure or arrest, and post resuscitation management.**	**Applies fundamental knowledge to provide basic and selected advanced emergency care and transportation based on assessment findings for a patient in shock, respiratory failure or arrest, cardiac failure or arrest, and post resuscitation management.**	**Integrates comprehensive knowledge of causes and pathophysiology into the management of cardiac arrest and peri-arrest states. Integrates a comprehensive knowledge of the causes and pathophysiology into the management of shock, respiratory failure or arrest with an emphasis on early intervention to prevent arrest.**

Trauma	**Uses simple knowledge to recognize and manage life threats based on assessment findings for an acutely injured patient while awaiting additional emergency medical response.**	**Applies fundamental knowledge to provide basic emergency care and transportation based on assessment findings for an acutely injured patient.**	**Applies fundamental knowledge to provide basic and selected advanced emergency care and transportation based on assessment findings for an acutely injured patient.**	**Integrates assessment findings with principles of epidemiology and pathophysiology to formulate a field impression to implement a comprehensive treatment/dispositio n plan for an acutely injured patient.**
Trauma Overview	**No knowledge related to this competency is applicable at this level.**	Fundamental depth, foundational breadth Pathophysiology, assessment, and management of the trauma patient • Trauma scoring • Rapid transport and destination issues • Transport mode	**Same as Previous Level**	**AEMT Material Plus:** Complex depth, comprehensive breadth Pathophysiology, assessment and management of the trauma patient • Trauma scoring • Transport and destination issues
Bleeding	Simple depth, simple breadth Recognition and management of • Bleeding	**EMR Material Plus:** Fundamental depth, foundational breadth Pathophysiology, assessment, and management of • Bleeding	**EMT Material Plus:** Complex depth, comprehensive breadth • Fluid resuscitation	**AEMT Material Plus:** Complex depth, comprehensive breadth Pathophysiology, assessment, and management of • Bleeding

Chest Trauma	Simple depth, simple breadth
	
	Recognition and management of:
	
	• Blunt versus penetrating mechanisms
	• Open chest wound
	• Impaled object
		EMR Material Plus:
		
		Fundamental depth, simple breadth
		
		Pathophysiology, assessment and management
		
		• Blunt versus penetrating mechanisms
		• Hemothorax
		• Pneumothorax
		  ○ Open
		  ○ Simple
		  ○ Tension
		• Cardiac tamponade
		• Rib fractures
		• Flail chest
		• Commotio cordis
			EMT Material Plus:
			
			Fundamental depth, foundational breadth
			
			Pathophysiology, assessment and management of:
			
			• Traumatic aortic disruption
			• Pulmonary contusion
			• Blunt cardiac injury
			• Hemothorax
			• Pneumothorax
			  ○ Open
			  ○ Simple
			  ○ Tension
			• Cardiac tamponade
			• Rib fractures
			• Flail chest
			• Commotio cordis
			• Traumatic asphyxia
				AEMT Material Plus:
				
				Complex depth, comprehensive breadth
				
				Pathophysiology, assessment, and management of:
				
				• Traumatic aortic disruption
				• Pulmonary contusion
				• Blunt cardiac injury
				• Hemothorax
				• Pneumothorax
				  ○ Open
				  ○ Simple
				  ○ Tension
				• Cardiac tamponade
				• Rib fractures
				• Flail chest
				• Commotio cordis
				• Tracheobronchial disruption
				• Diaphragmatic rupture
				• Traumatic asphyxia

Abdominal and Genitourinary Trauma	Simple depth, simple breadth Recognition and management of: • Blunt versus penetrating mechanisms • Evisceration • Impaled object	**EMR Material Plus:** Fundamental depth, simple breadth Pathophysiology, assessment and management of: • Solid and hollow organ injuries • Blunt versus penetrating mechanisms • Evisceration • Injuries to the external genitalia • Vaginal bleeding due to trauma • Sexual assault	**EMT Material Plus:** Fundamental depth, foundational breadth Pathophysiology, assessment, and management of: • Vascular injury • Solid and hollow organs injuries • Blunt versus penetrating mechanisms • Evisceration • Retroperitoneal injuries • Injuries to the external genitalia • Vaginal bleeding due to trauma • Sexual assault	**AEMT Material Plus:** Complex depth, comprehensive breadth Pathophysiology, assessment, and management of: • Vascular injury • Solid and hollow organ injuries • Blunt versus penetrating mechanisms • Evisceration • Retroperitoneal injuries • Injuries to the external genitalia
Orthopedic Trauma	Simple depth, simple breadth Recognition and management of: • Open fractures • Closed fractures • Dislocations • Amputations	**EMR Material Plus:** Pathophysiology, assessment, and management of: Fundamental depth, foundational breadth • Upper and lower extremity orthopedic trauma • Open fractures • Closed fractures • Dislocations • Sprains/strains • Pelvic fractures • Amputations / replantation	**EMT Material Plus:** Pathophysiology, assessment, and management of Simple depth, simple breadth • Compartment syndrome Complex depth, foundational breadth • Pelvic fractures • Amputations/replantation	**AEMT Material Plus:** Pathophysiology, assessment, and management of: Fundamental depth, foundational breadth • Pediatric fractures • Tendon laceration / transection / rupture (Achilles and patellar) • Compartment syndrome Complex depth, foundational breadth • Upper and lower extremity orthopedic trauma • Open fractures • Closed fractures • Dislocations

Soft Tissue Trauma	Simple depth, simple breadth
	
	Recognition and management of:
	
	• Wounds
	• Burns
	  ○ Electrical
	  ○ Chemical
	  ○ Thermal
	• Chemicals in the eye and on the skin
		EMR Material Plus:
		
		Fundamental depth, foundational breadth
		
		Pathophysiology, assessment, and management of:
		
		• Wounds
		  ○ Avulsions
		  ○ Bite wounds
		  ○ Lacerations
		  ○ Puncture wounds
		  ○ Incisions
		• Burns
		  ○ Electrical
		  ○ Chemical
		  ○ Thermal
		  ○ Radiation
		
		Simple depth, simple breadth
		
		• Crush syndrome
			EMT Material Plus:
			
			Fundamental depth, simple breadth
			
			• Crush syndrome
				AEMT Material Plus:
				
				Complex depth, comprehensive breadth
				
				Pathophysiology, assessment, and management of:
				
				• Wounds
				  ○ Avulsions
				  ○ Bite wounds
				  ○ Lacerations
				  ○ Puncture wounds
				• Burns
				  ○ Electrical
				  ○ Chemical
				  ○ Thermal
				• High-pressure injection
				• Crush syndrome

Head, Facial, Neck, and Spine trauma	Simple depth, simple breadth Recognition and management of: • Life threats • Spine trauma	**EMR Material Plus:** Fundamental depth, foundational breadth Pathophysiology, assessment, and management of: • Penetrating neck trauma • Laryngeotracheal injuries • Spine trauma Simple depth, simple breadth • Facial fractures • Skull fractures • Foreign bodies in the eyes • Dental trauma	**EMT Material Plus:** Complex depth, foundational breadth Pathophysiology, assessment, and management of: • Facial fractures • Laryngeotracheal injuries	**AEMT Material Plus:** Pathophysiology, assessment, and management of: Fundamental depth, foundational breadth • Unstable facial fractures • Orbital fractures • Perforated tympanic membrane Complex depth, comprehensive breadth • Skull fractures • Penetrating neck trauma • Laryngeotracheal injuries • Spine trauma ○ Dislocations /

Head, Facial, Neck, and Spine trauma (continued)				subluxations ○ Fractures ○ Sprains / strains • Mandibular fractures
Nervous System Trauma	**No knowledge related to this competency is applicable at this level.**	Fundamental depth, foundational breadth Pathophysiology, assessment, and management of • Traumatic brain injury • Spinal cord injury	**EMT Material Plus:** Complex depth, foundational breadth Pathophysiology, assessment, and management of: • Traumatic brain injury	**AEMT Material Plus:** Pathophysiology, assessment, and management of: Fundamental depth, foundational breadth • Cauda equina syndrome • Nerve root injury • Peripheral nerve injury Complex depth, comprehensive breadth • Traumatic brain injury • Spinal cord injury • Spinal shock
Special Considerations in Trauma	Simple depth, simple breadth Recognition and management of trauma in: • Pregnant patient • Pediatric patient • Geriatric patient	**EMR Material Plus:** Fundamental depth, foundational breadth Pathophysiology, assessment, and management of trauma in the: • Pregnant patient • Pediatric patient • Geriatric patient • Cognitively impaired patient	**EMT Material Plus:** Complex depth, foundational breadth Pathophysiology, assessment, and management of trauma in the: • Pregnant patient • Pediatric patient • Geriatric patient • Cognitively impaired patient	**AEMT Material Plus:** Complex depth, comprehensive breadth Pathophysiology, assessment, and management of trauma in the: • Pregnant patient • Pediatric patient • Geriatric patient • Cognitively impaired patient

Environmental Emergencies	Simple depth, simple breadth
	
	Recognition and management of:
	
	• Submersion incidents
	• Temperature-related illness
		EMR Material Plus:
		
		Fundamental depth, foundational breadth
		
		Pathophysiology, assessment, and management of:
		
		• Near drowning
		• Temperature-related illness
		• Bites and envenomations
		• Dysbarism
		  ○ High-altitude
		  ○ Diving injuries
		• Electrical injury
		• Radiation exposure
			Same as Previous Level	**AEMT Material Plus:**
				
				Complex depth, comprehensive breadth
				
				Pathophysiology, assessment, and management of:
				
				• Near-drowning
				• Temperature-related illness
				• Bites and envenomations
				• Dysbarism
				  ○ High-altitude
				  ○ Diving injuries
				• Electrical injury
				• High altitude illness

Multi-System Trauma	Simple depth, simple breadth Recognition and management of: • Multi-system trauma	**EMR Material Plus:** Fundamental depth, foundational breadth Pathophysiology, assessment, and management of: • Multi-system trauma • Blast injuries	**EMT Material Plus:** Complex depth, foundational breadth Pathophysiology, assessment and management of: • Multi-system trauma	**AEMT Material Plus:** Complex depth, comprehensive breadth Pathophysiology, assessment, and management of: • Multi-system trauma • Blast injuries
Special Patient Populations	**Recognizes and manages life threats based on simple assessment findings for a patient with special needs while awaiting additional emergency response.**	**Applies a fundamental knowledge of growth, development, and aging and assessment findings to provide basic emergency care and transportation for a patient with special needs.**	**Applies a fundamental knowledge of growth, development, and aging and assessment findings to provide basic and selected advanced emergency care and transportation for a patient with special needs.**	**Integrates assessment findings with principles of pathophysiology and knowledge of psychosocial needs to formulate a field impression and implement a comprehensive treatment/dispositio n plan for patients with special needs.**

Obstetrics	Simple depth, simple breadth
	
	Recognition and management of:
	
	• Normal delivery
	• Vaginal bleeding in the pregnant patient
		EMR Material Plus:
		
		Fundamental depth, foundational breadth
		
		• Anatomy and physiology of normal pregnancy
		• Pathophysiology of complications of pregnancy
		• Assessment of the pregnant patient
		• Management of:
		  ○ Normal delivery
		  ○ Abnormal delivery
		  ▪ Nuchal cord
		  ▪ Prolapsed cord
		  ▪ Breech delivery
		  ○ Third trimester bleeding
		  ▪ Placenta previa
		  ▪ Abruptio placenta
		  ○ Spontaneous abortion / miscarriage
		  ○ Ectopic pregnancy
		  ○ Preeclampsia / Eclampsia
			Same as Previous Level	**AEMT Material Plus:**
				
				Complex depth, comprehensive breadth
				
				• Anatomy and physiology of pregnancy
				• Pathophysiology of complications of pregnancy
				• Assessment of the pregnant patient
				
				Psychosocial impact, presentations, prognosis, and management of:
				
				• Normal delivery
				• Abnormal delivery
				  ○ Nuchal cord
				  ○ Prolapsed cord
				  ○ Breech
				• Spontaneous abortion / miscarriage
				• Ectopic pregnancy
				• Eclampsia
				• Antepartum hemorrhage
				• Pregnancy induced hypertension
				• Third trimester bleeding
				  ○ Placenta previa
				  ○ Abruptio placenta
				• High risk pregnancy
				• Complications of labor
				  ○ Fetal distress
				  ○ Pre-term
				  ○ Premature rupture of

Obstetrics (continued)				membranes ○ Rupture of uterus • Complication of delivery • Postpartum complications Foundational depth, foundational breadth • Hyperemesis gravidarum • Post partum depression
Neonatal care	Simple depth, simple breadth • Newborn care • Neonatal resuscitation	**EMR Material Plus:** Fundamental depth, foundational breadth Assessment and management: • Newborn • Neonatal resuscitation	**Same as Previous Level**	**AEMT Material Plus:** Complex depth, comprehensive breadth • Anatomy and physiology of neonatal circulation • Assessment of the newborn Presentation and management: • Newborn • Neonatal resuscitation
Pediatrics	Simple depth, simple breadth Age-related assessment findings, and age-related assessment and treatment modifications for pediatric- specific major diseases and/or emergencies: • Upper airway obstruction • Lower airway	**EMR Material Plus:** Fundamental depth, foundational breadth Age-related assessment findings, age-related, and developmental stage related assessment and treatment modifications for pediatric specific major diseases and/or	**Same as Previous Level**	**AEMT Material Plus**: Age-related assessment findings, age-related anatomic and physiologic variations, age-related and developmental stage related assessment and treatment modifications of the pediatric- specific

Pediatrics (continued)	reactive disease • Respiratory distress / failure / arrest • Shock • Seizures • Sudden Infant Death Syndrome	emergencies: • Upper airway obstruction • Lower airway reactive disease • Respiratory distress / failure / arrest • Shock • Seizures • Sudden Infant Death Syndrome • Gastrointestinal disease		major or common diseases and/or emergencies: Complex depth, comprehensive breadth • Foreign body (upper and lower) airway obstruction • Bacterial tracheitis • Asthma • Bronchiolitis • Respiratory Syncytial Virus (RSV) • Pneumonia • Croup • Epiglottitis • Respiratory distress / failure / arrest • Shock • Seizures • Sudden Infant Death Syndrome (SIDS) • Hyperglycemia • Hypoglycemia Fundamental depth, foundational breadth • Pertussis • Cystic fibrosis • Bronchopulmonary dysplasia • Congenital heart diseases • Hydrocephalus and ventricular shunts

Geriatrics	Simple depth, simple breadth • Impact of age-related changes on assessment and care	**EMR Material Plus:** Fundamental depth, foundational breadth Changes associated with aging, psychosocial aspects of aging and age-related assessment and treatment modifications for the major or common geriatric diseases and/or emergencies • Cardiovascular diseases • Respiratory diseases • Neurological diseases • Endocrine diseases • Alzheimer's • Dementia	**EMT Material Plus:** Complex depth, foundational breadth • Fluid resuscitation in the elderly	**AEMT Material Plus:** Normal and abnormal changes associated with aging, pharmacokinetic changes, psychosocial and economic aspects of aging, polypharmacy, and age-related assessment and treatment modifications for the major or common geriatric diseases and/or emergencies: Complex depth, comprehensive breadth • Cardiovascular diseases • Respiratory diseases • Neurological diseases • Endocrine diseases • Alzheimer's • Dementia • Delirium ○ Acute confusional state Fundamental depth, foundational breadth • Herpes zoster • Inflammatory arthritis

Patients with Special Challenges	Simple depth, simple breadth • Recognizing and reporting abuse and neglect	**EMR Material Plus:** Simple depth, simple breadth Healthcare implications of: • Abuse • Neglect • Homelessness • Poverty • Bariatrics • Technology dependent • Hospice / terminally ill • Tracheostomy care / dysfunction • Homecare • Sensory deficit/loss • Developmental disability	**EMT Material Plus:** Fundamental depth, foundational breadth Healthcare implications of: • Abuse • Neglect • Homelessness • Poverty • Bariatrics • Technology dependent • Hospice / terminally ill • Tracheostomy care / dysfunction • Homecare • Sensory deficit/loss • Developmental disability	**AEMT Material Plus:** Complex depth, comprehensive breadth Healthcare implications of: • Abuse • Neglect • Poverty • Bariatrics • Technology dependent • Hospice / terminally ill • Tracheostomy care / dysfunction
EMS Operations	**Knowledge of operational roles and responsibilities to ensure safe patient, public, and personnel safety**	**Same as Previous Level**	**Same as Previous Level**	**Same as Previous Level**
Principles of Safely Operating a Ground Ambulance	Simple depth, simple breadth • Risks and responsibilities of emergency response	**EMR Material Plus:** Simple depth, foundational breadth • Risks and responsibilities of transport	**Same as Previous Level**	**Same as Previous Level**
Incident Management	Simple depth, simple breadth • Establish and work within the incident management system	**EMR Material Plus:** Fundamental depth, foundational breadth • Establish and work within the incident management system	**Same as Previous Level**	**AEMT Material Plus:** Complex depth, comprehensive breadth • Establish and work within the incident management system

Multiple Casualty Incidents	Simple depth, simple breadth
	
	• Triage principles
	• Resource management
		EMR Material Plus:
		
		Simple depth, foundational breadth
		
		• Triage
		  ○ Performing
		  ○ Re-Triage
		  ○ Destination Decisions
		  ○ Post Traumatic and Cumulative Stress
			Same as Previous Level	**Same as Previous Level**

Air Medical	Simple depth, simple breadth • Safe air medical operations • Criteria for utilizing air medical response	**Same as Previous Level**	**Same as Previous Level**	**AEMT Material Plus:** Complex depth, comprehensive breadth • Medical risks / needs / advantages
Vehicle Extrication	Simple depth, simple breadth • Safe vehicle extrication • Use of simple hand tools	**Same as Previous Level**	**Same as Previous Level**	**Same as Previous Level**
Hazardous Materials Awareness	Simple depth, simple breadth • Risks and responsibilities of operating in a cold zone at a hazardous material or other special incident	**Same as Previous Level**	**Same as Previous Level**	**Same as Previous Level**

Mass Casualty Incidents due to Terrorism and Disaster (this section subject to ongoing collective and cooperative review and input from all stakeholders including the Department of Transportation, Department of Homeland Security and the Department of Health and Human Services)	Simple depth, simple breadth • Risks and responsibilities of operating on the scene of a natural or manmade disaster	**Same as Previous Level**	**Same as Previous Level**	**Same as Previous Level**

Clinical Behavior/Judgment				
	EMR	**EMT**	**AEMT**	**Paramedic**
Assessment	Perform a simple assessment to identify life threats, identify injuries requiring immobilization and conditions requiring treatment within the scope of practice of the EMR: including foreign substance in the eyes and nerve agent poisoning.	Perform a basic history and physical examination to identify acute complaints and monitor changes. Identify the actual and potential complaints of emergency patients.	Perform a basic history and physical examination to identify acute complaints and monitor changes. Identify the actual and potential complaints of emergency patients.	Perform a comprehensive history and physical examination to identify factors affecting the health and health needs of a patient. Formulate a field impression based on an analysis of comprehensive assessment findings, anatomy, physiology, pathophysiology, and epidemiology. Relate assessment findings to underlying pathological and physiological changes in the patient's condition. Integrate and synthesize the multiple determinants of health and clinical care. Perform health screening and referrals.
Therapeutic communication and cultural competency	Communicates to obtain and clearly transmit information with an awareness of cultural differences.	Communicate in a culturally sensitive manner.	Communicate in a culturally sensitive manner.	Effectively communicate in a manner that is culturally sensitive and intended to improve the patient outcome.

Clinical Behavior/Judgment				
	EMR	**EMT**	**AEMT**	**Paramedic**

Psychomotor Skills	Safely and effectively perform all psychomotor skills within the National EMS Scope of Practice Model AND state Scope of Practice at this level.
	
	Airway and Breathing
	• Basic Airway Maneuvers
	  ○ Head-tilt, chin-lift
	  ○ Jaw thrust
	  ○ Modified chin lift
	  ○ FBAO relief - manual
	• Oropharyngeal airway
	• Sellick's maneuver
	• Positive pressure ventilation devices such as BVM
	• Suction of the upper airway
	• Supplemental oxygen therapy
	  ○ Nasal cannula
	  ○ Non-rebreather mask
	
	Assessment
	• Manual B/P
	
	Pharmacologic interventions
	• Unit-dose autoinjectors (life- saving medications intended for self or peer rescue in hazardous materials situation, nerve agent antidote kit)
		Safely and effectively perform all psychomotor skills within the National EMS Scope of Practice Model AND state Scope of Practice at this level.
		
		Airway and Breathing
		• Nasopharyngeal airway
		• Positive pressure ventilation
		  ○ Manually-triggered ventilators
		  ○ Automatic transport ventilators
		• Supplemental oxygen therapy
		  ○ Humidifiers
		  ○ Partial-rebreather mask
		  ○ Venturi mask
		
		Assessment
		• Pulse oximetry
		• Automatic B/P
		
		Pharmacologic interventions
		• Assist patients in taking their own prescribed medications
		• Administration of OTC medications with medical oversight
		  ○ Oral glucose for hypoglycemia
		  ○ Aspirin for chest pain
		
		Medical/Cardiac care
		• Mechanical CPR
			Safely and effectively perform all psychomotor skills within the National EMS Scope of Practice Model AND state Scope of Practice at this level.
			
			Airway and Breathing
			• Airways not intended for insertion into the trachea
			  ○ Esophageal-tracheal
			  ○ Multi-lumen airway
			• Tracheal-bronchial suctioning of an already intubated patient
			
			Assessment
			• Blood glucose monitor
			
			Pharmacologic interventions
			• Establish and maintain peripheral intravenous access
			• Establish and maintain intraosseous access in pediatric patient
			• Administer (nonmedicated) intravenous fluid therapy
			• Sublingual nitroglycerin (chest pain)
			• Subcutaneous or intramuscular epinephrine
				Safely and effectively perform all psychomotor skills within the National EMS Scope of Practice Model AND state Scope of Practice at this level.
				
				Airway and Breathing
				• Oral and nasal endotracheal intubation
				• FBAO – direct laryngoscopy
				• Percutaneous cricothyrotomy
				• Pleural decompression
				• BiPAP, CPAP, PEEP
				• Chest tube monitoring
				• ETCO2 monitoring
				• NG/OG tube
				
				Assessment
				• ECG interpretation
				• 12-lead interpretation
				• Blood chemistry analysis
				
				Pharmacologic interventions
				• Intraosseous insertion
				• Enteral and parenteral administration of approved prescription medications
				• Access indwelling catheters and implanted central IV ports
				• Medications by

Clinical Behavior/Judgment				
	EMR	**EMT**	**AEMT**	**Paramedic**

Psychomotor Skills (continued)	Medical/Cardiac care
	• Manual CPR
	• AED
	• Assisted normal delivery
	
	Trauma care
	• Manual stabilization
	  ○ C-spine injuries
	  ○ Extremity fractures
	• Bleeding control
	• Emergency moves
	• Eye irrigation
		• Assisted complicated delivery
		
		Trauma care
		• Spinal immobilization
		  ○ Cervical collars
		  ○ Seated
		  ○ Longboard
		  ○ Rapid extrication
		• Splinting
		  ○ Extremity
		  ○ Traction
		  ○ PASG
		• Mechanical patient restraint
		• Tourniquet
			(anaphylaxis)
			• Glucagon (hypoglycemia)
			• Intravenous 50% dextrose (hypoglycemia)
			• Inhaled beta agonists (wheezing)
			• Intravenous narcotic antagonist (narcotic overdose)
			• Nitrous oxide (pain)
				IV infusion
				• Maintain infusion of blood or blood products
				• Blood sampling
				• Thrombolytic initiation
				• Administer physician approved medications
				
				Medical/Cardiac care
				• Cardioversion
				• Manual defibrillation
				• Transcutaneous pacing
				• Carotid massage
				
				Trauma care
				• Morgan lens
				
				Anticipate and prospectively intervene to improve patient outcome.

Professionalism	Demonstrate professional behavior including: but not limited to, integrity, empathy, self-motivation, appearance/personal hygiene, self-confidence, communications, time- management, teamwork/ diplomacy, respect, patient advocacy, and careful delivery of service.	Demonstrate professional behavior including: but not limited to, integrity, empathy, self-motivation, appearance/personal hygiene, self-confidence, communications, time- management, teamwork/ diplomacy, respect, patient advocacy, and careful delivery of service.	Demonstrate professional behavior including: but not limited to, integrity, empathy, self-motivation, appearance/personal hygiene, self-confidence, communications, time- management, teamwork/ diplomacy, respect, patient advocacy, and careful delivery of service.	Is a role model of exemplary professional behavior including: but not limited to, integrity, empathy, self-motivation, appearance/personal hygiene, self-confidence, communications, time- management, teamwork/ diplomacy, respect, patient advocacy, and careful delivery of service.

Clinical Behavior/Judgment				
	EMR	**EMT**	**AEMT**	**Paramedic**
Decision Making	Initiates simple interventions based on assessment findings.	Initiates basic interventions based on assessment findings intended to mitigate the emergency and provide limited symptom relief while providing access to definitive care	Initiates basic and selected advanced interventions based on assessment findings intended to mitigate the emergency and provide limited symptom relief while providing access to definitive care	Performs basic and advanced interventions as part of a treatment plan intended to mitigate the emergency, provide symptom relief, and improve the overall health of the patient. Evaluates the effectiveness of interventions and modifies treatment plan accordingly.
Record Keeping	Record simple assessment findings and interventions	Report and document assessment data and interventions.	Report and document assessment findings and interventions.	Report and document assessment findings and interventions. Collect and report data to be used for epidemiological and research purposes.
Patient Complaints	Perform a patient assessment and provide prehospital emergency care for patient complaints: abdominal pain, abuse/neglect, altered mental status/decreased level of consciousness, apnea, back pain, behavioral emergency, bleeding, cardiac arrest, chest pain, cyanosis, dyspnea, eye pain, GI bleeding, hypotension, multiple trauma, pain, paralysis, poisoning, shock, and	Perform a patient assessment and provide prehospital emergency care and transportation for patient complaints: abdominal pain, abuse/neglect, altered mental status/decreased level of consciousness, anxiety, apnea, ataxia, back pain, behavioral emergency, bleeding, cardiac arrest, cardiac rhythm disturbances, chest pain, constipation, cyanosis, dehydration, diarrhea, dizziness/vertigo,	Perform a patient assessment and provide prehospital emergency care and transportation for patient complaints: abdominal pain, abuse/neglect, altered mental status/decreased level of consciousness, anxiety, apnea, ataxia, back pain, behavioral emergency, bleeding, cardiac arrest, cardiac rhythm disturbances, chest pain, constipation, cyanosis, dehydration, diarrhea, dizziness/vertigo,	Perform a patient assessment, develop a treatment and disposition plan for patients with the following complains: abdominal pain, abuse/neglect, altered mental status/decreased level of consciousness, anxiety, apnea, ascites, ataxia, back pain, behavioral emergency, bleeding, blood and body fluid exposure, cardiac arrest, cardiac rhythm disturbances, chest pain, congestion, constipation,

Clinical Behavior/Judgment				
	EMR	**EMT**	**AEMT**	**Paramedic**
Patient Complaints (continued)	stridor/drooling.	dysphasia, dyspnea, edema, eye pain, fatigue, fever, GI bleeding, headache, hematuria, hemoptysis, hypertension, hypotension, joint pain/swelling, multiple trauma, nausea/vomiting, pain, paralysis, pediatric crying/fussiness, poisoning, rash, rectal pain, shock, sore throat, stridor/drooling, syncope, urinary retention, visual disturbances, weakness, and wheezing.	dysphasia, dyspnea, edema, eye pain, fatigue, fever, GI bleeding, headache, hematuria, hemoptysis, hypertension, hypotension, joint pain/swelling, multiple trauma, nausea/vomiting, pain, paralysis, pediatric crying/fussiness, poisoning, rash, rectal pain, shock, sore throat, stridor/drooling, syncope, urinary retention, visual disturbances, weakness, and wheezing.	cough/hiccough, cyanosis, dehydration, dental pain, diarrhea, dizziness/vertigo, dysmenorrhea, dysphasia, dyspnea, dysuria, ear pain, edema, eye pain, fatigue, feeding problems, fever, GI bleeding, headache, hearing disturbance, hematuria, hemoptysis, hypertension, hypotension, incontinence, jaundice, joint pain/swelling, malaise, multiple trauma, nausea/vomiting, pain, paralysis, pediatric crying/fussiness, poisoning, pruritus, rash, rectal pain, red/pink eye, shock, sore throat, stridor/drooling, syncope, tinnitus, tremor, urinary retention, visual disturbances, weakness, and wheezing.
Scene Leadership	Manage the scene until care is transferred to an EMS team member licensed at a higher level arrives.	Entry-level EMTs serve as an EMS team member on an emergency call with more experienced personnel in the lead role. EMTs may serve as a team leader following additional training and/or experience.	Serve as an EMS team leader of an emergency call.	Function as the team leader of a routine, single patient advanced life support emergency call.
Scene Safety	Ensure the safety of the rescuer and others during an emergency.	Ensure the safety of the rescuer and others during an emergency.	Ensure the safety of the rescuer and others during an emergency.	Ensure the safety of the rescuer and others during an emergency.

Educational Infrastructure				
	EMR	**EMT**	**AEMT**	**Paramedic**
Educational Facilities	• Facility sponsored or approved by sponsoring agency • ADA compliant facility • Sufficient space for class size • Controlled environment	**Same as Previous Level**	**Same as Previous Level**	• Reference Committee on Accreditation for EMS Professions (CoAEMSP) *Standards and Guidelines* (www.coaemsp.org)
Student Space	• Provide space sufficient for students to attend classroom sessions, take notes and participate in classroom activities • Provide space for students to participate in kinematic learning and practice activities	**Same as Previous Level**	**Same as Previous Level**	
Instructional Resources	• Provide basic instructional support material • Provide audio, visual, and kinematic aids to support and supplement didactic instruction	**Same as Previous Level**	**Same as Previous Level**	

[1] The *National EMS Education Agenda for the Future: A Systems Approach* calls for national accreditation of Paramedic programs. CoAEMSP is currently the only national agency that offers EMS paramedic education program accreditation; it is used or recognized by most States. While the CoAEMSP *Standards and Guidelines* are adopted for the Education Infrastructure section, this does not itself require the program to be CoAEMSP accredited. Recognition of national accreditation is the responsibility of each State.

Educational Infrastructure				
	EMR	**EMT**	**AEMT**	**Paramedic**
Instructor Preparation Resources	• Provide space for instructor preparation • Provide support equipment for instructor preparation	**Same as Previous Level**	**Same as Previous Level**	• Reference Committee on Accreditation for EMS Professions (CoAEMSP) *Standards and Guidelines* (www.coaemsp.org)
Storage Space	• Provide adequate and secure storage space for instructional materials	**Same as Previous Level**	**Same as Previous Level**	
Sponsorship	• Sponsoring organizations shall be one of the following: ○ Accredited educational institution, or ○ Public safety organization, or ○ Accredited hospital, clinic, or medical center, or ○ Other State approved institution or organization	**Same as Previous Level**	**Same as Previous Level**	
Programmatic Approval	• Sponsoring organization shall have programmatic approval by authority having jurisdiction for program approval (State)	**Same as Previous Level**	**Same as Previous Level**	

Educational Infrastructure				
	EMR	**EMT**	**AEMT**	**Paramedic**
Faculty	The course primary instructor should: • Be educated at a level higher than he or she is teaching; however, as a minimum, he or she must be educated at the level he or she is teaching • Have successfully completed an approved instructor training program or equivalent	**Same as Previous Level**	**Same as Previous Level**	• Reference Committee on Accreditation for EMS Professions (CoAEMSP) *Standards and Guidelines* (www.coaemsp.org)
Medical Director Oversight	• Provide medical oversight for all medical aspects of instruction	**Same as Previous Level**	**Same as Previous Level**	
Hospital/Clinical Experience	• None required at this level	• Students should observe emergency department operations for a period of time sufficient to gain an appreciation for the continuum of care Students must perform ten patient assessments. These can be performed in an emergency department, ambulance, clinic, nursing home, doctor's office, etc. or on standardized patients if clinical settings are not available.	• The student must demonstrate the ability to safely administer medications (the student should safely, and while performing all steps of each procedure, properly administer medications at least 15 times to a live or appropriate human patient simulator). • The student must demonstrate the ability to safely gain vascular access (the student should safely, and while performing all steps of each procedure, successfully	

Educational Infrastructure				
	EMR	**EMT**	**AEMT**	**Paramedic**
Hospital/Clinical Experience (continued)			access the venous circulation at least 25 times on live patients of various age groups or an appropriate human patient simulator). • The student should demonstrate the ability to effectively ventilate unintubated patients of all age groups (the student should effectively, and while performing all steps of each procedure, ventilate at least 20 live patients of various age groups or appropriate human patient simulator). • The student must demonstrate the ability to perform an adequate assessment and formulate and implement a treatment plan for patients with chest pain. • The student must demonstrate the ability to perform an adequate assessment and formulate and implement a treatment plan for patients with respiratory distress. • The student must	• Reference Committee on Accreditation for EMS Professions (CoAEMSP) *Standards and Guidelines* (www.coaemsp.org)

Educational Infrastructure				
	EMR	**EMT**	**AEMT**	**Paramedic**
Hospital/Clinical Experience (continued)			demonstrate the ability to perform an adequate assessment and formulate and implement a treatment plan for patients with altered mental status. • The student must demonstrate the ability to perform an adequate assessment on pediatric, adult and geriatric patients.	• Reference Committee on Accreditation for EMS Professions (CoAEMSP) *Standards and Guidelines* (www.coaemsp.org)
Field Experience	• None required at this level	• The student must participate in and document patient contacts in a field experience approved by the medical director and program director.	• The student must participate in and document team leadership in a field experience approved by the medical director and program director.	
Course Length	• Course length is based on competency, not hours • Course material can be delivered in multiple formats including but not limited to: ○ Independent student preparation ○ Synchronous/ Asynchronous distributive education ○ Face-to-face instruction ○ Pre- or co-requisites • Course length is estimated to take approximately **48-60** didactic and laboratory clock	• Course length is based on competency, not hours • Course material can be delivered in multiple formats including but not limited to: ○ Independent student preparation ○ Synchronous/ Asynchronous distributive education ○ Face-to-face instruction ○ Pre- or co-requisites • Course length is estimated to take approximately **150-190** clock hours including the	• Course length is based on competency, not hours • Course material can be delivered in multiple formats including but not limited to: ○ Independent student preparation ○ Synchronous/ Asynchronous distributive education ○ Face-to-face instruction ○ Pre- or co-requisites • Course length is estimated to take approximately **150-250** clock hours beyond	

Educational Infrastructure				
	EMR	**EMT**	**AEMT**	**Paramedic**
	hours	four integrated phases of education (didactic, laboratory, clinical and field) to cover material	EMT requirements including the four integrated phases of education (didactic, laboratory, clinical and field) to cover material	
Course Design	• Provide the following components of instruction: ○ Didactic instruction ○ Skills laboratories	• Provide the following components of instruction: ○ Didactic instruction ○ Skills laboratories ○ Hospital / Clinical experience ○ Field experience	**Same as Previous Level**	• Reference Committee on Accreditation for EMS Professions (CoAEMSP) *Standards and Guidelines* (www.coaemsp.org)
Student Assessment	• Perform knowledge, skill, and professional behavior evaluation based on educational standards and program objectives • Provide several methods of assessing achievement • Provide assessment that measures, as a minimum, entry level competency in all domains	**Same as Previous Level**	**Same as Previous Level**	
Program Evaluation	• Provide evaluation of program instructional effectiveness • Provide evaluation of organizational and administrative effectiveness of	**Same as Previous Level**	**Same as Previous Level**	

Educational Infrastructure				
	EMR	**EMT**	**AEMT**	**Paramedic**
	program			

Glossary for Education Standards

Academic institution - A body or establishment instituted for an educational purpose that provides college credit or awards degrees.

Accreditation - The granting of approval by an official review board after meeting specific requirements. The review board is nongovernmental, and the review is collegial and based on self-assessment, peer assessment, and judgment. The purpose of accreditation is student protection and public accountability.

Advanced-level care - Care that has greater potential benefit to the patient, but also greater potential risk to the patient if improperly or inappropriately performed. It is more difficult to attain and maintain competency in, and requires significant background knowledge in basic and applied sciences. This level of care includes invasive and pharmacological interventions.

Affective domain - Describes learning in terms of feelings/emotions, attitudes, and values. (NAEMSE, 2005, p. 306)

Asynchronous instruction/learning - An instructional method that allows the learner to use a self directed and self-paced learning format to move through the content of the course. In this type of instruction, learner-to-learner and learner-to-instructor interactions are independent of time and place. Communications and submission of work typically follow a schedule while learners and instructors do not interact at the same time.

Certification - The issuing of a certificate by a private agency based upon competency standards adopted by that agency and met by the individual.

Cognitive domain - Describes learning that takes place through the process of thinking—it deals with facts and knowledge. (NAEMSE, 2005, p. 306)

Competency - Expected behavior or knowledge to be achieved within a defined area of practice.

Credential - Generic term referring to all forms of professional qualification.

Credentialing - The umbrella term that includes the concepts of accreditation, licensure, registration, and professional certification. Credentialing can establish criteria for fairness, quality, competence, and/or safety for professional services provided by authorized individuals, for products, or for educational endeavors. Credentialing is the process by which an entity, authorized and qualified to do so, grants formal recognition to, or records the recognition status of individuals, organizations, institutions, programs, processes, services, or products that meet predetermined and standardized criteria. (NOCA, 2006)

Credentialing agency - An organization that certifies an institution's or individual's authority or claim of competence in a course of study or completion of objectives.

Curriculum - A particular course of study, often in a specialized field. For EMS education, it has traditionally included detailed lesson plans.

Didactic - The instructional theory, the lesson content. (NAEMSE, 2005, p. 307)

Distributive education - A generic term used to describe a variety of learning delivery methods that attempt to accommodate a geographical separation (at least for some of the time) of the instructor and learners. Distributed

education includes computer and web-based instruction, distance learning through television or video, web-based seminars, video conferencing, and electronic and traditional educational models.

Domains - A category of learning. (See Affective domain, Cognitive domain, and Psychomotor domain.) (NAEMSE, 2005, p. 307)

Entry-level competence - The level of competence expected of an individual who is about to begin a career. The minimum competence necessary to practice safely and effectively.

Health Screening - A test or exam performed to find a condition before symptoms begin. Screening tests may help find diseases or conditions early, when they may be easier to treat. (Medline Plus definition)

Instructional Guidelines - A resource document that provides initial guidance for content within the National EMS Education Standards—it is not a curriculum and should not be adopted by States.

Licensure - The act of granting an entity permission to do something that the entity could not legally do without such permission. Licensing is generally viewed by legislative bodies as a regulatory effort to protect the public from potential harm. In the health care delivery system, an individual who is licensed tends to enjoy a certain amount of autonomy in delivering health care services. Conversely, the licensed individual must satisfy ongoing requirements that ensure certain minimum levels of expertise. A license is generally considered a privilege, not a right.

Medical oversight - Physician review and approval of clinical content and matters relevant to medical authority.

National EMS Core Content - The document that defines the domain of out-of-hospital care.

National EMS Education Program Accreditation - The accreditation process for institutions that sponsor EMS educational programs.

National EMS Education Standards - The document that defines the terminal objectives for each licensure level.

National EMS Scope of Practice Model - The document that defines the scope of practice of the various levels of EMS licensure.

Patient simulation - An alternative to a human patient to help students improve patient assessment and management skills; a high fidelity patient simulator provides realistic simulation that responds physiologically to student therapies. These simulators have realistic features such as chests that rise and fall with respirations, pupils that react to light, pulses that can be palpated, etc

Post graduate internship and/or experience - Experience gained after the student has completed and graduated from school.

Practice analysis - A study conducted to determine the frequency and criticality of the tasks performed in practice.

Preceptor - A clinical teacher or instructor who is responsible for evaluating and ensuring student progress during hospital and field experiences. This individual typically has training to be able to function effectively in the role.

Primary instructor - A person who possesses the appropriate academic and/or allied health credentials, and understanding of the principles and theories of education, and required instructional experience necessary to provide quality instruction to students. (NAEMSE, 2005, p 309)

Program director - The individual responsible for an educational program or programs.

Psychomotor domain - Describes learning that takes place through the attainment of skills and bodily, or kinesthetic, movements. (NAEMSE, 2005, p309

Registration agency - An agency that is traditionally responsible for providing a product used to evaluate a chosen area. States may voluntarily adopt this product as part of their licensing process. The registration agency is also responsible for gathering and housing data to support the validity and reliability of their product.

Regulation - A rule or a statue that prescribes the management, governance, or operation parameters for a given group; tends to be a function of administrative agencies to which a legislative body has delegated authority to promulgate rules and regulations to "regulate a given industry or profession." Most regulations are intended to protect the public health, safety, and welfare.

Scope of practice - The description of what a licensed individual legally can and cannot perform.

Standardized patient - An individual who has been thoroughly trained to accurately simulate a real patient with a medical condition; a standardized patient plays the role of a patient for students learning patient assessment, history taking skills, communication skills, and other skills.

Standard of care - The domain of acceptable practice, as defined by scope of practice, current evidence, industry consensus, and experts. Standard of care can vary, depending on the independent variables of each situation.

Synchronous instruction - Instructional method whereby learners and instructors interact at the same time, either in the classroom or via a computer driven course. This method allows for more immediate learner guidance and feedback using face-to-face, instant text-based messaging, or real time voice communications.

Team leader - Someone who leads the call and provides guidance and direction for setting priorities, scene and patient assessment and management. The team leader may not actually perform all the interventions, but may assign others to do so.

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, January 19, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Gubernatorial Appointment Hearing	Allan R. Schneider of Garden City, Idaho was reappointed to the Commission for the Blind and Visually Impaired to serve a term commencing July, 1, 2015 and expiring July 1, 2018.	**Allan R. Schneider**
Gubernatorial Appointment Hearing	Sue A. Payne of Boise, Idaho was reappointed to the Commission for the Blind and Visually Impaired to serve a term commencing July, 1, 2015 and expiring July 1, 2018.	**Sue A. Payne**
Gubernatorial Appointment Hearing	Britt Raubenheimer of Sandpoint, Idaho was reappointed to the Commission for the Blind and Visually Impaired to serve a term commencing July, 1, 2015 and expiring July 1, 2018.	**Britt Raubenheimer**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, January 19, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	Senator Lodge
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting to order at 3:01 p.m. and welcomed everyone to this meeting of the Senate Health and Welfare Committee (Committee). **Chairman Heider** said there would be three gubernatorial appointments to the Commission for the Blind and Visually Impaired (CBVI or Commission), for which they will serve a three-year term.

GUBERNATORIAL APPOINTMENT: **Consideration of Gubernatorial Appointment of Allan R. Schneider to the Commission for the Blind and Visually Impaired. Chairman Heider** introduced Allan R. Schneider and thanked him for being at the Committee meeting. **Chairman Heider** asked Mr. Schneider to tell the Committee about himself and why he would like to be appointed to the Commission.

Mr. Schneider stated he has been a high school English teacher for 35 years and currently resides in Garden City. **Mr. Schneider** said he was about 30 years old when he was diagnosed with retinitis pigmentosa, which he said is a progressive disease. After gaining the courage to admit he needed help, he went to the CBVI's Assessment and Training Center (ATC) and took classes in mobility, Braille, assisted technology and daily living. The CBVI training changed his and his wife's lives. **Mr. Schneider** said he didn't realize how much his wife had been looking out for him; now, he is able to go to many places on his own. Serving on the CBVI board gives him the opportunity to give back to those people who helped him so much.

Chairman Heider thanked Mr. Schneider and called for questions.

Senator Martin asked Mr. Schneider how long he has served on the CBVI board. **Mr. Schneider** replied this would be his third confirmation hearing. **Senator Martin** asked what Mr. Schneider feels he and the board have accomplished while he's served on the Commission and what he would like the CBVI accomplish in the future. **Mr. Schneider** credits CBVI accomplishments to its staff. He mentioned how students praised the CBVI ATC and told the board it had changed their attitudes and lives. **Mr. Schneider** also mentioned that, even during budget cut struggles, he had only heard success stories from regional offices. He said he would want to continue to try and cultivate a culture in which people are with the CBVI to serve.

Senator Hagedorn asked Mr. Schneider what he sees as the greatest challenge before the Commission right now. **Mr. Schneider** said the answer was easy: The new Workforce Innovation and Opportunity Act, which has imposed many new regulations. **Mr. Schneider** stated one of the regulations requires 15 percent of their money to be spent on students transitioning from school to work. He said the regulations don't stipulate as to what types of expenditures are included in that 15 percent, such as contracting special teachers, transportation, books or computers. **Mr. Schneider** said that being asked to comply to the rule, without actually knowing included expenditures, is the board's greatest challenge. **Senator Hagedorn** inquired about the primary sources of funding for the Commission. **Mr. Schneider** responded that the CBVI received both federal and state funding.

Senator Nuxoll asked Mr. Schneider to elaborate on how the CBVI helped him to get around better. **Mr. Schneider** explained that the training he received changed his life because he gained confidence to be in crowds, which was challenging when he first began losing his sight. Discussing ATC training, **Mr. Schneider** said that very student, no matter if they are partially sighted, is completely blinded by sleep shades in ATC classes, including wood shop classes. Mr. Schneider explained the reason for this teaching method is to show students that blind people can do everything anybody else can do – they just do it differently.

Senator Schmidt said, as a Senate committee, it is their responsibility to fulfill their obligation to confirm that Mr. Schneider has met the statutory requirements for his position. **Senator Schmidt** said one of the requirements for this position is that at least three of the five members of the board must be blind or visually impaired and asked Mr. Schneider if he can tell the committee if that's the case. **Mr. Schneider** confirmed this requirement. **Senator Schmidt** said the other requirement is that not more than three people shall belong to the same political party and asked Mr. Schneider to speak on that. **Mr. Schneider** said he is a registered Democrat but that he did not know the political affiliations of all members of the board.

GUBERNATORIAL APPOINTMENT:

Consideration of Gubernatorial Appointment of Sue A. Payne to the Commission for the Blind and Visually Impaired. Chairman Heider introduced Sue A. Payne and asked Ms. Payne to tell the Committee about herself and why she would like to be appointed to the Commission.

Ms. Payne said she's lived in Boise for 29 years and has worked for the Division of Vocational Rehabilitation for 27 of those years – first in Idaho Falls, then in Boise. By working in that field, she thought she knew a fair amount about blindness and visual impairment. But, after working for the CBVI for two years, she said she learned she didn't know much about blindness at all. **Ms. Payne** said being with the CBVI was a great learning experience. One of the things she learned is that you use your other senses so much more when you don't have your vision. **Ms. Payne** called herself the board's token person, having no visual impairment. She said she took ATC classes to get a better idea of the students' experience. **Ms. Payne** said students have mentioned that the ATC instructors are wonderful. A lot of the instructors are visually impaired or blind themselves, and they lead their students through daily activities that sighted people don't give much thought to. Some of ATC students who go through training continue on to college and various careers. Many have started businesses or have secured good-paying jobs.

Senator Martin asked Ms. Payne to discuss what she has accomplished on the CBVI board – and tell the Committee about what she would like to achieve in the future. **Ms. Payne** stated one of her main strengths as a commissioner is her experience with vocational rehabilitation and knowledge of both federal and state laws and regulations. **Ms. Payne** indicated that she works to ensure that the Commission remains in compliance with all relevant laws and regulations. **Ms. Payne** stated that, in the future, she wants to prepare the Commission to comply with the federal Workforce Innovation and Opportunity Act.

Senator Schmidt indicated that for reasons of statutory requirements, the Committee would like to know her political affiliation. **Ms. Payne** said she is registered as a Democrat. **Senator Schmidt** asked if Ms. Payne was confident that the Commission has the appropriate representation. **Ms. Payne** said yes.

GUBERNATORIAL APPOINTMENT:

Consideration of Gubernatorial Appointment of Britt Raubenheimer to the Commission for the Blind and Visually Impaired. Chairman Heider introduced Britt Raubenheimer and asked Ms. Raubenheimer to tell the Committee about herself and why she would like to be appointed to the Commission.

Ms. Raubenheimer said she lost her vision about 15 years ago and assumed she would lose her job and her independence. Staff from the CBVI came to her home and taught her how to use a computer, which is critical to her work since she telecommutes and does almost all her work on a computer. She said they also taught her how to use a cane to travel and taught her the skills of daily living necessary for her to be able to take care of herself. They taught her that she could have confidence and remain independent and successful in her career. That confidence, she said, is really important. She has served on the CBVI board for nine years and this will be her fourth appointment, if appointed. She would like to continue working with the CBVI board to ensure that blind Idahoans remain active and independent so they can contribute to their communities and have the ability to retain or gain employment.

Chairman Heider asked what she did for the Scripps Institute. **Ms. Raubenheimer** replied she did her PhD and post doctoral work at Scripps Institution of Oceanography. As an ocean physicist by training, Ms. Raubenheimer said she studies coasts, shallow waters and large lakes and examines the effects of extreme events like Hurricane Sandy.

Senator Martin asked Ms. Raubenheimer to discuss what she has accomplished while serving on the CBVI board – and tell the Committee about what she would like to achieve in the future. **Ms. Raubenheimer** said it would be hard to isolate what she has done alone, and noted that the board makes suggestions to improve CBVI services. In particular, Ms. Raubenheimer stated that the CBVI board implemented a "college days" program to provide visually impaired students who are starting college with extra training in how to take notes and care for themselves on their own. **Ms. Raubenheimer** noted improvements in data tracking and evaluations of new and existing programs. She also highlighted the addition of a traveling assistive technologist to the CBVI staff, who provides visually impaired people in outlying regions with computer and technology assistance. **Ms. Raubenheimer** stated that, in the future, she wanted the CBVI to spend funds in accordance with the federal Workforce Innovation and Opportunity Act and in a way that increases the employment rate of blind and visually impaired students.

Senator Hagedorn asked Ms. Raubenheimer to describe her greatest accomplishment since losing her vision. **Ms. Raubenheimer** responded she was scared to go out of her house, even to walk to the mailbox, when she first lost her vision; so being able to continue doing what she does could be her greatest accomplishment. She explained the first few years were really tough and that pushing herself – even when she was scared – helped her to succeed and build up her confidence. **Ms. Raubenheimer** said the CBVI really helped her with this accomplishment.

VOTE ON GUBERNATORIAL APPOINTMENT: The Committee voted by **voice vote** to confirm the Gubernatorial appointment of Britt Raubenheimer to the Commission for the Blind and Visually Impaired. **Senator Keough** will carry Ms. Raubenheimer's appointment to the floor.

VOTE ON GUBERNATORIAL APPOINTMENT: The Committee voted by **voice vote** to confirm the Gubernatorial appointment of Sue A. Payne to the Commission for the Blind and Visually Impaired. **Senator Hagedorn** will carry Ms. Payne's appointment to the floor.

VOTE ON GUBERNATORIAL APPOINTMENT: The Committee voted by **voice vote** to confirm the Gubernatorial appointment of Allan R. Schneider to the Commission for the Blind and Visually Impaired. **Senator Schmidt** will carry Mr. Schneider's appointment to the floor.

ADJOURNED: **Chairman Heider** thanked all three appointees for their service. There being no further business, **Chairman Heider** adjourned the meeting at 3:40 p.m.

Senator Heider
Chair

Karen Westbrook
Secretary

Kara Machado
Assistant

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, January 20, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Docket No. 16-0202-1501	PENDING RULE: Rules of the Idaho Emergency Medical Services (EMS) Physician Commission	**Dr. Curtis Sandy** Idaho EMS Physician Commission
Docket No. 16-0301-1501	PENDING RULE: Eligibility for Health Care Assistance For Families and Children	**Julie Hammon** Division of Welfare
Docket No. 16-0305-1501	PENDING RULE: Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)	**Callie Harrold** Division of Welfare
Docket No. 16-0305-1502	PENDING RULE: Rules Governing Eligibility for AABD	**Callie Harrold**
Presentation	Prevention of Suicide in Idaho	**Dr. Linda Hatzenbuehler** Idaho Council on Suicide Prevention and **Dr. Robert Polk** Health Quality Planning Commission

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
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MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, January 20, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	Senators Lodge and Hagedorn
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:10 p.m.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Nuxoll to conduct the rules review.
DOCKET NO. 16-0202-1501	**Rules of the Department of Health and Welfare Relating to the Idaho Emergency Medical Services (EMS) Physician Commission. Dr. Curtis Sandy**, Chairman of the Idaho EMS Physician Commission (Commission), presented this docket. **Dr. Sandy** informed the Committee that the Commission maintains a standards manual, Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual (Manual), that describes the skills, treatments and procedures that licensed EMS personnel in Idaho may perform (see attachment 1). **Dr. Sandy** reported that changes were made to the Manual to reflect current best practices in EMS and include technical changes to align the Manual with the EMS education requirements. In addition, language was added that requires licensed paramedics to receive appropriate training and assessment prior to performing certain critical care interventions. **Dr. Sandy** explained that remaining changes reflect the incremental evolution of the scope of practice for various levels of EMS providers in Idaho. **Vice Chairman Nuxoll** called for questions. **Senator Lee** asked how many EMS providers are certified to perform critical care interventions in Idaho, specifically in rural areas. **Dr. Sandy** replied very few paramedics operate in rural areas and noted that the majority of critical care is performed in urban centers. **Senator Schmidt** sought clarification on whether the rule will go in to effect July 1, 2016, or at the end of the current legislative session. **Dr. Sandy** replied that in past sessions, there was a choice of date of enactment. He indicated that July 1 enactment is preferred so that statewide protocols correspond with the scope of practice. **Chairman Heider** clarified that the rules will go in to effect on July 1, 2016. **Vice Chairman Nuxoll** asked how often the Manual is revised and sought clarification on what "2011" refers to in the Manual. **Dr. Sandy** replied that the Manual is update annually. He then explained that "2011" refers to new licensure levels established in 2011.
MOTION:	There being no more questions, **Senator Martin** moved to approve **Docket No. 16-0202-1501**. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0301-1501 **Rules of the Department of Health and Welfare Relating to Eligibility for Health Care Assistance for Families and Children. Julie Hammon**, Deputy Administrator for the Division of Welfare, presented this docket. **Ms. Hammon** stated that the proposed rules address the reinstatement of the transitional Medicaid program for adults with children who have income below 26 percent of the federal poverty limit and who are currently receiving Medicaid but may lose benefits due to increased earnings. The purpose of this program is to transition families off Medicaid when a family member gains employment, incentivizing individuals to find work without fear of losing coverage by allowing 12 months of Medicaid coverage during job transition. Congress reinstated the transitional Medicaid program last year, as part of the children's health insurance program reauthorization. The reinstatement of the transitional Medicaid program in Idaho will bring the state back into compliance with federal regulations. **Ms. Hammon** indicated the Division of Welfare expects 2,700 participants each year, generating $9,771,060 in Medicaid payments to be administered annually, with $2,842,411 from the General Fund. **Ms. Hammon** reported that the proposed rules also remove specific references to "eligible institutions," which are already defined in IDAPA 16-0305-0107. Further, the proposed rules will remove reference to eligibility of individuals who are non-citizens and have a lawful status of employment but are not eligible for Medicaid benefits in Idaho, preventing erroneous payments. **Ms. Hammon** stated no negative comments were received during the public comment period.

Vice Chairman Nuxoll called for questions.

Senator Martin inquired if the 12-month coverage period was federally mandated. **Ms. Hammon** explained that mandate allows for a 6- or 12-month coverage period, but historically the 12-month period created a more efficient coverage process. **Senator Martin** then asked if the $9,771,060 is the cost of continuing to provide this service for 12 months to eligible individuals. **Ms. Hammon** affirmed.

Senator Jordan sought clarification on program costs. **Ms. Hammon** affirmed that $9,771,060 was the total cost, with $2,842,411 from the Idaho General Fund. **Senator Jordan** followed up by asking what the standard probationary time is for a newly employed individual to wait for health insurance benefits, and what the cost would be, in the form of additional benefits, for individuals who are unemployed for this same period of time. **Ms. Hammon** replied that she would seek more information regarding probationary periods and agreed that there would be costs related to other services provided for individuals who are unemployed.

Senator Lee asked if Idaho was currently out of compliance with federal rules and if there are related consequences. **Ms. Hammon** affirmed that Idaho is out of compliance, however, Idaho is still required to provide transitional Medicaid services.

Senator Schmidt asked for a general description of income level for an individual seeking transitional services. **Ms. Hammon** explained that only adults with children are eligible and stated that a family of two that makes $500 a month reaches the threshold to lose Medicaid coverage.

Vice Chairman Nuxoll inquired whether the rule changes were made to bring Idaho in compliance with federal code, to which **Ms. Hammon** affirmed. **Vice Chairman Nuxoll** sought clarification regarding the criteria for families seeking transitional services and **Ms. Hammon** responded that families with children losing Medicaid coverage due to increased earnings are eligible. **Vice Chairman Nuxoll** then sought clarification on why language referencing "eligible institution," was removed, to which **Ms. Hammon** explained that the language removes reference to the rule defining "eligible institution" which is defined separately.

MOTION: There being no more questions, **Chairman Heider** moved to approve **Docket No. 16-0301-1501**. **Senator Schmidt** seconded the motion. **Vice Chairman Nuxoll** stated her opposition to the transitional Medicaid program, commenting that eligibility should be determined on a case-by-case basis. **Vice Chairman Nuxoll** and **Senators Harris** and **Martin** asked to be recorded voting as nay. The motion carried by **voice vote**.

DOCKET NO. 16-0305-1501 **Rules of the Department of Health and Welfare Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD). Callie Harrold**, Medicaid Policy Specialist for the Division of Welfare, presented this docket. **Ms. Harrold** explained that when determining eligibility for long-term care services, a participant's total income is examined to determine if the participant must share in the cost of services, referred to as "share of costs." When determining share of costs, the participant's total income minus allowable expenses is examined. **Ms. Harrold** stated the rule change clarifies allowable expenses to include medical expenses incurred up to three months prior to application for assistance. She indicated the fiscal impact would be $403,600, with $120,960 from the General Fund, and that the rule change brings Idaho into compliance with federal regulations. **Ms. Harrold** pointed out that this was not negotiated rulemaking, but positive feedback was received.

MOTION: There being no questions, **Senator Schmidt** moved to approve **Docket No. 16-0305-1501**. **Senator Jordan** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0305-1502 **Rules of the Department of Health and Welfare Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD). Callie Harrold**, Medicaid Policy Specialist for the Division of Welfare, presented this docket. **Ms. Harrold** introduced the first rule change, which updates how self-employment is calculated when determining eligibility for the AABD program. The rule change removes the standard 50 percent deduction of self-employment income, instead using the actual self-employment expenses incurred. **Ms. Harrold** pointed out that this change aligns with other self-employment income formulas for all other Medicaid programs. She continued to explain the second rule change, which removes reference to the eligibility of individuals who are non-citizens and have a lawful employment status. She stated that these individuals are not eligible for Medicaid and the conflicting language was removed to prevent erroneous payments. **Ms. Harrold** reported that this was not negotiated rulemaking, but no negative feedback was received.

Vice Chairman Nuxoll called for questions.

Senator Schmidt asked if the self-employment deduction is applied to all eligibility determinations, to which **Ms. Harrold** replied that the rule change aligns AABD self-employment income calculation with federal Medicaid rules.

MOTION: There being no questions, **Senator Harris** moved to approve **Docket No. 16-0305-1502**. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

PASSED THE GAVEL: Vice Chairman Nuxoll passed the gavel back to Chairman Heider.

PRESENTATION: **Prevention of Suicide in Idaho**. **Dr. Linda Hatzenbuehler**, Chair of the Idaho Council of Suicide Prevention (Council); **Kim Kane**, Program Director for the Idaho Lives Project; and **Dr. Robert Polk**, Chair of the Health Quality Planning Commission (HQPC) made this presentation before the Committee.

Dr. Hatzenbuehler stated that the Council was developed by executive order in 2006 with the purpose of preventing deaths by suicide in Idaho and consists of community stakeholders from across the state. Reporting that death by suicide was a significant public health issue in Idaho, **Dr. Hatzenbuehler** presented statistics on Idaho suicide rates in Idaho and illustrated the related economic impact (see attachment 2). She reported that the number of deaths by suicide per capita in Idaho is among the highest in the nation, pointing out that the gap between the Idaho and national per capita rate is growing. **Dr. Hatzenbuehler** provided the Committee with (i) the Council's 2015 annual report (see attachment 3), (ii) the Idaho suicide prevention plan (see attachment 4) and (iii) a fact sheet related to suicide in Idaho prepared by the Suicide Prevention Action Network of Idaho (see attachment 5). **Dr. Hatzenbuehler** highlighted SCR 104, passed in 2014, which authorized the HQPC to implement the Idaho suicide prevention plan. **Dr. Hatzenbuehler** concluded her portion of the presentation by reiterating that deaths by suicide are preventable by implementing appropriate prevention programs.

Kim Kane, Program Director for the Idaho Lives Project, presented statistical trends in suicide rates and introduced successful prevention strategies (see attachment 2). She reported that recent suicide rates have been affected by the state of the economy, reporting an increase in suicide rates in relation to economic downturn. **Ms. Kane** pointed out that Idaho ranks in the top ten states of completed suicides per capita. **Ms. Kane** then highlighted effective strategies that help reduce deaths by suicide, including (i) effective state leadership, (ii) youth training programs, (iii) hotlines and (iv) public awareness via media campaigns.

Dr. Polk stated that the HQPC was established by the Legislature in 2006 and charged with examining the quality of care of Idahoans. He explained that 2014 SCR 104 charged the HQPC with implementing a comprehensive suicide prevention plan. The plan and corresponding budget was approved by the HQPC in December 2015. **Dr. Polk** reviewed statistical information pertaining to suicide rates and related economic costs (see attachment 6).

Dr. Polk stated that the HQPC set a goal to reduce suicide rates in Idaho by 10 percent by the year 2020 and he noted that implementation of the comprehensive suicide prevention plan would require an additional $971,102, which was not integrated in the FY 2017 Department of Health and Welfare budget request.

Dr. Polk then highlighted and discussed four priority initiatives (see attachment 6), including:

1. Creation of an office of suicide prevention, established within the Division of Public Health, to coordinate and implement effective prevention programs;
2. Youth training administered by the Idaho Lives Project, reaching 50 percent of middle and high school student over a five-year period;
3. Sustainable funding for the Idaho suicide prevention hotline to support 60 percent of its operations; and
4. Funding for public awareness campaigns, which are common in most public health initiatives and create awareness at the individual and community levels, provide information about how to seek help and increase awareness about mental illness.

Dr. Polk then briefly reviewed the remaining eight initiatives (see attachment 6), including (i) gatekeeper training, (ii) media training, (iii) behavioral health clinicians training, (iv) follow-up for suicidal patients, (v) immediate coroner reporting for suicide, (vi) professionals training, (vii) suicide support group training, (viii) obtain accurate and adequate suicide data reporting (see attachment 6).

Chairman Heider called for questions.

Vice Chairman Nuxoll asked if the statistics gathered per county were aggregated per 100,000; if so, how such data is collected for counties with populations less than 100,000. **Dr. Polk** answered that a mathematical adjustment is made to accurately reflect smaller populations.

Senator Harris asked why Idaho has such high suicide rates. **Dr. Polk** replied that there is no clear answer because it is a complex issue. He indicated that intermountain west states have the highest rates of suicide and described a current theory pertaining to "thwarted belongingness," which implies a relationship between suicide rates and a lack of human connection.

Chairman Heider inquired if there was a way to identify individuals with a suicide plan or intention to commit suicide. **Dr. Polk** stated that data is typically self-reported, but by providing youth training and making suicide prevention hotlines available, early identification and recognition of planning may be possible.

Vice Chairman Nuxoll asked why suicide rates among males are higher than females. **Dr. Polk** responded there is no definitive answer.

Chairman Heider asked how much money is needed to fund suicide prevention programs in a meaningful way. **Dr. Polk** asked Elke Shaw-Tulloch, Administrator for the Division of Public Health, to respond. **Ms. Shaw-Tulloch** recognized the difficulty in determining appropriate funding levels for such programs but noted that the Division of Public Health assisted the HQPC in establishing a conservative budget, based on other behavioral health programs. She indicated the tobacco program was used as a comparative example of best practices.

Senator Martin asked if efforts have been made to prioritize the initiatives outlined by the HQPC, to which **Dr. Polk** responded that the top four initiatives outlined in depth in his testimony are of top priority. **Senator Martin** followed up by asking if less money allocated for youth training would result in less than 50 percent of students receiving training, which **Dr. Polk** affirmed.

Chairman Heider thanked the presenters for their time and reiterated the commitment of the Legislature to reduce deaths by suicide in Idaho.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:30 p.m.

Senator Heider
Chair

Karen Westbrook
Secretary

Jennifer Carr
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Wednesday January 20, 2016

ATTACHMENT 1

STATE OF IDAHO

EMS PHYSICIAN COMMISSION

STANDARDS MANUAL

Authority:
Idaho Code § 56-1013A, § 56-1016, and § 56-1017(1)

Rules for EMS Physician Commission Idaho Administrative Procedures Act 16.02.02

Edition 2016-1

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Idaho EMS Physician Commission Standards Manual
Edition 2016-1
Effective July 1, 2016

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I. DEFINITIONS.

As promulgated by and in addition to the applicable definitions in Section 56-1012, Idaho Code, and IDAPA 16.01.02, Idaho Department of Health and Welfare, "Rules Governing Emergency Medical Services," the following terms are used in this manual as defined below:

Advanced Emergency Medical Technician (AEMT). A person who holds a current active license issued by the Bureau at the Advanced Emergency Medical Technician level and is in good standing with no restriction upon, or actions taken against, his license.

Affiliation. The recognition of an individual as a member or employee.

Bureau of Emergency Medical Services and Preparedness. The Bureau of Emergency Medical Services and Preparedness of the Idaho Department of Health and Welfare, hereafter referred to as "the Bureau."

Contemporaneous. Originating, existing, or occurring during the same period of time.

Credentialed EMS Personnel. Individuals who are authorized to provide medical care by the EMS medical director, hospital supervising physician, or medical clinic supervising physician.

Credentialing. The local process by which licensed EMS personnel are authorized to provide medical care in the out-of-hospital, hospital, and medical clinic setting, including the determination of a local scope of practice.

Critical Care Paramedic. A person who holds a current active license issued by the Bureau at the Paramedic or Emergency Medical Technician-Paramedic level and has successfully completed training objectives as set forth in the Critical Care Transport Curriculum Guide of the Bureau and who possesses a current active credential to provide Critical Care.

Critical Care Transport. The transportation of a patient with continuous care, monitoring, medication, or procedures requiring knowledge or skills not contained within the Paramedic curriculum approved by the State Health Officer.

Designated Clinician. A licensed Physician Assistant (PA) or Nurse Practitioner designated by the EMS medical director, hospital supervising physician, or medical clinic supervising physician who is responsible for direct (on-line) medical supervision of licensed EMS personnel in the temporary absence of the EMS medical director.

Direct (On-Line) Supervision. Contemporaneous instructions and directives about a specific patient encounter provided by a physician or designated clinician to licensed EMS personnel who are providing medical care.

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Emergency Medical Services (EMS). Under Section 56-1012(12), Idaho Code, emergency medical services or EMS is aid rendered by an individual or group of individuals who do the following:

a. Respond to a perceived need for medical care in order to prevent loss of life, aggravation of physiological or psychological illness, or injury;
b. Are prepared to provide interventions that are within the scope of practice as defined by the Idaho Emergency Medical Services Physician Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission";
c. Use an alerting mechanism to initiate a response to requests for medical care; and
d. Offer, advertise, or attempt to respond as described in Section 56-1012(12), (a) through (c), Idaho Code.
e. Aid rendered by a ski patroller, as described in Section 54-1804(1)(h), Idaho Code, is not EMS.

Emergency Medical Services Physician Commission. The Idaho Emergency Medical Services Physician Commission as created under Section 56-1013A, Idaho Code, hereafter referred to as "the Commission."

Emergency Medical Responder (EMR). A person who holds a current active license issued by the Bureau at the First Responder or Emergency Medical Responder level and is in good standing with no restriction upon, or actions taken against, his license.

Emergency Medical Technician (EMT). A person who holds a current active license issued by the Bureau at the Emergency Medical Technician or Emergency Medical Technician-Basic level and is in good standing with no restriction upon, or actions taken against, his license.

EMS Agency. An organization licensed by the Bureau to provide emergency medical services in Idaho.

EMS Medical Director. A physician who supervises the medical activities of licensed personnel affiliated with an EMS agency.

Hospital. A facility in Idaho licensed under Sections 39-1301 through 39-1314, Idaho Code, and defined in Section 39-1301(a)(1), Idaho Code.

Hospital Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a hospital.

Indirect (Off-Line) Supervision. The medical oversight provided by a physician to licensed EMS personnel who are providing medical care. The components of medical supervision include EMS system design, education, quality management, patient care guidelines, medical policies, and compliance.

License. A license issued by the Bureau to an individual for a specified period of time indicating that minimum standards corresponding to one (1) of several levels of EMS proficiency have been met.

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Licensed EMS Personnel. Individuals who possess a valid license issued by the Bureau.

Medical Clinic. A place devoted primarily to the maintenance and operation of facilities for outpatient medical, surgical, and emergency care of acute and chronic conditions or injury.

Medical Clinic Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a medical clinic.

Medical Supervision. The advice and direction provided by a physician, or under the direction of a physician, to licensed EMS personnel who are providing medical care, including direct and indirect supervision.

Medical Supervision Plan (MSP). The written document describing the provisions for medical supervision of licensed EMS personnel.

Nurse Practitioner. An Advanced Practice Professional Nurse, licensed in the category of Nurse Practitioner, as defined in IDAPA 23.01.01, "Rules of the Idaho Board of Nursing."

Out-of-hospital. Any setting outside of a hospital, including inter-facility transfers, in which the provision of emergency medical services may take place.

Paramedic. A person who holds a current active license issued by the Bureau at the Paramedic or Emergency Medical Technician-Paramedic level and is in good standing with no restriction upon, or actions taken against, his license.

Physician. A person who holds a current active license issued by the Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho and is in good standing with no restriction upon, or actions taken against, his license.

Physician Assistant. A person who meets all the applicable requirements to practice as a licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants."

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II. EMS Physician Commission Standards Manual Authority

Idaho Code 56-1013A(1) empowers the EMS Physician Commission with statutory authority to establish standards for scope of practice and medical supervision for licensed personnel, air medical, ambulance, and non-transport agencies licensed by the Bureau. Idaho Code 56-1017(1) specifically authorizes and directs the Commission to adopt appropriate rules defining the allowable scope of practice and acts and duties which can be performed by persons licensed by the department and the required level of supervision by a licensed physician.

IDAPA 16.02.02, "Rules of the EMS Physician Commission," Section 004 incorporate this EMS Physician Commission Standards Manual by reference. The purposes of this EMS Physician Commission Standards Manual are to establish the scope of practice of licensed EMS personnel and to specify the type and degree of medical supervision for specific skills, treatments, and procedures by level of EMS licensure.

III. EMS Personnel Authority to Act

To provide emergency medical services, EMS licensed personnel must comply with Idaho Code and IDAPA 16.02.02, "Rules of the EMS Physician Commission." The policies of the EMS Physician Commission are documented in this Standards Manual.

Licensed EMS personnel who are representing an Idaho EMS agency and who possess a valid credential issued by that agency's EMS medical director may act and provide services in the out-of-hospital setting under the following conditions:

1. When participating in a planned deployment of personnel resources approved by the EMS medical director; or
2. When administering first aid or emergency medical attention as a "Good Samaritan" and without expectation of remuneration in accordance with Idaho Code 5-330 or 5-331 in a manner approved by the EMS medical director; or
3. When participating in a training program approved by the Bureau or the EMS medical director.
4. When on duty, visibly display at all times identification specifying name and level of EMS licensure.

In addition, licensed EMS personnel may only provide out-of-hospital care when:

1. The patient care does not exceed the scope of practice as defined by this Standards Manual; and
2. Licensed EMS personnel have been trained, based on curricula or specialized training approved according to IDAPA 16.01.05, Idaho Department of Health and Welfare, "Emergency Medical Services (EMS) – Education, Instructor, and Examination Requirements" and
3. The patient care does not exceed the scope of practice approved by their EMS medical director and does not include assessments or interventions that have been specifically

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prohibited by their EMS medical director.

Licensed EMS personnel who are representing a hospital or medical clinic and who possess a valid credential issued by the hospital or medical clinic supervising physician may act and provide services in the hospital and medical clinic setting under the following conditions:

1. When participating in a planned deployment of personnel resources approved by the hospital or medical clinic supervising physician; or
2. When administering first aid or emergency medical attention as a "Good Samaritan" and without expectation of remuneration in accordance with Idaho Code 5-330 or 5-331 in a manner approved by the hospital or medical clinic supervising physician; or
3. When participating in a training program approved by the Bureau or the hospital or medical clinic supervising physician.

In addition, licensed EMS personnel may only provide hospital and medical clinic care when:

1. Licensed EMS personnel have been trained, based on curricula or specialized training approved according to IDAPA 16.01.05, Idaho Department of Health and Welfare, "Emergency Medical Services (EMS) – Education, Instructor, and Examination Requirements," or additional training approved by the hospital or medical clinic supervising physician and
2. The patient care does not exceed the scope of practice approved by their hospital or medical clinic supervising physician and does not include assessments or interventions that have been specifically prohibited by their hospital or medical clinic supervising physician.

IV. OUT-OF-HOSPITAL SUPERVISION

All Idaho-licensed EMS agencies, including hospital-based EMS agencies, must comply with the requirements described in this section. Hospital-based EMS agencies must comply with both the requirements described in this section and with the hospital and clinic supervision requirements described later in this Standards Manual when their licensed EMS personnel also have patient care duties in the hospital or clinic setting.

EMS Medical Director Qualifications, Authority and Responsibility.

In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated EMS medical director.

1. The EMS agency must designate a physician for the medical supervision of licensed EMS personnel affiliated with the EMS agency.
2. The EMS medical director can designate other physicians to supervise the licensed EMS personnel in the temporary absence of the EMS medical director.

The EMS medical director will have a written agreement with the EMS agency(s) that includes the following elements:

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1. Identification of the EMS agency(s) for which he provides medical supervision.
2. Acknowledgement of the authority of the EMS medical director as established in Idaho statute and IDAPA 16.02.02, "Rules of the EMS Physician Commission."
3. An effective date.
4. An expiration date or a provision for automatic renewal upon mutual agreement.
5. Assurance of EMS medical director access to relevant agency, hospital, or medical clinic records as permitted or required by statute to ensure responsible medical supervision of licensed EMS personnel.

The EMS medical director will provide the Bureau with documentation of the written agreement annually or upon request.

The EMS medical director must:

1. Accept responsibility for the medical direction and medical supervision of the activities provided by licensed EMS personnel.
2. Obtain and maintain knowledge of the contemporary design and operation of EMS systems.
3. Obtain and maintain knowledge of Idaho EMS laws, regulations and standards manuals.
4. The EMS medical director shall demonstrate appropriate training and/or expertise in adult and pediatric emergency medical services.
5. The EMS medical director for an air medical agency, in addition to the above requirements, must have training and experience in emergency medicine or critical care and have training in air ambulance operations that include flight physiology, stressors of flight, and air medical resource management.

The EMS medical director is authorized to:

1. Provide explicit approval for licensed EMS personnel under his supervision to provide medical care. Licensed EMS personnel may not provide medical care without the explicit approval of an EMS medical director.
2. Credential licensed EMS personnel under his supervision with a scope of practice. This scope of practice may be limited relative to the scope of practice authorized by the Commission and may not exceed the scope of practice established by the Commission.
3. Restrict the scope of practice of licensed EMS personnel under his supervision and withdraw approval of licensed EMS personnel to provide services when such personnel fail to meet or maintain proficiencies established by the EMS medical director or the Idaho EMS Bureau.
    a. Such restriction or withdrawal of approval must be reported in writing within fifteen (15) days of the action to the Bureau in accordance with Section 39-1393, Idaho Code.

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The EMS medical director is responsible for:

1. Approving the planned deployment of personnel resources.
2. Approving the manner in which licensed EMS personnel administer first aid or emergency medical attention as a "Good Samaritan" in accordance with Section 5-330 or 5-331, Idaho Code, without expectation of remuneration.
3. Documenting the review of the qualification, proficiencies, and all other EMS agency, hospital, and medical clinic affiliations of EMS personnel prior to credentialing the individual.
4. Documenting that the capabilities of licensed EMS personnel are maintained on an ongoing basis through education, skill proficiencies, and competency assessment.
5. Developing and implementing a program for continuous assessment and improvement of services by licensed EMS personnel under their supervision.
6. Reviewing and updating protocols, policies, and procedures at least every two (2) years.
7. Developing, implementing and overseeing a Medical Supervision Plan, as defined in this Standards Manual.
8. Collaborating with other EMS medical directors, hospital supervising physicians, and medical clinic supervising physicians to ensure EMS agencies and licensed EMS personnel have protocols, standards of care, and procedures that are consistent and compatible with one another.
9. Designating other physicians to supervise licensed EMS personnel in the temporary absence of the EMS medical director.
10. Designating Physician Assistants and Nurse Practitioners to serve as designated clinicians, as defined in this Standards Manual.

Direct Medical Supervision by Physician Assistants and Nurse Practitioners.

The EMS medical director can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct (on-line) medical supervision of licensed EMS personnel. Such designated clinicians may only provide direct medical supervision when a designated physician is not present in the anticipated receiving health care facility. The following conditions must also be satisfied:

1. A written agreement between the designated Nurse Practitioner and the EMS medical director which describes the role and responsibilities of the designated Nurse Practitioner is required.
2. A written agreement between the designated PA and the EMS medical director which describes the role and responsibilities of the designated PA related to supervision of EMS personnel is required.
3. Designated clinicians must possess and be familiar with the Medical Supervision Plan, as defined in this Standards Manual, protocols, standing orders, and standard operating procedures authorized by the EMS medical director.

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4. The physician supervising the PA, as defined in IDAPA 22.01.03, Idaho Department of Health and Welfare, "Rules for the Licensure of Physician Assistants," must authorize the designated PA to provide direct (on-line) supervision.

Provisions for direct medical supervision by designated clinicians must be documented in the Medical Supervision Plan.

Medical Supervision Plan for the Out-Of-Hospital Setting.

The medical supervision of licensed EMS personnel must be provided in accordance with a documented Medical Supervision Plan (MSP) that includes direct, indirect, on-scene, educational, and proficiency standards components. The EMS medical director is responsible for developing, implementing, and overseeing the MSP. However, non-physicians can assist the EMS medical director with the indirect medical supervision of licensed EMS personnel. The EMS medical director will submit the MSP to the Bureau upon request by the Bureau or the Commission. Medical Supervision Plans must be submitted within thirty (30) days of request. The Bureau must be notified of any changes in the MSP, including changes in designated clinicians, within thirty (30) days of the change(s).

At a minimum, the MSP must consist of the following elements:

A. Credentialing of licensed EMS personnel.

Credentialing is an EMS agency process by which licensed EMS personnel are authorized by the EMS medical director to provide medical care in accordance with a scope of practice that is established by the EMS medical director. The process for credentialing licensed EMS personnel is an extension of the "affiliating" of personnel and is consistent with contemporary EMS system design.

The process for credentialing will include the following:

1. Verification of Bureau licensure;
2. Affiliation to the EMS agency;
3. Review of the qualifications and proficiencies of the EMS provider, and all other EMS agency, hospital, and medical clinic affiliations.
4. Completion of an EMS agency orientation, as prescribed by the EMS agency, that includes:
    a. EMS agency policies;
    b. EMS agency procedures;
    c. Medical treatment protocols;
    d. Radio communications procedures;
    e. Hospital/facility destination policies;
    f. Other unique system features.

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Upon successful completion of the credentialing process, the EMS medical director may issue the EMS provider with a card, certificate, or other document which indicates explicit approval to provide patient care and specifically authorizes a scope of practice for the EMS provider.

- This credential should include a specific expiration date which may be the same date of expiration as the Bureau license.
- This credential will be sufficient evidence of "affiliation" for his or her license or renewal by the Bureau, if the dates are inclusive of the licensure period and the credential has not been withdrawn by the EMS medical director.

B. Indirect (off-line) medical supervision.

Indirect (off-line) supervision will include all of the following:

1. Written standing orders and treatment protocols for both adult and pediatric patients including direct (on-line) supervision criteria;
2. Description of authorized optional psychomotor skills and patient care interventions, as defined by the Commission;
3. Initial and continuing education in addition to those required by the Bureau;
4. Methods of assessment and improvement;
5. Periodic assessment of psychomotor skill proficiency;
6. Provisions for medical supervision of and defining the patient care provided by licensed EMS personnel who are present for a multiple or mass casualty incident, disaster response, or other significant event involving response of licensed EMS personnel;
7. Defining the response when licensed EMS personnel discover a need for EMS while not on duty;
8. The credentialing of licensed EMS personnel for emergency response;
9. The appropriate level of emergency response based upon dispatch information provided by the designated Public Safety Answering Point(s);
10. Triage, treatment, and transport guidelines;
11. Scene management for multiple EMS agencies anticipated to be on scene concurrently;
12. Criteria for determination of patient destination;
13. Criteria for utilization of air medical services in accordance with IDAPA 16.01.03, Idaho Department of Health and Welfare, "Emergency Medical Services (EMS) – Agency Licensing Requirements," Section 700-799;
14. Policies and protocols for patient refusal, "treat and release", advanced directives by patients and physicians, determination of death, termination of resuscitation and other predictable patient non-transport scenarios;
15. Criteria for cancellation or modification of EMS response;
16. Equipment authorized for patient care;

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17. Medical communications guidelines; and
18. Methods and elements of documentation of services provided by licensed EMS personnel.
19. Policies and protocols for the identification, treatment and transport of patients with ST-elevation myocardial infarction to ensure timely re-perfusion therapy.
20. Policy for recognition and utilization of bystander providers that are not credentialed by the local EMS system.

C. Direct (on-line) medical supervision.

Direct supervision may be accomplished by concurrent communication with the EMS medical director, other physicians designated by the EMS medical director, or designated clinicians, who must be available twenty-four (24) hours a day seven (7) days a week. Provisions for direct supervision, including on-scene supervision, will be documented in the MSP which shall identify designated clinicians.

The EMS medical director will develop and implement procedures in the event of on-scene supervision by:

1. The EMS medical director or other physician(s) designated by the EMS medical director;
2. A physician with a pre-existing relationship with the patient; and
3. A physician with no pre-existing relationship with the patient who may or may not be present for the duration of treatment on scene or transportation.

Direct supervision of licensed EMS personnel by other persons is prohibited except in the manner described in the MSP.

Designated on-line physicians and clinicians shall have appropriate training and/or expertise in adult and pediatric emergency care.

D. Standards of supervision and training for students of state-approved training programs.

The EMS medical director, in collaboration with the course medical director or course coordinator, will define standards of supervision and training for students of state-approved training programs, who have been placed for clinical practice and training. These standards will be defined, identified, and documented in the MSP.

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V. HOSPITAL AND MEDICAL CLINIC SUPERVISION

Licensed EMS Personnel Responsibilities.

The licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic must:

1. When on duty, visibly display at all times identification specifying their level of EMS licensure.
2. Report such employment or utilization to the Bureau within thirty (30) days of engaging in such activity.

Licensed EMS personnel will only provide patient care with on-site contemporaneous supervision by the hospital supervising physician, medical clinic supervising physician or designated clinicians, as defined in this Standards Manual.

Hospital Supervising Physician and Medical Clinic Supervising Physician Qualifications, Authority and Responsibility.

In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated hospital supervising physician or medical clinic supervising physician.

1. The hospital or medical clinic administration must designate a physician for the medical supervision of licensed EMS personnel employed or utilized in the hospital or medical clinic.
2. The hospital supervising physician or medical clinic supervising physician can designate other physicians to supervise the licensed EMS personnel during the periodic absence of the hospital supervising physician or medical clinic supervising physician.
3. Licensed EMS personnel will only provide patient care with on-site contemporaneous supervision by the hospital supervising physician, medical clinic supervising physician or designated clinicians, who are defined in this Standards Manual.

The hospital supervising physician and medical clinic supervising physician must:

1. Accept responsibility for the medical direction and medical supervision of the activities provided by licensed EMS personnel.
2. Obtain and maintain knowledge of the contemporary design and operation of EMS systems.
3. Obtain and maintain knowledge of Idaho EMS laws, regulations and standards manuals.

The hospital supervising physician and medical clinic supervising physician are authorized to:

1. Provide explicit approval for licensed EMS personnel under his supervision to provide medical care. Licensed EMS personnel may not provide medical care without the explicit approval of a hospital supervising physician or medical clinic supervising physician.

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2. Credential licensed EMS personnel under his supervision with a scope of practice. This scope of practice may be limited relative to the scope of practice authorized by the Commission. If the authorized scope of practice exceeds the out-of-hospital scope of practice established by the Commission, the hospital supervising physician and/or medical clinic supervising physician must approve additional training to ensure competency in the expanded scope of practice. The Commission recognizes that hospital and medical clinic policies, state rules and the local community standard of care will influence the specific elements of any expanded scope of practice and the development of additional local oversight requirements.
3. Restrict the scope of practice of licensed EMS personnel under his supervision and to withdraw approval of licensed EMS personnel to provide services when such personnel fail to meet or maintain proficiencies established by the hospital supervising physician or medical clinic supervising physician or the Bureau.
    - Such restriction or withdrawal of approval must be reported in writing within fifteen (15) days of the action to the Bureau in accordance with Section 39-1393, Idaho Code.

The hospital supervising physician and medical clinic supervising physician are responsible for:

1. Approving the planned deployment of personnel resources.
2. Approving the manner in which licensed EMS personnel administer first aid or emergency medical attention as a "Good Samaritan" in accordance with Section 5-330 or 5-331, Idaho Code, without expectation of remuneration.
3. Approving additional training when the local scope of practice exceeds the out-of-hospital scope of practice established by the Commission.
4. Documenting the review of the qualification, proficiencies, and all other EMS agency, hospital, and medical clinic affiliations of EMS personnel prior to credentialing the individual.
5. Documenting that the capabilities of licensed EMS personnel are maintained on an ongoing basis through education, skill proficiencies, and competency assessment.
6. Developing, implementing and overseeing a Medical Supervision Plan, as defined in this Standards Manual.
7. Collaborating with other EMS medical directors, hospital supervising physicians, and medical clinic supervising physicians to ensure EMS agencies and licensed EMS personnel have protocols, standards of care and procedures that are consistent and compatible with one another.
8. Designating other physicians to supervise the licensed EMS personnel during the periodic absence of the hospital supervising physician or medical clinic supervising physician.
9. Designating Physician Assistants and Nurse Practitioners to serve as designated clinicians, as defined in this Standards Manual.

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Direct Medical Supervision by Physician Assistants and Nurse Practitioners.

The hospital supervising physician or medical clinic supervising physician can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct (on-line) medical supervision of licensed EMS personnel under the following conditions:

1. A written agreement between the designated Nurse Practitioner and the hospital supervising physician or medical clinic supervising physician which describes the role and responsibilities of the designated Nurse Practitioner is required,
2. A written agreement between the designated PA and the hospital supervising physician or medical clinic supervising physician which describes the role and responsibilities of the designated PA related to supervision of EMS personnel is required,
3. Designated clinicians must possess and be familiar with the Medical Supervision Plan, as defined in this Standards Manual, protocols, standing orders, and standard operating procedures authorized by the hospital supervising physician or medical clinic supervising physician.
4. The physician supervising the PA, as defined in IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," must authorize the designated PA to provide direct (on-line) supervision.

Provisions for direct medical supervision by designated clinicians must be documented in the Medical Supervision Plan.

Medical Supervision Plan for the Hospital and Medical Clinic Settings.

The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan (MSP). The hospital supervising physician or medical clinic supervising physician is responsible for developing, implementing, and overseeing the MSP.

The MSP will include:

1. A credentialing process for licensed EMS personnel as defined by the hospital or medical clinic.
2. A current written description of acts and duties authorized by the hospital supervising physician or medical clinic supervising physician for credentialed EMS personnel.
3. The hospital or medical clinic will submit such descriptions upon request of the Commission or the Bureau.
4. Provisions for direct medical supervision by designated clinicians and the identification of designated clinicians.

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VI. BUREAU RESPONSIBILITIES.

The Bureau will provide:

1. Technical assistance to medical directors, hospital supervising physicians, medical clinic supervising physicians, and their administrators to develop appropriate Medical Supervision Plans.
2. The Commission with EMS agency Medical Supervision Plans upon request.
3. The Commission with the identification of EMS medical directors and their designated clinicians annually and upon request.

VII. EMS PHYSICIAN COMMISSION RESPONSIBILTIES.

The Commission will provide interpretation of the Rules of the Commission.

VIII. IDAHO AUTHORIZED SCOPE OF PRACTICE.

The Commission has approved the Scope of Practice for licensed EMS personnel, which is articulated in Appendix A. Appendix A lists specific psychomotor skills and patient care interventions and indicates the level of EMS licensure that may perform each skill or intervention. The EMS Medical Director, Hospital Supervising Physician, or Medical Clinic Supervising Physician must oversee a process to verify competency in all credentialed skills and interventions. The effective date of this Scope of Practice will be July 1, 2016.

It must be noted that not everyone is currently operating at the levels indicated by Xs in Appendix A and that it is only upon completion of required education, competency assessment, and endorsement or permission by their medical director that a provider can perform the procedures.

Appendix A implicitly defines both a "floor" and "ceiling" for each level of EMS licensure. Licensed EMS personnel must receive training and demonstrate competency in each skill and intervention that lies within their "floor." Training for skills and interventions within the "floor" is based on curricula or specialized training approved according to IDAPA 16.01.05, Idaho Department of Health and Welfare, "Emergency Medical Services (EMS) – Education, Instructor, and Examination Requirements." Training and competency in skills and interventions within the "floor" are verified by examination and state EMS licensure according to IDAPA 16.01.05, Idaho Department of Health and Welfare, "Emergency Medical Services (EMS) – Education, Instructor, and Examination Requirements" and IDAPA 16.01.07, Idaho Department of Health and Welfare, "Emergency Medical Services (EMS) – Personnel Licensing Requirements." Skills and interventions designated by an "X" in Appendix A are included in the "floor" for the specified level of EMS licensure.

Skills and interventions designated by "OM" in Appendix A may be authorized by the EMS Medical Director, Hospital Supervising Physician and/or Medical Clinic Supervising Physician and are considered optional. These skills and interventions lie between the "floor" and "ceiling" of the specified level of EMS licensure. The EMS Medical Director, Hospital Supervising

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Physician and/or Medical Clinic Supervising Physician must ensure that licensed EMS personnel receive appropriate initial and continuing training for optional skills and interventions. In addition, the EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician must take an active role in verifying competency in optional skills and interventions since state EMS licensing will not address optional skills or interventions. Agencies must provide the minimum equipment required for their authorized OMs.

When an EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician desires to incorporate an OM, they must:

1. Report patient care response data to the Idaho Prehospital Electronic Record Collection System (PERCS) directly or by way of an Idaho validated export from a National EMS Information System (NEMSIS) compliant software application.
    a. If an agency has not been able to obtain PERCS validation, they must report optional module usage on their annual agency renewal application. This method of reporting shall expire June 30, 2017.

2. Submit an addendum to their medical supervision plan to the Bureau that indicates which OM(s) they want to adopt.

3. Submit verification of credentialing to the Bureau prior to utilization of OM skills or interventions.

Psychomotor skills and patient care interventions that are not designated by either an "X" or "OM" in Appendix A fall outside the Commission's established Scope of Practice for the specified level of EMS licensure and may not be performed by licensed EMS personnel at that level in the out-of-hospital setting. As such, Appendix A defines the "ceiling' for the specified level of EMS licensure.

Appendix A includes a CC Skills (Critical Care Skills) column that designates optional psychomotor skills and patient care interventions that may be performed by a Paramedic who receives additional critical care education and has successfully completed the Board for Critical Care Transport Paramedic Certification (BCCTPC) exam for Flight Paramedic (FP-C) or Critical Care Paramedic (CCP-C). A Paramedic must be appropriately credentialed by the EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician before performing critical care skills. In addition, the EMS Medical Director, Hospital Supervising Physician and/or Medical Clinic Supervising Physician must ensure that licensed EMS personnel receive appropriate initial and continuing education of critical care skills and interventions, and must take an active role in verifying proficiency in those skills and interventions since state EMS personnel licensing will not address critical care or optional skills and interventions.

The Commission has created additional requirements for certain psychomotor skills and patient care interventions that, if done improperly, represent a significant hazard to the patient. Additional standards may include but are not limited to on-line medical direction prior to performance of the skill or intervention, completion of specified training prior to credentialing, required elements for Patient Care Report documentation, required elements for performance assessment and improvement and/or compliance with a state-wide protocol or guideline. See

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Appendices B through C. Skills and interventions with additional requirements are designated in Appendix A by a 1, 2, 3, 4, 5, etc. alongside the "X" or "OM".

Emergency Medical Responder (EMR)

The primary focus of the Emergency Medical Responder, which prior to July 1, 2009 was known as a certified First Responder, is to initiate immediate lifesaving care to critical patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide lifesaving interventions while awaiting additional EMS response and to assist higher level personnel at the scene and during transport. Emergency Medical Responders function as part of a comprehensive EMS response, under medical oversight. Emergency Medical Responders perform basic interventions with minimal equipment.

Description of the Profession

The Emergency Medical Responder's scope of practice includes simple skills focused on lifesaving interventions for critical patients. Typically, the Emergency Medical Responder renders on-scene emergency care while awaiting additional EMS response and may serve as part of the transporting crew, but not as the primary care giver.

In many communities, Emergency Medical Responders provide a mechanism to increase the likelihood that trained personnel and lifesaving equipment can be rapidly deployed to serious emergencies. In all cases, Emergency Medical Responders are part of a tiered response system. Emergency Medical Responders work alongside other EMS and health care professionals as an integral part of the emergency care team.

The Emergency Medical Responder's scope of practice includes simple, non-invasive interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. Additionally, the Emergency Medical Responder provides care designed to minimize secondary injury and comfort the patient and family while awaiting additional EMS resources.

A major difference between the lay person and the Emergency Medical Responder is the "duty to act" as part of an organized EMS response.

In some systems, Emergency Medical Responders serve as a part of the crew on transporting EMS units; however, the Emergency Medical Responder is not intended to be the highest level caregiver in such situations. They must function with an EMT or higher level personnel during the transportation of emergency patients. The scope of practice model of an Emergency Medical Responder is limited to simple skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight.

After initiating care, the Emergency Medical Responder transfers care to higher level personnel. The Emergency Medical Responder serves as part of an EMS response system that ensures a progressive increase in the level of assessment and care.

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Emergency Medical Technician (EMT)

The primary focus of the Emergency Medical Technician is to provide basic emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight. Emergency Medical Technicians perform interventions with the basic equipment typically found on an ambulance. The Emergency Medical Technician is a link from the scene to the emergency health care system.

Description of the Profession

The Emergency Medical Technician's scope of practice includes basic skills focused on the acute management and transportation of critical and emergent patients. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

In many communities Emergency Medical Technicians provide a large portion of the prehospital care. In some jurisdictions, especially rural areas, Emergency Medical Technicians provide the highest level of prehospital care. Emergency Medical Technicians work alongside other EMS and health care professionals as an integral part of the emergency care team.

Emergency Medical Technicians' scope of practice includes basic, non-invasive interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. Additionally, Emergency Medical Technicians provide care to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an emergency care facility.

An Emergency Medical Technician's knowledge, skills, and abilities are acquired through formal education and training. The Emergency Medical Technician has the knowledge of, and is expected to be competent in, all of the skills of the Emergency Medical Responder. A major difference between the Emergency Medical Responder and the Emergency Medical Technician is the knowledge and skills necessary to provide medical transportation of emergency patients.

The Emergency Medical Technician level is the minimum licensure level for personnel transporting patients in ambulances. The scope of practice is limited to basic skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight and limited training.

The Emergency Medical Technician transports all emergency patients to an appropriate medical facility. The Emergency Medical Technician is not prepared to make decisions independently regarding the appropriate disposition of patients. The Emergency Medical Technician serves as part of an EMS response system, assuring a progressive increase in the level of assessment and care. The Emergency Medical Technician may make destination decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility.

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In addition to emergency response, Emergency Medical Technicians often perform medical transport services of patients requiring care within their scope of practice.

Advanced Emergency Medical Technician (AEMT)

The primary focus of the Advanced Emergency Medical Technician is to provide basic and limited advanced emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Advanced Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight. Advanced Emergency Medical Technicians perform interventions with the basic and advanced equipment typically found on an ambulance. The Advanced Emergency Medical Technician is a link from the scene to the emergency health care system.

Description of the Profession

The Advanced Emergency Medical Technician's scope of practice includes basic and limited advanced skills focused on the acute management and transportation of critical and emergent patients. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

For many communities, Advanced Emergency Medical Technicians provide an option to provide high benefit, lower risk advanced skills for systems that cannot support or justify Paramedic level care. This is frequently the case in rural and volunteer systems. In some jurisdictions, Advanced Emergency Medical Technicians are the highest level of prehospital care. In communities which utilize emergency medical dispatch systems, Advanced Emergency Medical Technicians may function as part of a tiered response system. In all cases, Advanced Emergency Medical Technicians work alongside other EMS and health care professionals as an integral part of the emergency care team.

The Advanced Emergency Medical Technician's scope of practice includes basic and limited advanced interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. Additionally, Advanced Emergency Medical Technicians provide care to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an emergency care facility.

The Advanced Emergency Medical Technician's knowledge, skills, and abilities are acquired through formal education and training. The Advanced Emergency Medical Technician has the knowledge associated with, and is expected to be competent in, all of the skills of the Emergency Medical Responder and Emergency Medical Technician. The major difference between the Advanced Emergency Medical Technician and the Emergency Medical Technician is the ability to perform limited advanced skills for emergency patients.

The Advanced Emergency Medical Technician is the minimum licensure level for patients requiring limited advanced care at the scene or during transportation. The scope of practice is limited to lower risk, high benefit advanced skills that are effective and can be performed safely

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in an out-of-hospital setting with medical oversight and limited training.

The Advanced Emergency Medical Technician transports all emergency patients to an appropriate medical facility. The Advanced Emergency Medical Technician is not prepared to independently make decisions regarding the disposition of patients. The Advanced Emergency Medical Technician serves as part of an EMS response system assuring a progressive increase in the level of assessment and care. The Advanced Emergency Medical Technician may make destination decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility.

In addition to emergency response, Advanced Emergency Medical Technicians often perform medical transport services of patients requiring care within their scope of practice.

Those AEMTs whose licensure is based on the Intermediate 85 curriculum and who have chosen not to complete either the EMT-2011 or the AEMT-2011 transition are expected to be competent in all the skills of the EMR and EMT with the exception of Pulse Oximetry, ATV non-intubated, aspirin, epi-auto injector, atropine sulfate & 2-Pralidoxime chloride auto-injector.

Paramedic

The Paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system. This individual possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive EMS response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found on an ambulance. The Paramedic is a link from the scene into the health care system.

Description of the Profession

The Paramedic's scope of practice includes basic and advanced skills focused on the acute management and transportation of the broad range of patients who access the emergency medical system. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

In some communities, Paramedics provide a large portion of the prehospital care and represent the highest level of prehospital care. In communities that utilize emergency medical dispatch systems, Paramedics may be part of a tiered response system. In all cases, Paramedics work alongside other EMS and health care professionals as an integral part of the emergency care team.

The Paramedic's scope of practice includes invasive and pharmacological interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on an advanced assessment and the formulation of a field impression. The Paramedic provides care designed to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an appropriate health care

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facility.

The Paramedic has knowledge, skills, and abilities developed by appropriate formal education and training. The Paramedic has the knowledge associated with, and is expected to be competent in, all of the skills of the Emergency Medical Responder, Emergency Medical Technician, and Advanced Emergency Medical Technician. The major difference between the Paramedic and the Advanced Emergency Medical Technician is the ability to perform a broader range of advanced skills. These skills carry a greater risk for the patient if improperly or inappropriately performed, are more difficult to attain and maintain competency in, and require significant background knowledge in basic and applied sciences.

The Paramedic is the minimum licensure level for patients requiring the full range of advanced out-of-hospital care. The scope of practice is limited to advanced skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight.

The Paramedic transports all emergency patients to an appropriate medical facility. The Paramedic serves as part of an EMS response system, ensuring a progressive increase in the level of assessment and care. The Paramedic may make treat and release decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility.
In addition to emergency response, Paramedics often perform medical transport services of patients requiring care within their scope of practice.

IX. EMS Proficiency and Performance Assessment Requirement.

Additional performance assessment requirements exist for advanced airway management including all intubation attempts and placements by any personnel affiliated with the EMS agency. The responsibility of the EMS medical director includes implementation of these requirements and EMS personnel compliance pursuant to IDAPA 16.02.02.300.05 and .06. The required data elements to be supplied by every EMS provider who attempts advanced airway management will be defined by the EMS Physician Commission. EMS providers will electronically submit the required data elements directly to the EMS Physician Commission starting January 1, 2010, in a manner established by the EMS Physician Commission. EMS providers will submit the required data elements contemporaneously with the completion of their patient care documentation. In the interest of evaluating aggregate performance, the EMS Physician Commission will compile and supply the EMS medical director with submitted data elements.

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X. Idaho EMS Physician Commission Contact Information

EMSPhysiciancomm@dhw.idaho.gov

www.emspc.dhw.idaho.gov

Call Toll Free: 1-877-554-3367

Idaho EMS Physician Commission
2224 W. Old Penitentiary Road
PO Box 83720
Boise, Idaho 83720-0036
(208) 334-4000
Fax (208) 334-4015

XI. Idaho Bureau of EMS and Preparedness Contact Information

IdahoEMS@dhw.idaho.gov

www.idahoems.org

Call Toll Free: 1-877-554-3367

2224 W. Old Penitentiary Road
PO Box 83720
Boise, ID 83720-0036
(208) 334-4000
Fax (208) 334-4015

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	AIRWAY / VENTILATION / OXYGENATION	
1	Airway – Nasal	X
2	Airway – Oral	X
3	Bag-Valve-Mask (BVM)	X
4	Cricoid Pressure (Sellick)	X
5	Finger Sweep	X
6	Head-tilt/chin-lift	X
7	Jaw-thrust	X
8	Jaw-thrust - Modified (trauma)	OM
9	Modified Chin Lift	X
10	Mouth-to-Barrier	X
11	Mouth-to-Mask	X
12	Mouth-to-Mouth	X
13	Mouth-to-Nose	X
14	Mouth-to-Stoma	X
15	Obstruction – Manual	X
16	Oxygen Therapy – Humidifiers	X
17	Oxygen Therapy – Nasal Cannula	X
18	Oxygen Therapy – Non-rebreather Mask	X
19	Oxygen Therapy – Partial Rebreather Mask	X
20	Oxygen Therapy – Simple Face Mask	X
21	Oxygen Therapy – Venturi Mask	X
22	Suctioning – Upper Airway	X
23	**CARDIOVASCULAR / CIRCULATION**	
24	Cardiopulmonary Resuscitation (CPR)	X
25	Defibrillation – Automated / Semi-Automated	X
26	Hemorrhage Control – Direct Pressure	X
27	Hemorrhage Control - Dressing	X
28	Hemorrhage Control – Tourniquet	2,OM
29	**IMMOBILIZATION**	
30	Cervical Stabilization – Cervical Collar	2,OM
31	Spinal Immobilization – Long Board	2,OM
32	Cervical Stabilization – Manual	X
33	Spinal Immobilization – Seated Patient (KED, etc.)	2,OM
34	Extremity Stabilization - Manual	X
35	Extremity Splinting	2,OM
	TECHNIQUE OF MEDICATION ADMINISTRATION	
	Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.	
36	Auto-Injector	X
37	Intramuscular (IM)	2,OM
38	**MISCELLANEOUS**	
39	Assisted Childbirth Delivery - Normal	X
40	Blood Pressure – Manual	X
41	Emergency Moves for Endangered Patients	X
42	Taser Barb Removal	OM
43	**MEDICATION FORMULARY**	
44	Epinephrine (Adrenalin)	2,4,OM
45 46	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	5X
47	Oxygen	X
48	Vaccinations - at the request of the public health district if credentialed in IM adminstration	5,OM

Education based on Idaho Standard Curriculum (ISC) which was based on National Standard Curricula	
OM=Optional Module	
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires EMSPC protocol	4
Just In Time Training	5

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	AIRWAY / VENTILATION / OXYGENATION	
49	Airway – Oral	X
50	Bag-Valve-Mask (BVM)	X
51	Cricoid Pressure (Sellick)	X
52	Finger Sweep	X
53	Head-tilt/chin-lift	X
54	Jaw-thrust	X
55	Jaw-thrust - Modified (trauma)	OM
56	Modified Chin Lift	X
57	Mouth-to-Barrier	X
58	Mouth-to-Mask	X
59	Mouth-to-Mouth	X
60	Mouth-to-Nose	X
61	Mouth-to-Stoma	X
62	Obstruction – Manual	X
63	Oxygen Therapy – Nasal Cannula	X
64	Oxygen Therapy – Non-rebreather Mask	X
65	Suctioning – Upper Airway	X
	CARDIOVASCULAR / CIRCULATION	
66	Cardiopulmonary Resuscitation (CPR)	X
67	Defibrillation – Automated / Semi-Automated	X
68	Hemorrhage Control – Direct Pressure	X
69	Hemorrhage Control – Dressing	X
70	Hemorrhage Control – Tourniquet	X
	IMMOBILIZATION	
71	Cervical Stabilization – Cervical Collar	2,OM
72	Spinal Immobilization – Long Board	2,OM
73	Cervical Stabilization – Manual	X
74	Spinal Immobilization – Seated Patient (KED, etc.)	2,OM
75	Extremity Stabilization - Manual	X
76	Extremity Splinting	2,OM
	TECHNIQUE OF MEDICATION ADMINISTRATION	
	Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.	
77	Auto-Injector	X
78	Intramuscular (IM)	2,OM
	MISCELLANEOUS	
79	Assisted Childbirth Delivery - Normal	X
80	Blood Pressure – Manual	X
81	Emergency Moves for Endangered Patients	X
82	Eye Irrigation	X
83	Taser Barb Removal	OM
	MEDICATION FORMULARY	
84	Epinephrine (Adrenalin)	2,4,OM
85	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote) self & peer	X
86	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	4X
87	Naloxone (Narcan)	3, SS
88	Oxygen	X
89	Vaccinations - at the request of the public health district if credentialed in IM adminstration	5,OM

Education based on new 2011 Idaho EMS Curricula (IEC) which is based on National Education Standards	
	OM=Optional Module
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires EMSPC protocol	4
Just In Time Training	5

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	AIRWAY / VENTILATION / OXYGENATION	
95	Airway – Nasal	X
96	Airway – Oral	X
97	Bag-Valve-Mask (BVM)	X
98	Cricoid Pressure (Sellick)	X
99	Demand Valve – Manually triggered, flow restricted, ventilation	X
100	Finger Sweep	X
101	Head-tilt/chin-lift	X
102	Jaw-thrust	X
103	Jaw-thrust - Modified (trauma)	X
104	Modified Chin Lift	X
105	Mouth-to-Barrier	X
106	Mouth-to-Mask	X
107	Mouth-to-Mouth	X
108	Mouth-to-Nose	X
109	Mouth-to-Stoma	X
110	Obstruction – Manual	X
111	Oxygen Therapy – Humidifiers	X
112	Oxygen Therapy – Nasal Cannula	X
113	Oxygen Therapy – Non-rebreather Mask	X
114	Oxygen Therapy – Partial Rebreather Mask	X
115	Oxygen Therapy – Simple Face Mask	X
116	Oxygen Therapy – Venturi Mask	X
117	Pulse Oximetry	2,OM
118	CO Oximetry	2,4,OM
119	Suctioning – Upper Airway	X
120	**CARDIOVASCULAR / CIRCULATION**	
121	EKG - 12-lead data acquisition	2,OM
122	Cardiopulmonary Resuscitation (CPR)	X
123	Defibrillation – Automated / Semi-Automated	X
124	Hemorrhage Control – Direct Pressure	X
125	Hemorrhage Control - Dressing	X
126	Hemorrhage Control – Tourniquet	X
127	Impedance Threshold Device (ITD)	OM
128	Mechanical CPR Device	X
129	**IMMOBILIZATION**	
130	Cervical Stabilization – Cervical Collar	X
131	Spinal Immobilization – Long Board	X
132	Cervical Stabilization – Manual	X
133	Spinal Immobilization – Seated Patient (KED, etc.)	X
134	Extremity Stabilization - Manual	X
135	Extremity Splinting	X
136	Extremity Splinting – Traction	X
137	MAST/PASG for Pelvic Immobilization Only	X
138	Pelvic Immobilization Devices	OM

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	TECHNIQUE OF MEDICATION ADMINISTRATION	
	Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.	
139	Auto-Injector	X
140	Buccal	X
141	Intramuscular (IM)	2,OM
142	Oral	X
143	Subcutaneous	2,OM
144	**MISCELLANEOUS**	
145	Assist with Prescribed Meds	X
146	Assisted Childbirth Delivery - Normal	X
147	Assisted Childbirth Delivery- Complicated	X
148	Blood Glucose Monitoring - Automated	2,4,OM
149	Blood Pressure – Manual	X
150	Blood Pressure – Automated	X
151	Emergency Moves for Endangered Patients	X
152	Eye Irrigation	X
153	Mechanical Patient Restraints	X
154	Rapid Extrication	X
155	Taser Barb Removal	OM
156	**MEDICATION FORMULARY**	
157	Acetylsalicylic Acid (Aspirin) for suspected cardiac chest pain	OM
158	Epinephrine (Adrenalin)	2,4,OM
159	Glucagon	2,4,OM
160	Glucose (Oral)	X
161	Inhaled Beta Agonist (MDI)	X**
162	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	5X
163	Nitroglycerin - Sublingual	X**
164	Oxygen	X
165	Vaccinations - at the request of the public health district if credentialed in IM adminstration	5,OM

Education based on Idaho Standard Curriculum (ISC) which was based on National Standard Curricula	
	OM=Optional Module
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires EMSPC protocol	4
Just In Time Training	5
** May carry and administer only if already prescribed	

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	AIRWAY / VENTILATION / OXYGENATION	
166	Advanced Airway devices not intended to be inserted into trachea	2,3,OM*~
167	Airway – Nasal	X
168	Airway – Oral	X
169	Bag-Valve-Mask (BVM)	X
170	CPAP	2, OM
171	Cricoid Pressure (Sellick)	X
172	Demand Valve – Manually triggered, flow restricted, ventilation	X
173	End Tidal CO_2 Monitoring/Capnometry	2,3,OM~
174	Finger Sweep	X
175	Head-tilt/chin-lift	X
176	Jaw-thrust	X
177	Jaw-thrust - Modified (trauma)	X
178	Modified Chin Lift	X
179	Mouth-to-Barrier	X
180	Mouth-to-Mask	X
181	Mouth-to-Mouth	X
182	Mouth-to-Nose	X
183	Mouth-to-Stoma	X
184	Obstruction – Manual	X
185	Oxygen Therapy – Humidifiers	X
186	Oxygen Therapy – Nasal Cannula	X
187	Oxygen Therapy – Non-rebreather Mask	X
188	Oxygen Therapy – Partial Rebreather Mask	X
189	Oxygen Therapy – Simple Face Mask	X
190	Oxygen Therapy – Venturi Mask	X
191	Pulse Oximetry	X
192	CO Oximetry	2,4,OM
193	Suctioning – Tracheobronchial via advanced airway	2,OM
194	Suctioning – Upper Airway	X
195	Ventilators – Automated Transport (ATV) for non-intubated patients	X
	CARDIOVASCULAR / CIRCULATION	
196	EKG - 12-lead data acquisition	2,OM
197	Cardiopulmonary Resuscitation (CPR)	X
198	Defibrillation – Automated / Semi-Automated	X
199	Hemorrhage Control – Direct Pressure	X
200	Hemorrhage Control – Dressing	X
201	Hemorrhage Control – Tourniquet	X
202	Impedance Threshold Device (ITD)	OM
203	Mechanical CPR Device	X
	IMMOBILIZATION	
204	Cervical Stabilization – Cervical Collar	X
205	Spinal Immobilization – Long Board	X
206	Cervical Stabilization – Manual	X
207	Spinal Immobilization – Seated Patient (KED, etc.)	X
208	Extremity Stabilization - Manual	X
209	Extremity Splinting	X
210	Extremity Splinting – Traction	X
211	MAST/PASG for Pelvic Immobilization Only	X
212	Pelvic Immobilization Devices	OM
	VASCULAR ACCESS / FLUIDS	
213	Intraosseous – Pediatric	2,OM
214	Intraosseous – Adult	2,OM
215	Peripheral – Initiation (includes External Jugular)	2,OM
216	IV Fluid infusion - Non-medicated	2,OM

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	TECHNIQUE OF MEDICATION ADMINISTRATION	
	Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.	
217	Auto-Injector	X
218	Buccal	X
219	Intramuscular (IM)	2,OM
220	Intraosseous - Pediatric	2,4,OM
221	Intraosseous - Adult	2,4,OM
222	Oral	X
223	Subcutaneous	2,OM
	MISCELLANEOUS	
224	Assist with Prescribed Meds	X
225	Assisted Childbirth Delivery - Normal	X
226	Assisted Childbirth Delivery- Complicated	X
227	Blood Glucose Monitoring - Automated	2,4,OM
228	Blood Pressure – Manual	X
229	Blood Pressure – Automated	X
230	Emergency Moves for Endangered Patients	X
231	Eye Irrigation	X
232	Mechanical Patient Restraints	X
233	Rapid Extrication	X
234	Taser Barb Removal	OM
235	Venous Blood Sampling – Obtaining	2,OM
	MEDICATION FORMULARY	
236	Acetylsalicylic Acid (Aspirin) for suspected cardiac chest pain	X
237	Activated Charcoal	X
238	Epinephrine (Adrenalin)	X
239	Glucagon	2,4,OM
240	Glucose (Oral)	X
241	Inhaled Beta Agonist (MDI)	X**
242	Inhaled Beta Agonist (SVN)	X**
243	Lidocaine - as an adjunct for IO fluid administration	4 OM
244	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote) self & peer	X
245	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote)	X
246	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	4X
247	Naloxone (Narcan)	3, SS
248	Nitroglycerin - Sublingual	X**
249	Oxygen	X
250	Vaccinations - at the request of the public health district if credentialed in IM adminstration	5,OM

Education based on new 2011 Idaho EMS Curricula (IEC) which is based on National Education Standards	
OM=Optional Module	
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires additional standards as defined by the EMSPC	3
Requires EMSPC protocol	4
Just In Time Training	5

~End Tidal CO2 Monitoring/ Capnometry must be included if the Supraglottic Airway is selected as an EMT-2011 2,3 OM

* Adults Only

** May carry and administer only if already prescribed

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	AIRWAY / VENTILATION / OXYGENATION	
257	Advanced Airway devices not intended to be inserted into trachea	X*
258	Airway – Nasal	X
259	Airway – Oral	X
260	Bag-Valve-Mask (BVM)	X
261	CPAP	2,OM
262	Cricoid Pressure (Sellick)	X
263	Demand Valve – Manually triggered, flow restricted, ventilation	X
264	End Tidal CO_2 Monitoring/Capnometry	2,OM
265	Finger Sweep	X
266	Head-tilt/chin-lift	X
267	Jaw-thrust	X
268	Jaw-thrust - Modified (trauma)	X
269	Modified Chin Lift	X
270	Mouth-to-Barrier	X
271	Mouth-to-Mask	X
272	Mouth-to-Mouth	X
273	Mouth-to-Nose	X
274	Mouth-to-Stoma	X
275	Obstruction – Manual	X
276	Oxygen Therapy – Humidifiers	X
277	Oxygen Therapy – Nasal Cannula	X
278	Oxygen Therapy – Non-rebreather Mask	X
279	Oxygen Therapy – Partial Rebreather Mask	X
280	Oxygen Therapy – Simple Face Mask	X
281	Oxygen Therapy – Venturi Mask	X
282	Pulse Oximetry	2,OM
283	CO Oximetry	2,4,OM
284	Suctioning – Tracheobronchial via advanced airway	X
285	Suctioning – Upper Airway	X
286	**CARDIOVASCULAR / CIRCULATION**	
287	EKG - 12-lead data acquisition	2,OM
288	Cardiopulmonary Resuscitation (CPR)	X
289	Defibrillation – Automated / Semi-Automated	X
290	Hemorrhage Control – Direct Pressure	X
291	Hemorrhage Control – Dressing	X
292	Hemorrhage Control - Pressure Point	X
293	Hemorrhage Control – Tourniquet	X
294	Impedance Threshold Device (ITD)	OM
295	Mechanical CPR Device	X
296	**IMMOBILIZATION**	
297	Cervical Stabilization – Cervical Collar	X
298	Spinal Immobilization – Long Board	X
299	Cervical Stabilization – Manual	X
300	Spinal Immobilization – Seated Patient (KED, etc.)	X
301	Extremity Stabilization - Manual	X
302	Extremity Splinting	X
303	Extremity Splinting – Traction	X
304	MAST/PASG for Pelvic Immobilization Only	X
305	Pelvic Immobilization Devices	OM
306	**VASCULAR ACCESS / FLUIDS**	
307	Intraosseous – Pediatric	X
308	Intraosseous – Adult	OM
309	Peripheral – Initiation (includes External Jugular)	X
310	IV Fluid infusion - Non-medicated	X

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	TECHNIQUE OF MEDICATION ADMINISTRATION	
	Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.	
311	Auto-Injector	X
312	Buccal	X
313	Intramuscular (IM)	2,OM
314	Intraosseous - Pediatric	2,4,OM
315	Intraosseous - Adult	2,4,OM
316	Oral	X
317	Subcutaneous	2,OM
318	**MISCELLANEOUS**	
319	Assist with Prescribed Meds	X
320	Assisted Childbirth Delivery - Normal	X
321	Assisted Childbirth Delivery- Complicated	X
322	Blood Glucose Monitoring - Automated	X
323	Blood Pressure – Manual	X
324	Blood Pressure – Automated	X
325	Emergency Moves for Endangered Patients	X
326	Eye Irrigation	X
327	Mechanical Patient Restraints	X
328	Rapid Extrication	X
329	Taser Barb Removal	OM
330	Venous Blood Sampling – Obtaining	X
331	**MEDICATION FORMULARY**	
332	Acetylsalicylic Acid (Aspirin) for suspected cardiac chest pain	OM
333	Activated Charcoal	X
334	Epinephrine (Adrenalin)	2,4,OM
335	Glucagon	2,4,OM
336	Glucose (Oral)	X
337	Inhaled Beta Agonist (MDI)	X**
338	Lidocaine - as an adjunct for IO fluid administration	4,OM
339 340	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	5X
341	Nitroglycerin - Sublingual	X**
342	Oxygen	X
343	Vaccinations - at the request of the public health district if credentialed in IM adminstration	5,OM

Education based on Idaho Standard Curriculum (ISC) which was based on National Standard Curricula	
	OM=Optional Module
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires EMSPC protocol	4
Just In Time Training	5
* Adults Only **may carry and administer only if already prescribed	

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344	**AIRWAY / VENTILATION / OXYGENATION**	
345	Advanced Airway devices not intended to be inserted into trachea	X*
346	Airway – Nasal	X
347	Airway – Oral	X
348	Bag-Valve-Mask (BVM)	X
349	CPAP	2,OM
350	Cricoid Pressure (Sellick)	X
351	Demand Valve – Manually triggered, flow restricted, ventilation	X
352	End Tidal CO_2 Monitoring/Capnometry	2,OM
353	Finger Sweep	X
354	Head-tilt/chin-lift	X
355	Jaw-thrust	X
356	Jaw-thrust - Modified (trauma)	X
357	Modified Chin Lift	X
358	Mouth-to-Barrier	X
359	Mouth-to-Mask	X
360	Mouth-to-Mouth	X
361	Mouth-to-Nose	X
362	Mouth-to-Stoma	X
363	Obstruction – Manual	X
364	Oxygen Therapy – Humidifiers	X
365	Oxygen Therapy – Nasal Cannula	X
366	Oxygen Therapy – Non-rebreather Mask	X
367	Oxygen Therapy – Partial Rebreather Mask	X
368	Oxygen Therapy – Simple Face Mask	X
369	Oxygen Therapy – Venturi Mask	X
370	Pulse Oximetry	X
371	CO Oximetry	2,4,OM
372	Suctioning – Tracheobronchial via advanced airway	X
373	Suctioning – Upper Airway	X
374	Ventilators – Automated Transport (ATV) for non-intubated patients	X
375	**CARDIOVASCULAR / CIRCULATION**	
376	EKG - 12-lead data acquisition	2,OM
377	Cardiopulmonary Resuscitation (CPR)	X
378	Defibrillation – Automated / Semi-Automated	X
379	Hemorrhage Control – Direct Pressure	X
380	Hemorrhage Control – Dressing	X
381	Hemorrhage Control - Pressure Point	X
382	Hemorrhage Control – Tourniquet	X
383	Impedance Threshold Device (ITD)	OM
384	Mechanical CPR Device	X
385	**IMMOBILIZATION**	
386	Cervical Stabilization – Cervical Collar	X
387	Spinal Immobilization – Long Board	X
388	Cervical Stabilization - Manual	X
389	Spinal Immobilization – Seated Patient (KED, etc.)	X
390	Extremity Stabilization - Manual	X
391	Extremity Splinting	X
392	Extremity Splinting – Traction	X
393	MAST/PASG for Pelvic Immobilization Only	X
394	Pelvic Immobilization Devices	OM
395	**VASCULAR ACCESS / FLUIDS**	
396	Intraosseous – Pediatric	X
397	Intraosseous – Adult	X
398	Peripheral – Initiation (includes External Jugular)	X
399	IV Fluid infusion - Non-medicated	X

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	TECHNIQUE OF MEDICATION ADMINISTRATION	
	Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.	
400	Aerosolized (MDI)	X
401	Auto-Injector	X
402	Buccal	X
403	Inhaled - patient administered (nitrous oxide)	X
404	Intramuscular (IM)	X
405	Intranasal	X
406	Intraosseous - Pediatric	X
407	Intraosseous - Adult	X
408	IV Push-D50/concentrated dextrose solutions only / Naloxone (Narcan)	X
409	Nebulized (SVN)	X
410	Oral	X
411	Subcutaneous	X
412	Sub-lingual	X
413	Topical	OM
414	**MISCELLANEOUS**	
415	Assist with Prescribed Meds	X
416	Assisted Childbirth Delivery - Normal	X
417	Assisted Childbirth Delivery- Complicated	X
418	Blood Glucose Monitoring - Automated	X
419	Blood Pressure – Manual	X
420	Blood Pressure – Automated	X
421	Emergency Moves for Endangered Patients	X
422	Eye Irrigation	X
423	Mechanical Patient Restraints	X
424	Rapid Extrication	X
425	Taser Barb Removal	OM
426	Venous Blood Sampling – Obtaining	OM
427	**MEDICATION FORMULARY**	
428	Acetylsalicylic Acid (Aspirin) for suspected cardiac chest pain	X
429	Activated Charcoal	X
430	Dextrose 50%	X
431	Dextrose, concentrated solutions	X
432	Epinephrine (Adrenalin)	X
433	Glucagon	X
434	Glucose (Oral)	X
435	Inhaled Beta Agonist (MDI)	X
436	Inhaled Beta Agonist (SVN)	X
437	Lidocaine - as an adjunct for IO fluid administration	4,OM
438	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote) self & peer	X
439	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote)	X
440	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	4X
441	Naloxone (Narcan)	X
442	Nytroglycerin - Paste	OM
443	Nitroglycerin - Sublingual	X
444	Nitrous Oxide (Nitronox)	X
445	Oxygen	X
446	Vaccinations - at the request of the public health district if credentialed in IM adminstration	X

Education based on new 2011 Idaho EMS Curricula (IEC) which is based on National Education Standards	
OM=Optional Module	
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires EMSPC protocol	4
* Adults Only	

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	AIRWAY / VENTILATION / OXYGENATION		
	Skill	Paramedic-2011 (Licensed after 1-1-2013)	CC Skills Paramedic 2011
578	Advanced Airway devices not intended to be inserted into trachea	X	
579	Airway – Nasal	X	
580	Airway – Oral	X	
581	Airway – Obstruction - removal of foreign body by direct laryngoscopy	X	
582	Bag-Valve-Mask (BVM)	X	
583	BiPAP	X	
584	Chest Decompression – Needle	X	
585	Chest Tube Placement		2,3,OM
586	Chest Tube – Monitoring & Management	X	
587	CPAP	X	
588	Cricoid Pressure (Sellick)	X	
589	Cricothyrotomy – Needle/Percutaneous	X	
590	Cricothyrotomy - Surgical	2,OM	3X
591	Demand Valve – Manually triggered, flow restricted, ventilation	X	
592	End Tidal CO_2 Monitoring/Capnometry	X	
593	Finger Sweep	X	
594	Gastric Decompression – NG Tube	X	
595	Gastric Decompression – OG Tube	X	
596	Head-tilt/chin-lift	X	
597	Intubation – Digital	X	
598	Intubation – Medication Assisted (non-paralytic)	X	
599	Intubation – Medication Assisted (paralytics) (RSI)	2,3,OM	
600	Intubation - Nasotracheal	X	
601	Intubation - Orotracheal	X	
602	Intubation – Retrograde		
603	Jaw-thrust	X	
604	Jaw-thrust - Modified (trauma)	X	
605	Modified Chin Lift	X	
606	Mouth-to-Barrier	X	
607	Mouth-to-Mask	X	
608	Mouth-to-Mouth	X	
609	Mouth-to-Nose	X	
610	Mouth-to-Stoma	X	
611	Obstruction – Direct Laryngoscopy	X	
612	Obstruction – Manual	X	
613	Oxygen Therapy – Humidifiers	X	
614	Oxygen Therapy – Nasal Cannula	X	
615	Oxygen Therapy – Non-rebreather Mask	X	
616	Oxygen Therapy – Partial Rebreather Mask	X	
617	Oxygen Therapy – Simple Face Mask	X	
618	Oxygen Therapy – Venturi Mask	X	
619	PEEP – Therapeutic (>6cm H_2O pressure)	X	
620	Pulse Oximetry	X	
621	CO Oximetry	OM	
622	Suctioning – Tracheobronchial via advanced airway	X	
623	Suctioning – Upper Airway	X	
624	Ventilators – Automated Transport (ATV) for non-intubated patients	X	
625	Ventilators – Automated Transport (ATV)	X	
626	Ventilators, Automated – Enhanced Assessment & Management		3X

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	CARDIOVASCULAR / CIRCULATION		
	Skill	Paramedic-2011 (Licensed after 1-1-2013)	CC Skills Paramedic 2011
627	EKG - 12-lead data acquisition	X	
628	EKG - 12-lead interpretation	X	
629	EKG - 3-lead rhythm interpretation	X	
630	Cardiopulmonary Resuscitation (CPR)	X	
631	Cardioversion – Electrical	X	
632	Carotid Massage	X	
633	Defibrillation – Automated / Semi-Automated	X	
634	Defibrillation – Manual	X	
635	Hemorrhage Control – Direct Pressure	X	
636	Hemorrhage Control – Dressing	X	
637	Hemorrhage Control - Pressure Point	X	
638	Hemorrhage Control – Tourniquet	X	
639	Impedance Threshold Device (ITD)	OM	
640	IABP monitoring & management		3X
641	Invasive Hemodynamic Monitoring		3X
642	Mechanical CPR Device	X	
643	Pericardiocentesis		2,3,OM
644	Pacing - Transcutaneous	X	
645	Pacing - Transvenous & Epicardial – monitoring & management		3X
646	Pacing - Permanent/ICD		
647	IMMOBILIZATION		
648	Cervical Stabilization – Cervical Collar	X	
649	Spinal Immobilization – Long Board	X	
650	Cervical Stabilization – Manual	X	
651	Spinal Immobilization – Seated Patient (KED, etc.)	X	
652	Extremity Stabilization - Manual	X	
653	Extremity Splinting	X	
654	Extremity Splinting – Traction	X	
655	MAST/PASG for Pelvic Immobilization Only	X	
656	Pelvic Immobilization Devices	OM	
657	VASCULAR ACCESS / FLUIDS		
658	Arterial Line – Monitoring & Access Only		3X
659	Central Line – Placement		2,3,OM
660	Central Line – Monitor & Maintain Only	X	
661	Intraosseous – Pediatric	X	
662	Intraosseous – Adult	X	
663	Peripheral – Initiation (includes External Jugular)	X	
664	Umbilical - Initiation		2,3,OM
665	IV Fluid infusion - Non-medicated	X	
666	IV Fluid infusion - Maintenance of Medicated Fluids	X	

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	TECHNIQUE OF MEDICATION ADMINISTRATION		
	Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.		
	Skill	Paramedic-2011 (Licensed after 1-1-2013)	CC Skills Paramedic 2011
667	Aerosolized (MDI)	X	
668	Auto-Injector	X	
669	Buccal	X	
670	Endotracheal Tube (ET)	X	
671	Inhaled - patient administered (nitrous oxide)	X	
672	Intramuscular (IM)	X	
673	Intranasal	X	
674	Intraosseous - Pediatric	X	
675	Intraosseous - Adult	X	
676	IV Infusion	X	
677	IV Piggyback	X	
678	IV Programmable Volume Infusion Device	2, OM	3X
679	IV Push	X	
680	IV Push-D50/concentrated dextrose solutions only / Naloxone (Narcan)	X	
681	Accessing Implanted Central IV Port	X	
682	Nasogastric	X	
683	Nebulized (SVN)	X	
684	Oral	X	
685	Rectal	X	
686	Subcutaneous	X	
687	Sub-lingual	X	
688	Topical	X	
689	MISCELLANEOUS		
690	Arterial Blood Sampling, Radial Site - Obtaining		
691	Assist with Prescribed Meds	X	
692	Over-the-Counter Medications (OTC)	X	
693	Assisted Childbirth Delivery - Normal	X	
694	Assisted Childbirth Delivery- Complicated	X	
695	Blood Chemistry Analysis	X	
696	Blood Glucose Monitoring - Automated	X	
697	Blood Pressure – Manual	X	
698	Blood Pressure – Automated	X	
699	Emergency Moves for Endangered Patients	X	
700	Eye Irrigation	X	
701	Eye Irrigation – Morgan Lens	X	
702	Mechanical Patient Restraints	X	
703	Rapid Extrication	X	
704	ICP Monitoring		3X
705	Taser Barb Removal	OM	
706	Urinary Catheterization		2,3,OM
707	Venous Blood Sampling – Obtaining	X	

DRAFT

	MEDICATION FORMULARY		
	Formulary	Paramedic-2011 (Licensed after 1-1-2013)	CC Skills Paramedic 2011
708	Medical Director Approved Medications	X	
709	Blood Products Administration		3X
710	Maintenance of Blood Administration	X	
711	Plasma Volume Expander Administration		3X
712	Thrombolytic Therapy Administration	X	
713	Vaccinations - at the request of the public health district if credentialed in IM adminstration	X	

Education based on new 2011 Idaho EMS Curricula (IEC) which is based on National Education Standards	
	OM=Optional Module
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires additional standards as defined by the EMSPC	3

DRAFT

Paramedic Non-RSI Statewide Intubation Standards

Topic	Requirements	Available Options
Patient Selection		
Adult / Peds	Unconscious w/ineffective respiration	
	Cardiac arrest	
	Apnea or agonal respirations	
	Conscious with ineffective respirations (Nasal intubations only)	
Equipment		
Laryngoscope blades	adult & ped blade sizes	Macintosh
	2 different blade types	Miller
		other blade types permissable
Continuous Pulse Oximetry	before, during & after intubation	
Rescue device	must have at least one available	LMA
		Combitube
		King LT
		bougie/flexguide
Tube placement	must have at least one available	ETCO2, qualitative
		esophageal detector device (EDD)
Selection of tube size	based on patient age or size of 5th finger	Cuffed Sizes = 3.5 - 8.0 mm
		Uncuffed Sizes = 2.5 mm
Suction device	per minimum EMS Bureau equipment list	
Bag Valve Mask	per minimum EMS Bureau equipment list	
Oxygen	per minimum EMS Bureau equipment list	
Intubation Attempts		
Preoxygenation	100% oxygen prior to any attempts	Bag Valve Mask
		Non-Rebreatther Mask
Provider limited to 3 attempts	duration: each attempt should be no more than 30 seconds. If unsuccessful should oxygenate before subsequent attempts.	
Patient limited to 5 attempts	multiple attempts should not delay transport	
NAEMSP definition of attempt: insertion of laryngoscope blade into mouth or insertion of tube through nares		
Confirmation of Tube Placement		
Confirmation of Tube Placement	Utilize multiple methods	Breath sounds
		Epigastric sounds
		ETCO2
		EDD
		chest rise
		tube misting
		Patient response
PCR Documentation		
See 'EMSPC Intubation PCR Documentation List' for required data elements.		

DRAFT

Required Elements for Performance Assessment and Improvement		
Monitoring		
100% chart review		
Intubation success rate		
	agency	
	provider	
1st attempt success rate		
	agency	
	provider	
Rescue airway device utilization		
Complications (agency vs provider)		
	R mainstem (unrecognized)	
	esophageal intubation (unrecognized)	
	airway/dental trauma	
	hypoxia during intubation	
	bradycardia during intubation	
	inappropriate tube size	
	inappropriate tube depth	
Training		
1. Minimum annual demonstration of intubation proficiency		
2. Minimum annual review of intubation to include cognitive and psychomotor components with an emphasis on team coordination.		
Remediation		
Remediation at the discretion of the local EMS medical director		

DRAFT

EMSPC RSI Statewide Standards

Topic	Requirements	Available Options
Patient Selection		
Adult /Peds	Patient requires intubation; AND	
	is not flaccid, or	
	has intact protective airway reflexes.	
	Not a difficult airway	
Equipment		
Laryngoscope blades	adult & ped blade sizes	Macintosh
	2 different blade types	Miller
		other blade types permissable
Medications	As per local EMS Medical Director	
Continuous Pulse Oximetry	before during and after intubation	
Rescue device	must have at least one available	LMA
		Combitube
		King LT
		other
Tube placement	must have at least one available	ETCO2, qualitative
		esophageal detector device (EDD)
Selection of tube size	based on patient age or size of 5th finger	Cuffed Sizes = 3.5 - 8.0 mm
		Uncuffed Sizes = 2.5 mm
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Confirmation of Tube Placement	Utilize multiple methods	Breath sounds
		Epigastric sounds
		ETCO2
		EDD
		chest rise
		tube misting
		Patient response
PCR Documentation		
See 'EMSPC Intubation PCR Documentation List' for required data elements.		

DRAFT

Required Elements for Performance Assessment and Improvement		
Monitoring		
100% chart review		
Intubation success rate		
	agency	
	provider	
1st attempt success rate		
	agency	
	provider	
Rescue airway device utilization		
Complications (agency vs provider)		
	R mainstem (unrecognized)	
	esophageal intubation (unrecognized)	
	airway/dental trauma	
	hypoxia during intubation	
	bradycardia during intubation	
	inappropriate tube size	
	inappropriate tube depth	
Training		
1. Minimum annual demonstration of intubation proficiency		
2. Minimum annual review of intubation to include cognitive and psychomotor components with an emphasis on team coordination.		
Remediation		
Remediation at the discretion of the local EMS medical director		

DRAFT

SENATE HEALTH & WELFARE COMMITTEE
Wednesday January 20, 2016

ATTACHMENT 2

SUCCESS THROUGH COLLABORATION

Idaho Council on Suicide Prevention

Linda Hatzenbuehler, Chair

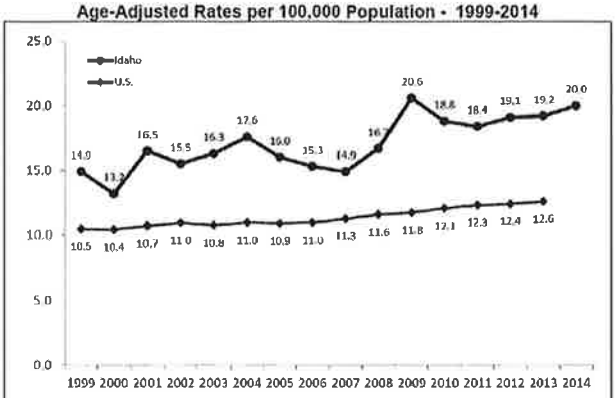
- 320
- Total deaths by suicide in Idaho (2014)
- 96
- School aged deaths (2010-2014)
- 20
- Children 14 and under (2010-2014)

Economic Impact of Deaths by Suicide in **Idaho** (2013 estimates)

- $1.3 million/annual medical costs
- $467 million, lifetime productivity losses

Idaho vs. US Suicide Rates, 1999 - 2014

Table 1: Idaho and U.S. Resident Suicide Deaths
Age-Adjusted Rates per 100,000 Population - 1999-2014



Age-adjusted Rate: Number of deaths per 100,000 population age-adjusted to the U.S. 2000 Standard Population.
U.S. Data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates.
Idaho Source: Bureau of Vital Records and Health Statistics; Division of Public Health.

Idaho and US Suicide Rates Over Time

Pre and Post Economic Decline

	1994-2007	2008-2014
US Avg. Rate	11.2	12.6
ID Ave. Rate	15.6	18.6

Changes Over the Last 5 Years in Idaho

	2010	2011	2012	2013	2014
Suicide Rate	18.5	17.9	18.7	19.1	19.6
State Rank in Suicides per Capita	6th	11th	8th	7th	9th
Total Suicide Deaths	209	284	299	308	320

Changes Over the Last 5 Years in Idaho

	2010	2011	2012	2013	2014
Youth, age 15-24 Suicide Rate	16.1	22.2	24.0	20.4	19.4
Youth, age 15-24 Rank in Suicides per Capita	8th	3rd	3rd	6th	9th
Number of Suicide Deaths Among School-Age Children (18 or younger) Over 5 Years	2006-10 72	2007-11 78	2008-12 83	2009-13 85	2010-14 96

What Works

- LEADERSHIP: State leadership is necessary for comprehensive, effective and sustainable suicide prevention programs
- YOUTH TRAINING: Training youth with positive, evidence-based, upstream approaches is the most effective way to reduce suicide rates over time.
- HOTLINES: A sustainable hotline is a critical and necessary component to suicide prevention infrastructure
- PUBLIC AWARENESS: Well-conceived, targeted media campaigns have a positive effect on suicidal behavior.

SENATE HEALTH & WELFARE COMMITTEE
Wednesday January 20, 2016

ATTACHMENT 3

SUCCESS THROUGH COLLABORATION

Report to Governor C.L. "Butch" Otter

December 2015

Idaho Council on Suicide Prevention
Linda Hatzenbuehler, Chair

COVER ACKNOWLEDGEMENT

Jean Calomeni
Sr. Health Education Specialist
Bureau of Community and Environmental Health
Division of Public Health
Idaho Department of Health and Welfare

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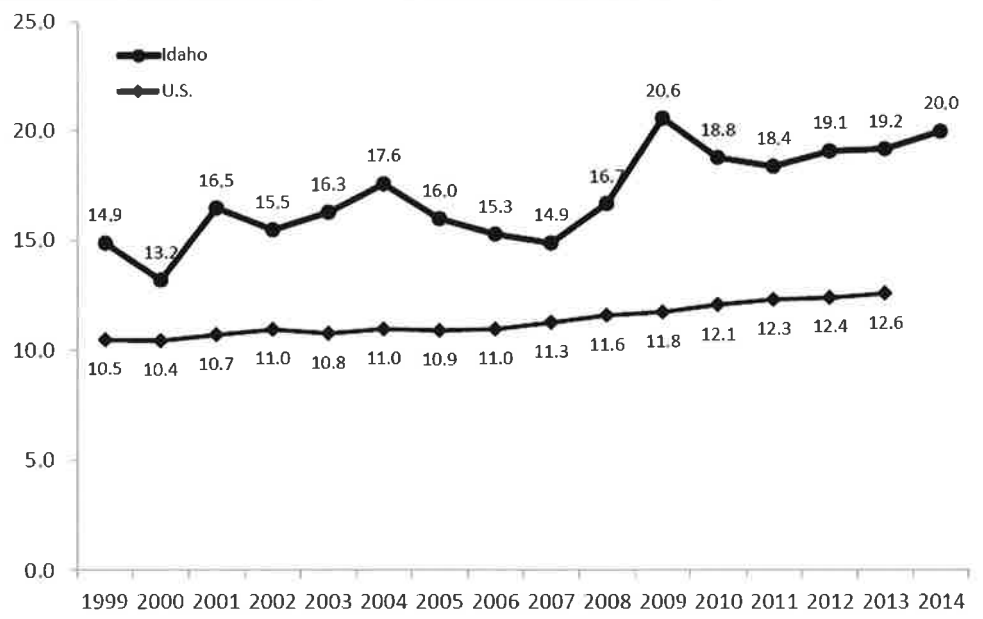
Introduction

The Idaho Council on Suicide Prevention (Council) was originally established by Governor Dirk Kempthorne in 2006. Governor C.L. "Butch" Otter reconfirmed the Council with Executive Order No 2010-12 in September 2010 and again in September 2014 with Executive Order No. 2014-08. The purpose of the Council is to:

a) Oversee the implementation of the Idaho Suicide Prevention Plan (2011);
b) Ensure the continued relevance of the of the Idaho Suicide Prevention Plan by evaluating implementation and developing changes and new priorities to update the plan;
c) Advocate for suicide prevention in Idaho;
d) Prepare an annual report on plan implementation for the Governor and Legislature.

The Council was developed because Idaho consistently ranks among the top 10 states in the country with the highest number of completed suicides per capita. Death by suicide is the second leading cause for youth under the age of 18 in Idaho. In 2014, there were six suicides per week in Idaho with a suicide rate of 19.6 per 100,000 population. The rate of suicides in Idaho per capita is increasing at a higher rate than the national rate. As shown in Table 1, in 2013, Idaho's rate per 100,000 people was 19.2 whereas the national rate per 100,000 was 12.6.

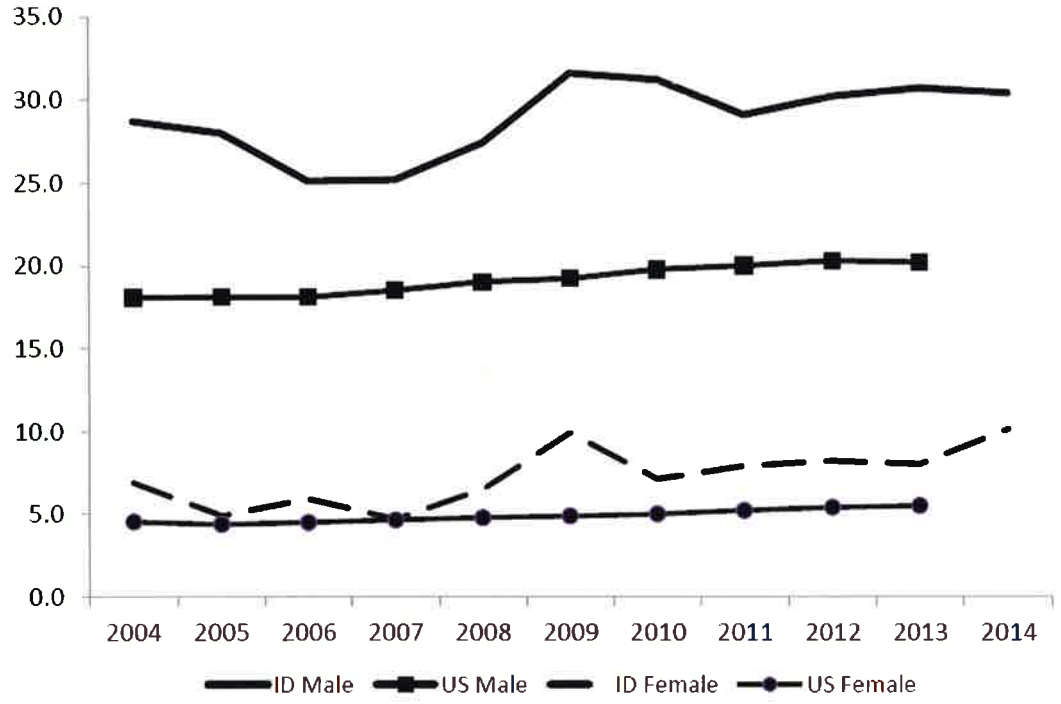
Table 1: Idaho and U.S. Resident Suicide Deaths
Age-Adjusted Rates per 100,000 Population - 1999-2014



Age-adjusted Rate: Number of deaths per 100,000 population age-adjusted to the U.S. 2000 Standard Population.
U.S. Data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates.
Idaho Source: Bureau of Vital Records and Health Statistics; Division of Public Health.

Table 2 shows that death by suicide is more common among males than females, but both genders in Idaho surpass the national average and are increasing at a more rapid rate than the national average.

Table 2: Idaho and U.S. Resident Suicide Deaths
Age-Adjusted Rates per 100,000 Population by Sex – 2004-2014



Age-adjusted Rate: Number of deaths per 100,000 population age-adjusted to the U.S. 2000 Standard Population.
U.S. data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates.
Idaho Source: Bureau of Vital Records and Health Statistics; Division of Public Health.

The Idaho map (Figure 1) shows the breakdown of Idaho's Public Health Districts while Table 3 presents the number of 2014 deaths by suicide per District. Table 4 shows the breakdown of 2014 deaths by suicide by age category. Some areas of Idaho surpass both the state and the national average for suicides.

Figure 1: Map of Idaho by Public Health District

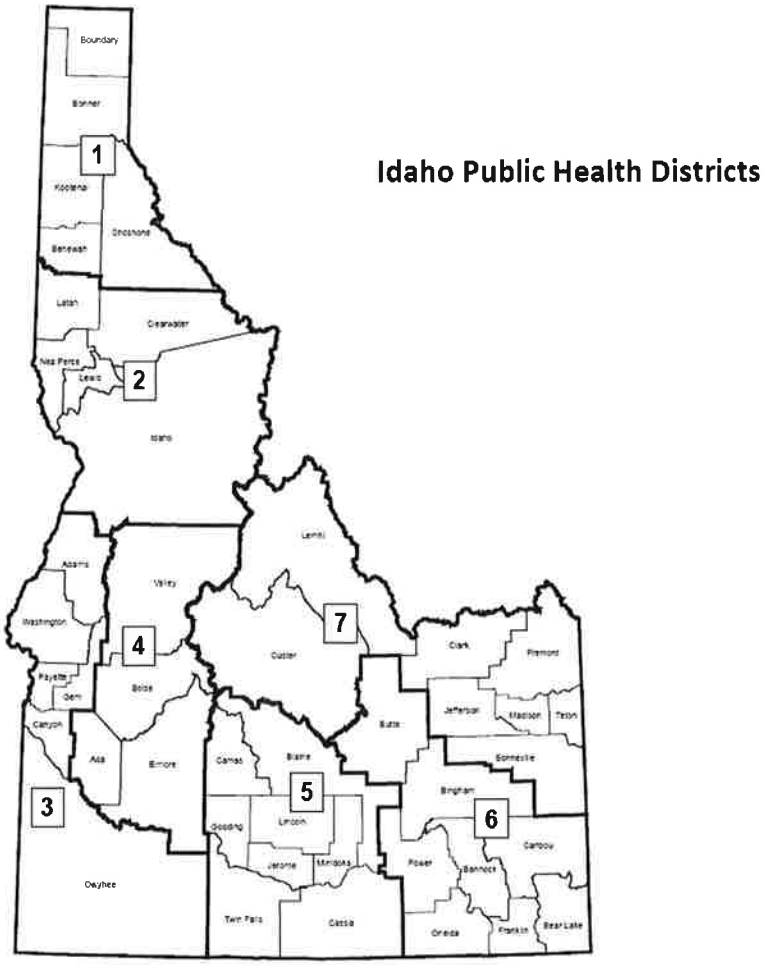
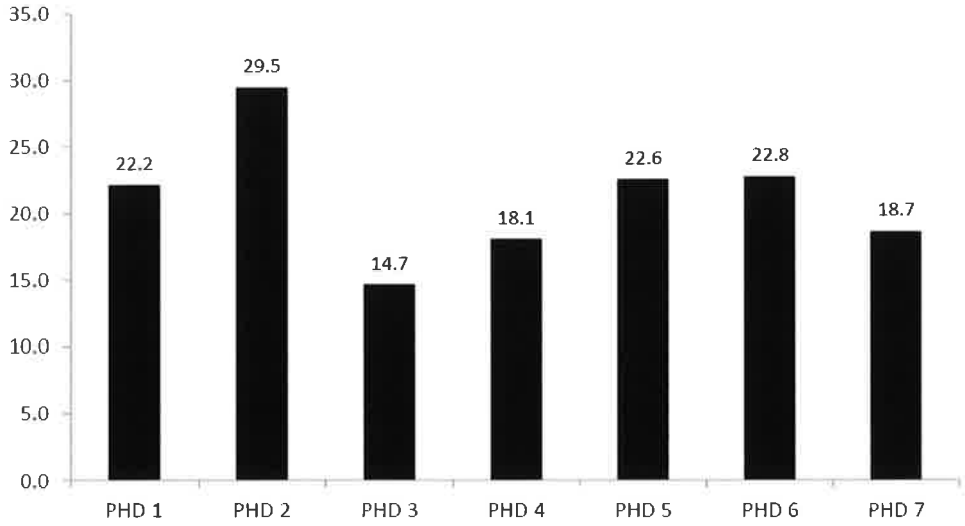
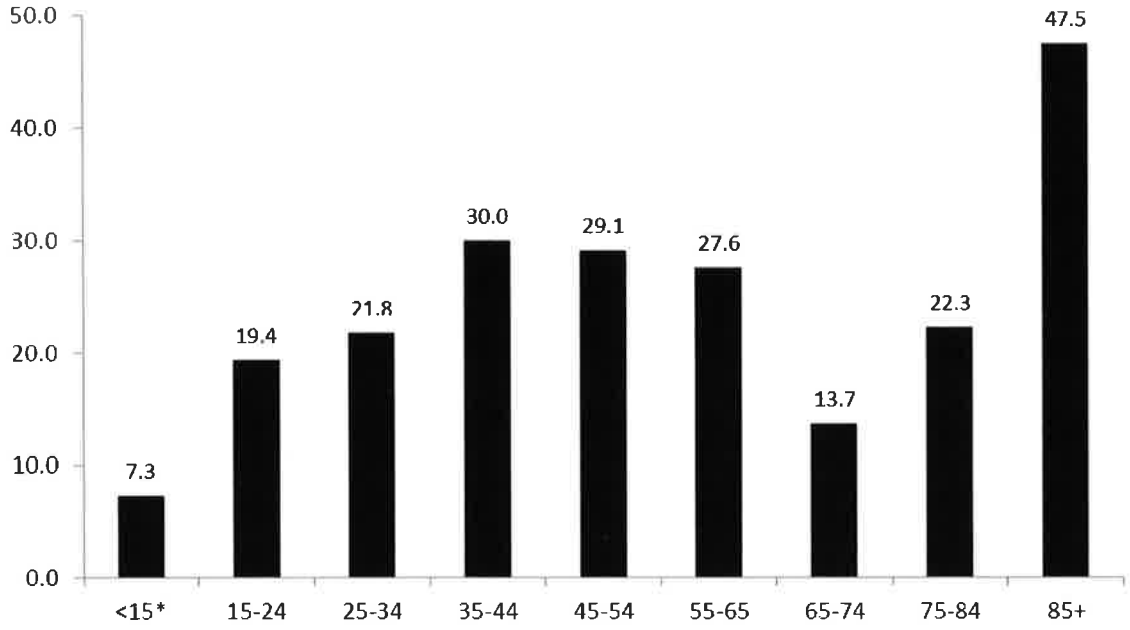


Table 3: Idaho Suicide Deaths by Public Health District of Residence 2014 Age-adjusted Rates per 100,000 Population



Age-adjusted Rate: Number of deaths per 100,000 population aged-adjusted to the U.S. 2000 Standard Population.
Idaho Source: Bureau of Vital Records and Health Statistics; Division of Public Health.

Table 4: Idaho Resident Suicide Deaths
2014 Rates per 100,000 Population by Age Category



*Number of deaths is based on ages <15; population is based on 10-14.
Age-specific Rate: Number of deaths per 100,000 population in age group.

Death by suicide is not just a devastating emotional trauma to family and friends but also presents a significant financial burden to the community, as well as loss of productivity in the state. The most recent available data (2013) estimates that nearly $1.3 Million in medical care costs and more than $467 million in total lifetime productivity losses are due to suicides. Suicide has a major impact on Idaho's economy and on the ability of individual communities to develop and prosper. (Neill Piland, Institute of Rural Health, Idaho State University, 2015.)

Idaho Council on Suicide Prevention 2015 Report to the Governor
Council Chair's Report

The Idaho Council on Suicide Prevention respectfully submits our 2015 annual report for the Governor and Legislature. This document reviews the events relevant to suicide prevention in Idaho during the past year. Through this report, you will see that 2015 was a watershed year for suicide prevention in Idaho. The Council met with the Health Quality Planning Commission (HQPC) in August 2014. Together, the Council and the HQPC recommended that a concurrent resolution be submitted to the 2015 Idaho Legislature in order to establish a system of care that prioritizes and implements the *2011 Idaho Suicide Prevention Plan: An Action Guide (ISPP)*.

Following the Council's presentation to the Idaho Legislature early during the 2015 legislative session (62nd), Senator Dan J. Schmidt, with Representative John Rusche's support, created Senate Concurrent Resolution 104 (SCR 104). The Concurrent Resolution was passed and charged the Health Quality Planning Commission (HQPC) with preparation of a plan for implementing a comprehensive suicide prevention program such as the one outlined in the *2011 Idaho Suicide Prevention Plan*. The Resolution further indicated that the HQPC should work with the Idaho Council on Suicide Prevention and other stakeholders on the implementation plan, which should give special consideration to institutional changes necessary to prevent suicide. SCR104 also directed that improved training be provided for state, education, health care, public safety personnel, and others likely to be able to prevent suicide through their interactions with persons at risk. The findings and recommendations of the HQPC including proposals for policy and statutory changes are expected in the 2016 session of the Idaho Legislature (63rd).

After SCR 104 was passed by the Legislature, a subgroup of the Council, the HQPC, and other leaders in suicide prevention met to select prevention strategies most likely to succeed and the infrastructure necessary to improve the coordination of prevention efforts.

SCR 104 Core Team
Subgroup of the Council, HQPC, and other leaders in suicide prevention met to select the prevention methods most likely to succeed and the infrastructure necessary to improve coordinated efforts.
Team Members: • Bob Polk, MD, Chair, Health Quality Planning Commission and Core Team • Jennifer Dickey, Idaho Lives Project • Ross Edmunds, Idaho Department of Health and Welfare, Division of Behavioral Health • Judy Gabert, SPAN Idaho and Idaho Lives Project • Jeni Griffin, SPAN Idaho • Linda Hatzenbuehler, Chair Idaho Council on Suicide Prevention • Kim Kane, Idaho Lives Project • Matt McCarter, State Department of Education • John Reusser, Idaho Suicide Prevention Hotline • Elke Shaw-Tulloch, Idaho Department of Health and Welfare, Division of Public Health • Dieuwke Dizney-Spencer, Idaho Department of Health and Welfare, Division of Public Health • Corey Surber, St. Alphonsus Hospital

This core group of individuals collaborated on the development of recommendations put forward to the HQPC for their consideration and approval. Specifically, they developed the recommendations below with the following vision and goal as their guide.

VISION: Idaho will have the lowest suicide rate in the nation.
GOAL: 10% reduction in suicide rate by 2020.

The core group reviewed the 10 goals articulated in the 2011 Suicide Prevention Plan and developed 12 initiatives that align with the plan's goals into five broad categories:

1) Upstream (prevention: pre-ideation or behavior)
2) Midstream (prevention: pre-ideation or behavior)
3) Downstream (treatment and follow-up)
4) Over the Falls (post-completed suicide)
5) Streambed (infrastructure).

The 12 initiatives were then organized using this new grouping mechanism with strategies articulated under each category.

ABBREVIATED SUICIDE PREVENTION STRATEGIES	POTENTIAL IMPACT	Idaho Suicide Prevention Plan GOAL
Upstream Interventions (Primary Prevention)		
1. **Public Awareness Campaigns** a. Mental health acceptance/parity b. Means restriction	Increased acceptance Successful intervention	1, 2 and 5
2. **Training of Youth** in strengths, hope, help, resilience, and mental health acceptance	Increased life-long resilience and well being	3
Mid-Stream Interventions (Secondary Prevention)		
3. Targeting **gatekeeper training** to those most likely to have the greatest impact a. Primary care personnel b. School personnel	Increased identification and referrals	3
4. **Train media** on safe and effective reporting	Reduced contagion	3
5. **Sustainable Funding: Idaho Suicide Prevention Hotline**	Increased intervention	8

Downstream: Treatment and Follow up (Tertiary Prevention)		
6. Ensure **training of behavioral health** clinicians in suicide assessment and management. a. Through university curricula b. Through re-licensing training	Increased treatment effectiveness	4
7. Effective, immediate **follow-up** of suicidal patients post emergency department or mental health facility discharge, or post health care visit.	Reduced lethality of highest risk periods	6
Over the Falls: Postvention		
8. Immediate **coroner reporting** of suicides	Reduce contagion and thereby decrease the number of deaths	7, 10
9. **Train professionals who encounter survivors** in the immediate aftermath of suicide loss		7
10. Train survivor of suicide loss **support group facilitators**		7
Riverbed: Infrastructure		
11. Creation of **an Office of Suicide Prevention** to ensure effective implementation of the ISPP strategies and interventions statewide	Increase effectiveness of suicide prevention efforts by assigning responsibility and resource management to a state office.	9
12. Overcome barriers to **accurate and adequate data reporting** of suicide and suicidal behavior	Increased ability to measure effectiveness and participation in the National Violent Death Reporting System	10

Following this analysis, priorities were set and three initiatives were raised to the surface for calendar year 2015, namely:

1. Development of an Office of Suicide Prevention to be housed within the Department of Health and Welfare, Division of Public Health.
2. Increase educational programs to be provided in public schools through a variety of platforms such as the Idaho Lives project.
3. Ongoing funding for the Idaho Suicide Prevention Hotline such that 60% of the funding for the Hotline would come from state-appropriated funds.

The Council together with the HQPC will seek funding for all three (3) initiatives during the 2016 Legislative session.

In addition to these major accomplishments, a number of other activities occurred associated with prevention, as well as intervention with individuals and families who were survivors of suicide. Full reports from our partners who implemented these other interventions begin on page 22. Report highlights are in the following Executive Summary.

Idaho Suicide Prevention Plan Implementation
2015 Highlights
Partner Reports Executive Summary

GOAL 1: PUBLIC AWARENESS

Idahoans understand that suicide is preventable and accept responsibility for their role in suicide prevention.

- A Chapter of the American Foundation for Suicide Prevention, a national organization that funds research, offers educational programs, advocates for public policy, and supports those affected by suicide was established in Idaho.

- KTVB, the Idaho Suicide Prevention Hotline, LiveWilder, and Meridian Mayor's Youth Advisory Council produced Public Service Announcement (PSA) https://www.youtube.com/watch?v=_lICtJeIcY4 . This PSA aired on September 7 and continues to run. There are plans for quarterly productions for targeted content and age groups, airing with affiliates throughout the state.

- Approximately 450 school counselors, teachers, administrators, school resource officers and community stakeholders attended the Idaho State Suicide Prevention and Support Conference. During the conference, the Suicide Prevention Action Network (SPAN) of Idaho presented information to help schools with suicide prevention, intervention, and postvention support.

- The Boise Veterans Affairs Medical Center (VAMC) organized the VA Mental Health Summit: *Building Futures* in August 2015: Approximately 110 community members attended the conference.

GOAL 2: ANTI-STIGMA

Idahoans understand and accept that seeking help for mental health issues is to be encouraged and supported.

- HB 246 Anti-Bullying Bill signed into law April 26, 2015. Representative Ilana Rubel and Senator Janie Ward-Engelking sponsored the legislation.

- Recovery Community Centers provide a meeting place for individuals to work on and maintain their recovery from substance use disorders and mental illness. These centers help fight stigma by acting as a face for recovery to the community as a whole.

- The Shoshone-Bannock Tribes hosted the second annual "Walk for Life" suicide awareness and prevention activity.

GOAL 3: GATEKEEPER EDUCATION

The education of professionals and others working with people at risk for suicide include effective suicide prevention curricula as well as ongoing gatekeeper and other suicide prevention training.

- In 2015, the Idaho Lives Project provided new *Sources of Strength* training to 16 schools statewide, and *Sources of Strength* booster (second or third) trainings to 22 schools. Over 940 middle and high school students, as well as 100 school adult advisors were trained through this program in 2015.

- Idaho Lives trained over 1,300 school staff, 725 other professionals (law enforcement, juvenile justice, clergy, foster care, EMS, and physicians, etc.) and 267 community members in 2015

- SPAN Idaho trained over 375 individuals who come into contact with people who might be at risk, have suicidal behaviors or been affected by suicide loss. These include coroners, juvenile justice, clergy, schools, health clinics, 4-H clubs, law enforcement, civic groups, and businesses. Warning signs, statistics, how to talk about suicide, and resources are just some of the topics covered.

- Departments at six major Idaho universities and colleges were queried and found to have no specific classes or curriculums available to educate students in the practices of effective assessment, treatment, and management of individuals at risk for suicide.

- A number of articles and materials that can be a resource to professors in the development of curriculum have been identified and will available on the Council website in 2016.

- The National Alliance on Mental Illness (NAMI) Idaho held "Question, Persuade, Refer" (QPR) training during their annual conference in Coeur d'Alene. Over 50 individuals were trained on warning signs and referral techniques for use in their communities.

GOAL 4: BEHAVIORAL HEALTH PROFESSIONAL READINESS

Mental health and substance abuse treatment professionals are trained to use current, appropriate, and recommended practices for assessing and treating individuals who show signs of suicide risk.

- *The More Than Sad,* a program designed by the American Foundation for Suicide Prevention, teaches how to recognize signs of depression and other mental health problems, initiate a conversation about mental health with youth, and get help. *The*

More than Sad was presented in coordination with a community partnership with All Under One Roof of South East Idaho in Pocatello on two occasions during their continuing education course offered to teachers and counselors through their Understanding Lesbian, Gay, Bisexual, and Transgender, (LGBT) Youth course.

- Boise VA Suicide Prevention Coordinator conducted training for 70 mental health professionals on suicide risk assessment in Twin Falls on August 27, 2015.

- A Council subcommittee reviewed the legislation passed in Washington that requires mental health professionals to complete continuing education in approved suicide assessment, treatment, and management training programs. The subcommittee has obtained a list of the programs and curriculum that have been approved in the state of Washington. This information will be made available on the Council website in 2016.

- In 2015, M. David Rudd, PhD provided suicide assessment and management training to over 800 behavioral health and primary care providers in 19 locations throughout Idaho.

- The Juvenile Justice Program continues to provide *Shield of Care* suicide prevention training to juvenile justice facilities throughout the state. *Shield of Care* is evidence-based suicide prevention training tailored specifically to the juvenile justice environment.

- The Boise VAMC presented at the Veterans Service Officer Conference on Suicide Prevention in July

GOAL 5: COMMUNITY INVOLVEMENT

Community leaders and stakeholders develop and implement suicide prevention activities that are current, recommended and culturally appropriate that are specific to their regions and communities.

- *The More Than Sad* was presented to parents and teachers on two (2) occasions at Idaho State University's Sexual and Gender Alliance (SAGA) Center in Pocatello.

- The Shoshone-Bannock Tribe was awarded the Garrett Lee Smith Youth Suicide Prevention Grant, hired a part time staff member, and started to administer the Patient Health Questionnaire 9 (PHQ-9), a depression and suicide screening form to all mental health patients.

- The Shoshone-Bannock Tribe applied for, and was awarded, the Department of Health and Human Services, Indian Health Services, Suicide Prevention Initiative grant.

- The Shoshone-Bannock Tribe established a Zero Suicide Implementation Team.

- The Speedy Foundation, in cooperation with Optum Idaho, continues to provide free Mental Health First Aid training courses throughout the state.

- The State Department of Education provided a "Safe Schools in Idaho" seminar for law enforcement and school officials which covered general principles of threat assessment in schools.

GOAL 6: ACCESS TO CARE

Crisis intervention and behavioral health services, including mental health and substance abuse treatment, are widely available, culturally appropriate, accessible, and valued by communities.

- The Crisis Centers can help people get the services and assistance they need without going to the emergency room or jail. The Legislature appropriated $1.7 Million for a second crisis center in northern Idaho in 2015.

- The Jeff D. Lawsuit agreement was finalized in June 2015. The agreement targets the provision of community-based children and families' Behavioral Health services, which has been the unresolved issue in the case.

- In the last 12 months, 80 Idaho Veterans have been identified as High Risk for Suicide and provided enhanced mental health services, 61 of those had suicide attempts. Eight (8) Veteran suicides were reported.

- In partnership with the Idaho Lives Project, the Idaho Suicide Prevention Hotline surveyed over 900 licensed behavioral health providers who were trained in suicide assessment and management by Dr. David Rudd to determine their readiness to manage suicidal clients and to add appropriate providers to the Hotline's referral list.

- Behavioral Health published a standard on Peer Support Specialists enhancing the existing requirement and transitioning the certification process to the department to implement. To date, there are 105 trained Peer Support Specialists with 83 of those certified.

GOAL 7: SURVIVOR SUPPORT

Information and services are in place in all regions of Idaho to support survivors and others affected by suicide in a sensitive and culturally appropriate manner.

- On the Saturday before our American Thanksgiving "National Survivors of Suicide Day," was held in Boise and Pocatello with survivors from across the state attending. Bryan Beddoes, MS, EDS, LPC spoke on the uniqueness of grief associated with suicide loss.

- The Idaho Lives Project trained 17 survivor support facilitators in August 2015.SPAN Idaho distributed over 250 survivor packets to families who have lost loved ones.

- SPAN Idaho distributed over 250 survivor packets during 2015. The packets contain information for families who have lost loved ones to suicide.

GOAL 8: SUICIDE PREVENTION HOTLINE

An Idaho statewide suicide prevention hotline is established and funded.

- In 2015, the Hotline trained over 60 prospective volunteers in the Applied Suicide Intervention Skills Training, or ASIST model.

- In 2015, the Hotline completed its third full year of operations.. The Hotline entered its second full year of 24/7 phone response and is on track to reach 5,000 calls in 2015. They are also preparing to launch Online Emotional Support (OES) via crisis text and chat response.

- The Idaho Suicide Prevention Coalition officially formed in June of 2015 with the goal to seek legislation to create sustainable State funding to support 60% of the Idaho Suicide Prevention Hotline's financial need. The Coalition will also seek sustainable funding from outside sources for the remaining 40% financial need for Idaho Suicide Prevention Hotline as a public and/or private initiative with statewide support for suicide prevention efforts and policy.

- All tribes in Idaho disseminated suicide hotline information through the Indian Health Service Centers and communities.

- The Idaho Lives Project and SPAN Idaho distributed hotline information and materials and over 120 trainings statewide in 2015.

GOAL 9: LEADERSHIP

The Idaho Council on Suicide Prevention oversees suicide prevention activities at all levels, as guided by the Idaho Suicide Prevention Plan, and works in collaboration with a lead Idaho state government agency that is responsible for Idaho's suicide prevention and intervention efforts.

- The Council assisted with the development of SCR 104, a concurrent legislative resolution charging the Health Quality and Planning Commission with the development of an implementation plan for suicide prevention in Idaho.

- The Council members participated in a core working group facilitated by HQPC leadership to develop an implementation plan and budget for the establishment of a State Office of Suicide Prevention. HQPC and Council leadership will present this proposal during the 2016 legislative session

GOAL 10: DATA

Data is available on which to make decisions regarding suicide prevention services.

- The Idaho Lives Project collected and analyzed data pertaining to school climate, student protective factors, and behavioral health provider skills.

In summary, 2015 was a progressive year for improving the prevention of death by suicide in Idaho. The Council is hopeful that the Legislature will look favorably upon our request to develop the Office of Suicide Prevention, as well as approve funding for the Idaho Suicide Prevention Hotline, and increase educational programs for schools. Moving these three (3) issues forward addresses several objectives of the 2011 Prevention Plan's Goal 9: Leadership from the Idaho Council on Suicide Prevention. We are most grateful to the HQPC and in particular the chairman, Dr. Robert Polk, for his leadership this year in advancing suicide prevention and the interests of the citizens of Idaho, and to Senator Dan Schmidt and Representative John Rusche for their leadership in passing SCR 104.

Respectfully submitted,

Linda C. Hatzenbuehler, Chair
Idaho Council on Suicide Prevention

SENATE CONCURRENT RESOLUTION 104

LEGISLATURE OF THE STATE OF IDAHO

Sixty-third Legislature First Regular Session - 2015

IN THE SENATE

SENATE CONCURRENT RESOLUTION NO. 104

BY HEALTH AND WELFARE COMMITTEE

A CONCURRENT RESOLUTION

STATING FINDINGS OF THE LEGISLATURE AND AUTHORIZING THE HEALTH QUALITY PLANNING COMMISSION TO PREPARE A PLAN FOR A COMPREHENSIVE SUICIDE PREVENTION PROGRAM IN IDAHO.

Be It Resolved by the Legislature of the State of Idaho:

WHEREAS, suicide is a leading cause of death among Idahoans; and

WHEREAS, Idaho has one of the highest suicide rates in the nation; and

WHEREAS, the difference between Idaho deaths by suicide and the national average continues to increase; and

WHEREAS, certain suicide risk factors have been identified by the Centers for Disease Control and Prevention; and

WHEREAS, the members of certain population groups in Idaho are at high risk of suicide; and

WHEREAS, the Health Quality Planning Commission is tasked with promoting the health and safety of Idahoans; and

WHEREAS, the Health Quality Planning Commission is tasked with making recommendations to the Legislature.

NOW, THEREFORE, BE IT RESOLVED by the members of the First Regular Session of the Sixty-third Idaho Legislature, the Senate and the House of Representatives concurring therein, that the Health Quality Planning Commission prepare an implementation plan for a comprehensive suicide prevention program such as the Idaho Suicide Prevention Plan published by the Idaho Council on Suicide Prevention.

BE IT FURTHER RESOLVED that the plan include the involvement of the Idaho Council on Suicide Prevention and other stakeholders, and that it give special consideration to the institutional changes necessary to better prevent suicide, to training for state, educational, health care and public safety personnel and others likely to be able to prevent suicide through their interaction with persons at risk, and to programs and policies designed to serve those most at risk of suicide.

BE IT FURTHER RESOLVED that the commission report its findings and recommendations, including proposals for policy or statutory changes, to the Second Regular Session of the Sixty-third Idaho Legislature.

SPAN IDAHO

SUICIDE PREVENTION ACTION NETWORK OF IDAHO

Suicide in Idaho: Fact Sheet
August 2015

- Suicide is the 2nd leading cause of death for Idahoans age 15-34 and for males age 10-14. (The leading cause of death is accidents.)
- Idaho is consistently among the states with the highest suicide rates. In 2013 Idaho had the 7th highest suicide rate, 47% higher than the national average.
- In 2014, 320 people completed suicide in Idaho; a slight increase from 2013.
- Between 2010 and 2014, 78% of Idaho suicides were by men.
- In 2014, 60% of Idaho suicides involved a firearm.
- 15.8% (1 in 7) of Idaho youth attending regular public and charter high schools reported seriously considering suicide in 2013. 7.0% (1 in 14) reported making at least one attempt.
- Between 2010 and 2014, 96 Idaho school children (age 18 and under) died by suicide. Twenty of these were age 14 and under.
- Number of emergency department visits for self-inflicted injury per year: 836,000 in the United States
- In 2013, there were 41,149 deaths by suicide in the United States, an average of 1 person every 12.8 minutes.

Idaho Resident Suicides by Region – 2014

Region	Anchor City	Suicides	Rate (per 100,000)	Population	Tot. # suicides 2010-2014	5-yr Avg Rate
1	Coeur d'Alene	53	23.9*	221,398	235	21.7
2	Lewiston	33	30.8*	107,033	119	22.4
3	Nampa	35	13.1-	268,080	220	16.9
4	Boise	85	18.1*	468,980	374	16.6
5	Twin Falls	42	22.1*	190,496	188	20.0
6	Pocatello	36	21.7-	166,232	175	21.1
7	Idaho Falls	36	17.0*	212,245	190	18.1

* Increase from 2013, - decrease from 2013

Idaho Suicides by Age/Gender 2010-14

Over 5 year period

Age	Total	Male	Rate	Female	Rate
< 15	20	18	3.3	2	0.7
15-24	231	182	31.6	49	8.9
25-34	212	171	31.8	41	7.9
35-44	255	192	38.9	63	13.1
45-54	303	226	44.6	77	15.1
55-64	248	186	39.4	62	12.8
65-74	117	99	32.6	18	5.7
75-84	69	62	42.7	7	4.1
85+	46	42	87.0	4	4.7

Method 2010-14

(all ages)

Firearm	60.4%
Poisoning	16.5%
Suffocation	18.5%
Cut/Pierce	1.0%
Fall	0.9 %
Other	2.6%

Idaho Suicide Rates 2005 – 2014

Year	Number	ID Rate	US Rate
2005	225	15.7	11.8
2006	218	14.9	11.2
2007	220	14.7	11.5
2008	251	16.7	11.9
2009	307	19.9	12.0
2010	209	18.5	12.4
2011	284	17.9	12.7
2012	299	18.7	12.9
2013	308	19.1	13.0
2014	320	19.6	N/A

Idaho Youth Risk Behavior Survey 2013 – Regular Public and Charter High School Students

Grade	Sad or Hopeless	Suicidal	Plan	Attempt	Medical Care For Attempt
9th	28.4%	18.2%	12.8%	8.3%	2.8%
10th	27.8	14.4	12.7	7.6	3.0
11th	31.0	15.3	11.9	6.8	2.0
12th	29.3	14.9	14.3	5.7	1.9
Idaho Overall	29.4	15.8	13.0	7.0	2.5

Idaho Suicide Rate by County

5-year total number and 5-year average annual rate 2010-2014

(Resident suicides per 100,000 people)

County	Number	Rate	County	Number	Rate
Ada	328	16.0	Gem	12	14.4
Adams	4	20.8	Gooding	14	18.3
Bannock	101	24.2	Idaho	16	19.7
Bear Lake	7	23.5	Jefferson	24	18.0
Benewah	9	19.7	Jerome	29	25.7
Bingham	38	16.7	Kootenai	143	20.0
Blaine	25	23.5	Latah	25	13.2
Boise	12	34.8	Lemhi	12	30.7
Bonner	42	20.5	Lewis	5	25.9
Bonneville	101	19.0	Lincoln	4	15.2
Boundary	16	29.4	Madison	12	6.4
Butte	3	21.9	Minidoka	13	12.9
Camas	-	-	Nez Perce	61	30.8
Canyon	168	17.2	Oneida	2	9.5
Caribou	11	32.1	Owyhee	7	12.2
Cassia	19	16.3	Payette	18	15.9
Clark	4	88.2	Power	3	7.8
Clearwater	12	27.8	Shoshone	25	39.6
Custer	11	51.4	Teton	14	27.5
Elmore	27	20.5	Twin Falls	84	21.3
Franklin	13	20.2	Valley	7	14.4
Fremont	9	13.8	Washington	11	21.8
			Idaho (total)	1,501	18.8 (5-year average)

Note: Rates for many counties are based on fewer than 20 deaths. Caution is advised when interpreting rates based on small numbers.

Sources: Idaho Bureau of Vital Records and Health Statistics,
Idaho Department of Health and Welfare,
Center for Disease Control and Prevention
State Department of Education, YRBS Idaho, 2013

Compiled by Jeni Griffin, Executive Director, SPAN Idaho
Special Thanks to Martjin Van Beek, Research Analyst Senior and Pam Harder, Research Analyst Supervisor, Bureau of Vital Records and Health Statistics

Idaho Council on Suicide Prevention 2015 Membership

Board Name: Idaho Council on Suicide Prevention

Board Purpose: The Council's responsibilities shall be to oversee the implementation of the Idaho Suicide Prevention Plan, to ensure the cont relevance of the Plan by evaluating implementation progress reports and developing changes and new priorities to update the Plan, to be a pı suicide prevention in Idaho, to prepare an annual report on Plan implementation for the Governor and Legislature.

Term of Office: 2

Member Name	Position Expires	Original Appointment	Board Position
Jeff Kirkman	October 25, 2017	September 11, 2015	Corrections
Vacant 3	October 25, 2017		Dept. of Educ.
Linda Hatzenbuehler	October 25, 2017	April 21, 2014	CHAIR
Kim Kane	October 25, 2017	April 21, 2014	Other--Idaho Lives Project
Matthew Olsen	October 25, 2017	October 25, 2006	Bannock Co. Juvenile Justice
Dieuwke Dizney-Spencer	October 25, 2017	December 14, 2012	Health & Welfare Rep.
Pamela Catt-Oliason	October 25, 2016	January 17, 2012	Comm. on Aging
Mary Pierce	October 25, 2017	November 20, 2010	Veterans Affairs
Jeni Griffin	October 25, 2017	March 2, 2012	SPAN
Vacant 01	October 25, 2014		House
Neva Santos	October 25, 2016	October 23, 2012	ID Academy Family Phusicians
John Reusser	October 25, 2016	October 23, 2012	ID Suicide Prevention HOTLINE
Heidi Lasser	October 25, 2017	November 20, 2012	Health & Welfare
Fred Martin	November 30, 2016	February 3, 2015	Senate
Kristy Broncho	October 25, 2017	October 30, 2013	Idaho Tribes Rep.
Amanda Wester	October 25, 2015	November 5, 2013	Youth Advovate
Catherine Perusse	October 25, 2017	September 10, 2014	NAMI Board Mbr.
Linda Peterson	October 25, 2017	September 10, 2014	Survivor
William Wilder	October 25, 2017	September 10, 2014	Mental Health Professional
Vacant 02	October 25, 2016		St. Al's

Partner Reports Index

American Foundation for Suicide Prevention: Idaho Chapter

Boise Veterans Affairs Medical Center

National Alliance on Mental Illness (NAMI)

Idaho Council on Suicide Prevention: Health Professions Subcommittee Report

Speedy Foundation

Idaho Lives Project

Idaho State Department of Education

Idaho State Department of Health and Welfare, Division of Behavioral Health

Idaho Suicide Prevention Hotline

LiveWilder Foundation

Shoshone-Bannock Tribes, Mental Health Program

Suicide Prevention Action Network of Idaho (SPAN Idaho)

AMERICAN FOUNDATION FOR
Suicide Prevention

The Idaho Chapter of The American Foundation for Suicide Prevention

Officially chartered - November of 2015

Board Members

Executive Committee:

Chairperson: Carmen Stanger
Secretary: Ruby Gallegos
Treasurer: Jeff Weeks

Board Members:

Sara Helmer
Jackie Sodaro
Darbi McKean
Natalie Galloway Hardenbrook
Darren Rux
Amanda Hundt

The American Foundation for Suicide Prevention is the leader in the fight against suicide. We fund research, offer educational programs, advocate for public policy, and support those affected by suicide. Led by CEO Robert Gebbia and headquartered in New York, AFSP has over 80 local chapters with programs and events nationwide. We are proud that Idaho recently become the 81st chapter in the fight to end suicide.

OVERVIEW 2015

2015 has been a challenging and very productive year for the Idaho AFSP Chapter. We made it our goal in the spring of 2015 to become an official chapter of the American Foundation for Suicide Prevent by the end of 2015. It required dedication, research and hard work of select suicide prevention advocates to bring the AFSP officially to Idaho. This hard work paid off, and Idaho received its official AFSP Charter on November 4th, 2015.

EDUCATION

MORE THAN SAD

More Than Sad - This program is designed by the AFSP to be presented to teens, parents, teachers and counselors. It helps teens to recognize the signs of depression in themselves and others, challenges the stigma surrounding depression, and demystifies the treatment process. This program teaches parents how to recognize signs of depression and other mental health problems, initiate a conversation about mental health with their child, and get help. It helps teach educators to recognize signs of mental health distress in students and refer them for help. The program complies with the requirements for teacher education suicide prevention training in many states.

The More Than Sad program was presented to parents and teachers on two occasions at Idaho State University's SAGA Center (Sexual and Gender Alliance) in Pocatello. It was also presented in coordination with a community partnership with All Under One Roof of South East Idaho in Pocatello on two occasions during their continuing education course offered to teachers and counselors through their Understanding LGBT Youth course. Due to local fundraising efforts, AFSP presents this program at no fee to the community. We received positive feedback for our presentations and additional requests for more presentations for the 2016 year. We travel to communities who request this program throughout the state at the expense of the AFSP Idaho Chapter and present this program free of charge to any school district or in any community that invites us to present it. More Than Sad has taught over a million students and educators throughout the nation how to be smart about mental health.

Additional education and awareness events:
The Idaho AFSP chapter attended several other events throughout the state including mental health fairs, counseling events, invitational seminars, and tabling opportunities with other partner agencies to increase community conversations and awareness on the resources available in Idaho.

PUBLIC POLICY

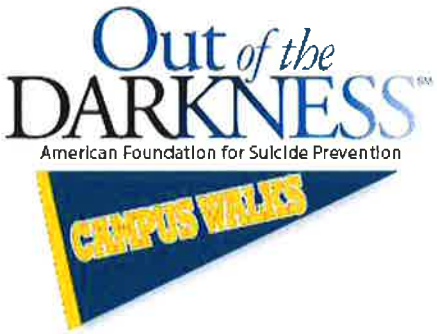
Annual Advocacy Forum- Each year, the Advocacy Forum brings together AFSP Chapter advocacy leaders and staff to network, share the latest research, and provide the public and policy makers with the information and tools they need to be effective advocates in preventing suicide.

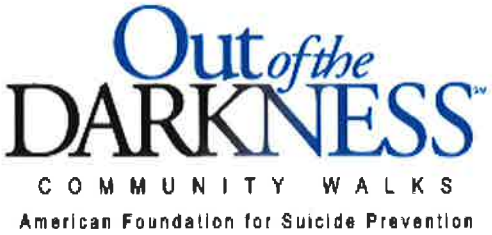
Three of Idaho's AFSP Field Advocates went to Washington D.C. in June of 2016, to meet with our U.S. Senators and Representatives to tell share their personal stories of loved ones lost to suicide, and to advocate for policies to support mental health care reform across the board, including the request for permanent funding for the suicide prevention hotline in all states. Among other issues, the Idaho AFSP Chapter sees funding the hotline as an immediate priority to help drive the rate of suicide down in the state of Idaho. We are committed to working with our state and national legislators, and partner agencies to advocate for permanent hotline funding.

Annual Leadership Conference- The AFSP Idaho Chapter sent one of its representatives to the annual leadership forum this year. The objective is to bring chapter members from all 50 states joined with AFSP Executive staff to connect, educate and share strategies to bring the local efforts to a national level. Attending this conference was significant for chapter development in Idaho because allowed for collaboration with other states to learn about successful and measurable programs, and implement a strategy to gain momentum in forwarding chapter development in the state of Idaho.

Support

Fundraising





We held two major fundraising events this year. One of the events was our Out of the Darkness Campus Walk held on the Idaho State University Campus in Pocatello this spring. The second fundraising event was our Boise Area Out of the Darkness Community walk held this fall. We are at once a grassroots movement, a support network, an educator, a professional research organization and a grant-making foundation totally funded through our fundraising events and private donations. While AFSP does not provide direct services, such as counseling or running a crisis hotline, we do work closely with the organizations providing these services. These two fundraising events will allow the Idaho Chapter of the AFSP to contribute significantly in the fight to end suicide in our state.

Survivor Support

Survivor Day & Grief Support Facilitator Training

In 1999, Senator Harry Reid, a survivor of his father's 1972 suicide, introduced a new resolution into the US Senate. With its passage, the US Congress designated the Saturday before American Thanksgiving "National Survivors of Suicide Day," a day on which friends and family of those who have died by suicide can join together for healing and support.

For many loss survivors, attending a Survivor Day event is the first time they realize they are not alone. Just hearing the stories—from people at all stages of healing—can be helpful. The gathering also provides participants with a chance to share their own stories with those who understand firsthand the challenges of living in the aftermath of a suicide loss.

Our annual event was held in Boise with survivors from across the state attending. Bryan Beddoes, MS, EDS, LPC spoke on the uniqueness of grief associated with suicide loss.

We also offer grief support facilitator training.

2016 PROJECTED PLAN

To fully achieve its mission, AFSP engages in the following Five Core Strategies:

- **Fund scientific research**
- **Offer educational programs for professionals**
- **Educate the public about mood disorders and suicide prevention**
- **Promote policies and legislation that impact suicide and prevention**
- **Provide programs and resources for survivors of suicide loss and people at risk, and involve them in the work of the Foundation**

As we increase funding for the Idaho Chapter of the AFSP, our goal is to become aligned with the Five Core Strategies. This is an effort that will take time and planning.

For the 2016 year, or plan and budget provides for as follows:

- **Offer educational programs for professionals:**

  More Than Sad Program: Suicide Prevention Education for Teachers and other School Personnel– To be provided to teachers and counselors throughout the state free of charge.

  SafeTalk Training – To be offered free to a limited number of professionals throughout the state as our budget will allow.

  ASIST Training – To be offered to a limited number of professionals throughout the state as our budget will allow.

- **Educate the public about mood disorders and suicide prevention**

  Talk Saves Lives – Present this program for free throughout the state and engage panel and community discussions with partner agencies on the risks, warning signs, and how to ask ask for help.

  More Than Sad: Teen Depression– To be presented to teens throughout the state free of charge.

  The Truth About Suicide: *Real Stories of Depression in College* – To be presented free of charge at campuses throughout the state to educate students on anxiety and depression among college students.

- **Promote policies and legislation that impact suicide and prevention**

  State Advocacy Day – The Idaho Chapter of the AFSP will be sponsoring a state advocacy day at the Capitol. We will be inviting several partner agencies to attend. The goal is to work in a collaborative effort with our partner agencies in the suicide prevention community to work together to draft legislation and testify at hearings, send

letters to decision makers and local media, facilitate trainings, promote quality educational programs, and develop relationships with our lawmakers. It is important to make it known that effective policies can make a difference in reducing suicide.

Annual Advocacy Forum -- The Idaho Chapter will send 3 delegates to Washington DC again to work with our legislators on a national level regarding mental health reform and funding issues, and keep them informed on the legislative needs of their Idaho constituents.

- **Provide programs and resources for survivors of suicide loss and people at risk, and involve them in the work of the Foundation**

International Survivors of Suicide Loss Day – We will be increasing this event to hopefully two additional locations throughout the state.

Grief Support Facilitator Training – We will continue to provide training guides for this program.

Campus and Community Walks – We will be increasing our walks to 2 campus walks and a community walk. This also gives people a way to honor their loved one, honor those with lived experience and participate in the work of the Foundation.

Partner Agency Referrals – We will continue an ongoing dialogue with key community partners of the suicide prevention community to continue building a solid referral network for those in crisis. Examples of a few of these key partners include: The Idaho Suicide Prevention Coalition, Idaho Lives, The Idaho Suicide Prevention Hotline, The Veterans Administration, The LiveWilder Foundation, Speedy Foundation, Health and Welfare Behavioral Health and Mobile Crisis Unit, Boise PD Crisis Intervention, The Idaho Federation for Families, and SPAN-Idaho.

Through our programs, we The American Foundation for Suicide Prevention have taken a leadership role in identifying and encouraging into treatment people who have the highest risk for suicide. We educate the public by disseminating vital information about suicide and its prevention, mobilize a national network of grassroots advocates who alert officials to policies and legislation that can help to prevent suicide, and reach out to those who have lost someone to suicide to offer support and opportunities to get involved in our work.

United States Department of Veterans Affairs

Boise Veterans Affairs Medical Center

Suicide Prevention Program

The Veterans Affairs' basic strategy for suicide prevention is to provide ready access to high quality mental health (and other health care) services supplemented by programs designed to help individuals and families engage in care and to address suicide prevention in high risk patients. Outreach, education and participation on community boards are also critical aspects of the Boise VAMC suicide prevention program.

- The Suicide Prevention Coordinator ensures suicidal Veterans receive the appropriate services. *In the last 12 months 302 Idaho Veterans were connected to the Suicide Prevention Coordinator by Veterans Crisis Line consults, community hospitals, various social welfare agencies, families and friends, and have been connected with VA Services.*

- Screening and assessment processes have been set up throughout the system to assist in the identification of Veterans at risk for suicide. A chart "flagging" system has been developed to assure continuity of care and provide awareness among providers. Veterans who have been identified as being at high risk receive an enhanced level of care, including missed appointment follow-ups, safety planning, weekly follow-up visits and care plans that directly address their suicidality. *In the last 12 months 80 Idaho Veterans have been identified as High Risk for Suicide and provided enhanced mental health services, 61 of those had suicide attempts. Eight Veteran suicides were reported.*

- The Suicide Prevention Coordinator and VA Mental Health staff provide community outreach that includes education on veterans mental health issues, suicide prevention

and intervention, and providing Veterans Crisis Line materials at community events. *The Boise VAMC Suicide Prevention efforts included:*

- 187 community outreach activities, including 36 presentations on the topics of suicide prevention, working with suicidal veterans, suicide risk assessment and intervention strategies.
- Outreach Highlights
  - VA Mental Health Summit, "Building Futures" on August 25, 2014. Approximately 110 community partners attended the conference.
  - Presented on Suicide Prevention and the Veterans Crisis Line at the Idaho Veterans Service Officer Training Conference on July 30, 2015.
  - Presented training on suicide risk assessment and working with suicidal clients to 70 mental health professionals in Twin Falls, Idaho on August 27, 2015. Attendees received 4 hours of continuing education credits at no cost.

- The Suicide Prevention Coordinator is a current member of Governor's Council on Suicide Prevention; Board member for the Idaho Suicide Prevention Action Network; and participates on the Advisory Board for the Idaho Suicide Prevention Hotline.

National Alliance on Mental Illness (NAMI) - Idaho

The NAMI – Idaho is committed to supporting suicide prevention efforts in our state. We have provided Question, Persuade, Refer (QPR) Gatekeeper trainings throughout the year at our quarterly statewide conferences. Additionally, NAMI – Idaho joint the Idaho Suicide Prevention Coalition. We have two NAMI – Idaho Board Members who sit on the Suicide Prevention Hotline Advisory Board and one Board member who sits on the Suicide Prevention Action Network Idaho Board of Directors.

Idaho Council on Suicide Prevention

Health Professions Subcommittee

Subcommittee Report - October 2015

The Health Professions Subcommittee focuses on the following goals of the Idaho Suicide Prevention Plan:

Goal 4: Behavior Health Professional Readiness

Goal 6: Access to Care

In an effort to enhance Behavior Health Professional Readiness and Access to Care, the committee developed several objectives for 2015.

Objective 1: Enhance the level of theoretical and practice education of students in undergraduate and graduate behavioral health professions programs at Idaho universities and colleges on the recognition of warning signs, assessment, treatment, and management for individuals at risk for suicide.

Activity 1: Identify the colleges and universities with behavioral health professional programs and departments and determine what classes and curriculum are currently being taught on the topics in Objective 1.

Progress: Departments at six major universities and colleges were contacted and we determined that there is not a specific class or curriculum currently being taught to educate students in the practices of effective assessment, treatment, and management of individuals at risk for suicide. The topic is being discussed in some classes. Education and gatekeeper education programs for students are being offered in some cases through counseling centers on campus.

Activity 2: Identify and provide curriculum materials that can be organized into a library of resources that college and university faculty may access to educate students in evidence-based practices for assessing, managing, and treating clients at risk for suicide.

Progress: We have submitted to the council for review a number of articles and resources that can be a resource to professors in the development of curriculum.

Objective 2: Enhance the practice skills of licensed providers in behavioral health professions.

Activity 1: Identify a list of curriculums and programs that can be used in continuing education workshops for licensed providers.

Progress: The subcommittee reviewed the legislation passed in Washington that requires mental health professionals to complete continuing education in approved suicide assessment, treatment, and management training programs. The subcommittee has obtained a list of the programs and curriculum that have been approved in the state of Washington, and have provided the information to the council members for review.

Mental Health First Aid Summary

November 2015

Optum Idaho – Georganne Benjamin

The Partnership

In August 2014, The Speedy Foundation partnered with Optum Idaho to offer free Mental Health First Aid courses in communities throughout the state, with a focus on offering courses in rural communities with limited access to mental health services. Through the partnership, The Speedy Foundation funded 10 sessions to be taught by certified Mental Health First Aid instructors from Optum Idaho. Sessions were conducted in Salmon, Sandpoint, Idaho City, Grangeville, Boise, Weiser, Montpelier, Shoshone, Duck Valley Indian Reservation and Challis, Idaho and over 100 individuals were certified in Mental Health First Aid.

About Mental Health First Aid

Mental Health First Aid is an 8-hour course that teaches people how to recognize the most common signs of mental illness including depression, anxiety disorders, eating disorders and substance abuse, and the steps they can take to help someone get professional support.

Mental Health First Aid is listed in the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices, a database of mental health and substance abuse interventions that catalogues programs that have been shown to be helpful for people with mental illness. According to the National Council for Behavioral Health, since it was first used in the United States in 2007, the adult Mental Health First Aid program has been delivered to nearly 100,000 Americans through a network of more than 2,500 instructors.

Participant Feedback

Participants expressed gratitude for making Mental Health First Aid training available in their communities and giving them the tools to help their friends, neighbors and families. Some examples of participant feedback are below:

- *"I just want you to know I have been able to utilize what I have learned in your class. My confidence level has really improved while assisting clients with behavioral health concerns … I can't thank you enough."*
- *"I learned a lot and know it will help me be a better peer specialist."*
- *"This was a great resource for future encounters with people in a crisis."*
- *"Great course, very well taught. Genuinely as applicable as physical first aid."*

- *"It was a solid basic introduction to mental illness and how to approach someone dealing with it."*
- *"This is probably one of the best trainings I have attended."*
- *"It made me look at myself more with what I struggle at. It was the best training I have taken this year."*
- *"I feel more equipped to help asses people in my community with mental health issues"*
- *"As a pastor I often deal with people dealing with trauma in their lives ... I believe this will help."*
- *"I learned so much. It was useful and motivating information that I can utilize in my own life as well as my profession in social services."*
- *"Great course! I learned so much from this training."*
- *"Greatly needed; leaving confident."*

2016 Mental Health First Aid

Plans for mental health first aid trainings in 2016 are in the development stages. Considerations include targeted regional trainings, partnering with additional trainers and community partners throughout the State to extend reach and focused trainings on supporting youth.

About Optum Idaho

Optum is a leading information and technology-enabled health services business dedicated to helping make the health system work better for everyone. Optum Idaho manages outpatient mental health and substance use disorder services for adults and children enrolled in Medicaid through the Idaho Behavioral Health Plan.

Optum Idaho's goal of helping people facing a mental health or substance use issue access the behavioral health services they need to reach long-term recovery, aligns closely with The Speedy Foundation's dedication to understanding mental illness, preventing suicide and fighting stigma through education, research, and advocacy. Optum Idaho partnered with The Speedy Foundation to offer Mental Health First Aid Training in order to teach more people to recognize the signs that someone is experiencing a mental health distress or crisis, and how to help that person get connected to appropriate professional care and treatment.

13601 W. McMillan Rd., Ste. 120, #237
Boise, ID 83713
www.idaholives.org

The Idaho Lives Project is a joint project of the State Department of Education and the Suicide Prevention Action Network of Idaho. The Project is federally funded by the Garrett Lee Smith State and Tribal Youth Suicide Prevention Grant awarded through the Substance Abuse and Mental Health Services Administration on October 7, 2013. The mission of this three-year Project is to foster connectedness and resilience throughout Idaho school communities to prevent youth suicide.

The Idaho Lives Project's four overlapping programs create a comprehensive approach to youth suicide prevention in Idaho.

The **School Communities Program** brings *Sources of Strength*, an ongoing, comprehensive wellness program, and the most well-researched program of its kind, into Idaho middle/junior high and high schools to build connectedness and resilience among the students, and increase referrals and treatment of students at risk for suicide. Because students in crisis must have trained, trusted adults to turn to, the program also trains school staff and communities to identify, assist and refer those at risk.

In 2015, the Project provided new *Sources of Strength* training to 16 schools statewide, and *Sources of Strength* booster (second or third) trainings to 22 schools. New schools included Burley Jr. HS, Caldwell HS, Cassia HS (Burley), Canyon-Owyhee School Services Agency (Widler), Declo HS, Kellogg HS, Eagle Academy, Lowell Scott MS (Meridian), Minco HS (Rupert), Mt. Harrison HS (Heyburn), Rimrock Jr/Sr HS (Bruneau), Rocky Mtn. (HS Meridian), Shoshone-Bannock HS, Total Learning Center (Rupert), Union HS (Nampa), and West Minico MS (Paul). Booster trainings were provided to all schools newly trained in 2014. Over 940 middle and high school students, and 100 school adult advisors were trained through this program in 2015. School staff members and community members also received training in suicide prevention. The Project trained over 1,300 school staff and 267 community members in 2015. The majority (over 80%) of school staff participants and 85% of community members rated the training and its value to them as outstanding or above average.

Qualitative data from the *Sources of Strength* trainings have been overwhelmingly positive with several examples of students utilizing skills learned in trainings, positive changes in student behavior and students identified for risk of suicide. One father attested that the *Sources* program at his son's school saved his son's life.

The **Health Professionals Program** is based on the knowledge that trained adults must be able to refer youth and their parents to well-trained health professionals. This program brings expert, evidence-based suicide assessment and management training to behavioral health and primary care professionals throughout Idaho.

The Project is federally funded by the State and Tribal Youth Suicide Prevention Grant awarded through the Substance Abuse and Mental Health Services Administration.

In 2015, M. David Rudd, PhD provided suicide assessment and management training to over 800 behavioral health and primary care providers in 19 locations throughout Idaho. A large majority of training participants (approximately 90%) strongly agreed or agreed that they increased knowledge in the essential tools needed to accurately assess suicide risk and manage challenging scenarios in an effective manner.

Qualitative data for Dr. Rudd's trainings also has been overwhelmingly positive. Training participants continue to request more of this training. In response, and though the Project had not originally intended to, Dr. Rudd will be brought back in February of 2016 for three more large-scale trainings.

The **Young Adults Program** addresses youth age 18 to 24 through outreach and training. The program provides suicide prevention training to young adult-serving agencies and groups, including college and university staff and students. It reaches out to businesses serving young adults with materials from the Idaho Suicide Prevention Hotline and targeted behavioral health messages including those through *Man Therapy.* College interns also participate in the School Communities Program.

The Project provided 24 trainings in 2015 to a variety of young-adult-serving professionals including law enforcement, EMS, foster care staff, clergy, disability workers, mental health providers, primary care providers and LGBTQ groups. More than 570 professionals were trained through these activities. The Project also conducted outreach to tens of thousands of others serving youth with information related to prevention and intervention including, but not limited to, materials for the Idaho Suicide Prevention Hotline and for *Man Therapy* including *Man Therapy* radio spots.

The **Juvenile Justice Program** provides *Shield of Care* suicide prevention training to juvenile justice facilities throughout the state. *Shield of Care* is evidence-based suicide prevention training tailored specifically to the juvenile justice environment. Ongoing technical assistance is provided to these facilities and to participants of all programs.

In 2015, the Project conducted a *Shield of Care* trainer update for mental health personnel from ten of the 13 juvenile justice facilities in Idaho. In 2015, the Project provided 13 in-depth, 4-6-hour suicide prevention trainings to seven Idaho Juvenile Justice facilities reaching 150 staff, and three shorter trainings for 50 juvenile probation, judges and facility staff.

The Idaho Lives Project continues to collect data to evaluate the effectiveness of its programs and to create program improvements to better serve the needs of Idaho youth. For more information about the Idaho Lives Project, visit www.idaholives.org.

The Project is federally funded by the State and Tribal Youth Suicide Prevention Grant awarded through the Substance Abuse and Mental Health Services Administration.

Idaho State Department of Education: 2015 Suicide Prevention Efforts

The Idaho State Prevention & Support Conference is hosted annually by the Idaho State Department of Education (SDE). The conference is a gathering focused on innovation, best practices, collective problem-solving and motivation to most effectively address youth risk behaviors, foster optimal health and realize academic success for Idaho students. The most recent conference was held in April, 2015, with workshops offering topics related to school safety planning, emergency operations, suicide prevention, law enforcement / school partnerships, drug and alcohol prevention, violence prevention, out of school programming and community engagement in schools. Participants included approximately 450 school counselors, teachers, administrators, school resource officers and community stakeholders. The conference also provided information from the Suicide Prevention Action Network of Idaho to help schools with suicide prevention, intervention and postvention support. These activities aligned closely with goals three and five of the Idaho Suicide Prevention Plan by educating the community and school professionals about appropriate suicide prevention activities and awareness.

The SDE is also the fiscal agent for a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The Idaho Lives Project (ILP) is a collaboration between the SDE, the Suicide Prevention Action Network of Idaho (SPAN Idaho) and partners to reduce suicide in Idaho by targeting youth, ages 10-24, whose suicide rates are significantly higher than the national average. ILP is a systematic and comprehensive approach using Sources of Strength, Shield of Care, community gatekeeper training and updated assessment and treatment training for health, mental health, and substance abuse professionals to foster resilience and connectedness throughout Idaho communities and prevent youth suicide. In addition to training students, ILP trains the staff from participating schools, community members and mental health clinicians on the warning signs of suicide and how to best respond. By increasing the number of individuals who have been trained statewide, ILP aims to ensure that youth at-risk for suicide are identified and referred to appropriate follow-up care. ILP entered the third and final year of the grant in October, 2015.

During the 2015 legislative session, the Idaho legislature appropriated $4,031,400.00 in funding to partially restore Safe and Drug Free schools money (SB 1186). The SDE has been

dispersing this funding to school districts for the provision of school safety improvements and/or prevention activities. In their applications for funding, many school districts identified suicide prevention as a district priority. In alignment and encouragement of the third goal in the Idaho Suicide Prevention Plan, the SDE has provided technical assistance and support for school districts regarding best practice programs about suicide prevention/response and additional school safety resources. The 2015 legislative session also passed a bill enhancing the previous bullying legislation. School districts and charter schools are now required to provide mandatory professional development focused on training staff to respond to harassment, intimidation and bullying. The SDE believes that this new mandatory training will help schools provide positive school climates and better support the well-being of their students.

Division of Behavioral Health Program Highlights – SYF 2015

The Division of Behavioral Health is dedicated to promoting quality services that are innovative and evidence-based. The division engages in a variety of special initiatives each year to advance the service delivery system. Special initiatives in SFY2015 included:

Establishing Behavioral Health Crisis Centers
After Idaho's first Behavioral Health Crisis Center opened in Idaho Falls in December 2014, funding was appropriated by the 2015 Idaho Legislature to establish a second facility in North Idaho. Crisis centers are available on a voluntary basis to all Idaho citizens, offering evaluation, intervention and referral for people who are experiencing a crisis because of serious mental illness or a co-occurring substance use disorder. The centers can help people get the services and assistance they need without going to the emergency room or being taken to jail. The Legislature appropriated $1.7 million for the crisis center in northern Idaho in 2015, which is evidence of the hard work done at the first crisis center in Idaho Falls and a testament to the commitment of lawmakers to helping those experiencing a behavioral health crisis.

Transforming Idaho's Behavioral Health System
Transformation legislation passed during the 2014 legislative session and became law in July 2014. Under a transformed and unified behavioral health system, the mental health and substance use disorder systems are being integrated. The advisory boards in each region, representing mental health and substance use disorders, have successfully combined to become Regional Behavioral Health Boards. Each newly formed board submitted the first required Gaps and Needs report in 2015 to the Idaho Behavioral Health Planning Council; the report addressed behavioral health concerns in each region. The boards are now actively involved in making decisions regarding whether to realign their advisory relationships to be under the public health districts or remain under the Division of Behavioral Health. If the boards choose to move under the public health districts, the division and the public health districts will then operate within a contractual agreement for continued support of the boards. This realignment is seen as strengthening the connection between physical and behavioral health and benefits all involved.

Behavioral Health Integration
In the last decade, studies have shown that people with mental health and/or substance use disorders die at a younger age than those in the overall population. Causes of these premature deaths are likely to include treatable health conditions such as heart disease and diabetes. A major reason for the high rates of illness and death among people with substance use disorders or mental health conditions has been their lack of contact with primary health services. The division, as a part of the State Healthcare Innovation Plan (SHIP), will spend the next four years working toward the integration of primary care and behavioral health care, which will allow health professionals to coordinate diagnoses and treatments so they can complement each other. The Behavioral Health Integration Sub-Committee will recommend models and best practice for behavioral health integration to the Idaho Healthcare Coalition. This will lead to better health and better outcomes for people with behavioral health issues.

Children's Mental Health Services
The federal court approved a settlement agreement in the 35-year-old Jeff D class action lawsuit concerning children's mental health services in June 2015. The agreement targets the provision of community-based services, which has been the unresolved issue in the case. The agreement is designed

to establish a comprehensive and coordinated system of care for Idaho children with serious emotional disturbances and their families. The agreement outlines an overall implementation time frame of about eight years. The first nine months is devoted to the development of an implementation plan, followed by four years to complete the plan. Once the implementation plan is completed, there is a three-year period of sustained performance. The agreement outlines specific measures to determine compliance with the implementation plan and sustained performance period. The case will be dismissed after substantial compliance has been shown. When the case is dismissed, the court is expected to issue a permanent injunction to continue the services and supports developed through the implementation plan.

Recovery Community Centers

Recovery Community Centers provide a meeting place for individuals to work on and maintain their recovery from substance use disorders and mental illness. These centers help fight stigma by acting as a face for recovery to the community as a whole. The centers offer a venue for building meaningful and healthy relationships, which is key to successful recovery. Recovery Community Centers respect all pathways to recovery and offer volunteer-driven activities and resources unique to each center, including peer support, job search assistance, smoking cessation classes, access to computers, courses covering a variety of issues, and referrals to other community supports.

During the 2015 Legislative Session, the division worked closely with the Idaho Association of Counties on a Millennium Fund Grant proposal to support four recovery community centers across the state. After obtaining that funding, all four centers opened in 2015, in Ada, Canyon, Gem, and Latah counties. Data will be collected at each of the centers, but more time is needed to analyze their effectiveness. Even so, anecdotal reports highlighting stories of success are plentiful. Idaho's model for recovery community centers is unique in that most recovery community centers across the country focus on addiction; Idaho's model services people suffering from mental illness, substance use disorders or both.

Accomplishments and Activities 2015

The Idaho Suicide Prevention Hotline is committed to the prevention of suicide in Idaho. The Hotline is a program of Mountain States Group, a 501 (c) (3) non-profit organization. The Hotline provides crisis intervention, emotional support, resource referrals, and follow-up calls if needed to all Idahoans. ISPH completes its third full year of operations, enters its second full year of 24/7 phone response, is on track to reach 5,000 calls this year, and prepares to launch Online Emotional Support (OES) via crisis text and chat response.

Idaho Suicide Prevention Hotline

Call Statistics

January 1 to September 30, 2015

	3rd Quarter	2015
Total Calls Received	1378	3648
Military Members / Families	126	489
Rescue Calls (approximate)	24	87
Follow Up Activities Completed	160	527
Percentage of Calls Receiving Follow Up Activities	7%	10%
Caller Age:		
10 – 14	23	104
15 – 19	115	353
20 – 24	103	297
25 – 34	190	460
35 – 44	175	320
45 – 54	126	332
55 – 64	176	556
65 – 74	27	83
75 – 84	6	17
85+	1	4
Didn't Report	436	1122
Total Calls Received	**1378**	**3648**

Volunteer and Staff Recruitment and Training

The hotline operates with 6.25 FTE's of paid staff, 3 interns and 2 Americorps volunteers. In 2015 ISPH trained approximately 60 + prospective volunteers in the ASIST (applied suicide intervention skills training) model. Approximately 85 volunteers are currently active as hotline Phone responders. In the first 3 quarters of 2015 volunteers contributed a total of 9880 hours, for an in-kind value of $168,000. ISPH operates 24 hours per day/7 days per week with 2-3 volunteer responders per shift from 9 am to 1 am. Overnight phone coverage is provided by a paid supervisory staff person. All shifts are onsite and calls are silently monitored and supervised by a master's level clinician or equivalent. We are continuing

to recruit non-phone worker volunteers or 'Hotline Ambassadors' to assist with community outreach and support tasks both in Boise and across the state and have provided quality display materials to our SPAN partners in the Coeur d'alene and Idaho Falls areas. Information about volunteer opportunities, including the 2016 volunteer training schedule can be found here:
www.idahosuicideprevention.org/volunteer/

Facilities

Our continued sincere thanks go to Jay Lugo, Executive Director of the Idaho Lions Sight and Hearing Foundation for their donation of a 2,200 square feet of operations/ office space for an in-kind value of $1,900 per month. Last year he hotline installed 4 distinct Responder stations in its existing space, improving acoustics during increasingly busy shifts and expanding capacity for higher call volume and 24/7 service provision.

Hotline Data Capacity

ISPH has 3 years' worth of data on calls. Responders request demographic info from each caller. Requests for statistics related to caller demographics should be directed to jreusser@jannus.org with "request for Hotline statistics" in the subject line. Our resource database is periodically updated by staff & volunteers; if your agency receives an email from noreply@icarol.com please complete the form provided to ensure we have the best, most recent information about your agency or program to share with our callers. 'One-pagers' or distillations of ISPH quarterly reports are available here for reference and distribution:
www.idahosuicideprevention.org/data/

Outreach

The Hotline has distributed approximately 100,000 tri-fold wallet cards and several hundred bilingual marketing kits containing wallet cards, posters, rack cards, magnets and both small and bumper sized stickers throughout the state. Outreach materials and a video PSA are available upon request by calling 208-258-6994, emailing tbarnes@jannus.org and including "request for Hotline marketing materials" in the subject line or linking/ downloading printer- ready PDF versions from our website:
www.idahosuicideprevention.org/outreach/

Goals for the Next Year

Top goals for the Hotline for 2016 include: increasing our response capacity via infrastructure improvements pending available funds and increasing volunteer staffing levels by training new Responder cohorts in February, May and October. We will continue to pursue sustainable funding strategies and broaden our advisory/ fundraising board to include representation from Eastern Idaho. We will increase the breadth and penetration of our outreach to include billboards, television and radio ads statewide and implementation of text and chat response.

Many thanks to our funders and partners, without whom this vital program would not have been possible: Idaho Department of Health and Welfare, Idaho Division of Veteran's Services, the Idaho State Legislature, SPAN-Idaho, U.S. Veterans Affairs, United Way of Treasure Valley, United Way of Kootenai County, United Way of Southeast Idaho, The Speedy Foundation, Idaho National Guard, Saint Alphonsus Regional Medical Center, Wells Fargo, JA & Kathryn Albertson Foundation, Saint Luke's Regional Medical Center, Ada County EMS, Meridian and Boise Police departments, and numerous other donors and supporters.

LIVEWilder™
ADVANCING ZERO SUICIDE FOR YOUTH

Idaho Suicide Prevention Plan:

Goal 1: Public Awareness and Goal 2: Anti-Stigma

Key Activities focused on Awareness, Anti-Stigma, Education/Training, and Community Involvement:

- Zero Means Zero Conference, March 10, 2015, held at Gonzaga University, Fiscal and Gold Sponsor. Planning underway for 2016 conference.
  ACHIEVING ZERO SUICIDE FOR OUR INLAND NORTHWEST COMMUNITIES, Representation from WA, ID, MT & WY
  http://www.gonzaga.edu/academics/events/zerosuicide/

- Public Outreach: Speaking and Community Events:
  - Board members, John Reusser and Stewart Wilder spoke with Boise State Psychology students about depression and suicide on Sept. 28, 2015
  - Community Walk:
    - AFSP Out of the Darkness walk: Saturday October 17, 2015. Resource booth and team.

- Public Service Announcements
  - KTVB (NBC affiliate), Hotline and LiveWilder: Meridian Mayor's Youth Advisory Council production. Started airing on National Suicide Prevention Week September 7, 2015. Planning for quarterly productions to air with NBC affiliates statewide.

  https://www.youtube.com/watch?v=_lICtJelcY4

- Policy
  - Supported HB 246 Anti-Bullying Bill signed into law April 26, 2015. Rep. Ilana Rubel, Sen. Janie Ward-Engelking, sponsors.

  http://www.spokesman.com/blogs/boise/2015/apr/06/otter-signs-anti-bullying-bill-law/

- Community Safe Youth Programming (Pilot Project), community partners include:
  - YMCA, Boise School District Administration, Dept. of Education, Boise Police Dept., area counselors and psychiatry, educators from Boise and Timberline High Schools, One Stone and LiveWilder.
    - Goal: to provide a safe place for youth to have connectivity with the community, peer and adult mentors, activities, volunteering, etc. Connecting parents will be a critical factor as well as there are no support groups for youth struggling with depression or other mental health/physical health issues or for parents dealing with their children who may be struggling.

- Partnership funding with SPAN Idaho to bring Sources of Strength to Rocky Mountain High School in Meridian through Idaho Lives Project.

- Structured and held a Community Conversation on depression and suicide at the Idaho Federation of Families for Children's Mental Health annual meeting.
  - Panel of experienced survivor, LiveWilder, SPAN Idaho, Idaho Lives Project, Senator Rubel and Representative McDonald all participated in the community discussion on suicide prevention.
  - The Federation of Families is working on a documentary on awareness, anti-stigma and education hopefully with Idaho Public Television and other media outlets in the Pacific Northwest.

Board of Directors

Stewart Wilder
President

Debbie Wilder
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Gary Morton
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800 W. Main Street
Suite 1460
Boise, Idaho 83702

208-401-9263
www.LiveWilder.org

The SHOSHONE-BANNOCK TRIBES

COUNSELING & FAMILY SERVICES
P. O. BOX 306
FORT HALL, IDAHO 83203
PHONE (208) 237-5631
LOCATION MISSION ROAD
FAX (208) 237-5796

TRIBAL HEALTH & HUMAN SERVICES DEPARTMENT
P.O. BOX 306
FORT HALL, IDAHO 83203
FAX (208) 238-3940

The Fort Hall Indian Reservation is located in southeastern Idaho and is home to the Shoshone and Bannock Tribes. There are 5844 enrolled members of the Shoshone-Bannock Tribes, with approximately 3800 of those member residing on the Reservation as well as many non-natives.

The Counseling and Family Services program offers a full range of outpatient mental health and medical social work services to the people of the Shoshone-Bannock Tribes and other eligible Native American recipients. Crisis services are available twenty-four hours a day, seven days a week. Our mission is to provide these services that integrate traditional Native American beliefs and practices with Western attitudes and approaches, and will be delivered in a culturallly competent, professional, confidential atmosphere.

Reported activities/events the Tribes has provided and/or participated in this year that meet the goals of the Idaho Suicide Prevention Plan are:

- Held three ASIST (Applied Suicide Intervention Skills Training) to the community and Portneuf Medical Center in Pocatello
- Started a SPAN (Suicide Prevention Action Network) Chapter here in Fort Hall
- Participated and help coordinate a Sources of Strength training at Sho-Ban Jr/Sr High School
- Held a Shield of Care training at the Fort Hall Justice Center
- Held two QPR (Question, Persuade, Refer) trainings here in the community
- Awarded the Garrett Lee Smith Youth Suicide Prevention Grant, hired a part time staff member and started to administer the PHQ-9 (depression/suicide) screening form to all MH patients, establised a Zero Suicide Implementation Team
- Hosted 2nd Annual "Walk for Life" Suicide Awareness/Prevention/Remembrance activity
- Developed a "Suicide Survivor- digital story" with local community member
- Applied for and was awarded the Department of Health and Human Services, Indian Health Services, Suicide Prevention Initiative grant
- Disseminated Idaho Suicide Hotline information in the community
- Participated in the State Juvenile Justice grant, provided Mental Health screenings to 65% or more of adolecents entering the Fort Hall Corrections
- Participate in Region 6 Behavioral Health Board, Protective Custody Task Force and Children's Mental Health Subcommittee

SPAN IDAHO

SUICIDE PREVENTION ACTION NETWORK OF IDAHO

ACCOMPLISHMENTS AND ACTIVITIES
November 2015

Overview

SPAN Idaho is a suicide prevention organization founded in 2002 as a 501 (c) (3) nonprofit organization. At the state level, SPAN Idaho comprises a volunteer board of directors and two part-time staff, with established chapters in each of the seven Idaho Department of Health and Welfare (IDHW) regions to carry out statewide suicide prevention awareness activities and to respond at a community level. From its beginning SPAN Idaho, as a grassroots organization, has encouraged and recognized the importance of regional and local involvement to prevent suicide. SPAN Idaho's mission is to reduce suicide in Idaho through statewide advocacy, collaboration and education in best practices. With the help of our chapters and other organizations, SPAN Idaho works to have zero suicides in our state.

Most Recent

In partnership with Idaho State Department of Education (SDE), SPAN Idaho received the Garrett Lee Smith Memorial Act (GLSMA) grant administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) to target youth, ages 10-24 in suicide prevention to begin October of 2013. The Idaho Lives Project (ILP) will reach more than 31,000 individuals over the three years of the grant, with training for youth, school staff, and community adults along with health and mental health providers to respond effectively to suicidal youth. All goals of the project align with the goals of the Idaho Suicide Prevention Plan (ISPP) and the National Strategy for Suicide Prevention (NSPP). We are in the last year of that grant. More about this project is included in this current report.

Training and Awareness

SPAN Idaho and its chapters consistently provide or co-host a variety of community activities to educate the public about mental health and wellness and suicide prevention. We also provide resources and support when there has been a suicide death. Some examples of SPAN's involvement, we

- Host a biennial conference in which we feature leading experts in suicide prevention. This valuable and up-to-date, best-practices conference ensures that we offer Idahoans training that is safe and current, and provides the latest in research and prevention.
- Developed and conducted presentations and trainings on suicide and suicide prevention for the Idaho Department of Labor, Idaho Criminal Justice Commission, IDHW Children's Mental Health, Idaho Juvenile Justice, Idaho State Tax Commission, Hispanic Commission, Idaho National Guard, schools, parent groups and community groups.
- Provided comprehensive trainings that were specific to clergy in the state at seven different locations with a two- hour workshop primarily centered on spiritual leaders and their congregations about suicide prevention, warning signs, resources and self-care.
- Held several regional annual Save-the-One walks to raise awareness and support survivors.
- Provided materials at community events and gatherings to share suicide warning signs and other prevention measures.

PO Box 2656, Idaho Falls ID 83403 • 208-860-1703 phone • www.spanidaho.org

- Conducted many regional projects through the chapters which include suicide prevention messages on radio, television and newspapers; joined other agencies to discuss and respond to area suicides; trained area school staff and others in suicide prevention and met monthly to plan and promote suicide prevention activities.

New and Ongoing

- We align our programs and activities to the Idaho Suicide Prevention Plan.
- We maintain a highly- informative and well-regarded website.
- We fulfill requests for information and resources on-line and on the phone which may include highly sensitive calls.
- We act as a conduit for suicide prevention information locally, statewide and nationally and engage and collaborate with other groups, including the Idaho Suicide Prevention Hotline, the Veterans' Administration, 211 Careline, the Commission on Aging, RADAR, SDE, IDHW and others. Nationally, SPAN Idaho engages with the major suicide prevention groups, participates in conferences and webinars, and writes articles to exchange best practices information, data and ideas.
- We provide information packets to suicide survivors through the Idaho Funeral Directors Association and county coroners as well as to suicide loss survivors on request to support the grieving and healing process.
- We offer information on suicide loss survivor support groups regionally.
- We distribute materials to the general public and community events.
- We offer QPR training and other specific suicide prevention training to groups on request.
- We provide information and guidance to high school and college students for their projects.
- We are members of the Idaho Council on Suicide Prevention and collaborate to carry out activities that implement the Idaho Suicide Prevention Plan along with coordinating efforts in Idaho communities to introduce the National Strategy for Suicide Prevention and bring more attention to national and local suicide prevention efforts.
- We continually review suicide prevention research and best practices to develop programs and distribute relevant information statewide.
- We partner with the Idaho Suicide Prevention Hotline to distribute Hotline information with the help of SPAN Idaho regional chapters and our Idaho Lives Project to carry out mutually helpful suicide prevention projects.
- We implement and evaluate the Idaho Lives Project which promotes overall wellness in youth to prevent suicidal behavior and identifies intervenes with referring students at risk for suicide.
- We developed a SPAN Idaho chapter in Fort Hall to enhance working with tribal members.

Upcoming

- Continue training specific groups in suicide prevention and survivor support including target groups such as first responders, mental health and health care providers, school personnel, aging services staff, corrections personnel, human resource management offices, parents and others.
- Support efforts to expand statewide leadership in suicide prevention.
- Increase suicide awareness activities on college campuses.
- Encourage growth in regional chapters.

For more information visit **spanidaho.org**

SENATE HEALTH & WELFARE COMMITTEE
Wednesday January 20, 2016

ATTACHMENT 4

IDAHO SUICIDE PREVENTION PLAN:

AN ACTION GUIDE

2011

"Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it's the only thing that ever has."

—Margaret Mead

Support staff that helped with creation of this plan:

Kirsti Beck – Graphic Designer, Idaho State University
Lynda Bennett – Researcher/Writer, Idaho State University
Corinne Johns – Administrative Support, Idaho State University
Donna Parker – Administrative Support, Idaho State University
Susan Soule – Workgroup Facilitator
Kathy Tidwell – Researcher/Writer

Cover Photo © Henry E. Stamm IV

Suggested Reference

Suicide Prevention (2011). Idaho Suicide Prevention Plan: An Action Guide. Boise, ID.

Electronic Copies

Electronic copies of the State Suicide Prevention Plan are available at several websites:
SPAN Idaho: www.spanidaho.org/ispplan.pdf
Department of Health and Welfare: http://healthandwelfare.idaho.gov (click on 's' and look for 'suicide prevention')
Idaho State University Institute of Rural Health: www.isu.edu/irh/publications

Dear Idahoans,

The Idaho Council on Suicide Prevention would like to thank you for the opportunity to address the critical issue of death by suicide in Idaho. Suicide is a major public health issue and has a devastating effect on Idaho's families, schools, faith-based organizations, businesses and communities.

This Idaho Suicide Prevention Plan is intended to empower communities in providing suicide prevention, intervention and response to suicide attempts and completions. Ultimately, our goal is to reduce the number of deaths by suicide throughout our state. Idaho consistently has a higher suicide rate than the United States as a whole. A total of 1,286 people died by suicide in Idaho in just five years from 2006 through 2010 (Bureau of Vital Records and Health Statistics, 2010, 2011).

The first Idaho Suicide Prevention Plan was presented in 2003. Since that time much positive work has been accomplished. In 2006, a Governor's Executive Order created the Idaho Council on Suicide Prevention to provide a coordinating body to lead suicide prevention efforts in Idaho. Strong collaborations have been established with the State Planning Council on Mental Health, the Division of Behavioral Health, the Division of Public Health, the Department of Education, Suicide Prevention Action Network of Idaho (SPAN Idaho), Idaho State University's Institute of Rural Health and other partners. However, there is much work yet to be done.

Today our state faces new challenges and new opportunities. The Governor's Executive Order has given the Idaho Council on Suicide Prevention the responsibility to ensure the continued relevance of the Idaho Suicide Prevention Plan. In order to meet that responsibility the Idaho Council on Suicide Prevention recognized it was time for a comprehensive review and revision of the Idaho Suicide Prevention Plan to meet today's realities. In 2010, the Idaho Council on Suicide Prevention began the development of this new Idaho Suicide Prevention Plan.

This Idaho Suicide Prevention Plan was created by gathering input from stakeholders from all across Idaho. The Idaho Council on Suicide Prevention has made a special effort to include the voices of all segments of the state: governmental leaders, individual citizens, faith-based groups, business community, military, Hispanics, Native Americans, community action organizations, health care providers, advocates for lesbian, gay, bisexual and transgendered (LGBT) persons, education professionals, survivors and others. Suicide prevention has a role for everyone. It is the hope of the Idaho Council on Suicide Prevention that you will be able to recognize a role for yourself and your community within the pages of this document.

It is with deep appreciation the Idaho Council on Suicide Prevention now recognizes the many collaborators and stakeholders who have contributed to creating this revised Idaho Suicide Prevention Plan. We look to the future because of the tremendous strength of our collective will to stop unnecessary death by suicide.

Sincerely,

Kathie Garrett

Chair – Idaho Council on Suicide Prevention

"There is a role for everyone in this action plan. You can make a difference."

Acknowledgement of Partners

This document would not have been possible without the dedicated efforts of many people throughout the state. Individuals have given of their time to attend meetings, work on committees, review data and to thoughtfully discuss the issue of suicide in Idaho. Idaho State University's Institute of Rural Health facilitated and funded the process through a grant from the U.S. Substance Abuse and Mental Health Services Administration.

We would like to thank the following people who have contributed to this effort:

Idaho Suicide Prevention Plan Review Work Group

Marilyn Baughman – Jason Foundation
Curt Braun – Benchmark Research and Safety, Inc.
Paula Campbell – National Alliance on Mental Illness (NAMI)
Pam Catt-Oliason – Idaho Commission on Aging
Ginger Floerchinger – Franks – Idaho Trauma Registry
Judy Gabert – Suicide Prevention Action Network of Idaho (SPAN Idaho)
Kathie Garrett – Chair, Idaho Council on Suicide Prevention
John Hanks – Physician
Margaret Henbest – Nurse Practitioner
Rick Huber – Consumer Advocate
Deedra Hunt – Idaho Commission on Aging
Crystal Ikebe – Jason Foundation
Kim Kane – Suicide Prevention Action Network of Idaho (SPAN Idaho)
Ann Kirkwood – Idaho State University - Institute of Rural Health
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IDAHO SUICIDE PREVENTION GOALS

Goal 1: Public Awareness
Idahoans understand that suicide is preventable and accept responsibility for their role in suicide prevention.

Goal 2: Anti-Stigma
Idahoans understand and accept that seeking help for mental health issues is to be encouraged and supported.

Goal 3: Gatekeeper Education
The education of professionals and others working with people at risk for suicide includes effective suicide prevention curricula and ongoing gatekeeper and other suicide prevention training.

Goal 4: Behavioral Health Professional Readiness
Mental health and substance abuse treatment professionals are trained to use current, appropriate, and recommended practices for assessing and treating individuals who show signs of suicide risk.

Goal 5: Community Involvement
Community leaders and stakeholders develop and implement suicide prevention activities that are current, recommended and culturally appropriate that are specific to their regions and communities.

Goal 6: Access to Care
Crisis intervention and behavioral health services, including mental health and substance abuse treatment, are widely available, culturally appropriate, accessible, and valued by communities.

Goal 7: Survivor Support
Information and services are in place in all regions of Idaho to support survivors and others affected by suicide in a sensitive and culturally appropriate manner.

Goal 8: Suicide Prevention Hotline
An Idaho statewide suicide prevention hotline is established and funded.

Goal 9: Leadership
The Idaho Council on Suicide Prevention oversees suicide prevention activities at all levels, as guided by the Idaho Suicide Prevention Plan, and works in collaboration with a lead Idaho state government agency that is responsible for Idaho's suicide prevention and intervention efforts.

Goal 10: Data
Data are available on which to make decisions regarding suicide prevention services.

INTRODUCTION

Suicide is a preventable tragedy. It takes lives, harms families and exacts a human and financial toll on our communities. Over five years from 2006 through 2010, more than 1,200 Idahoans died by suicide (1,286 deaths). Idaho consistently is listed in the top 10 states in the country for its rate of suicide, with rates ranging from a low of 12.8 per 100,000 people in 2000 to 19.9 in 2009 (Bureau of Vital Records and Health Statistics, 2011). Approximately 30,000-35,000 people die by suicide in the United States each year for a national rate of about 12 per 100,000 people.

Two hundred ninety Idahoans completed suicide in 2010. This followed 307 in 2009, the most in any given year on record (SPAN Idaho, 2010). The high number of suicide deaths is just part of the problem. Many people attempt suicide who do not die. While it is difficult to gather accurate information about the number of people who attempt suicide, or the number of people who are so troubled they often consider taking their own lives (called "suicidal ideation"), it has been estimated that for every completed suicide there are as many as 25 more people who attempt suicide but do not die (American Association of Suicidology, 2008). By this estimate, it is likely that as many as 7,250 people in Idaho attempted suicide in 2010, and approximately 825,000 attempt suicide in the United States each year.

"Suicide rate" is the number of suicide deaths per a population of 100,000 people in a specific time and place. By converting the numbers to a rate, comparisons of the frequencies of suicide in different places with different population sizes are possible.

Estimates of the number of people affected by a suicide death vary. This group called "suicide survivors" is made up of families, friends and others seriously affected by the suicide death of someone they care about.

"A suicide attempt is a non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior. A suicide attempt may or may not result in injury." (CDC)

Some estimates project that 5-6 people are affected by each suicide death. Others place the figure far higher at 14 (Jordan and McIntosh, 2011). This would mean as many as 18,004 people in Idaho became "suicide survivors" from 2006 through 2009. About 420,000-490,000 people in the United States each year become suicide survivors. Family members and friends also can be very concerned and worried about those who survive but are feeling so hopeless that they also attempt to take their own lives. While many factors influence whether or not a person will become suicidal, the loss of a family member or friend to death by suicide puts survivors at especially high risk for suicide themselves.

It is our hope that the Idaho Suicide Prevention Plan will empower communities to take action to make a difference. Together we can change the statistics and help all Idahoans embrace the most precious of all gifts - life. The Idaho Suicide Prevention Plan is an action guide to help individuals, organizations and communities plan suicide prevention activities that fit their specific needs. We believe there is a role for everyone in suicide prevention. The type of activities in which you choose to get involved will depend on many factors such as where you live (whether in a small rural community or a city), groups to which you belong (professional, cultural, or social) and your own personal values. Communities are more than geographic areas. They can be groups of like-minded people who agree to work together on an issue – in this case, suicide prevention.

History of Idaho Suicide Prevention Plan. Idaho's first Suicide Prevention Plan was written in 2003. The plan addressed awareness, infrastructure, and methodology for implementation. The full text of the original plan can be found at: http://healthandwelfare.idaho.gov/Portals/0/Children/DocumentsSrtView.pdf

Many of the first plan's objectives have been achieved. In 2006, the Idaho Council on Suicide Prevention was created by Executive Order of Governor Dirk Kempthorne. That Executive Order was renewed by both Governor Jim Risch and Governor C. L. "Butch" Otter. The Idaho Council on Suicide Prevention is made up of community leaders from all across Idaho who have a special interest in suicide prevention. There are representatives from government, education, health care, consumer advocacy groups, veteran's affairs, the state mental health authority, survivors, universities and others. One of the responsibilities given to the Idaho Council on Suicide Prevention is to oversee the suicide prevention activities being carried out throughout Idaho and to ensure the continued relevance of the Idaho Suicide Prevention Plan. In 2010, the Idaho Council on Suicide Prevention determined that it was time to review and update the Idaho Suicide Prevention Plan in light of successful completion of many of the original plan's initiatives and the new challenges which have emerged since 2003.

The 2011 Idaho Suicide Prevention Plan was created from input gathered from diverse stakeholders from all regions of the state under the direction of the Executive Committee of the Idaho Council on Suicide Prevention. In particular, the Suicide Prevention Plan Development Group, a gathering of more than 20 stakeholders from across the state, met in two working sessions in July and August 2010. At these meetings, facilitated and funded by the Idaho State University Institute of Rural Health, representatives discussed issues that affect our state and how we can work together to make a difference for suicide prevention. From those discussions, a set of Values and Guiding Principles were established which were approved and adopted by the Idaho Council on Suicide Prevention in October 2010.

Values & Guiding Principles

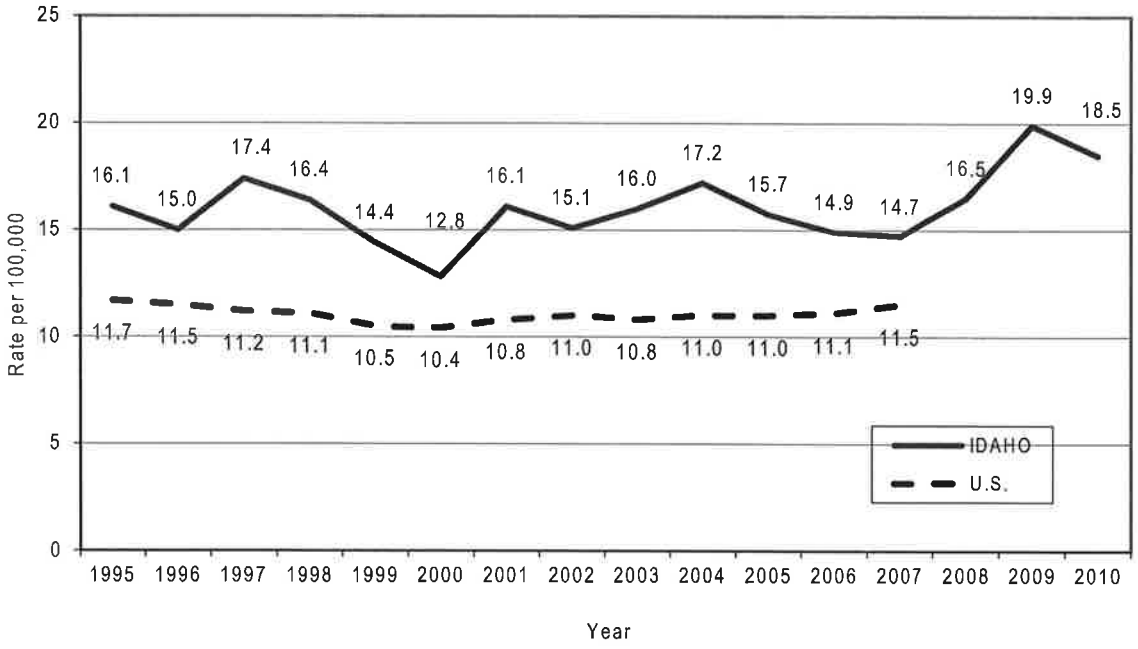
- **Suicide is a serious preventable public health problem that negatively affects communities and individual community members.**
- **Suicide arises from the interaction of individual, family, social and community factors. Suicide touches people of all ages and from all walks of life.**
- **Individuals who seek help for mental health concerns, including suicide, are to be accepted and supported, not stigmatized.**
- **Suicide prevention is the responsibility of the entire community and requires vision, will, and a commitment from the state, communities and individuals of Idaho.**
- **It is important for people to feel empowered to intervene with persons at risk for suicide.**
- **Adequate and accessible services for mental health diagnosis and treatment are essential for children and adults.**
- **Suicide prevention should be a part of an adequately funded and supported public and behavioral health system that addresses education, awareness, treatment and community engagement. It should include programs for communities and families with special attention paid to protect those known to be at high risk.**
- **Suicide prevention programs and program materials need to be culturally informed and respectful of the groups for which they are designed.**
- **Suicide prevention efforts should draw on appropriate best practice and evidence-based guidelines.**

ABOUT SUICIDE

Suicide is a major public health issue that affects tens of thousands of Americans every year. Although suicide is a problem for the whole country and throughout the world, it is important to know that suicide rates in Idaho are much higher than the United States as a whole. While there has been a slight drop in the Idaho suicide rate in 2010, we still have much work to do.

Figure 1 below shows Idaho suicide death rates as compared to the national rates over 16 years from 1995-2010.

Figure 1: Idaho and U.S. Resident Suicide Death Rates 1995 - 2010

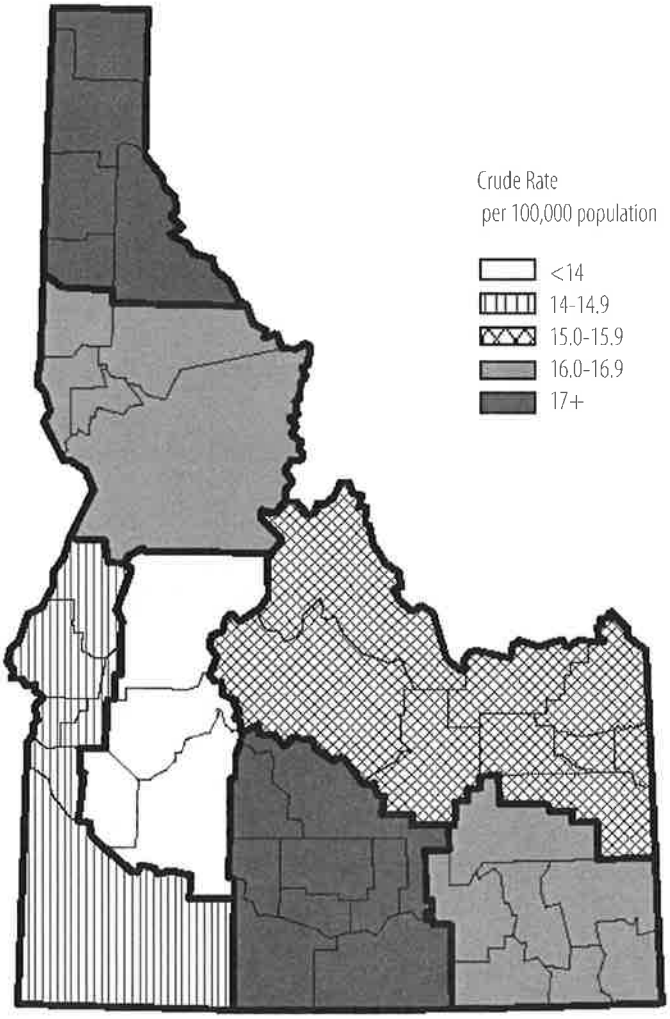


Rate: number of deaths per 100,000 population.
U.S. source: Centers for Disease Control and Prevention, CDC Wonder Mortality Query System.
Idaho source: Bureau of Vital Records and Health Statistics; Idaho Department of Health and Welfare (9/2011).

Idaho is among several states in the Intermountain West with rates much higher than the rest of the country. While the ranking of state suicide rates varies from year to year, Idaho typically ranks in the top 10. Just as suicide is not evenly distributed throughout the United States, it is not evenly distributed in Idaho. Some areas of our state have higher suicide rates than others. While the specific numbers for each region will vary from year to year, by looking at five year averages of rates we can get a better idea about patterns. The following chart shows how suicide rates vary in different parts of Idaho. It shows the highest rates are in the regions around Twin Falls and Coeur d'Alene, but all regions of Idaho are higher than the national rate of 12 suicides per 100,000 people.

People who kill themselves or attempt suicide have unique circumstances but there also are some overriding patterns we can study to help us target our suicide prevention efforts. Some of these patterns are:

Figure 2: Idaho Resident Suicide Death Rate by Region of Residence 2005-2009

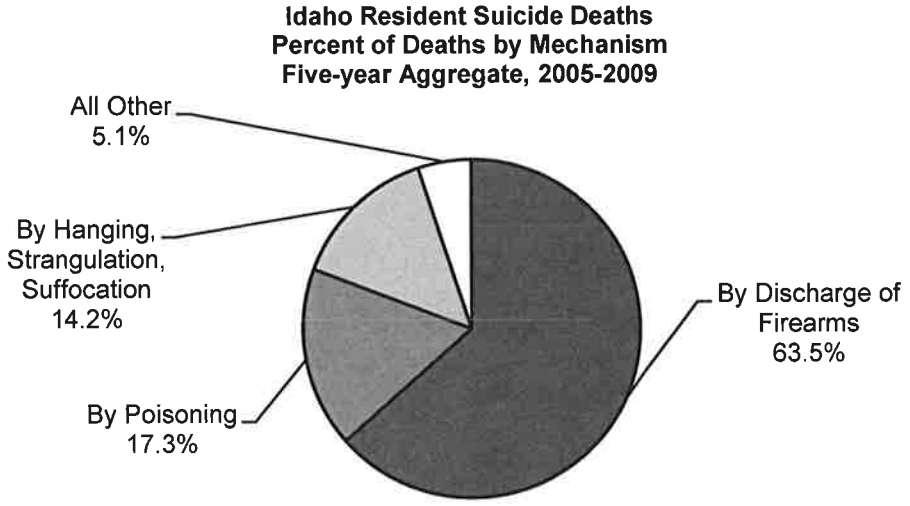


Source: Idaho Department of Health and Welfare Bureau of Vital Records and Health Statistics (4/2011)

- Men are much more likely to die by suicide than women. However, women attempt suicide about three times more often than men.
- The higher rate of attempted suicide in women is attributed to higher rates of mood disorders among females, such as major depression (American Foundation for Suicide Prevention, 2011).
- Men are more likely to use more immediate lethal means when they are suicidal, such as firearms. Most people who shoot themselves will die. Women often attempt suicide in other ways such as poisoning or drug overdose. While these suicide attempts are very serious and indicate a need for intervention, it is more likely that a person may be discovered and saved if they attempt through less lethal means.
- In Idaho, firearms are the primary means used for suicide deaths. Figure 3 illustrates that guns are used in 63.5 percent of all suicide deaths in Idaho while poisoning (which includes drug overdose) is the method used in 17.3 percent.
- These data emphasize the need for appropriate gun safety education and the availability of effective gun locks. If an individual is known to be at high risk for suicide it is recommended that all guns be removed from the home and stored in a safe place.

Figure 3 illustrates the methods used in completed suicide in Idaho from 1999 through 2003.

Figure 3: Suicide Methods in Idaho (1999-2003)



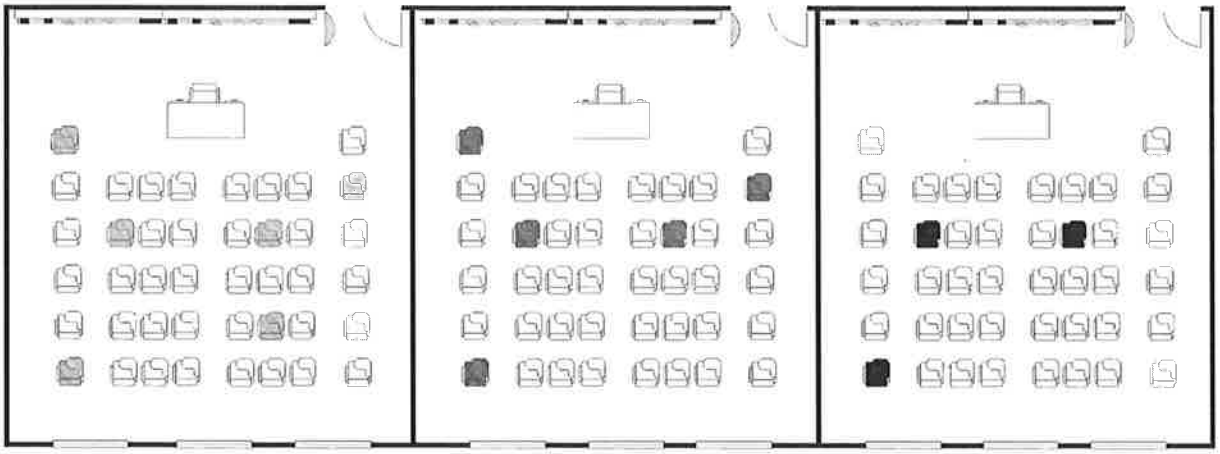
Source: Bureau of Vital Records and Health Statistics; Idaho Department of Health and Welfare (4/2011)

- Age is a factor in suicide risk. The age groups with the highest rates of suicide are those aged 65 and older, with those over 85 being at highest risk. Comprising only 13 percent of the U.S. population, individuals age 65 and older accounted for 18 percent of all suicide deaths in 2000. Among the highest rates (when categorized by gender and race) were white men age 85 and older.

- Of additional concern is the fact that "suicide rates for adolescents have doubled since 1970 and tripled since 1960, even as rates for other age groups have declined" (Mathur & Freeman, 2002).

Figure 4 shows the results of the Youth Risk Behavior Survey (YRBS), a survey that is given to students at public high schools in Idaho. It shows that in 2009 one in seven students who responded to this survey seriously considered suicide in the past year, one in eight students made a specific plan for suicide, and one in fourteen students actually made a suicide attempt.

Figure 4: Idaho High School Students Self-Reported Rates of Suicidal Ideation, Plan for Suicide and Attempted Suicide



One in 7 Idaho high school students has seriously considered suicide.

One in 8 Idaho high school students has a plan to complete suicide.

One in 14 Idaho high school students has attempted suicide.

Source: Idaho Youth Risk Behavior Survey (YRBS) 2009

Not everyone who attempts or completes suicide has a mental illness, and not all people with mental illnesses become suicidal. However, mental illnesses - especially depression – are a major risk factor for suicide. "While 95 percent of individuals with a mental illness and/or substance use disorder will never complete suicide, several decades of evidence consistently suggests that as many as 90 percent of individuals who do complete suicide experience a mental or substance use disorder, or both" (Center for Substance Abuse Treatment, 2008).

Research has shown that many people who die by suicide were drinking alcohol in the hours before they died (Kelly, 2009). Alcohol makes sad people feel worse. Alcohol clouds the ability to make good decisions and prompts impulsive acts. A person who is drinking and talking about suicide is at great risk for suicide.

Youths who bully and youths who are victims of bullying (including cyber-bullying) have also been identified as being at high risk for suicide (SPRC, 2011).

Warning Signs for Suicide

- **Threatening to, or talking about wanting to hurt or kill oneself**
- **Seeking access to methods of killing oneself**
- **Talking or writing about death, dying or suicide**
- **Abrupt personality changes**
- **Dramatic mood changes**
- **Feeling hopeless**
- **Feeling trapped**
- **Acting reckless or engaging in risky activities seemingly without thinking**
- **Hostile behavior**
- **Withdrawing from friends, family, and/or society**
- **Increasing alcohol or drug use**
- **Giving away possessions**
- **Previous suicide attempt**
- **Significant weight change**
- **Sleeping all the time or inability to sleep especially when accompanied by agitation**

Source: Idaho Suicide Prevention Action Network of Idaho (n.d.)

The Suicidal Process. Suicides often start as occasional thoughts about death and proceed to suicidal ideation. Suicide ideation is when severe, intrusive thoughts cause a person to dwell on the idea of suicide over a prolonged period of time.

Most people who think about suicide or develop a plan to kill themselves don't really want to die. They want the pain they are feeling to stop and are unable to see any other alternative.

The suicidal process happens over time beginning with the first thoughts about suicide. If the process does not stop, it may end in a completed suicide. The fact that the process takes time for most people means there is time to intervene successfully. There is time to reach out. There is time to get help.

Many different things may cause people to feel like killing themselves. Experts say the cause of suicide is "multidimensional," meaning that no single factor prompts a person to attempt suicide. Factors are present in clusters. For example, a person may not have the skills to solve problems. A mental illness may further complicate problem solving. Some other factors such as the sudden end of an important relationship or the loss of a job may contribute to the development of suicidal feelings. Factors such as these combine to create a great deal of emotional pain. Most of the time people manage to keep going until things improve. However, for some people, there are times when the pain seems too great. They feel they are unable to fix their lives or to feel better. They feel hopeless. They don't know where to turn to get help. They feel alone. They don't see any value to their lives. They feel useless or that they are a burden to others. Helpless, hopeless, alone, useless - these are the feelings behind thoughts of suicide. People with depression or other mood disorders have added vulnerability for suicide.

The Role of Economic Factors. A 2010 study on the impact of economic factors on U.S. suicide rates was conducted by the U.S. Centers for Disease Control and Prevention (CDC) and published online in the American Journal of Public Health. This research found that particularly among those in prime working ages (25-64), suicide rates were likely to increase during a recession. "Economic problems can impact how people feel about themselves and their futures as well as their relationships with family and friends. Economic downturns can also disrupt entire communities," said Feijun Luo, Ph.D., an economist in CDC's Division of Violence Prevention and the study's lead author

(CDC, 2011). In 2011, the Idaho Department of Labor reported that our state has lost over 58,000 jobs in recent years and that the current recession has cut more deeply into Idaho than any other since World War II. Additionally, Idaho ranks in the top ten states for home foreclosures. "The number of distressed properties, or properties in short sale, in foreclosure, or bank-owned reached 45 percent in December of 2010" (Idaho Business Review, 2011). One report says there has been a foreclosure filing for one in every 34 homes in the state as of summer 2011 (Estrella, 2011).

There are a number of ideas about why suicide rates are so high in Idaho and throughout the Intermountain West. Important factors may include remoteness, distance to care, a shortage of mental health care providers, economic stressors and access to lethal means, such as firearms. However, another key factor to consider is stigma.

The Stigma Connection. The word "stigma" literally means "a mark of shame or disgrace". A group of stigmatized people are seen as "less than" the rest of the population and may be subject to prejudice and discrimination. Stigma can erode an individual's sense of belonging and lead to hopelessness and isolation. Stigma contributes to suicide by making people with mental health concerns less willing to seek treatment. It also makes healing more difficult for family members and other survivors who feel judged if someone they cared about died by suicide.

An example of stigma related to suicide was seen in a study comparing the extent to which families lie about the cause of death for members who die in accidents or families of suicide victims. The study showed that family members of accident victims reported not lying about their relative's cause of death. However, 44 percent of the families of suicide victims reported lying at some time about their family member's cause of death (Joiner, 2005, pg. 6-7).

"Suicidal ideation" is a person's thought of harming or killing him/herself. The severity of suicidal ideation can be determined by assessing the frequency, intensity, and duration of these thoughts" (CDC, n.d.).

The report of the U.S. Surgeon General states that stigma regarding mental illness has been a barrier to treatment for decades (1999). Stigma appears to be worse in rural areas than in larger cities (Rost et al, 2011). In rural areas it is common to have a high degree of stigma and resistance to seeking help. As mentioned above, mental illness is a major factor for suicide. Nearly two-thirds of all people with diagnosable mental disorders do not seek treatment. Stigma surrounding the receipt of mental health care is among the many barriers that discourage people from seeking treatment (U.S. Public Health Service, n.d.).

Knowing More Through Research. Although more research is needed to improve our response to suicide, we do know that communities that are informed in suicide prevention awareness can reduce the number of deaths. Information about suicidal thoughts, feelings, and attempts as well as knowledge of warning signs, and understanding risk and protective factors can have a positive impact.

One compelling, research-based theory by Dr. Thomas Joiner suggests that people who feel a sense of burdensomeness and a failed sense of belongingness, and who learn to overcome physical pain, are more likely to complete suicide (Joiner, 2005, pg. 97-112). Though there are still things we do not fully understand about suicide, focusing efforts on belongingness and helping people feel effective and useful can save lives. Families, organizations, and communities can engage in activities that help people to feel included and needed and that address risky behaviors.

There are a variety of data sources to help individuals and organizations better understand the problem of suicide in Idaho and to plan suicide prevention activities. A list of these is provided in the section titled How to Find Additional Data Sources On Suicide page 34. It is also important to identify the data we would like to know that is not currently available. Only by knowing what information we know and what is needed can an individual or group determine the next steps to take.

The key factor to recognize in gathering data or in designing new suicide prevention activities is that you are not alone. There are a number of individuals, organizations and resources available to help you get started. By working in collaboration with others, people in Idaho can strengthen one another's efforts and help each other find solutions to barriers.

HOW TO USE THIS PLAN

The best ways to address the serious problem of suicide in your community will depend on a number of different factors, including community-specific resources and challenges. A community can mean many different things, such as a town, a neighborhood, a county, a region, even an entire state. "Community" also can refer to any group of people who come together with a common interest, such as a consumer group, religious denomination, political party or student association. You might relate to different communities for different goals. Your community may be a geographic area, a professional organization or an agency. Regardless of how you define "community" the efforts of a group of people to reduce suicide is extraordinarily valuable for suicide prevention.

TAKING ACTION IS IMPORTANT

We can prevent suicide because:

- Many people who complete suicide tell someone about their suicidal thoughts or show behaviors that indicate their plans before they take their lives.
- Many people who complete suicide see their doctor or mental health professional within one month before their death.
- Many people who attempt suicide are glad to have survived.
- Most people who are suicidal do not want to die – they want the pain to stop.

YOU CAN MAKE A DIFFERENCE

What ideas occur to you as you read about suicide, stigma, research and action? Can you think of some ways you might decrease stigma? Is there something you can do to strengthen your community? What efforts might help someone who might be struggling? **No matter what your ideas are for taking action, they are important.**

The next section contains ten goals adopted by the Idaho Council on Suicide Prevention you can use to guide your efforts. They are not listed in priority order; all goals are important. Following each goal are subcategories to help you identify specific activities as well as measures to determine the success of your activities.

"Community" can mean different things. It can refer to people who live in a specific area. It also can mean people in different locations who have common interests. A community of action is any social group working together to create change.

"How We Will Do It"— Under each goal are actions or strategies to guide how the goal can be implemented. Additional actions or strategies that support or help to accomplish the goal may be utilized.

"Ideas for Things We Can Do" —This section appears alongside each goal. It is a list of activities that communities can consider. There may be other activities that communities can select to carry out the goal. These are offered as suggestions to spark other ideas.

"Ideas for How We Measure Our Success" —This section offers some ways we can measure our progress in meeting the goal, measure our strategies and measure our activities. It answers the question: "Did our efforts make a difference?"

Whatever you do to implement and measure the goals outlined in this Idaho Suicide Prevention Plan, **we can make Idaho a stronger, healthier place to live by working together.**

Measuring your success can be easy

An important part of suicide prevention efforts is to measure whether your activities are effective. There are many ways to measure success. You can keep track of processes or outcomes. For example, if you hold a meeting, you can record how many people attended, their affiliations and other pertinent information. If you are distributing materials, you can keep track of how many are distributed and to whom. Measuring outcomes is somewhat harder but can be simplified. For example, you can survey people who attend a training to find out what they've learned and how they plan to use the new information in practical terms. You could then survey these people sometime after training to find out if they did use the information.

Idaho Voices

Wade Virgin, Survivor

The date of May 5, 2004 has now taken its place with the other significant dates such as birthdays and holidays that we remember each year in our family. For us, May 5th now has its own meaning. Of course, it is Cinco De Mayo, celebrated by many in our area. However, it has even a deeper meaning to me. This is the day that we lost our brilliant son Russell, a victim of suicide. Russ was a high honor student at the University of Idaho, just a few weeks from graduating as an architect. He had just received a scholarship to assist in completing an advanced degree. He was what I call the "All American Boy", loved by everyone who knew him. How could something like this happen to him? There is not even a close second to the pain you feel from losing a child to suicide. The pain radiates from your chest area and I felt that I had literally broken my heart. It took weeks before the feeling finally subsided. The second major issue I dealt with was the overwhelming feeling of guilt that I had. What was wrong with me? Why couldn't I see that my son was in crisis?

The Suicide Prevention Action Network (SPAN) has helped me the following ways:

1. It gave me someone to talk to who would just listen as I talked out my problems.

2. It taught me that guilt feelings and pain are normal for someone who has lost a family member to suicide.

3. I have learned that there are physical and emotional differences for those who attempt and complete suicide.

Finally, I have learned that life goes on and things do get better as time passes. It really helps knowing that others care. I thank God in heaven and the many friends and people that have assisted me through this process. It is extremely important that we be there to assist suicide survivors.

GOAL 1: PUBLIC AWARENESS

Idahoans understand that suicide is preventable and accept responsibility for their role in suicide prevention.

How We Will Do It

1. Increase awareness that mental health issues, including depression and substance use disorders, play a role in suicide and are treatable.

2. Ensure current, appropriate, recommended mental health and suicide prevention information is available in a variety of settings.

3. Create and implement a comprehensive social marketing campaign specific to mental health and suicide prevention.

4. Educate the media on their role in preventing suicide and encourage their use of current, appropriate, recommended media guidelines for safe and responsible messaging related to suicide.

5. Educate policy makers and public figures that suicide is preventable and the importance of their role in suicide prevention. Enlist community members to participate in suicide prevention.

"Social marketing is the application of marketing technologies developed in the commercial sector to the solution of social problems where the bottom line is (voluntary) behavior change." (Andreasen, 2005).

Ideas For Things We Can Do

- ✓ Identify a variety of community settings and distribute suicide prevention information.
- ✓ Conduct a wide variety of community awareness and education events related to suicide prevention.
- ✓ Meet with local media representatives and distribute current guidelines for responsible reporting regarding suicide and suicide prevention.
- ✓ The Idaho Council on Suicide Prevention will work with key state-level stakeholders to craft and make available consistent messages for suicide prevention education and social marketing efforts.

Ideas For How We Measure Our Success

- Efforts have been initiated to engage key stakeholders, including policy makers, health and mental health and substance use treatment professionals, in appropriate suicide prevention activities.
- A plan has been developed and implemented to get current information about suicide prevention to a wide array of community settings where it is needed.
- A plan has been written and funds have been identified for a social marketing campaign specific to suicide prevention.
- Participation of community members in suicide prevention is tracked.
- Media guidelines have been disseminated and contacts documented.

Idaho Voices

Julie, Suicide Attempt Survivor

I was twenty years old and it was near Christmas. I had not wanted to go to college right out of high school, but that was unacceptable to my family, so I went to U of I and had about eleven majors my freshman year because I had no idea what I wanted to do with my life. I started my sophomore year living at home with my mother and attending Boise State, trying out yet another major. I rarely attended classes. One weekend day, I decided I had to express how much pain I was in. I went into my mother's medicine cabinet, and took several different pills from her many prescriptions. My mother was at home, and I must have told her what I had done, because she got me in the car and drove me to the hospital. They put a tube down my throat and were administering charcoal to neutralize the drugs. I woke up and pulled the tube out of my throat, and charcoal went everywhere. My mother slept on a cot in my hospital room that night. The next morning my physician came in and talked to me briefly and basically said that I shouldn't do that again. I was released to go home that day. My father sent me a Christmas card that said, "I'm glad you are okay." I told him, "That's just the point. I'm NOT okay." He berated me for trying to manipulate his emotions. I saw a counselor a few times. Then we moved to California. Much later, I was living away from home in a gross little apartment while going to beauty school. My boyfriend had dumped me without even a good-bye. One evening, I called the Suicide Hotline, and the woman told me I needed to call a friend, and I told her I didn't want to bother anyone. I was living with a friend after not working for about a year due to chronic migraines. I was extremely depressed and was not on any anti-depressants. I was making plans to kill myself. I ended up calling my friend and telling her what I was planning. She gave me some hotline numbers to call, which I did. I also told my mother how I had been feeling and she told me that she had been so afraid that I was going to complete suicide. I ended up moving back to Boise and moving in with my mother so she could support me and get me the care that I needed. Fortunately, I did get the care I needed with a combination of the right drug combination and talk therapy. It did take a while to get the drugs to the right combination and dosage, but it was worth sticking it out. I haven't had any suicidal thoughts since I started meeting with my Psychiatric Nurse Practitioner and my therapist. If I start feeling low I have both of them to turn to, and I feel safe asking for help and being honest about how I am feeling. You don't have to feel bad. There are many, many people who want to help you not only feel better in the short term, but also to deal with what is causing your pain in the long term. DON'T GIVE UP!!!!!

GOAL 2: ANTI-STIGMA

Idahoans understand and accept that seeking help for mental health issues is to be encouraged and supported.

How We Will Do It

1. Identify barriers and opportunities related to seeking help for mental health issues.

2. Ensure current, appropriate, recommended mental health information is available in a variety of settings.

3. Create and implement a comprehensive social marketing campaign specific to mental health and stigma.

"Stigma is when someone judges you based on a personal trait. Unfortunately, this is a common experience for people who have a mental health condition." (Mayo Clinic, 2009)

Ideas For Things We Can Do

- ✓ Encourage community members, including health care providers, to engage in open dialogue about mental illness.

- ✓ Community leaders identify barriers to seeking treatment for mental health concerns.

- ✓ Educate community members about stigma and its negative consequences for individuals and their families.

- ✓ The Idaho Council on Suicide Prevention will work with key state-level stakeholders to provide information about the value of seeking mental health care.

Ideas For How We Measure Our Success

- Barriers and opportunities related to seeking help for mental health issues have been identified and documented.

- Information about barriers and opportunities related to seeking help for mental health issues has been disseminated statewide.

- Information is available to professionals regarding the need for self-care when working with people who are suicidal.

- A social marketing campaign specific to mental health and stigma has been initiated.

Idaho Voices

Jeni Griffin, Survivor
Community Advocate & Trainer

Sugar- Salem High School invited me to come and help with an assembly about suicide prevention. They wanted their focus to be on the warning signs, the code of silence that youth take with friends, and how there are people they can turn to for help. The first speakers that day was a father whose son died by suicide about a year ago.

Then I spoke. My son died seven years ago by suicide. The father's story was mostly about how much he was going to miss out on things with his son. He expressed feelings to the students about how they need to watch out for each other and never think, "oh, he won't hurt himself". My talk was about the warning signs and what students should watch for in their friends' behaviors. Also, if they had thought of suicide themselves, that there was hope and help available. I talked about the code of silence, and how it proved deadly for my son, because there were several friends who knew he was at risk and had attempted several nights before. We had counselors available that day for the students after the assembly in case there was need for an intervention or if somebody just needed to talk.

One student came up to me afterwards and said that he had been thinking about suicide and that he even had a plan and the means to complete the act soon. But my story was able to touch him deeply. He said that he had never thought about who might find him, especially his mom, because that would hurt her too much. He was able to talk to a counselor at that time and get some help for his feelings. Another young girl came up afterwards and said that she was really worried about her friend and could we help. The counselors were able to talk to the girl's friend and alert her parents to the possible suicide risk of their daughter. An intervention took place for at least two students because of this assembly and untold other conversations that took place between friends wanting to look out for each other.

GOAL 3: GATEKEEPER EDUCATION

The education of professionals and others working with people at risk for suicide includes effective suicide prevention curricula and ongoing gatekeeper and other suicide prevention training.

How We Will Do It

1. Secure funding and opportunities to provide training for relevant entities involved in professional education and development, including higher education and others.

2. Collaborate to assist, train and support relevant entities involved in professional licensure, education and development.

3. Ensure that ongoing gatekeeper training opportunities are available to people who work with individuals at risk for suicide.

A "gatekeeper" can mean different things, depending on the setting. For example, a healthcare provider may make referrals to specialists and otherwise manage a patient's care. A "community gatekeeper" is a trusted person who knows the warning signs for suicide and assists an at-risk person get the help they need.

Ideas For Things We Can Do

- ✓ Communities identify local gatekeepers.

- ✓ Communities identify and provide opportunities for current, appropriate, and recommended gatekeeper trainings involving suicide prevention, intervention, postvention and self-care.

- ✓ The Idaho Council on Suicide Prevention will collaborate with professionals, gatekeepers and others responsible for training and curriculum requirements, to determine whether suicide prevention content is included.

Ideas For How We Measure Our Success

- The field training and curriculum requirements for professionals, gatekeepers and others have been reviewed for suicide prevention content.

- Recommendations for strengthening suicide prevention content in curricula have been made.

- Resources for gatekeeper training have been provided.

Idaho Voices

John Landers, PhD
Clinical Psychologist

I work as a clinical psychologist in an inpatient psychiatric hospital. Most people come to this facility as a result of extreme distress, which often includes experiencing suicidal ideation or even acting on those thoughts. My primary role at the hospital is to provide psychological assessments of patients when there are uncertainties regarding the diagnosis or proper treatment of the patient. Risk to self is one factor that I assess with every patient with whom I work. My risk assessments often include looking at prior behaviors as well as current symptoms. Recently, I have begun to measure thwarted belongingness, perceived burdensomeness, and acquired capability for suicide (i.e., learned fearlessness) with all patients who have been hospitalized. These factors are based on Dr. Thomas Joiner's groundbreaking and innovative research on suicide risk and potential and are quite new to the field of suicide risk assessment. I have found that including these new measures not only greatly enhances my ability to assess risk, but also gives me the ability to speak the language of my patients.

Just last week, when providing feedback to an adolescent female who has attempted suicide at least 10 times in the past two years, she said, "I've never had anyone be able to state so clearly why I become suicidal. When I feel alone and like I'm bringing others down, that is when I attempt." This new tool for assessing risk has also informed treatment planning, as now therapists can work to increase belongingness and decrease burdensomeness in those where these factors are leading to suicidal ideation and behaviors. Keeping up to date on the newest and empirically supported practices has significantly enhanced my work and been a great benefit to my patients.

GOAL 4: BEHAVIORAL HEALTH PROFESSIONAL READINESS

Mental health and substance abuse treatment professionals are trained to use current, appropriate, and recommended practices for assessing and treating individuals who show signs of suicide risk.

How We Will Do It

1. Engage mental health and substance abuse treatment professionals and other providers in developing university curricula, continuing education courses, and other professional suicide prevention training.

2. Ensure current, appropriate, and recommended suicide prevention, assessment, intervention and postvention training is available to mental health professionals and other health care providers.

3. Identify and disseminate information and training to mental health professionals and other health care providers on current, appropriate, and recommended practices to assess and treat people at risk for suicide, including self-care.

"Behavioral Healthcare: The provision of mental health and chemical dependency (or substance abuse) services." (Blue Cross/Blue Shield, 2011)

Ideas For Things We Can Do

- ✓ Identify local mental health professionals and other health care providers and encourage them to follow current, appropriate, and recommended practices for suicide risk assessment, intervention and follow up.

- ✓ Disseminate current, appropriate, and recommended practices to all mental health and other providers working with people at risk for suicide.

- ✓ The Idaho Council on Suicide Prevention and State of Idaho lead agency will collaborate with mental health professionals and other health care providers in developing university curricula, continuing education courses, and other professional training.

Ideas For How We Measure Our Success

- The key decision makers among mental health professionals have been identified and actively participate in curriculum development and education.

- Current, appropriate, and recommended sources for training have been identified.

- Materials for training have been identified and are available to all mental health professionals and other audiences.

Postvention activities occur after a suicide and involve interventions to support bereaved family, friends, professionals and peers—who are at risk of suicide themselves.

Idaho Voices

Mary Pierce, LCSW
Veteran's Affairs Suicide Prevention Coordinator

As part of my duties for the Boise Veteran's Affairs Medical Center, I monitor and support the care of veterans after they have survived a suicide attempt or are evaluated to be a high risk for suicide. Research shows that the greatest time of risk for suicide is the first 30 days after psychiatric hospitalization. The Veteran's Affairs (VA) Suicide Prevention Initiative includes identifying veterans at high risk for suicide, providing enhanced care, e.g., therapy, regular psychiatric evaluation, safety planning (including listing the National Suicide Hotline phone number, persons and services to call when feeling suicidal, and coping strategies to decrease suicidal ideation), regular suicide risk assessment, and case monitoring by the Suicide Prevention Coordinator. During one call to check in with a veteran on the High Risk for Suicide List, the veteran informed me that it was his birthday and that he was not doing well. He felt misunderstood and ignored by his family and planned to kill himself. After some conversation the veteran agreed to come to the Boise VAMC and be admitted to the psychiatric unit. His plan of care was modified to include more intensive individual and family therapy. This veteran is currently doing well and been removed from the High Risk for Suicide List. The veteran calls occasionally to update me on his progress and thank me for saving his life.

GOAL 5: COMMUNITY INVOLVEMENT

Community leaders and stakeholders develop and implement suicide prevention activities that are current, recommended and culturally appropriate that are specific to their regions and communities.

How We Will Do It

1. Ensure community leaders and stakeholders are aware of the Idaho Suicide Prevention Plan and the resources are available to help them develop and implement suicide prevention efforts specific to their communities.

2. Assist, train and support community leaders and stakeholders about current, recommended, and culturally appropriate suicide prevention activities.

3. Assist community leaders and stakeholders to identify their community's suicide issues or people at risk for suicide.

4. Assist community leaders and stakeholders to identify and understand the unique cultural characteristics of their region that may relate to suicide.

5. Support the development of community groups that promote access to and use of mental health services.

6. Ensure current, culturally appropriate, recommended suicide prevention information is widely available in a variety of community settings.

7. Provide opportunities for communities to network and share information about suicide prevention.

Ideas For Things We Can Do

- ✓ Community members gather public input to determine the status of and needs for suicide prevention efforts in their communities.

- ✓ Community leaders implement the Idaho Suicide Prevention Plan in their local area.

- ✓ Community leaders identify and support culturally diverse groups in their region on suicide prevention efforts.

- ✓ The Idaho Council on Suicide Prevention will work with key state-level stakeholders to develop and implement a plan to get current, culturally appropriate, recommended suicide prevention information to those settings where it is needed.

Ideas For How We Measure Our Success

- Community leaders and stakeholders promote suicide prevention.

- Stakeholders and others have received the Idaho Suicide Prevention Plan and have identified ways to implement it in their regions.

- Community specific and culturally tailored training has been conducted and documented.

- Current suicide prevention information is available in settings where it is needed.

- Communities have provided opportunities for networking and information sharing about suicide prevention.

Idaho Voices

Paula Campbell
National Alliance on Mental Illness (NAMI)-Boise
Vice President and Program Director

Our family has dealt with the maze of mental health treatment for the past six years in order to meet the needs of our son who was hospitalized in 2004. NAMI-Boise provided valuable resource information and free education classes and support.

It is critical that we utilize the funds we have available from both federal and state to create a better continuum of care for those in crisis.

It is even more important that we educate the public on the power of prevention, recognizing symptoms and utilizing community services before hospitalization is needed.

Stigma needs to be reduced once and for all.

GOAL 6: ACCESS TO CARE

Crisis intervention and behavioral health services, including mental health and substance abuse treatment, are widely available, culturally appropriate, accessible and valued by communities.

How We Will Do It

1. Encourage communities to value crisis intervention and behavioral health services.
2. Support the integration of and equitable funding for mental health and physical health services.
3. Support widely available, diverse and accessible behavioral health services in all regions of Idaho.
4. Identify and engage community champions to address suicide prevention.
5. Provide training about culturally appropriate crisis intervention and behavioral health services to communities.
6. Empower communities to reach out to policy makers in support of widely available, culturally appropriate and accessible crisis intervention and behavioral health services.

"Culturally appropriate" refers to many things. It can address ethnic and racial issues but can be expanded to include rural, economic, religious, job type, and even differences between regional characteristics.

Ideas For Things We Can Do

- ✓ Community members collaborate with local media to educate the community on the value of crisis intervention and behavioral health services.
- ✓ Community members support those providing crisis intervention services to use current, appropriate, recommended, culturally relevant practices.
- ✓ The Idaho Council on Suicide Prevention will collaborate with policy makers to support widely available, culturally appropriate and accessible crisis intervention and behavioral health services throughout the state.

Ideas For How We Measure Our Success

- Champions or group leaders support widely available crisis intervention and behavioral health services.
- Efforts to promote equitable, adequate funding and integration of physical and mental health services have been monitored.
- Community-specific and culturally tailored events and training have been conducted and documented.
- Interaction between community leaders and decision makers to promote suicide prevention has been documented.

"Unfortunately, despite ongoing efforts to educate the public, the same social stigma that surrounds suicide also continues to stand between many people with mental and substance use disorders and the care they need — care that could help thwart potential suicide." (Center for Substance Abuse Treatment, 2008)

Idaho Voices

Rich and Trudy Jackson
Suicide Survivor Support Group Facilitators

Rich and Trudy Jackson are the survivors of the suicide death of their son Jason. They facilitated a suicide survivor support group in Boise for 20 years and are pioneers in suicide prevention in Idaho.

Survivor support groups play a vital role in helping survivors cope with grief and make the choice to find new meaning and direction in their lives. Many survivors have found their support to be a major factor in finding a new way of living in a world forever change by their loved one's decision.

GOAL 7: SURVIVOR SUPPORT

Information and services are in place in all regions of Idaho to support survivors and others affected by suicide in a sensitive and culturally appropriate manner.

How We Will Do It

1. Provide information and services to survivors and others affected by suicide that will help them deal with their grief and unique circumstances.

2. Support stakeholders to appropriately address the consequences of a community suicide crisis.

3. Support the development and continuation of community suicide survivors support groups.

Ideas For Things We Can Do

- ✓ Community members create and maintain suicide survivor support groups.
- ✓ Communities provide resources and information to assist survivors in healing and moving forward.
- ✓ Community leaders support stakeholders in local suicide response.
- ✓ The Idaho Council on Suicide Prevention works with state-level stakeholders to educate people about the particular difficulties associated with losing someone to suicide.

Ideas For How We Measure Our Success

- Appropriate information to help survivors deal with their grief has been identified and distributed.
- Community plans have been developed and implemented to support survivors.
- Survivors of suicide report feeling a reduced sense of stigma.

"Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description." (Kay Redfield Jamison in US DHHS, 2001)

"A suicide survivor is someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person" (Jordan and McIntosh, 2011).

Idaho Voices

Ann Kirkwood, MA

Idaho State University - Institute of Rural Health
Director, Youth Suicide Prevention & Hotline Research
Director, Better Todays. Better Tomorrows.

Suicide prevention hotlines work. They provide needed access to care in some areas where mental health services are not widely available. Their services are available 24/7, 365 days a year. Responding to callers who are in a suicide crisis does save lives. A suicide prevention hotline in Idaho closed in late 2006 and the national Suicide Prevention Lifeline took on Idaho's calls as a professional courtesy. The locally funded hotline in Portland, Oregon, has temporarily answered Idaho calls in recent years at no cost to Idaho.

According to information from Lifeline, call volume from Idaho being answered in other states has more than doubled since 2007 (increasing from 1,534 in 2007 to 3,633 calls in 2009). However, operators in other states taking Idaho calls reported difficulties in making referrals for follow up care, an essential component to prevent additional suicide attempts and completions. The formation of a suicide prevention hotline in Idaho represents an opportunity to effectively address the issue of Idaho's high suicide rate.

In 2009, the State entered into a contract with the Institute of Rural Health at Idaho State University to study how a 24-hour statewide hotline could be established and maintained in Idaho. Data were collected from about 20 individual sources and 13 research projects were initiated. A full report and implementation guide from that effort is available on the IRH website at www.isu.edu/irh/publications/hotline_Report_2010_web_pwp.pdf.

Maintaining funding for the Idaho hotline is an important step in establishing its presence in Idaho.

GOAL 8: SUICIDE PREVENTION HOTLINE

An Idaho statewide suicide prevention hotline is established and funded.

How We Will Do It

1. Identify an entity in Idaho to provide statewide suicide prevention hotline services.
2. Identify adequate and sustainable funding to support a statewide suicide prevention hotline.
3. Secure certification and accreditation for a statewide suicide prevention hotline.
4. Promote the Idaho suicide prevention hotline number statewide.
5. Evaluate usage patterns of the statewide suicide prevention hotline.
6. Evaluate community awareness of and attitudes toward a statewide suicide prevention hotline.

An Idaho hotline began as the Nampa Suicide Prevention Hotline in 1989. In 1994, it became Idaho Suicide Prevention Services operating statewide from Boise State University. The hotline was staffed almost entirely by volunteers. It closed in December 2006.

Ideas For Things We Can Do

- ✓ Distribute hotline cards.
- ✓ Promote the hotline at community events.
- ✓ Distribute hotline cards to specific groups that interact with people at risk for suicide.
- ✓ The Idaho Council on Suicide Prevention will provide leadership to identify an entity in Idaho to operate a statewide suicide prevention hotline.

Ideas For How We Measure Our Success

- An organization has been identified that will operate an Idaho suicide prevention hotline.
- Options for short- and long-term funding to support a certified and accredited hotline have been identified.
- An accreditation application for the Idaho suicide prevention hotline has been submitted.
- Calls to the Idaho suicide prevention hotline are tracked and reported.

Idaho Voices

Kathie Garrett

Chair, Idaho Council on Suicide Prevention

The Idaho Council on Suicide Prevention is proud to be a part of Idaho's efforts to address the critical issue of suicide. The Council was established by Governor Kempthorne in 2006 and most recently appointed by Governor C. L. "Butch" Otter.

The Council has been given the following charge:

- To oversee the implementation of the Idaho Suicide Prevention Plan.
- To ensure the continued relevance of the Plan.
- To report to the Governor and Legislature annually.

By working in collaboration with partner groups, positive work has been accomplished. Ultimately, our goal is to reduce the number of deaths by suicide in Idaho. There is much work yet to be done. Everyone's efforts are needed to achieve our goals.

GOAL 9: LEADERSHIP

The Idaho Council on Suicide Prevention oversees suicide prevention activities at all levels, as guided by the Idaho Suicide Prevention Plan, and works in collaboration with a lead Idaho state government agency that is responsible for Idaho's suicide prevention and intervention efforts.

How We Will Do It

1. Ensure the continuation of the Idaho Council on Suicide Prevention.
2. Support efforts to secure adequate funding and administrative support for the Idaho Council on Suicide Prevention.
3. Obtain support and recognition for the Idaho Council on Suicide Prevention from decision makers at all levels.
4. Ensure the Idaho Council on Suicide Prevention continually evaluates membership representation to include appropriate diverse groups.
5. Ensure the relevancy and progress of the Idaho Suicide Prevention Plan.
6. Seek endorsement of the Idaho Suicide Prevention Plan by key decision makers.
7. Widely disseminate the Idaho Suicide Prevention Plan.
8. Evaluate implementation of the Idaho Suicide Prevention Plan.
9. Identify a lead state government agency responsible for Idaho's suicide prevention and intervention activities.
10. Support efforts to secure adequate funding for suicide prevention within the lead Idaho state government agency responsible for Idaho suicide prevention and intervention activities.

Ideas For Things We Can Do

- ✓ The Idaho Council on Suicide Prevention will establish bylaws that reflect its mission and duties assigned by the governor's executive order.
- ✓ The Idaho Council on Suicide Prevention membership and progress of the Idaho Suicide Prevention Plan will be evaluated by the Council annually.
- ✓ The Idaho Council on Suicide Prevention will report annually to the Legislature and Governor on the progress of the Idaho Suicide Prevention Plan and Council activities.
- ✓ The Idaho Council on Suicide Prevention will develop and implement a dissemination strategy for the Idaho Suicide Prevention Plan.
- ✓ Stakeholders throughout Idaho will promote the naming of a lead state government agency responsible for Idaho Suicide prevention activities.

Ideas For How We Measure Our Success

- The Executive Order creating the Idaho Council on Suicide Prevention is renewed on a regular basis to ensure continuation.
- A budget to support the Idaho Council on Suicide Prevention has been developed.
- Key decision makers have been provided information about the Idaho Council on Suicide Prevention.
- The Governor and Legislature are provided with an annual report on suicide and suicide prevention activities in the state of Idaho.
- A literature review and information on best practices, comparing the activities of Idaho to national evidence-informed practices, have been compiled in support of the Idaho Suicide Prevention Plan.
- A lead Idaho state government agency has been named.

Idaho Voices

Elke Shaw-Tulloch, MHS

Chief, Bureau of Community & Environmental Health
Division of Public Health
Idaho Department of Health & Welfare

It is important to collect, analyze and interpret health data. This helps us to do several things:

- Prove or disprove what is perceived to be true in regard to a particular issue, topic or project,
- Dispel myth and rumor, and
- Make informed decisions.

For example, a hospital may review data about postpartum depression onset to determine that conducting a depression screening upon discharge is not as effective as a two week follow up telephone call to new moms to detect symptoms of depression. Public health tobacco prevention programs may obtain data to determine which segment of the population is the most impacted by tobacco use so they can target tailor-made interventions to that population. We use data in our daily lives also to help us make health-related decisions, such as reviewing the nutrition label on a food item to determine whether the amount of calories and sodium meets your health goals, determining the most economical health care clinic to get flu shots to protect your family, or tracking the number of your child's sleepless nights to initiate a discussion about anxiety with your child's health care professional.

This same informed decision-making approach must also be applied to suicide prevention, intervention and postvention activities to ensure that activities are purposefully targeted to have impact and make change.

GOAL 10: DATA

Data are available on which to make decisions regarding suicide prevention services.

How We Will Do It

1. Determine data needed for effective suicide prevention services including surveillance and outcome data.
2. Continue to collect and improve existing suicide-related data at state and community levels.
3. Promote the availability of and increase the access to suicide-related data.
4. Assist stakeholders in understanding how data can be used to plan and implement suicide prevention services.
5. Create and implement a method to share suicide-related data statewide, with a special emphasis on region-specific surveillance and outcome data.

Surveillance (data) helps to define the problem for a community. It documents the extent to which suicide is a burden to a community and how suicide rates vary by time... geographic regions, age groups, or special populations.(NSSP pg 31)

Ideas For Things We Can Do

- ✓ Statewide suicide prevention leaders educate local stakeholders on how data can be used appropriately to plan and implement suicide prevention programs.
- ✓ Communities identify and collect relevant, reputable data and use it appropriately to plan suicide prevention activities.
- ✓ Local stakeholders identify community members who need suicide data.
- ✓ Create and implement a method to share suicide-related data statewide, with a special emphasis on region-specific surveillance and outcome data.

Ideas For How We Measure Our Success

- A group has been established to determine suicide data needs.
- Suicide data have been collected, recorded, tracked and trends over time have been identified.
- Data to support planning and evaluation efforts have been identified.
- Stakeholders have been trained to work with data.
- Data have been made widely available, as appropriate, to protect confidentiality of individuals.

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HOW TO FIND ADDITIONAL DATA SOURCES ON SUICIDE

There are a variety of data sources that could be useful for planning and measuring suicide prevention activities. This section lists some suggested sources for Idaho data. Please note that some recommendations are for types of data and others for sources of data. In most cases the types of data information also includes potential sources.

- ***Youth Risk Behavior Survey (YRBS)*** is part of a national survey of CDC, administered by the Idaho State Department of Education to students in grades 9-12 and is a self-report survey. It contains suicide related questions in addition to tracking behaviors among youth related to the leading causes of mortality and morbidity in six categories. Currently, data are collected every other year in Idaho. www.sde.idaho.gov

- ***Behavior Risk Factor Surveillance System (BRFSS)*** is the YRBS for adults and contains similar suicide related questions. The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest, ongoing telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Currently, data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. www.cdc.gov/brfss

- ***Idaho Office of Vital Statistics*** The Idaho Bureau of Vital Records and Health Statistics maintains birth and death records filed from July 1911 to the present, and marriage and divorce records filed from May 1947 to the present. Some counties may have older birth, death, marriage, or divorce records in their files, but county files contain only records of vital events that occurred in that county. http://healthandwelfare.idaho.gov/?TabId=82

- ***Idaho State University Institute of Rural Health Awareness to Action Youth Suicide Prevention Project*** AAYSP conducts research and programs. Reports and data are produced, such as the Hotline Options Report. The purpose of the Idaho Awareness to Action Youth Suicide Prevention Project is to reduce suicide attempts and completions, regardless of ethnic/racial heritage, among Idaho youth ages 10-24. The overall goal of the project is to translate information into active suicide prevention by increasing adults' knowledge of youth suicide protective and risk factors and helping them to put that knowledge into active suicide prevention efforts. www.isu.edu/irh/projects/ysp/goals.shtml

- ***Idaho State University-Institute of Rural Health*** The IRH has offices in Pocatello and in Meridian. The mission of the IRH is to improve the health of communities through research, education, and service. The IRH conducts research and program activities. Specific projects or data requests are possible. Reports are available at www.isu.edu/irh.

- ***Idaho Suicide Data & Research Project*** presents Idaho-specific data for four special at-risk populations in Idaho. The website presents actual Idaho suicide data on each population, such as incidence, race, place of injury, mechanism of death, etc., as well as risk and protective factor data for each special population. The four special populations are teen males, Native American males, working age males, and elderly males. The reports page presents research-based reports on each of the special populations, as well as extensive research bibliographies. The project has been managed by Benchmark Research and Safety, Inc. www.idahosuicide.info

- ***National Violent Death Reporting System*** CDC has funded 18 states and established the National Violent Death Reporting System (NVDRS) to gather, share, and link state-level data on violent deaths. NVDRS provides CDC and states with a more accurate understanding of violent deaths. This enables policy makers and community leaders to make informed decisions about violence prevention programs, including those that address child maltreatment. Idaho is not among the NVDRS reporting states, however, NVDRS provides data that can be used to help guide Idaho programs.
  www.cdc.gov/ViolencePrevention/NVDRS

- ***Suicide Prevention Action Network, Idaho*** SPAN Idaho's mission is to reduce suicide in Idaho through statewide advocacy, collaboration and education in best practices. SPAN conducts suicide prevention conferences, trainings, survivor support, public awareness activities, and information and referral. SPAN spearheads statewide suicide prevention initiatives and works with national, state and local stakeholders to create positive change.
  www.spanidaho.org

- ***Suicide Prevention Resource Center*** SPRC includes 490 web pages and 250 library resources on suicide prevention information. The site includes a range of information from suicide prevention and mental health news to strategic tools for developing suicide prevention programs. The site includes individual state suicide prevention pages, news and events, an online library, training, and links to other web sites.
  www.sprc.org

- ***The National Suicide Prevention Lifeline*** 1-800-273-TALK (8255) is a 24-hour, toll-free, confidential suicide prevention hotline available to anyone in suicidal crisis or emotional distress. The Lifeline's national network of local crisis centers, provide crisis counseling and mental health referrals day and night. Although Idaho does not have a suicide prevention hotline that is part of the Lifeline system, Lifeline may be able to provide some data about Idaho calls that roll over to them. Idaho's calls as of summer 2011 were answered at the Portland, OR, call center which is funded by local Oregon resources.

- ***The Substance Use, Safety and School Climate survey and the Youth Risk Behavior Survey (YRBS)*** are administered bi-annually in alternating years by the SDE. The Substance Use, Safety and School Climate survey captures student reported data on risk behaviors and school safety. There were 15,200 students surveyed statewide in the fall of 2008. The YRBS captures student reported data on intentional and unintentional injuries, sexual behaviors that can result in HIV infection, other sexually transmitted diseases and unintended pregnancies; dietary behaviors, physically activity and suicidal tendencies. The 2009 YRBS survey was completed by 2,154 students in 53 public high schools.
  www.cdc.gov/HealthyYouth/yrbs

- ***WISQARS*** Web-based Injury Statistics Query and Reporting System (WISQARS), pronounced "whiskers", is an interactive database that provides national injury-related morbidity and mortality data used for research and for making informed public health decisions.
  www.cdc.gov/injury/wisqars

- One way to address the problem of suicide is through social marketing campaigns. Social marketing "refers primarily to efforts focused on influencing behaviors that will improve health, prevent injuries, protect the environment, and contribute to communities." (Kotler & Lee, 2008. p 7).

Social Marketing Resources

Archived webinar

ISU – Institute of Rural Health sponsored a webinar titled "Social Marketing: Putting it into Practice", which focused specifically on using social marketing for suicide prevention in July 2011. In this recorded webinar participants learn the basic principles of social marketing. Emphasis is placed on identifying appropriate behaviors, measuring change, and real world examples. The course is designed for people who are engaged in suicide prevention planning at the community level, but may be helpful to any grassroots effort for prevention or behavior change (http://vimeo.com/26646412).

Books

Andreasen, A. R. (1995). *Marketing social change: Changing behavior to promote health, social development and the environment.* San Francisco: Sage Publications.

Andreasen, A. R. (2006). *Social marketing in the 21st century.* Thousand Oaks, CA: Sage Publications.

Kotler, P. & Lee, N. R. (2008). *Social marketing: Influencing behaviors for good.* Third Edition. Thousand Oaks, CA: Sage Publications.

SENATE HEALTH & WELFARE COMMITTEE
Wednesday January 20, 2016

ATTACHMENT 5

SPAN IDAHO

SUICIDE PREVENTION ACTION NETWORK OF IDAHO

Suicide in Idaho: Fact Sheet
November 2015

- Suicide is the 2nd leading cause of death for Idahoans age 15-34 and for males age 10-14. (The leading cause of death is accidents.)
- Idaho is consistently among the states with the highest suicide rates. In 2013 Idaho had the 7th highest suicide rate, 47% higher than the national average.
- In 2014, 320 people completed suicide in Idaho; a slight increase from 2013.
- Between 2010 and 2014, 78% of Idaho suicides were by men.
- In 2014, 60% of Idaho suicides involved a firearm.
- 15.8% (1 in 6) of Idaho youth attending regular public and charter high schools reported seriously considering suicide in 2013. 7.0% (1 in 14) reported making at least one attempt.
- Between 2010 and 2014, 96 Idaho school children (age 18 and under) died by suicide. Twenty of these were age 14 and under.
- Number of emergency department visits for self-inflicted injury per year: 836,000 in the United States
- In 2013, there were 41,149 deaths by suicide in the United States, an average of 1 person every 12.8 minutes.

Idaho Resident Suicides by Region – 2014

Region	Anchor City	Suicides	Rate (per 100,000)	Population	Tot. # suicides 2010-2014	5-yr Avg Rate
1	Coeur d'Alene	53	23.9*	221,398	235	21.7
2	Lewiston	33	30.8*	107,033	119	22.4
3	Nampa	35	13.1-	268,080	220	16.9
4	Boise	85	18.1*	468,980	374	16.6
5	Twin Falls	42	22.1*	190,496	188	20.0
6	Pocatello	36	21.7-	166,232	175	21.1
7	Idaho Falls	36	17.0*	212,245	190	18.1

* Increase from 2013, - decrease from 2013

Idaho Suicides by Age/Gender 2010-14
Over 5 year period

Age	Total	Male	Rate	Female	Rate
< 15	20	18	3.3	2	0.7
15-24	231	182	31.6	49	8.9
25-34	212	171	31.8	41	7.9
35-44	255	192	38.9	63	13.1
45-54	303	226	44.6	77	15.1
55-64	248	186	39.4	62	12.8
65-74	117	99	32.6	18	5.7
75-84	69	62	42.7	7	4.1
85+	46	42	87.0	4	4.7

Method 2010-14
(all ages)

Firearm	60.4%
Poisoning	16.5%
Suffocation	18.5%
Cut/Pierce	1.0%
Fall	0.9 %
Other	2.6%

Idaho Suicide Rates 2005 – 2014

Year	Number	ID Rate	US Rate
2005	225	15.7	11.8
2006	218	14.9	11.2
2007	220	14.7	11.5
2008	251	16.7	11.9
2009	307	19.9	12.0
2010	209	18.5	12.4
2011	284	17.9	12.7
2012	299	18.7	12.9
2013	308	19.1	13.0
2014	320	19.6	N/A

Idaho Youth Risk Behavior Survey 2013 – Regular Public and Charter High School Students

Grade	Sad or Hopeless	Suicidal	Plan	Attempt	Medical Care For Attempt
9th	28.4%	18.2%	12.8%	8.3%	2.8%
10th	27.8	14.4	12.7	7.6	3.0
11th	31.0	15.3	11.9	6.8	2.0
12th	29.3	14.9	14.3	5.7	1.9
Idaho Overall	29.4	15.8	13.0	7.0	2.5

Idaho Suicide Rate by County

5-year total number and 5-year average annual rate 2010-2014

(Resident suicides per 100,000 people)

County	Number	Rate	County	Number	Rate
Ada	328	16.0	Gem	12	14.4
Adams	4	20.8	Gooding	14	18.3
Bannock	101	24.2	Idaho	16	19.7
Bear Lake	7	23.5	Jefferson	24	18.0
Benewah	9	19.7	Jerome	29	25.7
Bingham	38	16.7	Kootenai	143	20.0
Blaine	25	23.5	Latah	25	13.2
Boise	12	34.8	Lemhi	12	30.7
Bonner	42	20.5	Lewis	5	25.9
Bonneville	101	19.0	Lincoln	4	15.2
Boundary	16	29.4	Madison	12	6.4
Butte	3	21.9	Minidoka	13	12.9
Camas	-	-	Nez Perce	61	30.8
Canyon	168	17.2	Oneida	2	9.5
Caribou	11	32.1	Owyhee	7	12.2
Cassia	19	16.3	Payette	18	15.9
Clark	4	88.2	Power	3	7.8
Clearwater	12	27.8	Shoshone	25	39.6
Custer	11	51.4	Teton	14	27.5
Elmore	27	20.5	Twin Falls	84	21.3
Franklin	13	20.2	Valley	7	14.4
Fremont	9	13.8	Washington	11	21.8
			Idaho (total)	1,501	18.8 (5-year average)

Note: Rates for many counties are based on fewer than 20 deaths. Caution is advised when interpreting rates based on small numbers.

Sources: Idaho Bureau of Vital Records and Health Statistics,
Idaho Department of Health and Welfare,
Center for Disease Control and Prevention
State Department of Education, YRBS Idaho, 2013

Compiled by Jeni Griffin, Executive Director, SPAN Idaho
Special Thanks to Martjin Van Beek, Research Analyst Senior and Pam Harder, Research Analyst Supervisor, Bureau of Vital Records and Health Statistics

SENATE HEALTH & WELFARE COMMITTEE
Wednesday January 20, 2016

ATTACHMENT 6

Suicide Prevention 2016

Follow up to SCR 104
Senate Health and Welfare Committee
January 20, 2016
Health Quality Planning Commission
Suicide Prevention Core Team
J. Robert Polk, MD, MPH

2015 Legislative Session SCR 104

- Charged the HQPC to prepare an **implementation plan for a comprehensive suicide prevention program** such as the Idaho Suicide Prevention Plan (ISPP) as published by the Idaho Council on Suicide Prevention (ICSP).
- This plan and budget were approved by the HQPC December 9, 2015

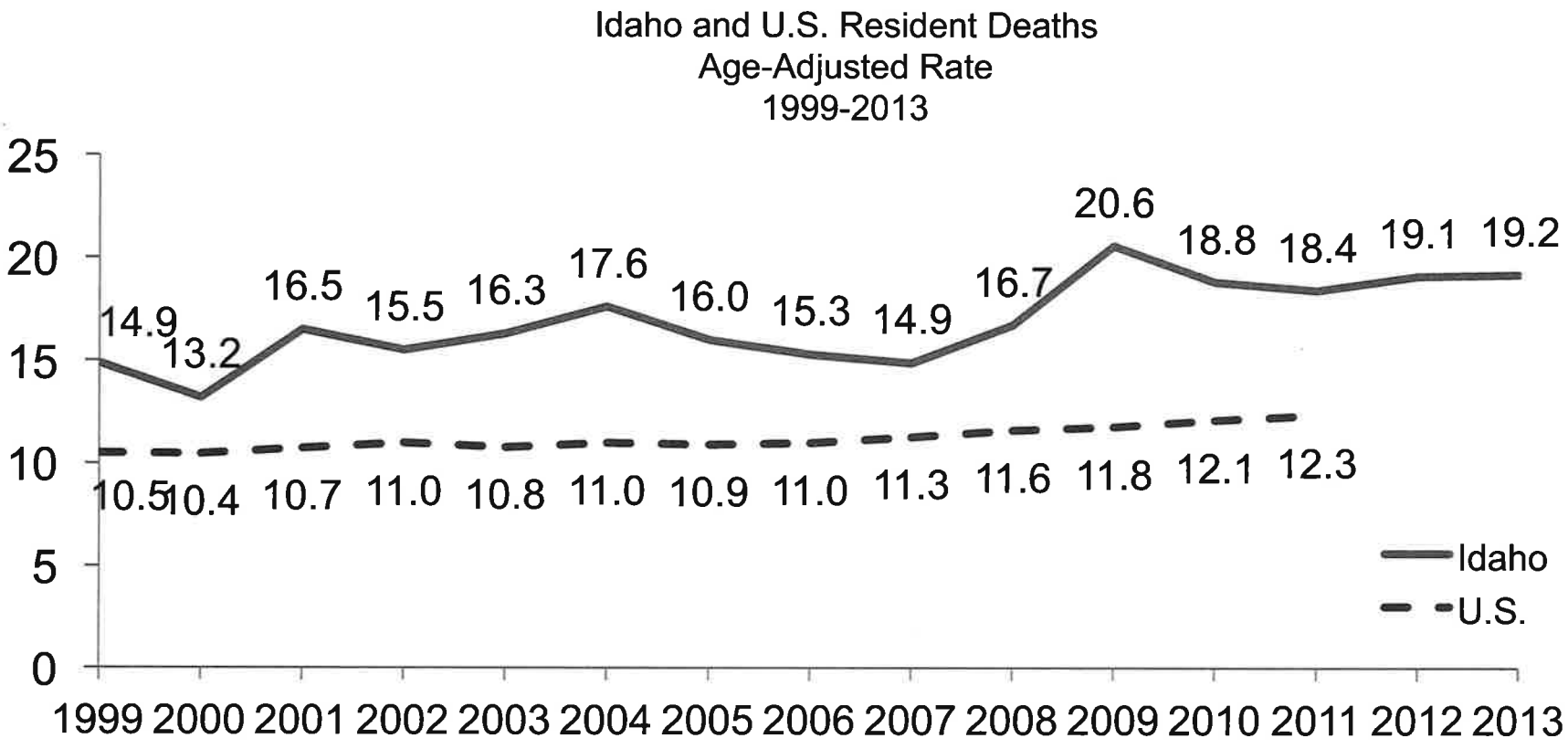
Suicide Prevention Core Team

- Subgroup of ICSP, HQPC, and other leaders in suicide prevention met **to select the prevention methods most likely to succeed and the infrastructure necessary to improve coordinated efforts across the state.**
- Team members: Bob Polk MD (Chair HQPC), Ross Edmunds (DHW), Elke Shaw-Tulloch (DHW), Linda Hatzenbuehler (ISU&ISPC Chair), Kim Kane (ILP&ISPC), Matt McCarter (SDE&ILP), Corey Surber (SAHS), Judy Gabert (SPAN Idaho&ILP), John Reusser (ISPH&ISPC), Dieuwke Spencer (DHW&ISPC), Jennifer Dickey (ILP), Jeni Griffin (SPAN Idaho), Jayne Tabb (DHW Support)

Suicide Data

- Idaho consistently in top 10 states with highest suicide rates; in 2013 Idaho 6th highest
- Consistently higher than US rate 19.2 vs 13.0 (2013)
- In 2014, Idaho at 6.15 deaths by suicide per week (2013 5.92/week)
- Mechanisms (2013): Poisoning, Firearms, Suffocation

Suicide Statistics: Trends



Rate per 100,000. Sources: Idaho data – Bureau of Vital Records and Health Statistics, U.S. NCHS Vital Statistics System

Suicide Facts in Idaho

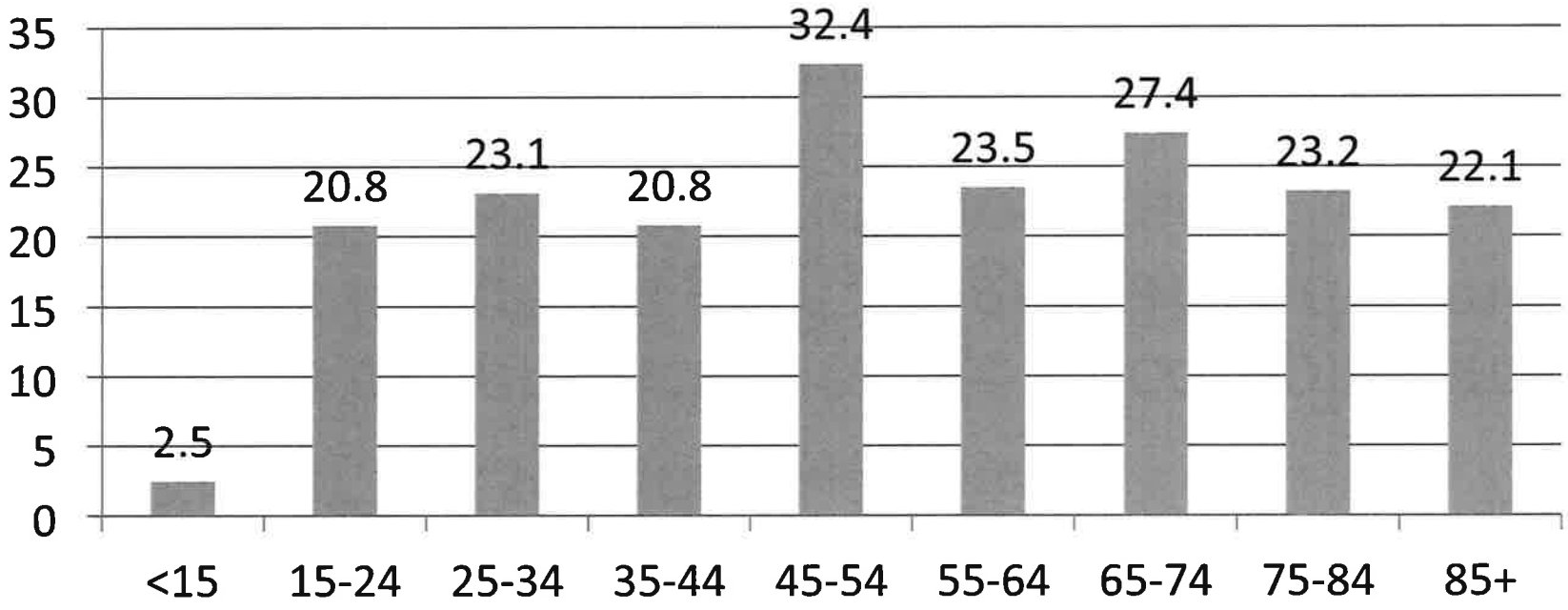
- 2013 Youth Risk Behavior Survey of Idaho High School students(regular and charter schools)
  - 1 in 6 have seriously considered suicide (15.8%)
  - **1 in 8 have a suicide plan (12.5%)**
  - **1 in 14 have attempted suicide (7%)**
- Idaho lost 96 (85) school age children(18 and younger) to suicide 2010-2014 (2009-2013); 20(15) of those were 14 or younger
- Idaho lost 155(134) college age youth, age 19-24 to suicide 2010-2014(2009-2013)

2009-2013 data in blue

Survivors of Suicide

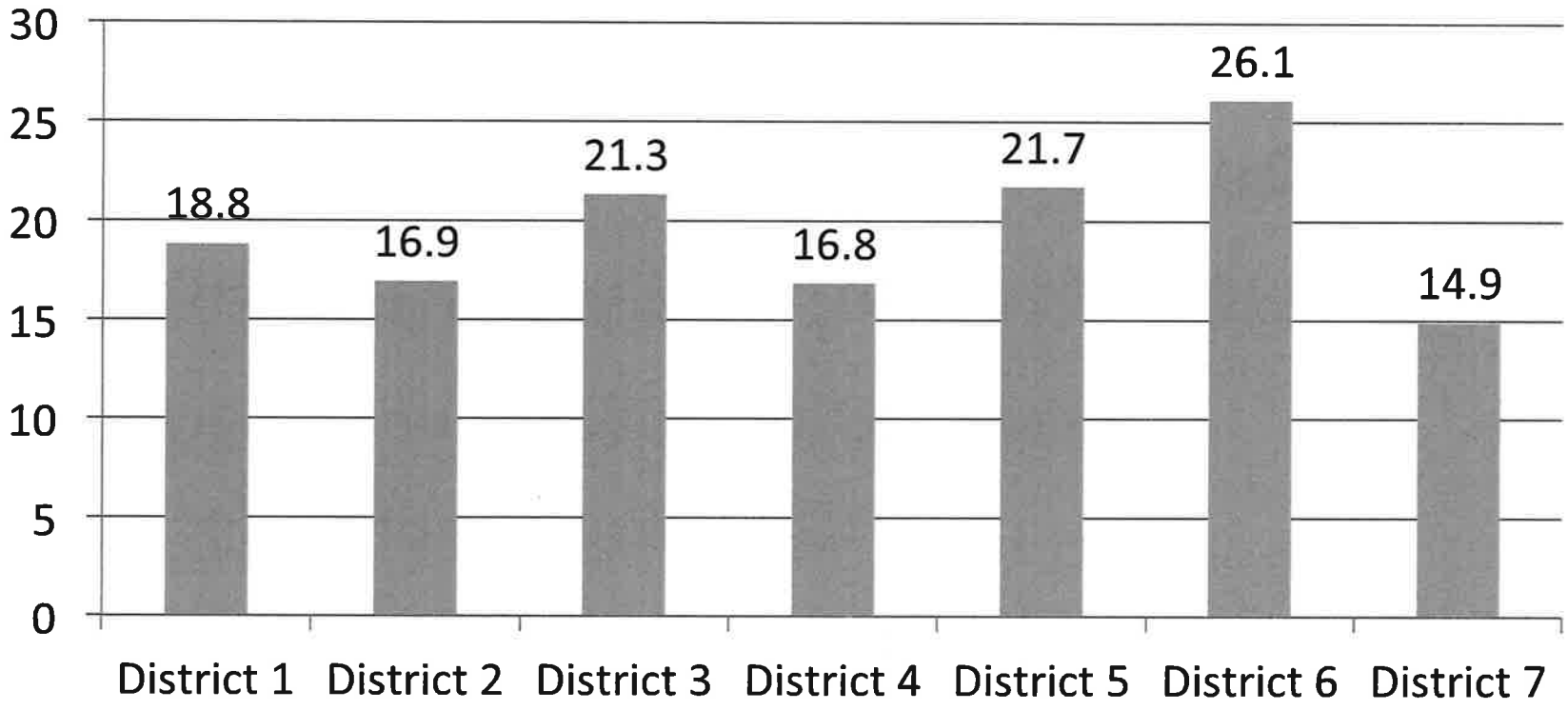
- Surviving the loss of a loved one to suicide is a risk factor for suicide (Brent, 2010)
- Survivors experience a range of complex grief reactions including guilt, anger, abandonment, denial, helplessness, and shock (Jordan, 2001, and Am Assoc Suicidology factsheet)
- Estimate median of 6-32 survivors per suicide (Berman, 2011)
- Estimate 7% of U.S. population knew someone who died of suicide in the previous 12 months (Crosby, 2002)

Idaho Suicides Rates by Age (rate per 100,000)



Rate per 100,000. Source: Bureau of Vital Records and Health Statistics, 2013 data

Total Idaho Suicides by Public Health District (rate per 100,000)



Rate per 100,000. Source: Bureau of Vital Records and Health Statistics, 2013 data

Economic Costs of Suicide in Idaho and Potential Benefits of Prevention

- 2013: 308 suicides, total cost $467 million
  - $1.2 mln in medical costs
  - $465 mln in foregone productivity
- Medical care cost non-fatal attempts $44 mln
- 10% reduction in suicides and attempts
  - Savings of $46 mln in foregone productivity
  - Savings of $4.4 mln in medical care for non-fatal attempts

Courtesy Neill Piland, Dr.P.H., Idaho State University

Overview of the Recommendations

- Vision: Idaho will have the lowest suicide rate in the nation.
- Goal: 10% rate reduction by 2020
- Twelve initiatives, all taken from the Idaho Suicide Prevention Plan
- Total funding request $971,102.90 (not in SFY17 IDHW budget request to JFAC)
- Program will require continued private/grant funding besides state funding.
- Provides comprehensive implementable program and leadership that are needed across the state of Idaho.

Four Priority Initiatives

1. Office of Suicide Prevention: $258,000 and four FTE's
   - Within IDHW, Division of Public Health
   - Idaho Council on Suicide Prevention as advisory group
2. Training of 50% of middle and high school students over 5 years in Sources of Strength: $165,000/year ($825,000 over 5 years)
3. Sustainability for Idaho Suicide Prevention Hotline : $273,000 will support 60% of operations
4. Public Awareness Campaign: $300,000

Initiatives continued

5. Gatekeeper Training
6. Train media on safe and effective reporting
7. Training of behavioral health clinicians in current suicide assessment and management
8. Effective, immediate follow up of suicidal patients post health care facility visit

Initiatives continued

9. Immediate coroner reporting of suicides
10. Train and support professionals who encounter survivors in the immediate aftermath of suicide loss
11. Train and support facilitators of suicide loss support groups and coordinate the groups
12. Overcome barriers to accurate and adequate data reporting of suicide and suicidal behavior and attempts

Questions and Next Steps

7-Dec-15

Division: Public Health

Program: Suicide Prevention

Personnel

Position	Hrly Wage	Hours/PP	# of PP's	Fringe	Percentage	Total
Health Program Manager	$ 26.77	80	26	1.4421	100%	$ 80,298.44
Health Education Specialist, Sr.	$ 20.96	80	26	1.4421	100%	$ 62,870.95
Human Services Program Specialist (BH Division)	$ 24.00	80	26	1.4421	100%	$ 71,989.63
Administrative Assistant 1	$ 14.15	80	26	1.4421	100%	$ 42,443.89
*Four FTE would also be requested						$ -
						$ 257,602.90

Personnel	**$**	**178,630**
Fringe	**$**	**78,973**
Total	**$**	**257,603**

Operating

Goal Area 1:	Public Awareness Campaign						$300,000
Goal Area 2:	Youth Programming	Contract with SDE					$165,000
		Current SDE grant ends 9/16					
Goal Area 5:	Hotline	Support 60% Annual Budget					$223,000
		BH currently provides $50,000 ongoing					
Goal Area 3,4:	*Gatekeeper Training	Travel of BH/PH Staff in state					$7,500.00
	*Train Media	Travel of BH/PH Staff in state					
Goal Area 6,7:	*BH Clinician training	Travel of BH Staff in state					
	*Patient Follow Up	Travel of BH Staff in state					
Goal Area 8:	*Coroner Reporting	Travel of PH Staff in state					
Goal Area 9,10:	*Survivor Training	Travel of BH Staff in state					
	*Support Group Faciliitator Training	Travel of BH Staff in state					
Goal Area 11:	Office of Suicide Prevention						$14,000
		National Trainings			$6,000		
		Resource Materials			$1,000		
			Office Supplies		$2,000		
			Computers		$4,000	On-time	
			Phones, Misc		$1,000	On-time	
Goal Area 12:	Data	BRFSS Questions -2ea suicide attempt					$4,000
						Total Operating	**$713,500**
	*Training/meeting travel will be combined to address multiple training/meeting needs and will be conducted two times in each health district/region of the state annually. This is an estimate and does not include meeting room or meals costs for meeting participants.						
						GRAND TOTAL	**$ 971,102.90**

This budget is not included in IDHW, Public Health Services SFY17 budget request to JFAC.

Addendum

- Acronyms:
  - HQPC, Health Quality Planning Commission
  - DHW, Department of Health and Welfare
  - ISU, Idaho State University
  - SDE, State Department of Education
  - ISPC, Idaho Suicide Prevention Council
  - ILP, Idaho Lives Project
  - SPAN Idaho, Suicide Prevention Action Network Idaho
  - ISPH, Idaho Suicide Prevention Hotline
  - SAHS, Saint Alphonsus Health System

Evidence on Sources of Strength

- http://www.sprc.org/news-events/the-weekly-spark/weekly-spark-friday-february-27-2015
- http://www.sprc.org/news-events/the-weekly-spark/weekly-spark-friday-march-13-2015
- http://www.sprc.org/training-institute/r2p-webinars/sources-strength-preventing-suicide-among-high-school-students-thr-0
- http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2009.190025
- http://www.sprc.org/sites/sprc.org/files/library/Upstream Youth Suicide Prevention Expert Panel Meeting%20Summary.pdf

Idaho Suicide Prevention Hotline
Cash Receipts
October 1, 2011 to November 15, 2015

Receipts		**Amount**
Night at the Flicks Event	$	1,193
Fees for Service - Link2Health Solutions, Inc.		2,500
Tattoo Event		3,052
Private Donor		3,500
Span Idaho		3,717
Ansy McClain Event		5,037
Donations >$100 (217)		7,289
Donations $101 to $500 (47)		10,551
Donations $501 to $1,000 (13)		10,687
Fees for Service - Suicide Prevention Action Network Idaho		11,000
Donations $1,000 to $3,000 (7)		13,742
St Alphonsus Regional Medical Center		20,000
Idaho State University - Planning Grant		25,000
The Park City Foundation		26,071
J.A. & Kathryn Albertson Foundation, Inc.		37,500
St. Luke's Foundation		37,500
United Way - Various Contributors		63,566
United Way Community Impact Grants		110,000
Division of Veterans Services		430,000
Dept of Health & Welfare		610,622
Total Receipts	**$**	**1,432,527**

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, January 21, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Introductory Remarks	Department of Environmental Quality	**John H. Tippets**
Docket No. 58-0108-1501	PENDING RULE: Rules for Public Drinking Water Systems	**Barry Burnell** Water Quality Division
Docket No. 58-0101-1501	PENDING RULE: Rules for the Control of Air Pollution in Idaho	**Tiffany Floyd** Air Quality Division
Docket No. 58-0105-1501	PENDING RULE: Rules and Standards for Hazardous Waste	**Orville Green** Waste Management and Remediation Division

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, January 21, 2016

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:02 p.m.

INTRODUCTORY REMARKS: **Chairman Heider** welcomed former Senator John Tippets, Director, Department of Environmental Quality (DEQ), who was a member of this Committee last year. **Director Tippets** stated his pleasure to be appearing before the Committee. **Director Tippets** introduced Barry Burnell, Administrator of the Water Quality Division; Tiffany Floyd, Administrator of the Air Quality Division; Orville Green, Administrator of the Waste Management and Remediation Division; Matt Alvarado and Carl Brown from the DEQ; and, Lisa Carlson, Deputy Attorney General assigned to the DEQ.

Director Tippets discussed the purpose and process for the incorporation by reference of federal regulations. In order for the DEQ to maintain primacy over certain federal programs, the DEQ must implement regulations that are at least as stringent as the corresponding federal regulations. And, unless otherwise authorized by the Legislature, Idaho law requires that DEQ regulations be no more stringent than the corresponding federal regulations. The DEQ incorporates federal regulations by reference into Idaho's corresponding regulations and, when authorized, also promulgates Idaho-specific regulations. Both types of regulations are necessary for the DEQ to operate its State programs.

Director Tippets stated that when federal regulations are changed, the DEQ must update the incorporation by reference in Idaho's corresponding regulations. In the past, the DEQ asked the Legislature to trust that the changes made by the federal government were appropriate for Idaho. This year, the DEQ has provided the Committee with a summary of the changes in the federal regulations that are proposed to be incorporated by reference into Idaho's corresponding regulations. He welcomed any feedback from the Committee. **Director Tippets** stated that the dockets presented by the DEQ primarily deal with the incorporation of federal regulations. He noted that, due to time constraints, the DEQ presenters will only give a brief summary of the federal changes to be incorporated by reference; more information can be found in the documents provided to the Committee (see attachment 1).

Chairman Heider asked Director Tippets to explain the importance of Idaho having primacy over federal programs. **Director Tippets** stated that, although there are some costs, DEQ primacy over federal programs (i) allows Idahoans to address regulatory issues with someone in Idaho, (ii) allows the DEQ to help Idahoans to understand and comply with the law and (iii) allows to the DEQ to enforce the law.

Senator Martin inquired about the timetable for water primacy. **Director Tippets** responded that the Legislature passed a statute in 2014 mandating that an application must be submitted to the Environmental Protection Agency (EPA) for primacy over the program that governs discharges to surface waters. **Director Tippets** indicated that Mr. Burnell and his team are on target to submit the required application by September 1, 2016.

PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Nuxoll to conduct the rules review.

DOCKET NO. 58-0108-1501 **Rules of the Department of Environmental Quality related to Public Drinking Water Systems**. **Barry Burnell**, Administrator of the DEQ Water Quality Division, presented this docket (see attachment 1 - tab 1).

Mr. Burnell stated that the proposed rule was initiated to incorporate the federal revised total coliform rule into State regulations to ensure that Idaho maintains primacy in implementing the federal drinking water program under the Safe Drinking Water Act. Additionally, incorporation of this federal rule would result in lower monitoring costs for owners or public water systems and would allow Idaho to issue waivers where appropriate. If this rule is not incorporated into Idaho regulations, the EPA will implement the federal rule and no waivers would be allowed. **Mr. Burnell** then reviewed the rulemaking process. He stated that the proposed rule was first published in April 2015 and negotiated rulemaking meeting was held on April 22, 2015. **Mr. Burnell** confirmed that representatives from municipalities, industry and water policy groups participated in the rulemaking meeting. The proposed rule was modified by the DEQ based upon the comments received during the rulemaking meeting and the revised rule was published on May 18, 2015. **Mr. Burnell** stated that no comments were received for the revised rule; nor did the DEQ receive comments upon final publication of the revised rule. **Mr. Burnell** said that the proposed rule would require the regulated community to update their sampling plan at their own costs and pay for certain assessments if total coliform or *E.coli* is detected. **Mr. Burnell** reported that approximately $30,000 of initial costs would be borne by the public water systems and, each year thereafter, the public water systems would save approximately $88,000 as a result of reduced monitoring. **Mr. Burnell** reported that no controversial issues were raised during the negotiated rulemaking. **Mr. Burnell** noted that, while meeting federal stringency requirements, the DEQ negotiated certain flexible issues including, (i) identification of approved parties for level 2 assessments when *E.coli* is detected in the drinking water system, (ii) waivers for certain requirements for seasonal systems and (iii) reduced total coliform monitoring.

Summarizing the major changes of the proposed rule, **Mr. Burnell** stated that the intent of the proposed rule is to provide increased public health protection by reducing the pathways that pathogens can enter into drinking water systems. More specifically, this proposed rule changes the maximum contaminant level (MCL) to *E.coli*; total coliform, which was the MCL, is now used only as an indicator. The DEQ is incorporating the Code of Federal Regulations (CFR) Part 141 except for Subpart X, which deals with aircraft drinking water regulations implemented by the EPA, and portions of Subpart Y that deal with annual monitoring provisions. Finally, **Mr. Burnell** reported that implementation of the proposed rule would not result in additional cost to the DEQ.

Vice Chairman Nuxoll asked how many primacies there are for water. **Mr. Burnell** responded that there is primacy for the drinking water program and the surface water program, and the DEQ is currently seeking primacy for the Idaho Pollutant Discharge Elimination System (IPDES). **Vice Chairman Nuxoll** stated her understanding that it is a one-time $30,000 cost for the public water systems the first year and after that there is an $88,000 savings per year for the next three years. **Mr. Burnell** concurred. **Senator Hagedorn** asked what the impact will be for small, rural users. **Mr. Burnell** responded that the Idaho Rural Water Association, which represents many of the small water systems in Idaho, was supportive of the rule.

Mr. Burnell explained each of the pending rule changes for **Docket No. 58-0108-1501**. First, he reviewed the CFR incorporation by reference. Second, **Mr. Burnell** reviewed modifications to defined terms including, (i) clean compliance history, (ii) level 1 assessment, (iii) level 2 assessment, (iv) protected water source, (v) sanitary defects and (vi) seasonal systems. Third, **Mr. Burnell** discussed the revisions to the total coliform assessment criteria. Fourth, **Mr. Burnell** reviewed additional changes regarding filtration and tracer compound requirements. Fifth, **Mr. Burnell** reviewed coliform treatment triggers, assessment requirements and approved parties for level 2 assessments. Finally, **Mr. Burnell** discussed flushing for disinfection and additional seasonal system requirements.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Referring to the newly added definition for "protected water source," **Senator Lee** asked Mr. Burnell to clarify how "contamination history" is used to identify protected water sources – how often is the source tested and how long must it remain uncontaminated to be considered a protected water source. **Mr. Burnell** noted that "contamination history" was one of three factors that could be used to identify a protected water source. He indicated that different contaminants required different sampling intervals – from monthly to every three years.

Senator Harris asked if the number of level 2 cases, less than ten per year, is changing from year to year. **Mr. Burnell** stated that ten is an average and he did not have actual trend numbers.

Referring to the start-up procedures for seasonal systems subject to certain monitoring and analytical requirements, **Senator Hagedorn** asked how the proposed rule would differentiate between a small cabin and a larger hotel-style lodge. **Mr. Burnell** referred Senator Hagedorn to the definition of "public drinking water system" and reviewed the differentiation between "community" and "noncommunity" water systems; he noted the further differentiation between "nontransient" and "transient" noncommunity water systems.

Vice Chairman Nuxoll asked for a definition of coliform. **Mr. Burnell** answered that coliform is a type of bacteria that generally indicates contamination in a water system, but *E.coli* specifically indicates an fecal contamination from warm-blooded animals, which suggests an acute human health problem.

Referring to revised rates for slow sand filtration, **Senator Schmidt** noted that the revisions allowed the department to approve alternate filtration rates and he inquired as to why the DEQ may need to approve alternate rates. **Mr. Burnell** answered that there are always engineering elements to a sand filter so they may vary from the .01 gallon per square foot rate based upon temperature. Any variance would be based on sound engineering principles to be protective of public health. **Senator Schmidt** asked if there are any water systems that might be in jeopardy given the proposed change to the rule. **Mr. Burnell** responded no.

Referring to the addition of "flushing" within the quantity and pressure requirements for public water systems, **Senator Lee** inquired whether "flushing" would be appropriate for ground water systems. **Mr. Burnell** stated that flushing is an option for ground water systems.

MOTION: There being no more questions, **Senator Martin** moved to approve **Docket No. 58-0108-1501**. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 58-0101-1501 **Rules of the Department of Environmental Quality related to the Control of Air Pollution in Idaho**. **Tiffany Floyd**, Administrator of the DEQ Air Quality Division, introduced Carl Brown, Air Quality Rules Coordinator and Paula Wilson from the Attorney General's office, and presented this docket (see attachment 1 - tab 2 and attachment 2).

Ms. Floyd stated that the purpose of the DEQ Air Quality Division is to protect public health and the environment and meet the requirements of the Clean Air Act. Specifically, the DEQ implements Idaho's state air quality program by monitoring pollution levels throughout the state to demonstrate that Idaho is complying with National Ambient Air Quality Standards. Also, the DEQ conducts outreach and education about air quality rules for industry, issues air quality permits, conducts inspections and ensures that industry is complying with the air quality rules.

First, **Ms. Floyd** stated that the proposed rule will incorporate changes made to federal regulations by reference into Idaho's corresponding regulations. Incorporation of federal regulations by reference (i) allows DEQ operate or to implement DEQ's Air Quality program in lieu of EPA implementation and (ii) provides one set of regulations for industry to follow. **Ms. Floyd** stated that the proposed rule incorporated 38 changes made to federal regulations; more information can be found in the documents provided to the Committee (see attachment 1 - tab 2).

Second, **Ms. Floyd** noted that there were two other minor revisions in the proposed rule, including (i) deleting obsolete sections and (ii) clarifying permitting language. Specifically, **Ms. Floyd** reported that the EPA removed certain provisions related greenhouse gas applicability definition for major sources from federal regulations to comply with a recent U.S. Supreme Court decision; and, for consistency, the same provision was being deleted from Idaho's regulations. Additionally, in connection with transportation conformity, the EPA simplified some of its standards and focused on coordination among transportation partners. **Ms. Floyd** reported that Idaho already implements those coordination requirements as specified by federal regulations; and, for consistency, obsolete provisions were being deleted from Idaho's regulations. Finally, **Ms. Floyd** reported that changes were being made to the procedures and requirements for permits to construct language to clarify that there are two different permitting scenarios: (i) permits in an area that meet the national ambient air quality standards and (ii) permits in an area that do not meet the national ambient air quality standards. **Ms. Floyd** confirmed that these clarifications did not change how the DEQ implements the permits to construct rules.

Third, **Ms. Floyd** stated that this proposed rule did not go through negotiated rulemaking, but the DEQ did hold a public comment period and a public hearing and did not receive any comments. The Idaho Board of Environmental Quality adopted the rule in November 2015.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Martin inquired about the air quality status in Ada County. **Ms. Floyd** said that Ada County is currently meeting all of the national ambient air quality standards. Specifically, **Ms. Floyd** noted that the national standard for ozone was recently lowered to 70 parts per billion; and Ada County ozone levels are currently at 68 parts per billion, just within the federal limits.

Referencing the overview of incorporations by reference for the DEQ air quality program (see attachment 1 - tab 2), **Vice Chairman Nuxoll** asked Ms. Floyd to explain the specific impact of the federal regulations on Idaho facilities and to discuss whether any federal regulations would be effective retroactively. **Ms. Floyd** responded that, under Part 60, there will be an impact to Idaho facilities related to the following three actions: (i) the updated opacity monitoring requirements may apply to a facility that produces emissions from a stack, (ii) new requirements for the oil and gas sector related to well completion and storage vessels would be included in applicable air quality permits and (iii) the residential wood heater rule regarding limits for particulate matter released applies mainly to wood stove manufacturers. **Vice Chairman Nuxoll** asked if Idaho maintained primacy for air quality. **Ms. Floyd** said that the state does have primacy for the entire air quality program in Idaho.

MOTION: There being no more questions, **Senator Lodge** moved to approve **Docket No. 58-0101-1501**. **Chairman Heider** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 58-0105-1501 **Rules of the Department of Environmental Quality related to Standards for Hazardous Waste**. **Orville Green**, Administrator of the DEQ Waste Management and Remediation Division, introduced Matt Alvarado, Rules Analyst, and presented this docket (see attachment 1 - tab 3 and attachment 3).

Mr. Green explained that **Docket 58-0105-1501** describes the adoption by reference of the final federal hazardous waste regulations; more detailed information can be found in the documents provided to the Committee (see attachment 1 - tab 3). **Mr. Green** noted that adoption by reference is a routine procedure that the DEQ performs annually to (i) satisfy consistency and stringency requirements of the Hazardous Waste Management Act (HWMA); (ii) meet the legislative intent to avoid duplicative, overlapping or conflicting state and federal regulatory systems; and (iii) provide for DEQ to maintain primacy and authorization to operate the Resource Conservation and Recovery Act (RCRA) program in lieu of the EPA.

Mr. Green stated that public notices of rulemaking were published in the August and December 2015 editions of the Idaho Administrative Bulletin. No public hearing was requested or held, and no written comments were received. **Mr. Green** reported that, on November 18, 2015, the Idaho Board of Environmental Quality approved the pending rule, which is neither broader in scope nor more stringent than federal regulations and does not regulate any activity that is not regulated by the federal government.

Mr. Green then reviewed the three primary changes made in the proposed rule:

1. The EPA is establishing the authority for the voluntary use of electronic manifests as a means to track off-site shipments of hazardous waste from the generator's site to the site of disposition. The rule establishes the framework for the e-Manifest system, which is not yet implemented. Certain portions of this rule are non-delegable to the states and must be implemented by the EPA. The e-Manifest Act supersedes any requirements under state law that are less stringent than the e-Manifest requirements and any requirements that are inconsistent with the e-Manifest requirements.
2. The EPA is revising certain export provisions of the Cathode Ray Tube (CRT) rule, which applies to items like old televisions and computer screens. The proposed rule will have no impact on individuals who choose to recycle those items; it only impacts exporters by requiring better tracking of CRT exports for reuse and recycling. The EPA does not authorize states to administer the federal import/export functions in any section of RCRA hazardous waste regulations. However, the DEQ is required to adopt these provisions to maintain an equivalency with the federal program.

3. The EPA is revising regulations associated with comparable fuels and gasification exclusions. A recent ruling issued by the U.S. Court of Appeals for the District of Columbia mandated the vacatur of these exclusions because the fuels produced from solid waste and hazardous waste respectively remain solid waste and hazardous waste and cannot be excluded from regulation. No Idaho facilities utilized either of these exclusions.

Mr. Green then reviewed the technical changes within the proposed rule. Finally, **Mr. Green** stated that all of the federal regulatory changes could have an impact on Idaho, and noted that the impact for the e-Manifest system will be positive.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Lodge thanked the presenters for providing the DEQ overviews and summaries for each docket. It is one of the best presentations she has seen.

MOTION: There being no more questions, **Senator Lee** moved to approve **Docket No. 58-0105-1501**. **Senator Harris** seconded the motion. The motion carried by **voice vote**.

PASSED THE GAVEL: Vice Chairman Nuxoll passed the gavel back to Chairman Heider.

Director Tippets recognized Paula Wilson for her work on these presentations.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:21 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Twyla Melton
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Thursday, January 21, 2016

ATTACHMENT 1

Idaho Department of Environmental Quality

Review of Rules Before the Idaho Legislature – 2016 Session

Senate Health and Welfare Committee

Lee Heider

Senate Health & Welfare Committee
List of DEQ Rules Submitted for Review
2016 Legislative Session

Water Quality Division

1	58-0108-1501 Pending Rule	Idaho Rules for Public Drinking Water Systems *Rulemaking initiated to adopt into state rules the federal Revised Total Coliform Rule*	Barry Burnell Water Quality Division Administrator

Air Quality Division

2	58-0101-1501 Pending Rule	Rules for the Control of Air Pollution in Idaho *Update of federal regulations incorporated by reference*	Tiffany Floyd Air Quality Division Administrator

Waste Management and Remediation Division

3	58-0105-1501 Pending Rule	Rules and Standards for Hazardous Waste *Update of federal regulations incorporated by reference*	Orville Green Waste Management and Remediation Division

SENATE HEALTH & WELFARE COMMITTEE
2016 LEGISLATIVE REVIEW
DEQ RULE DOCKET SUMMARY CHART

Rules for the Control of Air Pollution in Idaho, IDAPA 58.01.01		
Docket No. **58-0101-1501** Presented by Tiffany Floyd 373-0552	Rulemaking initiated to ensure that the state rules are consistent with federal regulations and to update federal regulations incorporated by reference to include those revised as of July 1, 2015. DEQ received no public comments, and the rule has been adopted as initially proposed.	**Pending Rule** Effective sine die 2016 if approved by the Legislature

Rules and Standards for Hazardous Waste, IDAPA 58.01.05		
Docket No. **58-0105-1501** Presented by Orville Green 373-0278	Rulemaking initiated to update federal regulations incorporated by reference. DEQ received no public comments, and the rule has been adopted as initially proposed.	**Pending Rule** Effective sine die 2016 if approved by the Legislature

Idaho Rules for Public Drinking Water Systems, IDAPA 58.01.08		
Docket No. **58-0108-1501** Presented by Barry Burnell 373-0194	***Negotiated Rulemaking*** This rulemaking has been initiated to adopt into state rules the federal Revised Total Coliform Rule (RTCR). DEQ received no public comments; however, Subsections 100.01, 100.10, 300.05.d.iii(3), and 552.08.a. were revised by removing referenced dates. The remainder of the rule has been adopted as initially proposed.	**Pending Rule** Effective sine die 2016 if approved by the Legislature

SENATE HEALTH & WELFARE COMMITTEE
Thursday, January 21, 2016

ATTACHMENT 1 – TAB 1

Overview of Incorporations by Reference for the DEQ Drinking Water Program

An efficient way to implement new or updated federal regulations is to incorporate them by reference. Reproducing the Code of Federal Regulations in state rules is impractical and costly. Therefore, when possible and as supported by the regulated community, DEQ incorporates federal regulations by reference. Sections with no changes are also incorporated to ensure the state rules are consistent with federal regulations and to provide one set of rules for industry to follow. Idaho's public water systems are required to comply with all applicable new and updated federal rules regardless of whether DEQ incorporates them by reference.

The following table summarizes the Code of Federal Regulations section that the DEQ Drinking Water Program incorporates by reference.

40 CFR Part	Title	Changes During Past Year?	Impact to Public Water Systems
141	National Primary Drinking Water Regulations	Yes	All systems; changes to practices, expect less cost overall– see cost analysis[1]

1. Cost Analysis from the Rulemaking and Public Comment Summary provided at the end of this document

DEQ did not adopt Subpart X, the Aircraft Drinking Water Rule, or portions of the Subpart Y for annual monitoring provisions. EPA implements the Aircraft Drinking Water Rule.

The changes are discussed in more detail below. The associated Federal Register notice was published on February 13, 2013 (FR Volume 78, Issue 30) and minor corrections published on February 26, 2014 (FR Volume 79, Issue 38).

The following subparts were revised and will have an impact on Idaho facilities:

Subpart A: General

- This section added several definitions and updated citations for variances and exemptions, which are not allowed for microbial contaminants.
- DEQ added a few of the definitions into the rules for ease of reference in other sections.
- The existing definition for sanitary defect was removed and the federal definition was modified to identify examples.

Subpart C: Monitoring and Analytical Requirements

- This section contains end dates related to the monitoring requirements for the original Total Coliform Rule.

Subpart F: Maximum Contaminant Level Goals and Maximum Residual Disinfection Level Goals

- This section identifies an end date for the Maximum Contaminant Level Goal for total coliforms for the original total coliform rule.

Subpart G: Maximum Contaminant Levels (MCLs) for Microbiological Contaminants.

- This section identifies the end date for the original total coliform rule MCL definitions and adds new definitions for the revised rule.
- This section provides an end date to the total coliform MCL and adds an *E.coli* MCL.
- This section identifies best technology, treatment techniques, or other means for achieving compliance with the MCL.

Subpart H: Filtration and Disinfection

- This section is revised to reflect the change in MCL from total coliform to *E.coli* for surface water systems.
- This section identifies the Subpart reference changes from the original rule to the revised rule in the requirements for residual disinfection monitoring for surface water systems.

Subpart L: Disinfectant Residuals, Disinfection Byproducts, and Disinfection Byproduct Precursors

- This section identifies the Subpart reference changes from the original rule to the revised rule in the requirements for residual disinfection monitoring for chlorine and chloramines.

Subpart O: Consumer Confidence Reports

- This section is revised to reflect changes in the requirements to notify consumers of community water systems in the annual consumer confidence reports about Level 1 and Level 2 assessments, violations, and *E.coli* MCLs.

Subpart Q: Public Notification of Drinking Water Violations

- This section was revised to include public notification requirement for exceeding the MCL for *E.coli* (Tier 1).
- This section added and revised the required form, manner, and frequency of notifications to consumers associated with violations of the revised rules.

Subpart S: Ground Water Rule

- This section revised monitoring language associated with the original total coliform language and references the revised rule for triggered source water monitoring.

Subpart Y: Revised Total Coliform Rule *(NEW SUBPART)*

- This section is the revised total coliform rule and includes compliance dates, monitoring requirements, analytical methods, seasonal system start-up requirements, assessment triggers and requirements, violations, and record keeping and reporting requirements.
- DEQ incorporated most of Subpart Y by reference but did not adopt annual monitoring provisions and did provide exemption criteria for seasonal system start-up requirements.

Cost Analysis from the Rulemaking and Public Comment Summary

Costs to the Agency:
Minimal to none anticipated, rule is required to retain primacy in the drinking water ***program.***

Costs to the Regulated Community:
This rule will affect all 1,958 public water systems in Idaho. According to the Environmental Protection Agency's (EPA's) Economic Analysis for the Final Revised Total Coliform Rule (RTCR), the majority of the costs associated with this rule will be incurred by performing either a Level 1 Assessment (basic review completed by the system owner or operator) or a Level 2 Assessment (in-depth review completed by a system operator or third party consultant). These costs to the system owner are reported to be offset by decreases in both routine and repeat monitoring as well as the reduction of the public notification requirements for non-acute Total Coliform Rule (TCR) maximum contaminant level (MCL) violations.

The Department estimates annual statewide savings for reduced analytical costs for system owners will be $125,000. The costs associated with performing Level 1 and 2 assessments are estimated at $37,000. The difference is expected to be an annual statewide savings of $88,000. During the first year of rule implementation, which will begin April 1, 2016, all public water system owners will be required to revise their total coliform site sampling plans with the costs estimated at $118,000 statewide. Therefore, the estimated statewide total costs for the first year of implementation is expected to be (118,000 – 88,000) = $30,000.
The second year of annual savings of $88,000 will offset the first year costs of $30,000. The second year of implementation will start to provide a net savings to the system owners, of $58,000.

IDAPA 58 - DEPARTMENT OF ENVIRONMENTAL QUALITY

58.01.08 - IDAHO RULES FOR PUBLIC DRINKING WATER SYSTEMS

DOCKET NO. 58-0108-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the Board of Environmental Quality (Board) and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule will become final and effective immediately upon the adjournment *sine die* of the Second Regular Session of the Sixty-third Idaho Legislature unless prior to that date the rule is rejected in whole or in part by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that the Board has adopted a pending rule. This action is authorized by Chapter 1, Title 39, Idaho Code, and Chapter 21, Title 37, Idaho Code.

DESCRIPTIVE SUMMARY: A detailed summary of the reason for adopting the rule is set forth in the initial proposal published in the Idaho Administrative Bulletin, July 1, 2015, **Vol. 15-7, pages 101 through 137**. DEQ received no public comments; however, Subsections 100.01, 100.10, 300.05.d.iii(3), and 552.08.a. were revised by removing referenced dates. The remainder of the rule has been adopted as initially proposed. The Rulemaking and Public Comment Summary can be obtained at **www.deq.idaho.gov/58-0108-1501** or by contacting the undersigned.

IDAHO CODE SECTION 39-107D STATEMENT: This rule does not regulate an activity not regulated by the federal government, nor is it broader in scope or more stringent than federal regulations.

FISCAL IMPACT STATEMENT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year when the pending rule will become effective: Not applicable.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this rulemaking, contact Jerri Henry at **jerri.henry@deq.idaho.gov** or (208)373-0471.

Dated this 2nd Day of December, 2015.

Paula J. Wilson
Hearing Coordinator
Department of Environmental Quality
1410 N. Hilton
Boise, Idaho 83706-1255
(208)373-0418/Fax No. (208)373-0481
paula.wilson@deq.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking. This rulemaking action is authorized by Chapter 1, Title 39, Idaho Code, and Chapter 21, Title 37, Idaho Code.

PUBLIC HEARING SCHEDULE: No hearings have been scheduled. Pursuant to Section 67-5222(2), Idaho Code, a public hearing will be held if requested in writing by twenty-five (25) persons, a political subdivision, or an agency. Written requests for a hearing must be received by the undersigned on or before July 15, 2015. If no such written request is received, a public hearing will not be held.

DESCRIPTIVE SUMMARY: This rulemaking has been initiated to adopt into state rules the federal Revised Total Coliform Rule (RTCR) (40 CFR 141, Subpart Y). The Environmental Protection Agency promulgated the RTCR on February 13, 2013. The RTCR is intended to increase public health protection through the reduction of potential pathways of entry for fecal contamination into public water distribution systems. To maintain primary enforcement authority, Idaho is required to adopt the RTCR by April 2016. The RTCR contains some options to negotiate.

The RTCR establishes a maximum contaminant level (MCL) for E.coli and uses E.coli and total coliform positive results to initiate or trigger assessments and follow up corrections as a "find and fix" approach to address fecal contamination that could enter into the distribution system. The rule removes the total coliform MCL and replaces it with a trigger level under which to perform an assessment. This rule also requires systems that operate seasonally to follow start-up procedures unless the system qualifies for an exemption from these procedures. Most of the substantive changes in the rule include performing assessments and changes in monitoring requirements.

DEQ proposes to incorporate most of the RTCR by reference from 40 CFR 141, Subpart Y, which addresses the definitions, sample siting plans, MCLs, assessment triggers and requirements, as well as monitoring and reporting requirements. Incorporation by reference simplifies the overall rule and reduces agency costs for rulemaking.

The negotiated rulemaking committee did discuss portions of the rule where options exist, which include reduced monitoring provisions, qualifications of assessors for Level 2 Assessments, criteria for waiving seasonal system start-up requirements, methods for consulting with the state, and types of sanitary defects.

Additionally, there are some changes DEQ proposes to make to the Idaho Rules for Public Drinking Water Systems that are not associated with the RTCR. These changes should provide clarification and remove unnecessary requirements and include removing the lower temperature flow criteria for slow-sand filters, adding flushing as an adequate means to remove contamination following depressurization, and providing clarifying language for the types of chemicals allowed in performing tracer studies to demonstrate disinfection contact time.

Drinking water system owners and operators, developers, consultants, engineers, cities, counties, industry, drinking water professional organizations, and the public at large may be interested in commenting on this proposed rule. The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which public comment should be addressed.

After consideration of public comments, DEQ intends to present the final proposal to the Board of Environmental Quality in the fall of 2015 for adoption of a pending rule. The rule is expected to be final and effective upon adjournment of the 2016 legislative session if adopted by the Board and approved by the Legislature.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the incorporation by reference is necessary:

This proposed rule incorporates federal regulations by reference. Incorporation by reference is necessary to ensure that the state rules are consistent with federal regulations. An electronic copy of the federal regulations incorporated by reference can be obtained at **www.gpoaccess.gov/ecfr**.

NEGOTIATED RULEMAKING: The text of the proposed rule has been drafted based on discussions held and concerns raised during negotiations conducted pursuant to Idaho Code § 67-5220 and IDAPA 58.01.23.810-815. The Notice of Negotiated Rulemaking was published in the April 2015 Idaho Administrative Bulletin, **Vol. 15-4**, and a preliminary draft rule was made available for public review. A meeting was held on April 22, 2015. Several members of the public participated in this negotiated rulemaking process by attending the meeting. The negotiated rulemaking record, which includes the negotiated rule drafts, and documents distributed during the negotiated rulemaking process, is available at **www.deq.idaho.gov/58-0108-1501**.

All comments received during the negotiated rulemaking process were considered by DEQ when making decisions that resulted in drafting the proposed rule. At the conclusion of the negotiated rulemaking process, DEQ formatted the final rule draft for publication as a proposed rule. DEQ is now seeking public comment on the proposed rule.

IDAHO CODE SECTION 39-107D STATEMENT: This proposed rule does not regulate an activity not regulated by the federal government, nor is it broader in scope or more stringent than federal regulations.

FISCAL IMPACT STATEMENT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year when the pending rule will become effective: Not applicable.

ASSISTANCE ON TECHNICAL QUESTIONS AND SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning this rulemaking, contact Jerri Henry at **jerri.henry@deq.idaho.gov** or (208) 373-0471.

Anyone may submit written comments by mail, fax or email at the address below regarding this proposed rule. DEQ will consider all written comments received by the undersigned on or before July 29, 2015.

Dated this 1st Day of July, 2015.

LSO Rules Analysis Memo

Italicized red text that is *double underscored* is new text that has been added to the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 58-0108-1501

002. INCORPORATION BY REFERENCE AND AVAILABILITY OF REFERENCED MATERIALS.

01. Incorporation by Reference. The following documents are incorporated by reference into these rules. (4-11-06)

a. 40 CFR Part 141, revised as of July 1, ~~2011~~ 2015 (excluding annual monitoring provisions in 40 CFR 141.854(a)(4),(d),(e),(f) and (h), and the Aircraft Drinking Water Rule in Subsection X), and 40 CFR Part 143, revised as of July 1, 2011. Any reference in these rules to requirements, procedures, or specific forms contained in any section or subsection of 40 CFR Parts 141 and 143 shall constitute the full adoption by reference of that section or subsection, including any notes and appendices therein, unless expressly provided otherwise in these rules. ~~(4-4-13)~~(____)

b. American Water Works Association (AWWA) Standards, effective December 2009, available for a fee from the AWWA, 6666 West Quincy Avenue, Denver, Colorado 80235, Telephone (800) 926-7337, http://apps.awwa.org/ebusmain/OnlineStore.aspx. (4-7-11)

02. Availability of Specific Referenced Material. Copies of specific documents referenced within these rules are available at the following locations: (4-11-06)

a. All federal regulations: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Telephone (202)783-3238; U.S. Government Bookstore, Room 194, Federal Bldg., 915 Second Ave., Seattle, WA 98174, (206) 553-4270; or Online at http://www.gpoaccess.gov/ecfr/index.html. (4-7-11)

b. All documents incorporated by reference are available for review at the Department of Environmental Quality, 1410 N. Hilton, Boise, ID 83706-1255, (208) 373-0502. (4-7-11)

c. Recommended Standards for Water Works: a report of the Water Supply Committee of the Great Lakes -- Upper Mississippi River Board of State and Provincial Public Health and Environmental Managers, published by Health Education Services, P.O. Box 7126, Albany, New York 12224, Telephone (518) 439-7286. (4-7-11)

d. Manual of Individual and Non-Public Water Supply Systems (EPA 570/9-91-004), published by the U.S. Environmental Protection Agency, available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C.20402, Telephone (202) 782-3238. (5-3-03)

e. U.S. Department of Commerce, National Bureau of Standards Handbook, No. 69, "Maximum Permissible Concentrations of Radionuclides in Air and in Water for Occupational Exposure" as amended in 1963, NCRP Publications, P.O. Box 20175, Washington, D.C. 20014. (12-10-92)

f. Rules of the Idaho Water Resources Board are available at http://www.adminrules.idaho.gov/rules/37/37index.htm, or the Idaho Department of Water Resources, Idaho Water Center, 322 E. Front St., P.O. Box 83720, Boise, Idaho 83720-0098, Telephone (208) 287-4800. (3-30-07)

g. ANSI/NSF Standard 44-2002e -- 2004, Residential Cation Exchange Water Softeners, available from the National Sanitation Foundation, 789 N. Dixboro Road, Ann Arbor, Michigan 48105, Telephone (734) 769-8010. (4-6-05)

h. ANSI/NSF Standard 53-2002e -- 2003, Drinking Water Treatment Units -- Health Effects, available from the National Sanitation Foundation, 789 N. Dixboro Road, Ann Arbor, Michigan 48105, Telephone (734) 769-8010. (4-6-05)

i. ANSI/NSF Standard 55-2002 -- 2002, Ultraviolet Microbiological Water Treatment Systems, available from the National Sanitation Foundation, 789 N. Dixboro Road, Ann Arbor, Michigan 48105, Telephone (734) 769-8010. (4-6-05)

j. ANSI/NSF Standard 58-2003 -- 2004, Reverse Osmosis Drinking Water Treatment Systems, available from the National Sanitation Foundation, 789 N. Dixboro Road, Ann Arbor, Michigan 48105, Telephone (734) 769-8010. (4-6-05)

k. ANSI/NSF Standard 60-2000a -- 2000, Drinking Water Treatment Chemicals -- Health Effects, available from the National Sanitation Foundation, 789 N. Dixboro Road, Ann Arbor, Michigan 48105, Telephone (734) 769-8010. (4-6-05)

l. ANSI/NSF Standard 61-2000a -- 2000, Drinking Water System Components -- Health Effects, available from the National Sanitation Foundation, 789 N. Dixboro Road, Ann Arbor, Michigan 48105, Telephone (734) 769-8010. (4-6-05)

m. American Water Works Association (AWWA) Standards, available from the AWWA, 6666 West Quincy Avenue, Denver, Colorado 80235, (800) 926-7337, www.awwa.org. (3-30-07)

n. Cross Connection Control Manual, available from Pacific Northwest Section of the American Water Works Association, P.O. Box 19581, Portland, OR, 97280-0581, Telephone (503) 246-5845. (3-30-07)

o. Manual of Cross-Connection Control, Foundation for Cross-Connection Control and Hydraulic Research, University of Southern California, KAP-200 University Park MC-2531, Los Angeles, CA 90089-2531, (866)545-6340, www.usc.edu/dept/fccchr/. (3-30-07)

p. Manual on Slow Sand Filtration (1991), published by AWWA Research Foundation 6666 West Quincy Avenue, Denver, CO 80235, (800)926-7337, www.awwa.org. (3-30-07)

q. Slow Sand Filtration (1991), published by the American Society of Civil Engineers American Society of Civil Engineers,1801Alexander Bell Drive, Reston, VA 20191, (800)548-2723, www.asce.org. (3-30-07)

r. Slow Sand Filtration and Diatomaceous Earth Filtration for Small Water Systems, DOH Pub #331-204 (4/03), Washington State Department of Health, Division of Environmental Health, Office of Drinking Water, PO Box 47828, Olympia WA 98504-7828, (360)236-3100 or (800)521-0323, http://www.doh.wa.gov/ehp/dw/Programs/water_sys_design.htm. (3-30-07)

s. Water System Design Manual, DOH Pub #331-123 (Rev. 8/01), Washington State Department of Health, Division of Environmental Health, Office of Drinking Water, PO Box 47828, Olympia WA 98504-7828, (360)236-3100 or (800)521-0323, http://www.doh.wa.gov/ehp/dw/Programs/water_sys_design.htm. (3-30-07)

t. Submersible Motors: Application, Installation, Maintenance (Franklin Electric AIM manual), Franklin Electric, Bluffton, Indiana 46714, (800)348-2420, http://www.franklin-electric.com/aim-manual.aspx. (3-30-07)

u. Guidance Manual for Compliance with the Filtration and Disinfection Requirements for Public Water Systems Using Surface Water Sources (March 1991 Edition), U.S. Environmental Protection Agency, http://water.epa.gov/lawsregs/rulesregs/sdwa/swtr/upload/guidsws.pdf. (3-30-07)

v. Standard Methods for the Examination of Water and Wastewater, a joint publication of the American Public Health Association, the Water Environment Federation, and the American Water Works Association, 6666 West Quincy Avenue, Denver, CO 80235, 800-926-7337, www.standardmethods.org (3-30-07)

w. F480-02 Standard Specification for Thermoplastic Well Casing Pipe and Couplings Made in Standard Dimension ratios (SDR), SCH 40 and SCH 80, American Society for Testing and Materials (ASTM Standard F480-02). (3-30-07)

x. "Idaho Standards for Public Works Construction," Local Highway Technical Assistance Council, 3330 Grace Street, Boise, ID 83605, (208)344-0565. (4-4-13)

y. Memorandum of Understanding between the Idaho Department of Environmental Quality and the Idaho Division of Building Safety Plumbing Bureau, Idaho Department of Environmental Quality, 1410 North Hilton, Boise, Idaho 83706, www.deq.idaho.gov. (3-30-07)

z. Idaho General Safety and Health Standards (IGSHS), available from the Idaho Division of Building Safety, 1090 E. Watertower St., Meridian, Idaho 83642, (208)334-3950, http://dbs.idaho.gov/. (3-30-07)

aa. Implementation Guidance for the Long Term 2 Enhanced Surface Water Treatment Rule, Idaho Department of Environmental Quality, 1410 North Hilton, Boise, Idaho 83706, www.deq.idaho.gov. (4-2-08)

bb. Implementation Guidance for the Stage 2 Disinfectants and Disinfection Byproducts Rule, Idaho Department of Environmental Quality, 1410 North Hilton, Boise, Idaho 83706, www.deq.idaho.gov. (4-2-08)

cc. Implementation Guidance for the Ground Water Rule, Idaho Department of Environmental Quality, 1410 North Hilton, Boise, Idaho 83706, www.deq.idaho.gov. (5-8-09)

dd. AWWA Recommended Practice for Backflow Prevention and Cross-Connection Control (M14), available from the AWWA, 6666 West Quincy Avenue, Denver, Colorado 80235, Telephone (800) 926-7337. (4-7-11)

ee. Membrane Filtration Guidance Manual (EPA 815-R-06-009) published by the U.S. Environmental Protection Agency, available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Telephone (202) 782-3238, http://www.epa.gov/ogwdw/disinfection/lt2/pdfs/guide_lt2_membranefiltration_final.pdf. (4-4-13)

ff. Ultraviolet Disinfection Guidance Manual for the Final Long Term 2 Enhanced Surface water Treatment Rule (EPA 815-R-06-007) published by the U.S. Environmental Protection Agency, available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C.20402, Telephone (202) 782-3238, www.epa.gov/safewater/disinfection/lt2/pdfs/guide_lt2_uvguidance.pdf. (4-4-13)

gg. Improving Clearwell Design for CT Compliance, Report #90756, available from the Water Research Foundation, http://waterrf.org/ProjectsReports/PublicReportLibrary/RFR90756_2000_271.pdf. (4-4-13)

hh. Surface Water Treatment Rule Compliance Guidance, dated January 10, 1996, Idaho Department of Environmental Quality, www.deq.idaho.gov. (4-4-13)

ii. Uniform Plumbing Code, available at Division of Building Safety, 1090 E. Watertower St., Meridian, Idaho 83642; and at the Division of Building Safety, 1250 Ironwood Dr., Ste. 220, Coeur d'Alene, Idaho 83814, http://dbs.idaho.gov. (4-4-13)

03. Precedence. In the event of conflict or inconsistency between the language in these rules and that found in any document incorporated by reference, these rules shall prevail. (4-11-06)

003. DEFINITIONS.
The definitions set forth in 40 CFR 141.2 are herein incorporated by reference except for the definition of the terms "action level," "disinfection," "noncommunity water system," and "person." (4-4-13)

01. Action Level. The concentration of lead or copper in water that determines, in some cases, whether a water system must install corrosion control treatment, monitor source water, replace lead service lines, or undertake a public education program. (12-10-92)

02. Administrator. The Administrator of the United States Environmental Protection Agency.(4-5-00)

03. Annual Samples. Samples that are required once per calendar year. (12-10-92)

04. Annular Opening. As used in well construction, this term refers to the nominal inside diameter of the borehole minus the outside diameter of the casing divided by two (2). (3-30-07)

05. Aquifer. A geological formation of permeable saturated material, such as rock, sand, gravel, etc., capable of yielding an economic quantity of water to wells and springs. (5-3-03)

06. Average Day Demand. The volume of water used by a system on an average day based on a one (1) year period. See also the definition of Water Demand in these rules. (5-8-09)

07. Backflow. The reverse from normal flow direction in a plumbing system or water system caused by back pressure or back siphonage. (12-10-92)

08. Bag Filters. Pressure-driven separation devices that remove particulate matter larger than one (1) micrometer using an engineered porous filtration media. They are typically constructed of a non-rigid, fabric filtration media housed in a pressure vessel in which the direction of flow is from the inside of the bag to the outside. (4-2-08)

09. Bank Filtration. A water treatment process that uses a well to recover surface water that has naturally infiltrated into ground water through a river bed or bank(s). Infiltration is typically enhanced by the hydraulic gradient imposed by a nearby pumping water supply or other well(s). (4-2-08)

10. Board. The Idaho Board of Environmental Quality. (5-3-03)

11. Capacity. The capabilities required of a public drinking water system in order to achieve and maintain compliance with these rules and the requirements of the federal Safe Drinking Water Act. It is divided into three (3) main elements: (4-5-00)

a. Technical capacity means the system has the physical infrastructure to consistently meet drinking water quality standards and treatment requirements and is able to meet the requirements of routine and emergency operations. It further means the ability of system personnel to adequately operate and maintain the system and to otherwise implement technical knowledge. Training of operator(s) is required, as appropriate, for the system size and

complexity. (4-6-05)

b. Financial capacity means the financial resources of the water system, including an appropriate budget; rate structure; cash reserves sufficient for current operation and maintenance, future needs and emergency situations; and adequate fiscal controls. (5-8-09)

c. Managerial capacity means that the management structure of the water system embodies the aspects of water system operations, including, but not limited to; (5-8-09)

i. Short and long range planning; (4-5-00)

ii. Personnel management; (4-5-00)

iii. Fiduciary responsibility; (4-5-00)

iv. Emergency response; (4-5-00)

v. Customer responsiveness; (4-5-00)

vi. Source water protection; (4-5-00)

vii. Administrative functions such as billing and consumer awareness; and (4-5-00)

viii. Ability to meet the intent of the federal Safe Drinking Water Act. (4-5-00)

12. Cartridge Filters. Pressure-driven separation devices that remove particulate matter larger than one (1) micrometer using an engineered porous filtration media. They are typically constructed as rigid or semi-rigid, self-supporting filter elements housed in pressure vessels in which flow is from the outside of the cartridge to the inside. (4-2-08)

13. Clean Compliance History. For the purposes of the Revised Total Coliform Rule in Subsection 100.01, clean compliance history means a record of no maximum contaminant level violations under Subsection 050.05, no monitoring violations under Subsection 100.01, and no coliform treatment technique trigger exceedances or treatment technique violations under Subsection 100.01. (____)

1~~3~~4. Combined Distribution System. The interconnected distribution system consisting of the distribution systems of wholesale systems and of the consecutive systems that receive finished water. (4-2-08)

1~~4~~5. Community Water System. A public water system which serves at least fifteen (15) service connections used by year-round residents or regularly serves at least twenty-five (25) year-round residents. See also the definition of a Public Drinking Water System in these rules. (5-8-09)

1~~5~~6. Components of Finished Water Storage. Storage is available to serve the system if the storage structure or facility is elevated sufficiently or is equipped with sufficient booster pumping capability to pressurize the system. Components of finished water storage are further defined as: (5-8-09)

a. Dead Storage. Storage that is either not available for use in the system or can provide only substandard flows and pressures. (3-30-07)

b. Effective Storage. Effective storage is all storage other than dead storage and is made up of the additive components described in Paragraphs c. through f. of this Subsection. (5-8-09)

c. Operational Storage. Operational storage supplies water when, under normal conditions, the sources are off. This component is the larger of; (3-30-07)

i. The volume required to prevent excess pump cycling and ensure that the following volume components are full and ready for use when needed; or (3-30-07)

ii. The volume needed to compensate for the sensitivity of the water level sensors. (3-30-07)

d. Equalization Storage. Storage of finished water in sufficient quantity to compensate for the difference between a water system's maximum pumping capacity and peak hour demand. (3-30-07)

e. Fire Suppression Storage. The water needed to support fire flow in those systems that provide it. (3-30-07)

f. Standby Storage. Standby storage provides a measure of reliability or safety factor should sources fail or when unusual conditions impose higher than anticipated demands. Normally used for emergency operation, if standby power is not provided, to provide water for eight (8) hours of operation at average day demand. (5-8-09)

16~~7~~. **Composite Correction Program (CCP).** A systematic approach to identifying opportunities for improving the performance of water treatment and implementing changes that will capitalize on these opportunities. The CCP consists of two (2) elements: (4-5-00)

a. Comprehensive Performance Evaluation (CPE). A thorough review and analysis of a treatment plant's performance-based capabilities and associated administrative, operation, and maintenance practices. It is conducted to identify factors that may be adversely impacting a plant's capability to achieve compliance and emphasizes approaches that can be implemented without significant capital improvements. The CPE must consist of at least the following components: assessment of plant performance; evaluation of major unit processes; identification and prioritization of performance limiting factors; assessment of the applicability of comprehensive technical assistance; and preparation of a CPE report. (4-5-00)

b. Comprehensive Technical Assistance (CTA). The implementation phase that is carried out if the CPE results indicate improved performance potential. During the CTA phase, the system must identify and systematically address plant-specific factors. The CTA consists of follow-up to the CPE results, implementation of process control priority setting techniques, and maintaining long term involvement to systematically train staff and administrators. (4-5-00)

17~~8~~. **Compositing of Samples.** The mixing of up to five (5) samples by the laboratory. (4-5-00)

18~~9~~. **Confining Layer.** A nearly impermeable subsurface stratum which is located adjacent to one (1) or more aquifers and does not yield a significant quantity of water to a well. (5-3-03)

~~19~~20. **Confirmation Sample.** A sample of water taken from the same point in the system as the original sample and at a time as soon as possible after the original sample was taken. (12-10-92)

20~~0~~1. **Connection.** Each structure, facility, or premises which is connected to a water system, and which is or could be used for domestic purposes, is considered a single connection. A single family residence is considered to be a premises. Multi-family dwellings and apartment, condominium, and office complexes are considered single connections unless individual units are billed separately for water by the water system, in which case each such unit shall be considered a single connection. (4-7-11)

21~~1~~2. **Consecutive System.** A public water system that receives some or all of its finished water from one (1) or more wholesale systems. Delivery may be through a direct connection or through the distribution system of one (1) or more consecutive systems. (4-2-08)

22~~2~~3. **Consumer.** Any person served by a public water system. (12-10-92)

23~~3~~4. **Consumer Confidence Report (CCR).** An annual report that community water systems must deliver to their customers. The reports must contain information on the quality of the water delivered by the systems and characterize the risks (if any) from exposure to contaminants detected in the drinking water in an accurate and understandable manner. (4-5-00)

24~~5~~5. **Contaminant.** Any physical, chemical, biological, or radiological substance or matter in water.

(12-10-92)

2~~5~~6. **Cross Connection**. Any actual or potential connection or piping arrangement between a public or a consumer's potable water system and any other source or system through which it is possible to introduce into any part of the potable water system used water, water from any source other than an approved public water system, industrial fluid, gas or substance other than the intended potable water with which the system is supplied. Cross connections include bypass arrangements, jumper connections, removable sections, swivel or change-over devices and other temporary or permanent devices which, or because of which "backflow" can or may occur. (10-1-93)

2~~6~~7. **Dead End Main**. A distribution main of any diameter and length that does not loop back into the distribution system. (3-30-07)

2~~7~~8. **Dead Storage**. Storage that is either not available for use in the system or can provide only substandard flows and pressures. See also the definition of Components of Finished Water Storage in these rules. (5-8-09)

2~~8~~9. **Department**. The Idaho Department of Environmental Quality. (12-10-92)

~~29~~30. **Director**. The Director of the Department of Environmental Quality or his designee. (12-10-92)

3~~0~~1. **Direct Integrity Test (DIT)**. A physical test applied to a microfiltration or ultrafiltration membrane unit in order to identify integrity breaches. (4-4-13)

3~~1~~2. **Disinfection**. Introduction of chlorine, other agents, or processes that are approved by the Department (such as ultraviolet light) in sufficient concentration, dosage, or application, and for the time required to kill or inactivate pathogenic and indicator organisms. (4-4-13)

3~~2~~3. **Disinfection Profile**. A summary of daily Giardia lamblia inactivation through the drinking water treatment plant. The procedure for developing a disinfection profile is contained in 40 CFR 141.172 and 40 CFR 141.530-141.536. (5-3-03)

3~~3~~4. **Distribution System**. Any combination of pipes, tanks, pumps, and other equipment which delivers water from the source(s), treatment facility(ies), or a combination of source(s) and treatment facility(ies) to the consumer. Chlorination may be considered as a function of a distribution system. (5-8-09)

3~~4~~5. **Drinking Water**. Means "water for human consumption." (3-30-07)

3~~5~~6. **Drinking Water System**. All mains, pipes, and structures through which water is obtained and distributed, including wells and well structures, intakes and cribs, pumping stations, treatment plants, reservoirs, storage tanks and appurtenances, collectively or severally, actually used or intended for use for the purpose of furnishing water for drinking or general domestic use. (12-10-92)

3~~6~~7. **Dual Sample Set**. A set of two (2) samples collected at the same time and same location, with one (1) sample analyzed for TTHM and the other sample analyzed for HAA5. Dual sample sets are collected for the purposes of conducting an Initial Distribution System Evaluation (40 CFR Part 141, Subpart U) and for determining compliance with the TTHM and HAA5 MCLs under the Stage 2 Disinfection Byproducts Requirements (40 CFR Part 141, Subpart V). (4-2-08)

3~~7~~8. **Effective Contact Time**. For the purpose of these rules, effective contact time means the time in minutes that it takes for water to move from the point of completely mixed chemical application to the point where residual concentration is measured. It is the "T" in contact time (CT) calculations and is either "demonstrated" or "calculated." It is the contact time sufficient to achieve the inactivation of target pathogens under the expected range of raw water pH and temperature variation and must be demonstrated through tracer studies or other evaluations or calculations acceptable to the Department. "Improving Clearwell Design for CT Compliance," referenced in Subsection 002.02, contains information that may be used as guidance for these calculations. (4-4-13)

3~~8~~9. **Effective Storage**. Effective storage is all storage other than dead storage and is made up of the

additive components described in Paragraphs c. through f. of the definition of Components of Finished Water Storage in these rules. (4-4-13)

~~39~~40. **Enhanced Coagulation**. The addition of sufficient coagulant for improved removal of disinfection byproduct precursors by conventional filtration treatment. Conventional filtration treatment is defined in 40 CFR 141.2. (5-3-03)

4~~0~~1. **Enhanced Softening**. The improved removal of disinfection byproduct precursors by precipitative softening. (4-5-00)

4~~1~~2. **Equalization Storage**. Storage of finished water in sufficient quantity to compensate for the difference between a water system's maximum pumping capacity and peak hour demand. See also the definition of Components of Finished Water Storage in these rules. (5-8-09)

4~~2~~3. **Equivalent Dwelling Unit (EDU)**. A unit of measure that standardizes all land use types (housing, retail, office, etc.) to the level of demand created by a single-family detached housing unit within a water system. The demand for one (1) equivalent dwelling unit is equivalent to the amount of water provided to the average single-family detached housing unit within a water system. For example, a business designed to use three (3) times as much water as an average single-family detached housing unit would have a demand of three (3) equivalent dwelling units. (5-8-09)

4~~3~~4. **Exemption**. A temporary deferment of compliance with a maximum contaminant level or treatment technique requirement which may be granted only if the system demonstrates to the satisfaction of the Department that the system cannot comply due to compelling factors and the deferment does not cause an unreasonable risk to public health. (12-10-92)

4~~4~~5. **Facility Plan**. The facility plan for a public drinking water system describes the overall system, including sources of water, treatment processes and facilities, pumping stations and distribution piping, finished water storage, and waste disposal. It is a comprehensive planning document for infrastructure and includes a plan for the future of the system/facility, including upgrades and additions. It is usually updated on a regular basis due to anticipated or unanticipated growth patterns, regulatory requirements, or other infrastructure needs. A facility plan is sometimes referred to as a master plan or facilities planning study. In general, a facility plan is an overall system-wide plan as opposed to a project specific plan. (3-30-07)

4~~5~~6. **Facility Standards and Design Standards**. Facility standards and design standards are described in Sections 500 through 552 of these rules. Facility and design standards found in Sections 500 through 552 of these rules must be followed in the planning, design, construction, and review of public drinking water facilities. (3-30-07)

4~~6~~7. **Fee Assessment**. A charge assessed on public drinking water systems based on a rate structure calculated by system size. (10-1-93)

4~~7~~8. **Filter Profile**. A graphical representation of individual filter performance, based on continuous turbidity measurements or total particle counts versus time for an entire filter run, from startup to backwash inclusively, that includes an assessment of filter performance while another filter is being backwashed. (4-5-00)

4~~8~~9. **Filtrate**. As the term relates to microfiltration and ultrafiltration, the product water or the portion of the feed stream that has passed through the membrane. (4-4-13)

~~49~~50. **Finished Water**. Water that is introduced into the distribution system of a public water system and is intended for distribution and consumption without further treatment, except as necessary to maintain water quality in the distribution system (e.g., booster disinfection, addition of corrosion control chemicals). (4-2-08)

5~~0~~1. **Finished Water Storage Structures or Facilities**. Finished water storage structures or facilities are defined as: (5-8-09)

a. Above-ground storage structure or facility. A finished water storage structure or facility with a bottom elevation above normal ground surface. (5-8-09)

b. Ground-level storage structure or facility. A finished water storage structure or facility with a bottom elevation at normal ground surface. (5-8-09)

c. Partially buried storage structure or facility. A finished water storage structure or facility with a bottom elevation below normal ground surface and any portion of the structure or facility above normal ground surface. (5-8-09)

d. Below-ground storage structure or facility. A finished water storage structure or facility with a bottom elevation and top elevation below normal ground surface. (5-8-09)

5~~1~~2. **Fire Flow Capacity**. The water system capacity, in addition to maximum day demand, that is available for fire fighting purposes within the water system or distribution system pressure zone. Adequacy of the water system fire flow capacity is determined by the local fire authority or through a hydraulic analysis performed by a licensed professional engineer to establish required fire flows in accordance with the International Fire Code as adopted by the State Fire Marshal. (4-4-13)

5~~2~~3. **Fire Suppression Storage**. The water needed to support fire flow in those systems that provide it. See also the definition of Components of Finished Water Storage in these rules. (5-8-09)

5~~3~~4. **Fixture Protection**. The practice of installing backflow prevention assemblies or devices to isolate one (1) or more cross connections within a customer's facility. (5-8-09)

5~~4~~5. **Flowing Stream**. As used in the Long Term 2 Enhanced Surface Water Treatment Rule (40 CFR Part 141, Subpart W), this term means a course of running water flowing in a definite channel. (4-2-08)

5~~5~~6. **Flux**. The throughput of a pressure-driven membrane filtration process expressed as flow per unit of membrane area, usually in gallons per square foot per day or liters per hour per square meter. (4-4-13)

5~~6~~7. **Ground Water System**. A public water system which is supplied exclusively by a ground water source or sources. (12-10-92)

5~~7~~8. **Ground Water Under the Direct Influence of Surface Water (GWUDI)**. Any water beneath the surface of the ground with significant occurrence of insects or other macroorganisms, algae, or large diameter pathogens such as Giardia lamblia or Cryptosporidium, or significant and relatively rapid shifts in water characteristics such as turbidity, temperature, conductivity, or pH which closely correlate to climatological or surface water conditions. Direct influence shall be determined by the Department for individual sources. The determination of direct influence may be based on site-specific measurements of water quality, documentation of well construction characteristics and geology with field evaluation, a combination of water quality and documentation, or other information required by the Department. (4-4-13)

5~~8~~9. **Haloacetic Acids (Five) (HAA5)**. The sum of the concentrations in milligrams per liter of the haloacetic acid compounds (monochloroacetic acid, dichloroacetic acid, trichloroacetic acid, monobromoacetic acid, and dibromoacetic acid) rounded to two (2) significant figures after addition. (4-5-00)

~~59~~60. **Health Hazards**. Any condition which creates, or may create, a danger to the consumer's health. Health hazards may consist of, but are not limited to, design, construction, operational, structural, collection, storage, distribution, monitoring, treatment or water quality elements of a public water system. See also the definition of Significant Deficiency, which refers to a health hazard identified during a sanitary survey. (5-3-03)

6~~0~~1. **Indirect Integrity Monitoring**. Monitoring some aspect of filtrate water quality that is indicative of the removal of particulate matter. (4-4-13)

6~~1~~2. **Inorganic**. Generally refers to compounds that do not contain carbon and hydrogen. (12-10-92)

6~~2~~3. **Internal or In-Plant Isolation**. The practice of installing backflow prevention assemblies to protect an area within a water customer's structure, facility, or premises from contaminating another part of the

structure, facility, or premises. (4-7-11)

~~*63.* ***Laboratory Certification Reciprocity.*** *Acceptance of a laboratory certification made by another state. Laboratory reciprocity may be granted to laboratories outside of Idaho after application, proof of home state certification, and EPA performance evaluation results are submitted and reviewed. Reciprocity must be renewed after a time specified by the Idaho Laboratory Certification Officer to remain valid.* *(4-5-00)*~~

64. **Lake/Reservoir**. As used in the Long Term 2 Enhanced Surface Water Treatment Rule (40 CFR Part 141, Subpart W), this term means a natural or man-made basin or hollow on the Earth's surface in which water collects or is stored that may or may not have a current or single direction of flow. (4-2-08)

65. **Level 1 Assessment**. A Level 1 Assessment is an evaluation to identify the possible presence of sanitary defects, defects in distribution system coliform monitoring practices, and (when possible) the likely reason that the system triggered the assessment. It is conducted by the system operator or owner. Minimum elements include review and identification of atypical events that could affect distributed water quality or indicate that distributed water quality was impaired; changes in distribution system maintenance and operation that could affect distributed water quality (including water storage); source and treatment considerations that bear on distributed water quality, where appropriate (e.g., whether a ground water system is disinfected); existing water quality monitoring data; and inadequacies in sample sites, sampling protocol, and sample processing. The system must conduct the assessment consistent with any Department directives that tailor specific assessment elements with respect to the size and type of the system and the size, type, and characteristics of the distribution system. ( )

66. **Level 2 Assessment**. A Level 2 Assessment is an evaluation to identify the possible presence of sanitary defects, defects in distribution system coliform monitoring practices, and (when possible) the likely reason that the system triggered the assessment. A Level 2 assessment provides a more detailed examination of the system (including the system's monitoring and operational practices) than does a Level 1 assessment through the use of more comprehensive investigation and review of available information, additional internal and external resources, and other relevant practices. It is conducted by an individual approved by the Department in accordance with Subsection 305.03, which may include the system operator. Minimum elements include review and identification of atypical events that could affect distributed water quality or indicate that distributed water quality was impaired; changes in distribution system maintenance and operation that could affect distributed water quality (including water storage); source and treatment considerations that bear on distributed water quality, where appropriate (e.g., whether a ground water system is disinfected); existing water quality monitoring data; and inadequacies in sample sites, sampling protocol, and sample processing. ( )

6~~5~~7. **License**. A physical document issued by the Idaho Bureau of Occupational Licenses certifying that an individual has met the appropriate qualifications and has been granted the authority to practice in Idaho under the provisions of Chapter 24, Title 54, Idaho Code. (4-6-05)

6~~6~~8. **Locational Running Annual Average (LRAA)**. The average of sample analytical results for samples taken at a particular monitoring location during the previous four (4) calendar quarters, as set forth in the Stage 2 Disinfection Byproducts Requirements (40 CFR Part 141, Subpart V). (4-2-08)

6~~7~~9. **Log**. Logarithm to the base ten (10). In the context of these rules, it is used in the determination of removal or inactivation efficiencies. It is expressed as the logarithm to the base ten (10) or "log" of the concentration of the feed or raw water minus the log of the concentration in the filtrate or product water. For example, if the incoming feed or raw water concentration is one hundred (100), and the outgoing filtrate or product water concentration is ten (10), a 10-fold reduction was attained; or 1-log removal. 1-log removal also equates to ninety percent (90%) removal, as ninety (90) of the original feed concentration counts had been removed, leaving ten (10) in the filtrate. Similarly, 2-log equates to ninety-nine percent (99%) removal. (4-4-13)

~~68~~70. **Log Removal Value (LRV)**. LRV is a measure of filtration removal efficiency for a target organism, particulate, or surrogate expressed as Logarithm to the base ten (10). (4-4-13)

~~69~~71. **Material Deviation**. A change from the design plans that significantly alters the type or location of facilities, requires engineering judgment to design, or impacts the public safety or welfare. (4-11-06)

~~70~~2. **Material Modification.** Those modifications of an existing public water system that are intended to increase system capacity or alter the methods or processes employed. Any project that adds source water to a system, increases the pumping capacity of a system, increases the potential population served by the system or the number of service connections within the system, adds new or alters existing drinking water system components, or affects the water demand of the system is considered to be increasing system capacity or altering the methods or processes employed. Maintenance and repair performed on the system and the replacement of valves, pumps, or other similar items with new items of the same size and type are not considered a material modification. (5-8-09)

~~71~~3. **Maximum Contaminant Level (MCL).** The maximum permissible level of a contaminant in water which is delivered to any user of a public water system. (3-30-07)

~~72~~4. **Maximum Day Demand.** The average rate of consumption for the twenty-four (24) hour period in which total consumption is the largest for the design year. See also the definition of Water Demand in these rules. (5-8-09)

~~73~~5. **Maximum Pumping Capacity.** The pumping capacity with the largest source or pump out of service. (5-8-09)

~~74~~6. **Maximum Residual Disinfectant Level (MRDL).** A level of a disinfectant added for water treatment that may not be exceeded at the consumer's tap without an unacceptable possibility of adverse health effects. For chlorine and chloramines, a public water system is in compliance with the MRDL, when the running annual average of monthly averages of samples taken in the distribution system, computed quarterly, is less than or equal to the MRDL. For chlorine dioxide, a public water system is in compliance with the MRDL when daily samples are taken at the entrance to the distribution system and no two (2) consecutive daily samples exceed the MRDL. MRDLs are enforceable in the same manner as maximum contaminant levels under Section 1412 of the Safe Drinking Water Act. There is convincing evidence that addition of a disinfectant is necessary for control of waterborne microbial contaminants. Notwithstanding the MRDLs listed in 40 CFR 141.65, operators may increase residual disinfectant levels of chlorine or chloramines (but not chlorine dioxide) in the distribution system to a level and for a time necessary to protect public health to address specific microbiological contamination problems caused by circumstances such as distribution line breaks, storm runoff events, source water contamination, or cross-connections. (4-4-13)

~~75~~7. **Maximum Residual Disinfectant Level Goal (MRDLG).** The maximum level of a disinfectant added for water treatment at which no known or anticipated adverse effect on the health of persons would occur, and which allows an adequate margin of safety. MRDLGs are nonenforceable health goals and do not reflect the benefit of the addition of the chemical for control of waterborne microbial contaminants. (4-5-00)

~~76~~8. **Membrane Filtration.** A pressure or vacuum driven separation process in which particulate matter larger than one (1) micrometer (μm) is rejected by an engineered barrier, primarily through a size-exclusion mechanism. This definition includes the common membrane technologies of microfiltration, ultrafiltration, nanofiltration, and reverse osmosis. (4-4-13)

~~77~~9. **Membrane Unit.** A group of treatment systems or membrane modules that usually share common control and valving so that the group can be isolated for testing or cleaning. (4-4-13)

~~78~~0. **Method Detection Limit (MDL).** The lowest concentration which can be determined to be greater than zero with ninety-nine percent (99%) confidence, for a particular analytical method. (12-10-92)

~~79~~81. **Microfiltration (MF).** A low pressure membrane filtration process with pore diameter normally in the range of 0.1 to 0.5 μm. (4-4-13)

~~80~~2. **Module.** As the term relates to membrane filtration, it is the smallest component of a membrane unit in which a specific membrane surface area is housed. The component is typically equipped with a feedwater inlet, a filtrate outlet, and concentrate or backwash outlet structure. (4-4-13)

~~81~~3. **Nanofiltration (NF).** A membrane filtration process that removes dissolved constituents from water. Nanofiltration is similar to reverse osmosis but allows a higher percentage of certain ions to pass through the

membrane. These systems typically operate under higher pressure than microfiltration and ultrafiltration. (4-4-13)

8~~2~~4. **New System**. Any water system that meets, for the first time, the definition of a public water system provided in Section 1401 of the federal Safe Drinking Water Act (42 U.S.C. Section 300f). This includes systems that are entirely new construction and previously unregulated systems that are expanding. (4-5-00)

8~~3~~5. **Noncommunity Water System**. A public water system that is not a community water system. A non-community water system is either a transient noncommunity water system or a non-transient noncommunity water system. See also the definition of a Public Drinking Water System in these rules. (5-8-09)

8~~4~~6. **Non-Potable Fluids**. Any fluids that do not meet the definition of potable water. This definition also includes any gases that are heavier than air such as propane. (4-4-13)

8~~5~~7. **Non-Potable Mains**. Pipelines that collect, deliver, or otherwise convey non-potable fluids. (4-4-13)

8~~6~~8. **Non-Potable Services or Lines**. Pipelines that collect, deliver, or otherwise convey non-potable fluids to or from a non-potable main. These pipelines connect individual facilities to the non-potable main. This term also refers to pipelines that convey non-potable fluids from a pressurized irrigation system, reclaimed wastewater system, and other non-potable systems to individual consumers. (4-4-13)

8~~7~~9. **Nontransient Noncommunity Water System**. A public water system that is not a community water system and that regularly serves at least twenty-five (25) of the same persons over six (6) months per year. See also the definition of a Public Drinking Water System in these rules. (5-8-09)

~~88~~90. **Operating Shift**. That period of time during which water system operator decisions that affect public health are necessary for proper operation of the system. (4-5-00)

~~8~~91. **Operational Storage**. Operational storage supplies water when, under normal conditions, the sources are off. This component is the larger of the volume required to prevent excess pump cycling and ensure that the following volume components are full and ready for use when needed or the volume needed to compensate for the sensitivity of the water level sensors. See also the definition of Components of Finished Water Storage in these rules. (5-8-09)

9~~0~~2. **Operation and Maintenance Manual**. An operation and maintenance manual typically covers three main subjects: a water system specific operations plan (see definition of Operations Plan); maintenance information and checklists; and manufacturer's product information (including trouble shooting information, a parts list and parts order form, special tools, spare parts list, etc.). An operation and maintenance manual may cover every aspect of the water system or any part of the water system, including but not limited to the following: treatment, pump stations, storage reservoirs, distribution system, pressure reducing valve stations, etc. (4-4-13)

9~~1~~3. **Operations Plan**. The operations plan is part of an operation and maintenance manual. Depending on which facilities of the water system are being addressed, the operations plan may cover many types of information including but not limited to the following: daily, weekly, monthly, and yearly operating instructions; information specific to a particular type of treatment; location of valves and other key distribution system features; pertinent telephone and address contact information including the responsible charge water system operator and water system owner; operator safety procedures; alarm system; emergency procedures; trouble-shooting advice; water quality testing; depressurization events; customer service; and response to customer complaints. (4-4-13)

9~~2~~4. **Owner/Purveyor of Water/Supplier of Water**. The person, company, corporation, association, or other organizational entity which holds legal title to the public water system, who provides, or intends to provide, drinking water to the customers, and who is ultimately responsible for the public water system operation. (5-8-09)

9~~3~~5. **Peak Hour Demand**. The highest hourly flow, excluding fire flow, that a water system or distribution system pressure zone is likely to experience in the design year. See also the definition of Water Demand in these rules. (5-8-09)

~~94~~6. **Person**. A human being, municipality, or other governmental or political subdivision or other public agency, or public or private corporation, any partnership, firm, association, or other organization, any receiver, trustee, assignee, agent or other legal representative of the foregoing or other legal entity. (12-10-92)

~~95~~7. **Pesticides**. Substances which meet the criteria for regulation pursuant to the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), as amended, and any regulations adopted pursuant to FIFRA. For example, pesticides include, but are not limited to insecticides, fungicides, rodenticides, herbicides, and algaecides. (12-10-92)

~~96~~8. **Plant Design Capacity**. The maximum design flow through treatment units. The minimum plant design capacity could be equal to peak hour demand but could also be equal to the maximum day demand if equalization storage is provided. (4-4-13)

~~97~~9. **Plant**. A physical facility where drinking water or wastewater is treated or processed. (3-30-07)

~~98~~100. **Point of Use (POU) Treatment Device**. A treatment device applied to a single tap used for the purpose of reducing contaminants in drinking water at that one tap. (3-30-07)

~~99~~101. **Point of Use (POU) Treatment System**. A collection of POU treatment devices. (3-30-07)

~~100~~2. **Potable Mains**. Pipelines that deliver potable water to multiple service connections. (3-30-07)

~~101~~3. **Potable Services**. Pipelines that convey potable water from a connection to the potable water main to individual consumers. (3-30-07)

~~102~~4. **Potable Water**. Water for human consumption. See the definition of Water for Human Consumption in Section 003. (4-4-13)

~~103~~5. **Preliminary Engineering Report**. The preliminary engineering report for a public drinking water system facility is a report that addresses specific portions of the system or facility for which modifications are being designed. Modifications may include, but are not limited to, significant changes to existing processes or facilities, system expansion, addition of treatment, or installation of other processes and facilities. This report addresses specific purpose and scope, design requirements, alternative solutions, costs, operation and maintenance requirements, and other requirements as described in Section 503. Preliminary engineering reports are generally project specific as opposed to an overall system-wide plan, such as a facility plan. (4-4-13)

~~104~~6. **Premises Isolation or Containment**. The practice of separating the customer's structure, facility, or premises from the purveyor's system by means of a backflow prevention assembly installed on the service line before any distribution takes place. (4-7-11)

~~105~~7. **Presedimentation**. A preliminary treatment process used to remove gravel, sand, and other particulate material from the source water through settling before the water enters the primary clarification and filtration processes in a treatment plant. (4-2-08)

108. **Protected Water Source**. For the purposes of the Revised Total Coliform Rule (40 CFR Part 141, Subpart Y), a protected water source is a ground water well that is not susceptible to contamination on the basis of well construction, hydrologic data, or contamination history. (____)

~~106~~9. **Public Notice**. The notification of public water system consumers of information pertaining to that water system including information regarding water quality or compliance status of the water system. (12-10-92)

~~107~~. **Public Drinking Water System**. A system for the provision to the public of water for human consumption through pipes or, after August 5, 1998, other constructed conveyances, if such system has at least fifteen (15) service connections, regardless of the number of water sources or configuration of the distribution system, or regularly serves an average of at least twenty-five (25) individuals daily at least sixty (60) days out of the year. Such term includes: any collection, treatment, storage, and distribution facilities under the control of the operator of such system and used primarily in connection with such system; and any collection or pretreatment storage facilities not under such control which are used primarily in connection with such system. Such term does not include any "special

irrigation district." A public water system is either a "community water system" or a "noncommunity water system" as further defined as: (5-8-09)

a. Community water system. A public water system which serves at least fifteen (15) service connections used by year-round residents or regularly serves at least twenty-five (25) year-round residents. (5-8-09)

b. Noncommunity water system. A public water system that is not a community water system. A non-community water system is either a transient noncommunity water system or a non-transient noncommunity water system. (5-8-09)

c. Nontransient noncommunity water system. A public water system that is not a community water system and that regularly serves at least twenty-five (25) of the same persons over six (6) months per year. (5-8-09)

d. Transient noncommunity public water system. A noncommunity water system which does not regularly serve at least twenty-five (25) of the same persons over six (6) months per year. (5-8-09)

1~~08~~11. Public Water System/Water System/System. Means "public drinking water system." (4-5-00)

1~~09~~12. Pump House. A structure containing important water system components, such as a well, hydropneumatic tank, booster pump, pump controls, flow meter, well discharge line, or a treatment unit. Pump houses are often called well houses in common usage, even though in modern construction these structures may not contain either a well or a pump. These terms are used interchangeably in national standards and trade publications. (4-4-13)

11~~0~~3. Qualified Licensed Professional Engineer (QLPE). A professional engineer licensed by the state of Idaho; qualified by education or experience in the specific technical fields involved in these rules; and retained or employed by a city, county, quasi-municipal corporation, or regulated public utility for the purposes of plan and specification review. (5-8-09)

11~~1~~4. Quasi-Municipal Corporation. A public entity, other than community government, created or authorized by the legislature to aid the state in, or to take charge of, some public or state work for the general welfare. For the purpose of these rules, this term refers to drinking water districts. (4-11-06)

11~~2~~5. Raw Water. Raw water is any ground water, spring water, or surface water utilized as source water prior to treatment for the purpose of producing potable water. (4-4-13)

11~~3~~6. Redundancy. The installation of duplicate components or backup systems that are designed to maintain minimum pressure and capacity of the system should any component fail or otherwise be out of service for maintenance or repair. (4-4-13)

11~~4~~7. Regulated Public Utility. For the purpose of these rules, any public water system that falls under the jurisdiction of the Idaho Public Utilities Commission and is subject to the rules thereof. (3-30-07)

11~~5~~8. Reverse Osmosis (RO). A membrane filtration process that removes dissolved constituents from water. Reverse osmosis is similar to nanofiltration but allows a lower percentage of certain ions to pass through the membrane. These systems typically operate under higher pressure than microfiltration and ultrafiltration. (4-4-13)

11~~6~~9. Repeat Compliance Period. Any subsequent compliance period after the initial compliance period. (12-10-92)

1~~17~~20. Resolution. As the term relates to membrane treatment, it is the size of the smallest integrity breach that contributes to a response from a direct integrity test when testing low pressure membranes. (4-4-13)

1~~18~~21. Responsible Charge (RC). Responsible Charge means active, daily on-site or on-call responsibility for the performance of operations or active, on-going, on-site, or on-call direction of employees and assistants. (5-8-09)

1~~19~~22. Responsible Charge Operator. An operator of a public drinking water system, designated by the

system owner, who holds a valid license at a class equal to or greater than the drinking water system classification, who is in responsible charge of the public drinking water system. (4-6-05)

12~~0~~3. **Reviewing Authority**. For those projects requiring preconstruction approval by the Department, the Department is the reviewing authority. For those projects allowing for preconstruction approval by others, pursuant to Subsection 504.03.b. of these rules, the qualified Idaho licensed professional engineer (QLPE) is also the reviewing authority. (5-8-09)

12~~1~~4. **Sampling Point**. The location in a public water system from which a sample is drawn. (12-10-92)

12~~2~~5. **Sanitary Defects**. ~~*Any faulty structural condition which may allow the water supply to become contaminated.*~~ A defect that could provide a pathway of entry for microbial contamination into the distribution system or that is indicative of a failure or imminent failure in a barrier that is already in place. Examples of sanitary defects include but are not limited to: cross connections, inadequate distribution system pressures, inadequate or missing sanitary seal, improperly screened storage tank vents, inadequate protection from contamination during flooding, history of treatment failures, deterioration of system components, and water main leaks or breaks. ~~*(12-10-92)*~~(____)

12~~3~~6. **Sanitary Survey**. An onsite review of the water source, facilities, equipment, operation and maintenance of a public water system for the purpose of evaluating the adequacy of such source, facilities, equipment, operation and maintenance for producing and distributing safe drinking water. The sanitary survey will include, but is not limited to the following elements: (4-5-00)

a. Source; (4-5-00)

b. Treatment; (4-5-00)

c. Distribution system; (4-5-00)

d. Finished water storage; (4-5-00)

e. Pumps, pump facilities, and controls; (4-5-00)

f. Monitoring and reporting and data verification; (4-5-00)

g. System management and operation; and (4-5-00)

h. Operator compliance with state requirements. (4-5-00)

12~~4~~7. **SDWIS-State**. An acronym that stands for "Safe Drinking Water Information System-State Version." It is a software package developed under contract to the U.S. Environmental Protection Agency and used by a majority of U.S. states to collect, maintain, and report data about regulated public water systems. (4-4-13)

128. Seasonal System. A noncommunity water system that is not operated as a public water system on a year-round basis and starts up and shuts down at the beginning and end of each operating season. (____)

12~~5~~9. **Sensitivity**. As the term relates to membrane treatment, it is the maximum log removal value (LRV) for a specific resolution that can be reliably verified by the direct integrity test associated with a given low pressure membrane filtration system. (4-4-13)

1~~26~~30. **Sewage**. The water-carried human or animal waste from residences, buildings, industrial establishments or other places, together with such ground water infiltration and surface water as may be present. (3-30-07)

1~~27~~31. **Significant Deficiency**. As identified during a sanitary survey, any defect in a system's design, operation, maintenance, or administration, as well as any failure or malfunction of any system component, that the Department or its agent determines to cause, or have potential to cause, risk to health or safety, or that could affect the

reliable delivery of safe drinking water. See also the definition of Health Hazards. (5-3-03)

1~~28~~32. **Simple Water Main Extension**. New or replacement water main(s) that require plan and specification review by a qualified licensed professional engineer (QLPE) or by the Department per these rules and that is connected to existing water main facilities and does not require the addition of system components designed to control quantity or pressure, including, but not limited to, booster stations, new sources, pressure reducing valve stations, or reservoirs; and continues to provide the pressure and quantity requirements of Subsection 552.01. (4-4-13)

1~~29~~33. **Special Irrigation District**. An irrigation district in existence prior to May 18, 1994 that provides primarily agricultural service through a piped water system with only incidental residential or similar use where the system or the residential or similar users of the system comply with the exclusion provisions in Section 1401(4)(B)(i)(II) or (III) of the Safe Drinking Water Act. (4-6-05)

13~~0~~4. **Spring**. A source of water which flows from a laterally percolating water table's intersection with the surface or from a geological fault that allows the flow of water from an artesian aquifer. (12-10-92)

13~~1~~5. **Standby Storage**. Standby storage provides a measure of reliability or safety factor should sources fail or when unusual conditions impose higher than anticipated demands. See also the definition of Components of Finished Water Storage in these rules. (5-8-09)

13~~2~~6. **Substantially Modified**. The Department shall consider a public water system to be substantially modified when, as the result of one (1) or more projects, there is a combined increase of twenty-five percent (25%) or more above the system's existing configuration in the population served or number of service connections, the total length of transmission and distribution water mains, and the peak or average water demand. (5-8-09)

13~~3~~7. **Substitute Responsible Charge Operator**. An operator of a public drinking water system who holds a valid license at a class equal to or greater than the drinking water system classification, designated by the system owner to replace and to perform the duties of the responsible charge operator when the responsible charge operator is not available or accessible. (4-6-05)

13~~4~~8. **Surface Water System**. A public water system which is supplied by one (1) or more surface water sources or ground water sources under the direct influence of surface water. Also called subpart H systems in applicable sections of 40 CFR Part 141. (4-5-00)

13~~5~~9. **Total Organic Carbon (TOC)**. Total organic carbon in mg/l measured using heat, oxygen, ultraviolet irradiation, chemical oxidants, or combinations of these oxidants that convert organic carbon to carbon dioxide, rounded to two (2) significant figures. (4-5-00)

1~~36~~40. **Total Trihalomethanes (TTHM)**. The sum of the concentration in milligrams per liter of the trihalomethane compounds (trichloromethane [chloroform], dibromochloromethane, bromodichloromethane and tribromomethane [bromoform]), rounded to two (2) significant figures. (4-2-08)

1~~37~~41. **Transient Noncommunity Public Water System**. A noncommunity water system which does not regularly serve at least twenty-five (25) of the same persons over six (6) months per year. See also the definition of a Public Drinking Water System in these rules. (5-8-09)

1~~38~~42. **Treatment Facility**. Any place(s) where a public drinking water system or nontransient noncommunity water system alters the physical or chemical characteristics of the drinking water. Chlorination may be considered as a function of a distribution system. (4-5-00)

1~~39~~43. **Turbidity**. A measure of the interference of light passage through water, or visual depth restriction due to the presence of suspended matter such as clay, silt, nonliving organic particulates, plankton and other microscopic organisms. Operationally, turbidity measurements are expressions of certain light scattering and absorbing properties of a water sample. Turbidity is measured by the Nephelometric method. (12-10-92)

14~~0~~4. **Ultrafiltration (UF)**. A low pressure membrane filtration process with pore diameter normally in

the range of five thousandths to one tenth micrometer (0.005 to 0.1 μm). (4-4-13)

14~~1~~5. Ultraviolet (UV) Light Technology. A physical disinfection process that has proven effective against common pathogens in drinking water. (4-4-13)

14~~2~~6. UV Transmittance (UVT). A measure of the fraction of incident light transmitted through a material (e.g., water sample or quartz). The UVT is usually reported for a wavelength of two hundred fifty-four (254) nm and a pathlength of one (1) cm. It is often represented as a percentage. (4-4-13)

14~~3~~7. Unregulated Contaminant. Any substance that may affect the quality of water but for which a maximum contaminant level or treatment technique has not been established. (12-10-92)

14~~4~~8. Use Assessment. For the purpose of obtaining a waiver from certain monitoring requirements, a use assessment is an evaluation as to whether synthetic organic contaminants are being or have been used, manufactured, transported, stored, or disposed of in the watershed for surface water or the zone of influence for ground water. (5-8-09)

14~~5~~9. Variance. A temporary deferment of compliance with a maximum contaminant level or treatment technique requirement which may be granted only when the system demonstrates to the satisfaction of the Department that the raw water characteristics prevent compliance with the MCL or requirement after installation of the best available technology or treatment technique and the determent does not cause an unreasonable risk to public health. (12-10-92)

14~~6~~50. Very Small Public Drinking Water System. A Community or Nontransient Noncommunity Public Water System that serves five hundred (500) persons or less and has no treatment other than disinfection or has only treatment which does not require any chemical treatment, process adjustment, backwashing or media regeneration by an operator (e.g. calcium carbonate filters, granular activated carbon filters, cartridge filters, ion exchangers). (4-5-00)

14~~7~~51. Volatile Organic Chemicals (VOCs). VOCs are lightweight organic compounds that vaporize or evaporate easily. (10-1-93)

14~~8~~52. Vulnerability Assessment. A determination of the risk of future contamination of a public drinking water supply. (12-10-92)

14~~9~~53. Waiver. (12-10-92)

a. For the purposes of these rules, except Sections 500 through 552, "waiver" means the Department approval of a temporary reduction in sampling requirements for a particular contaminant. (3-30-07)

b. For purposes of Sections 500 through 552, "waiver" means a dismissal of any requirement of compliance. (3-30-07)

c. For the purposes of Section 010, "waiver" means the deferral of a fee assessment for a public drinking water system. (10-1-93)

15~~0~~4. Wastewater. Any combination of liquid or water and pollutants from activities and processes occurring in dwellings, commercial buildings, industrial plants, institutions and other establishments, together with any ground water, surface water, and storm water that may be present; liquid or water that is chemically, biologically, physically or rationally identifiable as containing blackwater, gray water or commercial or industrial pollutants; and sewage. See IDAPA 58.01.16, "Wastewater Rules," for additional information. (4-7-11)

15~~1~~5. Water for Human Consumption. Water that is used by humans for drinking, bathing for purposes of personal hygiene (including hand-washing), showering, cooking, dishwashing, and maintaining oral hygiene. In common usage, the terms "culinary water," "drinking water," and "potable water" are frequently used as synonyms. (5-3-03)

15~~2~~6. **Water Demand**. The volume of water requested by system users to satisfy their needs. Water demand can be further categorized as: (5-8-09)

a. Average day demand. The volume of water used by a system on an average day based on a one (1) year period. (5-8-09)

b. Maximum day demand. The average rate of consumption for the twenty-four (24) hour period in which total consumption is the largest for the design year. (5-8-09)

c. Peak hour demand. The highest hourly flow, excluding fire flow, that a water system or distribution system pressure zone is likely to experience in the design year. (5-8-09)

15~~3~~7. **Water Main**. A pipe within a public water system which is under the control of the system operator and conveys water to two (2) or more service connections or conveys water to a fire hydrant. The collection of water mains within a given water supply is called the distribution system. (5-8-09)

15~~4~~8. **Watershed**. The land area from which water flows into a stream or other body of water which drains the area. (3-30-07)

15~~5~~9. **Wholesale System**. A public water system that treats source water as necessary to produce finished water and then delivers some or all of that finished water to another public water system. Delivery may be through a direct connection or through the distribution system of one (1) or more consecutive systems. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

100. MONITORING AND ANALYTICAL REQUIREMENTS.

01. ~~***Microbiological Contaminant***~~ **Total Coliform Sampling and Analytical Requirements**. The Total Coliform Rule, 40 CFR 141.21, is herein incorporated by reference. The Revised Total Coliform Rule, 40 CFR Part 141, Subpart Y, is herein incorporated by reference, excluding the annual monitoring provisions in 40 CFR 141.854 (a)(4), (d), (e), (f) and (h). ~~*(10-1-93)*~~(____)

a. ~~*40 CFR 141.21 is herein incorporated by reference*~~ Routine monitoring requirements for public water systems serving more than one thousand (1,000) people. 40 CFR 141.857 is herein incorporated by reference. ~~*(4-4-13)*~~(____)

b. ~~*The Department may reduce the total coliform monitoring frequency for community water systems serving twenty-five (25) to one thousand (1000) persons, as specified in 40 CFR 141.21(a)(2) and Subsection 100.01. The Department may allow community water systems serving twenty-five (25) to one thousand (1000) persons to reduce the total coliform monitoring frequency to once per quarter when:*~~ Routine monitoring requirements for community water systems serving one thousand (1,000) or fewer people using only ground water. 40 CFR 141.855 is herein incorporated by reference. ~~*(12-10-92)*~~(____)

~~*i. The system submits a written request to the Department in advance of the requirement; and (12-10-92)*~~

~~*ii. There has been no history of total coliform contamination in its current configuration; and (10-1-93)*~~

~~*iii. The system has been in compliance with the total coliform monitoring requirements for the last three (3) years; and (12-10-92)*~~

~~*iv. A sanitary survey has been conducted within the past five (5) years which indicates to the Department that there are no deficiencies which could affect microbial quality; and (12-10-92)*~~

~~v. The system uses only a ground water source that is protected.~~ ~~(12-10-92)~~

c. ~~The Department may reduce the total coliform monitoring frequency for noncommunity water systems serving less than one thousand (1000) persons as specified in 40 CFR 141.21(a)(3)(i) and Subsection 100.01 of this rule. The Department may allow noncommunity water systems serving less than one thousand (1000) persons to reduce the total coliform monitoring frequency to once per year when;~~ Routine monitoring requirements for subpart H public water system serving one thousand (1,000) or fewer people. 40 CFR 141.856 is herein incorporated by reference. ~~(12-10-92)~~(____)

~~i. The system submits a written request to the Department in advance of the requirement; and~~ ~~(12-10-92)~~

~~ii. No coliforms have been detected in the last three (3) years of monitoring; and~~ ~~(12-10-92)~~

~~iii. The system has been in compliance with the total coliform monitoring requirements for the last three (3) years; and~~ ~~(12-10-92)~~

~~iv. A sanitary survey has been conducted within the past five (5) years which indicates to the Department that there are no deficiencies which could affect microbial quality; and~~ ~~(12-10-92)~~

~~v. The system uses only a ground water source that is protected.~~ ~~(12-10-92)~~

d. ~~The Department may reduce the total coliform monitoring frequency for noncommunity water systems serving more than one thousand (1000) persons during any month the system serves one thousand (1000) persons or fewer as specified in 40 CFR 141.21(a)(3)(ii) and Subsection 100.01. The Department will allow noncommunity water systems serving more than one thousand (1000) persons to reduce the total coliform monitoring frequency for any month the system serves one thousand (1000) persons or fewer, down to a minimum of one (1) sample per year; provided;~~ Routine monitoring requirements for non-community water system serving one thousand (1,000) or fewer people using only ground water. 40 CFR 141.854 is herein incorporated by reference, excluding the annual monitoring provisions in 40 CFR 141.854 (a)(4), (d), (e), (f), and (h). ~~(10-1-93)~~(____)

~~i. The system submits a written request to the Department in advance of the requirement; and~~ ~~(12-10-92)~~

~~ii. No coliforms have been detected in the last three (3) years of monitoring; and~~ ~~(12-10-92)~~

~~iii. The system has been in compliance with the total coliform monitoring requirements for the last three (3) years; and~~ ~~(12-10-92)~~

~~iv. A sanitary survey has been conducted within the past five (5) years which indicates that there are no deficiencies which could affect microbial quality; and~~ ~~(4-4-13)~~

~~v. The system uses only a ground water source that is protected.~~ ~~(12-10-92)~~

~~e. A system must collect repeat samples within twenty-four (24) hours of notification of positive results as specified in 40 CFR 141.21(b) and Subsection 100.01. The Department may allow a system to delay collection of repeat samples if the system:~~ ~~(12-10-92)~~

~~i. Identifies the cause of the contamination;~~ ~~(12-10-92)~~

~~ii. Is making progress towards correcting the problem;~~ ~~(12-10-92)~~

~~iii. Submits a written request to delay collecting repeat samples and a written statement admitting an acute MCL violation;~~ ~~(12-10-92)~~

~~iv. Follows public notification requirements specified under 40 CFR Part 141, Subpart Q for Tier 1 MCL violations including notice for consumers to boil their water;~~ ~~(4-4-13)~~

~~v. Continues to collect the regularly scheduled number of routine samples; (12-10-92)~~

~~vi. Collects all repeat samples immediately following correction of the problem; and (12-10-92)~~

~~vii. Collects five (5) routine samples during the month following the end of the violation as required under 40 CFR 141.21 (b)(5), unless waived as allowed under that paragraph. (12-10-92)~~

02. Turbidity Sampling and Analytical Requirements. 40 CFR 141.22 is herein incorporated by reference. (4-4-13)

03. Inorganic Chemical Sampling and Analytical Requirements. 40 CFR 141.23 is herein incorporated by reference. (4-4-13)

04. Organic Chemicals, Sampling and Analytical Requirements. 40 CFR 141.24 is herein incorporated by reference. (4-4-13)

05. Analytical Methods for Radioactivity. 40 CFR 141.25 is herein incorporated by reference. (4-4-13)

06. Monitoring Frequency and Compliance Requirements for Radioactivity in Community Water Systems. 40CFR 141.26 is herein incorporated by reference. (4-4-13)

07. Monitoring Waivers. 40 CFR 141.23(b) 141.23(c), 141.24(f), 141.24(h) are herein incorporated by reference. (4-4-13)

a. Waivers from sampling requirements in Subsections 100.03, 100.04, 200.01, and 503.03.e.v. may be available to all systems for all contaminants except nitrate, nitrite, and disinfection byproducts and are based upon a vulnerability assessment, use assessment, the analytical results of previous sampling, or some combination of vulnerability assessment, use assessment, and analytical results. (4-4-13)

b. There are two (2) general types of monitoring waivers: (12-10-92)

i. Waivers based exclusively upon previous analytical data (12-10-92)

ii. Waivers based on a use or vulnerability assessment. (12-10-92)

c. Waivers are to be made by the Department on a contaminant specific basis and must be in writing. (12-10-92)

d. Vulnerability assessments may be conducted by the Department, the water system, or a third party organization. The Department shall approve or disapprove all vulnerability assessments in writing. (12-10-92)

e. Water systems which do not receive waivers shall sample at the required initial and repeat monitoring frequencies. (12-10-92)

f. If a system elects to request a waiver from monitoring, it shall do so in writing at least sixty (60) days prior to the required monitoring deadline date. (10-1-93)

08. Initial Monitoring Schedule. In addition to the requirements specified in 40 CFR 141.23, 40 CFR 141.24, and 40 CFR 141.40, initial monitoring must be completed according to the following schedule unless otherwise specified by the Department: (4-4-13)

a. Public water systems serving more than one hundred (100) people must conduct initial monitoring before January 1, 1995 except that: (10-1-93)

i. Initial monitoring for nitrate and nitrite must be completed before January 1, 1994 for all surface

water sources serving transient noncommunity public water systems and for all ground water sources serving any public water system. (10-1-93)

ii. Initial monitoring for nitrate and nitrite must be completed before April 1, 1993 for all surface water sources serving community or nontransient noncommunity public water systems. (10-1-93)

iii. Initial monitoring required under 40 CFR 141.23(c) must be completed before January 1, 1994 for all surface water sources serving community or nontransient noncommunity public water systems. (10-1-93)

b. Public water systems serving one hundred (100) or less people must conduct initial monitoring before January 1, 1996 except that: (10-1-93)

i. Initial monitoring for nitrate and nitrite must be completed before January 1, 1994 for all surface water sources serving transient noncommunity public water systems and for all ground water sources serving a public water system. (10-1-93)

ii. Initial monitoring for nitrate and nitrite must be completed before April 1, 1993 for all surface water sources serving community or nontransient noncommunity public water systems. (10-1-93)

iii. Initial monitoring required under 40 CFR 141.23(c) must be completed before January 1, 1994 for all surface water sources serving community or nontransient noncommunity public water systems. (10-1-93)

09. Alternate Analytical Techniques. 40 CFR 141.27 is herein incorporated by reference. (10-1-93)

10. Approved Laboratories. 40 CFR 141.28 and 40 CFR 141.852(b) ~~is~~ are herein incorporated by reference. All analyses conducted pursuant to these rules, except those listed below, shall be performed in laboratories certified or granted reciprocity by the Idaho Department of Health and Welfare, Bureau of Laboratories, as provided in IDAPA 16.02.13, "Rules Governing Certification of Idaho Water Quality Laboratories." The following analyses may be performed by any person acceptable to the Department of Environmental Quality: ~~(4-4-13)~~( )

a. pH; (12-10-92)

b. Turbidity (Nephelometric method only); (12-10-92)

c. Daily analysis for fluoride; (12-10-92)

d. Temperature; (5-8-09)

e. Disinfectant residuals, except ozone, which shall be analyzed using the Indigo Method or an acceptable automated method pursuant to Subsection 300.05.~~e~~d.; ~~(5-8-09)~~( )

f. Alkalinity; (5-8-09)

g. Calcium; (5-8-09)

h. Conductivity; (5-8-09)

i. Silica; and (5-8-09)

j. Orthophosphate. (5-8-09)

11. Monitoring of Consecutive Water Systems. 40 CFR 141.29 is herein incorporated by reference. (4-4-13)

12. Disinfection Residuals, Disinfection Byproducts, and Disinfection Byproduct Precursors. 40 CFR Part 141, Subpart L is herein incorporated by reference. (4-4-13)

(BREAK IN CONTINUITY OF SECTIONS)

150. REPORTING, PUBLIC NOTIFICATION, RECORDKEEPING.

01. Reporting Requirements. 40 CFR 141.31 is herein incorporated by reference. (4-4-13)

02. Public Notification of Drinking Water Violations. 40 CFR Part 141, Subpart Q is herein incorporated by reference. (4-4-13)

03. Record Maintenance. 40 CFR 141.33 is herein incorporated by reference. (4-4-13)

04. Reporting for Unregulated Contaminant Monitoring Results. 40 CFR 141.35 is herein incorporated by reference. (4-4-13)

05. Reporting and Record Keeping Requirements for the Interim Enhanced Surface Water Treatment Rule. 40 CFR 141.175 is herein incorporated by reference. (4-4-13)

06. Reporting and Record Keeping Requirements for the Disinfectants and Disinfectant Byproducts Rule. 40 CFR 141.134 is herein incorporated by reference. (4-4-13)

07. Reporting and Record Keeping Requirements for the Revised Total Coliform Rule. 40 CFR 141.861 is herein incorporated by reference. (____)

(BREAK IN CONTINUITY OF SECTIONS)

300. FILTRATION AND DISINFECTION.

01. General Requirements. 40 CFR 141.70 is herein incorporated by reference. Each public water system using a surface water source or ground water source directly influenced by surface water shall be operated by personnel, as specified in Sections 553 and 554, who have met state requirements for licensing of water system operators. (4-4-13)

02. Filtration. 40 CFR 141.73 is herein incorporated by reference. (4-4-13)

a. Each system which provides filtration treatment shall submit engineering evaluations, other documentation, or some combination of engineering evaluations and other documentation as required by the Department to demonstrate ongoing compliance with these rules. (4-7-11)

b. The Department will establish filtration removal credit on a system-by-system basis. Unless otherwise demonstrated to the satisfaction of the Department, the maximum log removal credit allowed for filtration is as follows:

Maximum Log Removal			
Filtration Type	**Giardia lamblia**	**Viruses**	**Cryptosporidium**
Conventional	2.5	2.0	2.5
Direct	2.0	1.0	2.0
Slow sand	2.0	2.0	2.0
Diatomaceous earth	2.0	1.0	2.0
Microfiltration	3.0	0.5	3.0

Maximum Log Removal			
Filtration Type	**Giardia lamblia**	**Viruses**	**Cryptosporidium**
Ultrafiltration	3.5	2.0	3.5
Nanofiltration	4.0	3.0	4.0
Reverse Osmosis	4.0	3.0	4.0
Alternate technology	2.0	0	2.0

(4-4-13)

c. Filtration removal credit shall be granted for filtration treatment provided the system is: (4-7-11)

i. Operated in accordance with the Operations Plan specified in Subsection 552.03.a.; and (4-7-11)

ii. The system is in compliance with the turbidity performance criteria specified under 40 CFR 141.73; and (4-7-11)

iii. Coagulant chemicals must be added and coagulation and flocculation unit process must be used at all times during which conventional and direct filtration treatment plants are in operation; and (4-7-11)

iv. Slow sand filters are operated at rates not to exceed~~:~~ one-tenth (0.1) gallons per minute per square foot or as approved by the Department; and ~~(4-4-13)~~(____)

~~(1) One-tenth (0.1) gallons per minute per square foot when anticipated temperatures are expected above five degrees Celsius (5°C); and (4-4-13)~~

~~(2) Five hundredths (0.05) gallons per minute per square foot when anticipated temperatures are expected at or below five degrees Celsius (5°C); and (4-4-13)~~

v. Diatomaceous earth filters are operated at a rate not to exceed one point five (1.5) gallons per minute per square foot. (4-7-11)

03. Criteria for Avoiding Filtration. 40 CFR 141.71 is herein incorporated by reference. (4-4-13)

04. Disinfection. 40 CFR 141.72 is herein incorporated by reference. (10-1-93)

a. In addition to the disinfection requirements in 40 CFR 141.72, each system with a surface water source or ground water source directly influenced by surface water shall maintain a minimum of at least two-tenths (0.2) parts per million of chlorine in the treated water after an effective contact time of at least thirty (30) minutes at peak hour demand before delivery to the first customer. Effective contact time is either demonstrated or calculated. (____)

i. Demonstrated effective contact time is generally determined by tracer studies on a completed contact basin. Prior to conducting a tracer study, a testing plan shall be submitted to the Department for review and approval. The tracer chemical shall not be reactive with anything in the water or be consumed in the process. (____)

ii. Calculated effective contact time for tank type contact basins is based on tank baffling and inlet/outlet configurations for the maximum hourly flow rate through that contact basin. Calculated effective contact time in a "pipeline type contact basin" (often called a pipeline contactor) is calculated by dividing the internal volume of the pipe by the maximum hourly flow rate through that pipeline contactor. ~~(4-4-13)~~(____)

b. The Department may allow a system to utilize automatic shut-off of water to the distribution system whenever total disinfectant residual is less than two-tenths (0.2) mg/l rather than provide redundant disinfection components and auxiliary power as required in 40 CFR 141.72(a)(2). An automatic water shut-off may

be used if the system demonstrates to the satisfaction of the Department that, at all times, a minimum of twenty (20) psi pressure and adequate fire flow can be maintained in the distribution system when water delivery is shut-off to the distribution system and, at all times, minimum Giardia lamblia and virus inactivation removal rates can be achieved prior to the first customer. (12-10-92)

c. Each system which is required to provide filtration must provide disinfection treatment such that filtration plus disinfection provide at least 3-Log or ninety-nine and nine tenths percent (99.9%) inactivation/removal of Giardia lamblia cysts and at least 4-Log or ninety-nine and ninety-nine hundredths percent (99.99%) inactivation/ removal of viruses as specified in 40 CFR 141.72 and Section 300, and at least 2-Log or ninety-nine percent (99%) removal of Cryptosporidium as required by 40 CFR Part 141, Subpart P or Subpart T. However, in all cases the disinfection portion of the treatment train shall be designed to provide not less than five tenths (0.5) log Giardia lamblia inactivation, irrespective of the Giardia lamblia removal credit awarded to the filtration portion of the treatment train. (4-4-13)

05. Analytical and Monitoring Requirements. 40 CFR 141.74 is herein incorporated by reference. (4-4-13)

a. Each public water system which is required to provide disinfection shall monitor as follows: (4-4-13)

i. Each day the system is in operation, the purveyor shall determine the total level of inactivation of Giardia lamblia cysts and viruses achieved through disinfection based on CT99.9 values provided in 40 CFR 141.74(b)(3) (Tables 1.1 through 1.6, 2.1 and 3.1). (12-10-92)

ii. At least once per day, the system shall monitor the following parameters to determine the total inactivation ratio achieved through disinfection: (12-10-92)

(1) Temperature of the disinfected water at each residual disinfectant concentration sampling point; and (12-10-92)

(2) If using chlorine, the pH of the disinfected water at each chlorine residual sampling point. (12-10-92)

(3) The effective contact time, "T," must be determined each day during peak hour demand. Disinfectant contact time, "T," in pipelines used for Giardia lamblia and virus inactivation shall be calculated by dividing the internal volume of the pipe by the peak hour flow rate through that pipe. Effective contact time, "T," for all other system components used for Giardia lamblia and virus inactivation shall be determined by tracer studies or other evaluations or calculations acceptable to the Department. (4-4-13)

(4) The residual disinfectant concentrations at each residual disinfectant sampling point at or before the first customer, must be determined each day during peak hour demand, or at other times approved by the Department. (5-8-09)

iii. The purveyor may demonstrate to the Department, based on a Department approved on-site disinfection challenge study protocol, that the system is achieving disinfection requirements specified in Subsection 300.04 utilizing CT99.9 values other than those specified in 40 CFR 141.74(b)(3) (Tables 2.1 and 3.1) for ozone, chlorine dioxide, and chloramine. (4-4-13)

iv. The total inactivation ratio shall be calculated as follows: (12-10-92)

(1) If the system applies disinfectant at only one (1) point, the system shall determine the total inactivation ratio by either of the two (2) following methods: (12-10-92)

(a) One inactivation ratio (CTcalc/CT99.9) is determined at/or before the first customer during peak hour demand; or (5-8-09)

(b) Sequential inactivation ratios are calculated between the point of disinfectant application and a

point at or before the first customer during peak hour demand. The following method must be used to calculate the total inactivation ratio: (5-8-09)

(i) Step 1: Determine (CTcalc/CT99.9) for each sequence. (12-10-92)

(ii) Step 2: Add the (CTcalc/CT99.9) values for all sequences. The result is the total inactivation ratio. (12-10-92)

(2) If the system uses more than one point of disinfectant application at or before the first customer, the system must determine the CT value of each disinfection sequence immediately prior to the next point of disinfectant application during peak hour demand. The sum of the (CTcalc/CT99.9) values from all sequences is the total inactivation ratio. (CTcalc/CT99.9) must be determined by the methods described in 40 CFR 141.74(b)(4)(i)(B). (5-8-09)

v. Log removal credit for disinfection shall be determined by multiplying the total inactivation ratio by three (3). (12-10-92)

vi. The Department may reduce the CT monitoring requirements specified under Section 300, for any system which demonstrates that the required inactivation levels are consistently exceeded. Reduced CT monitoring shall be allowed only where the reduction in monitoring will not endanger the health of consumers served by the water system. (12-10-92)

b. Residual disinfectant concentrations for ozone must be measured using the Indigo Method, or automated methods may be used if approved by the Department as provided for in 40 CFR 141.74(a)(~~4~~2). ~~(4-4-13)~~(____)

c. Unfiltered Subpart H systems. 40 CFR 141.857(c) is herein incorporated by reference. (____)

d. As provided for in 40 CFR 141.74(b), the Department may specify interim monitoring requirements for unfiltered systems notified by the Department or U.S. Environmental Protection Agency that filtration treatment must be installed. Until filtration is installed, systems shall conduct monitoring for turbidity and disinfectant residuals as follows unless otherwise specified by the Department~~s:~~. ~~(4-4-13)~~(____)

i. Disinfectant residual concentrations entering the distribution system shall be measured at the following minimum frequencies, and samples must be taken at evenly spaced intervals throughout the workday.

Minimum Frequencies	
Population	**Samples/day**
Less than 500	1
501 - 1000	2
1,001 - 2,500	3
Greater than 2501	4

(12-10-92)

ii. Turbidity shall be measured at least once per day at the entry point to the distribution system. (12-10-92)

iii. The Department may, at its discretion, reduce the turbidity monitoring frequency for any noncommunity system which demonstrates to the satisfaction of the Department: (12-10-92)

(1) A free chlorine residual of two-tenths (0.2) part per million is maintained throughout the distribution system; (12-10-92)

(2) The water source is well protected; (12-10-92)

(3) The total coliform MCL is not exceeded or a Level 1 or Level 2 Assessment has not been triggered in accordance with 40 CFR 141.859; and ~~(12-10-92)~~( )

(4) No significant health risk is present. (12-10-92)

~~d~~e. The Department may allow systems with surface water sources or ground water sources under the direct influence of surface water, to substitute continuous turbidity monitoring for grab sample monitoring as specified in 40 CFR 141.74(b)(2) and 40 CFR 141.74(c)(1) and Subsection 300.05. The Department may allow continuous turbidity monitoring provided the continuous turbidimeter is operated, maintained, standardized and calibrated per the manufacturer's recommendations. For purposes of determining compliance with turbidity performance criteria, discrete values must be recorded every four (4) hours water is supplied to the distribution system. (10-1-93)

~~e~~f. The Department may allow systems using both a surface water source(s), or ground water source(s) under the direct influence of surface water, and one (1) or more ground water sources, to measure disinfectant residual at points other than the total coliform sampling points, as specified in 40 CFR 141.74(b)(6)(i) and 40 CFR 141.74(c)(3)(i) and Subsection 300.05. The Department may allow alternate sampling points provided the system submits an ~~acceptable~~ alternate monitoring plan to the Department for approval in advance of the monitoring requirement that demonstrates the alternative points are more representative of treated (disinfected) water quality within the distribution system. Heterotrophic bacteria, measured as heterotrophic plate count (HPC) as specified in 40 CFR 141.74(a)(1), may be measured in lieu of residual disinfectant concentration as outlined in 40 CFR 141.74(b)(6)(i). ~~(10-1-93)~~( )

~~f~~g. The Department may allow a reduced turbidity monitoring frequency for systems using slow sand filtration or technology other than conventional, direct, or diatomaceous earth filtration, as specified in 40 CFR 141.74(c)(1) and Subsection 300.05. To be considered for a reduced turbidity monitoring frequency, a system must submit a written request to the Department in advance of the monitoring requirement. (12-10-92)

06. Reporting and Recordkeeping Requirements. 40 CFR 141.75 is herein incorporated by reference. (4-4-13)

a. As provided in 40 CFR 141.75(a) and Section 300, the Department may establish interim reporting requirements for systems notified by the Department or U.S. Environmental Protection Agency that filtration treatment must be installed as specified in 40 CFR 141.75(a) and as referred to in Subsection 300.06. Until filtration treatment is installed, systems required to install filtration treatment shall report as follows: (4-4-13)

i. The purveyor shall immediately report to the Department via telephone or other equally rapid means, but no later than the end of the next business day, the following information: (12-10-92)

(1) The occurrence of a waterborne disease outbreak potentially attributable to that water system; (12-10-92)

(2) Any turbidity measurement which exceeds five (5) NTU; and (12-10-92)

(3) Any result indicating that the disinfectant residual concentration entering the distribution system is below two-tenths (0.2) mg/l free chlorine. (12-10-92)

ii. The purveyor shall report to the Department within ten (10) days after the end of each month the system serves water to the public the following monitoring information using a Department-approved form: (12-10-92)

(1) Turbidity monitoring information; and (12-10-92)

(2) Disinfectant residual concentrations entering the distribution system. (12-10-92)

iii. Personnel qualified under Subsection 300.01 shall complete and sign the monthly report forms submitted to the Department as required in Subsection 300.06. (12-10-92)

b. In addition to the reporting requirements in 40 CFR 141.75(b) pertaining to systems with filtration treatment, each public water system which provides filtration treatment must report the level of Giardia lamblia and virus inactivation/removal achieved each day by filtration and disinfection. (4-4-13)

07. Recycle Provisions. 40 CFR 141.76 is herein incorporated by reference. (4-4-13)

a. The Department shall evaluate recycling records kept by water systems pursuant to 40 CFR 141.76 during sanitary surveys, comprehensive performance evaluations, or other inspections. (5-3-03)

b. The Department may require a system to modify recycling practices if it can be shown that these

(BREAK IN CONTINUITY OF SECTIONS)

303. SANITARY SURVEYS FOR PUBLIC WATER SYSTEMS USING GROUND WATER.
The Department shall conduct a sanitary survey of all public water systems that use ground water. 40 CFR Part 141, Subpart S, is herein incorporated by reference. (4-4-13)

01. Frequency. For non-community water systems, a sanitary survey shall be conducted every five (5) years. For community water systems, a sanitary survey shall be conducted every three (3) years, except as provided below. (5-8-09)

a. A community water system may have a sanitary survey conducted every five (5) years if the system provides at least a four (4)-log treatment of viruses (using inactivation, removal, or a Department approved combination of 4-log inactivation and removal) before or at the first customer for all of its ground water sources. (5-8-09)

b. A community water system may have a sanitary survey conducted every five (5) years if it has an outstanding performance record, as determined by the Department and documented in previous sanitary surveys, and has no history of Total Coliform Rule or Revised Total Coliform Rule MCL or monitoring violations under Subsection 100.01~~.a.~~ since the last sanitary survey. ~~(5-8-09)~~(____)

02. Report. A report describing the results of the sanitary survey shall be provided to the water system. (5-8-09)

a. As part of the sanitary survey report or as an independent action, the Department shall provide written notice to the water system describing any significant deficiency within thirty (30) days after the Department identifies the significant deficiency. The notice may specify corrective actions and deadlines for completion of corrective actions. (5-8-09)

b. The Department may, at its discretion, provide this written notice at the time of the sanitary survey. (5-8-09)

03. Significant Deficiencies. For each of the eight (8) elements of a sanitary survey of a ground water system, the following deficiencies shall in all cases be considered significant for the purposes of the notice required in Subsection 303.02. Decisions about the significance of other deficiencies identified during the sanitary survey shall be at the Department's discretion, as indicated in the Department's sanitary survey protocol. (5-8-09)

a. Source: Lack of a sanitary well cap as specified in Subsection 511.06.b. (5-8-09)

b. Treatment: (4-4-13)

i. Chemical addition lacks emergency shut-off as specified in Subsection 531.02.b.ii. (4-4-13)

ii. Chemical addition is not flow proportioned where the rate of flow or chemical demand is not reasonably constant, as specified in Subsection 531.02.b.ii. (4-4-13)

c. Distribution system: No means for flushing dead end water mains, as specified in Subsection 542.09. (5-8-09)

d. Finished water storage: Roof leaking, as specified in Subsections 544.09 and 544.09.c. (5-8-09)

e. Pumps, pump facilities, and controls: No accessible check valve between pump and shut-off valve, as specified in Subsection 511.04. (5-8-09)

f. Monitoring, reporting, and data verification: Repeated failure to collect the required number and type of Total Coliform Rule or the Revised Total Coliform Rule samples during the most recent two (2) year period, as specified in Subsection 100.01~~.a~~. ~~(5-8-09)~~(____)

g. System management and operation: History of frequent depressurization in the distribution system in violation of Subsection 552.01. (5-8-09)

h. Operator compliance with state licensing requirements: Responsible charge operator is not licensed as required in Subsection 554.02. (5-8-09)

04. Response Required. The owner of a public water system must respond in writing, describing how and on what schedule the system will address all significant deficiencies, not later than thirty (30) days after receiving notification from the Department. (4-4-13)

05. Consultation with the Department. Public water systems shall consult with the Department prior to taking specific corrective actions in response to significant deficiencies identified during a sanitary survey unless such corrective actions are specified in detail by the Department in its written notification under Subsection 303.02. (5-8-09)

06. Violation. Failure to address significant deficiencies identified in a sanitary survey that are within the control of the public water system and its governing body shall constitute a violation of these rules. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

305. COLIFORM TREATMENT TECHNIQUE TRIGGERS AND ASSESSMENT REQUIREMENTS FOR PROTECTION AGAINST POTENTIAL FECAL CONTAMINATION.
40 CFR 141.859, excluding 40 CFR 141.859(a)(2)(iii), is herein incorporated by reference. (____)

01. Treatment Technique Triggers. Systems owners and operators must ensure that assessments are conducted in accordance with Subsection 305.02 after exceeding treatment technique triggers in this subsection. (____)

a. Level 1 treatment technique triggers: (____)

i. For systems taking forty (40) or more samples per month, the system exceeds five percent (5.0%) total coliform-positive samples for the month. (____)

ii. For systems taking fewer than forty (40) samples per month, the system has two (2) or more total coliform positive samples in the same month. (____)

iii. The system owner or operator fails to take every required repeat sample after any single total coliform-positive sample. (____)

b. Level 2 treatment technique triggers: ( )

i. An *E.coli* MCL violation, as specified in Subsection 050.05 and Subsection 101.01 of these rules; or ( )

ii. A second or any additional Level 1 triggers as defined in Subsection 305.01.a. within a rolling 12-month period, unless the Department has determined a likely reason that the samples that caused the first Level 1 treatment technique trigger were total coliform-positive and has established that the system has corrected the problem. ( )

02. Requirements For Assessments. ( )

a. System owners and operators must ensure that Level 1 and 2 assessments are conducted in order to identify the possible presence of sanitary defects and defects in distribution system coliform monitoring practices. The assessment must be conducted consistent with any Department directives that tailor specific assessment elements with respect to the size and type of the system and the size, type, and characteristics of the distribution system.( )

b. When conducting assessments, owners and operators must ensure that the assessor evaluates minimum elements that include review and identification of inadequacies in sample sites; sampling protocol; sample processing; atypical events that could affect distributed water quality or indicate that distributed water quality was impaired; changes in distribution system maintenance and operation that could affect distributed water quality (including water storage); source and treatment considerations that bear on distributed water quality, where appropriate (e.g., small ground water systems); and existing water quality monitoring data. The system owner or operator must ensure the assessments are consistent with the elements in the Department provided forms for Level 1 and Level 2 assessments. ( )

c. Level 1 Assessments. A system owner or operator must conduct a Level 1 assessment if the system exceeds one of the treatment technique triggers in Subsection 305.01.a. as soon as practical after any trigger level is identified and submit a completed Level 1 assessment report or form to the Department within thirty (30) days after the system learns that it has exceeded a trigger. ( )

i. The completed assessment report or form must describe sanitary defects detected, corrective actions completed, and a proposed timetable for any corrective actions not already completed. The assessment report or form may also note that no sanitary defects were identified. ( )

ii. If the Department reviews the completed Level 1 report or form and determines that the assessment is not sufficient (including any proposed timetable for any corrective actions not already completed), the Department will consult with the owner or operator of the system. If the Department requires revisions after consultation, the system owner or operator must submit a revised assessment report or form to the Department on an agreed-upon schedule not to exceed thirty (30) days from the date of consultation. ( )

iii. Upon completion and submission of the assessment report or form by the system owner or operator, the Department will determine if the system has identified a likely cause for the Level 1 trigger and, if so, establish that the system has corrected the problem, or has included a schedule acceptable to the Department for correcting the problem. ( )

d. Level 2 Assessments. A system owner or operator must ensure that a Level 2 assessment is conducted if the system exceeds one of the treatment technique triggers in Subsection 305.01.b. The owner or operator must comply with any expedited actions or additional action required by the Department in the case of an *E.coli* MCL violation. ( )

i. The system owner or operator must ensure that a Level 2 assessment is conducted by the Department or a party approved by the Department as described in Subsection 305.03 as soon as practical after any trigger in Subsection 305.01.b. and must submit a completed Level 2 assessment report or form to the Department within 30 (thirty) days after the system learns that it has exceeded a trigger if the assessment was conducted by a party other than the Department. ( )

ii. The Department will schedule and conduct Level 2 assessments for an *E.coli* treatment technique trigger in Subsection 305.01.b.i. unless the Department approves another party to conduct the assessment as outlined in Subsection 305.03. ( )

iii. A second or any additional triggered Level 2 Assessment within a rolling twelve-month period must be conducted by a Department approved third party even if the public water system has staff or management approved under Subsection 305.03. ( )

iv. The completed assessment report or form must describe sanitary defects detected, corrective actions completed, and a proposed timetable for any corrective actions not already completed. The assessment report or form may also note that no sanitary defects were identified. ( )

v. If the Department reviews the completed Level 2 report or form and determines that the assessment is not sufficient (including any proposed timetable for any corrective actions not already completed), the Department will consult with the owner or operator of the system. If the Department requires revisions after consultation, the system owner or operator must submit a revised assessment report or form to the Department on an agreed-upon schedule not to exceed 30 (thirty) days from the date of consultation. ( )

vi. Upon completion and submission of the assessment report or form by the system owner or operator, the Department will determine if the system has identified a likely cause for the Level 2 trigger and, if so, establish that the system has corrected the problem, or has included a schedule acceptable to Department for correcting the problem. ( )

e. Corrective action. Systems must correct sanitary defects found through either Level 1 or Level 2 assessments conducted under this section. For corrections not completed by the time of submission of the assessment report or form, the system must complete the corrective action(s) in compliance with a timetable approved by the Department in consultation with the system. The system must notify the Department when each scheduled corrective action is completed. ( )

f. Consultation. At any time during the assessment or corrective action phase, either the water system or the Department may request a consultation with the other party to determine the appropriate actions to be taken. The system may consult with the Department on all relevant information that may impact its ability to comply with a requirement of this Section, including the method of accomplishment, an appropriate timeframe, and other relevant information. ( )

03. Approved Parties for Level 2 Assessments. The system may conduct a Level 2 assessment if the system has staff or management with the certification or qualifications outlined in this Subsection or if the system hires parties that meet the qualifications in this Subsection. The following parties are approved by the Department to conduct Level 2 assessments: ( )

a. The Department or persons contracted with the Department who are trained to conduct sanitary surveys; ( )

b. Currently licensed operators in good standing that are licensed through the Idaho Bureau of Occupational Licensing with a drinking water classification of Distribution I through IV or Treatment I through IV and that are licensed at least to the classification level of the public water system requiring the Level 2 assessment; or ( )

c. Licensed professional engineers licensed by the state of Idaho and qualified by education and experience in the specific technical fields involved in these rules. ( )

(BREAK IN CONTINUITY OF SECTIONS)

552. OPERATING CRITERIA FOR PUBLIC WATER SYSTEMS.

01. Quantity and Pressure Requirements. Design requirements regarding pressure analysis are found in Section 542.13. (5-8-09)

a. Minimum Capacity. The capacity of a public drinking water system shall be at least eight hundred (800) gallons per day per residence. (5-8-09)

i. The minimum capacity of eight hundred (800) gallons per day shall be the design maximum day demand rate exclusive of irrigation and fire flow requirements. (5-8-09)

ii. The minimum capacity of eight hundred (800) gallons per day is only acceptable if the public drinking water system has equalization storage of finished water in sufficient quantity to compensate for the difference between a water system's maximum pumping capacity and peak hour demand. (5-8-09)

iii. The design capacity of a public drinking water system for material modifications may be less than eight hundred (800) gallons per day per residence if the water system owner provides information that demonstrates to the Department's satisfaction the maximum day demand for the system, exclusive of irrigation and fire flows, is less than eight hundred (800) gallons per day per residence. (5-8-09)

b. Pressure. All public water systems shall meet the following requirements: (4-7-11)

i. Any public water system shall be capable of providing sufficient water during maximum day demand conditions, including fire flow where provided, to maintain a minimum pressure of twenty (20) psi throughout the distribution system, at ground level, as measured at the service connection or along the property line adjacent to the consumer's premises. (4-7-11)

ii. Public Notification. (4-4-13)

(1) During unplanned or emergency situations, when water pressure within the system is known to have fallen below twenty (20) psi, the water supplier must notify the Department, provide public notice to the affected customers within twenty-four (24) hours, and disinfect or flush the system as appropriate. When sampling and corrective procedures have been conducted and after determination by the Department that the water is safe, the water supplier may re-notify the affected customers that the water is safe for consumption. The water supplier shall notify the affected customers if the water is not safe for consumption. ~~(4-4-13)~~(____)

(2) During planned maintenance or repair situations, when water pressure within the system is expected to fall below twenty (20) psi, the water supplier must provide public notice to the affected customers prior to the planned maintenance or repair activity and shall ensure that the water is safe for consumption. (4-4-13)

iii. If an initial investigation by the water supplier fails to discover the causes of inadequate or excessive pressure, the Department may require the water supplier to conduct a local pressure monitoring study to diagnose and correct pressure problems. Compliance with these requirements by water systems that do not have a meter vault or other point of access at the service connection or along the property line adjacent to the consumer's premises where pressure in the distribution system can be reliably measured shall be determined by measurements within the consumer's premises, or at another representative location acceptable to the Department. (4-4-13)

iv. Copies of pressure monitoring study reports required under Subsection 552.01.b.iii. detailing study results and any resulting corrective actions planned or performed by the public water system shall be submitted to the Department in accordance with these rules. (4-7-11)

v. The following public water systems or service areas of public water systems shall maintain a minimum pressure of forty (40) psi throughout the distribution system, during peak hour demand conditions, excluding fire flow, measured at the service connection or along the property line adjacent to the consumer's premises. (5-8-09)

(1) Any public water system constructed or substantially modified after July 1, 1985. (5-8-09)

(2) Any new service areas. (5-8-09)

(3) Any public water system that is undergoing material modification where it is feasible to meet the pressure requirements as part of the material modification. (5-8-09)

vi. Any public water system shall keep static pressure within the distribution system below one hundred (100) psi and should ordinarily keep static pressure below eighty (80) psi. Pressures above one hundred (100) psi shall be controlled by pressure reducing valve stations installed in the distribution main. In areas where failure of installed pressure reducing valve stations would result in extremely high pressure, pressure relief valves may be required. The Department may approve the use of pressure reducing devices at individual service connections on a case by case basis, if it can be demonstrated that higher pressures in portions of the distribution system are required for efficient system operation. If system modification will cause pressure to routinely exceed eighty (80) psi, or if a check valve or an individual pressure reducing device is added to the service line, the water system owner shall notify affected customers. Notification may include reasons for the elevated pressure, problems or damage that elevated pressure can inflict on appliances or plumbing systems, and suggested procedures or mitigation efforts affected property owners may initiate to minimize problems or damage. (4-4-13)

vii. The Department may allow the installation of booster pump systems at individual service connections on a case by case basis. However, such an installation may only occur with the full knowledge and agreement of the public water system, including assurance by the water system that the individual booster pump will cause no adverse effects on system operation. (4-11-06)

viii. For elevated storage tanks, pressure calculations during peak hour demand shall be based on the lowest water level after both operational storage and equalization storage have been exhausted. Pressure calculations during fire flow demands shall be based on the lowest water level after operational storage, equalization storage, and fire suppression storage have been exhausted. (4-4-13)

ix. For hydropneumatic tanks, pressure calculations shall be based on the lowest pressure of the pressure cycle and this requirement shall be noted in the operation and maintenance manual. (4-4-13)

c. Fire Flows. Any public water system designed to provide fire flows shall ensure that such flows are compatible with the water demand of existing and planned fire-fighting equipment and fire fighting practices in the area served by the system. (5-3-03)

d. Irrigation Flows. (12-1-92)

i. Any public water system constructed after November 1, 1977, shall be capable of providing water for uncontrolled, simultaneous foreseeable irrigation demand, which shall include all acreage that the system is designed to irrigate. (5-3-03)

(1) The Department must concur with assumptions regarding the acreage to be irrigated. In general, an assumption that no outside watering will occur is considered unsound and is unlikely to be approved. (5-3-03)

(2) An assumption of minimal outside watering, as in recreational subdivisions, may be acceptable if design flows are adequate for maintenance of "green zones" for protection against wildland fire. (5-3-03)

ii. The requirement of Subsection 552.01.d.i. may be modified by the Department if: (5-3-03)

(1) A separate irrigation system is provided; or (12-10-92)

(2) The supplier of water can regulate the rate of irrigation through its police powers, and the water system is designed to accommodate a regulated rate of irrigation flow. The Department may require the water system to submit a legal opinion addressing the enforceability of such police powers. (5-3-03)

iii. If a separate non-potable irrigation system is provided for the consumers, all mains, hydrants and appurtenances shall be easily identified as non-potable. The Department must concur with a plan to ensure that each new potable water service is not cross-connected with the irrigation system. (5-3-03)

02. Ground Water. (12-10-92)

a. Public water systems constructed after July 1, 1985, and supplied by ground water, shall treat water within the system by disinfection if the ground water source is not protected from contamination. (12-10-92)

b. The Department may, in its discretion, require disinfection for any existing public water system supplied by ground water if the system ~~*consistently exceeds the MCL for*~~ has repeated coliform present samples or *E.coli* MCL exceedances, and if the system does not appear adequately protected from contamination. Adequate protection will be determined based upon at least the following factors: ~~*(12-10-92)*~~(____)

i. Location of possible sources of contamination; (12-10-92)

ii. Size of the well lot; (12-10-92)

iii. Depth of the source of water; (12-10-92)

iv. Bacteriological quality of the aquifer; (12-10-92)

v. Geological characteristics of the area; and (12-10-92)

vi. Adequacy of development of the source. (12-10-92)

03. Operating Criteria. The operating criteria for systems that provide filtration shall be as follows: (4-4-13)

a. A project specific operation and maintenance manual shall be provided as required in Subsection 501.12. See definition of Operation and Maintenance Manual in Section 003 for the typical contents of an operation and maintenance manual and the included operations plan. For the operations plan in the operation and maintenance manual, additional guidance for several types of filtration systems can be found in the Department's SWTR Compliance Guidance referenced in Subsection 002.02. (4-4-13)

b. The system shall conduct monitoring specified by the Department before serving water to the public in order to protect the health of consumers served by the system. (4-4-13)

c. New treatment facilities shall be operated in accordance with Subsection 552.03.b., and the system shall conduct monitoring specified by the Department for a trial period specified by the Department before serving water to the public in order to protect the health of consumers served by the system. (3-30-07)

04. Chlorination. Systems that regularly add chlorine to their water are subject to the provisions of Section 320. Systems using surface water or ground water under the direct influence of surface water, are subject to the disinfection requirements of Sections 300 and 518. (3-30-07)

a. Systems using only ground water that add chlorine for the purpose of disinfection, as defined in Section 003, are subject to the following requirements: (4-6-05)

i. Chlorinator and chlorine contact tank capacity shall be such that the system is able to demonstrate that it is routinely achieving four (4) logs (ninety-nine point ninety-nine percent) (99.99%)) inactivation/removal of viruses. The required effective contact time will be specified by the Department. This condition must be attainable even when the plant design capacity coincides with anticipated maximum chlorine demands. (4-4-13)

ii. A detectable chlorine residual shall be maintained throughout the distribution system. (4-6-05)

iii. Automatic proportioning chlorinators are required where the rate of flow or chlorine demand is not reasonably constant. (4-4-13)

iv. Analysis for free chlorine residual shall be conducted at a location at or prior to the first service

connection at least daily and records of these analyses shall be kept by the supplier of water for at least one (1) year. A report of all daily chlorine residual measurements for each calendar month shall be submitted to the Department no later than the tenth day of the following month. The frequency of measuring free chlorine residuals shall be sufficient to detect variations in chlorine demand or changes in water flow. (5-8-09)

v. If gas chlorination equipment is provided, a separate and ventilated room is required. (4-4-13)

vi. The Department may, in its discretion, require a treatment rate higher than that specified in Subsection 552.04.a.i. (3-30-07)

vii. When chlorine gas is used, chlorine leak detection devices and safety equipment shall be provided and equipped with both an audible alarm and a warning light. (5-8-09)

viii. The Department may require redundant chlorine pumping capabilities with automatic switchover for systems with documented source water contamination problems and that lack adequate storage to supply the system during a pump failure. (5-8-09)

b. Systems using only ground water that add chlorine for the purpose of maintaining a disinfectant residual in the distribution system, when the source(s) is not at risk of microbial contamination, are subject to the following requirements: (4-6-05)

i. Automatic proportioning chlorinators are required where the rate of flow or chlorine demand is not reasonably constant. (4-4-13)

ii. Analysis for free chlorine residual shall be made at a frequency that is sufficient to detect variations in chlorine demand or changes in water flow. (4-6-05)

c. Systems using only ground water that add chlorine for other purposes, such as oxidation of metals or taste and odor control, when the source(s) is known to be free of microbial contamination, must ensure that chlorine residual entering the distribution system after treatment is less than four (4.0) mg/L. The requirements in Subsection 552.04.b.ii. also apply if the system maintains a chlorine residual in the distribution system. (3-30-07)

05. Fluoridation. (12-1-92)

a. Commercial sodium fluoride, sodium silico fluoride and hydrofluosilicic acid which conform to the applicable American Water Works Association (AWWA) Standards, incorporated by reference into these rules at Subsection 002.01, are acceptable. Use of other chemicals shall be specifically approved by the Department. (3-30-07)

b. Fluoride compounds shall be stored in covered or unopened shipping containers. (3-30-07)

c. Provisions shall be made to minimize the quantity of fluoride dust. Empty bags, drums, or barrels shall be disposed of in a manner that will minimize exposure to fluoride dusts. (3-30-07)

d. Daily records of flow and amounts of fluoride added shall be kept. An analysis for fluoride in finished water shall be made at least weekly. Records of these analyses shall be kept by the supplier of water for five (5) years. (12-10-92)

06. Cross Connection Control Program - Community Water Systems. The water purveyor is responsible through its cross connection control program to take reasonable and prudent measures to protect the water system against contamination and pollution from cross connections through premises isolation, internal or in-plant isolation, fixture protection, or some combination of premises isolation, internal isolation, and fixture protection. Pursuant to Section 543, all suppliers of water for community water systems shall implement a cross connection control program to prevent the entrance to the system of materials known to be toxic or hazardous. The water purveyor is responsible to enforce the system's cross connection control program. The program will at a minimum include: (4-7-11)

a. An inspection program to locate cross connections and determine required suitable protection. For new connections, suitable protection must be installed prior to providing water service. (5-8-09)

b. Required installation and operation of adequate backflow prevention assemblies. Appropriate and adequate backflow prevention assembly types for various facilities, fixtures, equipment, and uses of water should be selected from the AWWA Pacific Northwest Section Cross Connection Control Manual, the Uniform Plumbing Code, the AWWA Recommended Practice for Backflow Prevention and Cross Connection Control (M14), the USC Foundation Manual of Cross Connection Control, or other sources deemed acceptable by the Department. The assemblies must meet the requirements of Section 543 and comply with local ordinances. (4-4-13)

c. Annual inspections and testing of all installed backflow prevention assemblies by a tester licensed by a licensing authority recognized by the Department. Testing shall be done in accordance with the test procedures published by the University of Southern California Foundation for Cross-Connection Control and Hydraulic Research. See the USC Foundation Manual of Cross-Connection Control referenced in Subsection 002.02. (4-7-11)

d. Discontinuance of service to any structure, facility, or premises where suitable backflow protection has not been provided for a cross connection. (4-7-11)

e. Assemblies that cannot pass annual tests or those found to be defective shall be repaired, replaced, or isolated within ten (10) business days. If the failed assembly cannot be repaired, replaced, or isolated within ten (10) business days, water service to the failed assembly shall be discontinued. (4-4-13)

07. Cross Connection Control - Non-Community Water Systems. All suppliers of water for non-community water systems shall ensure that cross connections do not exist or are isolated from the potable water system by an approved backflow prevention assembly. Backflow prevention assemblies shall be inspected and tested annually for functionality by an Idaho licensed tester, as specified in Subsections 552.06.c. and 552.06.e. (4-4-13)

08. Start-up Procedures For Seasonal Systems Subject To Subsections 100.01.a., c., and d. ( )

a. All seasonal system owners and operators must demonstrate completion of a Department approved start-up procedure, including start-up sampling, prior to serving water to the public. The system owner or operator must submit information on a Department provided or approved form that includes a statement certifying that the system owner or operator followed proper start-up procedures. The form shall be submitted to the Department within 30 (thirty) days following the system's start-up date. ( )

b. The Department may exempt any seasonal system from Subsection 552.08.a. if the entire distribution system remains pressurized during the entire period that the system is not operating, except that the systems that monitor less frequently than monthly must still monitor during the vulnerable period designated by the Department. The Department may exempt a seasonal system from Subsection 552.08.a. if the owner or operator of the system meets all of the following conditions: ( )

i. Requests an exemption in writing to the Department for approval; ( )

ii. Demonstrates a clean compliance history as defined in Section 003 for a minimum of five (5) years; ( )

iii. Has no uncorrected significant deficiencies from the most recent sanitary survey; and ( )

iv. Total coliform samples submitted to a certified laboratory within 30 (thirty) days prior to serving water to the public demonstrate the absence of total coliform. ( )

SENATE HEALTH & WELFARE COMMITTEE
Thursday, January 21, 2016

ATTACHMENT 1 – TAB 2

Overview of Incorporations by Reference for the DEQ Air Quality Program

An efficient way to implement new or updated federal regulations is to incorporate them by reference. Reproducing the Code of Federal Regulations in state rules is impractical and costly. Therefore when possible and as supported by Idaho industry, DEQ incorporates federal regulations by reference. Sections with no changes are also incorporated to ensure the state rules are consistent with federal regulations and to provide one set of rules for industry to follow. Idaho industry is required to comply with all applicable new and updated federal rules regardless of whether DEQ incorporates them by reference.

In addition, for DEQ to be the implementing authority for the Clean Air Act in the state of Idaho, the agency is required to (1) implement the National Ambient Air Quality Standards and (2) implement an air quality operating permit program for facilities with significant emissions.

(1) **National Ambient Air Quality Standards (NAAQS) Implementation**—If an area in Idaho exceeds a National Ambient Air Quality Standard, DEQ will develop a state plan to improve air quality in that area. Whenever EPA updates a federal standard, DEQ also must demonstrate to EPA that it has the authority and infrastructure necessary to implement the new standard. To obtain the appropriate authority, DEQ incorporates by reference the following sections from the Code of Federal Regulations: Parts 50, 51, 52, 53, and 58.

(2) **Operating Permit Program**—Operating permit requirements are outlined under Parts 64 and 70 of the Code of Federal Regulations. To write these permits in Idaho, DEQ must have the authority to put in air permits all of the applicable requirements that have been listed by EPA. These requirements are contained in the Code of Federal Regulations Parts 52, 60, 61, 62, 63, 73, and 82.

To maintain authority for implementing the Clean Air Act in Idaho, DEQ is required to continually demonstrate that our air quality program meets minimum federal requirements.

Note, if DEQ's air program does not meet EPA's minimum requirements, EPA could impose sanctions on Idaho as outlined in the Clean Air Act (42 USC 7509). Under certain circumstances, these sanctions could include withholding federal highway funds or DEQ operating funds.

The following table summarizes the Code of Federal Regulations sections the DEQ Air Quality Program incorporates by reference.

40 CFR Part	Title	Changes During Past Year?	Impact on Idaho
50	National primary and secondary ambient air quality standards	**Yes**	**Minimal**
51	Requirements for preparation, adoption, and submittal of implementation plans	**Yes**	**Minimal**
52	Subparts A and N and Appendices D and E: Approval and promulgation of implementation plans	**Yes**	Administrative
53	Ambient air monitoring reference and equivalent methods	**Yes**	**Minimal**
58	Ambient air surveillance	No	–
60	Standards of performance for new stationary sources	**Yes**	**Yes**
61	National emission standards for hazardous air pollutants	No	–
62	Subpart HHH: Federal plan requirements for hospital/medical/infectious waste incinerators constructed on or before December 1, 2008	No	–
63	National emission standards for hazardous air pollutants for source categories	**Yes**	None
64	Compliance assurance monitoring	No	–
70	State operating permit programs	**Yes**	Administrative
72	Permits	No	–
73	Sulfur dioxide allowance system	No	–
82	Protection of stratospheric ozone	**Yes**	**Minimal**

These changes are discussed in more detail below. The associated Federal Register notices are denoted in parentheses as hyperlinks.

The following part was revised and will have an impact on Idaho facilities:

Part 60: Standards of performance for new stationary sources

- The section describes the permitting requirements for new facilities of specific industries.
- The current update includes four updates to new source performance standards: (1) units that implement continuous opacity monitoring systems (FR-2014-05-16), (2) the oil and natural gas sector (FR-2014-12-31), (3) residential wood heaters (FR-2015-03-16), and (4) and fossil fuel fired power plants (FR-2014-11-19).
- There will be an impact to Idaho from three of these actions. The continuous opacity monitoring update would apply to new source performance standard affected facilities required to implement continuous opacity monitoring. The new requirements for the oil and natural gas sector would be included in applicable air quality permits (like those for Alta Mesa), and the residential wood heater rule applies mainly to woodstove manufacturers (those requirements are implemented by EPA).

The following parts were revised and will have minimal impact on Idaho facilities:

Part 50: National primary and secondary ambient air quality standards

- This section contains the air quality standards that EPA promulgates for the criteria pollutants: course and fine particulate matter (PM_{10} and $PM_{2.5}$), ozone, sulfur dioxide (SO_2), nitrogen dioxide (NO_2), lead, and carbon monoxide (CO).
- This past year EPA promulgated one rule (FR-2015-03-06) in this section that implements the 2008 ozone standard (75 parts per billion).[1]

Part 51: Requirements for preparation, adoption, and submittal of implementation plans

- States are required to have a state implementation plan, which includes our rules and area-specific plans that address NAAQS. This section outlines what state environmental agencies need to include in their state implementation plans.
- There were three actions in this section: one related to reporting lead emissions in a state's emission inventory (FR-2015-02-19), one implementing the 2008 ozone standard (75 parts per billion) (FR-2015-03-06),[1] and another providing for the electronic submission of state implementation plans to EPA (FR-2015-02-10).

Part 53: Ambient air monitoring reference and equivalent methods

- DEQ is required to implement a NAAQS monitoring program in Idaho. Any updates to approved monitoring methods are included in this section. Approved industrial monitoring methods are also included in this section.
- For this incorporation by reference period, there are three updates to monitoring methods that Idaho is incorporating: one for PM_{10} (FR-2014-08-20); one for $PM_{2.5}$, CO, and ozone (FR-2014-11-04); and another for $PM_{2.5}$ and ozone (FR-2015-06-05).

Part 82: Protection of stratospheric ozone

- The purpose of this section is to implement the Montreal Protocol, which addresses substances that deplete the ozone layer.

[1] The ozone standard was lowered to 70 parts per billion in late 2015.

- There are currently five updates to this section DEQ is incorporating by reference: (1) methyl bromide exemptions (FR-2014-07-31), (2) list of substitutes for ozone depleting substances (FR-2014-10-21), (3) allowance system for hydrofluorochlorocarbons (FR-2014-10-28), (4) laboratory exemption for certain ozone depleting substances (FR-2015-01-26), and (5) list of acceptable substitute refrigerants (FR-2015-04-10).

The following parts were revised but are administrative in nature:

Part 52, Subparts A and N and Appendices D and E: Approval and promulgation of implementation plans

- This section contains general provisions associated with state implementation plans and Idaho-specific state implementation plan actions.
- EPA promulgated 11 rules in this section, most of which are EPA responses to Idaho state implementation plan submittals: a PM and ozone infrastructure state implementation plan approval (FR-2014-07-14), a Portneuf Valley state implementation plan motor vehicle budget approval (FR-2014-07-17), a Franklin County PM emission inventory approval (FR-2014-07-18), an NO_2 and SO_2 infrastructure state implementation plan approval (FR-2014-08-11), an approval of the Ada County second 10-year PM_{10} maintenance plan submittal (FR-2014-10-02), recognition that DEQ completed the infrastructure state implementation plan requirements for NO_2 (other states were found out of compliance) (FR-2014-11-24), an update of the rules that have been approved into the Idaho state implementation plan (FR-2015-04-01), the EPA response to the DEQ 2014 incorporation by reference rulemaking submittal (FR-2015-04-07), a $PM_{2.5}$ interstate transport state implementation plan approval (FR-2015-04-17), a rule implementing the 2008 ozone standard (75 parts per billion) (FR-2015-03-06),[1] and another rule providing for the electronic submission of state implementation plans to EPA (FR-2015-02-10).

Part 70: State operating permit programs

- This section describes the minimum requirements for state permitting programs. DEQ is incorporating by reference two updates to this section: one implements the 2008 ozone NAAQS (75 parts per billion) (FR-2015-03-06)[1] and the other fixes an inadvertent change in the compliance certification requirements (FR-2014-07-28).

The following part was revised but Idaho does not have any affected facilities:

Part 63: National emission standards for hazardous air pollutants for source categories

- This section addresses national emission standards for hazardous air pollutants for specific source categories (i.e., industries).
- There are currently 9 updates to rules in this section that DEQ is incorporating by reference: manufacture of amino/phenolic resins (FR-2014-10-08), coal and oil fired energy generating units (FR-2014-11-19, FR-2014-11-19, FR-2015-03-24), polyvinyl chloride and copolymers productions (FR-2015-02-04), off-site waste and recovery operations (FR-2015-03-18), flexible polyurethane foam production (FR-2014-08-15), ferroalloys production (FR-2015-06-30), and an administrative update (FR-2015-06-03).

The following parts were not revised:

Part 58: Ambient air surveillance

- This section describes the requirements for states to operate a monitoring program.

Part 61: National emission standards for hazardous air pollutants

- This section addresses the national emission standards for certain hazardous air pollutants.

Part 62, Subpart HHH: Federal plan requirements for hospital/medical/infectious waste incinerators constructed on or before December 1, 2008

- This section describes the requirements for hospital/medical/infectious waste incinerators. DEQ took delegation of these federal plan requirements.

Part 64: Compliance assurance monitoring

- This section outlines the compliance assurance monitoring requirements for emission units at major sources.

Part 72: Permits

- This section establishes permit requirements under the Acid Rain Program.

Part 73: Sulfur dioxide allowance system

- This part establishes the requirements and procedures for an SO_2 pollutant trading program.
- Idaho currently does not have any sources participating in a pollutant trading program.

IDAPA 58 - DEPARTMENT OF ENVIRONMENTAL QUALITY

58.01.01 - RULES FOR THE CONTROL OF AIR POLLUTION IN IDAHO

DOCKET NO. 58-0101-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the Board of Environmental Quality (Board) and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule will become final and effective immediately upon the adjournment *sine die* of the Second Regular Session of the Sixty-third Idaho Legislature unless prior to that date the rule is rejected in whole or in part by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that the Board has adopted a pending rule. The action is authorized by Sections 39-105 and 39-107, Idaho Code. This rulemaking updates federal regulations incorporated by reference as mandated by the U.S. Environmental Protection Agency (EPA) for approval of Idaho's Title V Operating Permit Program pursuant to 40 CFR Part 70 and fulfilling the requirements of Idaho's delegation agreement with EPA under Section 112(l) of the Clean Air Act. It also updates citations to other federal regulations necessary to retain state primacy of Clean Air Act programs.

DESCRIPTIVE SUMMARY: A detailed summary of the reason for adopting the rule is set forth in the initial proposal published in the Idaho Administrative Bulletin, August 5, 2015, **Vol. 15-8, pages 141 through 146**. DEQ received no public comments, and the rule has been adopted as initially proposed. The Rulemaking and Public Comment Summary can be obtained at **www.deq.idaho.gov/58-0101-1501** or by contacting the undersigned.

IDAHO CODE SECTION 39-107D STATEMENT: This rule does not regulate an activity not regulated by the federal government, nor is it broader in scope or more stringent than federal regulations.

FISCAL IMPACT STATEMENT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year when the pending rule will become effective: Not applicable.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this rulemaking, contact Tiffany Floyd at **tiffany.floyd@deq.idaho.gov** or (208) 373-0440.

Dated this 2nd Day of December, 2015.

Paula J. Wilson
Hearing Coordinator
Department of Environmental Quality
1410 N. Hilton
Boise, Idaho 83706-1255
(208)373-0418/Fax No. (208)373-0481
paula.wilson@deq.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking. The action is authorized by Sections 39-105 and 39-107, Idaho Code. This rulemaking updates federal regulations incorporated by reference as mandated by the U.S. Environmental Protection Agency (EPA) for approval of Idaho's Title V Operating Permit Program pursuant to 40 CFR Part 70 and fulfilling the requirements of Idaho's delegation agreement with EPA under Section 112(l) of the Clean Air Act. It also updates citations to other federal regulations necessary to retain state primacy of Clean Air Act programs.

PUBLIC HEARING SCHEDULE: A public hearing concerning this proposed rulemaking will be held as follows:

Wednesday, September 9, 2015, 3:00 p.m.

Department of Environmental Quality
Conference Room A
1410 N. Hilton, Boise, Idaho

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made no later than five (5) days prior to the hearing. For arrangements, contact the undersigned at (208) 373-0418.

DESCRIPTIVE SUMMARY: The purpose of this rulemaking is to ensure that the state rules are consistent with federal regulations and to update federal regulations incorporated by reference to include those revised as of July 1, 2015.

This rulemaking reconciles Idaho's state rules with federal regulations by making three minor revisions:

1. The greenhouse gas definition of major source at Section 008 is now obsolete after the federal definition was vacated by the U.S. Supreme Court. This definition is being removed.

2. The federal regulations incorporated by reference are updated by capturing revisions as of July 1, 2015 (Section107) and by removing two federal provisions that are no longer required (Sections107.03.q. and 564).

3. The permit to construct section (Section 200) is clarified to define a major source to include both the prevention of significant deterioration (PSD) and nonattainment new source review definitions. The current rule implies that only the PSD definition applies. Idaho is required by federal law to implement both as appropriate.

Members of the regulated community who may be subject to Idaho's air quality rules, special interest groups, public officials, and members of the public who have an interest in the regulation of air emissions from sources in Idaho may be interested in commenting on this proposed rule. The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which public comment should be addressed.

After consideration of public comments, DEQ intends to present the final proposal to the Board of Environmental Quality in the fall of 2015 for adoption of a pending rule. The rule is expected to be final and effective upon adjournment of the 2016 legislative session if adopted by the Board and approved by the Legislature. DEQ will submit the final rule to EPA for approval.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the incorporation by reference is necessary:

Incorporation by reference is necessary to ensure that the state rules are consistent with federal regulations. Information for obtaining a copy of the federal regulations is included in the rule.

NEGOTIATED RULEMAKING: Negotiated rulemaking was not conducted. DEQ determined that negotiated rulemaking is not feasible due to the simple nature of this rulemaking and because DEQ has no discretion with respect to adopting federal regulations that are necessary for EPA approval of Idaho's Title V Operating Permit Program and state primacy of Clean Air Act programs. Whenever possible, DEQ incorporates federal regulations by reference to ensure that the state rules are consistent with federal regulations.

IDAHO CODE SECTION 39-107D STATEMENT: This proposed rule does not regulate an activity not regulated by the federal government, nor is it broader in scope or more stringent than federal regulations.

FISCAL IMPACT STATEMENT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: Not applicable.

ASSISTANCE ON TECHNICAL QUESTIONS AND SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning this rulemaking, contact Tiffany Floyd at **tiffany.floyd@deq.idaho.gov** or (208) 373-0440.

Anyone may submit written comments by mail, fax or e-mail at the address below regarding this proposed rule. DEQ will consider all written comments received by the undersigned on or before September 9, 2015.

DATED this 5th Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 58-0101-1501

008. DEFINITIONS FOR THE PURPOSES OF SECTIONS 300 THROUGH 386.

01. Affected States. All States: (5-1-94)

a. Whose air quality may be affected by the emissions of the Tier I source and that are contiguous to Idaho; or (5-1-94)

b. That are within fifty (50) miles of the Tier I source. (5-1-94)

02. Allowance. An authorization allocated to a Phase II source by the EPA to emit during or after a specified calendar year, one (1) ton of sulfur dioxide. (5-1-94)

03. Applicable Requirement. All of the following if approved or promulgated by EPA as they apply to emissions units in a Tier I source (including requirements that have been promulgated through rulemaking at the time of permit issuance but which have future-effective compliance dates): (5-1-94)

a. Any standard or other requirement provided for in the applicable state implementation plan, including any revisions to that plan that are specified in 40 CFR Parts 52.670 through 52.690. (5-1-94)

b. Any term or condition of any permits to construct issued by the Department pursuant to Sections 200 through 223 or by EPA pursuant to 42 U.S.C. Sections 7401 through 7515; provided that terms or conditions relevant only to toxic air pollutants are not applicable requirements. (4-5-00)

c. Any standard or other requirement under 42 U.S.C. Section 7411 including 40 CFR Part 60; (5-1-94)

d. Any standard or other requirement under 42 U.S.C. Section 7412 including 40 CFR Part 61 and 40 CFR Part 63; (5-1-94)

e. Any standard or other requirement of the acid rain program under 42 U.S.C. Sections 7651 through 7651o; (5-1-94)

f. Any requirements established pursuant to 42 U.S.C. Section 7414(a)(3), 42 U.S.C. Section 7661c(b) or Sections 120 through 128 of these rules; (3-23-98)

g. Any standard or other requirement governing solid waste incineration, under 42 U.S.C. Section 7429; (5-1-94)

h. Any standard or other requirement for consumer and commercial products and tank vessels, under 42 U.S.C. Sections 7511b(e) and (f); and (5-1-94)

i. Any standard or other requirement under 42 U.S.C. Sections 7671 through 7671q including 40 CFR Part 82. (5-1-94)

j. Any ambient air quality standard or increment or visibility requirement provided in 42 U.S.C. Sections 7470 through 7492, but only as applied to temporary sources receiving Tier I operating permits under Section 324. (5-1-94)

04. Designated Representative. A responsible person or official authorized by the owner or operator of a Phase II unit to represent the owner or operator in matters pertaining to the holding, transfer, or disposition of allowances allocated to a Phase II unit, and the submission of and compliance with permits, permit applications, and compliance plans for the Phase II unit. (5-1-94)

05. Draft Permit. The version of a Tier I operating permit that is made available by the Department for public participation and affected State review. (5-1-94)

06. Emergency. For the purposes of Section 332, an emergency is any situation arising from sudden and reasonably unforeseeable events beyond the control of the owner or operator, including acts of God, which situation requires immediate corrective action to restore normal operation and that causes the Tier I source to exceed a technology-based emission limitation under the Tier I operating permit due to unavoidable increases in emissions attributable to the emergency. An emergency shall not include noncompliance to the extent caused by improperly designed equipment, lack of preventative maintenance, careless or improper operation, or operator error. (4-5-00)

07. Final Permit. The version of a Tier I permit issued by the Department that has completed all review procedures required in Sections 364 and 366. (5-1-94)

08. General Permit. A Tier I permit issued pursuant to Section 335. (3-23-98)

09. Insignificant Activity. Those activities that qualify as insignificant in accordance with Section 317. (3-23-98)

10. Major Facility. A facility (as defined in Section 006) is major if the facility meets any of the following criteria: (3-23-98)

a. For hazardous air pollutants: (3-23-98)

i. The facility emits or has the potential to emit ten (10) tons per year (tpy) or more of any hazardous air pollutant, other than radionuclides, which has been listed pursuant to 42 U.S.C. Section 7412(b); provided that emissions from any oil or gas exploration or production well (with its associated equipment) and emissions from any oil or gas pipeline compressor or pump station shall not be aggregated with emissions from other similar emission units within the facility. (5-1-94)

ii. The facility emits or has the potential to emit twenty-five (25) tpy or more of any combination of any hazardous air pollutants, other than radionuclides, which have been listed pursuant to 42 U.S.C. 7412(b); provided that emissions from any oil or gas exploration or production well (with its associated equipment) and emissions from any oil or gas pipeline compressor or pump station shall not be aggregated with emissions from other similar emission units within the facility. (5-1-94)

b. For non-attainment areas: (3-23-98)

i. The facility is located in a "serious" particulate matter (PM-10) nonattainment area and the facility has the potential to emit seventy (70) tpy or more of PM-10. (5-1-94)

ii. The facility is located in a "serious" carbon monoxide nonattainment area in which stationary sources are significant contributors to carbon monoxide levels and the facility has the potential to emit fifty (50) tpy or more of carbon monoxide. (5-1-94)

iii. The facility is located in an ozone transport region established pursuant to 42 U.S.C. Section 7511c and the facility has the potential to emit fifty (50) tpy or more of volatile organic compounds. (5-1-94)

iv. The facility is located in an ozone nonattainment area and, depending upon the classification of the nonattainment area, the facility has the potential to emit the following amounts of volatile organic compounds or oxides of nitrogen; provided that oxides of nitrogen shall not be included if the facility has been identified in accordance with 42 U.S.C. Section 7411a(f)(1) or (2) if the area is "marginal" or "moderate," one hundred (100) tpy or more, if the area is "serious," fifty (50) tpy or more, if the area is "severe," twenty-five (25) tpy or more, and if the area is "extreme," ten (10) tpy or more. (3-23-98)

c. The facility emits or has the potential to emit one hundred (100) tons per year or more of any regulated air pollutant. The fugitive emissions shall not be considered in determining whether the facility is major unless the facility belongs to one (1) of the following categories: (4-11-06)

i. Designated facilities. (3-23-98)

ii. All other source categories regulated by 40 CFR Part 60, 40 CFR Part 61 or 40 CFR Part 63, but only with respect to those air pollutants that have been regulated for that category and only if determined by rule by the Administrator of EPA pursuant to Section 302(j) of the Clean Air Act. (4-5-00)

~~**d.** *For greenhouse gases: As of July 1, 2011, any facility that emits or has the potential to emit one hundred thousand (100,000) tpy or more of any of the aggregate group of six (6) greenhouse gases (carbon dioxide, nitrous oxide, methane, hydrofluorocarbons, perfluorocarbons, and sulfur hexafluoride on a carbon dioxide equivalent basis) and one hundred (100) tpy or more of carbon dioxide on a mass basis, pursuant to 40 CFR 70.2, incorporated by reference into these rules at Section 107.* (4-4-13)~~

(BREAK IN CONTINUITY OF SECTIONS)

107. INCORPORATIONS BY REFERENCE.

01. General. Unless expressly provided otherwise, any reference in these rules to any document identified in Subsection 107.03 shall constitute the full incorporation into these rules of that document for the purposes of the reference, including any notes and appendices therein. The term "documents" includes codes, standards or rules which have been adopted by an agency of the state or of the United States or by any nationally recognized organization or association. (5-1-94)

02. Availability of Referenced Material. Copies of the documents incorporated by reference into these rules are available at the following locations: (5-1-94)

a. All federal publications: U.S. Government Printing Office at ~~*http://www.gpoaccess.gov/ecfr/index.html*~~ http://www.ecfr.gov/cgi-bin/ECFR; and; ~~(3-20-14)~~(____)

b. Statutes of the state of Idaho: http://legislature.idaho.gov/idstat/TOC/IDStatutesTOC.htm; and (3-20-14)

c. All documents herein incorporated by reference: (7-1-97)

i. Department of Environmental Quality, 1410 N. Hilton, Boise, Idaho 83706-1255 at (208) 373-0502. (7-1-97)

ii. State Law Library, 451 W. State Street, P.O. Box 83720, Boise, Idaho 83720-0051, (208) 334-3316. (7-1-97)

03. Documents Incorporated by Reference. The following documents are incorporated by reference into these rules: (5-1-94)

a. Requirements for Preparation, Adoption, and Submittal of Implementation Plans, 40 CFR Part 51 revised as of July 1, 201~~4~~5. The following portions of 40 CFR Part 51 are expressly excluded from any incorporation by reference into these rules: ~~(4-11-15)~~(____)

i. All sections included in 40 CFR Part 51, Subpart P, Protection of Visibility, except that 40 CFR 51.301, 51.304(a), 51.307, and 51.308 are incorporated by reference into these rules; and (3-30-07)

ii. Appendix Y to Part 51, Guidelines for BART Determinations Under the Regional Haze Rule. (3-30-07)

b. National Primary and Secondary Ambient Air Quality Standards, 40 CFR Part 50, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

c. Approval and Promulgation of Implementation Plans, 40 CFR Part 52, Subparts A and N and Appendices D and E, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

d. Ambient Air Monitoring Reference and Equivalent Methods, 40 CFR Part 53, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

e. Ambient Air Quality Surveillance, 40 CFR Part 58, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

f. Standards of Performance for New Stationary Sources, 40 CFR Part 60, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

g. National Emission Standards for Hazardous Air Pollutants, 40 CFR Part 61, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

h. Federal Plan Requirements for Hospital/Medical/Infectious Waste Incinerators Constructed on or Before December 1, 2008, 40 CFR Part 62, Subpart HHH, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

i. National Emission Standards for Hazardous Air Pollutants for Source Categories, 40 CFR Part 63, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

j. Compliance Assurance Monitoring, 40 CFR Part 64, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

k. State Operating Permit Programs, 40 CFR Part 70, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

l. Permits, 40 CFR Part 72, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

m. Sulfur Dioxide Allowance System, 40 CFR Part 73, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

n. Protection of Stratospheric Ozone, 40 CFR Part 82, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

o. Clean Air Act, 42 U.S.C. Sections 7401 through 7671g (1997). (3-19-99)

p. Medical Waste Combustors, Section 39-128, Idaho Code (1992). (3-20-14)

~~q. Determining Conformity of Federal Actions to State or Federal Implementation Plans: Conformity to State or Federal Implementation Plans of Transportation Plans, Programs and Projects Developed, Funded or Approved Under Title 23 U.S.C. or the Federal Transit Laws, 40 CFR Part 93, Subpart A, Sections 93.100 through 93.129, revised as of July 1, 2013, except that Sections 93.102(e), 93.104(d), 93.104(e)(2), 93.105, 93.109(e)-(f), 93.118(e), 93.119(f)(3), 93.120(a)(2), 93.121(a)(1), and 93.124(b) are expressly omitted from the incorporation by reference.~~ ~~(3-20-14)~~

(BREAK IN CONTINUITY OF SECTIONS)

200. PROCEDURES AND REQUIREMENTS FOR PERMITS TO CONSTRUCT.
The purposes of Sections 200 through 228 is to establish uniform procedures and requirements for the issuance of "Permits to Construct." As used throughout Sections 200 through 228 and 578 through 581, major facility shall be defined as major stationary source in 40 CFR 52.21(b) and 40 CFR 51.165, incorporated by reference into these rules at Section 107, and major modification shall be defined as in 40 CFR 52.21(b) and 40 CFR 51.165, incorporated by reference into these rules at Section 107. These CFR sections have been codified in the electronic CFR which is available at www.ecfr.gov. ~~(1-2-08)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

563. TRANSPORTATION CONFORMITY.
The purpose of Sections 563 through 574 is to adopt and implement Section 176(c) of the Clean Air Act (CAA), as amended [42 U.S.C. 7401 et seq.], and the related requirements of 23 U.S.C. 109(j), with respect to the conformity of transportation plans, programs, and projects developed, funded, or approved by the United States Department of Transportation (USDOT), and by metropolitan planning organizations (MPOs) or other recipients of funds under Title 23 U.S.C. or the Federal Transit Laws (49 U.S.C. Chapter 53). These sections set forth policy, criteria, and procedures for demonstrating and assuring conformity of such activities to an applicable implementation plan developed pursuant to Section 110 and Part D of the CAA. The publications referred to ~~or incorporated by reference~~ in Sections 563 through 574 are available from the IDEQ. ~~(3-30-01)~~(____)

564. ~~INCORPORATION BY REFERENCE.~~ (RESERVED)
~~With the exception of Sections 93.102(e), 93.104(d), 93.104(e)(2), 93.105, 93.109(e)-(f), 93.118(e), 93.119(f)(3), 93.120(a)(2), 93.121(a)(1), and 93.124(b), 40 CFR Part 93, Subpart A, Sections 93.100-93.129, are incorporated by reference into these rules at Section 107 of these rules.~~ ~~(3-30-01)~~

SENATE HEALTH & WELFARE COMMITTEE
Thursday, January 21, 2016

ATTACHMENT 1 – TAB 3

Overview of Incorporations by Reference for the DEQ Hazardous Waste Program

Rulemaking docket 58-0105-1501 describes adoption by reference of final federal hazardous waste regulations promulgated with effective dates from July 1, 2014, through June 30, 2015.

Adoption by reference of federal hazardous waste regulations is a routine procedure that DEQ performs annually to: (1) satisfy the consistency and stringency requirements of the Hazardous Waste Management Act (HWMA—Idaho Code, Section 39-4404); (2) meet the legislative intent to avoid the existence of duplicative, overlapping, or conflicting state and federal regulatory systems; and (3) provide for DEQ to maintain primacy and authorization to operate the federal Resource Conservation and Recovery Act (RCRA) program in lieu of EPA.

The public notices for the rulemaking appeared in the August and December 2015 editions of the Idaho Administrative Bulletin. No public hearing was requested or held; no written comments were received from the public, and the Idaho Board of Environmental Quality approved this docket as a pending rule on November 18, 2015. This pending rule is neither broader in scope nor more stringent than federal regulations and does not regulate an activity that is not regulated by the federal government.

The following table summarizes the Code of Federal Regulations sections the DEQ Hazardous Waste Program incorporates by reference. References are listed in the order listed in IDAPA 58.01.05, Rules and Standards for Hazardous Waste. Excluded provisions are specifically identified in the rules.

40 CFR Part	Title	Changes During Past Year?	Impact on Idaho
260	Hazardous Waste Management System	**Yes**	**Yes**
261	Identification and Listing of Hazardous Waste	**Yes**	**Yes**
262	Standards Applicable to Generators of Hazardous Waste	**Yes**	**Yes**
263	Standards Applicable to Transporters of Hazardous Waste	**Yes**	**Yes**
264	Standards for Owners and Operators of Hazardous Waste Treatment, Storage and Disposal Facilities	**Yes**	**Yes**
265	Interim Status Standards for Owners and Operators of Hazardous Waste Treatment, Storage and Disposal Facilities	**Yes**	**Yes**
266	Standards for the Management of Specific Hazardous Wastes and Specific Types of Hazardous Waste Facilities	No	–
268	Land Disposal Restrictions	No	–
270	Hazardous Waste Permit Program	No	–
124	Procedures for Decision-Making (State Procedures for RCRA or HWMA Permit Applications	No	–
279	Standards for the Management of Used Oil	No	–
273	Standards for Universal Waste Management	No	–
278	Criteria for the Management of Granular Mine Tailings (CHAT) in Asphalt Concrete and Portland Cement Concrete in Transportation Construction Projects Funded in Whole or in Part by Federal Funds	No	–
267	Standards for Owners and Operators of Hazardous Waste Facilities Operating Under a Standardized Permit	No	–

These changes are discussed in more detail below. Links to the pdf files associated with the Federal Register notices are denoted in parentheses as hyperlinks.

The following parts were revised and may have an impact on Idaho facilities:

Parts 260, 262, 263, 264, and 265

- EPA is establishing new requirements (www.gpo.gov/fdsys/pkg/FR-2014-02-07/pdf/2014-01352.pdf) that will authorize the voluntary use of electronic manifests as a means to track off-site shipments of hazardous waste from a generator's site to the site of receipt and disposition of the hazardous wastes. The rule establishes the legal and policy framework for the e-Manifest system, but the system is not yet implemented. Certain portions of this rule are non-delegable to the states and must be implemented by EPA. Those portions are identified in the rule.
    - According to the Federal Register, authorized states must adopt program revisions equivalent to and consistent with these federal requirements, but EPA will implement these electronic manifest regulations unless and until the states are fully authorized to implement them in lieu of EPA. The requirements under the e-Manifest Act supersede any requirements under state law that are less stringent than EPA's e-Manifest requirements, and they also supersede any requirements that are non-uniform or inconsistent with EPA's e-Manifest requirements.

The following parts were revised and will have minimal or no impact on Idaho facilities:

Parts 260 and 261

- EPA is revising certain export provisions of the Cathode Ray Tube (CRT) rule (www.gpo.gov/fdsys/pkg/FR-2014-06-26/pdf/2014-14996.pdf). The revisions will allow for better tracking of exports of CRTs for reuse and recycling, ensuring safer management of these materials. Certain portions of this rule are non-delegable to the states and must be implemented by EPA. Those portions are identified in the rule.
    - EPA does not authorize states to administer federal import/export functions in any section of the RCRA hazardous waste regulations. Nevertheless, state programs are still required to adopt these provisions to maintain their equivalency with the federal program.
- EPA is also revising regulations (www.gpo.gov/fdsys/pkg/FR-2015-04-08/pdf/2015-07992.pdf) associated with the comparable fuels exclusion and gasification exclusion originally issued by EPA. These revisions were made as a result of vacaturs ordered by the US Court of Appeals for the District of Columbia Circuit. The Court issued a mandate effectuating the vacatur of the comparable fuels rule on March 30, 2015; the gasification rule vacatur mandate was issued on November 3, 2014. In both vacaturs, the court ruled that the exclusions EPA previously issued violated RCRA Section 3004(q) because fuels produced from solid and hazardous waste remain solid and hazardous waste and cannot be excluded from regulation.
    - EPA will no longer consider state rules that previously were authorized for these exclusions to be part of the authorized program.
    - No Idaho facilities utilized either of these exclusions.

IDAPA 58 - DEPARTMENT OF ENVIRONMENTAL QUALITY

58.01.05 - RULES AND STANDARDS FOR HAZARDOUS WASTE

DOCKET NO. 58-0105-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the Board of Environmental Quality (Board) and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule will become final and effective immediately upon the adjournment *sine die* of the Second Regular Session of the Sixty-third Idaho Legislature unless prior to that date the rule is rejected in whole or in part by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that the Board has adopted a pending rule. The action is authorized by Chapters 44 and 58, Title 39, Idaho Code. In addition, 40 CFR 271.21(e) and Section 39-4404, Idaho Code, require DEQ to adopt amendments to federal law as proposed under this docket.

DESCRIPTIVE SUMMARY: A detailed summary of the reason for adopting the rule is set forth in the initial proposal published in the Idaho Administrative Bulletin, August 5, 2015, **Vol. 15-8, pages 161 through 167.** DEQ received no public comments, and the rule has been adopted as initially proposed. The Rulemaking and Public Comment Summary can be obtained at **www.deq.idaho.gov/58-0105-1501** or by contacting the undersigned.

IDAHO CODE SECTION 39-107D STATEMENT: This rule does not regulate an activity not regulated by the federal government, nor is it broader in scope or more stringent than federal regulations.

FISCAL IMPACT STATEMENT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year when the pending rule will become effective: Not applicable.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this rulemaking, contact Matt Alvarado at **matt.alvarado@deq.idaho.gov** or (208)373-0554.

Dated this 2nd Day of December, 2015.

Paula J. Wilson
Hearing Coordinator
Department of Environmental Quality
1410 N. Hilton
Boise, Idaho 83706-1255
(208)373-0418/Fax No. (208)373-0481
paula.wilson@deq.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking. The action is authorized by Chapters 44 and 58, Title 39, Idaho Code. In addition, 40 CFR 271.21(e) and Section 39-4404, Idaho Code, require DEQ to adopt amendments to federal law as proposed under this docket.

PUBLIC HEARING SCHEDULE: No hearings have been scheduled. Pursuant to Section 67-5222(2), Idaho Code, a public hearing will be held if requested in writing by twenty-five (25) persons, a political subdivision, or an agency. Written requests for a hearing must be received by the undersigned on or before August 19, 2015. If no such written request is received, a public hearing will not be held.

DESCRIPTIVE SUMMARY: Idaho's Rules and Standards for Hazardous Waste are updated annually to maintain consistency with the U.S. Environmental Protection Agency's (EPA's) federal regulations implementing the Resource Conservation and Recovery Act (RCRA) as directed by the Idaho Hazardous Waste Management Act (HWMA). This proposed rule updates federal regulations incorporated by reference to include those revised as of July 1, 2015. In addition, this rulemaking also denotes areas of the rules that are non-delegable to the states and must be implemented by EPA. In those instances, "EPA" will be defined as the U.S. Environmental Protection Agency.

Groups interested in hazardous waste and handlers of hazardous waste including generators, transporters, and treatment, storage, and disposal facilities may be interested in commenting on this proposed rule. The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which public comment should be addressed.

After consideration of public comments, DEQ intends to present the final proposal to the Board of Environmental Quality in the fall of 2015 for adoption of a pending rule. The rule is expected to be final and effective upon the conclusion of the 2016 legislative session if adopted by the Board and approved by the Legislature.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the incorporation by reference is necessary:

Idaho has historically adopted both required and optional federal regulations so that Idaho's hazardous waste rules are the same as federal requirements. Optional federal regulations usually allow more flexibility to the regulated community; required federal regulations are necessary to maintain program primacy. Adoption by reference allows DEQ to keep its rules up to date with federal regulation changes and minimizes the EPA Region 10 effort needed to keep Idaho's authorization current. Adoption by reference also simplifies compliance for the regulated community. Information for obtaining a copy of the federal regulations is included in the rule.

NEGOTIATED RULEMAKING: Negotiated rulemaking was not conducted. DEQ determined that negotiated rulemaking is not feasible due to the simple nature of this rulemaking and because DEQ has no discretion with respect to adopting EPA's federal regulations implementing the Resource Conservation and Recovery Act (RCRA) as directed by the Idaho Hazardous Waste Management Act (HWMA). Whenever possible, DEQ incorporates federal regulations by reference to ensure that the state rules are consistent with federal regulations.

IDAHO CODE SECTION 39-107D STATEMENT: This proposed rule does not regulate an activity not regulated by the federal government, nor is it broader in scope or more stringent than federal regulations.

FISCAL IMPACT STATEMENT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: Not applicable.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on questions concerning the proposed rulemaking, contact Matt Alvarado at **matt.alvarado@deq.idaho.gov** or (208)373-0554.

Anyone can submit written comments by mail, fax or e-mail at the address below regarding this proposed rule. The Department will consider all written comments received by the undersigned on or before September 2, 2015.

Dated this 5th Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 58-0105-1501

002. INCORPORATION BY REFERENCE OF FEDERAL REGULATIONS.
Any reference in these rules to requirements, procedures, or specific forms contained in the Code of Federal Regulations (CFR), Title 40, Parts 124, 260 - 268, 270, 273, 278, and 279 shall constitute the full adoption by reference of that part and Subparts as they appear in 40 CFR, revised as of July 1, 2014~~4~~5, including any notes and appendices therein, unless expressly provided otherwise in these rules. ~~(4-11-15)~~(____)

01. Exceptions. Nothing in 40 CFR Parts 260 - 268, 270, 273, 278, 279 or Part 124 as pertains to permits for Underground Injection Control (U.I.C.) under the Safe Drinking Water Act, the Dredge or Fill Program under Section 404 of the Clean Water Act, the National Pollution Discharge Elimination System (NPDES) under the Clean Water Act or Prevention of Significant Deterioration Program (PSD) under the Clean Air Act is adopted or included by reference herein. (5-8-09)

02. Availability of Referenced Material. The federal regulations adopted by reference throughout these rules are maintained at the following locations: (7-2-97)

a. U.S. Government Printing Office, ~~http://wwwgpoaccess.gov/cefr/index.html~~ http://www.ecfr.gov/cgi-bin/ECFR; and ~~(4-7-11)~~(____)

b. State Law Library, 451 W. State Street, P.O. Box 83720, Boise, ID 83720-0051, (208) 334-3316; and (7-2-97)

c. Department of Environmental Quality, 1410 N. Hilton, Boise, ID 83706-1255, (208) 373-0502. (7-2-97)

(BREAK IN CONTINUITY OF SECTIONS)

004. HAZARDOUS WASTE MANAGEMENT SYSTEM.
40 CFR Part 260 and all Subparts, except 40 CFR 260.2, are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 2014~~4~~5. For the purposes of 40 CFR 260.10 in the definition of electronic manifest and electronic manifest system, "EPA" shall be defined as the U.S. Environmental Protection Agency. For purposes of 40 CFR 260.10, in the definition of hazardous waste constituent, "Administrator" shall be defined as the U.S. Environmental Protection Agency Administrator. For purposes of 40 CFR 260.20, "Federal Register" shall be defined as the Idaho Administrative Bulletin. ~~(4-11-15)~~(____)

005. IDENTIFICATION AND LISTING OF HAZARDOUS WASTE.
40 CFR Part 261 and all Subparts (excluding 261.4(b)(17)), except the language "in the Region where the sample is collected" in 40 CFR 261.4(e)(3)(iii), are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 2014~~4~~5. For purposes of 40 CFR 261.10 and 40 CFR 261.11, "Administrator" shall be defined as the U.S. Environmental Protection Agency Administrator. ~~For purposes of 40 CFR 261.41(a), Regional Administrator shall be defined as U.S. Environmental Protection Agency Region 10 Regional Administrator. Copies of advance notification required under this section should also be sent to the Director.~~ For purposes of 40 CFR 261.4(b)(11)(ii), 40 CFR 261.39(a)(5), 40 CFR 261.41, and 40 CFR 261 Appendix IX, "EPA" shall be defined as the U.S. Environmental Protection Agency. Copies of annual reports and advance notifications under these sections shall also be sent to the Director. ~~(4-11-15)~~(____)

01. Excluded Wastes. Chemically Stabilized Electric Arc Furnace Dust (CSEAFD) generated by Envirosafe Services of Idaho, Inc. (ESII) at ESII's facility in Grand View, Idaho using the Super Detox(R) treatment process as modified by ESII and that is disposed of in a Subtitle D or Subtitle C landfill is excluded from the lists of hazardous waste provided ESII implements a program that meets the following conditions: (3-16-96)

a. Verification Testing Requirements. Sample Collection and analyses, including quality control procedures, conducted pursuant to Subsections 005.01.b. and 005.01.c., must be performed according to SW-846 methodologies and the RCRA Part B permit, including future revisions. (3-16-96)

b. Initial Verification Testing. (3-16-96)

i. For purposes of Subsections 005.01.b., "new source" shall mean any generator of Electric Arc Furnace Dust (EAFD), EPA and Idaho Department of Environmental Quality Hazardous Waste No. KO61, whose waste has not previously been processed by ESII using the Super Detox(R) treatment process resulting in processed EAFD which has been subjected to initial verification testing and has demonstrated compliance with the delisting levels specified in Subsection 005.01.d. (3-16-96)

ii. Prior to the initial treatment of any new source of EAFD, ESII must notify the Department in writing. The written notification shall include: (3-16-96)

(1) The waste profile information; and (3-16-96)

(2) The name and address of the generator. (3-16-96)

iii. The first four (4) consecutive batches treated must be sampled in accordance with Subsection 005.01.a. Each of the four (4) samples shall be analyzed to determine if the CSEAFD generated meets the delisting levels specified in Subsection 005.01.d. (3-16-96)

iv. If the initial verification testing demonstrates that the CSEAFD samples meet the delisting levels specified in Subsection 005.01.d., ESII shall submit the operational and analytical test data, including quality control information, to the Department, in accordance with Subsection 005.01.f. Subsequent to such data submittal, the CSEAFD generated from EAFD originating from the new source shall be considered delisted. (3-16-96)

v. CSEAFD generated by ESII from EAFD originating from a new source shall be managed as hazardous waste in accordance with Subtitle C of RCRA until: (3-16-96)

(1) Initial verification testing demonstrates that the CSEAFD meets the delisting levels specified in Subsection 005.01.d.; and (3-16-96)

(2) The operational and analytical test data is submitted to the Department pursuant to Subsection 005.01.b.iv. (3-16-96)

vi. For purposes of Subsections 005.01.b. and 005.01.c., "batch" shall mean the CSEAFD which results from a single treatment episode in a full scale mixing vessel. (3-16-96)

c. Subsequent Verification Testing. (3-16-96)

i. Subsequent to initial verification testing, ESII shall collect a representative sample, in accordance with Subsection 005.01.a., from each batch of CSEAFD generated by ESII. ESII may, at its discretion, conduct subsequent verification testing on composite samples. In no event shall a composite sample consist of representative samples from more than twenty (20) batches of CSEAFD. (3-16-96)

ii. The samples shall be analyzed prior to disposal of each batch of CSEAFD to determine if the CSEAFD meets the delisting levels specified in Subsection 005.01.d. (3-16-96)

iii. Each batch of CSEAFD generated by ESII shall be subjected to subsequent verification testing no later than thirty (30) days after it is generated by ESII. (3-16-96)

iv. If the levels of constituents measured in a sample, or composite sample, of CSEAFD do not exceed the levels set forth in Subsection 005.01.d., then any batch of CSEAFD which contributed to the sample that does not exceed the levels set forth in Subsection 005.01.d. is non-hazardous and may be managed and/or disposed of in a Subtitle D or Subtitle C landfill. (3-16-96)

v. If the constituent levels in a sample, or composite sample, exceed any of the delisting levels set forth in Subsection 005.01.d., then ESII must submit written notification of the results of the analysis to the Department within fifteen (15) days from receiving the final analytical results, and any CSEAFD which contributed

to the sample must be: (3-16-96)

(1) Retested, and retreated if necessary, until it meets the levels set forth in Subsection 005.01.d.; or (3-16-96)

(2) Managed and disposed of in accordance with Subtitle C of RCRA. (3-16-96)

vi. Each batch of CSEAFD shall be managed as hazardous waste in accordance with Subtitle C of RCRA until subsequent verification testing demonstrates that the CSEAFD meets the delisting levels specified in Subsection 005.01.d. (3-16-96)

d. Delisting Levels. (3-16-96)

i. All leachable concentrations for these metals must not exceed the following levels (mg/l):

antimony	0.06		mercury	0.009
arsenic	0.50		nickel	1
barium	7.60		selenium	0.16
beryllium	0.010		silver	0.30
cadmium	0.050		thallium	0.020
chromium	0.33		vanadium	2
lead	0.15		zinc	70

(3-16-96)

ii. Metal concentrations must be measured in the waste leachate by the method specified in 40 CFR Part 261.24. (3-16-96)

e. Modification of Treatment Process. (3-16-96)

i. If ESII makes a decision to modify the Super Detox(R) treatment process from the description of the process as set forth in ESII's Petition for Delisting Treated K061 Dust by the Super Detox(R) Process submitted to the Department on July 14, 1995, ESII shall notify the Department in writing prior to implementing the modification. (3-16-96)

ii. After ESII's receipt of written approval from the Department, and subject to any conditions included with the approval, ESII may implement the proposed modification. (3-16-96)

iii. If ESII modifies its treatment process without first receiving written approval from the Department, this exclusion of waste will be void from the time the process was modified. (3-16-96)

iv. ESII's Petition for Delisting Treated K061 Dust by the Super Detox(R) Process submitted to the Department on July 14, 1995 is available at the Department of Environmental Quality, Waste Management and Remediation Division, 1410 N. Hilton, Boise, Idaho 83706. (3-29-12)

f. Records and Data Retention and Submittal. (3-16-96)

i. Records of disposal site, operating conditions and analytical data from verification testing must be compiled, summarized, and maintained at ESII's Grand View facility for a minimum of five (5) years from the date the records or data are generated. (3-16-96)

ii. The records and data maintained by ESII must be furnished upon request to the Department or EPA. (3-16-96)

iii. Failure to submit requested records or data within ten (10) business days of receipt of a written request or failure to maintain the required records and data on site for the specified time, will be considered by the Department, at its discretion, sufficient basis to revoke the exclusion to the extent directed by the Department. (3-16-96)

iv. All records or data submitted to the Department must be accompanied by a signed copy of the following certification statement to attest to the truth and accuracy of the records or data submitted: "Under civil and/ or criminal penalty of law for the making or submission of false or fraudulent statements or representations, I certify that the information contained in or accompanying this document is true, accurate, and complete. As to any identified sections of this document for which I cannot personally verify the truth and accuracy, I certify as the ESII official having supervisory responsibility for the persons who, acting under my direct instructions, made the verification that this information is true, accurate, and complete. In the event that any of this information is determined by the Department in its sole discretion to be false, inaccurate, or incomplete, and upon conveyance of this fact to ESII, I recognize and agree that this exclusion of waste will be void as if it never had effect or to the extent directed by the Department and that ESII will be liable for any actions taken in contravention of ESII's RCRA and CERCLA obligations premised upon ESII's reliance on the void exclusion." (3-16-96)

g. Facility Merger and Name Change. On May 4, 2001, the Department was notified of a stock transfer that resulted in ESII's facility merging with American Ecology. This created a name change from Envirosafe Services of Idaho, Inc. (ESII) to US Ecology Idaho, Inc. effective May 1, 2001. All references to Envirosafe Services of Idaho, Inc. or ESII now refer to US Ecology Idaho, Inc. (3-15-02)

006. STANDARDS APPLICABLE TO GENERATORS OF HAZARDOUS WASTE.

01. Incorporation by Reference. 40 CFR Part 262 and all Subparts (excluding Subparts I and J and 40 CFR 262.10(j), 262.34(j),(k),(l)), except for the language "for the Region in which the generator is located" in 40 CFR 262.42(a)(2) and 40 CFR 262.42(b), are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 201~~4~~5. For purposes of 40 CFR 262.53, 262.55, and 262.56, "EPA" shall be defined as the U.S. Environmental Protection Agency. Copies of advance notification, annual reports, and exception reports, required under those sections, shall also be provided to the Director. For purposes of 40 CFR 262.20, 262.21, 262.24, 262.25, 262.51, ~~262.53,~~ 262.54(e), 262.54(g)(1), 262.55, 262.56, 262.60, and 262.85(g), EPA or Environmental Protection Agency shall be defined as the U.S. Environmental Protection Agency. For purposes of 40 CFR Part 262 Subparts E, F, H, and 40 CFR 262.41(a)(4), "United States or U.S." shall be defined as the United States. ~~(4-11-15)~~(____)

02. Generator Emergency Notification. In addition to the emergency notification required by 40 CFR 265.56(d)(2), 262.34(d)(5)(iv)(C), (see 40 CFR 262.34(a)(4)), 263.30(c)(1), and 264.56(d)(2), the emergency coordinator must also immediately notify the State Communications Center by telephone, 1-800-632-8000, to file an identical report. (3-15-02)

007. STANDARDS APPLICABLE TO TRANSPORTERS OF HAZARDOUS WASTE.
40 CFR Part 263 and all Subparts are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 201~~4~~5. For purposes of 40 CFR 263.20(g), 263.20(g)(1), 263.20(g)(4), 263.21(a)(4), and 263.22(d), "United States" shall be defined as the United States. For the purposes of 40 CFR 263.20(a), "EPA" shall be defined as U.S. Environmental Protection Agency. ~~(4-11-15)~~(____)

008. STANDARDS FOR OWNERS AND OPERATORS OF HAZARDOUS WASTE TREATMENT, STORAGE AND DISPOSAL FACILITIES.
40 CFR Part 264 and all Subparts (excluding 40 CFR 264.1(f), 264.1(g)(12), 264.149, 264.150, 264.301(l), 264.1030(d), 264.1050(g), 264.1080(e), 264.1080(f) and 264.1080(g)) are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 201~~4~~5. For purposes of 40 CFR Subsection 264.12(a), "Regional Administrator" shall be defined as the U.S. Environmental Protection Agency Region 10 Regional Administrator. For purposes of 40 CFR 264.71~~(a)(3)~~ and 264.1082(c)(4)(ii), "EPA" shall be defined as the U.S. Environmental Protection Agency. ~~(4-11-15)~~(____)

009. INTERIM STATUS STANDARDS FOR OWNERS AND OPERATORS OF HAZARDOUS WASTE TREATMENT, STORAGE AND DISPOSAL FACILITIES.

40 CFR Part 265, and all Subparts (excluding Subpart R, 40 CFR 265.1(c)(4), 265.1(c)(15), 265.149, 265.150, 265.1030(c), 265.1050(f), 265.1080(e), 265.1080(f), and 265.1080(g)), except the language contained in 40 CFR 265.340(b)(2) as replaced with: "The following requirements continue to apply even when the owner or operator has demonstrated compliance with the MACT requirements of part 63, subpart EEE of this chapter: 40 CFR 265.351 (closure) and the applicable requirements of Subparts A through H, BB and CC of this part," are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 201~~4~~5. For purposes of 40 CFR Subsection 265.12(a), "Regional Administrator" shall be defined as the U.S. Environmental Protection Agency Region 10 Regional Administrator. For purposes of 40 CFR 265.71~~(a)(3)~~ and 265.1083(c)(4)(ii), "EPA" shall be defined as the U.S. Environmental Protection Agency. ~~(4-11-15)~~(____)

010. STANDARDS FOR THE MANAGEMENT OF SPECIFIC HAZARDOUS WASTES AND SPECIFIC TYPES OF HAZARDOUS WASTE FACILITIES.
40 CFR Part 266 and all Subparts are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

011. LAND DISPOSAL RESTRICTIONS.
40 CFR Part 268 and all Subparts are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 201~~4~~5, except for 40 CFR 268.1(e)(3), 268.5, 268.6, 268.13, 268.42(b), and 268.44(a) through (g). The authority for implementing the provisions of these excluded sections remains with the EPA. However, the requirements of Sections 39-4403(17) and 39-4423, Idaho Code, shall be applied in all cases where these requirements are more stringent than the federal standards. If the Administrator of the EPA grants a case-by-case variance pursuant to 40 CFR 268.5, that variance will simultaneously create the same case-by-case variance to the equivalent requirement of these rules. For purposes of 40 CFR 268.(2)(j) "EPA" shall be defined as the U.S. Environmental Protection Agency. For purposes of 40 CFR 268.40(b), "Administrator" shall be defined as U.S. Environmental Protection Agency Administrator. In 40 CFR 268.7(a)(9)(iii), "D009" is excluded, (from lab packs as noted in 40 CFR Part 268 Appendix IV.)
~~(4-11-15)~~(____)

012. HAZARDOUS WASTE PERMIT PROGRAM.
40 CFR Part 270 and all Subparts, except 40 CFR 270.1(c)(2)(ix), 270.12(a) and 40 CFR 270.14(b)(18), are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 201~~4~~5. For purposes of 40 CFR 270.2, 270.5, 270.10(e)(2), 270.10(e)(3), 270.10(f)(2), 270.10(f)(3), 270.10(g), 270.11(a)(3), 270.32(a), 270.32(b)(2), 270.32(c), 270.51, 270.72(a)(5), and 270.72(b)(5), "EPA" and "Administrator" or "Regional Administrator" shall be defined as the U.S. Environmental Protection Agency and the U.S. Environmental Protection Agency Region 10 Regional Administrator respectively. ~~(4-11-15)~~(____)

013. PROCEDURES FOR DECISION-MAKING (STATE PROCEDURES FOR RCRA OR HWMA PERMIT APPLICATIONS).
40 CFR Part 124, Subparts A, B and G are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 201~~4~~5, except that the last sentence of 40 CFR 124.10(b)(1), 40 CFR 124.19, the fourth sentence of 40 CFR 124.31(a), the third sentence of 40 CFR 124.32(a), and the second sentence of 40 CFR 124.33(a) are expressly omitted from the incorporation by reference of each of those subsections. For purposes of 40 CFR 124.6(e), 124.10(b), and 124.10(c)(1)(ii) "EPA" and "Administrator" or "Regional Administrator" shall be defined as the U.S. Environmental Protection Agency and the U.S. Environmental Protection Agency Region 10 Regional Administrator, respectively. ~~(4-11-15)~~(____)

014. (RESERVED)

015. STANDARDS FOR THE MANAGEMENT OF USED OIL.

01. Incorporation by Reference. 40 CFR Part 279 and all Subparts are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 201~~4~~5. For purposes of 40 CFR 279.43(c)(3)(ii) "Director" shall be defined as the Director, U.S.DOT Office of Hazardous Materials Regulation. ~~(4-11-15)~~(____)

02. Used Oil as a Dust Suppressant. 40 CFR Part 279 contains a prohibition on the use of used oil as a dust suppressant at 279.82(a), however, States may petition EPA to allow the use of used oil as a dust suppressant. Members of the public may petition the State to make this application to EPA. This petition to the State must:
(2-11-94)

a. Be submitted to the Idaho Department of Environmental Quality, 1410 North Hilton, Boise, Idaho 83706-1255; and (2-11-94)

b. Demonstrate how the requirements of 40 CFR 279.82(b) will be met. (2-11-94)

016. STANDARDS FOR UNIVERSAL WASTE MANAGEMENT.
40 CFR Part 273 and all Subparts are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 201~~4~~5. For purposes of 40 CFR 273.32(a)(3), "EPA" shall be defined as the U.S. Environmental Protection Agency. ~~(4-11-15)~~(____)

017. CRITERIA FOR THE MANAGEMENT OF GRANULAR MINE TAILINGS (CHAT) IN ASPHALT CONCRETE AND PORTLAND CEMENT CONCRETE IN TRANSPORTATION CONSTRUCTION PROJECTS FUNDED IN WHOLE OR IN PART BY FEDERAL FUNDS.
40 CFR Part 278 and all Subparts are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

018. STANDARDS FOR OWNERS AND OPERATORS OF HAZARDOUS WASTE FACILITIES OPERATING UNDER A STANDARDIZED PERMIT.
40 CFR Part 267 and all Subparts, except 40 CFR 267.150, are herein incorporated by reference as provided in 40 CFR, revised as of July 1, 201~~4~~5. ~~(4-11-15)~~(____)

SENATE HEALTH & WELFARE COMMITTEE
Thursday, January 21, 2016

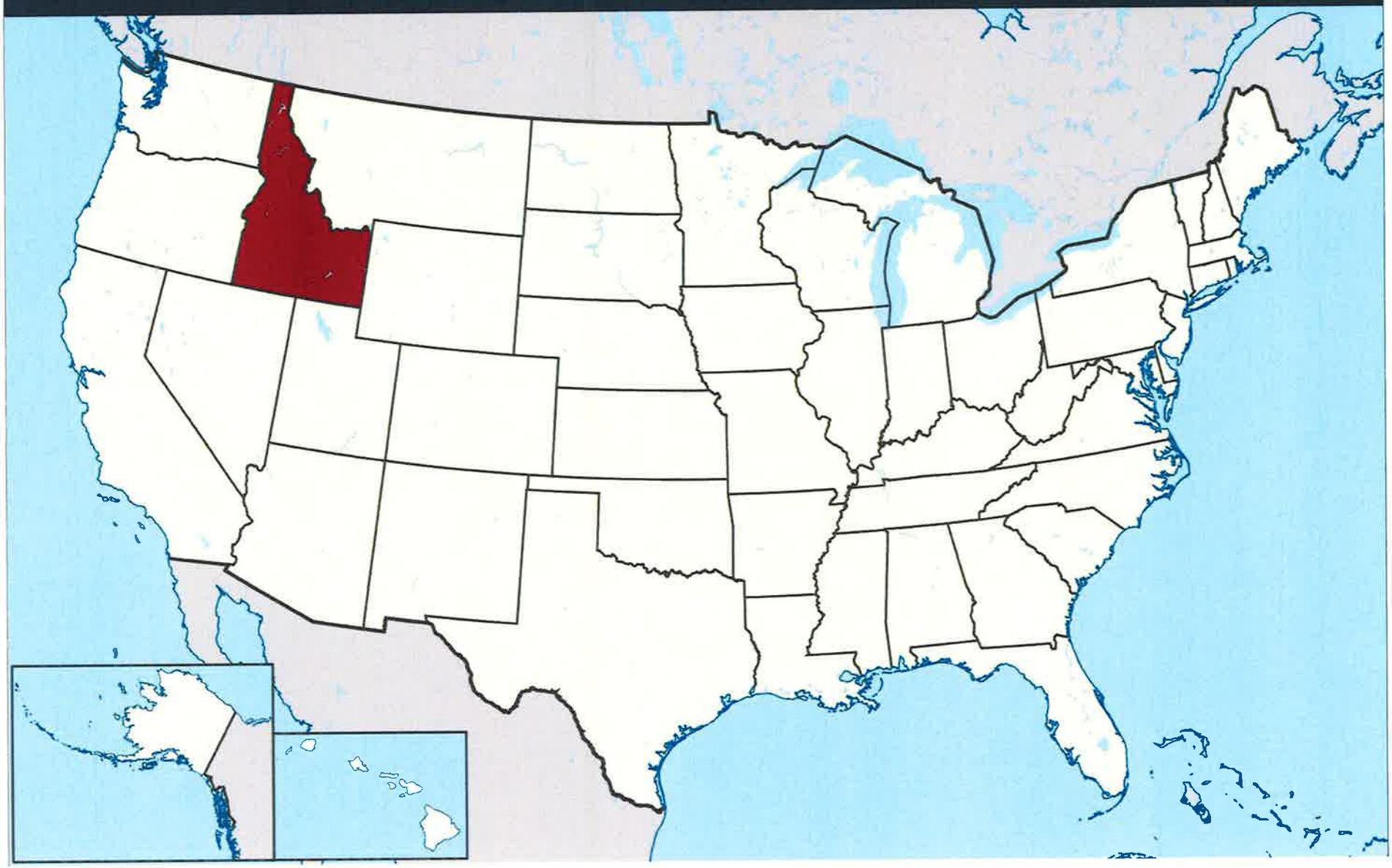
ATTACHMENT 2

Idaho Department of Environmental Quality

Rules for the Control of Air Pollution in Idaho

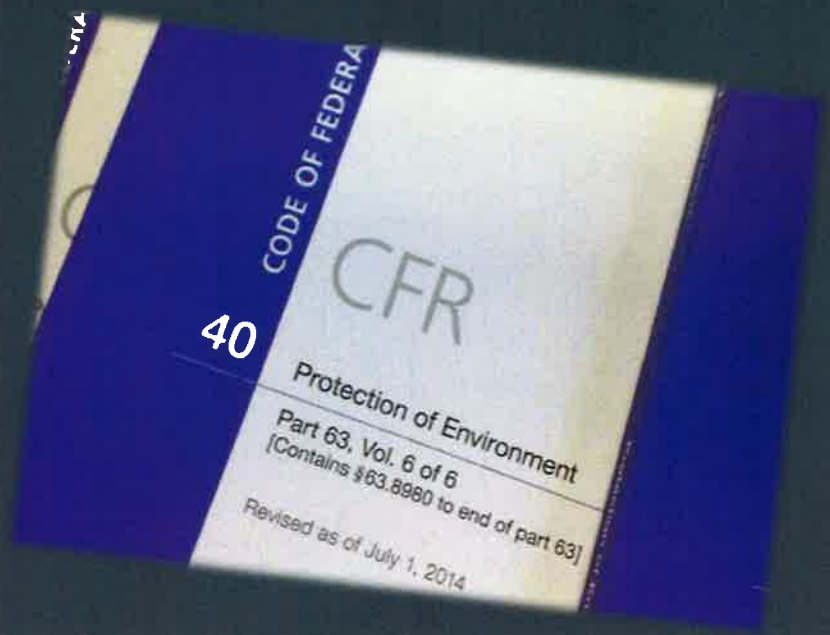
Docket No. 58-0101-1501

Implementing the Clean Air Act



Rule Docket Summary

- Annual incorporation by reference
- Current as of July 1, 2015
- See review summary for full details



Minor Revisions

- Delete obsolete sections
- Clarify permitting language

Public Participation

- No negotiated rulemaking
- Public comment period & public hearing
  - No comments received

SENATE HEALTH & WELFARE COMMITTEE
Thursday, January 21, 2016

ATTACHMENT 3

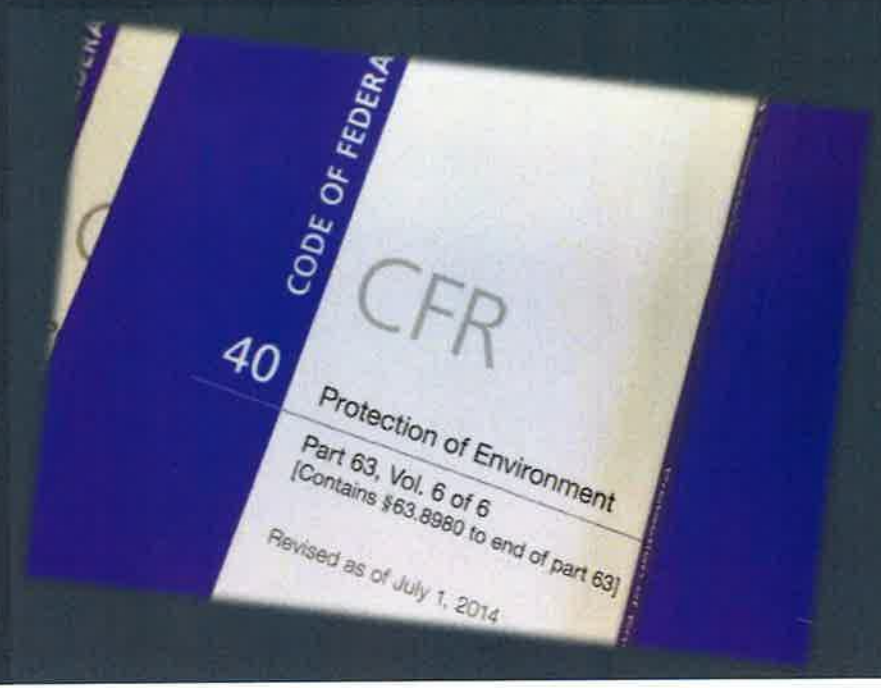
Idaho Department of Environmental Quality

Rules & Standards for Hazardous Waste

Docket No. 58-0105-1501

Rule Docket Summary

- Annual incorporation by reference
- Current as of July 1, 2015
- See review summary for full details



Why was rulemaking necessary?

Idaho Code requires DEQ to:

- Enact and carryout the program
- Promulgate rules consistent with federal requirements
- Avoid duplicative, overlapping, or conflicting regulations

Public Participation

- Public notice of proposed rule in August 2015
- No public hearing requested
- No written comments received
- Board approved rule November 18, 2015
- Public notice of pending rule in December 2015

Stringency

- Proposed changes are not broader in scope nor more stringent than federal regulations
- Proposed changes do not regulate an activity not regulated by the federal government

What does the rule do?

- Incorporates the electronic manifest system
- Incorporates revisions to the export provisions of the Cathode Ray Tube Rule
- Responds to vacaturs of the Comparable Fuels Rule and Gasification Rule

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, January 25, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Docket No. 16-0201-1401	PENDING FEE RULE: Rules of the Idaho Time Sensitive Emergency System Council	**Dr. Bill Morgan**, Chairman Time Sensitive Emergency System Council
Docket No. 16-0310-1501	PENDING RULE: Medicaid Enhanced Plan Benefits	**Art Evans** Division of Medicaid
Docket No. 16-0313-1501	PENDING RULE: Consumer-Directed Services	**Art Evans**
Docket No. 16-0304-1501	PENDING RULE: Rules Governing the Food Stamp Program in Idaho	**Kristen Matthews** Division of Welfare
Docket No. 16-0402-1501	PENDING RULE: Idaho Telecommunication Service Assistance Program Rules	**Kristen Matthews**
Docket. No. 16-0413-1501	PENDING RULE: Rules Governing the Emergency Food Assistance Program	**Kristen Matthews**
Docket No. 16-0414-1501	PENDING RULE: Rules Governing the Low Income Home Energy Assistance Program	**Kristen Matthews**
Docket No. 16-0416-1501	PENDING RULE: Weatherization Assistance Program in Idaho	**Kristen Matthews**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

Sen Martin

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Monday, January 25, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the Senate Health and Welfare Committee (Committee) meeting to order at 3:01 p.m.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Nuxoll.

DOCKET NO. 16-0201-1401

Rules of the Department of Health and Welfare related to the Idaho Time Sensitive Emergency System Council. **Dr. Bill Morgan**, Chairman of the Time Sensitive Emergency (TSE) System Council (Council), presented this docket.

Dr. Morgan said, over the past year, the Council has rewritten some of the temporary rules. Notice of rulemaking regarding the proposed rule and amendment to temporary rule was published in July 2015. **Dr. Morgan** reviewed the main changes in the proposed rule including, (i) updating the standard manuals to include stroke and STEMI (ST-segment elevation myocardial infarctions) designations in addition to the trauma designation; and (ii) revising the fiscal impact wording to be more specific. **Dr. Morgan** reported that the six regional TSE committees for the State have been organized; and he noted that the Council had received its first application from a facility requesting state-designation as a level-four trauma center. Highlighting a new provision related to communication between surveyors and facilities, **Dr. Morgan** stated that, in order to standardize ethical practice, all communication between surveyors and facilities prior to the survey must now be facilitated by a Time Sensitive Emergency (TSE) program staff member.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Martin requested more information on how the program is doing overall. **Dr. Morgan** stated that the Council is a very cohesive group of individuals who all have a similar goal: making health care better for everyone in Idaho. The State was divided into six regional TSE committees; the first to start operating was the region two TSE committee in the Lewiston area. The region two TSE committee conducted peer review of patients transferred within their region, identified issues and corrected those issues; and, now, patient flows in the region are much better. **Dr. Morgan** reiterated that a critical access hospital in Arco has submitted the first application requesting state-designation as a level-four trauma center. Additionally, **Dr. Morgan** said there are currently three level-two trauma centers in Idaho that have been verified by the American College of Surgeons: Saint Alphonsus Regional Medical Center in Boise, Portneuf Medical Center in Pocatello and Eastern Idaho Regional Medical Center in Idaho Falls. **Dr. Morgan** said all of them have submitted applications to become state-designated and will re-designate through the American College of Surgeons.

Vice Chairman Nuxoll inquired as to why a facility would want to be a state-designated TSE center. **Dr. Morgan** responded that he thinks that the representatives of the facilities realized that they can be something better as a group than they could as individuals. **Dr. Morgan** added that he thinks facilities want to improve patient care and communications. **Vice Chairman Nuxoll** asked if the fiscal impact is $225,800 to the General Fund. **Dr. Morgan** confirmed. **Vice Chairman Nuxoll** asked what types of facilities could be state-designated, TSE centers. **Dr. Morgan** responded that it has been the Council's intention that any hospital in Idaho that meets the criteria and chooses to apply can become a state-designated, TSE center. **Vice Chairman Nuxoll** asked if state-designated TSE centers would have to raise rates to cover their fees for state-designation. **Dr. Morgan** said no, a charge is a charge. There is one proviso, an activation fee, and it's only for trauma.

Senator Hagedorn inquired about the progress for improving information-sharing among facilities. **Dr. Morgan** responded that information is shared through the regional committees. In particular, **Dr. Morgan** noted that the sharing of educational information would increase as the Council began reviewing and designating TSE facilities.

Vice Chairman Nuxoll inquired about the relationship between the medical community and the Council. **Dr. Morgan** answered he has not heard anything negative, just positive.

MOTION: There being no more questions, **Senator Martin** moved to approve **Docket 16-0201-1401**. **Chairman Heider** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0310-1501 **Rules of the Department of Health and Welfare related to Medicaid Enhanced Plan Benefits**. **Arthur Evans**, Bureau Chief of Developmental Disability Services for the Division of Medicaid and the Department of Health and Welfare (Department), presented this docket.

Mr. Evans said the proposed rules are designed to ensure people who receive Home and Community Based Services (HCBS) have the same rights and freedoms as an individual who does not require or receive help to remain in the community. New federal regulations, which became effective in March of 2014, are the basis for the proposed rule changes. **Mr. Evans** informed the Committee that the new federal regulations require HCBS provide each participant with the following: services integrated in, and support access to, the greater community; opportunity to seek employment in competitive settings; opportunity to engage in community life; controlled personal resources; safeguard of the right to receive services in the community to the same degree of access as individuals who do not receive HCBS; optimization of individual initiative and independence in making life choices with person-centered planning services based on participant need, preferences, resources and choices; rights of privacy, dignity, respect and freedom from coercion and restraint; and choice regarding services and supports and who provides them. **Mr. Evans** noted that these rules may impact service provision in residential assisted-living facilities, certified family homes and nonresidential settings where HCBS are provided.

Mr. Evans stated that the Department engaged stakeholders through eight webinars, 23 face-to-face meetings, nine teleconferences and five meetings with the Idaho Council on Developmental Disabilities (ICDD) and DisAbility Rights Idaho. The Department held a statewide negotiated rulemaking meeting and three public hearings. **Mr. Evans** also reported that stakeholders also had access on three separate occasions to review and comment on Idaho's HCBS transition plan to ensure compliance with the new regulations. He stated that comments from those activities were reviewed, responded to and incorporated into the proposed rules as appropriate. Additionally, he noted that the ICDD has worked closely with the Department to ensure participants are informed of the proposed rules and how their rights are more fully supported by the new regulations. **Mr. Evans** reviewed the Departments efforts to disseminate information to stakeholders and participants. Providers will be given six months from the effective date of these rules to come into compliance. At the end of that time, **Mr. Evans** said the Department will begin compliance activities and continue to assist providers and agencies in identifying any additional changes that may be needed. **Mr. Evans** added that every effort is being made to ensure all agencies have the assistance needed to understand the rules and assess their services according to the rules and have time to transition into compliance.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Martin asked for clarification on the significance of underlined and double-underlined sections. **Mr. Evans** responded the items single underlined in red are the rules developed by the Department. The items double underlined and italicized are changes made after comments were received.

Chairman Heider asked if the Department and the providers are in agreement with the rules. **Mr. Evans** said he believes they are in 99.9 percent agreement moving forward.

Vice Chairman Nuxoll asked for clarification on services delivered in the participant's own home. **Mr. Evans** responded that these services are known as "residential habilitation." When providing residential rehabilitation services, an agency goes into a participant's home and provides support services to them, including behavioral and medical services. Referencing additional language in the same section, **Vice Chairman Nuxoll** asked for further explanation about restrictions imposed on HCBS setting qualities if goals and strategies to mitigate risks were identified. **Mr. Evans** stated that some HCBS participants have behaviors that may require certain restrictions. Under the proposed rules, providers and participants have the opportunity, through the person-centered planning process, to assess those behaviors and mitigate associated risks. **Vice Chairman Nuxoll** asked whether plan development for each participant was a new approach being taken by the Department. **Mr. Evans** said the Department has always required a person-centered plan for individuals who are receiving state-plan services, HCBS or 1915(i) services. **Vice Chairman Nuxoll** also asked for clarification regarding state-plan services, waivers, and options. **Mr. Evans** responded that state-plan only services include basic medical care, occupational therapy, physical therapy and speech language therapy; the 1915(c) wavier services include HCBS; and the 1915(i) services include developmental therapy and crisis therapy.

Senator Lee asked whether community crisis supports were in place before this rule was drafted, or if community crisis supports are newly available services. **Mr. Evans** replied crisis services were in place, but the Department is trying to clarify the language. **Senator Lee** asked Mr. Evans to define "crisis supports." **Mr. Evans** answered, as the rules currently stand, crisis would be loss of home, loss of job, or any type of imminent danger to the participant. He added that he would find the specific section that defines "crisis supports" and provide that information to her.

Senator Hagedorn questioned how, with these new rules, patients are better off. **Mr. Evans** said it's always been the Department's assumption that HCBS provided these rights to individuals, but the proposed rules give the Department the ability to encourage better services and enhance quality. **Senator Hagedorn** asked what burdens would result from these proposed rules. **Mr. Evans** responded that the providers will be required to do a one self-assessment and maintain an annual service plan; and the Department will utilize its current quality assurance staff to assess and enforce compliance.

Referring to home and community based qualities, **Senator Jordan** noted that the proposed rule required mitigation if a setting requirement presented a health and safety risk to the participant. She inquired how health and safety risks were assessed for participants. **Mr. Evans** replied the person-centered planning team helps identify the risks unique to each individual. Referring to the "access to food" provision in the proposed rule, **Senator Jordan** asked if there are nutritional standards for the food provided to participants. **Mr. Evans** responded the person-centered planning team would identify potential risks, write goals and talk about how those risks could be mitigated to prevent someone from injuring himself or herself.

Senator Schmidt asked if the Department took a recent Idaho Supreme Court decision, regarding support, into consideration while writing the rules. **Mr. Evans** responded that the referenced court decision did not directly relate to these proposed rules.

TESTIMONY: **Vice Chairman Nuxoll** called for testimony.

Ian Bott testified that he represents Idaho Self-Advocate Leadership Network and ICDD. Mr. Bott stated his support for the proposed rules. He said he feels the proposed rules would be a win-win and could help more people get the chance to be reintegrated into society.

Christine Pisani, Executive Director of ICDD, testified that the ICDD supports the proposed rules and that the HCBS rule aligns with the mission and the values of ICDD (see attachment 1). **Senator Martin** asked if Ms. Pisani felt comfortable with the amount of input the ICDD was able to give in the rulemaking process. **Ms. Pisani** said she did.

Bill Benkula, President of Idaho Association of Community Providers (IACP), testified that the IACP supports the proposed rules. Due to the potential costs involved, **Mr. Benkula** formally requested that members of his association be involved in the implementation of the rules (see attachment 2).

Jim Baugh, executive director of DisAbility Rights Idaho (DRI), a private, nonprofit corporation, testified that DRI supports the proposed rules and noted that the State rules are a reflection of many years of struggle by people with disabilities dependent on this type of Medicaid service. **Mr. Baugh** stated it is important that people who need these Medicaid services are still entitled to the freedoms, liberties and rights that they had before they had a disability. **Mr. Baugh** expressed some benefits of the rule change: allowing people to choose who their provider is; having individualized person-centered planning; allowing individuals more control and choice about their services; the right to make decisions about where they live and how they live; an improved service system; and improved life for those who participate. DRI participated in the process of developing the rules and supplied some comments. **Mr. Baugh** added he would like to see more rules to deal with some other issues that – within Medicaid – limit people's choices and potentially make it difficult for them to integrate into communities.

Vice Chairman Nuxoll asked for Mr. Baugh's input on the notion that if rules are not implemented with costs in mind there could be an additional cost to the various businesses that contract with the Department. **Mr. Baugh** said it is always true that you can take a rule that appears to be no different from the past and then change the way you implement it in such a way that it becomes burdensome. But, for the most part, these rules are more clarifying rules than they are new impositions. **Mr. Baugh** added he thinks, in varying cases, the burden would be small and the benefit would be great.

Kelly Keele, representing Vocational Services of Idaho (VSI), testified that the VSI supports the proposed rules (see attachment 3).

There being no further testimony, **Vice Chairman Nuxoll** asked Mr. Evans to make a closing statement. **Mr. Evans** said the Department has committed to developing tools and working with agencies and providers to implement the rules. The rules are broad and overarching and do not have a lot of specifics because the Department recognizes the uniqueness of rural versus urban areas, as well as varying facilities and agencies. The Department has a staff member who is committed full time to help implement the rules. **Mr. Evans** said it is the Department's full intent to work very closely with providers, advocates and stakeholders to make sure that the rules are implemented in the most efficient manner possible.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Hagedorn asked Mr. Evans if he foresees the Department requiring any new full-time positions (FTP) as a result of implementing these rules, in the next couple of years. **Mr. Evans** referred the question to Lisa Hettinger, Idaho Medicaid Division Administrator. **Ms. Hettinger** said, at this point in time, the Department does not anticipate any new FTP need.

MOTION: There being no more questions, **Chairman Heider** moved to approve **Docket 16-0310-1501**. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0313-1501 **Rules of the Department of Health and Welfare related to Consumer-Directed Services**. **Mr. Evans** presented this docket.

Mr. Evans said the proposed rules are a companion to **Docket No. 16-0310-1501** and they provide for the enhancement of the quality of life for elderly and disabled individuals receiving HCBS by ensuring their basic rights. The changes presented are to ensure these participants receive services that comply with the new federal regulations. In developing these rules, the Department engaged in 45 stakeholder meetings, conducted a statewide negotiated rulemaking meeting, held three public hearings, published the Idaho State Transition Plan on three separate occasions and allowed public comment for each posting. Comments from those activities have been reviewed, responded to and incorporated as appropriate. **Mr. Evans** added the Department has committed to ongoing work with participants and agencies to assist in transition.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Vice Chairman Nuxoll asked why this rule was needed when it looks like it's connected to the rules that were just passed. **Mr. Evans** said the rules are specific to consumer direction so the Department had to modify them to align with the rules that were just passed.

MOTION: There being no more questions, **Senator Hagedorn** moved to approve **Docket No. 16-0313-1501**. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0304-1501 **Rules of the Department of Health and Welfare related to the Food Stamp Program in Idaho**. **Kristen Matthews**, Program Manager with the Department of Health and Welfare (Department), presented this docket.

Ms. Matthews stated that the proposed rules contain clarifications that keep the food stamp program (also known as the Supplemental Nutrition Assistance Program or SNAP) in compliance with federal program regulations and the Department's processing standards. SNAP, which is completely funded by the U.S. Department of Agriculture, provides food assistance to Idaho's neediest families. **Ms. Matthews** stated that in 2011 the Idaho Legislature approved a $5,000 resource limit for qualifying households. The proposed rules align SNAP with federal regulations that exclude households from qualifying for the $5,000 resource limit when they are disqualified from SNAP for not following program rules. Specifically, the proposed rules lower the resource limit to $2,250 or $3,250 for households that include a person with a disability or an elderly person. The Department did not conduct negotiated rulemaking and did not receive negative comments during the public comment period. **Ms. Matthews** reported there is no fiscal impact to the State as a result of this change.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

MOTION: There being no questions, **Chairman Heider** moved to approve **Docket No. 16-0304-1501**. **Senator Harris** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0402-1501 **Rules of the Department of Health and Welfare related to the Idaho Telecommunication Service Assistance Program**. **Ms. Matthews** presented this docket.

Ms. Matthews stated that the proposed rules clarify language in rule by naming the Department the responsible party for the Idaho Telecommunications Service Assistance Program. The updates will also align Idaho rule with state policies and the Department's administration of the program. Although there was no negotiated rulemaking, no negative comments were received during the public comment period. **Ms. Matthews** reported there is no fiscal impact to the State as a result of this change.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Schmidt asked if the eligibility changes are easily combined with the eligibility assessment performed by the Department. **Ms. Matthews** replied the changes in the docket are intended to clarify that the Department is the grant holder, or responsible party, for administering the program. It does not change any of the eligibility requirements, how eligibility is determined or how applications are taken.

Senator Hagedorn questioned why a community action agency did not comment on the change. **Ms. Matthews** responded that the Department currently contracts the administration of this program out to the State association that represents the community action agencies; before bringing these changes forward, the Department met with that association. The State association contacted the community action agencies to determine if there were any issues with the Department making the change. They didn't have any issues at that time, so there was no negotiated rulemaking. **Ms. Matthews** added no one came forward during the comment period.

MOTION: There being no more questions, **Senator Hagedorn** moved to approve **Docket No. 16-0402-1501**. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0413-1501 **Rules of the Department of Health and Welfare related to the Emergency Food Assistance Program**. **Ms. Matthews** presented this docket.

Ms. Matthews stated that the proposed rules clarify language in rule by naming the Department as the responsible party for the Emergency Food Assistance Program. The Department did not conduct negotiated rulemaking, and did not receive negative comments during the public comment period. **Ms. Matthews** reported there is no fiscal impact to the State as a result of this change.

MOTION: There being no questions, **Senator Schmidt** moved to approve **Docket No. 16-0413-1501**. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0414-1501 **Rules of the Department of Health and Welfare related to the Low Income Home Energy Assistance Program**. **Ms. Matthews** presented this docket.

Ms. Matthews stated that the proposed rules update language, remove obsolete references and clarify accountability by naming the Department as the responsible party for the Low Income Home Energy Assistance Program. The updates align Idaho rule with State policies and the Department's administration of the program. The Department did not conduct negotiated rulemaking and did not receive negative comments during the public comment period. **Ms. Matthews** reported there is no fiscal impact to the State as a result of this change.

MOTION: There being no questions, **Senator Schmidt** moved to approve **Docket No. 16-0414-1501**. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0416-1501 **Rules of the Department of Health and Welfare related to the Weatherization Assistance Program**. **Ms. Matthews** presented this docket.

Ms. Matthews indicated that the proposed rule changes were identical to the previous rule as applied to the Weatherization Assistance Program.

Senator Martin inquired why the language regarding community action agencies was removed from the proposed rule. **Ms. Matthews** responded the language is being removed in order to name the Department as the responsible agent and allows the Department to contract or bid out to agencies that meet the requirements of the program. **Ms. Matthews** stated that, ultimately, the individuals or entities the Department works with could be private entities, a contractor, a nonprofit agency or a community action agency.

MOTION: There being no more questions, **Senator Martin** moved to approve **Docket No. 16-0416-1501**. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

PASSED THE GAVEL: Vice Chairman Nuxoll passed the gavel back to Chairman Heider.

ADJOURNED: **Chairman Heider** expressed appreciation and thanks to the Department of Health and Welfare. There being no further business, **Chairman Heider** adjourned the meeting at 4:19 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Kara Machado
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Monday, January 25, 2016

ATTACHMENT 1

IDAHO COUNCIL ON
DEVELOPMENTAL
DISABILITIES

700 W. State St.
JRW Building
First Floor West
Boise, ID 83702-5868
Phone: 208-334-2178
1-800-544-2433
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C. L. "Butch" Otter
Governor

Debra Parsons
Chair

Christine Pisani
Executive Director

January 25, 2016

Senator Heider, Chairman
Health and Welfare Committee
Statehouse
Boise, ID 83720

RE: DOCKET NO. 16-0310-1501

Dear Senator Heider and Committee Members:

The Council on Developmental Disabilities is authorized by federal and state law to monitor systems and policies and to advocate for improved and enhanced services that enable Idahoans with developmental disabilities to live meaningful lives, included in their communities. The Council is comprised of 23 volunteers appointed by the Governor.

The Idaho Council on Developmental Disabilities is in support of this rules docket. The Federal Centers for Medicaid and Medicare (CMS) Home and Community Based Services (HCBS) Rule aligns with the mission and values of the Council. The implementation of this rule supports:

- Enhanced quality in Home and Community Based Services
- Improved quality assurance features for individuals receiving services and supports through Medicaid's HCBS programs
- Full access of individuals to the benefits of community living
- Individuals receiving services in the most integrated setting

Since the passage of these rules at the Federal level in March 2014, the Council worked collaboratively with the Department in the following ways:

- Provided user-friendly language to interpret the rules for people with disabilities and families in Idaho
- Participated in joint meetings with the Division of Medicaid to provide input into the (CMS) Home and Community Based Service Rules
- Provided public comment to both published CMS HCBS Rules State Transition Plans.
- Conducted a focus group with adults with developmental disabilities to learn their specific recommendations on how to improve the quality of person centered planning.

However, our largest investment in the implementation of these rules has been the statewide face to face study currently underway with the Center on Disabilities and Human Development at the University of Idaho.

This statewide study was created to reflect the diverse range of support needs of all participants in the Developmental Disability waiver, an HCBS program. This study intends to establish a baseline of what the service system looks like now through the eyes of adults with developmental disabilities when asked about integration, choice, control, and privacy through HCBS services. The Council and CDHD piloted interview questions and initiated the interview process with 20 participants interviewed in north Idaho (Region 1) and 18 participants in north central Idaho (Region 2). Interviews are currently being conducted in southwestern Idaho (Region 3). The baseline of this initial study will be provided to the Division of Medicaid for use in evaluating service provider compliance within the first year of implementation of the HCBS rules. A follow-up study is intended to take place with the same DD waiver participants in 2019 to provide a comparison between pre and post implementation of the HCBS rules.

The Council believes that the Department should identify face-to-face statewide training as a long-term investment in the service system and the lives it is intended to support. The Council recommends a comprehensive approach to the many components of necessary face-to-face training for meaningful compliance with the rules for service providers. More importantly, face-to-face education is needed for individuals and families to learn about the rules and ways in which they may exercise choice, control, and have the support needed to lead lives of their choosing. As part of this training, the Council strongly emphasizes teaching individuals and families about their rights under Medicaid rules.

Thank you for considering the comments of the Idaho Council on Developmental Disabilities. The Council supports implementation of these rules to ensure true community integration be realized by Idahoans living in HCBS settings.

Respectfully Submitted,

Christine Pisani
Executive Director

SENATE HEALTH & WELFARE COMMITTEE
Monday, January 25, 2016

ATTACHMENT 2

Idaho Association of Community Providers

William Benkula, President
Idaho Association of Community Providers (IACP)
P. O. Box 1862
Twin Falls, Idaho 83301

January 25,2016

Idaho Senate Health and Welfare Committee members:

My name is Bill Benkula, I am the current president of the Idaho Association of Community providers.

Recently, sixty–four (64) local business, associations and community organizations joined forces in Idaho to form the Idaho Association of Community Providers (IACP). Our Association consists of providers of Mental Health Services, Substance Abuse Treatment and Recovery Services, Developmental Disability Agency Services, Case Management Services, and Residential Habilitation–Supported Living Services that share a common goal and objective to ensure that quality community–based services are person–centered, least restrictive, most accessible, offer choice and are functional through education and on–going advocacy. As the President of this group, I stand here giving our association's support to Docket 16-0310-1501.

It should be noted however, that these rules are written in broad terms and can be wide open to various interpretations and applications. We therefore formally ask that the various sub-types of our association be involved in the implementation of these rules. While the department states that there will be no fiscal impact in approving these rules, if not done with costs in mind, they could well result in additional expenses for the various business that contract with the Idaho Department of Health and Welfare and the department itself.

We have strived to become a working partner with the department in our short history and look forward to continue to develop this relationships through further collaboration. With that said Rr. chair, members of the committee, I stand for questions

.

Bill Benkula

William Benkula, President
Idaho Association of Community Providers (IACP)
P. O. Box 1862, Twin Falls, Idaho 83301
(208) 734–4344 ext 108
bbenkula@hotmail.com

SENATE HEALTH & WELFARE COMMITTEE
Monday, January 25, 2016

ATTACHMENT 3

MEDICAID ENHANCED PLAN BENEFITS

HOME AND COMMUNITY BASED SERVICES (HCBS)

DOCKET NO. 16-0310-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

This letter of support for Docket 16-0310-1501 is presented on behalf of the members of Vocational Services of Idaho (VSI). VSI represents community vocational service providers from throughout the state. The positive result of implementing these new rules is well stated in the Notice of Rule Making descriptive summary, which reads, in part:

"The purpose of the regulations is to enhance participants' opportunity to receive services in the most integrated settings appropriate, and to increase their opportunities for choice and access to the benefits of community living. New rules pertaining to Home and Community Based Services are being added to this chapter to ensure that participants receiving HCBS live in and receive services in settings that comply with required qualities of settings, service delivery methods, and person-centered planning processes. "

In real life this means people with disabilities will have better opportunities to be included in their communities. This will be accomplished in several ways but primarily by offering individuals more choice and control in their own lives.

Specifically changes include:

- The person Centered Planning Process will truly focus on the person with very clear guidelines on how decisions are made and by who.
- Community based settings are clearly defined including five required qualities. These qualities include:
  - a. Full access to the person's community including their decisions on how they spend their time.
  - b. Settings, for services and activities, are selected by the individual and are based on their own preferences.
  - c. The person's rights of privacy, dignity and respect are honored.
  - d. Independence in making choices is encouraged.
  - e. The opportunity for individual choices is supported by the settings.

From our perspective, as providers of vocational opportunities, we see this as major step towards an "Employment First Model" where everyone has the opportunity to work and be productive in their own community.

Thank You.

J. Kelly Keele, Executive Director
Transitions, Inc.
1920 East 17th St. Suite 209
Idaho Falls, Idaho 83404
Skil4Life@aol.com
(208) 521-4294 cell

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, January 26, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Docket No. 22-0101-1501	PENDING RULE: Rules of the Board of Medicine for the Licensure to Practice Medicine and Surgery and Osteopathic Medicine and Surgery in Idaho	**Anne Lawler**, Executive Director Board of Medicine
Docket No. 22-0115-1501	PENDING RULE: Rules Relating to Telehealth Services	**Anne Lawler**
Presentation	Primary Care Access Program	**Richard Armstrong**, Director Department of Health and Welfare

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, January 26, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:06 p.m.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Nuxoll.
DOCKET NO. 22-0101-1501	**Rules of the Idaho State Board of Medicine related to the licensure to practice medicine and surgery and osteopathic medicine and surgery in Idaho**. **Anne Lawler**, Executive Director of the Idaho State Board of Medicine, presented this docket.

Ms. Lawler stated that the pending rule docket amends the existing rule regarding the licensure of international medical school graduates. Under the current rule, international medical school graduates (residents) are not allowed to apply for licensure in Idaho prior to completion of three years of their residency program, while U.S. medical school graduates may apply for licensure in Idaho after completion of one year of their residency program. The current rule discourages international medical school graduates from seeking residency training and returning to Idaho to practice medicine. Therefore, the pending rule would allow international medical school graduates who are attending an Idaho-based residency program to apply for licensure after completion of two years of their residency program. The reasons for the change are to increase the pool of resident physicians who can support understaffed rural areas; to allow residents to obtain controlled substance licenses and authorize medical equipment or home health; and to provide residents with additional training and experience that come with medical practice in the community.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Hagedorn asked how "successful completion" is defined in the proposed rules. In response, **Ms. Lawler** reviewed the requirements of successful completion set forth in sections 051.e.i-v of the docket.

Vice Chairman Nuxoll asked for clarification on why some Idahoans have difficulty obtaining licensure after earning a medical degree. **Ms. Lawler** stated that there are no medical schools in Idaho. Therefore, Idahoans who want to become physicians must leave Idaho to attend medical school. After medical school, graduates must attend a residency program, which is typically a three-year program based upon the participant's chosen specialty. Most physicians ultimately practice medicine in the location of their residency program. **Ms. Lawler** indicated that some Idahoans attend domestic medical schools and some Idahoans attend international medical schools. Because Idaho is currently more restrictive than many other states on the licensure requirements for international medical school graduates, international graduates choose to go to other states instead of returning to practice medicine in Idaho.

MOTION: There being no more questions, **Senator Harris** moved to approve **Docket No. 22-0101-1501**. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 22-0115-1501 **Rules of the Idaho State Board of Medicine related to telehealth services**. **Anne Lawler** presented this docket.

Ms. Lawler stated that the pending rule docket was prompted by the passage of the Idaho Telehealth Access Act and clarifies the obligations of licensed health care providers in providing telehealth services to patients located in Idaho. **Ms. Lawler** stated that the pending rule is based on the model telehealth rules promulgated by the Federation of State Medical Boards and fined-tuned/finalized by the Idaho Telehealth Council. The Telehealth Council is comprised of many stakeholders, including Representative Rusche, regulatory board members and directors and representatives from the insurance industry, Medicaid, the Idaho Hospital Association, the Idaho Medical Association, and various Idaho hospital systems. **Ms. Lawler** reported that a public hearing was held on September 15, 2015. The Board of Medicine received and reviewed two written comments to the proposed rule changes. Strongly believing that patients should have freedom to choose providers where possible, the Board of Medicine did not make changes to the proposed rule draft.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Schmidt asked how the provider selection would work in a telehealth format. **Ms. Lawler** said many of the telehealth service providers are companies located in a central location and provide services to various states. The telehealth service companies have a large roster of health care providers. This rule would allow a telehealth patient to choose, when appropriate, a health care provider from the roster. **Ms. Lawler** gave examples of how patients may opt to speak to a variety of medical doctors, such as a pediatrician versus a family practice physician or a female doctor versus a male doctor.

MOTION: There being no more questions, **Senator Schmidt** moved to approve **Docket No. 22-0115-1501**. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

PASSED THE GAVEL: Vice Chairman Nuxoll passed the gavel back to Chairman Heider.

PRESENTATION: **Primary Care Access Program in Idaho**. **Richard Armstrong**, Director of the Idaho State Department of Health and Welfare (Department), made this presentation before the Committee.

Director Armstrong thanked the Committee and gave a brief overview of the topics he would discuss in his presentation (see attachment 1 for the complete presentation). First, **Director Armstrong** discussed how the Primary Care Access Program (PCAP) will build on foundations and strengths of Department and community resources and the demographics of people in the gap. Second, **Director Armstrong** reviewed the nine-step PCAP experience from the perspective of the patient or member, including (i) application, (ii) verification, (iii) eligibility determinations, (iv) medical home assignments, (v) patient engagement, (vi) patient assessment, (vii) patient care plan development, (viii) medical home patient services and obligations and (ix) ongoing case management. Third, **Director Armstrong** presented the values and outcomes expected from the PCAP. Finally, **Director Armstrong** reviewed the next steps for the PCAP.

Chairman Heider asked if the Catastrophic Health Care Cost Program (CAT) fund would remain in place. **Director Armstrong** confirmed that the CAT fund would continue to be used for specialty and hospital care. **Chairman Heider** asked if hospital emergency rooms (ERs) will refer some people to an outside doctor or a patient-centered medical home. **Director Armstrong** answered that, by law, a hospital can't turn people away. However, he believed there would be coordination for patients' outside follow-up care. **Director Armstrong** added that by assigning participants to patient-centered medical homes, he believes there will be a reduction in ER visits.

Senator Hagedorn commented that he was concerned about whether rural health care clinics have the same capabilities as urban clinics and asked if services such as mammograms, colonoscopies and certain cancer screenings would be included in preventive care. **Director Armstrong** said because there are variations in service capacity across the State, the goal is to work with clinics to be able to help them increase their ability to serve. **Senator Hagedorn** asked what the motivation would be for participants to seek preventative care and appropriate follow-up care from the PCAP. **Director Armstrong** responded that the providers in the patient-centered medical homes would assist the participants and provide reminders for care.

Noting his belief that the number of participants could be higher, **Senator Harris** asked how the Department determined that 78,000 individuals would be eligible to receive PCAP services. **Director Armstrong** responded that the number of participants were estimated and tested on several occasions by professional consultants. **Director Armstrong** stated his confidence that 78,000 reflected the maximum number of expected participants in the PCAP.

Vice Chairman Nuxoll asked Director Armstrong to clarify the payment structure for PCAP health care providers. **Director Armstrong** responded that the total cost for 78,000 PCAP participants would be approximately $30 million. The capitated rate paid to health care providers would be $32 per patient, per month. **Director Armstrong** noted that if the PCAP received less than $30 million in funding, PCAP enrollment would be limited instead of reducing payments to providers.

Regarding the costs patients would incur when seeking health care services from a PCAP clinic, **Senator Martin** asked Director Armstrong who would determine the cost, would there be a cap on the cost and who would receive the payment. **Director Armstrong** replied each clinic has a sliding fee scale and that revenue goes to the clinic. **Senator Martin** asked what would encourage an individual to go to a clinic if an ER visit is free. **Director Armstrong** noted that ER services are not free, and he answered that it would be important to educate participants on the value of PCAP services.

Senator Schmidt asked if it is possible to track and report both outcomes and clinical data with the current systems in place. **Director Armstrong** said that, today, the Department looks to Medicaid to pull all the paid claim data. **Director Armstrong** stated that the Department would now need to pull all clinical data from the electronic health records maintained by clinics. He added that the Department would make use of reports already being provided by clinics to the federal government to track PCAP outcomes and clinical data. **Senator Schmidt** asked whether some of the 78,000 estimated participants are currently receiving services from clinics that will serve as PCAP clinics. **Director Armstrong** responded that the Department does believe there is a crossover, but the degree of crossover has not yet been determined. He added the Department was hoping to do a data match, but due to restrictions with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and personally identifiable information, a data match was not done and that information is not yet available.

Senator Lee commented that her district has good, hard-working people, but noted that it has one of the highest gap populations in the State. She asked if the Department would focus initial resources in areas of the State that have the highest gap population in order to reduce costs to the State, hospitals and local providers. **Director Armstrong** answered no and that the Department is not looking at a targeted approach. However, he stated that if the Department has a limited in budget, then the Department may have to take a targeted approach.

Senator Lodge asked if the State has enough medical providers that will go into rural areas and if there are sufficient education programs to ensure there are enough people graduating in the needed disciplines. **Director Armstrong** answered the Department is concerned about staffing levels. Under the Department's proposed approach, clinics will have the opportunity to increase staffing levels to meet necessity. Commenting that Idaho has two law schools but not a medical school, **Senator Lodge** noted that she is still interested in seeing what could be done to expand Idaho's training for medical professionals.

Senator Jordan asked what kind of analysis has been done to determine the clinics' ability to increase their capacity and to sustain the capacity with a proposal that includes a sunset and a year-to-year review of what should be a sustainable funding source. **Director Armstrong** responded one of the reasons the Department wanted to have a dedicated funds source, based on talks with clinics, was to establish a sustainable program. **Senator Jordan** asked what would happen if a person came into a clinic to manage a chronic disease and something else was found, such as cancer. Specifically, she asked whether that person would go back to the same delivery system that exists right now, which is no insurance and the CAT fund. **Director Armstrong** answered the clinics refer patients to a place where they can be cared for, but some of those individuals will then end up indigent and seeking CAT fund assistance.

Vice Chairman Nuxoll asked if, rather than a five-year sunset clause, would it be better to have a three-year sunset clause. **Director Armstrong** stated that five years is the shortest duration that can produce a good scientific outcome.

Noting that the target PCAP funding amount is $30 million, **Senator Hagedorn** asked the minimum amount needed to implement the program or if that sum exists. **Director Armstrong** said the Department does not have that minimum number and hopes the Legislature could reach the Department's target.

Chairman Heider inquired about the Department's next steps. **Director Armstrong** said the Department has drafted a bill and he thinks they will have that ready to introduce soon.

ADJOURNED: **Chairman Heider** thanked Director Armstrong and his Department. There being no further business, **Chairman Heider** adjourned the meeting at 4:42 p.m.

_____

Senator Heider
Chair

_____

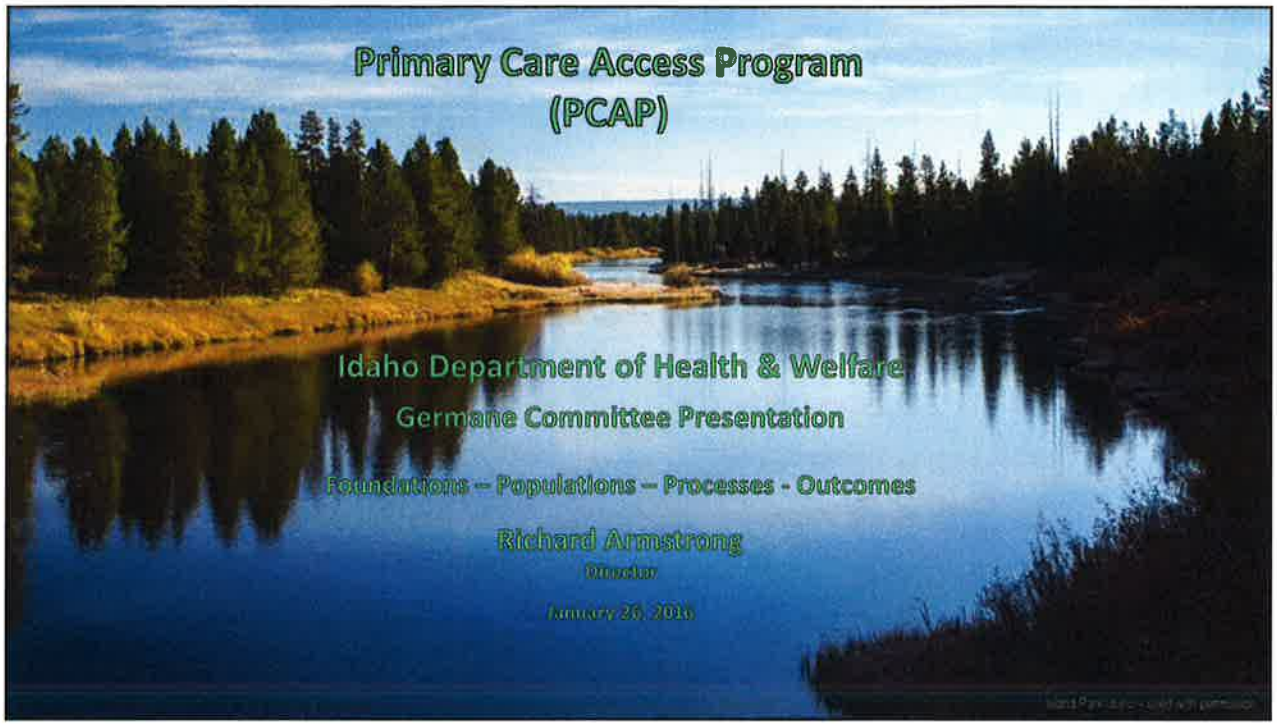
Karen R. Westbrook
Secretary

_____

Kara Machado
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, January 26, 2016

ATTACHMENT 1



Primary Care Access Program (PCAP) Overview

IDAHO DEPARTMENT OF HEALTH & WELFARE

2

1

BUILDING ON OUR FOUNDATION & STRENGTHS
- Patient-centered Medical Home Model
- Community Health Centers
- SHIP, Medicaid Building Capacity

2

PEOPLE IN THE GAP
- Federal Poverty Level Income
- Family/Employment Demographics
- Healthcare Access

3

PCAP EXPERIENCED BY THE PARTICIPANT

Eligibility Functions
- Application
- Verification
- Eligibility
- Medical Home Assignment

4

Health Clinic Services
- Outreach
- Patient Assessment
- Patient Care Plan
- Clinic Services
- Pharmacy & Behavioral Health
- Ongoing Care Management

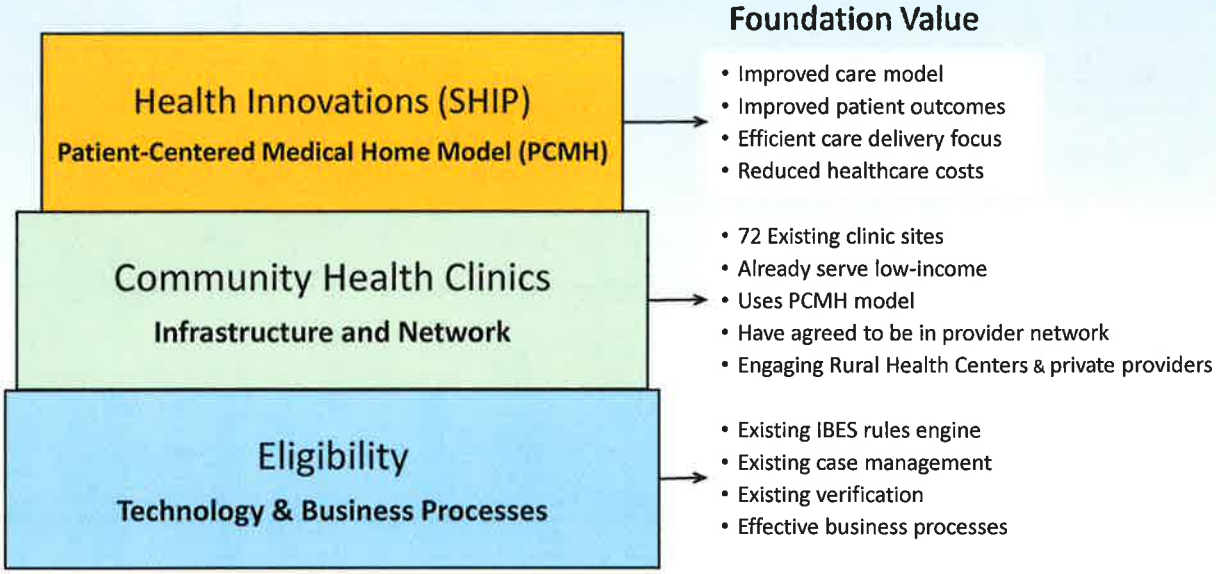
5

VALUE & OUTCOMES
- Access to Services
- Active Management
- Healthier Population
- Avoided Costs
- Examples

PCAP: Building on Existing Foundations and Strengths

IDAHO DEPARTMENT OF HEALTH & WELFARE

3



Target Population: People in the Gap

IDAHO DEPARTMENT OF HEALTH & WELFARE

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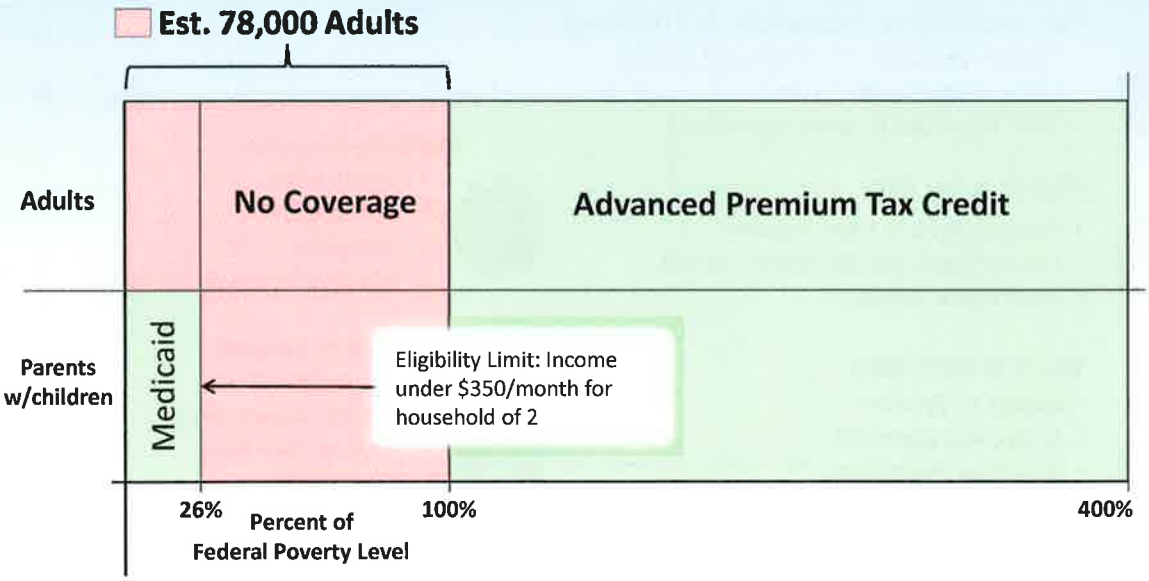

Gap Population: Where do They Live?

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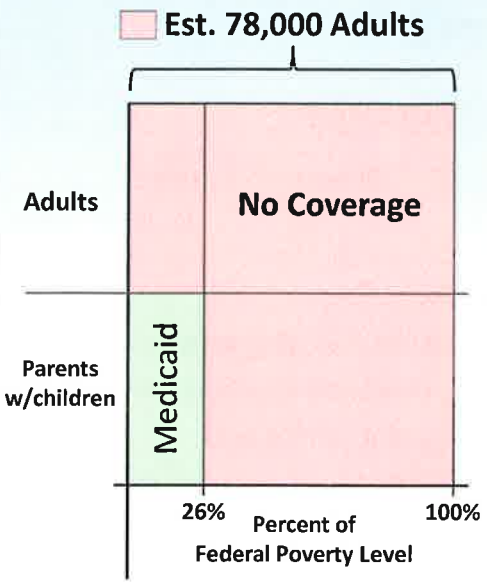
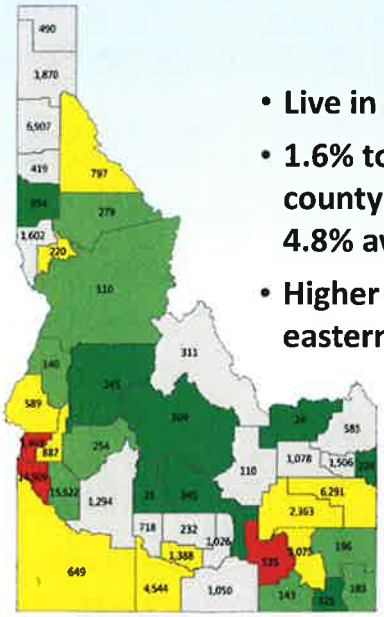
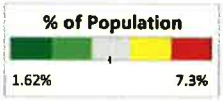




- Live in every county
- 1.6% to 7.3% of county population; 4.8% average
- Higher in southwest & eastern Idaho



Gap Population: Demographics

IDAHO DEPARTMENT OF HEALTH & WELFARE

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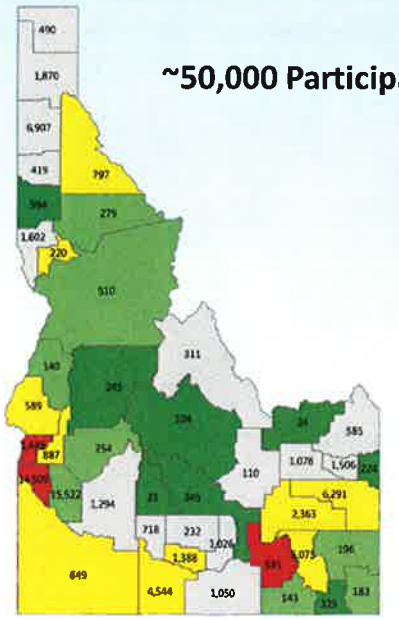
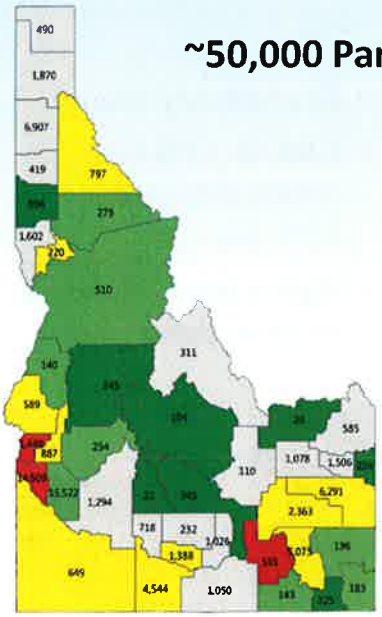


~50,000 Participants known in Idaho Benefit Eligibility System (IBES)

- 55% are female; 45% male
- 84% between ages 18-50; 16% are older than 50
- 65% live in households with at least one child
  (Child usually in Medicaid; parents stuck in the Gap)
- 25% are a household of one, 17% with two , and 58% in households with 3 or more

Gap Population: Demographics

IDAHO DEPARTMENT OF HEALTH & WELFARE



~50,000 Participants known in IBES

77% have household income

- 65% are in a household with earned income
- Typical jobs include:
  - Food service workers
  - Laborers in construction, farming and forestry
  - Home health aides, childcare workers, retail sales
  - Transportation, janitorial, office and administrative support
- Other income often includes Social Security, child support, pensions

Gap Population: Current Health Demographics

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- Uninsured, low-income adults are under-served by medical system
  - Poor uninsured create bad debt, driving up costs for everyone
  - Private providers reluctant to serve
- Gap folks access care through:
  - Hospital emergency departments
  - Community Health Centers
  - Rural Health Clinics
  - Charity care
  - Indigent healthcare programs
  - Catastrophic healthcare programs

- Gap adults access episodic care, frequently waiting until conditions escalate, resulting in the most expensive and least effective care
  - No preventive plan
  - No treatment plan
  - No chronic condition management
  - No care coordination

Gap Population: Higher Incidence of Chronic Diseases

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Poverty's Impact on Chronic Disease Prevalence			
Chronic Condition	In Poverty	Not In Poverty	Difference
Depression	30.9%	15.8%	>95%
Asthma	17.1%	11.0%	>55%
Obesity	31.8%	26.0%	>22%
Diabetes	14.8%	10.1%	>46%
High Blood Pressure	31.8%	29.1%	>9%
Heart Attack	5.8%	3.8%	>52%

Gallup-Healthways Well-Being Index: 2012 Report

- Prevalence of chronic conditions for adults 45-64 is more than twice as high among those in poverty
- Men with incomes > 400% poverty live an average of 8 years longer than men in poverty
- Other factors contributing to poor health outcomes for adults in poverty
  - Substandard housing
  - Food insecurity
  - Lower level of education
  - Risky behaviors

Gap Population: Not a Static Population

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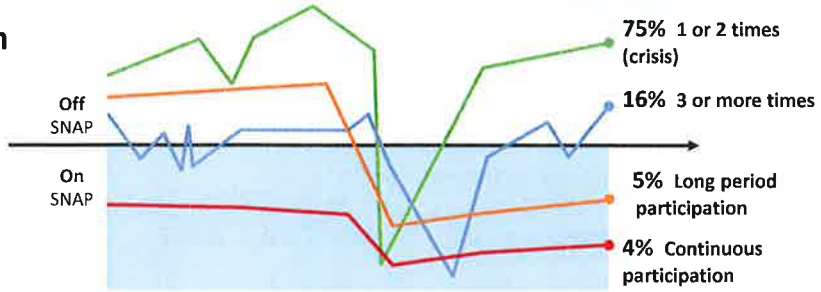
- Income fluctuates with job changes, employment loss, family changes, insurance opportunities
- Participants are expected to move on and off PCAP program as circumstances change and health issues are stabilized
- Data from SNAP illustrate the dynamic changes to individual participation: month to month the participant count may change little but the individuals churn on and off services continuously

575,000 People received SNAP Benefits during the past 6 years

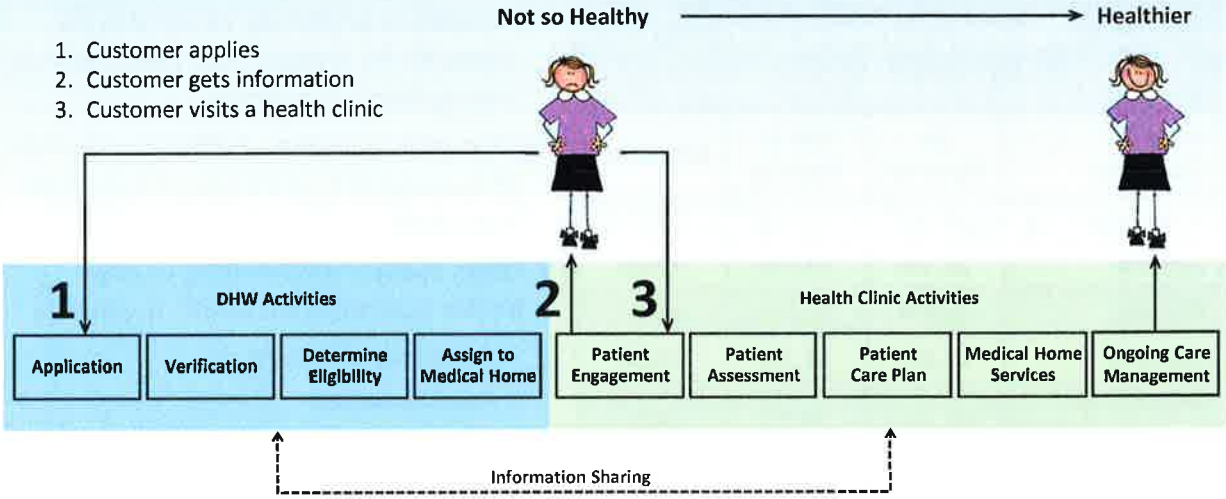


The Primary Care Access Program 9 Step Process

IDAHO DEPARTMENT OF HEALTH & WELFARE

Customer Interactions

1. Customer applies
2. Customer gets information
3. Customer visits a health clinic

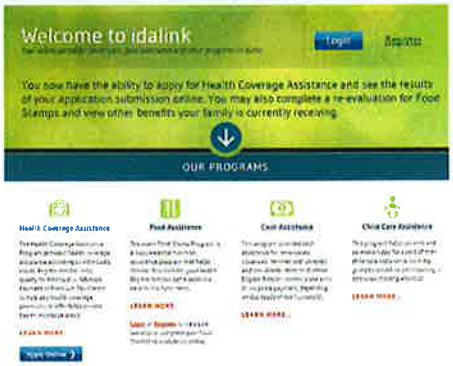


The PCAP Process: Step 1 - Application

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | Determine Eligibility | Assign to Medical Home | Patient Engagement | Patient Assessment | Patient Care Plan | Medical Home Services | Ongoing Care Management

- **Completed by the individual or by someone acting on their behalf**
- **Healthcare Coverage applications will also consider Medicaid and APTC**
- **Applications can be submitted in many venues:**
  - **Online 24/7 at DHW's idalink site or Your Health Idaho**
  - **By phone during DHW office hours**
  - **In person at 19 DHW state offices statewide**
  - **Paper applications by mail, email or FAX**
  - **Enrollment assistors at CHCs**
- **Average processing time is less than 5 days**



The PCAP Process: Step 2 - Verification

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | **Verification** | Determine Eligibility | Assign to Medical Home | Patient Engagement | Patient Assessment | Patient Care Plan | Medical Home Services | Ongoing Care Management

PCAP will verify individual circumstances for eligibility

- **Identity** ✓
- **Residence** ✓
- **Income** ✓
- **Citizenship** ✓
- **Other Insurance** ✓
- **Household** ✓

The PCAP Process: Step 3 Determine Eligibility

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | **Determine Eligibility** | Assign to Medical Home | Patient Engagement | Patient Assessment | Patient Care Plan | Medical Home Services | Ongoing Care Management

- **Adults 19-64 years old with no access to health insurance coverage**
- **Income below 100% federal poverty: $ 981/m for 1; $ 1,328/m for 2**
- **Must be U.S. citizen or legal resident who meets 5-year requirement**
- **Individuals move to appropriate coverage based on circumstances**
  Eligibility testing will move individuals to Medicaid or APTC as warranted
- **Eligibility starts in the month of application**
- **Up to 12 month certifications aligned with other Health Coverage programs**
- **Individuals must contribute to healthcare costs**
- **Individuals must engage in their treatment plans for prevention/treatment**

The PCAP Process: Step 4 Assign to Medical Home

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | Determine Eligibility | **Assign to Medical Home** | Patient Engagement | Patient Assessment | Patient Care Plan | Medical Home Services | Ongoing Care Management

- Geo coding will be used for medical home assignments
- Participant notified of clinic assignment; participant can change to a preferred location
- Provider notified of participant assignment; automatically assumes responsibility to provide PCMH services to individual
- 24x7 database delivers real-time eligibility status to all providers

The PCAP Process: Step 5 – Patient Engagement

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | Determine Eligibility | Assign to Medical Home | **Patient Engagement** | Patient Assessment | Patient Care Plan | Medical Home Services | Ongoing Care Management

- Provider pro-actively contacts and welcomes participant to PCMH via phone, email or letter
- Provider explains:
  - PCMH model of care, health assessment process, care plan
  - Participant responsibilities include paying share of costs, active participation in both assessment and care plans
  - Next steps

The PCAP Process: Step 6 – Patient Assessment

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | Determine Eligibility | Assign to Medical Home | Patient Engagement | **Patient Assessment** | Patient Care Plan | Medical Home Services | Ongoing Care Management

- Practice contacts patient after patient is assigned to their medical home
- Initial assessment is completed over telephone or in-person with clinic staff to assess current health status
- Assessment results indicate patient's current health status and ongoing level of care needed
- Patient/practice arrange office visit to develop care plan

The PCAP Process: Step 7 - Patient Care Plan

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | Determine Eligibility | Assign to Medical Home | Patient Engagement | Patient Assessment | **Patient Care Plan** | Medical Home Services | Ongoing Care Management

Patient Assessment results used to develop Patient Care Plan

- **Healthy individual:**
  Basic preventive care, guidance for self-care and education about how to access appropriate care when needed

- **Individual w/some concerning issues:**
  Meets with provider to develop care plan, access needed medications, and agree to actively participate in self-care

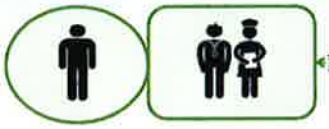
- **Individual with one or more chronic conditions:**
  Meets with provider to develop care plan, regular monitoring by PCMH, agree to actively participate in care plan

The PCAP Process: Step 8 – Medical Home Services

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | Determine Eligibility | Assign to Medical Home | Patient Engagement | Patient Assessment | Patient Care Plan | **Medical Home Services** | Ongoing Care Management

The primary care provider is responsible for a patient's basic preventive, physical and mental health needs



Participant

Patient-Centered Medical Home

- Primary & Preventive Care: Physicals, screenings, tobacco cessation
- Acute care for injuries, illnesses
- Basic medications, labs, X-rays
- Coordinates care for chronic conditions
- Connects to other community services

The PCAP Process: Step 8 – Medical Home Services

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | Determine Eligibility | Assign to Medical Home | Patient Engagement | Patient Assessment | Patient Care Plan | **Medical Home Services** → **RX** | Ongoing Care Management

PCAP provides access to prescriptions, often at deeply discounted pricing

- CHCs either have an on-site pharmacy or contract with a local pharmacy to provide discounted medications
- The community health centers presently have access to comprehensive out-patient formulary at very low costs
- Examples:
  - Diabetes medication: Average wholesale price is $484; PCAP participant pays $17.16
  - Asthma inhaler: AWP is $85.39; PCAP participant pays $17.08

The PCAP Process: Step 8 – Medical Home Services

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | Determine Eligibility | Assign to Medical Home | Patient Engagement | Patient Assessment | Patient Care Plan | **Medical Home Services** | Ongoing Care Management

→ Behavioral Health

Office-based Behavioral Health

- Community Health Centers care for individuals with behavioral health issues that can be managed in a primary care setting
- Presently 22% of their patients have behavioral health issues
- All participating PCAP providers will be expected to provide behavioral health services on-site and connect patients with more serious conditions to community resources
- Individuals with more serious behavioral health issues may also be referred to, and served in partnership with, the local DHW Behavioral Health Office

The PCAP Process: Step 9 - Ongoing Case Management

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | Determine Eligibility | Assign to Medical Home | Patient Engagement | Patient Assessment | Patient Care Plan | Medical Home Services | **Ongoing Care Management**

- Amount of ongoing care management depends on participant's health status and care plan
- Individuals in good health may not need regular monitoring, but will require periodic check-in to ensure their health status has not changed
- Participants with one or more chronic conditions may need to:
  - Report regularly to clinic regarding health indicators such as weight, blood sugar levels, blood pressure readings
  - Participate in group visits/classes with other individuals with similar conditions, such as health education class for diabetics

Outcomes: Tracking & Reporting

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | Determine Eligibility | Assign to Medical Home | Patient Engagement | Patient Assessment | Patient Care Plan | Medical Home Services | Ongoing Care Management

Providers are required to track patient care and outcomes

- Service utilization by participants:
  - Successful engagement
  - Breakdown of health status of participants
  - Percentage adhering to care plan
- Clinical measures for participants:
  - Aggregate data on participants with chronic conditions
  - Percentage of chronic conditions under control, etc.
- Data will be reported to Legislature for program evaluation

Value for Taxpayers

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | Determine Eligibility | Assign to Medical Home | Patient Engagement | Patient Assessment | Patient Care Plan | Medical Home Services | Ongoing Care Management

Possible impact on County/State Indigent Costs

SFY 2015 State and County Indigent/CAT Caseloads	
Total Served: 3,680 People	Total Amount Paid: $36.3 M.

Possible PCAP Covered Services in 2015 Caseloads		
Diagnosis	People Served	Amount Paid
Mental Illness	1,594	$5.8 M.
Coronary	278	$6.4 M.
Chronic Disease	129	$2.4 M.
Respiratory	97	$2.1 M.
Infectious Disease	15	$170,000
Total	**2,113**	**$16.8 M.**

Medical reviews in CAT program identify specific preventable hospitalization cases

1. 61-year-old obese male w/history of edema, diabetes, etc. Hospital charge = $191,382.
2. 42-year-old female, hospitalized for foot abscess due to undiagnosed diabetes. Lack of regular care – Hospital charge = $70,353
3. 41-year-old uninsured male with history of hypertension and sleep apnea – had undiagnosed diabetes - hospital charge = $96,182

Value Provided by PCAP Services

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | Determine Eligibility | Assign to Medical Home | Patient Engagement | Patient Assessment | Patient Care Plan | Medical Home Services | Ongoing Care Management

The Primary Care Access Program provides:

- **Patient Engagement**
  - Pro-active participant contacts and expected participant engagement
  - Education for appropriate health care system use
  - Education for emergency vs medical home use
- **Patient Assessment**
  - Identify individuals with emerging or chronic health conditions manageable in a medical home setting
- **Patient Care Plan**
  - Develops appropriate care and preventive plans
  - Engages the individual with a long term view of their own health
- **Ongoing Care Management**
  - Special focus on those with chronic conditions

Value to Communities

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application | Verification | Determine Eligibility | Assign to Medical Home | Patient Engagement | Patient Assessment | Patient Care Plan | Medical Home Services | Ongoing Care Management

Live Better Idaho
Discover. Connect. Empower.
www.LiveBetterIdaho.org

- **Healthier, more productive workforce**
- **Lower healthcare costs for non-Gap Idaho citizens**
- **Utilizes current medical infrastructure and state systems to reduce costs**
- **Engages the Gap group in regular medical care that Idaho can use to build on for the future if there is consensus to improve program**
- **Other community resources can empower people in poverty to improve their lives: Work training, nutrition education, housing, etc.**

PCAP is NOT an Entitlement Program

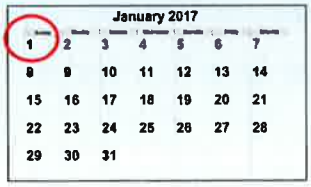
IDAHO DEPARTMENT OF HEALTH & WELFARE

- Enrollment is subject to available funding: If funding does not support demand, a waiting list will be created and used
- Participants must pay share of costs and be invested in their care plan, or they can be disenrolled
- Eligibility criteria can be adjusted to improve program performance or administrative efficiency
- Annual utilization and clinical quality report allows legislators and stakeholders to regularly review program results and monitor effectiveness
- 5-year automatic sunset clause if performance outcomes are not achieved or state wants to change program

PCAP: Next Steps

IDAHO DEPARTMENT OF HEALTH & WELFARE

If Approved



Start Date
Jan. 1, 2017

- Programming PCAP Rules and Verification in IBES begins after SNAP multi-day issuance launches on July 1, 2016
- Modifying business processes and hiring and training new staff starting on July 1, 2016 to support startup efforts between July and December 2016
- Coordinating PCAP eligibility with current insurance exchange open enrollment, which begins October 2016, for administrative efficiencies and reduced state costs
- Allowing CHCs and other providers to evaluate demand so they can expand staff and administrative capacity/training to provide for projected enrollees

IDAHO DEPARTMENT OF HEALTH & WELFARE

QUESTIONS?

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, January 27, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Docket No. 16-0219-1501	PENDING RULE: Food Safety and Sanitation Standards for Food Establishments (The Idaho Food Code)	**Patrick Guzzle** Division of Public Health
Docket No. 16-0701-1501	PENDING RULE: Behavioral Health Sliding Fee Schedules	**Jamie Teeter** Division of Behavioral Health
Docket No. 16-0710-1501	PENDING RULE: Behavioral Health Development Grants	**Jamie Teeter**
Docket No. 16-0715-1501	PENDING FEE RULE: Behavioral Health Programs	**Jamie Teeter**
Docket No. 16-0717-1501	PENDING RULE: Alcohol and Substance Use Disorders Services	**Jamie Teeter**
Docket No. 16-0720-1501	PENDING RULE: Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs	**Jamie Teeter**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, January 27, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:03 p.m.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Nuxoll to conduct the rules review.
DOCKET NO. 16-0219-1501	**Rules of the Department of Health and Welfare Related to Food Safety and Sanitation Standards for Food Establishments (The Idaho Food Code)**. **Patrick Guzzle**, Food Protection Program Manager, Division of Public Health in the Department of Health and Welfare (Department), presented this docket.

Mr. Guzzle stated that the pending rules update the current Idaho Food Code and adopt, by reference, the 2013 Food and Drug Administration (FDA) Model Food Code, with specific changes for Idaho. The Department negotiated these pending rules with representatives from the retail food industry, lodging and restaurant industry and small food-producing businesses. He reported that the proposed rules reflect current best practices and provide consistency for food businesses. **Mr. Guzzle** reviewed three major changes within the pending rules related to (i) cottage foods, (ii) certified food protection managers and (iii) acidified foods.

First, regarding the cottage foods updates, **Mr. Guzzle** reported that the Department held 18 public meetings around the State to speak with producers of cottage foods. He stated that the negotiated pending rules clearly define examples of "cottage food products" and noted that cottage food products have properties that do not allow for the growth of harmful bacteria nor do these foods have a history of causing outbreaks of foodborne illness. **Mr. Guzzle** indicated that, although cottage food producers are exempt from the general food establishment rules, these pending rules clearly specify where and how cottage food products may be distributed. **Mr. Guzzle** commented that the Department has established an informational website for cottage food producers, which can be found at www.foodsafety.idaho.gov.

Second, **Mr. Guzzle** reported that the pending rules require each applicable food establishment to have a "certified food protection manager" available. This update will not become effective until July 1, 2018, in order to allow businesses adequate time to complete the necessary courses and exams. He clarified that a certified manager need not be present during all hours of service of preparation.

Third, **Mr. Guzzle** stated that an "acidified food" is a food to which an acid ingredient, such as vinegar, has been added in order to make the product shelf-stable. He stated that the pending rules clarify the standards for producers of these types of foods and the regulatory community.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Noting that the pending rule delegated certain regulatory authorities to two entities (the public health districts and the Division of Licensing and Certification), **Senator Schmidt** asked Mr. Guzzle to clarify the regulatory responsibilities of the entities, such as who sets and collects the fees authorized in these rules. **Mr. Guzzle** explained that the seven public health districts are separate agencies from the Department, and the Division of Licensing and Certification (DLC) is a part of the Department. The DLC is responsible for inspecting hospitals, nursing homes and assisted living centers. The public health districts are responsible for inspecting grocery stores, restaurants and other retail food operations. **Mr. Guzzle** stated that the fees collected go directly to the public health district. **Senator Schmidt** asked Mr. Guzzle to clarify the DLC's regulatory role. **Mr. Guzzle** replied that, as part of the DLC's certification of hospitals and other health care facilities, the DLC conducts a kitchen inspection. The public health districts do not inspect these kitchens because the efforts would be duplicative. **Senator Schmidt** reiterated his question regarding who sets the fees. **Mr. Guzzle** replied that the fees are set in statute.

Senator Lee asked Mr. Guzzle the approximate cost of certification as a food protection manager. **Mr. Guzzle** answered that the test can cost between $25 for the exam alone to $125 for a review course and the exam. He clarified that the rule only requires that a person pass the certifying exam. A passed exam is valid for five years.

Senator Hagedorn asked as of what date must acidified food products meet the requirements of Code of Federal Regulations (CFR) 114. **Mr. Guzzle** replied that the rules are written to be effective as of July 1, 2016. **Senator Hagedorn** commented that CFRs are subject to change; he requested that, going forward, the Department include the date of the CFRs being approved in the rules.

Vice Chairman Nuxoll asked for clarification regarding the definition of "intermittent food establishment" and the exclusion of "vendors of farm-fresh ungraded eggs at a recurring event." **Mr. Guzzle** responded that the language in the pending rules aligns with specific statutory language. He clarified that a person selling farm-fresh, ungraded eggs at a farmer's market would not be considered an intermittent food establishment. **Vice Chairman Nuxoll** asked for an example of a recurring event. **Mr. Guzzle** said one example would be a farmer's market or holiday fair that is held consistently and approximately at the same time, not exceeding ten consecutive days.

TESTIMONY: **Vice Chairman Nuxoll** invited testimony regarding this docket.

Elizabeth Criner testified on behalf of the Northwest Food Processors Association (NWFPA) (see attachment 1). **Ms. Criner** stated that the NWFPA has been engaged in the rulemaking process and supports the bulk of pending rule. However, the NWFPA does not support the exemption of cottage foods from food safety regulation. She recommended that the provisions allowing exemption for cottage foods from regulation be stricken. **Senator Martin** asked Ms. Criner to provide the page on which the referenced cottage foods exemption is located. **Ms. Criner** replied that she did not have the rule before her. However, she directed the Committee members to an NWFPA letter, which includes citations. She noted that regulations can be seen as negative, but she believes the regulations can be helpful and educate cottage food producers.

Julia Page testified as a member of the Idaho Organization of Resource Councils (IORC). **Ms. Page** stated that the IORC supports the pending rules. **Senator Jordan** asked which safety rules are in place to mitigate the concerns of the NWFPA. **Ms. Page** replied that (i) cottage foods are not time and temperature controlled for safety and have historically been safe and (ii) it is in the business interest of these producers to sell safe products. Inquiring about the liability of cottage food producers, **Senator Lodge** asked how both the producers and the public would be protected. Second, **Senator Lodge** asked whether cottage foods would be allowed in public schools. **Ms. Page** answered that she was unsure how these rules would affect donations to public schools. Regarding liability, the public would be protected by labeling requirements and the producers could purchase liability insurance.

Troy Darmody, Senior Manager of Food Safety and Quality Assurance for Albertsons/Safeway, testified that Albertsons/Safeway supports the pending rules because the language aligns with the most current version of the FDA Model Food Code. This alignment makes centralized training programs more efficient.

MOTION: There being no further questions, **Senator Hagedorn** moved to approve **Docket No. 16-0219-1501**. **Senator Harris** seconded the motion.

Vice Chairman Nuxoll requested that the Department specify the date of the CFRs incorporated by reference in future rules. **Senator Schmidt** observed that there needs to be flexibility in the oversight these rules. **Senator Lee** indicated that she was in support of the motion, but stated the Committee would be looking for the updates next year. **Vice Chairman Nuxoll** commented that she was impressed with the negotiated rule making.

The motion carried by **voice vote**.

DOCKET NO. 16-0701-1501 **Rules of the Department of Health and Welfare Related to Behavioral Health Sliding Fee Schedules. Jamie Teeter**, Bureau Chief, Division of Behavioral Health in the Department of Health and Welfare (Department), presented this docket.

Ms. Teeter said that the pending rules combine the fee schedules for mental health and substance use disorder services into one fee schedule instead of two fee schedules; the fee schedule percentages were not changed. **Ms. Teeter** also stated that certain provisions referencing obsolete Medicaid rates have been deleted from the rule. **Ms. Teeter** noted that negotiated rulemaking was not conducted for these pending rules because the changes were not substantial; no negative comments were received. Further, **Ms. Teeter** indicated that there is no anticipated fiscal impact on the State General Fund or any other fund.

MOTION: There being no questions, **Senator Schmidt** moved to approve **Docket No. 16-0701-1501**. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0710-1501 **Rules of the Department of Health and Welfare Related to Behavioral Health Sliding Fee Schedules. Ms. Teeter** presented this docket.

Ms. Teeter stated that the Department would like to repeal this chapter of rule because all appropriated grant funds have been disbursed. The Regional Behavioral Health Services Act allows community providers to seek funding through the regional behavioral health boards. **Ms. Teeter** stated that negotiated rulemaking was not conducted for these pending rules because the lack of appropriations made this chapter obsolete. Further, **Ms. Teeter** indicated there is no anticipated fiscal impact on the State General Fund or any other funds.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Hagedorn asked if the Department's intent was to completely repeal the rule. **Ms. Teeter** answered yes.

Senator Schmidt asked how the regional behavioral health boards would receive funding if this rule is repealed. **Ms. Teeter** replied that the Regional Behavioral Health Services Act allows for the funding to come from the Department or other sources. **Senator Schmidt** asked Ms. Teeter to confirm that statute or rule allows for the flow of funding from the Department to the regional behavioral health boards. **Ms. Teeter** deferred to Ross Edmunds. **Ross Edmunds**, Administrator of the Division of Behavioral Health in the Department, indicated that the mechanism for funding is contractual and not grants. The path for funding is established by statute. **Senator Schmidt** asked if regional boards could form contracts with Department, but not receive funding from them. **Mr. Edmunds** replied that the contracts involve the exchange of funds. He clarified that the regional behavioral health boards partner with health districts to contract with the Department.

MOTION: There being no further questions, **Senator Hagedorn** moved to approve **Docket No. 16-0710-1501**. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0715-1501 **Rules of the Department of Health and Welfare Related to Behavioral Health Programs. Ms. Teeter** presented this docket.

Ms. Teeter stated that the purpose of the pending rules is to move towards an integrated behavioral health system that includes both mental health and substance use disorder providers. The pending rules establish one behavioral health certification process for both mental health and substance use disorder providers. Historically, the Division of Medicaid certified mental health providers and the Division of Behavioral Health certified substance use disorder providers; the new single certification process will be administered by the Division of Behavioral Health.

Ms. Teeter stated that the Idaho Alcohol and Intoxication Treatment Act directs the Department to (i) establish a comprehensive substance use disorder program and (ii) set standards for provider certification. Historically, the Department met this directive under IDAPA 16.07.20; the Department proposes to replace IDAPA 16.07.20 with these pending rules.

Ms. Teeter stated that when managed care was implemented in Idaho, oversight of the certification process for mental health providers was moved to Idaho's managed care contractor, Optum Idaho. During negotiated rulemaking, mental health providers advocated for the return of state certification. Specifically, mental health providers commented that (i) State certification is required by certain private payers, like Blue Cross, in order for providers to receive payments and (ii) State certification is often required in order to obtain federal grant funding.

However, during negotiated rulemaking, behavioral health providers also commented that mandatory audits are becoming administratively burdensome to their business. As a result of these comments, the Department will complete the certification process by requiring attestations from the providers, conducting selected site audits and reviewing other certification audits – a process called "deeming." **Ms. Teeter** stated that "deeming" means that the Division of Behavioral Health reviews audit findings from other groups, including national certification bodies, in lieu of a certification audit by the State. **Ms. Teeter** noted that this practice is common in other states.

Ms. Teeter pointed out that there were two provisions in the pending rules for which a consensus among stakeholders was not reached. First, if a behavioral health provider fails a criminal history background check, the pending rules allow the provider to request a waiver of this requirement. **Ms. Teeter** explained that this waiver program only applies to behavioral health providers and does not apply to the Department's whole criminal history process. Second, the pending rules allow the Department to grant variances from compliance. The Department wanted to maintain flexibility of the certification rules in order to align with future best practices set at the national level.

Ms. Teeter indicated that there is no anticipated fiscal impact for this rule. The Department currently collects a fee of $100 for treatment program facilities and $50 for recovery support providers, such as taxi companies and child care providers. The proposed rule will create a flat $100 fee for each behavioral health program.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Regarding background check waivers for behavioral health providers, **Senator Jordan** asked if successful graduates from drug court, who later became behavioral health counselors, could provide services in the same facility in which they received treatment. **Ms. Teeter** answered that this example was exactly the intention of these waivers.

Vice Chairman Nuxoll asked if the entire rule was rewritten. **Ms. Teeter** replied that it was rewritten.

Senator Martin asked if there was a backlog in the current inspection process and, if so, how long is the backlog. **Ms. Teeter** answered that there is no current backlog for inspections. She noted that the substance use disorder network is approximately 150 sites or 120 to 130 providers. The Department performs approximately ten inspections a month.

Senator Harris asked for clarification about the number of times audits take place for a provider. **Ms. Teeter** replied that the proposed rule is for one State certification, which involves the review of minimum standards for behavioral health providers. However, each payer or entity that reimburses providers has its own auditing schedule and requirements for providers. Therefore, it depends on who the provider is billing and the exact requirements for that entity.

To clarify the modification of the current fees to a flat fee, **Senator Hagedorn** asked what the current fee is for a recovery support provider – for example a taxi company – and what its fee will be after the rule is implemented. **Ms. Teeter** answered that the current fee for a taxi company is $50. After the rule is implemented, a taxi company would pay $0. Second, if a payer to a behavioral health provider requires certain certification standards for that provider and there is a national certification a provider can obtain, **Senator Hagedorn** asked why the Department offering another certification. **Ms. Teeter** answered that the Department wants to make sure that providers understand the particular State statutes and rules that impact them, and to provide an optional path for State certification for providers who are required by their payers to be State certified. **Senator Hagedorn** asked why the Department was implementing a State certification process based on the opportunity to inform all providers of State policy, if Optum Idaho is already informing providers of State policy. **Ms. Teeter** noted that Optum only informs Medicaid providers. However, there are other providers in Idaho, who are not part of Optum Idaho's network, who may need State certification to obtain payments from certain payers. **Senator Hagedorn** asked if a national certification would satisfy those other payers such

as Blue Cross. **Ms. Teeter** answered that it is her understanding that a national certification would not satisfy Blue Cross requirements.

Senator Schmidt asked if a behavioral health provider is the same as a behavioral health program, as mentioned in the rules. **Ms. Teeter** replied that these are the same. **Senator Schmidt** inquired if a recovery center or recovery support service be considered a behavioral health program. **Ms. Teeter** answered that it depended on the direction the recovery center took. For example, those that want to become billable service providers will fall into this rule. **Senator Schmidt** asked why the definition of a behavioral health program does not include billable services as a requirement, if that is part of the intent. **Ms. Teeter** replied that the rule is aimed at providers who provide out-patient services that would be billable such as individual, group and family therapy.

TESTIMONY: **Vice Chairman Nuxoll** invited testimony.

Greg Dickerson, Mental Health Provider, Director and Treasurer of the Idaho Association of Community Providers (IACP), testified that IACP opposes the pending rules (see attachment 2). Referencing the costs of accreditation (see attachment 2 - handout 4b), **Senator Hagedorn** asked why the handout estimated cost of accreditation at $3,000 and Mr. Dickerson stated the IACP's cost of accreditation was approximately $9,000. **Mr. Dickerson** replied that the $3,000 was the approximate cost of accreditation by the Joint Commission. IACP was certified by the Commission on Accreditation of Rehabilitation Facilities (CARF). **Senator Hagedorn** asked if the Joint Commission and CARF are both national accrediting bodies. **Mr. Dickerson** replied that both are national accrediting bodies, but noted that the Joint Commission accredits mostly hospitals and rehabilitation services. Noting that State certification is optional, **Senator Jordan** asked why the Committee should reject the pending rules. **Mr. Dickerson** answered this rule is the lead-in for proposed rules related mental health providers and that the goal for this rule is to align substance abuse providers under the same credentialing system for mental health providers. **Vice Chairman Nuxoll** asked why a provider would want to pay for national accreditation. **Mr. Dickerson** replied that IACP has maintained its CARF accreditation because the CARF standards manual provides a lot of technical data that helps the association's business. **Senator Schmidt** asked if Mr. Dickerson was a representative for the Mental Health Providers Association of Idaho (MHPAI). **Mr. Dickerson** answered that he is a representative for IACP, which was formerly known as several other organizations including the MHPAI. **Senator Schmidt** asked about the scope and membership size of the IACP. **Mr. Dickerson** replied that the IACP consists of mental health, substance abuse, residential habilitation, case management and developmental disability providers. The IACP includes 60 mental health service providers and an unknown number of substance use disorder service providers. He commented that only 60 percent of its members support current legislation, while 30 percent of its members oppose current legislation and 10 percent of members were undecided. **Senator Schmidt** asked for clarification regarding the disposition of IACP members towards the pending rules. **Mr. Dickerson** answered that 60 percent of IACP members represent a good majority for the IACP for recommendations.

Senator Hagedorn asked Ms. Teeter why the Department is proposing State certification to conform with a private insurance company instead of having the insurance company change their rules. **Ms. Teeter** stated that the Department's goal is to streamline the credentialing process for behavioral health providers. She stated that State statute requires mandatory State certification for substance abuse providers, while State certification for mental health providers is optional; the Department is working to integrate the certification process for both types of behavioral health providers. Questioning the statutory authority for these rules, **Senator Hagedorn** asked if creating a State statute rather than making a rule would better accomplish the task of bringing in mental health providers under the mandatory standards that substance abuse providers have to abide by. **Ms. Teeter** responded that the Department worked with the Deputy Attorney General and concluded that the Regional Behavioral Health Services statute provides the statutory authority necessary to promulgate rules such as this one. **Mr. Edmunds** summarized that the purpose of this rule is to streamline the process that is already in place via rules and State statutes for substance use disorder providers. On the mental health side, the rule creates a voluntary State approval process to allow mental health providers to obtain State certification if such certification is required by their respective funding bodies. He suggested that if the proposed rule required national accreditation for all mental health providers in the State, there would be a line out the door in opposition.

Kelly Keele, Executive director of Children's Supportive Service, Inc., testified that the pending rules should be rejected (see attachment 3).

Sara Bartles, Contract Manager, BPA Health (BPA), testified in favor of State accreditation. **Ms. Bartles** noted BPA's acceptance of national accreditation, but stated that BPA understands that State accreditation is a more feasible option for some providers. **Senator Schmidt** asked if BPA was a member of IACP. **Ms. Bartles** stated that BPA is not a member of IACP because they are not a direct service provider. **Senator Schmidt** asked if members of BPA are part of IACP. **Ms. Bartles** answered some BPA network members are members of IACP, but not all. **Senator Hagedorn** asked if approval of this rule docket would allow BPA providers to bill Blue Cross. **Ms. Bartles** replied that some BPA members are contracted with Blue Cross. She commented that if providers interested in delivering services in the BPA network, they would have to seek facility approval from the Department. **Senator Hagedorn** asked if BPA members are providers to Optum and whether they met Optum's credentialing. **Ms. Bartles** responded that there are providers in the BPA network that are providers in Optum's network, but it is not a complete overlap.

Senator Martin asked Mr. Dickerson to clarify his position after the Committee had heard other testimony. **Mr. Dickerson** indicated that mental health providers are concerned about being included in the State's certification process when they are already audited by their respective funding sources. **Senator Jordan** asked whether there are people in the community who need mental health services but are unable to access those services because of the inability of the provider to bill the insurance company due to the absence of the opportunity to have a State certification. **Mr. Dickerson** answered that he did not understand the concern about Blue Cross, since the IACP is part of Blue Cross' network and has never been required to produce a State certification. IACP reached out to a provider that was required to provide a State certification to Blue Cross, but that provider was trying to be credentialed as a substance provider. IACP has applied for federal contracts and responds to the State requirement questions by stating that there is no certification available. The IACP has been successful in obtaining federal contracts. **Senator Jordan** asked if there are other grants

or resources that may require State certification. **Mr. Dickerson** stated that he was not aware of any such examples.

MOTION: **Chairman Heider** moved to hold **Docket 16-0715-1501** in Committee and that the providers and networks come back before the Committee after they are able to come to an agreement. **Senator Martin** seconded the motion.

Senator Lee supported the motion, but commented that not all rulemaking results in agreement by all parties. **Senator Hagedorn** stated that there are unanswered questions and enough concern from both sides that the Committee might not ever be able to come to a conclusion. He commented that if the rule is held until the end of the Legislative session, the rule goes into effect whether the Committee votes on it or not. He stated his opposition to accepting this rule. He stated his support for the current motion. **Senator Lodge** requested that the Department answer some of the questions posed by Mr. Dickerson. She asked how many organizations were involved in the rule making process.

The motion carried by **voice vote**.

Vice Chairman Nuxoll stated that in lieu of time the Committee would wait with the other dockets. **Ms. Teeter** stated that the next two dockets would not need to be discussed if the previous docket does not pass.

PASSED THE GAVEL: Vice Chairman Nuxoll passed the gavel back to Chairman Heider.

Chairman Heider explained that **Docket 16-0715-1501**, **Docket 16-0717-1501** and **Docket 16-0720-1501** will be held indefinitely until the Department would like to present them.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:56 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Michael Jeppson
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, January 27, 2016

ATTACHMENT 1

NORTHWEST FOOD PROCESSORS ASSOCIATION

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The Honorable Lee Heider
Chairman, Senate Health and Welfare
Idaho Statehouse, Room EW14
P.O. Box 83720
Boise, ID 83720-0038

Re: Docket No. 16-0219-1501 Food Safety and Cottage Foods Rulemaking

The Northwest Food Processors Association (NWFPA) represents food processing companies across Idaho. Our members place the highest priority in providing food products to consumers that are worthy of their trust that consuming them is safe. It is for this reason that NWFPA is submitting these comments with regard to proposed amendments to the Idaho "Food Safety and Sanitation Standards for Food Establishments," IDAPA Chapter 16.02.19, also known as the Idaho Food Code.

NWFPA vigorously supports adoption of the 2013 Food Code by Idaho Department of Health and Welfare (IDHW). The 2013 edition is the eighth edition of the Food Code and represents the latest thinking by food safety professionals across the country about practical, science-based procedures for mitigating foodborne illness. It is the gold standard for protecting people consuming food products that they purchase at retail or foodservice establishments and helps to ensure them that they will have equal protection from foodborne illness whether they are in Boise, Blackfoot, New York, Los Angeles or any place else in the country.

The value of a national standard for safe food practices is that foodborne illness knows no boundaries. Consumers should not have to grapple with a patchwork of different food safety standards depending on where they are. As the Legislature reviews these updates, we would express our support for your adoption of this portion of the rule changes as the agency is helping to protect Idahoans from foodborne illness when they are at home, at their grocery store, in a restaurant, or when they travel, by recognizing the need for and supporting consistency in food safety standards throughout the country.

However, NWFPA members are concerned that the agency's concurrent attempt to exempt cottage food establishments from these standards is counterproductive to consistent, science-based approach to public health and endangers Idahoans. We oppose this action because it jeopardizes the confidence in the safety of the food supply that food processors work so hard to establish and maintain and the strength of the State regulatory systems upon which food processors rely.

Section 001.04(h) of the docket proposes to add to establishments not subject to the rules:

> *Cottage food operations, when the consumer is informed and must be provided contact information for the cottage food operations as follows:*

- *By a clearly legible label on the product packaging; or a clearly visible placard at the sales or service location that also states:*
- *The food was prepared in a home kitchen that is not subject to regulation and inspection by the regulatory authority; and*
- *The food may contain allergens.*

NWFPA opposes this exemption for these reasons:

1. **The home kitchen operation, which is not subject to regulation and inspection by the regulatory authority, is not consistent with best practices recommendations by the nation's regulatory food safety experts.**

This exemption is contrary to the recommendation of the very Food Code that the Idaho Department of Health and Welfare (IDHW) proposes to adopt in this same docket. Chapter 3 of the 2013 Food Code says the following:

> *"Food should be purchased from commercial supplies under regulatory control. Home kitchens, with their varieties of food and open entry to humans and pet animals, are frequently implicated in the microbial contamination of food. Because commercial items seldom are eaten right away, the home kitchen's limited capacity for maintaining food at proper temperatures may result in considerable microbial growth and toxin production by microorganisms introduced through the diverse sources of contamination. Controlled processing is required for the safe preparation of food entering commerce."*
>
> *Chapter 3, 2013 Food Code*

The Association of Food and Drug Officials (AFDO), which is a national association representing state and federal food safety regulatory professionals from across the country, has recognized the controversial and difficult nature of providing oversight to these businesses which is both sensitive to their unique needs while being reasonably protective of public health. To that end, they have developed a guidance document for best practices in the regulation of cottage food businesses. The intent of this document, like the Food Code itself, is to provide uniform standards for adoption across the country.

The AFDO guidance has among its prerequisite requirements the following:

> *All cottage food operations must be permitted annually by the regulatory authority on forms developed by that authority. The permit will identify a specific listing of the food products allowed to be produced by the cottage food operation.*
>
> *Prior to permitting, the regulatory authority will examine the premises of the cottage food operation to determine it to be in substantial compliance with the requirements of this guidance document.*

These requirements are warranted for public health safety, not only to function as an enforcement mechanism to the business, but to serve as educational vehicles to assist the business owner in establishing a operation that will remain viable and not destroyed because foodborne illness tragedies have put them out of business. They do that by addressing such issues as:

Are the operation's personnel trained to handle food safely?
Are the product recipes really low risks for microbial hazards (non-time/temperature control for safety (non-TCS) foods)? How about foods that require acid to control microbial hazards?
Are there other hazards, such as physical or chemical hazards, that may render the food unsafe?
Are the products prepared consistently with the recipes to ensure safety?
Are there other domestic activities being conducted in the area besides the person preparing the food that may contaminate it, such as dishwashing, clothes washing, cleaning, tending babies or pets?
Is the equipment sufficient to produce a safe product?
Are the ingredients stored and handled in a way that they are free of rodents and insects?
Are the food preparers not ill when handling the food product?
Is the water supply potable?
Are the raw agricultural materials handled in a way to prevent cross-contamination of the finished product? How about the solid and liquid waste?

All of these and more are factors that the health inspector can assist the business owner in identifying and correcting before the product is made and potentially endangers someone's safety.

2. **The proposed rules send confusing food safety messages to consumers and leave cottage food businesses and consumers unprotected.**

The proposed rules require that the consumer is informed and must be provided contact information for the cottage food operations by a clearly legible label on the product packaging or a clearly visible placard at the sales or service location.

A label statement or placard, in this context, is not protective of public health. While company contact information is an important part of all food labeling schemes, it is designed to be reactive. Its purpose is to provide the consumer or the regulatory body the information needed to contact the producer of the product *after* someone has been damaged by it. It is needed to seek reparations and to help prevent further damage.

Labeling a product made in a home kitchen is a great way to tell consumers that this food is regulated *differently* than their traditional counterparts. However, allowing food sold with no regulatory oversight jeopardizes food safety. There must be middle ground that achieves minimal oversight to allow these businesses to flourish AND protects the public health. Removing these foods from any regulatory oversight not only puts the cottage food producer at risk, but also puts public health at risk too.

The Food Safety Modernization Act, enacted in 2011, requires food processors to institute systems in their operations that prevent food hazards. This law contains an exemption to for these very small processors who sell directly to end-users. However, there is a catch. They must document either that they have oversight by an appropriate regulatory body or they have identified potential hazards in the food being produced, are implementing preventive controls to address them and are monitoring to ensure the controls are effective. IDHW's proposal leaves cottage foods businesses with no oversight and few means to comply with federal law. IDHW's proposed exemption walks away from creating a buffer between the Idaho cottage foods industry and the federal government.

NWFPA appreciates and supports that IDHW seeks to improve the safety of the food supply for Idahoans. However, we respectfully disagree with the proposal to exempt cottage foods businesses from regulatory oversight by the agency. We believe that the AFDO model serves as a good compromise for the special needs of these very small businesses, assists them in complying with federal law, and is sufficiently protective of public health. Furthermore, reasonable oversight in the AFDO model provides consistency consumers depend upon when purchasing foods regardless of their location. We believe this approach will help that sector grow their businesses and become viable contributors to their communities. We urge the language in Section 001.04(h), Sections 110.06, 110.07 and 110.13 a&b, and the language added to Section 620, of the docket be struck from the rule and the remainder of the rule (Docket No. 16-0219-1501) be accepted.

We strongly support the AFDO model and appreciate the incorporation of AFDO principles in the bulk of this rule. However, we cannot support the divergent direction the IDHW has taken with respect to cottage foods. We hope Idaho retains some reasonable level of oversight for the burgeoning cottage food industry that ensures public safety. Thank you for the opportunity to provide comments.

Sincerely,

Ian Tolleson

Ian Tolleson
Vice President, Government Affairs

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, January 27, 2016

ATTACHMENT 2

IDAHO ASSOCIATION OF COMMUNITY PROVIDERS, INC.
4477 W. Emerald St, Suite C100
Boise, ID 83706

Docket Number 16.0715.1501

Presented to the House and Senate Health & Welfare Committees

Mr. (Madam) Chairman, and members of the committee. My name is Greg Dickerson and I am a Mental Health Director and Treasurer of the Idaho Association of Community Providers (IACP). The IACP is the result of a merger between the Mental Health Provider Association of Idaho, The Idaho Association of Developmental Disability Agencies, the Case Management Association of Idaho, the Idaho Residential Support Association, and Advocates for Addiction Counseling and Treatment.

I am here today to represent our associations' opposition to the proposed rules describing "State Approval of Behavioral Health Programs" in Docket 16.0715.1501. This initiative is not in alignment with Idaho Statute and its intent and will create additional costs for the State of Idaho than stated in the fiscal impact statement.

During the 2010 and 2011 Legislative sessions, the Department and the Mental Health Provider Association worked with the House and Senate committees in identifying alternative cost savings to the proposed elimination of whole categories of Medicaid funded services. One of the suggestions providers introduced was to replace the Department Credentialing program by requiring mental health providers to become Nationally Accredited. At that time, the Department acknowledged that its minimal credentialing program for mental health providers cost the State $779,300 per year. The result of that work was captured in House Bill 260 of the 2011 Legislative session. This language is currently in Title 56, Chapter 2 Medicaid Managed Care Plan. (Please refer to Handouts 1 & 2a. and b.)

Not only did the legislation direct the Department to develop a Medicaid Managed Care Plan, but also directed that Mental Health services be "delivered by providers that meet national accreditation standards". To date, this docket of rules, along with the Departments' "Behavioral Health Standards Manual" is the first indication of efforts to implement this directive. These "standards" were copied from the major national accreditation bodies, yet do not contain all of the standards a provider would need to adopt to achieve national accreditation. In its introduction, the main function of these standards are stated to *"Serve as a guide for practitioners and agencies to provide best practice Behavioral Health and Recovery Support Service in Idaho. Contractors may use any portion(s) of this manual for auditing purposes".* Over the past 5 years, several providers across the state have achieved national accreditation in compliance with the statute, while others have waited for the Department to implement its provisions. (Please refer to handouts 3a., b., & c.)

The Fiscal Impact Statement of these rules states: "The fiscal impact for this rule change is anticipated to be cost neutral for state general funds and all other funds". The section goes on to describe the $100 fee per treatment facility and $50 fee for recovery support services. This is an inaccurate assessment of the costs of any credentialing effort. The real costs of credentialing comes from the process by which the authority conducts site visits and confirms that providers' are conforming to the standards. Since most of the standards described in these rules are based on national accreditation guidelines, a reasonable comparison of the ultimate costs of this program may be drawn from the actual costs of national accreditation processes.

The agency I work for underwent its 4th CARF accreditation review earlier this year. CARF surveys are for the purposes of verifying conformance with the standards and are provided at rate that allows CARF to break even in offsetting its costs. Each survey team is assigned based on the size of the agency, the number of locations surveyed, and the number of programs that are surveyed. From this formula, CARF charges are based on the number of surveyor days. For this agency with 2 locations and 3 program areas surveyed, it required 2 surveyors for 3 days each. At the rate charged of $1,550.00 per surveyor day, our accreditation review cost $9300.00. To make this a fair comparison, a part of these fees are used to compensate the travel expenses of the surveyors. However, the surveyors are not compensated as employees of the Department or as its' potential contractor will be for performing these same functions. The point is that the minimal fees described in the rule will most certainly be insufficient to meet these costs.

It is unlikely to say the least that the Department of Health & Welfare or its managed care contractors will replicate the value that National Accreditation Bodies such as CARF or the Joint Commission have brought to a wide range of health care facilities over the past several decades. (Please refer to handouts 4 a & b)

Our request is that the committee please reject these rules, and instead direct the department to follow through with the intent of the legislature when it approved HB260. In this way the State will externalize the cost of providers achieving national accreditation, and will instead focus our limited resources on direct services to meet the needs of the citizens of Idaho. I thank you for your consideration of this request, and I will stand for any questions.

Gregory Dickerson, MSW, MBA
Mental Health Provider Type Director & Treasurer,
Idaho Association of Community Providers, Inc.
(208)321-0160

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, January 27, 2016

ATTACHMENT 2 – HANDOUT 1

Mental Health Providers Association of Idaho

These proposals are designed to provide savings that will not impact actual participant services.

1. Eliminate credentialing and replace it with accreditation, which eliminates the cost of credentialing staff.
Savings: $1 million

2. For credentialing that is already scheduled conduct only one survey per agency to look at both clinic and PSR programs.
Savings: $1 million

3. Eliminate the requirement for participants to be seen annually by the agency's supervising physician. Federal rules only require one time.
Savings: $500,000

4a. Carve Mental Health Services out of the Healthy Connections Services, eliminating visits required by rule but unnecessary to the participant's health as well as transportation costs. OR
Savings: $1.5 Million

4b. Alternately, instead of #4a, accept the Healthy Connection Physician Referral as evidence of Medical necessity and in lieu of the History and Physical.
Savings: $1.5 Million

5. Return to the pre-2010 rule on assessments which allows accessing or developing a reference diagnosis and then completing a comprehensive assessment with bachelor level PSR's rather than requiring 2 full assessments: the Comprehensive Diagnostic Assessment and the Functional Assessment.
Savings: $4 Million

6. After the initial assessment, allow an update rather than a full-blown assessment each year. Currently the rules would allow this but the Prior Authorization unit requires it.
Savings: depends on the extent of the update

7. For adults only: Since treatment plans are reviewed every 120 days, remove the requirement to completely rewrite the plan every year and require it to be updated as needed.
Savings: $1.5 Million

8. If a client is qualified for both Adult Mental Health Service Coordination and PSR services and are receiving both services from the same agency, use the PSR Comprehensive Assessment (see #6) as the assessment for both services instead of developing a separate assessment for each service. Also, write the service coordination services into the PSR treatment plan instead of developing 2 separate treatment plans.
Savings: $4 Million

9. Since Mental Health service provision in the private sector is significantly less expensive than direct services provided by DHW staff, immediately refer all mental health treatment being provided by DHW staff to the private sector. Contract for indigent, uninsured individuals at the Medicaid rate. We do not have enough information to quantify the savings that could be realized by implementing this idea.

10. This suggestion may increase other expenditures, such as hospitalizations and incarcerations as needs above 5 hours per week are addressed only when the participant is in crisis and is, therefore, only recommended with great reservation: Reduce PSR services (skills training and community integration) from 10 hours per week to a maximum of 5 hours per week which would eliminate the Prior Authorization unit. Existing staff in each region could process crisis service requests. Savings would include all PSR hours currently authorized over 5 per week (Savings Unknown) plus the expense of operating the Prior Authorization Unit.
Savings: $1 Million

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, January 27, 2016

ATTACHMENT 2 – HANDOUT 2a

Division of Medicaid/Mental Health Provider Meeting
6/15/2010

Attendance: Paula Marcotte – Provider Association, Lee Barton – Provider Association, Randy May - DHW, Tom Nielsen - DHW, Pat Guidry - DHW and Paul Leary – DHW

The focus of the meeting was to review the saving proposal from the Mental Health Provider Association that was presented to the Department in a meeting during the legislative session. The following is a summary of the discussion around each recommendation:

- The projected savings that were included in the Association's proposal were a guesstimate. The first two items in the proposal point to inaccurate estimates.
    - Currently the State cost for accreditation is $779,300 – so unsure how these two suggestions would save the projected $2,000,000.
    - If national accreditation was required the State would have some responsibilities related to complaint investigation – so would need to retain some staff and operational function in the Department.
- **Recommendation #1** - The Department supports moving the accreditation process from the state to a nationally recognized accrediting body as is evidence in our current administrative rules that allow national accreditation in lieu of state accreditation.
    - Only 3 of approximately 400 mental health agencies have chosen national accreditation instead of state accreditation. This is most likely due to the cost of national accreditation compared to no agency cost for state accreditation.
- **Recommendation #2** – Both the provider association and the Department are committed to streamlining the accreditation process while assuring that all needed information is obtained in the most efficient manner for the provider and the Department.
- **Recommendation #3** – The State has no flexibility in this area as long as Mental Health clinics are authorized in the clinic section of the Medical Assistance State Plan. This is a federal requirement of all clinics that operate under this authority.
    - The option would be to move Mental Health clinic from the clinic section to the rehabilitation section of the State Plan.
    - Would require federal approval which may present some of its own challenges.
- **Recommendation #4** – Idaho Medicaid is committed to the Primary Care Case Management model and is interested in strengthening and not weakening that model of care. Indeed there is a national push to move toward Medical Homes (called Health Homes in the Patient Protection and Affordable Care Act) – not to further fractionate the health care system.
    - The provider perception is that the Department – through this rule - has made them responsible to make sure that the primary physician is doing the history and physical.
    - The intent of the rule is to assure that the patients symptoms are truly a mental health and not a physical health issue. The department had several examples of individuals that were receiving mental health services when in fact their symptoms were related to a metabolic condition.

SENATE HEALTH & WELFARE COMMITTEE
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ATTACHMENT 2 – HANDOUT 2b

- Both the provider association and the Department are in agreement with the intent of this rule – both are committed to working together to minimize the burden on the mental health provider while still meeting the intent of this rule.

- **Recommendation #5** – All in attendance felt that the "2010" rule has resulted in higher quality assessments of participants and that we should not revert back to the pre-2010 assessment rules. There was also strong agreement that the move to a single comprehensive assessment for an individual that is used by all services is a move in the right direction.
  - Commitment from both the provider association and the Department to work on a single assessment tool.
  - Tool should assess the individual's needs – not the needs of any one specific service.
  - This work will align with legislative intent stated in HB 701.
  - Pat will include both Lee and Paula in the assessment work group.
- **Recommendation #6** – Current rules (IDAPA 16.03.10.114) allow for providers to determine whether or not a full diagnostic assessment or an update is appropriate. Issue that has been seen by the Department is that some updates that have been received have contained insufficient information for the care manager to make a decision about authorization. Both Paula and Lee expressed that they have not had any issues gaining authorization based on updates.
  - Since the rules already allow for updates it may be more of an educational issue than a policy issue.
  - This is an opportunity for the Department and the provider association to work together in educating providers about what information is needed in order for the care managers to make prior authorization decisions.
- **Recommendation #7** – this recommendation is supported by both the provider association and the Department. It offers the opportunity to eliminate some billing for services that have minimal if any affect on patient outcome. Pat is going to research further to make sure there is not a federal requirement.
  - If there is nothing to impede this recommendation from occurring – Pat will work with providers to put a process together that assures that the participant's treatment plan is updated appropriately and matches the current functioning and status of the participant.
- **Recommendation #8** – See recommendation #5
- **Recommendation #9** – This recommendation is being addressed in the Division of Behavioral Health. It appears that there may be movement in this direction coming out of the Governor's Behavioral Health Work Group.
- **Recommendation #10** – The Department concurs with this recommendation but must retain a UM function over this service. All were in agreement that it would be a positive outcome to increase the UM function of the department in this area to assure that participants are getting the services that they need – and that providers that are misusing the services are brought in line.

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, January 27, 2016

ATTACHMENT 2 – HANDOUT 3a

INTRODUCTION

The Division of Behavioral Health has begun an ongoing process of developing best practice standards, which are anticipated to improve behavioral health services provided in the state of Idaho. The standards carry the intention of serving as a consistent base for the provision of high quality behavioral health care in Idaho, by providing increased awareness, understanding and utilization of best-practice service and treatment modalities.

The first release of standards (known presently as the "Core 18") includes principles that are intended to apply to all behavioral health treatment and recovery support service providers in Idaho. Additional standards will be developed according to priority and system need, and may apply to only those entities that offer the services or serve the populations identified in the standards.

Throughout the development process, careful consideration has been paid to: a) evidence-based behavioral health practices; b) widely accepted standards of behavioral health care; c) Idaho Administrative Rule (program specific); d) State contractual requirements; e) current practice; f) need throughout the state; and g) input from community providers, consumers, and stakeholders. Using the following guiding principles, a research team from Division of Behavioral Health has developed best practice standards for implementation by behavioral health providers across the state of Idaho.

Guiding Principles:
As an effort to produce standards that are unique to Idaho's behavioral health infrastructure, 11 guiding principles were established as the foundation for standards development and decision-making. These guiding principles define the qualities that are essential to the improvement of behavioral health service delivery in Idaho.

- ✓ Provide effective direction for the state of Idaho's evolving behavioral health system.
- ✓ Practice responsible management of finances and resources.
- ✓ Place a heavy emphasis on providing exceptional customer service to participants and their families, providers and stakeholders, by modeling professional and ethical behavior.
- ✓ Demonstrate respect for and encouragement of diversity and cultural awareness.
- ✓ Strive for continuous enhancement of Idaho's Best Practice Standards.
- ✓ Foster recovery, resiliency and independence by providing strengths-based, person-centered and family-focused care.
- ✓ Endorse comprehensive and integrated healthcare whereby both mental health and substance use disorders care is coordinated with primary care.
- ✓ Provide guidance for programming that is innovative and evidence-based/best practices, through decision-making that is guided by research and data analysis.
- ✓ Promote ongoing quality improvement based on participation and collaboration in development of services, policy, and planning from providers, stakeholders and participants.
- ✓ Encourage preemptive and valuable staff training and education.
- ✓ Prevention and intervention services are outcomes-based, established to minimize risks and support recovery.

SENATE HEALTH & WELFARE COMMITTEE
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ATTACHMENT 2 – HANDOUT 3b

What is the main function of standards?
Serve as a guide for practitioners and agencies to provide best practice Behavioral Health and Recovery Support Service in Idaho. Contractors may use any portion(s) of this manual for auditing purposes.

How do I use this manual?
This manual is intended to serve as a user-friendly reference guide for providers, consumers, and stakeholders; it offers guidelines on the provision of behavioral health care in Idaho. It is fully searchable by simply using the keyword search box. The guidelines contained within these standards are to be interpreted as benchmarks rooted in up-to-date evidence for not only community providers, but funding contractors as well.

What are the expectations for implementation?
Currently, the basis for implementation of these standards is opt-in, but the Department will be integrating them into current practices, and suggests that partners and stakeholders begin to do so also.

Anatomy of a Standard:

7.0 Behavioral Health Crisis Intervention and Response
7.1. Agency Protocols for Behavioral Health Crisis Intervention and Response
Rationale: Effective interventions and responses to behavioral health crisis situations can substantially enhance participants' recovery experiences, improve their overall quality of life, and even result in fewer future crisis situations. Agency has protocols in place to help guide how to effectively intervene and respond to a wide range of crisis situations.

7.1.1. Agency develops and implements strategies for guidance of staff members in carrying out crisis response and intervention strategies.
7.1.2. Agency defines 'crisis', as it applies to the services provided/population served.
7.1.3. Agency's scope as it relates to the ability to intervene or respond to crises is clearly documented.
7.1.4. Agency defines actions to be taken if it is not prepared or qualified to handle certain crisis situations.
7.1.5. Agency employs protocol for managing crises during, as well as, outside of business hours.
7.1.6. Interventions/responses foster recovery and empowerment of individual served.
7.1.7. Crisis interventions/responses are intended to stabilize participant as soon as possible so he/she may function at the same level as prior to the crisis.
7.1.8. Agency practices only within their scope of care, and provides referrals as necessary when it cannot provide required crisis services.
7.1.9. A protocol is developed and implemented for following up with participants after a crisis is experienced.

Special Considerations: For guidance on environmental disasters, reference Facility Safety section of manual.

For guidance on infection control, reference section on Reducing Risk of Spreading Infection.

References for Standard 7.0:
Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual.* Tucson: CARF International.
(pgs. 60-68, 71-72)

IDAPA Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs 16.07.20, §§ 390-392, 399 (2013).

The sub-standards are short subtitles that introduce the key components of each standard.

The "Rationale" describes the logical foundation for each sub-standard.

Below the rationale section, you will see application guidelines that specifically discuss how the agency is to carry out or evidence compliance with standards.

Sub-standards may include a category for Special Considerations. This category is designed to include any caveats that may apply to the sub-standard to which it is attached.

References are located at the end of the respective standard.

►**Future Section:** After each standard, there is a Question/Answer section that is to be continuously updated with answers to questions asked by community providers, consumers and stakeholders regarding that specific standard.
**The Question/Answer sections will be added after the initial public comment period, as questions pertaining to specific standards are submitted.*

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, January 27, 2016

ATTACHMENT 2 – HANDOUT 3c

How will the manual be distributed?
For ease of access and to ensure the most recent copy available at all times, this manual will be published electronically. Please sign up on our website to receive email updates when changes to the eManual are made.

How often will the manual be updated?
This manual will be updated on an annual basis or more frequently, according to factors including: public comment, frequently asked questions addition/changes, behavioral health field and evidence base enhancement, implementation of new services, rule/statute changes, and other identified needs.

How can I provide input?
Public input is always welcome and solicited for a period of at least 30 days prior to publication of any new standards. Comments and feedback are collected via our website (mentalhealth.idaho.gov). Please sign up on our website to receive email updates when comment periods open on proposed standards. If you have a specific comment or question, please email us at BHSurvey@dhw.idaho.gov.

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, January 27, 2016

ATTACHMENT 2 – HANDOUT 4a

Payers choose CARF to reduce risk and raise accountability

Payers -- whether a third-party funder, referral agency, insurance company, or governmental regulator -- look for CARF-accredited service providers to lessen risk and provide greater accountability.

Payers prefer CARF International as an independent accrediting body of health and human service providers. Our accredited providers have applied a comprehensive set of standards for quality to their business and service delivery practices. Because CARF accreditation signals a provider's demonstrated conformance to internationally accepted standards, it can significantly reduce governmental monitoring and help to streamline regulation processes.

In addition, CARF accreditation confirms that a program or service is committed to continuous quality improvement, accountability for its performance through outcomes evidence, and monitoring the satisfaction of the persons served. Countries, states, territories, and provinces on five continents recognize one or more of CARF International's areas of accreditation, and many mandate CARF exclusively in at least one area of accreditation.

As a third-party payer, referral source, insurer, or governmental regulator, you have access to searches and lists of CARF-accredited service providers and current CARF standards manuals and monographs. Login here or request a new payer account.

About CARF movie

View the About CARF movie (Flash, 3 min.) for an introduction to CARF International. Or view the script.

Aging services lenders

Lenders seeking to invest in the senio housing and services sector may have questions about accreditation and how it helps identify an organization that is prepared to meet the terms of a lending arrangement.

Visit www.carf.org/lenders to get started.

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4/a.

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, January 27, 2016

ATTACHMENT 2 – HANDOUT 4b

Topic Details

Tuesday 1:20 CST, January 19, 2016

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Topic Library Item

Facts about Behavioral Health Care Accreditation

November 30, 2015

In 1969, The Joint Commission began accrediting providers of programs/services for persons with intellectual and developmental disabilities, and expanded in 1972 to include the evaluation and accreditation of organizations providing mental health and chemical dependency services. Today, The Joint Commission accredits more than 2,200 organizations under the *Comprehensive Accreditation Manual for Behavioral Health Care*. Accreditation is available to organizations that provide a wide range of services and programs within a variety of settings across the continuum of care (see box).

Standards

Joint Commission standards address the behavioral health care organization's performance in specific areas, and specify requirements to ensure that care, treatment and services are provided in a safe manner. A trauma-informed, recovery/resilience-oriented philosophy and approach to care, treatment and services is embedded in the requirements. The Joint Commission develops its standards in consultation with behavioral health care experts, providers, measurement experts, as well as individuals and their families. The *Comprehensive Accreditation Manual for Behavioral Health Care* is available for purchase in both hardcover and electronic format. There are additional requirements specific to the unique needs of medication-assisted opioid treatment programs, foster care programs and certification requirements for health homes.

Accreditation process

The Joint Commission's accreditation process concentrates on operational systems critical to the safety and quality of care, treatment or services provided to the individual. Surveys are conducted by experienced and licensed behavioral health care professionals, including psychologists, social workers, professional counselors, behavioral health care nurses and administrators. Many Joint Commission surveyors are actively working in a range of behavioral health care settings.

Benefits of accreditation

Joint Commission behavioral health care accreditation provides a framework to help manage risk and enhance the quality and safety of care, treatment and services. Recognized by more than 198 state authorities, accreditation can be a useful tool to demonstrate compliance with state regulations or licensure requirements. Joint Commission accreditation also is a condition of reimbursement for certain insurers, including Medicaid and commercial payers. The process provides a customized, intensive review, and enhances staff recruitment and development.

Optional certification

Behavioral Health Home Certification is an optional certification to recognize organizations that coordinate and integrate all health care needs of a population served. The optional certification goes above and beyond what is required for accreditation and provides additional recognition as a health home.

Cost of accreditation

The on-site survey fee is paid at the end of the on-site survey and covers survey-related direct costs. The on-site fee for a small organization starts at $3,020. The annual fee, which is based on an organization's volume and type of services provided, is due each January and covers Joint Commission accreditation related services. Annual fees for behavioral health care organizations start at $1,820 and are adjusted based on the number of individuals served, the types of services and programs provided, and sites of care, treatment or services. The Joint Commission Connect extranet includes a fee calculator to help estimate annual subscription billing costs for current customers. For more information about pricing, contact The Joint Commission's Pricing Unit at 630-792-5115 or pricingunit@jointcommission.org.

Read more about behavioral health care accreditation

(4b)

Joint Commission Accredited Behavioral Healthcare Providers in Idaho

Organization	Address	
CenterPointe, Inc.	915 Park Centre Way, Suite 7	Nampa, ID 83651
Community Health Clinics, Inc. DBA: Terry Reilly Health Services	1224 1st S. Suite 302	Nampa, ID 83651
Community Health Clinics, Inc. DBA: Terry Reilly - Caldwell Elgin	1411 Hope Ln	Caldwell, ID 83605
Terry Reilly Health Services DBA: Terry Reilly Medical - Nampa 16th Ave	223 16th Ave, N.	Nampa, ID 83653
DBA: Terry Reilly Medical / Mental Health/ SANE Solutions - Boise	300 S. 23rd Street	Boise, ID 83702
DBA: Terry Reilly Medical / Mental Health - Caldwell	2005 Arlington	Caldwell, ID 83605
Terry Reilly Health Services DBA: Terry Reilly Medical / Mental Health - Homedale	116 E. Idaho	Homedale, ID 83628
Terry Reilly Health Services DBA: Terry Reilly Medical / Mental Health - Marsing	201 Main Street	Marsing, ID 83639
Terry Reilly Health Services DBA: Terry Reilly SANE Solutions - Boise	408 N. Allumbaugh	Boise, ID 83704
Terry Reilly Health Services DBA: Terry Reilly Medical / Dental / Mental Health - Middleton	201 S. First Ave. E	Middleton, ID 83644
Terry Reilly Health Services DBA: Terry Reilly - Boise Latah	848 LaCassia	Boise, ID 83705
Lewiston Community Based Outpatient Clinic DBA: VA Lewiston Community Based Outpatient Clinic	1630 23rd Ave. Suites 302 & 401 Bldg. 2	Lewiston, ID 83501
Community Based Outpatient Clinic	915 W. Emma Avenue	Coeur D Alene, ID 83814
Northpoint Recovery	10787 W. Ustick Road	Boise, ID 83713
Project PATCH Ranch	25 Miracle Lane	Garden Valley, ID 83622

CARF Accredited Behavioral Healthcare Providers in Idaho

A to Z Family Services	Blackfoot
A to Z Family Services	Pocatello
A to Z Family Services	American Falls
A to Z Family Services	Malad
A to Z Family Services	Idaho Falls
Boise VA Medical Center	Boise
Human Supports of Idaho	Boise
Human Supports of Idaho	Caldwell
Idaho Behavioral Health	Boise
Idaho Behavioral Health	Caldwell
Idaho Behavioral Health	Mountain Home
Joshua D. Smith & Associates	Idaho Falls
Joshua D. Smith & Associates	Pocatello
The Walker Center	Gooding
The Walker Center	Twin Falls
Easter Seals Goodwill	Boise
Easter Seals Goodwill	Caldwell
Easter Seals Goodwill	Moscow
Easter Seals Goodwill	Couer d Alene
Easter Seals Goodwill	Lewiston
Easter Seals Goodwill	Ponderay
Center for Behavioral Health	Boise
Center for Behavioral Health	Meridian
Raise The Bottom Training & Counseling Center	Boise

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, January 27, 2016

ATTACHMENT 2 – HANDOUT 5

HOUSE BILL NO. 260

The purpose of this legislation is to reduce health care costs in the Medicaid budget and improve the healthcare delivery system in Medicaid. The proposed changes to the law will implement policies that should be changed or deleted temporarily because of the current economic situation, with the possibility of being continued later, because they are found to be excellent business practices; permanently discontinue policies when they are poor business practices; discontinue benefit programs when the preponderance of scientific evidence does not support the outcomes; re-design certain optional programs to reflect those basic needs that are necessary to prevent elevated costs in other areas; propose to eliminate the fee-for-service healthcare delivery to a managed care approach which will focus on improved healthcare outcomes; remove all forms of self-referral by certain healthcare providers; maximimze co-pays to the extent allowed under federal law to encourage personal responsibility; provide structural support to implement changes.

(d) Mental health services delivered by providers that meet national
19 accreditation standards, including:
20 (i) Inpatient psychiatric facility services whether in a hospi-
21 tal, or for persons under age twenty-two (22) years in a freestand-
22 ing psychiatric facility, as permitted by federal law, in excess
23 of those limits in department rules on inpatient psychiatric fa-
24 cility services provided under subsection (5) of this section;
25 (ii) Outpatient mental health services in excess of those limits
26 in department rules on outpatient mental health services provided
27 under subsection (5) of this section; and
28 (iii) Psychosocial rehabilitation for reduction of mental dis-
29 ability for children under the age of eighteen (18) years with a
30 serious emotional disturbance (SED) and for severely and persis-
31 tently mentally ill adults,. Individuals aged eighteen (18) years
32 or older, to age twenty-one (21) years with severe and persistent
33 mental illness shall have access to benefits up to a weekly cap of
34 five (5) hours while adults over the age of twenty-one (21) years
35 with severe and persistent mental illness shall have access to
36 benefits up to a weekly cap of four (4) hours

TITLE 56
PUBLIC ASSISTANCE AND WELFARE
CHAPTER 2
PUBLIC ASSISTANCE LAW

56-255. MEDICAL ASSISTANCE PROGRAM -- SERVICES TO BE PROVIDED.

(ix) Behavioral health services, including:
1. Outpatient behavioral health services that are appropriate, delivered by providers that meet national accreditation standards and may include community-based rehabilitation services and case management; and
2. Inpatient psychiatric facility services whether in a hospital, or for persons under the age of twenty-two (22) years in a freestanding psychiatric facility as permitted by federal law;

TITLE 56
PUBLIC ASSISTANCE AND WELFARE
CHAPTER 2
PUBLIC ASSISTANCE LAW

56-263. MEDICAID MANAGED CARE PLAN.

(c) Managed care contracts to pay for behavioral health benefits as described in executive order number 2011-01 and in any implementing legislation. At a minimum, the system should include independent, standardized, statewide assessment and evidence-based benefits provided by businesses that meet national accreditation standards.

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, January 27, 2016

ATTACHMENT 3

Regarding the Rejection of
Pending Fee Rule for Behavioral Health Programs in
Docket 16-0715-1501

Representing Children's Supportive Services and in support of The Idaho Association of Community Providers, which represents Behavioral Health providers throughout the state, I am requesting you oppose the new chapter of Pending Fee Rule which would establish a credentialing program for Behavioral Health Programs operated by State employees. Such a program would not add any value, duplicates reviews already conducted by the Managed Care Organization (Optum Idaho) and does not meet the requirement in Idaho code for Behavioral Health Agencies to meet national accreditation standards.

The rules that raise our concern are contained in Docket 16-0715-1501, this set of rule is interrelated to Docket 16-0717-1501 which were both published in the September 2015 Bulletin:

http://adminrules.idaho.gov/bulletin/2015/09.pdf

Both of these sets of rules are related to a set of "Behavioral Health Standards" available on the Division of Behavioral Health's Mental Health site here:

http://healthandwelfare.idaho.gov/Default.aspx?TabId=103

Five Reasons to Reject This Pending Fee Rule

(1) Prior to 2013 the Department of Health & Welfare spent $779,000.00 per year conducting an ineffective credentialing process.

(2) HB260 was passed which requires Behavioral Health Agencies to meet national accreditation standards. This requirement has yet to be implemented by the Department.

(3) In the original rules announcement the descriptive summary stated: *"This new chapter of rule is being written to* ***meet the needs of the Department*** *in developing a behavioral health system of care".*

(4) The Behavioral Health Managed Care Organization (Optum Idaho) is already paid for and conducts credentialing reviews on all providers in their network.

(5) A move to the National Accreditation, as required in Idaho Code, would improve quality and outcomes of Behavioral Health Services.

Please vote to reject this rule and, instead, request the Department set up negotiated rule making this Spring to require a "sunset" date by which time National Accreditation will be required for all Behavioral Health Providers.

Thank you.

J. Kelly Keele, Executive Director
Children's Supportive Services, Inc.
1565 E. Lincoln Rd., Idaho Falls, Idaho 83401
Skil4Life@aol.com
(208) 521-4294 cell

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, January 28, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Docket No. 24-1501-1501	PENDING RULE: Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists	**Mitchell Toryanski** Attorney, Bureau of Occupational Licenses
Docket No. 24-1701-1501	PENDING RULE: Rules of the State Board of Acupuncture	**Mitchell Toryanski**
Docket No. 24-2401-1501	PENDING FEE RULE: Rules of the Genetic Counselors Licensing Board	**Mitchell Toryanski**
Docket No. 24-0301-1501	PENDING RULE: Rules of the State Board of Chiropractic Physicians	**Roger Hales** Attorney, Bureau of Occupational Licenses
Docket No. 24-0501-1501	PENDING RULE: Rules of the Board of Drinking Water and Wastewater Professionals	**Roger Hales**
Docket No. 24-0601-1501	PENDING RULE: Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants	**Roger Hales**
Docket No. 24-1201-1501	PENDING FEE RULE: Rules of the Idaho State Board of Psychologist Examiners	**Roger Hales**
RS24009	RELATING TO CHIROPRACTIC PRACTICE: Amending to revise restrictions relating to prescribing, dispensing, independently administering, distributing, directing or suggesting to patients certain drugs, substance or products.	**Roger Hales**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

Sen Martin

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, January 28, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:03 p.m.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Nuxoll to conduct the rules review.
DOCKET NO. 24-1501-1501	**Rules of the Bureau of Occupational Licenses Related to the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists** (PCMFT Board). **Mitchell Toryanski**, Attorney, Bureau of Occupational Licenses (BOL), presented this docket. **Mr. Toryanski** stated that the pending rules update the incorporated references to the American Association for Marriage and Family Therapy (AAMFT) code of ethics, which was revised and went into effect in January 2015. He stated that the pending rules create a registration renewal process for the supervisors of counselor and therapist applicants and include a requirement for supervisor training. The rule change will allow the PCMFT Board to know which supervisors are still active and qualified. **Mr. Toryanski** reported that the PCMFT Board held an open meeting for these pending rules. Additionally, a postcard was mailed to all licensees in the State of Idaho that informed them of the changes and invited comments. **Mr. Toryanski** stated that no comments were received. **Vice Chairman Nuxoll** asked the Committee members if they had any questions.
MOTION:	There being no questions, **Senator Harris** moved to approve **Docket No. 24-1501-1501**. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.
DOCKET NO. 24-1701-1501	**Rules of the Bureau of Occupational Licenses Related to the State Board of Acupuncture** (Acupuncture Board). **Mr. Toryanski**, BOL, presented this docket.

Mr. Toryanski stated that the pending rules include two changes related to continuing education (CE) requirements for acupuncturist licensees. First, **Mr. Toryanski** reported that, for licensees who have failed to timely renew their license, the pending rules cap reinstatement CE requirements at two years. He explained that acupuncturist licenses are required to be renewed annually. Currently, a licensee can reinstate their license that has lapsed if, within five years, the licensee pays a $250 license reinstatement fee and shows that they have obtained 15 credit hours of CE for each year of the lapse. The Acupuncture Board felt this current requirement was too burdensome. Therefore, the pending rules require that a licensee needs 15 credit hours of CE to reinstate a license that has lapsed for a year or less; a licensee needs 30 credit hours of CE to reinstate a license that has lapsed for more than a year.

Second, **Mr. Toryanski** stated that the pending rules allow licensees to receive CE credits for both attending and teaching a course approved by the Acupuncture Board. **Mr. Toryanski** stated that many boards give credits to licensees for teaching approved CE courses. The pending rules would allow a licensee to receive one hour of CE credit for every two hours of teaching – up to a maximum of five CE credits per year. Notice of the rule change was given to all State licensees in the same manner as the previous docket item. He stated that no comments were received.

Mr. Toryanski reported that the Acupuncture Board held an open meeting for these pending rules. Additionally, a postcard was mailed to all licensees in the State of Idaho that informed them of the changes and invited comments. **Mr. Toryanski** stated that no comments were received.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Chairman Heider asked how common it was for acupuncturists to allow their licenses to expire. **Mr. Toryanski** answered that not many of the 177 licensees fail to renew their licenses and that it varies from year to year.

MOTION: There being no further questions, **Senator Martin** moved to approve **Docket No. 24-1701-1501**. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 24-2401-1501 **Rules of the Bureau of Occupational Licenses Related to the Genetic Counselors Licensing Board** (GC Board). **Mr. Toryanski**, BOL, presented this docket.

Mr. Toryanski introduced the GC Board Chairman, Heather Hussey. The GC Board was created last year by the Legislature through the Genetic Counselors Licensing Act. The pending fee rules detail (i) operations of the GC Board, (ii) the license application process, (iii) fee schedules, (iv) licensure requirements, (v) CE requirements and (vi) disciplinary standards. **Mr. Toryanski** reported that the GC Board held open meetings for these pending rules.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Schmidt asked how many genetic counselors the State expects to license. **Mr. Toryanski** replied that there are approximately 12 in the State currently. However, since the passage of the Idaho Telehealth Access Act, the GC Board expects between 70 to 100 genetic counselors from outside the State to apply for State licensure.

Senator Martin asked why the Idaho Telehealth Access Act will increase the number of genetic counselors. **Mr. Toryanski** answered that the BOL serves multiple boards that are capable of providing services through electronic means. He stated that providing services via electronic means is becoming more popular and will increase interest by out-of-state practitioners. **Senator Schmidt** asked how the fee was established at $500. **Mr. Toryanski** replied that $500 fee in the pending rules is the maximum allowed by law. It is still undetermined how many practitioners will be applying for licenses. He stated that the GC Board is approximately $3,000 in debt. The pending rules are aimed at helping the GC Board pay off its debt; once the GC Board maintains 100 percent to 150 percent of their operating budget on balance, the GC Board will request a fee reduction.

MOTION: There being no further questions, **Senator Schmidt** moved to approve **Docket No. 24-2401-1501**. **Chairman Heider** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 24-0301-1501 **Rules of the Bureau of Occupational Licenses Related to the State Idaho Board of Chiropractic Physicians** (Chiropractic Board). **Roger Hales**, Attorney, BOL, presented this docket.

Mr. Hales identified the relevant documents provided to the Committee, including (i) time lines, (ii) letters to licensees, (iii) notices regarding public hearings and rulemaking and (iv) a letter from the attorney general's office to Representative Fred Wood (see attachment 1). Referencing hearings from the previous Legislative Session, **Mr. Hales** reviewed testimonies of chiropractors regarding certain procedures performed on the public and involving the use of legend and prescriptive drugs such as injectable Vitamin B12. The chiropractors cited IDAPA 24.03.01.020 (Rule 020) as their authority to use legend or prescriptive drugs. Chiropractic statutes prohibit chiropractors from using legend or prescriptive drugs. Chairman Wood of the House Health and Welfare Committee proposed legislation last year to strike Rule 020 completely, but ultimately decided to allow the Chiropractic Board one year to fix Rule 020.

Mr. Hales stated that some chiropractors believe that the language"in all their forms" within Rule 020 justified administration of injectable or intravenous vitamins. A vitamin in injectable or intravenous form is a legend or prescriptive drug. Therefore, these pending rules strike the language "in all their forms"to eliminate confusion and to clarify that the law prohibits the use of legend and prescriptive drugs by chiropractors. Additionally, the pending rules refer back to the statutory scope of practice.

Mr. Hales stated that the Chiropractic Board noticed rulemaking, held open public hearings and solicited comments from the public regarding this rule. **Mr. Hales** recognized in attendance: Dr. Mary Jo White, Chairman of the Chiropractic Board; Dr. Herbert Oliver, Chiropractic Board Member; and Berk Fraser, Deputy Executive Director of the State Board of Pharmacy.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Martin asked how many chiropractors will be affected by this change. **Mr. Hales** replied that only a small percentage would be affected. Of those chiropractors, **Senator Martin** inquired what percentage of their practice involves the use of legend or prescriptive drugs. **Mr. Hales** answered that he did not know the answer to that question.

Reviewing Idaho Code § 54-704, **Senator Hagedorn** asked what provisions could be construed to give chiropractors the authority to inject patients. **Mr. Hales** indicated that the referenced provision of Idaho Code authorizes "clinical nutritional methods." Rule 020 further defines "clinical nutritional methods" and includes "in all their forms." This is the authorization cited by chiropractors administering vitamins in injectable or intravenous form. **Senator Hagedorn** asked if there is another type of license that would allow chiropractors to use vitamins in injectable or intravenous form in their treatments. **Mr. Hales** replied that chiropractors are currently prohibited by law from these types of treatments; however, their scope of practice can be expanded in statute in the future.

Vice Chairman Nuxoll asked if a change in the definition of legend and prescriptive drugs by the Food and Drug Administration (FDA) in 1997 resulted in the current interpretation that chiropractors' use of injectable or intravenous vitamins is prohibited; such use was not prohibited prior to the modification of this definition. **Mr. Hales** replied that the FDA changed the federal definition of legend or prescriptive drugs around 1997. He reiterated that present law is clear that chiropractors are prohibited from using legend or prescriptive drugs. **Vice Chairman Nuxoll** asked Mr. Hales to confirm that a change in federal rules modified BOL's enforcement of Idaho regulations, even though the phrase "in all its forms" remained in Rule 020. **Mr. Hales** replied that Rule 020 was adopted in 2008, after the federal government changed its definition of legend or prescriptive drugs. **Vice Chairman Nuxoll** asked if Idaho can change the definition of legend or prescriptive drugs to include injectable drugs for acceptable use by chiropractors. **Mr. Hales** replied that there is an opportunity to allow chiropractors the ability to prescribe legend or prescriptive drugs if the Legislature approved it. **Vice Chairman Nuxoll** asked if this could include injectable vitamins. **Mr. Hales** answered that injectable vitamins are currently considered legend drugs, but the Legislature could authorize to prescribe selected legend or prescriptive drugs.

TESTIMONY: **Vice Chairman Nuxoll** invited testimony.

Dr. Mary Jo White, Chiropractor and Chairman of the Chiropractic Board, testified she supports approval of the pending rules. She stated that the pending rules accurately reflect current statute and will protect the public.

Ryan Fitzgerald testified on behalf of the Idaho Association of Chiropractic Physicians (IACP). **Mr. Fitzgerald** stated that the IACP is planning on bringing forth legislation that will (i) establish education standards for chiropractors' use of legend and prescriptive drugs and (ii) establish a formulary of vitamins, minerals and nutrients that may be used by chiropractors. **Chairman Heider** asked whether chiropractors will practice within the framework of the rules and in a safe manner for the public if these pending rules are approved. **Mr. Fitzgerald** replied that IACP is neutral on this rule change. He reiterated that IACP intends to propose the previously described legislation. He noted that chiropractors in the IACP are willing to return to school for additional training. **Vice Chairman Nuxoll** asked if the proposed legislation from the IACP would include injectables. **Mr. Fitzgerald** answered that it included injectables.

Vice Chairman Nuxoll read a letter from a chiropractor in her district. The chiropractor indicated that, as a result of this rule change, more than 30 chiropractors will each experience a $100,000 to $500,000 change in their gross income annually for a total of $3 million to $15 million per year in gross revenue. This revenue change would account for the loss of approximately $10,000 in General Fund taxes annually. The chiropractor stated that there have been hundreds of thousands of treatments with no complaints or harm done. The chiropractor reviewed the 1997 federal changes to the definition of legend or prescriptive drugs. The chiropractor noted that legal action could result if the rule passes without the additional proposed favorable legislation. **Vice Chairman Nuxoll** indicated that she considered holding the rule and the law changes in Committee, but she stated she was willing to vote to pass the rule in conjunction with IACP proposing new legislation. She stated her personal interest in this legislation; she noted her two daughters have Lyme disease. Her daughters first experienced relief from the symptoms of Lyme disease when they received certain injectables from a chiropractor. **Vice Chairman Nuxoll** questioned whether or not the pending rules were meant to protect the public or protect them from getting healthy.

Senator Hagedorn indicated that this was a complicated issue, and he noted that the pending rules are focused on those who are practicing outside the scope of the law. He commended the Chiropractic Board for addressing this issue. He suggested that there have been no reports of injectable-related injuries because there was no mechanism for reporting.

MOTION: There being no further questions, **Senator Hagedorn** moved to approve **Docket No. 24-0301-1501**. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 24-0501-1501 **Rules of the Bureau of Occupational Licenses Related to the Idaho Board of Drinking Water and Wastewater Professionals** (Water Board). **Mr. Hales**, BOL, presented the docket.

Mr. Hales introduced the Water Board members in attendance: Barry Burnell, Dr. Joan Cloonan, John Lee, and Michael Shepherd. **Mr. Hales** stated that the Water Board regulates the professions of drinking water and waste water operators and backflow assembly testers. First, **Mr. Hales** stated that the pending rules clarify the experience required for Class III and Class IV operators. **Mr. Hales** explained that the pending rules (i) require Class III and Class IV operators to have four years of acceptable, relevant, on-site operating experience and (ii) clarify that for two of the total four years the operator needs to be responsible for a major segment of the system in the same or next lower class.

Second, **Mr. Hales** stated that the pending rules establish a code of ethics and standards of conduct for backflow assembly testers. Backflow assembly testers ensure that backflow assembly devices operate properly. Generally, backflow assembly devices prevent the backflow of potentially contaminated irrigated water from entering the public drinking water system. **Mr. Hales** detailed the four ethics requirements and eight standards of conduct set forth within the pending rules. **Mr. Hales** informed the Committee that the Water Board has been working on the code of ethics and standards of conduct for two years. He reported that the Water Board held an open meeting for these pending rules. Additionally, a postcard was mailed to all backflow assembly testers that informed them of the changes and the rule was posted on the Water Board's website.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Harris asked what type of feedback the Water Board received during the rulemaking process. **Mr. Hales** replied that there were approximately three or four comments that expressed concern with the adoption of a code of ethics and with the language within the pending rules.

Senator Martin expressed concern with the length of the time backflow assembly testers were allowed to report a failed inspection. **Mr. Hales** replied that two business days is a standard timeframe for backflow assembly testers to respond. He indicated that backflow assembly testers usually respond much sooner with findings of failed tests, but that two business days was the maximum.

Senator Hagedorn asked if there was another rule for backflow assembly testers that includes additional testing and reporting requirements. **Mr. Hales** answered that water system operators have a direct relationship with the backflow assembly testers. He indicated that there are many standards that set forth tools and procedures for testing. **Senator Hagedorn** asked if the standard of conduct are in conflict with the processes of any local owners. **Mr. Hales** responded that there is no conflict to his knowledge.

Senator Schmidt asked if there has been conduct problem with backflow assembly testers. **Mr. Hales** replied that there was a specific case in which a tester did not test, yet stated that he had tested. **Mr. Hales** indicated that the pending rules are intended as a proactive measure by the Water Board to establish certain minimum standards.

Chairman Heider asked if any of the backflow assembly testers in attendance had any objections to the proposed rule. No one indicated objection.

TESTIMONY: **Vice Chairman Nuxoll** invited tesitmony.

Dr. Joan Cloonan, Vice Chair of the Water Board, testified in support of the pending rules. **Dr. Cloonan** stated that the Water Board's purpose is to protect the public health, safety and welfare. Backflow assembly testers are not subject to rules of municipalities because they do not work for municipalities. She reviewed some of the complaints the Water Board received concerning backflow assembly testers. **Dr. Cloonan** commented that the code of ethics and standards of conduct reassure the public. She reviewed the details of the rulemaking process for the Committee. The Water Board made substantial effort to address the comments received. **Senator Harris** asked Dr. Cloonan what concerns were received regarding the pending rules. **Dr. Cloonan** answered that some testers wanted to perform tasks that were more appropriately under the scope of plumbers duties.

Leslie Wilder, Owner of BAT and Supply LLC, submitted written testimony in opposition of the pending rules, but did not testify during the meeting (see attachment 2).

MOTION: There being no further questions, **Chairman Heider** moved to approve **Docket No. 24-0501-1501**. **Senator Martin** seconded the motion. **Senator Harris** requested that he be recorded as voting nay. The motion carried by **voice vote**.

DOCKET NO. 24-0601-1501 **Rules of the Bureau of Occupational Licenses Related to the Licensure of Occupational Therapists and Occupational Therapy Assistants** . **Mr. Hales**, BOL, presented the docket.

Mr. Hales recognized in attendance: Kristin Guidry, Board Member, State Occupational Therapy Licensure Board (OT Board). First, **Mr. Hales** stated that the pending rules delete the requirement that licensees obtain professional development units, but still requires continuing education units, in order to renew or reinstate their license. This change aligns the rules with Idaho Code § 54-3711, which was revised in 2015 by H 024. Second, **Mr. Hales** stated that the pending rules clarify the deadlines for licensees to comply with the continuing education unit requirements. Third, **Mr. Hales** stated that the pending rules reduce the number of required supervised clinical hours required to perform deep thermal and electrotherapeutic modalities and manage wound care. Forty hours of supervised clinical training in each of these disciplines is now required to perform these techniques. The hours can be earned concurrently. **Mr. Hales** stated that the OT Board felt that the previous requirement of 160 hours for each discipline was overly burdensome, which resulted in reduced services and access for the public. Forty hours of supervised clinical training is within practice guidelines and appropriate for best practice. **Mr. Hales** reviewed the remaining minor and technical changes within the pending rules. **Mr. Hales** reported that the OT Board held an open meeting for these pending rules. Additionally, a postcard was mailed to licensees that informed them of the rule changes. **Mr. Hales** stated that he was not aware of opposition to these pending rules.

MOTION: There being no questions, **Senator Harris** moved to approve **Docket No. 24-0601-1501**. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 24-1201-1501 **Rules of the Bureau of Occupational Licenses Related to the Idaho State Board of Psychologist Examiners** (Psychologist Board). **Mr. Hales**, BOL, presented this docket.

Summarizing proposed changes, **Mr. Hales** stated that the pending rules (i) amend the ethical code of the Psychologist Board to prohibit the violation of patients' human rights, (ii) reduce licensure fees collected by approximately $19,000 annually, (iii) modify license reinstatement requirements to comply with Idaho Code § 67-2614, which was revised in 2015 by H 117, (iv) revise endorsement qualification, allowing five years experience within the last seven years and (v) clarify continuing education requirements for reinstatement of an expired license.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Martin asked if the reserve accounts of the Psychologist Board are adequate for reducing fees. **Mr. Hales** answered that the Psychologist Board has a cash balance of approximately $187,000, with $81,000 as the average yearly budget. The Psychologist Board is reducing the fees for the benefit of the licensees.

MOTION: There being no further questions, **Senator Lodge** moved to approve **Docket No. 24-1201-1501**. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

PASSED THE GAVEL: Vice Chairman Nuxoll passed the gavel back to Chairman Heider.

RS 24009 **Relating to Chiropractic Practice**. **Mr. Hales**, BOL, presented this RS.

Mr. Hales stated that this RS will eliminate confusion created by existing statutes, by clearly identifying what acts are prohibited by a chiropractor regarding the use of legend or prescriptive drugs. **Mr. Hales** stated that the existing statute prohibits chiropractors from "direct[ing] or suggest[ing]" the use of certain substances to patients; revisions proposed in this RS will prohibit chiropractors from prescribing, dispensing, independently administering, distributing, directing or suggesting the use of certain substances to patients. Additionally, **Mr. Hales** noted that the proposed RS will clarify the labeling language used to identify legend or prescriptive drugs. He indicated that the modifications are standard modifications in this area. **Mr. Hales** reported that the Idaho Board of Chiropractic Physicians held meetings for this RS. Additionally, a letter was mailed to licensees that informed them of the changes in the proposed RS.

MOTION: There being no questions, **Senator Hagedorn** moved to send **RS 24009** to print. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:31 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Michael Jeppson
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Thursday, January 28, 2016

ATTACHMENT 1

Idaho Board of Chiropractic Physicians Timeline on Rulemaking and Scope of Practice
November 20, 2015

Introduction

The Idaho Chiropractic Practice Act regulates the practice of chiropractic in Idaho. The Board of Chiropractic Physicians is part of the executive branch of government and was created by statute to enforce and administer the Idaho Chiropractic Practice Act. As a governmental entity the Board's sole purpose is to protect the public health, safety, and welfare.

One of the Board's powers to carry out its charge is to establish administrative rules as necessary to implement the provisions of the Idaho Chiropractic Physicians Act. These rules are subordinate to the laws that comprise the Idaho Chiropractic Physicians Act, and they cannot expand beyond what the law authorizes.

Every agency that has rulemaking authority has to follow specific timeframes, processes, and procedures. These include review by the governor's office, publishing of notices in the Idaho Administrative Bulletin, and an ultimate review by the legislature.

Background to Previously Proposed Law Change to the Scope of Practice

May 2, 2014 – *Public Meeting of the Board*

The Board was advised by legal counsel from the Idaho Attorney General's Office about a conflict between the interpretation of Rule 020 and the scope of practice established in the statutes. Specifically, there was concern that Rule 020 went beyond the limits of a chiropractor's scope of practice set forth in Idaho Code § 54-704(2). It was recommended that any change to the Chiropractic scope of practice be done through the legislative process to change Idaho Code § 54-704(2). The Board was advised that ideally changes to the scope of practice are brought by the profession's association because those issues are driven by the industry.

The Board decided to invite the Idaho Association of Chiropractic Physicians (IACP) to the next meeting to discuss a joint effort to change the law and review Rule 020. The Board subsequently created a subcommittee to work on a proposal.

May 30, 2014-September 11, 2014 – *Subcommittee and Board meetings on Legislative Proposal for Scope of Practice relating to Clinical Nutritional Methods*

Subcommittee meetings and Board meetings were held to craft a legislative proposal to amend the statutory scope of practice as it related to use of clinical nutritional methods.

Subcommittee members included:
Dr. Henze, D.C. (Board member); Dr. Gaertner-Ewing D.C.; Dr. West D.C.; Ryan Fitzgerald, IACP; Molly Steckel, Idaho Medical Association; Representative from Board of Medicine; Representative from Board of Pharmacy; Reed Phillips, D.C., PhD.

Board meetings held in 2014: May 30, June 27, July 11, Aug. 1, Aug. 22, Sept. 5, Sept. 11.

Minutes available through the Board website
at: http://ibol.idaho.gov/IBOL/BoardAdditional.aspx?Bureau=CHI&BureauLinkID=70

September 15, 2014 – *Final draft of proposal sent to Governor's Office.*

Deadline to submit final legislative proposal to Governor's Office for review.

September 15, 2014-October 2014 - *Final draft of proposal sent to industry and regulatory entities.*

Final draft of legislative proposal sent to Board of Veterinary Medicine, the Board of Pharmacy, the Board of Medicine, the Idaho Medical Association, and the Idaho Association of Chiropractic Physicians.

November 11, 2014 – *Disapproval by the Governor's Office*

Legislative proposal disapproved by the Division of Financial Management in Office of the Governor.

January 30, 2015 – *Public Meeting of Board*

The Board was informed that its proposed law regarding the scope of practice was not approved by the Governor's Office and returned to the Board. The Board was advised by the Governor's Office that as a scope of practice issue, the legislation needed to be brought by the industry association rather than the Board.

Dr. Henze, a Board member, reported that Ryan Fitzgerald, Executive of the Idaho Association of Chiropractic Physicians called him and reported that the Idaho Chiropractic Association had drafted a Bill and would be presenting it for the 2015 Legislation Session.

Minutes available through the Board website
at: http://ibol.idaho.gov/IBOL/CHI/Minutes/CHI_MINUTES_2015-01-30.pdf

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Timeline and Background for Board of Chiropractic Physicians Rulemaking – Docket No. 24-0301-1501

Wednesday, March 18, 2015 – *Hearing of House Health and Welfare Committee*

Representative Fred Wood, Chairman of the House Health and Welfare Committee, introduced RS 23876 (which became HCR 20) rejecting IDAPA 24.03.01.020 stating that the Board was being given notice and an opportunity to work on an amendment before the 2016 legislative session to resolve concerns that the language of Rule 020 was inconsistent with the legislative intent.

Interested Parties in Attendance: Ryan Fitzgerald, IACP
March 18, 2015 Amended Agenda & Minutes of the House Health & Welfare*
HCR 20 Bill Text & Statement of Purpose

**Representative Wood stated in committee that he had discussed the issue with the Board, but he actually discussed the issue with the IACP.*

Tuesday, March 24, 2015 – *Public Meeting of the Board*

The Board discussed HCR 20 with Representative Wood. The Board directed the Chair to work with the Bureau on developing a plan to work to address these issues and bring a report to the May 1, 2015 Board meeting.

Interested Parties in Attendance: none
March 24, 2015 Agenda for the Meeting of the Board of Chiropractic Physicians
March 24, 2015 Minutes of the Board of Chiropractic Physicians

Friday, May 1, 2015 – *Public Meeting of the Board*

The Board discussed the concerns about Rule 020 and Idaho Code § 54-704. It was discussed that the administrative rules may not exceed what the laws allow. The Board decided to work on modernizing Idaho Code § 54-704 and revisions to Rule 020 to bring it in line with the statute.

Interested Parties in Attendance: Kris Ellis and Tony Smith, Eiguren, Fisher & Ellis.
May 1, 2015 Agenda for the Meeting of the Board of Chiropractic Physicians
May 1, 2015 Minutes of the Board of Chiropractic Physicians

Friday, June 12, 2015 – *Public Meeting of the Board*

The Board reviewed proposed changes to Idaho Code § 54-704(2)(b) and proposed changes in Rule 020. The specific language updating the definition in the law regarding the prohibition on the use of legend and prescriptive drugs was discussed. Additionally, the Board reviewed the proposed revisions to Rule 020.

The Board recognized Ryan Fitzgerald of the IACP who informed the Board that the IACP had been discussing the law and rule changes with Representative Wood. He reported that the IACP would be providing education to chiropractors regarding the issue. He also informed the Board that the IACP was working on draft legislation that was broader in scope.

Interested Parties in Attendance: Ryan Fitzgerald, IACP; Tony Smith, Eiguren, Fisher & Ellis
June 12, 2015 Agenda for the Meeting of the Board of Chiropractic Physicians
June 12, 2015 Minutes of the Board of Chiropractic Physicians

Friday, July 17, 2015 – *Public Meeting of the Board*

The Board reviewed in detail the specific proposed language changes to Idaho Code § 54-704(2)(b) and Rule 020. The Board passed a motion to submit the proposed language for the law and rule changes to the Governor's Office.

Ryan Fitzgerald of the IACP addressed the Board and stated that the IACP had met with Representative Wood about the law and rule changes. The IACP was also researching curriculum regarding the use of prescriptive drugs in chiropractic; however, the IACP did not have a presentation at that time.

Interested Parties in Attendance: Ryan Fitzgerald, IACP; Tony Smith, Eiguren, Fisher, Ellis
July 17, 2015 Agenda for the Meeting of the Board of Chiropractic Physicians
July 17, 2015 Minutes of the Board of Chiropractic Physicians

Tuesday, September 1, 2015 – *Proposed Rule approved by Governor's Office*

Division of Financial Management of the Office of the Governor notifies the Bureau of final approval for proposed rule change.

Thursday, October 1, 2015 – *Public Meeting of the Board*

The Bureau reported that the draft language for the law change had been submitted to the Governor's Office and the proposed rule change had been submitted for publication in the October 7, 2015 Administrative Bulletin. It was noted that the proposed law and rule changes would be linked to the Board's website, and notifications sent to interested parties.

The Board reviewed and approved a letter that would be reviewed by the Governor's Office and then sent to all licensees regarding the proposed law and rule changes.

Interested Parties in Attendance: none
Oct. 1, 2015 Agenda for the Meeting of the Board of Chiropractic Physicians
Oct. 1, 2015 Draft Minutes of the Board of Chiropractic Physicians
Proposed Law & Rule section of Board's website

Wednesday, October 7, 2015 – *Notice of Rulemaking published in Administrative Bulletin*

Idaho Administrative Bulletin, October 7, 2015, Vol. 15-10, pp. 416-417

Friday, October 9, 2015

Bureau notifies IACP that the law and rule changes are available on the Board's website.

Wednesday, October 14, 2015 – *Letter sent to all licensees regarding law and rule changes*

Letter to all licensees from the Chair of the Board with notice and information of law and rule changes.

Friday, October 16, 2015 – *Notice to legislative advisors of availability of law and rule changes*

Bureau notifies legislative advisors that commonly work with Boards served by the Bureau that the proposed law and rule changes for each Board are available on their respective websites.

Friday, October 23, 2015 - *Notice of Public Hearing posted; notification to IACP*

Notice of Public Hearing published on Board website, and Bureau personally notifies Ryan Fitzgerald, Executive of IACP, of Public Hearing.

Notice of Public Hearing added to Proposed Law & Rule section of Board's website
Notice of Public Hearing

Idaho Board of Chiropractic Physicians Timeline on Rulemaking and Scope of Practice
November 20, 2015

Tuesday, October 27, 2015 – *Notification sent to interested parties regarding Public Hearing*

Email to all individuals requesting a public hearing on the rulemaking providing them with notification of Public Hearing.

Wednesday, October 28, 2015 – *Postcard sent to all licenses regarding Public Hearing*

Board mails a postcard to all licensees providing them with notification of Public Hearing.

Wednesday, November 4, 2015 – *Notice of Public Hearing published in Administrative Bulletin*

Publication of Notice of Public Hearing in Administrative Bulletin

Friday, November 6, 2015 – *Public Meeting of the Board*

The Bureau reviewed the timeline of the law and rules changes and that enough comments on the proposed rule had been received to hold a public hearing, which had been scheduled for November 10, 2015. The process for the hearing was also reviewed. The Board also reviewed the proposed law change and the letter that was sent by the Board to all licensees.

The Board also reviewed an email request from Ryan Fitzgerald, Executive of the IACP, for the Board to review a conceptual piece of legislation. The Board decided to invite Mr. Fitzgerald and the IACP to the next meeting of the Board and requested that the Board be allowed to review the proposed legislation or concept prior to that date.

Nov. 6, 2015 Agenda for the Meeting of the Board of Chiropractic Physicians
Nov. 6, 2015 Draft Minutes of the Board of Chiropractic Physicians

Tuesday, November 10, 2015 – *Public Hearing on Rulemaking*

Public Hearing on rulemaking.

Friday, November 20, 2015 – *Public Meeting of the Board*

Nov. 20, 2015 Agenda for the Meeting of the Board of Chiropractic Physicians

A hearing regarding the Idaho Board of Chiropractic Physicians' proposed rule will be held Tuesday, November 10, 2015 beginning at 9:00 a.m. at the JR Williams Building West Meeting Room, 700 West State Street, Boise ID 83702. Anyone may submit written comments at the public hearing regarding this rulemaking. Any written comments submitted at a public hearing carry the same weight as oral testimony. The proposal and hearing notice can be found on the Board's website by going to www.ibol.idaho.gov. Click on the Chiropractic Board link on the left. Click on the third link from the top on the left hand side of the screen entitled "Proposed Laws & Rules." The proposal and notice will be in blue links on that page. If you have questions about the hearing on the proposed rule, please contact Cherie Simpson at 208-334-3233.

STATE OF IDAHO

BUREAU OF OCCUPATIONAL LICENSES

700 West State Street
PO Box 83720
Boise, Idaho 83720-0063
(208) 334-3233
FAX (208) 334-3945
E-Mail ibol@ibol.idaho.gov
Website www.ibol.idaho.gov

October 14, 2015

Dear Licensee:

The Board of Chiropractic Physicians has submitted a proposed rule change and proposed law change for consideration by the 2016 Legislature. The Board has worked with interested parties on this issue.

The proposed rule change is in response to House Concurrent Resolution 20 that was introduced in the 2015 Legislative Session. **The House Concurrent Resolution proposed to strike Rule 020, which defines clinical nutritional methods.** This was in response to legislators' concerns that the current rule is being misinterpreted as allowing practice beyond the scope of the Idaho Chiropractic Act. The Resolution to strike Rule 020 was held in the House Health and Welfare Committee in order to allow the Board an opportunity to draft a rule in line with legislative intent. Rule 020 is being amended to remove the words "in all their forms" and to make sure everyone understands that clinical nutritional methods cannot exceed the scope of practice set forth in Section 54-704(2), Idaho Code.

The proposed law change modernizes the statutory language prohibiting chiropractors from administering, dispensing or using legend or prescriptive drugs in their practice. The proposed language mirrors the language defining a prescriptive/legend drug in the Idaho Pharmacy Act.

The proposals can be found on the Board's website by going to www.ibol.idaho.gov. Click on the Idaho Board of Chiropractic Physicians link on the left. Click on the third link on the left hand side of the screen entitled "Proposed Laws & Rules." The proposals will be a blue link on that page. Please take time to review the proposals. If you have questions or comments please submit them by **October 28, 2015**, to CHI@ibol.idaho.gov or by mail to: The Bureau of Occupational Licenses, P.O. Box 83720, Boise, ID 83720-0063.

You may be interested to know that the Board worked with the Idaho Association of Chiropractic Physicians on these issues last year and submitted a proposal to the Office of the Governor. That proposal was not approved for submission to the 2015 Legislature because it expanded the scope of practice, and traditionally, expansions of scope of practice are pursued by associations. It is the Board's understanding that the Association is aware of this and that it would need to work on any proposed legislation for the expansion of the scope of practice.

We hope this information is helpful to you.

Sincerely,

MaryJo White DC, Chair

MaryJo White, D.C., Chair
Idaho State Board of Chiropractic Physicians

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.03.01 - RULES OF THE STATE BOARD OF CHIROPRACTIC PHYSICIANS

DOCKET NO. 24-0301-1501

NOTICE OF PUBLIC HEARING

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5222, Idaho Code, notice is hereby given that this agency has scheduled a public hearing. The action is authorized pursuant to Section(s) 54-707, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be held as follows:

Tuesday, November 10, 2015 - 9:00 a.m.

JR WILLIAMS BLDG – WEST MEETING ROOM
700 W STATE ST
BOISE, ID 83702

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The summary of this action is found in Idaho Administrative Bulletin **Vol. 15-10, dated October 7, 2015, pages 416 to 417.**

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this rulemaking or the hearing schedule, contact Cherie Simpson at (208) 334-3233 or Cherie.simpson@ibol.idaho.gov.

Anyone may submit written comments at the public hearing regarding this rulemaking. Any written comments submitted at a public hearing carry the same weight as oral testimony.

DATED this 22nd Day of October, 2015.

Tana Cory, Bureau Chief
Bureau of Occupational Licenses
700 W State Street
P O Box 83720
Boise, ID 83720-0063
Ph: (208) 334-3233 / Fax: (208) 334-3945

STATE OF IDAHO

BUREAU OF OCCUPATIONAL LICENSES

700 West State Street
P.O. Box 83720
Boise, Idaho 83720-0063
(208) 334-3233
FAX (208) 334-3945
E-Mail ibol@ibol.idaho.gov
Website www.ibol.idaho.gov

January 11, 2016

Dear Licensees:

As you know from the Idaho Board of Chiropractic Physician's prior correspondence, the Board has initiated rulemaking to amend Rule 20 and the Board is also proposing a bill to change the language in Section 54-704(2), Idaho Code. Based upon comments the Board has received from its previous correspondence, there seems to be some confusion about the proposed changes.

By way of background, the issue with the rule was brought to the Board's attention based upon the testimony of some Chiropractors before the legislature last year regarding the Naturopath legislation. Apparently during their testimony, a number of Chiropractors reviewed the type of treatment they currently provided which included the use of prescription/legend drugs. When the Chiropractors were questioned by legislators regarding under what authority they could utilize prescription/legend drugs, they cited Rule 20. A number of legislators were surprised and concerned about chiropractors exceeding their statutory scope of practice. As a result, a House Concurrent Resolution was proposed last year by a legislator to strike Rule 20 in its entirety. However, the Chairman of the House Health and Welfare Committee agreed to postpone consideration of the Concurrent Resolution which eliminated Rule 20 in its entirety, and gave the Board an opportunity to revise Rule 20. The Chairman also suggested that the Board should modernize its law. The Board has now proposed a rule and law change to clarify (and eliminate any confusion) that the use of prescription/legend drugs is not part of a chiropractor's scope of practice.

The Board is charged with ensuring the public health, safety and welfare. To that end, the legislature has empowered the Board to establish administrative rules, as necessary, to implement laws comprising the Act. These rules are subordinate to the Act and they cannot expand beyond what the Act authorizes. In short, administrative rules only implement laws; they cannot exceed what is allowed by the law. The Board's proposed Rule 20 is being amended to remove "in all their forms" and to make sure everyone understands that clinical nutritional methods cannot exceed the scope of practice set forth in 54-704 (2), Idaho Code.

The Board's proposed law change is intended to clarify the statutory language currently prohibiting the use of legend/prescriptive drugs in the practice of chiropractic. The proposed changes utilize language from the Idaho Pharmacy Act to modernize the definition of a legend/prescriptive drug. Under the proposal, Chiropractors can continue to use any clinical nutritional substance as long as the substance is not a legend/prescriptive drug.

At the same time the Chairman of House Health and Welfare visited with the Board about Rule 20 and modernizing the law, he also visited with the Idaho Association of Chiropractic Physicians (IACP) about what they would need to do if they wanted to change the scope of practice for chiropractors. At the Board's meeting on November 20th, 2015, the IACP presented to the Board draft legislation it was considering presenting to the 2016 Legislature regarding the scope of practice for chiropractic physicians. Their proposal includes allowing chiropractors with certain education and training to use certain legend/prescriptive drugs in their practice. If you have questions on the IACP's proposed legislation, please direct those questions to the IACP.

For more in-depth information regarding the current rulemaking and the proposed laws change as well as a detailed timeline with links to the minutes of the Board's meetings, please visit the Board's website at www.ibol.idaho.gov. Click on the Idaho Board of Chiropractic Physicians link on the left. Click on the third link on the left hand side of the screen entitled "Proposed Laws & Rules." The timeline will be a blue link on that page.

The Board's charge is public protection and it must work within the current law. The Association's charge is to promote the profession and any changes to the scope of practice are within the purview of the Association.

Sincerely,

MaryJo White DC, Chair

MaryJo White, D.C., Chair
Idaho State Board of Chiropractic Physicians

STATEMENT OF PURPOSE

RS 24009

In this bill, the Idaho Board of Chiropractic Physicians is modernizing the language with regard to the statutory prohibition that provides chiropractors are not entitled to administer, dispense, or use legend or prescriptive drugs in their practice.

FISCAL NOTE

There is no impact on the General Fund or the Bureau's dedicated fund.

Contact:
Cherie Simpson
Idaho Board of Chiropractic Physicians
208-334-3233

RS24009

LEGISLATURE OF THE STATE OF IDAHO

Sixty-third Legislature Second Regular Session - 2016

IN THE _____

BILL NO. _____

BY _____

AN ACT

RELATING TO CHIROPRACTIC PRACTICE; AMENDING SECTION 54-704, IDAHO CODE, TO REVISE RESTRICTIONS RELATING TO PRESCRIBING, DISPENSING, INDEPENDENTLY ADMINISTERING, DISTRIBUTING, DIRECTING OR SUGGESTING TO PATIENTS CERTAIN DRUGS, SUBSTANCES OR PRODUCTS AND TO MAKE TECHNICAL CORRECTIONS.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 54-704, Idaho Code, be, and the same is hereby amended to read as follows:

54-704. CHIROPRACTIC PRACTICE. Chiropractic practice and procedures which may be employed by physicians are as follows:

(1) The system of specific adjustment or manipulation of the articulations and tissues of the body; the investigation, examination and clinical diagnosis of conditions of the human body and the treatment of the human body by the application of manipulative, manual, mechanical, physiotherapeutic or clinical nutritional methods and may include the use of diagnostic X-rays.

(a) "Adjustment" means the application of a precisely controlled force applied by hand or by mechanical device to a specific focal point on the anatomy for the express purpose of creating a desired angular movement in skeletal joint structures in order to eliminate or decrease interference with neural transmission and correct or attempt to correct subluxation complex; "chiropractic adjustment" utilizes, as appropriate, short lever force, high velocity force, short amplitude force, or specific line-of-correction force to achieve the desired angular movement, as well as low force neuromuscular, neurovascular, neuro-cranial, or neuro-lymphatic reflex technique procedures.

(b) "Manipulation" means an application of a resistive movement by applying a nonspecific force without the use of a thrust~~,~~ that is directed into a region and not into a focal point of the anatomy for the general purpose of restoring movement and reducing fixation.

(c) "Massage therapy," also called massology, means the systematic manual or mechanical mobilization of the soft tissue of the body by such movements as rubbing, kneading, pressing, rolling, slapping and tapping~~,~~ for the purpose of promoting circulation of the blood and lymph, relaxation of muscles, release from pain, restoration of metabolic balance, and the other benefits both physical and mental.

(2) Nothing herein contained shall allow any physician to:

(a) Perform surgical operations or practice obstetrics;

(b) Prescribe, dispense, independently administer, distribute, d~~D~~irect or suggest to ~~the~~ a patient ~~that such patient shall use~~ a drug, substance ~~which~~ or product that, under federal law is required, prior

to being dispensed or delivered, to be labeled with ~~either~~ any of the following statements: (i) "Caution: Federal Law Prohibits Dispensing Without Prescription"; ~~or~~ (ii) "Rx only"; (iii) "Caution: Federal Law Restricts This Drug To Use By or On The Order Of A Licensed Veterinarian"; or (~~iii~~iv) is a drug, substance or product which is required by any applicable federal or state law or regulation to be dispensed on prescription drug order only or is restricted to use by practitioners only.

(3) Chiropractic practice, as herein defined, is hereby declared not to be the practice of medicine within the meaning of the laws of the state of Idaho defining the same, and physicians licensed pursuant to this chapter shall not be subject to the provisions of chapter 18, title 54, Idaho Code, nor liable to any prosecution thereunder, when acting within the scope of practice as defined in this chapter.

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.03.01 - RULES OF THE STATE BOARD OF CHIROPRACTIC PHYSICIANS

DOCKET NO. 24-0301-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date as specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-707, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This pending rule adopts the amendments made in the proposed rule to Rule 20. This rule is being amended to remove the words "in all their forms" and to make sure everyone understands that clinical nutritional methods cannot exceed the scope of practice set forth in 54-704(2), Idaho Code.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 7, 2015 Idaho Administrative Bulletin, **Vol. 15-10, pages 416 and 417.**

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: NA

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at (208) 334-3233.

DATED this 23rd day of November, 2015.

Tana Cory, Bureau Chief
Bureau of Occupational Licenses
700 W. State Street
P.O. Box 83720
Boise, ID 83702
Ph. (208) 334-3233 / Fax (208) 334-3945

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-707, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Rule 20 is being amended to remove the words "in all their forms" and to make sure everyone understands that clinical nutritional methods cannot exceed the scope of practice set forth in 54-704(2), Idaho Code.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year resulting from this rulemaking: NA

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the revisions to this rule are simple in nature. This proposal was discussed during noticed, open meetings of the Board with interested parties in attendance.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: NA

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 577-2584.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 4th Day of September, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0301-1501

020. SCOPE OF PRACTICE (RULE 20).
Clinical nutritional methods as referenced in Section 54-704, Idaho Code, include, but are not limited to, the clinical use, administration, recommendation, compounding, prescribing, selling, and distributing vitamins, minerals, botanical medicine, herbals, homeopathic, phytonutrients, antioxidants, enzymes and glandular extracts, and durable and non-durable medical goods and devices ~~*in all their forms*~~. Nothing herein shall allow any deviation from Section 54-704(2), Idaho Code. ~~*(4-2-08)*~~(____)

November 27, 2015

Representative Fred Wood
VIA EMAIL: fwood@house.idaho.gov

Re: Chiropractic Statute

Dear Representative Wood:

Recently you inquired about the chiropractic statute and whether it permits licensees to dispense prescribed medications. Following is a response to your questions.

As you may be aware, the history of the practice of chiropractic in this state can be traced back to the early 1900's. Early efforts at legislative creation of a practice act date from 1917. If there is one common thread that can be followed from early days until more recent times, it is that the chiropractic scope of practice has always been a matter of some controversy. Historically, issues have included discussion of whether chiropractors are "physicians" for purposes of providing Medicare services; or if practitioners are entitled to use diagnostic and clinical laboratory procedures for diagnosis; or does the practice extend from use of air, water, heat and light to include the use of vitamins and minerals. When the current Chiropractic Practice Act (Act) was adopted in 1980, Idaho Code section 54-704 (1) set forth "practices and procedures" which could be used, including the use of clinical nutritional methods, as well as clinical diagnosis of conditions of the body and the use of diagnostic x-rays. Idaho Code section 54-704 (1).

Although the definition of "practice of chiropractic" remains unchanged since 1980, the Act was amended in 1993 to further define the terms adjustment, manipulation, and massage therapy. Idaho Code section 54-704 (1)(a-c). Although the topic has been mentioned in board meeting minutes on a fairly regular basis since 1972, the phrase "clinical nutritional methods," was not further defined in 1993 nor has it since been further updated or defined in code. For the past several years, however, this phrase has been the source of much controversy. Further definition of the term has been the subject of several rule making efforts, a current rule, a withdrawn "written interpretation," and a pending rule promulgation.

1. Does Idaho Code section 54-704 (2) (a-b) permit a chiropractic physician to prescribe medications that require a prescription?

No. Neither Idaho Code section 54-704 (2) (a), nor 54-704 (2) (b), permit chiropractic physicians to prescribe prescription medications. Strictly construed, Idaho Code section 54-704 (2) (b) prohibits chiropractic physicians from even suggesting or directing that a patient use a prescription medication.

In relevant part, Idaho Code section 54-704 provides:

(2) Nothing herein contained shall allow any physician to:

(a) Perform surgical operations or practice obstetrics;

(b) Direct or suggest to the patient that such patient shall use a substance which, under federal law is required, prior to being dispensed or delivered, to be labeled with either of the following statements: (i) "Caution: Federal Law Prohibits Dispensing Without Prescription"; or (ii) "Caution: Federal Law Restricts This Drug To Use By or On The Order Of A Licensed Veterinarian"; or (iii) a product which is required by any applicable federal or state law regulation to be dispensed on prescription only or is restricted to use by practitioners only.

2. If Idaho Code section 54-704(2)(a-b) prohibits chiropractic physicians from prescribing medicines, may the Board of Chiropractic Physicians permit the prescription of medications contained in Idaho Code section 54-704(2)(a-b) by promulgating a board rule?

No. Within their delegated authority, regulatory boards are permitted to promulgate rules which implement, interpret, or prescribe (1) law or policy or (2) the agency's procedural or practice requirements. This analysis will assume, but does not opine, that a board's authority to promulgate rules for the "administration" of its chapter can be read to allow it to adopt rules clarifying the statutorily established scope of practice. Assuming that the requisite statutory authority to promulgate a rule exists, a board rule may interpret the statutory scope of practice in a manner consistent with the underlying statute. The rule cannot "override" the legislatively created scope of practice by permitting activities which are otherwise prohibited. To the extent that Idaho Code section 54-704(2)(a-b) prohibits practitioners from prescribing certain medications, it is impermissible for the board to promulgate a rule to the contrary.

Referred to as Rule 20, IDAPA 24.03.01.020 clarifies the term "clinical nutritional methods," one of several treatment modalities included within the chiropractic scope of practice. The term is not further defined within the statute. As promulgated, the rule permits "the clinical use, administration, recommendation, compounding, prescribing, selling, and distributing vitamins, minerals, botanical medicine, herbals, homeopathic, phytonutrients, antioxidants, enzymes, and glandular extracts, durable and non-durable medical goods and devices in all their forms." Read in context with the statute, Rule 20 permits a licensed chiropractic physician to utilize those "vitamins, minerals, botanical medicines, herbals, homeopathic, phytonutrients, antioxidants, enzymes or glandular extracts, medical goods and devices" which are not otherwise prohibited by Idaho Code section 54-704 (2)(a-b).

This response is provided to assist you. If you have any questions or concerns, please do not hesitate to call me at (208) 334-4111 or email at kay.christensen@ag.idaho.gov.

Sincerely,

S. KAY CHRISTENSEN
Division Chief
Contracts and Administrative Law Division

c: Brian Kane, Assistant Chief Deputy, Legislative Counsel

SENATE HEALTH & WELFARE COMMITTEE
Thursday, January 28, 2016

ATTACHMENT 2

B.A.T. & Supply LLC

Backflow Assembly Testing & Supply LLC
208 456 BATS (2287)phone ***888 977 3406 FAX***
e-mail bftest @ ida.net ***P.O. Box 359 Tetonia, Idaho 83452***

Idaho Senate
Health & Welfare Committee
RE: Proposed Rules

Dear Members,
I am writing with concerns of proposed rules for the Drinking Water and Wastewater Professionals. The docket # for this is 24.0501.1501.

I feel some of these rule changes are unnecessary and bias against Backflow Assembly Testers also referred to as BATS. For a board who governs over drinking water and wastewater operators along with the BATS I cannot understand why one of these professions should be singled out to have a code of ethics and standard of conduct.

My company is one of two companies in the State of Idaho that provides training to gain certification which in turn allows those who are successful to file for license with the Bureau of Licenses to provide backflow assembly testing. This gives me opportunity to interact with testers throughout the state on a regular basis along with water purveyors. I have received input from many of the water purveyors and they feel that the proposed rules would take their authority and power away that they already have in running a backflow prevention program. The Idaho Rules for Public Drinking Water Systems "IDAPA 58.01.08" gives them guidance and authority to manage their programs and the BATS that test valves within their water system. One of these program managers made the comment ***"I have worked hard to get my program running the way I want it and it runs very well. I don't need a board telling me I have to turn over my authority to them to dictate what BATS can do within my system. It is my responsibility to assure the drinking water safety not theirs and IDAPA gives me this."***

Some of the wanted rule additions have me concerned because of inaccuracies and rules just to have rules without a way to enforce them. Under the Standards of Conduct section of the proposed rules - Principle 4 there is mention of a requirement pertaining to the field test kits. There is no such requirement in the manual (PNWS AWWA Cross Connection Control), it only recommends the practice referred to and is an industry standard that many water purveyors already require. Another point of concern pertaining to this is the fact that the PNWS AWWA manual is what the Plumbing Bureau currently follows as the standard for backflow prevention and cross connection control and is in the process of being changed as they are looking at adopting either the International Association of Plumbing & Mechanical Officials (IAPMO) code or the Uniform Plumbing Code (UPC) and eliminating the PNWS AWWA. I have been informed that this change will probably go into effect in 2018.

B.A.T. & Supply LLC

Backflow Assembly Testing & Supply LLC
208 456 BATS (2287)phone ***888 977 3406 FAX***
e-mail bftest @ ida.net ***P.O. Box 359 Tetonia, Idaho 83452***

This profession is my livelihood I have been in this industry since 1997. I stay actively involved with all aspects as much as possible with traveling nationwide to attend trainings and staying informed with updates and changes. This allows me to remain versed in the subject and able to provide professionalism when providing training in Idaho and other states.

I feel that the board for the Drinking Water and Wastewater Professionals is trying to dictate my day to day operations as a Backflow Assembly Tester. Many of the items listed in the proposed rules are things that are taught during a training course and testers could not have passed the exam to become a tester without this knowledge.

As for being honest and truthful in their day to day work, I don't think having a rule such as wanted in the last line of the proposed rule document will make that happen. *"A Backflow Assembly Tester shall not falsify the results of a backflow prevention assembly field test or inspection".* Illegal anyway. Everyone always wears a seatbelt because it's the law, correct.

Basically, I don't see a need for this to become rule. Having rules on top of rules already in place is an opportunity to have confliction with other agencies and unnecessary.

Thank you for taking time to hear my concerns and views. If you have questions about any of my comments please do not hesitate to contact me.

Leslie Wilder - Owner
BAT & Supply LLC
208 456 2287
bftest@ida.net

April 4, 2014

Dear Board Members,

Thank you once again for the opportunity for input regarding the Code of Ethics/Conduct.

Personally, I do not see a need for this past a basic statement. Water purveyors are already the ones with enforcement power over testers and should be left to decide how to enforce their program requirements with corrective steps against testers who do not comply with said programs, which includes filing complaints with the Bureau of Occupational Licenses.

There are steps in place currently for anyone feeling the need to pursue action against a tester for non compliance of the rules. If power of enforcement is in anyway taken away from or side tracked from the water purveyor, a tester with questionable practices on the local level will continue on with this for a time while the Bureau addresses it through the legal process. This exposes the safety of the drinking water at that local level. Program managers "with justification" must be able to halt anyone who is not following the rules, regulations and proper practices of a backflow assembly tester.

I also see a possible overload to the Bureau of Occupational Licenses with an increase of complaints being filed because of frivolous, minor infractions that could and should be handled by the water purveyor.

If you have any questions of me or would like more clarification of my comments please contact me.

Thank you again,

Leslie Wilder

BAT & Supply
P.O. Box 359
Tetonia, ID 83452
208 456 2287 office
208 221 6988 cell
Email – bftest@ida.net

Below you will find more input from me concerning verbiage in definitions & principles;

General Code of Ethics

A licensed Backflow Assembly Tester shall:

1. Recognize at all time that his/her primary obligation is to perform his/her duties with due care and diligence to protect the safety, health and welfare of the public;
2. Comply with this chapter and all applicable state and federal laws and regulations relating to backflow assembly testing;
3. Perform only the duties consistent with experience and training appropriate to his/her experience, skills, abilities, and level of certification; and
4. Be completely objective and truthful in all professional reports, statements, or testimony and include all relevant and pertinent information in such reports, statements or testimony.

Definitions: Why do we need to repeat and redefine definitions already in place?

Approved Backflow Prevention Assembly: an assembly such as a Double Check Valve Assembly (DCVA), a Pressure Vacuum Breaker Assembly (PVBA), a Reduced Pressure Backflow Assembly (RPBA), or a Spill-Resistant Pressure Vacuum Breaker Assembly (SVBA) used for the protection of the public water supply per the provisions of IDAPA 58.01.08 under the jurisdiction of the Idaho Department of Environmental Quality. For new construction or replacement the specific assembly shall be on the current approval list as referenced by the Rule and as approved by the University of Southern California Foundation for Cross-Connection Control and Hydraulic Research (USCFCCCHR)

Approved Backflow Prevention Device: a device such as an Atmospheric Vacuum Breaker (AVB) which does not contain valves or test ports, or method such as an air gap utilized to prevent cross connections to a public water supply.

Backflow Assembly Tester (BAT): means a person who tests backflow prevention assemblies and who holds a current Idaho Backflow Assembly Tester (BAT) license in the state of Idaho Only this is state in Title 54, Chapter 24, Idaho Code.
for the purpose of conducting field performance tests, maintenance, repairs, like-kind replacement, and inspections of approved backflow assemblies as defined in Title 54, Chapter 24, Idaho Code. (Replacement does not include fire flow protection assemblies.)

Calibration/verification: the annual verification and/or calibration of a backflow assembly field test kit by an approved who will be determining the approval? instrument calibration laboratory/facility or by a person qualified (e.g. manufacturer, licensed dealer, or calibration technician).

Certification: the regular certification training program approved by the Board of Drinking Water and Wastewater Professionals stipulating that the Backflow Assembly Tester has demonstrated sufficient competency to correctly test approved backflow prevention assemblies in the state of Idaho as defined in the Rule of the Board of Drinking Water and Wastewater Professionals (IDAPA 24.05.01).

Customer: means the owner of the property or his/her authorized or appointed agent.

Field Test Kit: an instrument, either mechanical or electronic in design, and all related fittings, tools, equipment and appurtenances necessary to perform field verification tests on approved backflow prevention assemblies.

IDAPA: Idaho Administrative Procedures Act, specifically in this case, covers Rules of the Board of Drinking Water and Wastewater Professionals (IDAPA 24.05.01) for licensing and the Idaho Rules for Public Drinking Water Systems (IDAPA 58.01.08).

License: means a physical document issued by the Board of Drinking Water and Wastewater Professionals through the Idaho Bureau of Occupational Licenses certifying that an individual has met the appropriate qualifications and has been granted the authority to practice in Idaho under the provisions of Chapter 24, Title 54, Idaho Code.

Public Water System: public water systems are defined in IDAPA 58.01.08 and supply potable water to the customers who own the approved backflow prevention assemblies. Public Water System owners or operators are administratively responsible for the cross connection control programs.

Test Procedures: standardized test procedures for each approved backflow prevention assembly consistent with the Backflow Assembly Tester's most recent training course and/or practical exam, and acceptable to the public water system having jurisdiction.

Test Report: a standardized form acceptable to the public water system used to record all crucial information regarding the field test, maintenance, repairs, replacements, and inspections performed on the particular approved backflow prevention assembly. The owner of the public water system may specify a standardized form to use when submitting a Test Report. This can already be specified by the water system.

Continue to Principles Below

Standards of Conduct

Principle 1

A Backflow Assembly Tester shall notify the customer, identify, inspect, observe, field test, maintain, repair, what if they do not have the skills or abilities to accomplish this? and replace approved backflow prevention assemblies, approved backflow prevention devices, and air gaps that are utilized to protect the public water supply. Backflow Assembly Testers under authorization of the customer may perform maintenance, repair and replacement of assemblies, devices or air gaps. Keep in mind that backflow assembly testers in gaining license were NOT trained deeply in repairs, especially of large valves and not at all on installing valves (just installation criteria). They were trained to conduct tests and very basic repairs. See level of certification in opening **General Code of Ethics** under # 3.

Principle 2
When conducting inspections and field tests of approved backflow prevention assemblies, a Backflow Assembly Tester shall use procedures that meet the requirements as referenced by IDAPA 58.01.08 and are consistent with the field test procedures and methods used on the Tester's most recently passed Idaho approved training course and/or practical exam.

Principle 3
The Backflow Assembly Tester shall observe or inspect existing installations of backflow prevention assemblies to ensure the assembly is correct for the level of protection and the type of hazard present. Improperly installed assemblies should be reported to the customer and the Public Water System. If the assembly is not the correct type of protection, or the installation is improper, the tester shall note the discrepancy on the Test Report form and submit the form to the customer and the Public Water System.

Principle 4
A Backflow Assembly Tester shall use a properly working and calibrated field test kit that meets the requirements this is only recommendations in the manual of the Northwest Section of the American Water Works Association Cross Connection Control Manual, most recent approved edition, as referenced by IDAPA 58.01.08. A Backflow Assembly Tester shall submit to the public water system owner or operator, upon request, a calibration report that verifies the accuracy of the field test kit at least once within the twelve month period before the inspection and field test date. A Backflow Assembly Tester may also be requested to submit a copy of the Board issued validation card that verifies the Backflow Assembly Tester's current certification status.

The only references in IDAPA 58.01.08 to
AWWA Pacific Northwest Section Cross Connection Control Manual is for **Assembly selection**

543. FACILITY AND DESIGN STANDARDS: CROSS CONNECTION CONTROL.
04. Assembly Selection. Appropriate and adequate backflow prevention assembly types for various facilities, fixtures, equipment, and uses of water should be selected from the AWWA Pacific Northwest Section Cross Connection Control Manual, the Uniform Plumbing Code, the AWWA Recommended Practice for Backflow Prevention and Cross Connection Control (M14), the USC Foundation Manual of Cross Connection Control, or other sources deemed acceptable by the Department. The selected assembly manufacturer model number must be included on the USC Foundation "List of Approved Assemblies" and must comply with local ordinances. (4-4-13)

06. Cross Connection Control Program - Community Water Systems.
b. Required installation and operation of adequate backflow prevention assemblies. Appropriate and adequate backflow prevention assembly types for various facilities, fixtures, equipment, and uses of water should be selected from the AWWA Pacific Northwest Section Cross Connection Control Manual, the Uniform Plumbing Code, the AWWA Recommended Practice for Backflow Prevention and Cross Connection Control (M14), the USC Foundation Manual of Cross Connection Control, or other sources deemed acceptable by the Department. The assemblies must meet the requirements of Section 543 and comply with local ordinances. (4-4-13)

Principle 5
The Backflow Assembly Tester must be adequately trained and capable of using a field test kit, all tools, and other equipment and appurtenances necessary to inspect and field test approved backflow prevention assemblies, inspect air gaps and atmospheric vacuum breakers.

Principle 6
When maintaining, repairing, or replacing an approved backflow prevention assembly or AVB, a Backflow Assembly Tester shall ensure the backflow assembly or AVB meets the original manufacturer's specifications or otherwise be approvable by the USC foundation as required by IDAPA 58.01.08.

Principle 7
If the backflow prevention assembly passed the field test, then the Backflow Assembly Tester shall submit a passing field Test Report form to the customer and the appropriate public water system having jurisdiction within twenty (20) calendar days of performing the field test. This is a water purveyor's enforcement issue not an issue the IBOL Water and Wastewater Board should be addressing.

Principle 8
If the backflow prevention assembly is defective or fails to pass the field test, then the Backflow Assembly Tester shall submit a failing field Test Report form to the customer and the appropriate public water system having jurisdiction immediately if possible, or no later than two business days. The customer has ten (10) business days to repair or replace the failed assembly. After ten (10) business days of notification, if the public water system has not received a passing Test Report form, service may be terminated in accordance with IDAPA 58.01.08.552.06.e. This is a water purveyor's enforcement issue not an issue the IBOL Water and Wastewater Board should be addressing.

Principle 9
The Backflow Assembly Tester shall only record data and sign test forms of approved backflow prevention assemblies they have tested. A Backflow Assembly Tester shall not knowingly falsify the results of backflow prevention assembly field tests performed by him/her. All Test Reports must be submitted on proper forms approved by the public water system having jurisdiction. They must be legible and contain all appropriate information pertaining to the test including make, model, size, serial number, orientation, test results, repairs and parts listed if applicable, and result of second test if required.

Principle 10
All Backflow Assembly Testers shall be certified licensed by the state of Idaho and shall participate in the recertification refresher process at least once every two (2) years. Additionally, all Backflow Assembly Testers should have their test equipment standardized and/or examined by a person who is qualified (e.g. manufacturer, licensed dealer, or calibration technician) *repetitive from the definitions* and again who will determine who is qualified and approve those people? at least once every year or as required by the public water system having jurisdiction.

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, February 01, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Docket No. 16-0316-1501	Premium Assistance - Chapter Repeal	**Tiffany Kinzler** Division of Medicaid
Docket No. 16-0309-1503	Medicaid Basic Plan Benefits - Clarify Third-Party Liability Exceptions	**Sheila Pugatch** Division of Medicaid
Docket No. 16-0309-1502	Medicaid Basic Plan Benefits - Patient Centered Medical Home Program Changes	**Matt Wimmer** Division of Medicaid
Docket No. 16-0309-1501	Medicaid Basic Plan Benefits - Update and Align School-Based and Therapy Services	**Matt Wimmer**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Monday, February 01, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:12 p.m.
INTRODUCTIONS:	**Chairman Heider** recognized in attendance: Neva Santos, Executive Director of the Idaho Academy of Family Physicians and second-year residents from the Family Medicine Residency of Idaho. **Chairman Heider** and **Senator Hagedorn** invited the residents to introduce themselves and tell the Committee the percentage of interest on their respective student loans. **Jaclyn Cooperrider** stated she has approximately $250,000 of medical school debt at 6 percent interest. **Chairman Heider** asked whether all of the residents in attendance were in similar situations. Those that responded confirmed that they were similarly situated. **Chairman Heider** and **Senator Hagedorn** thanked the resident for sharing this information and noted that they admired the work the residents were doing.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Nuxoll to conduct the rules review.
DOCKET NO. 16-0316-1501	**Rules of the Department of Health and Welfare related to Premium Assistance**. **Tiffany Kinzler**, Bureau Chief of the Bureau of Medical Care for the Division of Medicaid in the Department of Health and Welfare (Department), presented this docket. **Ms. Kinzler** stated that this docket repeals the chapter of rules for the premium assistance program. This program, which is no longer funded, was run as a demonstration project between July 2004 and September 2014. This chapter of rules defined how Idaho provided premium assistance for (i) children eligible for the State's Children's Health Insurance Program and (ii) parent and childless adults under 185% of the federal poverty level. **Ms. Kinzler** stated that the docket did not go through the negotiated rulemaking process because it repeals a chapter of rules for which federal and state authority no longer exists.
MOTION:	There being no questions, **Senator Schmidt** moved to approve **Docket No. 16-0316-1501**. **Senator Martin** seconded the motion. The motion carried by **voice vote**.
DOCKET NO. 16-0309-1503	**Rules of the Department of Health and Welfare Related to Medicaid Basic Plan Benefits and Third Party Liability Exceptions**. **Sheila Pugatch**, Bureau Chief of the Bureau of Financial Operations for the Division of Medicaid in the Department, presented this docket.

Ms. Pugatch stated that these pending changes will align Idaho rules with recent modifications to federal statutes regarding third party liability. Federal regulations require providers to bill all known third parties with liability before submitting a claim to Medicaid. A liable third party is typically any insurance company, private individual, corporation or business that can be held legally responsible for the payment of all or part of the costs attributed to a Medicaid member. **Ms. Pugatch** stated that the pending rule does contain exceptions for specific situations when a provider may bill Medicaid before other third party payers. **Ms. Pugatch** noted that no comments to these rules were received.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Vice Chairman Nuxoll asked why prenatal and preventive pediatric care services were excluded from the requirement that providers of such services bill third parties before Medicaid. **Ms. Pugatch** responded that these services were excepted from the requirement because the Division of Medicaid wanted to ensure that these services are rendered in a timely fashion.

MOTION: There being no more questions, **Senator Harris** moved to approve **Docket No. 16-0309-1503**. **Senator Jordan** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0309-1502 **Rules of the Department of Health and Welfare Related to Medicaid Basic Plan Benefits and Patient Centered Medical Home Program Changes**. **Matt Wimmer**, Deputy Administrator for Policy for the Division of Medicaid in the Department, presented this docket.

Mr. Wimmer stated that these pending rules would allow the Division of Medicaid to pay primary care providers for delivering better health care rather than solely for delivering services. In 2014, the Governor established the Idaho Health Care Coalition and charged the coalition with developing an integrated, coordinated health care system with a focus on improved population health, improved individual health outcomes and greater cost efficiencies; these rule changes are a result of those efforts. **Mr. Wimmer** reported that the Division of Medicaid conducted extensive negotiated rulemaking for this docket. The Division of Medicaid engaged many stakeholders and provided opportunities for comment at hearings conducted across Idaho.

Mr. Wimmer stated that, in addition to supporting increased reimbursement to primary care providers who positively impact patients health, these pending rules (i) support the use of telemedicine to enable patient in rural areas to access care and (ii) set conditions and boundaries around the provision of care to avoid misuse of services. **Mr. Wimmer** reported that these pending rules are expected to result in a net cost savings to the State.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Vice Chairman Nuxoll asked why certain changes were single underlined, while other changes were double underlined. **Mr. Wimmer** answered that the single underlined changes were changes proposed by the Division and double underlined changes were changes made in response to comments received.

Referencing the changes to the "Healthy Connections" provisions, **Senator Jordan** asked whether family planning services were still covered under the program. **Mr. Wimmer** confirmed that family planning services were still covered by the program; the rule changes moved the referral requirements for such services from the rules to the Idaho Medicaid Provider Handbook.

Regarding the Idaho Medicaid Provider Handbook, **Senator Hagedorn** asked how often the handbook is updated and whether or not the handbook promotes the provision of telehealth services. **Mr. Wimmer** responded that the handbook is continually updated and takes a neutral position regarding the provision of telehealth services. **Mr. Wimmer** noted that the decision to use telehealth services is left to the provider and patient. **Senator Hagedorn** asked whether there are payment incentives to encourage physicians to provide telehealth services to patients in rural Idaho. **Mr. Wimmer** reported that Medicaid currently reimburses telehealth services and office services at the same rate; some insurers reimburse telehealth services at a lower rate.

Senator Schmidt asked Mr. Wimmer to clarify what "twenty-four hour, seven days per week access to an on-call medical professional" entails. **Mr. Wimmer** responded that clinics must provide telephonic access to on-call professionals. However, **Mr. Wimmer** indicated that he was unsure whether such professionals would be staffed in Idaho or out-of-state.

Senator Martin asked Mr. Wimmer if there was data regarding telehealth usage in Idaho. **Mr. Wimmer** noted that for Medicaid historically had little telehealth usage. **Senator Martin** asked why usage was so low. **Mr. Wimmer** responded that prior to the passage of the Telehealth Access Act in 2015, there was ambiguity as to whether telehealth was an acceptable practice for physicians. With the passage of the Telehealth Access Act, Medicaid and commercial providers in Idaho are moving forward with greater coverage of telehealth services.

Vice Chairman Nuxoll asked why punitive measures are taken when services are provided without a referral. **Mr. Wimmer** responded that the requirements for referrals are a long-standing practice. The purpose of referral requirements is to foster good care coordination between primary care providers and the patients that they serve. In some circumstances, the Division of Medicaid has removed referral requirements and replaced them with communication requirements.

Referencing provisions related to provider qualifications and duties, **Senator Schmidt** asked whether the Division of Medicaid should require certain permissive services such as the reporting of clinical data to the Department of Health and Welfare. **Mr. Wimmer** stated that some of these permissive services will be required in the future; the services are permissive at this time because providers are currently at different levels of readiness to provide these services.

Vice Chairman Nuxoll requested that references to federal codes should be dated.

MOTION: There being no more questions, **Senator Schmidt** moved to approve **Docket No. 16-0309-1502**. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0309-1501 **Rules of the Department of Health and Welfare Related to Medicaid Basic Plan Benefits to Update and Align School-Based and Therapy Services**. **Matt Wimmer**, Deputy Administrator for Policy for the Division of Medicaid in the Department, presented this docket.

Mr. Wimmer stated that the purpose of this docket is to reduce administrative burden for providers, clarify requirements for services and ensure appropriate delivery of physical, occupational and speech therapy and school based services. School based services are benefits delivered by qualified school staff in the school for children whose special needs qualify them for specific Medicaid benefits. For services to be covered by Medicaid, the child's needs must meet medical necessity criteria outlined in IDAPA and be identified in an individualized education plan (IEP). **Mr. Wimmer** reported that the department conducted negotiated rulemaking sessions and worked extensively with both school and therapy providers to develop these rules. He noted that the Division of Medicaid received numerous comments and responded with significant revisions to meet most but not all of the concerns expressed.

Mr. Wimmer stated that, when the docket was presented to the House Health and Welfare Committee, the Division of Medicaid heard concerns from several providers regarding section 733.01.a related to the physician order requirements for therapy services. **Mr. Wimmer** stated that the revised language (i) allows services to proceed once an evaluation is completed without waiting for a physician order and (ii) aligns Medicaid requirements with Medicare requirements. He informed that Committee that rejecting section 733.01.a would not remove the requirement for physician orders. **Mr. Wimmer** stated that the Division of Medicaid understands that physician orders are a concern for services delivered in schools. The Division of Medicaid will continue to work with the Department of Education and school-based providers to identify ways to minimize administrative burden while ensuring that Medicaid participants receive high-quality and well-coordinated care.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Chairman Heider asked Mr. Wimmer to clarify the action the Division of Medicaid wanted the Committee to take regarding this docket. **Mr. Wimmer** confirmed that the Division of Mediciad was requesting that the rule be approved in its entirety. The House Health and Welfare Committee previously approved the rule in its entirety.

Referencing the provisions related to service-specific participant eligibility for school-based services, **Senator Schmidt** asked whether a change requiring that certain information be kept in school records instead of medical records would result in Health Insurance Portability and Accountability Act (HIPAA) privacy concerns. **Mr. Wimmer** stated that all providers are required to maintain HIPAA compliant records and schools are subject to similar requirements under the Family Educational Rights and Privacy Act (FERPA). The records kept by school administrators are school records. **Senator Schmidt** asked Mr. Wimmer to clarify why the following subsection referenced "medical" records instead of "school" records. **Mr. Wimmer** indicated that the discrepancy may have been an oversight in drafting.

Senator Hagedorn noted that some provisions require that supervising practitioners must have regular one-to-one meetings with student participants to review treatment provided. **Senator Hagedorn** asked if there were accommodations regarding this requirement for students in rural areas. **Mr. Wimmer** responded that supervision would be allowed via telehealth. **Senator Hagedorn** asked how physicians would meet the requirements of section 733.01.a via telehealth. **Mr. Wimmer** answered that the physician order requirements were a separate issue from the requirements for community-based rehabilitation services which allowed for telehealth services.

Senator Schmidt asked Mr. Wimmer if these pending rules would improve the process for schools to bill and to be compensated for their provision of Medicaid services. **Mr. Wimmer** stated that the Division is doing its best to minimize the administrative burden for schools; he expects to continue working with schools to resolve their concerns.

TESTIMONY: **Vice Chairman Nuxoll** invited testimony.

Cliff Hart testified on behalf of the Idaho Association of School Administrators (IASA). The IASA has established a legislative priority to remove obstructions in school-based Medicaid reimbursement programs. **Mr. Hart** reviewed his qualifications and many responsibilities as a special education director in a rural school district. In connection with rural school districts, **Mr. Hart** reviewed the impact of the physician order provisions found in sections 733.01.a.i-iii of the pending rules. **Mr. Hart** stated that rural school districts must typically contract with providers outside of their communities to obtain necessary school-based health services. **Mr. Hart** informed the Committee that these providers typically charge for health services, student participant evaluations, administrative costs, costs to attend IEP meetings and travel costs; Medicaid typically pays for the direct costs of health services and evaluations. **Mr. Hart** reviewed typical obligations and time constraints to assessing eligibility, designing IEPs and scheduling the provision of school-based services. Under the Individuals with Disabilities Education Act (IDEA), **Mr. Hart** stated that physician orders are not required to refer students to special education or to design and implement an IEP. However, requiring physician orders to obtain Medicaid funding for IEP would delay a rural school's reimbursement by 7 to10 days. He commented that federal regulations do not require a physcian's signature to obtain reimbursement for school-based services. **Mr. Hart** requested that sections 733.01.a.i-iii be rejected by the Committee.

Vice Chairman Nuxoll asked Mr. Hart if a physician's signature was required under federal regulations. Mr. Hart confirmed that only a referral or recommendation is required to obtain reimbursement for school-based services.

Senator Lee asked Mr. Hart to clarify how these pending rules will impede current practice. **Mr. Hart** clarified that schools could lose up to 30 days of Medicaid reimbursement.

Senator Schmidt asked if it was Mr. Hart's understanding that the current rule required a physician's order to begin services. **Mr. Hart** stated that schools could provide services based on a physician's diagnosis but could not be reimbursed for services until the physician's dated signature is obtained. **Senator Schmidt** asked how schools currently obtain a necessary diagnosis. **Mr. Hart** responded that many times schools obtain information from the child's personal physician. He noted that the physician's signature is typically obtained from a consulting physician.

Senator Lodge noted that if Medicaid is going to pay for school-based services, they must be assured that the services are medically necessary. **Senator Lodge** asked if a physician is not involved, how do schools determine services are medically necessary. **Mr. Hart** clarified that he did not have an issue with obtaining a physician's signature; he has an issue obtaining a physician's signature that is dated. **Senator Lodge** asked if Mr. Hart's concern was that Medicaid would not reimburse schools for services provided prior to the date of the physician's signature. **Mr. Hart** indicated yes. **Senator Lodge** asked whether schools could wait until a physician's signature was obtained to begin providing services. **Mr. Hart** discussed time constraints. **Senator Lodge** reiterated the importance of determining that services are medically necessary.

Senator Hagedorn asked Mr. Hart how small schools afford to develop IEPs and provide school-based services while waiting for Medicaid approvals and reimbursements. Speaking to his experience with small schools, **Mr. Hart** stated that school experienced great difficulty.

Allison Walters, President of the Autism Society of the Treasure Valley, testified against the physician order provisions of the pending rules and submitted letters from Misty-Dawn James and Heather Irons (see attachment 1) for consideration. **Ms. Walters** specifically requested that the Committee reject the rule and ask the Division of Medicaid to allow reimbursement for school-based services on order of the "IEP team." **Ms. Walters** spoke to the capabilities and effectiveness of the IEP teams.

Senator Jordan asked Ms. Walters to discuss the structure of the IEP teams. **Ms. Walters** responded that there were minimum requirements for the types of professionals included on IEP teams.

Gwen Lloyd testified on behalf of School District 25 in Pocatello. **Ms. Lloyd** stated that she has been involved in education for over 40 years, and specifically has worked as an IEP specialist, a curriculum specialist and a medicaid reimbursement specialist. **Ms. Lloyd** asked the Committee to reject sections 733.01.a.i-iii of the pending rules. **Ms. Lloyd** reviewed the qualifications of select IEP team members and noted the members' abilities to make therapy determinations. In summary, **Ms. Lloyd** stated that the pending rules would limit Medicaid reimbursement funds received by schools and are overly burdensome for school administrators.

Senator Lee asked if the requirements for school-based services are similar to the requirements for community-based services. **Ms. Lloyd** responded that her school district is complying with current rules, but time delays impede the provision of services and reimbursements.

Senator Jordan asked whether Ms. Lloyd has ever had a physician question services being provided. **Ms. Lloyd** responded no.

Senator Lodge asked Ms. Lloyd to clarify her concerns regarding the timing of Medicaid reimbursements. **Ms. Lloyd** responded that there are certain situations that result in the loss of federal reimbursements and the schools are therefore required to spend State funds to provide services.

Kindel Mason, Special Education Director of the Jerome School District, testified against sections 733.01.a.i-iii of the pending rules. **Mr. Mason** requested that professionals who sit on IEP teams be authorized to sign necessary orders. Referencing earlier questions, **Mr. Mason** noted that schools do not get paid without physicians' signatures.

Tammy Emerson testified on behalf of the Idaho Speech and Hearing Association and in support of the pending rules. **Ms. Emerson** addressed providers' specific concerns regarding the physician order requirements.

Karen Echeverria , Executive Director of the Idaho School Boards Association, testified against sections 733.01.a.i-iii (see attachment 2). **Ms. Echeverria** stated that schools do not receive Medicaid reimbursement until a physician signs orders. As a result of the physician order requirements, Idaho schools lose $10 to $40 million dollars in federal funding.

Kelly Hall, Special Education Supervisor for the Boise School District, stated that the Boise School District does currently seek Medicaid reimbursement for its special education programs. **Ms. Hall** expressed appreciation to the Department of Health and Welfare. She noted that, while the Boise School District supports the majority of these pending rules, the Boise School District did have concerns regarding select provisions. Specifically, the Boise School District would like to add special education teachers to the list of providers of community-based rehabilitation services. Additionally, **Ms. Hall** discussed concerns regarding the therapist provisions in section 730.08 of the pending rules.

DISCUSSION: **Vice Chairman Nuxoll** asked Dennis Stevenson, the Administrative Rules Coordinator of the Idaho Department of Administration, to explain what will happen if the Committee rejects this rule. **Mr. Stevenson** replied that if the Committee rejected any portion of this rule, it would request that a current resolution be drafted.

Senator Martin asked if the House has passed this rule. **Vice Chairman Nuxoll** confirmed that the House Health and Welfare Committee approved the rule as written. **Mr. Stevenson** responded that if this Committee drafts a concurrent resolution to reject this rule and the House does accept the resolution, the rule will be approved for lack of concurrence to reject.

Redirecting the discussion to Mr. Wimmer, **Senator Martin** asked Mr. Wimmer to discuss the impact of striking sections 733.01.a.i-iii on the current practices of the Division of Medicaid. **Mr. Wimmer** responded that the intent of these rules was to give the providers of school-based services 30 extra days to get a physician's order. **Senator Martin** asked Mr. Wimmer to confirm that school-based providers would be reimbursed for services provided during those 30 days. **Mr. Wimmer** confirmed. He stated that no claims can be made until the physician's order is obtained, but noted that claims for that period may be made if the physician's order covers that period.

Senator Lee asked what problem the Division of Medicaid was trying to solve with this set of pending rules. **Mr. Wimmer** responded that the Division of Medicaid was attempting to remove a burden, not to create one.

MOTION: **Chairman Heider** moved to hold **Docket No. 16-0309-1501** in Committee. **Senator Martin** seconded the motion.

SUBSTITUTE MOTION: **Senator Hagedorn** made a substitute motion to approve **Docket No. 16-0309-1501** except for the changes in sections 733.01.a.i-iii. **Senator Harris** seconded the substitute motion.

ROLL CALL VOTE ON SUBSTITUTE MOTION: **Senator Martin** called for a roll call vote on the substitute motion. **Vice Chairman Nuxoll**, **Senator Hagedorn**, **Senator Lee** and **Senator Harris** voted aye. **Senator Lodge**, **Senator Martin**, **Senator Jordan** and **Chairman Heider** voted nay. **Senator Schmidt** was absent for the vote. **Senator Jordan** noted that she voted nay to allow time for all issues regarding this rule to be addressed. The substitute motion failed.

ROLL CALL VOTE ON ORIGINAL MOTION: **Vice Chairman Nuxoll** called for a roll call vote on the original motion. **Vice Chairman Nuxoll**, **Senator Lodge**, **Senator Hagedorn**, **Senator Martin**, **Senator Lee**, **Senator Jordan** and **Chairman Heider** voted aye. **Senator Schmidt** was absent for the vote. The original motion carried.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 5:15 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

SENATE HEALTH & WELFARE COMMITTEE
Monday, February 1, 2016

ATTACHMENT 1

January 24, 2016

Dear Health and Welfare House Committee Members & Mr. Chairman Wood,

Re: Docket No. 16-0309-1501- School Based Medicaid Rule change proposal

Hello, my name is Misty-Dawn James and I live in Nampa, Idaho. Thank you for taking the time to listen to us today as you review the rule changes regarding school-based Medicaid. As an Idahoan, I appreciate knowing that you are all looking out for us. Your committee is our safety net, especially when we sometimes miss the public input announcements from the H & W. As a small business owner, former alternative education teacher, former PSR worker, and parent to a young-adult with Autism, I sometimes miss those invitations.

From my experience and multiple perspectives, I would like share a few concerns and ask a few questions while you are all reviewing the proposed rule changes.

1. H & W Public Input Invitation- I heard they posted the invitation for feedback in late fall of 2015 with short notice. From a parent and educator stand point, that is when the relevant stakeholders, whom these changes will impact the most, are busy with the start of the school year which often entails beginning-of-the-year IEP meetings, child-well checks, and annual reviews for providers. To improve the success rate of soliciting feedback in the future, is it possible to ask H & W if they would send the invitation out to the schools for the staff to share with parents at the IEP meetings? Or email the list of parents who have children on IEPs? They usually ask us for a copy of our children's IEP during the application process for DD and/or Children's Mental Health services.

2. Question on section 732.01 (f) pg. 122-

Occupational and Physical Therapists are critical to supporting student success for children with disabilities. State Certified Speech Therapists are equally important. Can we add them, please?

3. Suggestion for 733.01 (a) on pg. 124-

In my experience, my daughter's own physician expressed her discomfort in "prescribing" or "ordering" school services by signing that form every year. She was not familiar with the types of services available and never got any feedback or updates from the schools on my daughter's progress. As a professional, I understood her hesitation. There seems to be a lack of collaboration between the medical and school professionals on what their roles and who is responsible. As a former PSR worker and teacher who taught special education students, I saw the stress on the school resources to continuously provide services while waiting for those forms- sometimes up to 6 months later. While the community agency was required to stop services until that form was returned, signed by a doctor. It is illegal for schools to enforce that kind of policy.

So what if we found a compromise? Having a person at the IEP meeting who is clinically licensed, such as a School Psychologist, Master SLP, LCSW or Occupational Therapist that can objectively assess and prescribe the Medicaid school services necessary to appropriately support the student academic goals? Someone who is not under the direct supervision of the Site Principal.

As a former teacher, I would caution how you write this rule. We know the goal of every IEP meeting is to create a successful program to support that individual child's ability to learn. However, there are often competing points of view at the table as well. Parents want what is best, school administrators want what is practical, teachers want what is helpful, and physicians are not even there. Having another professional- who is licensed and objective- at that table will help to insure that the prescribed services are necessary, beneficial to the child, and responsibly appropriated. Allowing the IEP Team, with a licensed professional at the table will lessen the burden on the doctors and their staff, the schools and their budgets, as well as saving parents another appointment and/or paper to chase down. They do that a lot already, I promise.

4. A burning question on this topic that may appeal to your curiosity as well-

If Medicaid recipients receive quarterly statements about the extended services their child receives from providers in the community to decrease fraud or billing errors and improve transparency, why is it that parents are not provided the same information when schools bill Medicaid?

As a parent, there was a time or two that I called H & W to report a billing, after receiving a statement of the units billed for my daughter's case management. One time, I asked if I could get a copy of what the school was billing and I was told, "that is private information because it is billed from a public entity."

I have always been curious about that statement. It is important to have transparency, will all Medicaid billing. That way as parents, we can help our system in their goal to be transparent and efficient.

In closing, thank you again for taking your time to consider these items with such deep consideration.

Kindly,

Misty-Dawn James

7601 E. Flamingo Ave

Nampa, ID 83687

Regarding docket # 16-0309-1501

My name is Heather Irons. I am the mother of a 14-year-old autistic boy who requires services mandated by his IEP.

My son, JT, was diagnosed with autism in the second grade. From preschool through the time of his diagnosis, JT struggled greatly with learning. Once an IEP and an IEP team were in place, JT finally began to make progress academically. IEPs are not all about academics, though. JT has also required speech, occupational therapy, and social/behavioral supports. Without a knowledgeable IEP team who developed, and continues to develop, JT's plans and supports, his academic, social, and emotional growth would be even more negatively impacted.

The members of JT's IEP team work closely with me, JT, and each other to produce the best possible outcomes for JT. JT's physician does not know JT or his academic needs as intimately as JT's IEP team.

I request that you reject rule 733, section 01, "Physicians Orders," and ask the Department of Health and Welfare to include the phrase "or the IEP Team."

Thank you for your consideration.

SENATE HEALTH & WELFARE COMMITTEE
Monday, February 1, 2016

ATTACHMENT 2

2016 ISBA RESOLUTION NO. 7

OPTIMIZE REIMBURSEMENTS TO THE SCHOOL-BASED MEDICAID PROGRAM

WHEREAS, the federal Individual with Disabilities Act (IDEA) governs all state and local education agencies (LEAs) that provide specially designed instructional services to all eligible children with disabilities between the ages of three and twenty-one to receive special education and health-related services under Part B of IDEA; and

WHEREAS, school districts are simultaneously facing tighter budgets and growing populations of children with special needs; and

WHEREAS, the federal government will reimburse with federal, not state, Medicaid dollars, 70% of school districts' expenditures on health-related services for eligible children with disabilities; and

WHEREAS, state and local education dollars are spent to fund this program where federal dollars are available for reimbursement but are not being fully accessed; and

WHEREAS, in January, 2013 the Idaho School Boards Association and the Idaho Association of School Administrators co-signed a letter to the regional Medicaid Services director, asking for "guidance and intervention" into Idaho's lack of an interagency agreement between the Idaho Department of Health and Welfare (DHW) and the Idaho State Department of Education (SDE) specific to this program; and

WHEREAS, the current Memorandum of Understanding (MOU) between the DHW and the SDE does not provide effective and appropriate guidance for the School-Based Medicaid program; and

WHEREAS, it is estimated that between $10 million and $40 million of federal reimbursements to Idaho's School Based Medicaid Program are going unclaimed annually by Idaho school districts;

NOW THEREFORE BE IT RESOLVED, that the Idaho Schools Boards Association will work with the Idaho Legislature and other stakeholders to ensure that districts can fully optimize federal reimbursements to the School-Based Medicaid Program.

STATEMENT OF PURPOSE

In recent years, school district special education personnel have been forced to shift their focus away from students and instead spend precious resources on burdensome – and in some cases, unique – regulations associated with the School-Based Medicaid Program. The Idaho School Boards Association is concerned that the needs of school children and special education teachers are not being met with respect to this program, due in part to a lack of funding. With millions of reimbursement dollars available, Idaho should be incentivizing districts to maximize those reimbursements, not discouraging participation.

Submitted by Twin Falls School District No. 411
Submitted by American Falls School District No. 318
Submitted by Jerome School District No. 261

PASSED	**AYES**	**3783**
	NAYES	**12**
	TOTAL	**3795**

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, February 02, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
RS24067	Advanced Practice Registered Nurse Compact	**Sandra Evans** Board of Nursing
RS24056	Nurse Licensure Compact	**Sandra Evans**
RS24058	Nursing Definition Revised	**Sandra Evans**
S 1204	Medicaid Eligibility Expansion	**Senator Dan J. Schmidt**
S 1205	Medical Assistance Eligibility Standards	**Senator Dan J. Schmidt**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, February 02, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:02 p.m. **Chairman Heider** indicated his preference that the Committee gather information regarding **S 1204** and **S 1205** during today's meeting and not hold a vote on these bills until the Committee has had the opportunity to hear the alternate proposal to care for the gap population as developed by the Governor's Office and the Department of Health and Welfare.

RS 24067 **Relating to the Advanced Practice Registered Nurse Compact**. **Sandra Evans**, Executive Director of the Idaho State Board of Nursing, presented this RS.

Ms. Evans stated that the purpose of this RS is to adopt the Advanced Practice Registered Nurse (APRN) Compact, an interstate compact for multistate licensure, which facilitates cross-border practice (APRN Compact). An APRN is an RN with graduate or post-graduate education in nursing who is prepared with advanced knowledge and skills to practice in the role of certified midwife, clinical nurse specialist, nurse practitioner or registered nurse anesthetist. **Ms. Evans** reported that Idaho adopted and implemented the Nurse Licensure Compact for RNs and LPNs in 2001; the compact has proven to be an effective way to reduce unnecessary regulatory barriers to the delivery of health care, including telehealth. APRNs are not included in the Nurse Licensure Compact. **Ms. Evans** stated that the APRN Compact would allow an APRN to have one multistate license that permits practice in other APRN Compact member states. She noted, however, that each state would retain regulatory autonomy through its standards of conduct for practice within its borders. **Ms. Evans** reviewed the eleven articles of the APRN Compact with the Committee. She stated that the proposed legislation will have minimal fiscal impact on the dedicated fund maintained by the Board of Nursing.

Chairman Heider asked the members if they had any questions.

Senator Martin asked how the APRN Compact will increase the provision of telehealth services in Idaho. **Ms. Evans** stated that the practice of nursing takes place at the location of the recipient of care, not the location of the provider of care. The APRN Compact was designed the facilitate cross-border practice of nursing.

Senator Hagedorn asked, if an APRN is registered in another state, how will the Idaho Board of Nursing find out about potential licensure concerns. **Ms. Evans** stated that the APRN Compact requires participation in a centralized information exchange system established through the National Council of State Boards of Nursing. Through this system, participating Boards of Nursing can share licensure information and investigatory and disciplinary information. Idaho could take disciplinary action against the privilege to practice in Idaho. **Senator Hagedorn** asked how the APRN Compact addresses formularies. **Ms. Evans** stated that the APRN Compact is silent on the issue. She noted that in Idaho, APRN's prescribing authority is based upon their educational preparation, demonstrated competence, and relationship to specialty area.

MOTION: There being no more questions, **Vice Chairman Nuxoll** moved to send **RS 24067** to print. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

RS 24056 **Relating to the Nurse Licensure Compact**. **Sandra Evans** presented this RS.

Ms. Evans stated that the purpose of this RS is to adopt the new enhanced Nurse Licensure Compact to replace the current compact. The enhanced compact is an amended version of the current compact, of which Idaho has been a member since 2001. **Ms. Evans** stated that the Nurse Licensure Compact creates a regulatory process that permits nurses to practice freely among participating states on the license issued by their primary state of residence without the need to hold additional licenses in those other states. **Ms. Evans** discussed the successes of the current Nurse Licensure Compact, but noted that membership had stalled at 25 states. Enhancements were made to the current compact to encourage adoption by more states and thereby increase access to quality nursing care nationwide. **Ms. Evans** reviewed the enhancements to the Nurse Licensure Compact, including (i) incorporation of uniform licensure requirements, (ii) clarification of the role and relationships of the compact governing body, (iii) clarification or processes for rulemaking based on provisions of the Model Administrative Procedures Act, (iv) oversight and enforcement of the compact and (v) grandfathering nurses who hold a multi-state license at the time of transition to the enhanced compact. She noted that, once implemented, the enhanced Nurse Licensure Compact provides for the withdrawal from the current compact. **Ms. Evans** reported that the proposed legislation will have minimal fiscal impact on the dedicated fund of the Board of Nursing.

Chairman Heider asked the members if they had any questions.

Senator Schmidt asked Ms. Evans if the enhanced compact had a section for repeal of the existing compact. **Ms. Evans** responded yes and directed Senator Schmidt to Article 10 of the enhanced compact and noted that sections 1 and 2 of the proposed legislation provide for the repeal of the existing compact and replacement by the enhanced compact.

Vice Chairman Nuxoll asked whether these types of compacts have similar wording. **Ms. Evans** responded yes.

MOTION: There being no more questions, **Senator Martin** moved to send **RS 24056** to print. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

RS 24058 **Relating to the Definition of Nursing**. **Sandra Evans** presented this RS.

Ms. Evans stated that the current definition for the "practice of nursing" is outdated and is no longer descriptive of today's practice. The purpose of the RS is to update the definition of the "practice of nursing" to more clearly articulate the depth and breadth of what constitutes nursing practice. **Ms. Evans** stated that the proposed legislation has no fiscal impact.

Chairman Heider asked the members if they had any questions.

Senator Martin asked whether the last sentence of the RS was related to telehealth. **Ms. Evans** responded that the Board of Nursing wanted to clearly articulate a provision of the Telehealth Access Act and confirm that the practice of nursing occurs at the physical location of the recipient.

MOTION: There being no more questions, **Senator Lodge** moved to send **RS 24058** to print. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**.

S 1204 **Relating to Medicaid**. **Senator Dan J. Schmidt** presented this bill together with **S 1205**.

S 1205 **Relating to Medical Assistance**. **Senator Dan J. Schmidt** presented this bill together with **S 1204**.

OPENING REMARKS: **Senator Schmidt** stated that his goals for today's meeting were to have a discussion and to address the Committee's concerns about this public policy choice. **Senator Schmidt** commented that he will honor the role of the Committee and the role of the Senate as this discussion takes place. **Senator Schmidt** stated that **S 1204** is a bill that directly reflects the recommendation of the health care workgroup that Senator Schmidt served on, which also made a recommendation to the Governor. **Senator Schmidt** stated that **S 1205** is a recommendation from another health care workgroup that Chairman Heider worked on that made an alternate recommendation to the Governor. Upon Senator Schmidt's request, **Chairman Heider** invited Dr. Ted Epperly to speak on behalf of **S 1204** and **S 1205**.

Dr. Ted Epperly, a family physician, Chief Executive Officer of the Family Medicine Residency of Idaho and Chairman of the Idaho Health Care Coalition that oversees Idaho's State Health Care Innovation Plan, discussed **S 1204** and **S 1205** with the Committee. **Dr. Epperly** also noted that he served on both of health care work groups convened by the Governor.

First, **Dr. Epperly** applauded Governor Otter for continuing to seek solutions for those who fall into Idaho's health care coverage gap. When Governor Otter first convened the Medicaid Redesign Work Group in 2012, he charged the group to study and determine whether Idaho should accept Medicaid expansion funds as set forth in the Affordable Care Act to provide coverage for Idahoans earning less than 138 percent of the federal poverty level. **Dr. Epperly** stated that the workgroup studied a broad range of information, including (i) an overview of the gap population, their demographics and their health needs, and (ii) actuarial analyses of costs and savings to the State both if Idaho accepted Medicaid expansion or rejected expansion and continued its indigent programs. After considerable analysis and discussion, the workgroup voted unanimously to recommend that Idaho accept Medicaid expansion.

Second, given the lack of legislative interest in Medicaid expansion under the Affordable Care Act, **Dr. Epperly** said the Governor reconvened the work group in 2014 and charged the group to study alternative plans being put forward by other states because the Centers for Medicare and Medicaid Services (CMS) had shown unprecedented flexibility towards states that wanted to cover their gap populations but structure their programs differently. **Dr. Epperly** said that the work group studied a number of different waiver models but ultimately developed its own hybrid waiver model with the following key objectives: (i) retain individuals earning 100 to 138 percent of the federal poverty level (FPL) in private coverage through Idaho's health exchange, (ii) place individuals earning below 100 percent FPL in Medicaid managed care incorporating health behavior incentives and the maximum personal responsibility in this form of cost sharing, (iii) encourage access for patients to a usual source of care through the primary care models of the patient-centered medical home and direct primary care, (iv) create a discontinuation provision to protect Idaho if Congress decided to shift more of the burden to the states beyond the 10 percent maximum set by the Affordable Care Act and (v) provide for ongoing

dialogue with CMS to ensure that Idaho's waiver plan would be accepted once approved by the Idaho Legislature.

To summarize, **Dr. Epperly** stated that **S 1204** represents the workgroup's first recommendation in 2012: straight Medicaid expansion pursuant to the Affordable Care Act. He said **S 1205** represents the workgroup's second recommendation in 2014: the Healthy Idaho Plan, which is a hybrid private-option model developed in Idaho, by Idahoans, for Idahoans. **Dr. Epperly** reviewed the key differences between **S 1204** and **S 1205**. Both bills eliminate the State Catastrophic (CAT) Fund and the County Indigent Fund because the individuals served under these programs would receive Medicaid coverage saving the State approximately $55 million per year. Both bills would provide patients the full range of essential health benefits, including primary care, prescription medications, diagnostics, behavioral health care, specialty care, emergency room utilization and hospitalization when necessary. **Dr. Epperly** stated that **S 1204**, the straight Medicaid expansion model, would pull individuals earning from 100 to 133 percent of the FPL who are currently in private exchange plans into Medicaid, while **S 1205** would keep these individuals in the private exchange plans.

Utilizing $40 million of grant funding received for the State Healthcare Innovation Plan (SHIP), **Dr. Epperly** said Idaho has been transforming its health care system to better provide accessible, integrated and coordinated primary care through the development and scaling of the patient-centered medical home concept. According the Commonwealth Fund, two things drive better health care outcomes for populations of people: (i) a usual source of care and (ii) some type of insurance coverage. **Dr. Epperly** informed the Committee that **S 1205** will provide the comprehensive insurance coverage that will align with the SHIP transformation of our primary care system to provide a usual source of care.

In closing, **Dr. Epperly** said he hopes the Committee votes to send **S 1205** – the Healthy Idaho Plan – to the floor with a do pass recommendation. This plan represents three years of hard work by Idaho experts on the Governor's workgroup and it represents a tremendous opportunity to save taxpayer dollars by leveraging Idaho's share of federal dollars back to the State and eliminating wasteful county and State programs that would no longer be necessary. **Dr. Epperly** suggested that an even better reason to pass **S 1205** would be to save and improve the lives of low-income, working Idahoans who fall into the health care coverage gap.

Chairman Heider asked the members if they had any questions.

Senator Hagedorn asked if there were enough doctors available in Idaho to accept the new Medicaid patients that would be enrolled as a result of these bills. **Dr. Epperly** responded yes. Acknowledging a shortage of primary care physicians, **Dr. Epperly** suggested that nurse practitioners and physicians assistants would need to become part of the solution. He said Idaho has an expanded workforce that could care for Idaho's population, but Idaho would still need to continue to build out the primary care workforce. **Dr. Epperly** reiterated that Idaho has enough providers.

Chairman Heider asked Dr. Epperly to explain the major differences between **S 1204** and **S 1205** and the Governor's primary care access program. **Dr. Epperly** responded that **S 1204** and **S 1205** provide comprehensive insurance coverage – all services that a person may need. He said the Governor's proposal will only provide limited primary care. This means that the Governor's proposal will provide a usual source of care, but he suggested that it will not go far enough to cover the needs of Idahoans. Discussing the funding differences, **Dr. Epperly** noted that **S 1204** and **S 1205** will save Idaho roughly $25 million to $35 million per year. Whereas the Governor's proposal will cost $30 million to implement and will not end the County Indigent Fund or the CAT Fund. In aggregate, the Governor's proposal will cost the state $85 million. **Dr. Epperly** added that Medicaid expansion would

bring $577 million to Idaho over 10 years. He said that is roughly $57 million per year in addition to the cost savings, which would result in a positive economic impact of approximately $1 billion per year to the economy of Idaho.

TESTIMONY: **Chairman Heider** invited further testimony.

Dr. Kenneth Krell, a physician from Idaho Falls, testified in support of **S 1205**. **Dr. Krell** stated that he sees emergency room patients almost daily who present with end stage disease because they were not able to get medical care when their disease process might have been arrested. He commented that, as a result, many of these patients are left severely injured or die. **Dr. Krell** indicated that a *New England Journal of Medicine* study found that the failure to expand medicaid costs 19.7 lives per 100,000 in population, an estimated 324 lives per year in Idaho. **Dr. Krell** related the story of his patient, Jenny Steinke, who died of complications from asthma. He said Jenny's case exemplifies what is wrong with Idaho's health care system. In closing, **Dr. Krell** requested the Committee consider approving Medicaid expansion for Idaho.

Mayor David Bieter, mayor of Boise, testified in support of the Healthy Idaho Plan. He believes health care is the most important public policy issue before the Legislature. **Mayor Bieter** discussed three gaps that affect citizens. First is the gap that leads to 78,000 citizens not having health insurance coverage. He said they are one diagnosis away from a catastrophe because they either don't seek medical services or don't have the money to pay for medical services. Second is the economic activity gap. He indicated that the Kaiser Foundation estimated that $3 billion and 11,000 jobs will not occur without the expansion of Medicaid. **Mayor Bieter** stated that without $3 billion of activity, Idaho's competitiveness is going to be compromised. Third is the gap between our beliefs and our actions. Thousands of people suffer without this coverage. He suggested that Idahoans have a moral obligation to do what we can to lessen or eliminate suffering. In closing, **Mayor Bieter** stated that this is an Idaho law, for Idahoans, by Idahoans.

Mike Brassey, representing St. Luke's Health System, testified in support of **S 1205** – the Healthy Idaho Plan. He stated that this legislation was developed by health care professionals over an extended period of time and it is designed to work for the State of Idaho. **Mr. Brassey** urged the Committee to support the legislation.

Fred Birnbaum, Idaho Freedom Foundation, testified in opposition of **S 1204** and **S 1205**. **Mr. Birnbaum** referenced a provision in the proposed legislation that would allow the State to repeal Medicaid expansion if the federal government reduces its contribution percentage. He argued that, based upon the U.S. Supreme Court decision in *NFIB v. Sebelius*, the State would be unable to repeal Medicaid expansion without threatening all federal Medicaid dollars it receives. Next, **Mr. Birnbaum** referenced the assertion by supporters that Medicaid expansion would result in cost savings to the State. **Mr. Birnbaum** stated that it is unreasonable to presume that the federal government can continue to fund 90 percent of Medicaid expansion costs into perpetuity. Further, **Mr. Birnbaum** asserted that, instead of saving money, Medicaid expansion would ultimately cost the State more money than estimated. He pointed to the experiences of other states. He said that, due to higher than expected enrollments, Ohio exceeded its Medicaid expansion budget by $1.5 billion during the program's first 18 months and Washington exceed its Medicaid expansion budget by $2.3 billion. In closing, **Mr. Birnbaum** discussed a *New England Journal of Medicine* study that showed that Medicaid expansion did not improve health outcomes. Referencing Mr. Birnbaum's comments related to other states' cost overruns due to higher than expected enrollments, **Senator Jordan** asked what actuarial data those states used. Specifically, how did these states make their enrollment estimates and how did they exceed their enrollment estimates? **Mr. Birnbaum** indicated that he only had the data regarding the actual

cost overruns and did not have information regarding the estimating methodologies used by the states.

Michelle Gluch testified in support of **S 1205** – the Healthy Idaho Plan – and shared her family's story of living without health insurance (see attachment 1). She stated that her husband is chronically ill. Despite working and returning to college to find a better career, her husband's health care requirements have left them in $60,000 of medical debt. She noted that many of her friends fall into Idaho's health care gap. They are waitresses, care providers, construction workers, adjunct faculty and store clerks; they are the people who keep Idaho running but they live in the gap and are denied the most basic of medical care. **Ms. Gluch** requested that the Committee consider the Healthy Idaho Plan, so that the working poor can have dignity and control over their own health and financial futures.

Jim Baugh, Executive Director of DisAbility Rights Idaho, testified in support of **S 1204** and **S 1205** (see attachment 2). **Mr. Baugh** began by stating that, contrary to popular opinion, not all Idahoans with disabilities who live in poverty are eligible for Medicaid or other health insurance programs. First, **Mr. Baugh** stated that people with severe and persistent (chronic) mental illness live in the health care gap. They need more than primary care; they need specialty care, hospitalization and coordinated care. Second, **Mr. Baugh** stated that people who acquire a progressive condition like cancer or some other illness can no longer work and usually apply for social security disability benefits. If a person's benefits are more than $734 per month, he is disqualified from medicaid. Additionally, these individuals cannot qualify for Medicare for two years. **Mr. Baugh** referenced a recent study that found that 42 percent of the individuals accessing county indigent care services were individuals who qualified for social security disability benefits but were waiting for Medicare coverage to become effective. In closing, **Mr. Baugh** reminded the Committee that tens of thousands of people with severe disabilities do not have any form of health insurance coverage.

Yvette Ashton, volunteer with AARP Idaho, testified in support of **S 1205** (see attachment 3). **Ms. Ashton** stated that AARP Idaho is a nonprofit, non-partisan organization that represents 177,000 members across the State. They are helping older Idahoans have independence and control over their lives. She stated that there are more than 26,000 Idahoans ages 50-64 who are currently in the health care coverage gap. Many of these individuals are AARP members and they have lost their jobs, but they are still trying to find new ones. In closing, **Ms. Ashton** stated that Idahoans who have access to health services can be productive members of the workforce, focus more time on their family and have income and resources to put back into the economy.

Bonnie Markham, an Idaho citizen, testified in support of **S 1205** – the Healthy Idaho Plan. **Ms. Markham** stated that she is a single working mom who is studying for a masters degree in social work. She is one of the 78,000 Idahoans living in the health care coverage gap. **Ms. Markham** discussed her financial circumstances and noted the difficulty in making ends meet. She had to stop taking many of her medications because she cannot afford them. **Ms. Markham** stated that she values hard work. She works a job, attends Northwest Nazarene University and participates in two internship programs. But she gets discouraged when she works as hard as she can, and she still cannot afford basic health insurance. In closing, **Ms. Markham** indicated that the State of Idaho must do something to help people become healthy, contributing citizens.

Jon Brown, a retired methodist minister, testified in support of **S 1205** (see attachment 4). Noting that he has a daughter who has paranoid personality disorder and a grandson who is autistic, **Mr. Brown** related his experiences with health care in Idaho. He commented that people in the health care gap are our cousins, daughters and grandsons, and they are a part of our community. He noted that they are people who suffer from chronic pain, from arthritis, from work-related injuries, opiate abuse/overdose, alcoholism and liver disease and suicide. In closing, **Mr. Brown** related the Biblical story of Dives and Lazarus.

Tom Lamar, a Latah County Commissioner, testified in support of **S 1205** (see attachment 5). **Commissioner Lamar** stated that the taxpayers of his county pay approximately $550,000 annually to provide medical care to people who have no insurance. The remainder of these individuals' medical costs not covered by the county is passed along to the CAT Fund to be paid by all Idaho taxpayers. This process is repeated throughout the other 43 counties. **Commissioner Lamar** stated that with the passage of **S 1205**, the county indigent program and the CAT Fund could be repealed, thereby providing property tax relief to county and State taxpayers. In closing, **Commissioner Lamar** indicated that the Legislature should close the health care gap and build a healthy, compassionate Idaho.

Dr. Bruce Belzer, a family physician in Boise and President-Elect of the Idaho Medical Association, testified in support of **S 1205** – the Healthy Idaho Plan. **Dr. Belzer** showed the Committee a newspaper article he brought with him regarding the death of Dr. Krell's patient, Jenny Steinke. He stated that he was saddened and angered by Ms. Steinke's death. Unfortunately, **Dr. Belzer** commented that every physician in Idaho could tell story after story of patient after patient who falls into the health care gap and who has critical and chronic care needs that are not being met. **Dr. Belzer** related the story of one of his patients who had developed chronic obstructive pulmonary disease. He said she worked two jobs, had no insurance, and refused to seek medical assistance because her moral code did not allow her to incur debt she couldn't pay. Dr. Belzer asked her to let him help her despite her inability to pay for his services. Eventually, his patient spent 10 days in the hospital's intensive care unit because she did not seek ongoing treatment. In closing, **Dr. Belzer** stated that there is no wrong time to do the right thing. **S 1205** is the right thing to do. **Senator Hagedorn** commented that for the last ten years, Idaho has been 49th in the nation for doctors per capita, 46th in the nation for primary care physicians per capita, 48th in the nation for OBGYN physicians per capita, and sixth in the nation for population growth. He asked Dr. Belzer if the Legislature passed **S 1205**, how would Idaho's physicians be able to provide the necessary services for Idaho's growing population. **Dr. Belzer** said he believes it can be done. He said the State would need to maintain the WAMI and residency program to fill the pipeline. **Dr. Belzer** said that if the Legislature provides the opportunity, he believes physicians, nurse practitioners and the ancillary work force will rise to the opportunity and take care of these patients. **Senator Hagedorn** stated he believed if this were the case and were possible, those doctors that are no longer accepting Medicaid patients would find a way to do that now.

WRITTEN TESTIMONY: The following individuals and groups testified in support of **S 1205** – The Healthy Idaho Plan (see attachment 6):

1. Dr. Ingrid Brudenell;
2. Elinor Chehey;
3. Close the Gap Idaho;
4. Karleen Davis;
5. Dr. Scott Eliason, representing Boise Forensic Psychiatry;
6. Matt Forge, representing St. Mary's Hospital and Clinics;
7. Audrey Gatewood;
8. Penelope Hansen, representing the Boise Police Department;
9. Kerry Hong, representing the Community and Family Justice Services Division of the Idaho Supreme Court;
10. Mindy Hong, representing the Pocatello Free Clinic;
11. Po Huang;
12. Yvonne Ketchum-Ward, representing the Idaho Primary Care Association;
13. Kathryn McNary;
14. Liz Merrill;
15. Danielle Ryals, read by Christa Rowland;
16. Michael Sandvig, representing the National Alliance on Mental Illness - Idaho;
17. Neva Santos, representing the Idaho Academy of Family Physicians;
18. Corey Surber, representing Saint Alphonsus Health System; and
19. Idaho Voices for Children.

The following individuals and groups testified in support of **S 1204** and **S 1205** (see attachment 7):

1. Mike Baker, representing Heritage Health;
2. Sylvia Chariton, representing the American Association of University Women of Idaho;
3. Michael Traficante;
4. Lee Juan Tyler, representing the Fort Hall Business Council; and
5. Aaron Wilson, representing CHAS Health.

The following individuals testified as follows (see attachment 8):

1. Linda Anderson testified in support of Medicaid expansion;
2. Dr. Danielle Davies testified in support of affordable medication; and
3. Clella Steinke testified in support of closing the coverage gap.

CLOSING REMARKS: **Senator Schmidt** thanked the Committee for hearing the testimony regarding **S 1204** and **S 1205**. He stated that he serves on the CAT Fund, which reviews approximately 200 to 300 cases every two months and these cases are tragic. **Senator Schmidt** stated, however, that the Committee should not make public policy choices based on tragedy. He believes the Committee should make public policy choices based on good policy. He said tragedies do happen and if legislators can make good policy to prevent tragedies then that is their job. Referring to the opposition's argument that Idaho cannot afford to expand Medicaid because of the national debt, **Senator Schmidt** argued that the $500 million that would come back to Idaho under Medicaid expansion has not been saved, but rather these costs have been shifted to payments to private insurers. Referring to the State Healthcare Innovation Plan, **Senator Schmidt** commented that Idaho health care is moving in the right direction. He believes the Legislature has the foundation for good policy. He urged the Committee's support for this legislation, and asked them to consider sending **S 1205** to the floor with a do pass recommendation.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:31 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 2, 2016

ATTACHMENT 1

Hearing Address

Good Afternoon Chairman and committee members, I am Chelle Gluch and I live in the gap. I am here to share my story because, unfortunately, it is not a singular story.

78,000 Idahoans live in the gap; it's a scary place. There is no dignity here. We scrape by as best we can, always looking for a way out, a way to escape.

Living in the gap has dire consequences. We live in terror of illness and injury—one emergency can devastate us. We are often forced to choose between seeing a doctor, keeping the lights and heat on, or filling our gas tank. We simply cannot afford medical care.

From the beginning, my family felt squeezed. My husband is chronically ill—he struggles with stomach pains so severe that he often cannot stand and vomits for hours, sometimes for days. Dealing with this has been like trying to escape quicksand. My husband wants to work, and so when the pain got severe, he sought medical care. But with only my income, bills mounted quickly. Soon, we owed thousands of dollars.

So we cobbled together a method to receive care. We utilize cheap care we can find it, but mostly we ignore it until the pain is too much and we end up in the ER. Whenever possible we found a doctor who would work with him. We were reaching for hope to pull us out of the muck.

It's been ten years. We owe 60,000 dollars in medical debt. But without answers my husband can't work. We are stuck tight in this terrible cycle.

I can't breathe, I am squeezed so tight. Despite the fact that I've returned to college to find a better career with health benefits, I'm afraid we will never escape the pit; there are so many bills. I can't breathe.

My story is not unique. Most of my friends fall into the gap—waitresses, care providers, construction workers, adjunct faculty, store clerks-- the people who keep Idaho running. But we live in the gap and are denied the most basic medical care.

And that is why I am so excited about the Healthy Idaho Plan. It requires that participants take responsibility for our own health while helping us out of the quicksand. With the Healthy Idaho Plan, the working poor will have some control over our own health and futures. While I thank Governor Otter for his efforts, the PCAP leaves the working poor teetering on the brink of financial ruin by excluding emergency care.

I ask you today to please adopt the Healthy Idaho Plan so that the working poor can have some dignity and control over their own health and financial futures. We do not want to be the burdens that society perceives us to be. Give us a chance to show you what we can do with this opportunity.

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 2, 2016

ATTACHMENT 2

DISABILITY RIGHTS IDAHO
Protection & Advocacy for Individuals with Disabilities

Idahoans with Disabilities in the Health Insurance Gap: The Healthy Idaho Plan

Contrary to popular opinion, not all Idahoans with disabilities, living in poverty, are eligible for Medicaid, Medicare or any other health insurance program. Many low income Idahoans with serious disabilities fall into the health insurance gap (for information on the gap, http://closethegapidaho.org).

Governor Otter's Work Group on Medicaid Redesign1 recommended that Idaho create our own solution to the health insurance gap by requesting a waiver of federal Medicaid rules. State and private stakeholders designed a plan which could solve the problem. It is called the "Healthy Idaho Plan". The Plan uses federal Medicaid funding to buy health coverage on the state insurance exchange for eligible families between 100% and 138% of the Federal Poverty Level2, and extends Medicaid to eligible families below the poverty level. The plan would also extend Medicaid coverage to low income people with disabilities, and chronic health conditions, who are not currently covered. The Healthy Idaho Plan will be a great benefit to many Idahoans with disabilities.

Two large groups of people with disabilities are currently excluded from coverage. Of the roughly 41,000 Idahoans who have a serious and persistent mental illness (SPMI), only about 10,000 are currently eligible for Medicaid. About 12,000 more get some level of treatment each year from the Department of Health and Welfare, but only if their illness becomes so severe that that they pose a serious risk to themselves or others, or if services are ordered by a court. This group (SPMI) includes only people whose mental illness is disabling and recurring. The Healthy Idaho Plan would cover almost all of these people. The plan would provide federal funding for the care they need and relieve the burden on county indigent funds, and state general funds for the Catastrophic Health Care, and the Division of Behavioral Health programs. **Currently, most**

1 http://www.gov.idaho.gov/pdf/1204%20Medicaid%20Workgroup%20Report.pdf
2 https://www.healthcare.gov/glossary/federal-poverty-level-FPL

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Idahoans with SPMI have no coverage for mental health treatment, or for the expensive prescription drugs needed to control their symptoms.

People, who acquire disabilities after a period of employment, and are unable to work, often qualify for Social Security Disability benefits. **Federal law, however, prevents these people from obtaining Medicare coverage for two years after the onset of their disability.** If their Social Security benefits exceed $734/month, they are also excluded from Medicaid coverage, unless they are in need of nursing home care. There are always thousands of Idahoans with disabilities in this waiting period. A recent study of a random sample of county indigent program claims conducted by Dr. Douglas Dammrose revealed that 42% of the claimants are in this category3.

There are other people with disabilities, including many veterans, who are in this coverage gap due to individual circumstances. All of them need affordable health care coverage. People with SPMI need a robust benefits package to get adequate care and to maximize savings from state general fund programs. Many people in the Medicare waiting period may need long term in-home supports and services to keep them out of expensive nursing home placements. Idaho must insure that people with particular health care issues caused by disabilities, have access to regular Medicaid coverage to meet their needs and prevent higher cost services.

Conclusion:

The Healthy Idaho Plan would provide health care coverage for tens of thousands of low income Idahoans with disabilities. This would replace state and county tax dollars being spent in county indigent and state catastrophic health care and state mental health programs, with 90% federal Medicaid funds. This saves Idaho taxpayers tens of millions per year. It would provide access to mental health care and prescription drugs for people with serious and persistent mental illness. It would provide ongoing medical care for people with disabilities who are waiting for Medicare coverage. It would also make health care coverage affordable for the rest of the 78,000 Idahoans in the health care coverage gap.

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3 http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MoreInformation/08-14-2014%20Medicaid%20Redesign-Idaho%20Doug%20Dammrose.pdf

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 2, 2016

ATTACHMENT 3

AARP Real Possibilities in Idaho

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AARP Testimony – SB 1205
February 2, 2015 – Senate Health & Welfare

Chairman Heider and Members of the Committee,

My name is Yvette Ashton. I am from Boise, Idaho and I am a volunteer with AARP Idaho. AARP is a nonprofit, nonpartisan organization, representing 177,000 members across the state helping older Idahoans have independence, choice and control.

I appreciate the opportunity to appear before your committee on this important matter.

I speak today in support of Senate bill 1205.

Several years ago, I learned a valuable lesson in my life, and it was how to look at things in a different perspective. I used to look at people who lived in poverty and people who used assistance as taking advantage. My perspective now has changed.

Life is unpredictable. No one wants to get sick from a catastrophic illness and then go on to sell off their possessions, their house, and live on assistance. Nobody wakes up and wants to lose their job and not be able to afford their prescriptions. But it happens. Thousands of hard-working Idaho families, including my daughter and her family, are struggling with basic needs. She's younger but there are more than 26,000 Idahoans 50 to 64 who are currently in the coverage gap. Many of these folks are AARP members and have lost their jobs while still trying to find new ones.

We can build a healthy Idaho and lower barriers to preventive care. Healthy citizens mean we have healthy taxpayers. Idahoans who have access to health services can be productive members of the workforce, focus more time on family and have income and resources to put back into the economy.

Instead of being stuck in our perceptions about what Medicaid is politically, let's change our perspective to a healthy Idahoan is a contributing Idahoan.

Thank you for your time and your consideration. It is greatly appreciated.

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 2, 2016

ATTACHMENT 4

Mortality and Education

A new discovery about mortality, the causes and ages of death, was reported in The New York Tmes, The Atlantic magazine, and The Boise Weekly. In a highly respected study by Dr Angus Eaton, a Noble Prize winning economist from Princeton, the only group with an increasing death rate, that is, a group that is dying at younger and younger years, are poor, middle aged, white people. This is a surprise because conventional wisdom tells us that the most at risk of an increasing mortality rate might be people of color, or those in deepest poverty.

This group is between 45 and 54, with low income, high school education or less, dying at an increasing and alarming rate: 415 per 100,000.

Idaho has a population of just over 1.6 million people. That means that over 6,700 of our middle aged, white citizens will die this year from suicide, opiod (pain killers) overdoses, and liver disease resulting from alcohol abuse. This has been said well by the above sources, but not how that applies to Idaho, nor what we can do about it

First, the Idaho legislature has so far refused to expand the $178,000,000 Medicaid to the 78,000 people who would qualify, but instead spends millions (now proposed at $30,000,000) of state money on some of them. This amount could be totally paid for through The Affordable Care Act by expanding Medicaid, and would cover medications, hospitalizations and needed procedures.

Second, that would free up $30+MILLIONs for education. Why education? Because the key characteristic of this at risk white group, besides lower than average income, is that they are poorly educated! In fact, "the lower the education the higher the suicide rate and the opiod/ alcohol problem." The "increases in mortality rates (also) rose in parallel with their increasing reports of pain, poor health and distress," said Dr. Angus Deaton, a Noble Prize winner in Economic Science.

"This group tends to have a more pessimistic outlook about their financial futures," than comparable Black or Hispanic or Asian cohorts of the same age range, says Dr. Deaton. He goes on to say, "for a high school graduate their inflation adusted **income fell by 19%" between 1994-2004!** They complain mostly of chronic joint pain and Sciatica. Work related injuries, inability to work, poor socialization skills ,inadequate information about personal health care, no money for a doctor visit,no money for prescription drugs, no health insurance, all add to this depressing, pessimistic outlook. These are our sisters and brothers right here in Idaho!

In a nutshell, we are leaving $178,000,000 of federal money on the table, and pay out state money for inadequate health care for the distressed. And who pays for this? You and me in poorly directed tax money. But the low income, poorly educated, and especially the 6,700 white Idaho citizens, pay with their lives! And the elderly, the children, the mothers; as well as Latino, Native and Black sick people, pay with worse health outcomes.

Third, lets get the conversation started this legislative session about those Medicaid dollars and the great improvement in education that will come with increased funding. Let's put that $178,000,000,where we need it most—in education . Let's help out the 6,700 who will die this year, the 78,000 without adequate Medicaid health care, and raise our educational outcomes

through adequate funding. Let's attract the best talent, retain the gifted teachers, and raise the level of literacy and save the 6,700 (18/day) and empower the 78,000. And all that without raising taxes.
"Without a vision, the people perish."

Jon Brown,

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 2, 2016

ATTACHMENT 5

The Healthy Idaho Plan will save lives and money

Testimony in support of SB1205

Presented by Commissioner Tom Lamar

2 February 2016

On behalf of the:

Latah County Commission: Richard Walser, Chair, Dave McGraw, Tom Lamar

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Passing SB 1205 will save Idaho lives, and save Idaho money.

As County Commissioners, our job includes weekly meetings with the County Clerk and staff to review stacks of files pertaining to the many cases of medically indigent residents in Latah County. During this fiscal year, providing medical care to people who have no insurance will cost the taxpayers of our county about $550,000. The remainder of the cost not covered by the county is passed along to the state Catastrophic (CAT) fund to be paid by all Idaho taxpayers.

This process is repeated throughout the other 43 counties of Idaho, to pay for the medical costs of tens of thousands of Idaho rèsidents. An estimated 78,000 or so working Idahoans have jobs that pay so little that they can't afford health insurance and don't qualify for health insurance tax credits, but make too much to qualify for Medicaid in Idaho. Many are hardworking Idahoans stricken with serious medical problems. The combination of County indigency funds, and Idaho's CAT fund is their only avenue to pay for needed medical care when crisis arises.

It's right to help these citizens. But there's a better way to do it. Today, Idaho state policy does not fully take advantage of available funds. We need the Legislature to act. We need to pass SB 1205.

The Governor created a Medicaid Redesign Workgroup to study this issue and offer recommendations on how best to deal with the lack of access to healthcare for so many Idahoans. This group, comprised of various stakeholders and experts from the healthcare and insurance industries, as well as government representatives such as county commissioners, has twice recommended the state expand access to care utilizing available dollars to close the coverage gap.

Last February, the Workgroup presented its plan, "Healthy Idaho: An Idaho Alternative to Medicaid Expansion," to the Legislature. In March of last year, the Latah County Commissioners recommended that lawmakers pursue this plan immediately. In September, the Idaho Association of Counties general session voted overwhelmingly to support the Healthy Idaho plan.

If the Governor's Medicaid Redesign Workgroup's recommendation were implemented, medical expenses for indigent persons would be covered, along with some mental health treatment costs. Passing SB 1205 makes health care affordable for Idaho's working poor.

With the passage of SB 1205, the county indigent program and CAT program could be repealed, providing property tax relief to county and state taxpayers.

The Healthy Idaho Medicaid plan will save Idaho taxpayers millions of dollars, save lives, and reduce visits to hospital emergency rooms. We would also expect to benefit from an improvement in the health of our workforce.

Implementing the Healthy Idaho plan will bring home taxes that Idahoans are already paying to Washington DC for health care costs. These taxes paid by Idahoans should be spent in Idaho to solve Idaho problems, not spent in New York, Massachusetts, and California to help solve their health care issues. Passing SB 1205 is the right thing to do for Idaho taxpayers.

We Latah County Commissioners believe the Idaho Legislature and the Governor need to solve this problem. We need to change Medicaid eligibility rules to include the "gap population" and to increase the number of Idahoans covered by private health care management plans. Affordable health insurance coverage for every Idahoan is within reach. Let's work together to close the gap and build a healthy, compassionate Idaho. Passing SB 1205 today is the first step to making that happen.

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 2, 2016

ATTACHMENT 6

Chairman Heider, Committee members, My name is Dr. Ingrid Brudenell, I have worked as a nurse for 46 years and am an emeritus professor from Boise State University.

Over the last four years there have been many state wide efforts to educate, inform, and implement the Healthy Idaho Plan, or Medicaid expansion to cover the working poor. Now you have an opportunity to support SB 1205 and pass it to the full senate for consideration and a vote.

So many groups like the Idaho Medical Association, Nurses Association and American Cancer Society are in favor of expanding medicaid through the Healthy Idaho Plan. We have 78,000 Idahoans in the gap without health coverage which they need to survive. Let's pass this legislation and use the federal subsidies to offset costs and decrease the need for the CAT and indigent funds. Now more than ever we need **comprehensive healt**h coverage for all.

Why especially now? Several recent developments highlight how each of us is connected in the world. The first is emerging infectious diseases like Ebola, Dengue fever, Tuberculosis and Ziker virus. Climate change is increasing risks in locations previously unknown to these conditions. We are vulnerable to exposure to infectious diseases. Ongoing access to assessment and treatment, is essential to reduce risks for all of us.

Second, environmental changes, heat, contamination from polluted rivers and aquifers, and water shortages create and aggravate chronic health conditions. We have thousands of abandoned mines which continue to expose the public to heavy metal and lead contamination. Many of our low wage earners are disproportionately exposed to unhealthful environmental conditions through employment and living locations. How will individuals be assessed and receive treatments without access to care and follow up? We will not even know about the environmental or infectious disease exposures without ongoing health monitoring.

Third, SB 1205 will send a strong message that we value and support not only health care providers but their education. Reimbursements

realistically tied to patient needs and using best practices to provide quality care at reasonable costs will encourage providers to work in our state. Students considering health careers will be more inclined to study and work in the state if there are good paying job opportunities. The Healthy Idaho Plan will generate jobs and opportunities.

Fourth, our tax monies will be returned to our state to support the Healthy Idaho plan which will benefit not just the working poor but all of us and our communities. The Otter plan will cost the tax payers and continue to rely on the indigent and catastrophic funds from the counties to pay for medical care. If we implement the Healthy Idaho Plan these funds could be directed at other needed services.

In conclusion, I urge you to support SB1205 and pass the Healthy Idaho Plan and expand insurance coverage through Medicaid. If I can provide additional information or follow up please contact me. Thank you.

Dr. Ingrid Brudenell

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Boise, Id 83712

Contacts 208-336-4136, ibrudenell@gmail.com

February 2, 2016

Re: S 1205

Mr. Chairman, members of the Committee, I am Elinor Chehey, speaking for myself as a member of the United Methodist Women. I live in Boise at 617 N. Ross St.

I would like to tell you what the Social Principles of the United Methodist Church say about health care.

Health Care is a condition of physical, mental, social and spiritual well being. Creating the personal, environmental, and social conditions in which health can thrive is a joint responsibility—public and private. We encourage individuals to pursue a healthy lifestyle to achieve good health. Health care is a basic human right

Providing the care needed to maintain health, prevent disease, and restore health after injury or illness is a responsibility each person owes others and government owes to all, a responsibility government ignores at its peril. In Ezekiel 34:4a, God points out the failures of the leadership of Israel to care of the weak: "You have not strengthened the weak, you have not healed the sick, you have not bound up the injured." As a result, all suffer. (Social Principles, ¶162V)

Extending Medicaid to those who fall through the cracks is an idea whose time is long overdue.

Please vote YES on S 1205.

CLOSE THE GAP

I D A H O

We appreciate that you took the time to be here today. Your support for Senate Bill 1205 and the implementation of the Healthy Idaho Plan will help gain coverage for the 78,000 Idahoans in the gap. We are thankful that Senator Heider and the Committee are allowing a hearing and accepting public testimony. Close the Gap looks forward to working with the legislature on a full, comprehensive solution to the coverage gap.

Senate Bill 1205 and the Healthy Idaho Plan: Key Messages

Theme	Messages
What is the Coverage Gap?	The "coverage gap" refers to the **78,000 Idahoans** who lack any form of health insurance coverage. People in the gap don't qualify for traditional Medicaid and earn too little to qualify for assistance on Idaho's insurance exchange.
A Full Solution with Complete Coverage	Senate Bill 1205 would implement the Health Idaho Plan, a **full solution** created just for Idaho that provides the coverage gap population with **comprehensive health coverage**. Comprehensive coverage includes: ✓ Coordinated primary care ✓ Emergency room & hospital care ✓ Specialists ✓ Full prescription coverage ✓ Full diagnostics ✓ Full mental health care A full solution will: ✓ Save state and county tax dollars ✓ Increase economic activity ✓ Reduce behavioral health crises & costs ✓ Reduce dependence on emergency rooms ✓ Create accountability ✓ Incentivize healthy behaviors
Save Lives and Promote Quality of Life	**Idahoans living in the gap are needlessly suffering**, often delaying health care until their situations become dire and costly. We want Idaho families to be able to go to the doctor and get the care they need without facing huge medical bills. The Healthy Idaho Plan would allow for full coverage; it will enhance quality of life and save lives. ✓ Prevent hundreds of deaths annually ✓ Alleviate stress, pain and suffering for thousands of families ✓ Focus on prevention & primary care ✓ Reduce the number of medical bankruptcies and debt
Spend Our Tax Dollars Wisely and Save Local & State Dollars	The Healthy Idaho Plan **spends our tax dollars wisely** and creates a more efficient and cost-effective health system in Idaho. In addition, a full solution **would increase the financial security of Idaho businesses and communities**. ✓ Create 15,000 jobs ✓ Generate hundreds of millions of dollars in new economic activity ✓ Eliminate inefficient and costly state & county indigent programs ✓ Save state and local tax dollars ✓ Improve the health of the small business workforce ✓ Build a strong economy for future generations ✓ Support hard working Idaho families
Idaho Legislators Must Make Closing the Gap a Top Priority! **Let's work together on a full, comprehensive solution to the gap.**	• **Close the Gap supports Senate Bill 1205 and the implementation of the Healthy Idaho Plan.** • We appreciate the time Governor Otter's Workgroup put into developing the Healthy Idaho Plan and are grateful for SB1205's public hearing. We look forward to working with the legislature on a full, comprehensive solution to the coverage gap. • The Healthy Idaho Plan, designed by and for Idaho, would provide comprehensive health coverage to the 78,000 Idahoans living in the gap while saving millions in state and local taxpayer dollars. • A full solution to the coverage gap would save hundreds of lives every year. • The Healthy Idaho Plan creates a more efficient and cost-effective health system in Idaho and spends our tax dollars wisely.

Updated 2/1/16

Good afternoon Senator Heider, and Committee Members.

My name is Karleen Davis. I live in Boise and I am here, representing myself.

First, I want to thank you for holding this hearing. I am grateful that you are focusing on this issue, and I hope that all parties will be able to come together to help our friends and neighbors who are suffering without access to adequate healthcare.

I am here today because I am a landlord and I care about the well-being of my neighbors and community. I rent at the lower end of the market and most of the people I rent to are in the coverage gap. They are honest, hard-working people – because, of course, I don't rent to people who are dishonest or unemployed.

For my renters in the coverage gap a medical misfortune can be a disaster. A trip to the emergency room after an accident on the basketball court, treatment for food poisoning after a bad sandwich, or a suspicious spot on a face that should be checked by a dermatologist for cancer -- any of these quickly leads to large medical bills, missed work, delayed rent payments, and worse.

This can be expensive for me, but, of course, it is worse for those in the gap.

A couple years ago, one of my renters, a mason, became ill and briefly hospitalized. He lost work, reducing his income and was unable to continue paying rent here in Boise. He chose to return to his family home in Twin Falls where there was little work, but he had a place to live. When he approached the county indigent program to get help repaying the hospital and doctor bills, both Ada County and Twin Falls County denied his application. He was not considered to be a resident of either county.

I honestly don't know what the final outcome was, but I do know that the struggle was stressful and hugely time-consuming. I continue to be stunned by the administrative hurdles and cost of those programs. They do not serve the patients or the medical providers adequately.

I think that Senate Bill 1205 and the Healthy Idaho Plan is a good solution to the Coverage Gap. It requires personal responsibility on the part of patients, while it will relieve the administrative burden associated with the county indigent programs and the Idaho CAT program. It will save us all money, reward hard work, and strengthen our communities.

I hope you will be able to vote "due pass" for Senate Bill 1205.

Thank you for your attention.

Karleen Davis
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Boise Forensic Psychiatry

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February 2, 2016

Senate Health and Welfare Committee
State of Idaho

Chairman Heider and Committee Members,

My name is Dr. Scott Eliason. I would like to thank Chairman Heider and the rest of the committee for holding this hearing on the healthy Idaho Plan. I work for Corizon which is a private company that contracts with the Idaho Department of Corrections to provide healthcare for the inmates in our state prisons. I supervise all the psychiatric services throughout the prison system. The prison system is full of people who are there because of un-treated mental health conditions. While this is tragic it is somewhat understandable because they may not have realized that it was their mental health problems that were leading to incarcerations. The true tragedy of the incarceration of those with mental health problems is that all too often, after they are expertly diagnosed and treated during their incarceration, upon release they cannot afford to continue with their treatment. Their mental health problems then return and they are sent back to prison. Most of the people I am talking about would have a very good prognosis if they were able to receive treatment in the community. What I mean by this is they would likely be able to become productive members of our community- working, raising their children, and helping others. Instead they are being untreated and sent back to prison to receive the treatment they need. It is my opinion that the Healthy Idaho Plan would greatly help in many ways, but specifically it would decrease the incarceration of the mentally ill. Thank You

Sincerely yours,

Scott Eliason, MD

Testimony: Matt Forge, CAO St. Mary's Hospital and Clinics, February 2, 2016

Hello, my name is Matt Forge and I am the Chief Administrative Officer of St. Mary's Hospital and Clinics based in Cottonwood, ID and serve the health of the people in Idaho, Lewis, and Clearwater Counties.

I would first like to thank Chairman Heider and the Health and Welfare Committee for hearing the bill S1205, Healthy Idaho Plan. I would also like to take a second to thank Senator Nuxoll for her longstanding commitment and service to the 8th district. This is an all important issue for the state of Idaho and it is encouraging to see that we are taking steps to consider the health and wellbeing of more than 78,000 Idahoans that fall within the health insurance coverage gap.

This bill is about people, and specifically, people that we know and love. The communities of the region served by St. Mary's and Clearwater Valley Hospital and Clinics are a lot like that of much of rural Idaho, made up of small, family based, traditional communities. It would be hard pressed in Cottonwood, to find someone who doesn't have a family member, or at the very least a friend or neighbor, that isn't affected by the lack of insurance coverage in our state/region. These people work on our farms, work in our forests, and most importantly, work hard to provide a living for themselves and their families. These people go to work, every day, risking an event that, are not at all uncommon, and could mean financial ruin and hardship, and most importantly, keep them from working and providing for their families.

This is not a hypothetical situation. This occurs regularly in Clearwater, Idaho, and Lewis Counties. A story that comes to mind, is with a local, well liked and respected, Cottonwood farm hand, who falls into the coverage gap, who had an accident involving a fall from a combine. This injury has left him with debt, due to the Emergency Room and follow-up visits, and significant pain that prevents him from retaking the work he loves. He does not come in for regular visits, as he cannot afford them, and does not pursue the surgery that would allow him to retake his position working on the farm, because he cannot afford it, or the three hour trip to the specialist just for a pre-visit. Instead, he works odd jobs, toughing it out and straining to make ends meet. This is not a person who wants a hand out, he wants to work to support his family. Without access to health insurance and care, that is not his reality.

I have many more stories like this including people with uncontrolled diabetes, logging accidents, high blood pressure, that are not accessing services because of the financial strain it will cause them and their families. The consistent theme is that these are people with values consistent with the state and region, including family, hard work, loyalty, pride, community.

Access to preventative and primary care services must be a priority for the state of Idaho and this legislature, for the people of Idaho and the service providers that care for them. The Healthy Idaho Plan will be a major step in taking us there. Governor Otter's plan is a step, but it is not enough to ensure that the people of Idaho will have the security of access to healthcare, to maintain their ability to work and care for themselves and their families. Please send bill S1205 to the Senate Floor, and please recommend that we pass these bills. The Health of the People of Idaho, and our labor force, is counting on it.

Thank you very much for your time and consideration on this very important issue.

February 2, 2016

Audrey Gatewood's Testimony

Support of SB1205

My name is Audrey Gatewood. I am a full-time student at Boise State University, a student affiliate of AAUW, and a full-time single mother of two. Me and my daughters live here in Boise.

Thank you Chairman Heider and the committee for giving us this opportunity and for your willingness to hear us today regarding the Healthy Idaho Plan. We are overwhelmed with appreciation for the opportunity to speak at this hearing today.

Being an advocate for Senate Bill 1205 comes from my current daily struggles. I never expected to be on Medicaid. I never expected to become injured to a point it was disabling. Everyday I am in fear of not having health care coverage because I might make just too much. I have chosen at times to reduce the hours I put in for my part-time income to avoid being kicked off of medicaid and potentially being left with having zero health care coverage.

The medications I need access to are anticonvulsants and could cause me severely negative effects if I were not able to get these medications. Without having health care coverage I would not be able to afford these medications. I have two daughters that rely on me to take care of them and I would not be able to efficiently provide or care for them without access to these medications.

Some days I do not know how I will afford things as simple as shelter, clothing, or normal daily goods such as soap. Having such a limited income and ability to purchase the basics for my family causes me stress but the stress of potentially ending up in the hospital with no health care coverage causes me intense apprehensions in making just too much.

Hearing all of this hard work being put into health care in Idaho has been tremendously inspiring to me and I cannot tell you enough how grateful I am and how grateful we all are for this opportunity to be here today. We will respect any decisions made but I implore this committee to support the Healthy Idaho Plan and close the coverage gap.

Close the Gap Idaho

Thank you Chairman Heider and members of the committee for holding this hearing. My name is Penelope Hansen and I am the Mental Health Coordinator for Boise Police Department. I'm here to discuss Close the Gap Idaho. I work daily with individuals experiencing mental health crises; these citizens include those that have a serious persistent mental health illness, individuals experiencing homelessness and Veterans & Service Members who do not have health coverage. Due to the lack of health insurance, the burden of care falls on the emergency system, including the police, EMTS/Paramedics, Emergency Rooms, State Hospitals and unfortunately, often jails. Many of our vulnerable citizens repeatedly end up in the back of ambulances and are transported to the Emergency Room or go to jail for minor crimes that are related to their mental health conditions; this situation has created a chronic cycle of utilizing emergency healthcare systems. I have seen citizens enter this turnstile never truly get treatment and experience poor outcomes and have even ended in their deaths. Our system is currently set up to treat these individuals in the most inefficient and expensive way possible unduly taxing the local counties indigent funds. If these citizens in our communities had access to preventive and primary care and mental health treatment, Idahoan's could save a great deal of resources and the individuals would have access to and could receive adequate care that would likely assist in ending the chronic cycle they are currently revolving through. In addition, the individuals would have a better quality of life and be able to contribute within our communities. I recently spoke to one of our outstanding officers at the Boise Police Department about the current healthcare system; he stated that "it is our duty to protect and serve, and in doing that we do not pick and choose who we protect and serve and that currently we need to do better for many of our citizens." Help us do better. I hope you will support the Healthy Idaho Plan (Senate Bill 1205) and Close the Gap. Thank you for your time and consideration. Have a good day.

2/2/2016

K. Hong Testimony Re: SB 1205

Chairman Heider and members of the committee,

My name is Kerry Hong. I serve as the Director of Community and Family Justice Services Division for the Idaho Supreme Court. I am here today upon invitation from Sen. Schmidt to speak to the potential impact of this proposed legislation on criminal justice populations, specifically to offenders participating in Idaho's problem solving courts.

The Judiciary is respectful of the policy domain of the Legislature and I take no position on the ultimate question of whether this bill is good policy, but the courts do have an interest in behavioral health issues as they pertain to reducing recidivism, protecting our communities and rehabilitating offenders.

Problem solving courts use a team based approach, led by a judge, to supervise and treat offenders in the community that have high risk to recidivate and have behavioral health issues. These courts provide an evidence based alternative to costly incarceration. There are 69 problem solving courts spread throughout Idaho's 7 judicial districts, serving approximately 2,500 offenders in FY2015.

Often, offenders come into PSC with primary health concerns in addition to addiction and mental health disorders. It is not uncommon to hear from offenders and their treatment providers that their use of illegal substances was connected to self-medication for chronic health conditions or unmanaged mental health disorders. These offenders frequently have poor employment history and limited financial resources. However, our PSC coordinators have reported that only about 9% of these offenders are currently eligible for services through Medicaid. We anticipate that Medicaid eligibility for adults up to 138% of federal poverty level would significantly increase this percentage and may help meet the needs of this population.

In addition to offenders in PSC, there are thousands of moderate and high risk to recidivate offenders on probation and parole that have behavioral health treatment needs that may be going unmet. The JRI Gap analysis submitted to the legislature this year by the Department of Correction and the Department of Health and Welfare estimates a gap nearly $15 million to provide substance abuse and mental health treatment to all moderate and high risk to recidivate offenders who may need it. This estimate is for felons and doesn't measure the needs of the misdemeanants who are also being supervised in the community. Expanded eligibility to Medicaid may provide many these offenders with access to care and assist with their rehabilitation.

Thank you for the opportunity to provide this testimony. I now stand for any questions.

Mindy Hong, Executive Director
Pocatello Free Clinic
Phone: 208-233-6245
www.pocatellofreeclinic.com

Testimony to Senate Health and Welfare in support of S1205
February 2, 2016

At the Pocatello Free Clinic, we are proud of the work we do and the stories we get to help change. In 2015, the PFC provided our sick and in-need neighbors with 2,800 healthcare visits for 847 individuals. With the aid of many volunteers $718,000 in services were delivered to low-income, uninsured individuals and families. Sixty percent of our patients make less than 100% of the federal poverty level and fall into Idaho's coverage gap. I want to tell you what it is like to work every day with the gap population in healthcare.

At my clinic we have worked hard to let our patients know about Idaho's very successful health exchange. In 2014, we had insurance agents meet with patients to provide education and options. A few patients were able to get on the exchange. Most were not. I want you to know how hard it is to explain to these individuals that they do not make enough money to qualify for help. The individuals who did not qualify were frustrated, tearful, and even angry. These individuals and families are confused when told that if they made a couple hundred or a couple thousand dollars more a year, they could get an affordable healthcare plan.

I also want you to know that every day, I, a co-worker, or a volunteer has to tell at least one patient that there is nothing we can do for them. Like community health centers or your own primary care office, we are a family or general practice clinic. As a primary care based clinic, we are limited by the types and severity of conditions we can treat. At present, we have many patients who need imaging, surgery, or specialty care which we do not have the capacity to provide. Because of liability issues we have to make difficult decisions to discharge some of our patients. The medical providers at our clinic go above and beyond but treating severe mental health issues, kidney failure, cancer, and similar conditions are outside the scope of what a family practice medical provider can do. We do have a few specialists who volunteer their services. However, their role is very limited because of the lack of resources available. For example, we have an orthopedic surgeon who

sees patients every month. Seeing our patients is extremely frustrating for him. Many have needed surgical intervention for years – mostly for hip or shoulder replacements or rotator cuff tears. We can do little for these patients but give injections and offer anti inflammatories.

Before I started working at the free clinic three years ago, I wanted to do public health in developing countries. I had no idea that the need for services was so great in my own community and that it would be at times like working in a third world country. I would like to share a few stories with you.

Ann discovered the free clinic one year ago. She had been in a car wreck two years earlier and had some lingering issues. One of which was a surgical pin protruding through her finger in two places. She had surgery right after her wreck but couldn't get back in to see anyone because she lost her job and insurance and fell into the coverage gap. Fortunately, one of our partners did some pro bono work and removed the pin. But Ann had suffered with pain and dysfunction for two years before she was able to get help.

Lisa is in her fifties and has thirteen grandchildren. Four of those have been under her care for the past few years because their mom, her daughter, was in a car wreck which caused a traumatic brain injury. Lisa lost her health insurance through divorce and her job through health issues. Her family has a history of major health problems. Lisa has had multiple heart attacks and now suffers from congestive heart failure, kidney disease and liver disease. Last year she developed clotting issues and thirty percent of her body turned a deep purple color because of bleeding. She was in the hospital for a week and now has a bill she will probably never pay off. I check in on Lisa every couple weeks and I am astonished every time I talk to her because she is still hanging on despite being told several times that she has six months to live. Lisa cannot get the specialty care she needs because she falls into Idaho's coverage gap.

We have many stories to tell. Stories with positive outcomes that make the work we do rewarding. But too often we have the other kind of stories. Patients who are told they have a lump but that we cannot provide diagnostic imaging or treatment. Patients who are told they have heart disease but there are no resources for them.

Saving lives and improving the quality of life are reasons we urge the Idaho Legislature to close the coverage gap. Economics is another motive. When families without insurance acquire high-cost medical bills, medical

bankruptcy may occur. Unpaid bills are ultimately paid for through taxes and higher healthcare costs for paying patients. Many of our patients bounce between our clinic, our community Health Center-Health West, and the hospital for their care. Many times they are in debt to these other organizations and are in collections and embarrassed.

The Healthy Idaho Plan is a solution that could save Idaho millions of dollars and prevent sickness and death. During this legislative session, we urge Idaho legislators to take action with a "do pass" recommendation for Senate Bill 1205 and give the coverage gap population the ultimate gift: relief.

Thank you for the opportunity to testify today.

My name is Po Huang. I have been practicing emergency medicine in Idaho for 16 years, both in the rural and urban setting.

I have specific interests in rural medicine and work force training.

As citizen legislators, you are given the difficult task of determining how to spend and invest state funds. In this case, how do we balance state and federal dollars to provide health care coverage for as many Idahoans as possible.

We are facing a physician shortages and the county and state indigent/catastrophic coverage program are costly.

The Healthy Idaho Plan can save state dollars by extending medical coverage that is currently being paid by state and county funds. The Healthy Idaho Plan benefits rural hospitals allowing them to keep the doors open, given their high population of working poor. Rural health care facilities provide not only access to care, but well paying jobs as well. Loss of these facilities would only serve to increase the rural – metro household income gap.

One of my best impression of Idaho was about a rancher, who broke his leg while working. He drove his beat up truck to the ED and hobbled in. This man was stoic, well tanned, and wrinkled from hard work. A man who is used to taking care of himself now needed care. The Healthy Idaho plan will insure that that good care is close to home and available.

I have many inspiring and tragic stories from the emergency department. Some of which are covered in my my written testimony about the health care struggles of the working poor. I hope you had a chance to read it.

For these and all the reasons you have heard and will hear today. Please support SB 1205.

IPCA
IDAHO PRIMARY CARE ASSOCIATION

1087 W. River Street, Suite 160
Boise, Idaho 83702 | www.idahopca.org

February 2, 2016

Idaho State Legislature
Senate Health and Welfare Committee
Hearing for SB1205 – Medicaid Expansion

Chairman Heider and Members of the Committee,

On behalf of the Idaho Primary Care Association and Idaho's community health centers, we offer our full support for Senate Bill 1205. If passed this bill would expand Medicaid and implement the Healthy Idaho Plan, a path forward supported by Governor Otter's Medicaid Redesign Workgroup.

Community health centers are leaders in providing high quality primary care for Idahoans—including those who are uninsured. Too many Idahoans lack access to healthcare coverage and they suffer unnecessarily.

In 2014, Idaho's community health centers served 156,651 patients—nearly 1 in 10 Idahoans.

Primary care reduces disease through treatment and prevention, reduces the economic costs of poor health, and reduces the use of emergency and hospital visits. However, too often a patient's health needs require care outside of the scope of primary healthcare. Though our community health centers do all they can, it's just not enough for those patients whose needs go beyond what can be provided in a primary care setting.

In order to close the coverage gap, we must enact policies that provide access to comprehensive healthcare coverage for all Idahoans.

The Idaho Primary Care Association and Idaho's community health centers (listed below) support closing the healthcare gap through passage and implementation of Senate Bill 1205.

- Kaniksu Health Services
- Heritage Health
- Benewah Medical Center
- CHAS Health
- Adams County Health Center
- Valley Family Health Care
- Terry Reilly
- Family Medicine Residency of Idaho
- Glenns Ferry Health Center
- Family Health Services
- Health West
- Shoshone-Bannock Community Health Center
- Community Family Clinic
- Grand Peaks Medical and Dental

Thank you for holding this public hearing. We appreciate the opportunity to have this important discussion.

Respectfully,

Yvonne Ketchum-Ward, CEO
Idaho Primary Care Association

Idaho Primary Care Association is the membership organization that represents Idaho's community health centers. Health centers provide high-quality, affordable primary and preventive healthcare, as well as dental and behavioral services in 47 communities.

Chairman and Comittee members

My name is Kathryn McNary. I live in Caldwell. I am one of the 78,000 Idahoens that do not have health insurance. I do not work and am trying to get my disablity. I do not qualify for Obama Care Credits because I do not work at least part time and Sence I am not concidered disabled yet I do not qualify for Medicaid. My husband and I Live on his disablity and cannot pay 300+ dollars for medical coverage for me. He is covered because he is disabled. As it is now I am in debt over 15,000 dollars just in the past year for medical bills that I cannot afford to pay. I have to see the doctor every month to keep me from going off the deep end or winding up in the hospital. I pay 180 dollars out of pocket every month for the doctor and my meds. I ask you to please give a due pass on Senate Bill 1205 to close the gap that will give me the health care I need and a right that everyone should have.

Thank you

February 2, 2016

Chairman Heider, and members of the committee. Thank you for providing this opportunity to testify regarding SB 1205 the Healthy Idaho Plan.

My name is Liz Merrill, I am a mother, and homemaker. I live at 3801 N. Tamarack Dr., in Boise. I am here because I care about the Healthy Idaho Plan.

This affects me personally because I teach part time at the College of Western Idaho. My students are adults whose first language is not English. They come from all over the world. In one class last fall, I had ten students who spoke 13 different languages. The people in my classes come from a variety of backgrounds and countries. They all had some schooling in the countries in which they lived previously. Most of the people who are my students work hard in low wage jobs, without benefits. Most of my students have children. Medicaid covers children's health care, but not the health care of the parents. When the people in my class get sick, and they don't have health insurance, they cannot afford to go to the doctor. Without proper health care, they are sick longer. When people are sick, they don't come to school. They fall behind. They get discouraged. It takes them longer to master English. It takes them longer to find a better job. If they are sick and can't go to work, they might lose their job and have to find another, starting over. If they are sick they are less available to care for and support their children. All of this makes it harder for the people who are my students to fulfill the opportunity they are offered by being Americans.

I am here today to ask to you support SB 1205, the Healthy Idaho Plan, because I believe making it possible for Idaho families to go to the doctor and get the care they need without facing huge medical bills, will alleviate pain and suffering for many of the people I teach and profoundly improve the quality of their lives.

I ask that the Senate Health and Welfare committee send Senate Bill 1205 to the Senate Floor with a "due pass" recommendation.

Thank you.

Testimony of Danielle Ryals
347 East North Street, Albion, ID 83311
To present to Senate Health and Welfare, Feb 2, 2016

Thank you Chairman Heider and members of this committee for allowing testimonials to be presented today. My name is Christa Rowland, and I will be reading a testimonial on behalf of Danielle Ryals, of Albion, Idaho, who was unable to be here today. Danielle recently got a part-time job and could not miss a day of work to drive to Boise. She is still in the gap and recently had her phone shut-down for several days.

My husband and I fall into the coverage gap, and we are concerned about our lack of access to affordable health insurance. While we appreciate the governor's recent initiatives regarding closing the healthcare gap, the Primary Care Access Plan is not enough. We need affordable access to full healthcare coverage.

My husband works on a nearby farm and I run the household, take care of my three young children, and recently got a part-time job—but it does not pay well. I used to work as a Certified Nursing Assistant but had to quit that job when a respiratory infection went untreated. My husband has high-blood pressure but we can't afford the medication for it. Last year, I fell down the stairs and broke a rib. If we saw a cardiologist, we would need to pay for a visit in full and we can't afford to visit a specialist and pay for food and clothes for our kids. More recently, my husband broke his finger and we can't afford to get that fixed either.

My family is not looking for a government hand-out. What I most want to convey to you today is that closing the coverage gap would be one of the most important things you could do to make my family, and other families like mine, healthier and more productive. Being in the gap makes it harder to work. By helping us access affordable healthcare coverage, we will be more productive and able to support our family without government assistance. We hope you will support Senate Bill 1205, thank you for your time and consideration.

NAMI Idaho
National Alliance on Mental Illness

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February 1, 2016

The Honorable Dan J. Schmidt
P.O. Box 83720
Boise, Idaho 83720-0081

RE: SB 1205 Healthy Idaho Plan

Dear Senator Schmidt,

NAMI Idaho supports SB 1205 and implementation of the Health Idaho Plan.

1. The Healthy Idaho Plan is one of the most important changes that the legislature could make this year to improve the mental health system in the state of Idaho. 41,000 persons in Idaho have a serious and persistent mental illness that impairs their functioning in society. More than half of these are uninsured and have no access to care. Many of these have disabilities and chronic health conditions.
2. Under a new system, diseases could be diagnosed earlier with potential better outcomes. Persons living with mental illness currently die on the average of 25 years sooner due to chronic medical conditions. Mental health problems could be diagnosed and treated earlier before a full blown psychiatric crisis.
3. The Healthy Idaho Plan would provide for a federal funding match and relieve the burden on county indigent funds and state general funds for the Catastrophic Health care and mental health care cost now covered by the Division of Behavioral Health.

Finally, we ask that you support the Healthy Idaho Plan.

Sincerely,

Michael Sandvig, President
208 520-4210
idahonami.president@gmail.com

IDAHO ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR IDAHO

777 N. RAYMOND, SUITE 100 BOISE, IDAHO 83704 • PHONE (208) 323-1156 • FAX (208) 323-9661

Thank you, Chairman Heider and members of the committee. I appreciate you holding this hearing today. My name is Neva Santos, I'm the executive director of the Idaho Academy of Family Physicians, the medical organization in Idaho that represents more than 750 family physicians, Family Medicine residents and medical students. I'm here because the family doctors in Idaho are concerned about the more than 78000 Idahoans who fall in the coverage gap. Family physicians treat more patients in Idaho than any other specialty and they provide primary care to all types of patients. Family doctors need the ability to provide their patients with the best quality of care at the lowest price possible. These patients are Idaho's working poor, the waitress that serves you coffee at your favorite restaurant; the construction worker who is building homes just down the road from your house; the mechanic that works on your car or the college student working to put themselves through school. If we continue to ignore these patients, they will become even more expensive to the tax payers in Idaho and cause a larger drain on our healthcare system. Physicians are required by law to provide the best care possible. Without the needed diagnostic and treatment tools, patients will not receive high quality care and this will put physicians in legal challenges. We can't ignore theses citizens any longer; we must make sure they are able to receive comprehensive care just the same as you or me. I hope you will recommend a due pass for Senate Bill 1205 so the full Senate is able to discuss this issue. Thank you for your time.

Senate Health & Welfare Committee Hearing

Senate Bill 1204/1205

Corey Surber, Director, State Advocacy, Saint Alphonsus Health System & Trinity Health

- Chairman Heider and members of the Committee: My name is Corey Surber, and I serve as Director of State Advocacy for Saint Alphonsus Health System.

- Over the past 4 years I have had the privilege to serve as the facilitator for the Governor's Medicaid Redesign Workgroup and saw firsthand as a host of experts from across the state of Idaho, including a number of legislators, carefully reviewed multiple options to close Idaho's coverage gap. The workgroup reviewed numerous studies and innovative models developed by other states, before deciding what Idaho's unique plan should look like.

- Senate Bill 1205, the Healthy Idaho Plan, represents the culmination of work by the Governor's Workgroup, and it represents an alternative to Medicaid expansion as envisioned in the Affordable Care Act. It incorporates Idaho ideals: personal responsibility, a focus on wellness & prevention, eliminating wasteful public programs, reducing tax burden, and creating a business friendly environment.

- Saint Alphonsus supports the Healthy Idaho Plan for a number of reasons but I will focus on just a few of them today:
    - It provides meaningful, comprehensive coverage to the 78,000 Idahoans living in the gap. These are our friends and neighbors – construction workers, servers in restaurants and coffee shops, veterans, administrative assistants, farmers, janitorial staff, childcare workers.
    - It relieves Idahoans of the triple-taxation they currently face. Currently they pay federal taxes to cover the gap population, but because we have not accepted our share of the federal funds, we are donating our share to other states who are better off than we are. As charitable as Idahoans are, I think they would rather be helping their friends and neighbors here in the state. Because we have not accepted these available funds, we also pay county and state taxes to fund indigent programs that pay for episodic crisis care only and are not focused on managing/improving health.
    - Lastly, the Healthy Idaho Plan would help offset around $600 M in payment cuts faced by Idaho hospitals – cuts that were intended to help pay for the coverage

expansion Idaho is not taking advantage of. Saint Alphonsus' Boise and Nampa facilities are facing $194 M in these cuts. Keep in mind that Idaho has many small, rural hospitals which are especially vulnerable to harm from these cuts, and they serve as vital economic hubs for the communities they serve

- I will conclude by saying that Saint Alphonsus supports the Healthy Idaho Plan because it is the best way for us to achieve the Triple Aim. Better health, better care, and lower costs. It is about a solution developed right here in Idaho, by Idahoans, to help our fellow Idahoans.

- With that, Mr. Chairman, I am happy to stand for questions.

Saint Alphonsus Health System

Closing Idaho's Coverage Gap: The Healthy Idaho Plan

The Coverage Gap: The intent through the Affordable Care Act was to cover most uninsured Americans by requiring states to expand their Medicaid programs to cover those below 133% of the federal poverty level (approximately minimum wage in Idaho), and offer affordability subsidies to those from 100-400% of federal poverty so they could purchase private insurance plans through Your Health Idaho (the Idaho health insurance exchange). Since the US Supreme Court decided that Medicaid Expansion should be optional for states, and Idaho decided not to expand Medicaid, Idaho continues to experience a coverage gap for those adults below poverty, who do not have access to subsidies to buy insurance, and do not qualify for Medicaid. These Idahoans often must resort to using emergency departments as their main source of care, a more costly option for several reasons: First, uninsured people often delay care or forego preventative care that they cannot afford meaning they are sicker when they come in. Second for eligible parties, that care is funded through the county & state indigent programs (funded by our property & state taxes) meaning that we pay the bill for those visits, all at an unmatched rate (vs. the Medicaid program that is funded by primarily Federal dollars along with state funds).

Who Falls in the Gap?

- 78,000 adults, primarily working Idahoans: 68% in households with at least one full-time worker; 16% in households with one or more part-time worker
    - Includes 11,000 food service workers, 11,000 construction workers, 7,000 fishing, farming & forestry workers, and 7,000 office/administrative workers
    - Also includes many Idahoans with serious mental illness and/or disabilities (many who are injured/disabled must wait 2 years to qualify for Medicare and in the meantime incur significant costs for their healthcare needs)
    - Idaho has the 2nd highest rate of uninsured veterans (approximately 3200 of these fall below poverty)

Reasons for Idaho to Accept the Healthy Idaho Plan:

- Achieve the triple aim: better health, better care, lower costs
- Use a unique solution developed in Idaho by Idaho citizens, as an alternative to traditional Medicaid expansion. The Healthy Idaho Plan would keep Idahoans from 100-133% of the Federal Poverty level in Idaho's very successful health insurance exchange (Your Health Idaho), while covering those truly in the coverage gap below the poverty line.
- End double taxation to Idaho taxpayers by eliminating wasteful and inefficient county and state indigent programs
- Save money: The Governor's Medicaid Expansion Workgroup studied various options, and the Healthy Idaho Plan has the lowest 10-year net cost to state and local government. By accepting

the federal funds that Idaho taxpayers pay into the system to cover uninsured adults, we eliminate duplication and wasteful programs. Without the Healthy Idaho Plan, Idaho will lose $3.3 billion in federal Medicaid funds and $1.5 billion for hospital reimbursement over the next decade

- Reduce cost shifting to the insured population from uncompensated care
- Bring Idaho's tax dollars back to the state to create positive economic impact, stimulating job creation and revenues that would not occur otherwise. If we reject the Healthy Idaho Plan, Idaho taxpayers will pay $1.24 B to extend the program in other states, while receiving nothing in return.
- Protect Idaho employers from coverage penalties

The Healthy Idaho Plan Helps Kids and Families

The Healthy Idaho Plan—A Real Solution

One of the best ways to make sure Idaho children grow up in families that are healthy and financially stable is for their parents to be able to get medical care when they need it.

Too often today that isn't the case. Fortunately there's a solution: the Healthy Idaho Plan, proposed by a working group named by Governor Otter, would cover 78,000 adults who can't afford health insurance.

An estimated 63% of people in the coverage gap are parents or primary caregivers of children.[i] When moms and dads have their health care needs met they are better prepared both physically and mentally for the demands of parenting. And affordable medical care not only keeps families healthy, it also helps them avoid the financially devastating costs associated with serious health issues. Plus, parents with health insurance are more likely to make sure their kids are covered too – for example, through the Idaho children's insurance program. [ii]

The Healthy Idaho Plan addresses the critical needs of Idaho parents whose jobs don't offer the health insurance needed to maintain a healthy, safe, stable, and financially secure environment for their children.

Income Levels to Qualify for Tax Credit to Purchase Health Care

Household Size	100%
1	$11,770.00
2	$15,930.00
3	$20,090.00
4	$24,250.00
5	$28,410.00
6	$32,570.00
7	$36,730.00
8	$40,890.00
For additional person, add	$4,160.00

Source: healthcare.gov

An estimated 63% of people in the coverage gap are parents or primary caregivers of children

These parents are in what's called the "coverage gap." As they struggle to make ends meet they find their incomes are just below the eligibility level for subsidies on the Idaho health insurance exchange and just above what qualifies for Idaho Medicaid.

The Healthy Idaho Plan—Important Benefits for Families

- **Dismantles the Medicaid Parent Penalty**
  Today, working parents who struggle to make ends meet are penalized. A single, childless worker earning minimum wage qualifies for help to purchase insurance in Idaho's health insurance exchange. But if that worker is a parent and the sole earner for the family, the family doesn't receive any help. In this scenario, if that parent quits their job, he or she could receive Medicaid. Under the Healthy Idaho Plan, single parents no longer would have to choose between working and receiving health care through traditional Medicaid.

- **Promotes Health Insurance Coverage for Children**
  Research shows that when parents have insurance, kids are more likely to have it too.[i] As of 2013, 8.9% of children in Idaho are uninsured, which is above the national average of 7.1%.[ii] That means over 38,000 Idaho children do not have the health care they need. Whether they have something treatable, such as strep throat, or a more complicated long-term or chronic illness, these kids are more likely to be enrolled in the Children's Health Insurance Program (CHIP) if their parents are insured.

- **Provides the Full Range of Care for all Households**
  The Healthy Idaho Plan is the only solution to Idaho's health care issues that would provide comprehensive health care to those in the coverage Gap. Instead of families having to wait for emergency room care, they would be able to see a doctor regularly for preventive care. The Healthy Idaho Plan would provide access to care from specialists to treat chronic illnesses, cover emergency room visits, hospitalizations, access to lifesaving medication and the screening and diagnostic tools that will lead to early detection and treatment. That means healthier families.

Healthy Idaho is a public/private, or "hybrid" plan. Income eligibility would vary by family size. A family of four earning up to $32,913 per year would get help purchasing private coverage. Families of four making less than $24,250 a year could get coverage through care management provided by the Idaho Department of Healthy and Welfare.

And, Healthy Idaho includes provisions to encourage good health and personal responsibility, such as minimum co-pays and incentives for preventive care.

The Healthy Idaho Plan is Cost Effective for the State, Localities, and Families

- It brings our tax dollars home. Right now our taxes are funding health care in other states. There would be no additional tax on families.
- It saves state and local governments money by eliminating the need for our antiquated and expensive state and county indigent care funds.
- It will spur economic growth. Families will have more money in their pockets to spend at local businesses.

Thousands of our friends and neighbors who can't get health insurance today would be covered – making our state stronger and Idahoans healthier.

Notes:

i. Idaho Department of Health and Welfare, Self-Reliance Data, 2015. Approximately 51,808 Idahoans are in the coverage gap according to IDHW. IDHW's estimate is a count of all the people who:1) applied for and were denied Health Coverage Assistance because their income fell below 100% of the federal poverty threshold and/or 2) receive Supplemental Nutrition Assistance Program benefits and do not qualify for Health Coverage Assistance. This is a subset of the statewide estimate of approximately 78,000 Idahoans in the coverage gap, the rest of whom do not receive public benefits have never applied for them through DHW. People in this group are considered parents or caregivers if they have at least one child living in the home.

ii. Alker, Joan and Chester, Alice, Georgetown University Health Policy Institute, Center for Children and Families, "Children's Coverage at a Crossroads: Progress Slows," November 2014.

Idaho Voices for Children
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IVC IDAHO VOICES FOR CHILDREN

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 2, 2016

ATTACHMENT 7

Heritage Health

February 2, 2016

Dear Chairman Heider and Members of the Committee,

After passage of the Affordable Care Act, Idaho was one of about 20 states that made the decision to not expand Medicaid. In doing so, a gap was created affecting approximately 78,000 residents who would not qualify for Medicaid or for subsidies in the private market. Even though a governor-appointed panel made recommendations in 2015 to expand Medicaid, the issue has not been able to generate traction in Idaho's Legislature.

Today, that has changed. We are excited to see Senator Dan Schmidt of Moscow, who is also a physician, get a hearing with the Senate Health and Welfare committee on two of his long time projects. SB1204 a bill looking for a full Medicaid expansion and SB1205 a bill for Healthy Idaho Plans will be heard at 2 pm MST on February 2nd.

As Senator Schmidt said, "I've worked for over two years promoting the Healthy Idaho plan. This extends health insurance coverage to Idahoans who fall below 138% of the federal poverty level. This would "close the gap" on 78,000 hard-working Idahoans currently uninsured and save $44 million for state and county level taxpayers. Governor Otter's proposed Primary Care Access Plan is an expensive, complicated program that does not cover emergency care, prescription drugs or chronic health conditions as the Healthy Idaho plan does. Idahoans deserve to be unburdened from bankruptcy due to medical catastrophe as under our current county indigent and state catastrophic payment plan."

At Heritage Health, we sit on the front lines of this issue. We see those residents of Idaho who fall inside this gap and are unable to pay for insurance. We understand the pressure these residents feel not being able to get the medical care they need. Our mission is to deliver a healthcare experience that provides hope, inspires changes and extends the life of our patients and our community. We see Senator Schmidt's proposals as an important part of fulfilling our mission. To that end we fully support Senator Schmidt's proposals to expand Medicaid and help provide coverage to all of Idaho's residents.

We urge each of you to take a brave step forward and trust the citizens of Idaho to engage with you on a new frontier, one where all citizens of Idaho have access to affordable healthcare. As one of the community health centers in Idaho, we can commit to you that we will provide a medical home for these patients and we will work with them to restore health and extend life.

The time has come, please be a part of the solution this year and have the courage to look past the politics of healthcare and see the hearts of the 78,000 people in this State that have no hope other than this of having access to affordable healthcare.

Sincerely,

Mike Baker

Mike Baker, CEO

Heritage Health
2201 Ironwood Place
Coeur d'Alene, ID. 83814
www.myheritagehealth.org

AAUW
empowering women since 1881

10483 W. Shadow Rock Street
Boise, Idaho 83714
208-869-1739
sylvia@integatedis.com

January 30, 2016

AAUW- Idaho Testimony in Support of Medicaid Eligibility Expansion

Chairman Heider & Committee:

My name is Sylvia Chariton and I represent the American Assn. of University Women of Idaho (AAUW). AAUW - Idaho fully supports closing Idaho's coverage gap by expanding Medicaid eligibility as outlined in SB 1204 & 1205. Since AAUW largely represents a women's organization, this brief testimony will be female specific.

According to a recent Idaho Department of Health & Welfare report, females are 55 percent of the Medicaid Gap population. Because women are more likely than men to be covered as dependents, a woman is at a greater risk of losing her insurance if she becomes widowed or divorced, if her spouse loses his job, or her spouse's employer drops family coverage or increases premiums and out-of-pocket costs to unaffordable levels.

Based on stats from a recent Kaiser Family Foundation Study, the gap in private sector and publicly funded programs left 18% of Idaho women uninsured. Also, the same study shows that low income working women, women of color as well as single women are at a greater risk of being uninsured. According to Kaiser, these marginalized women have inadequate access to care, get a lower standard of care when they are in the health system, and have poorer health outcomes.

Compared with women with insurance, uninsured women have lower use of important preventative services such as mammograms, pap tests and are two to three times as likely to forgo medical services due to cost.

Poor women from rural areas are even more disenfranchised since there is a provider shortage in those areas. Some of these Idaho communities have fallen so far through the cracks that it feels like the rest of the state has left them behind. For example, the poverty level in Madison County is 27.1 percent; by comparison the poverty level in Ada County is 11.6 percent. The rural enclaves of Owyhee, Latah and Shoshone Counties sustain poverty levels that hover around twice what Ada County experiences.

When these disenfranchised women end up in the Emergency Departments across the state, Idahoans already pay for their bills either through cost shifting at the hospitals or through their county's Catastrophic Fund using our tax payer dollars.

Many Idaho low income women, many of whom labor daily as low wage workers have been the needless victims of bad policy and shortsighted decisions. Since these women and their children have no lobby, no power, no voice and certainly no money; we serve as their advocates. Please take action and expand Medicaid!

Respectfully submitted,

Sylvia Chariton
President-elect,
AAUW Boise Area Branch

AAUW advances equity for women and girls through advocacy, education, philanthropy and research.

Dear Committee Members. Thank you for this opportunity to speak on SB 1204 and SB 1205. My name is Michael Traficante and I own Fairways Insurance Agency, an Agency helping people navigate the different government based Healthcare systems and enroll Idahoans in Health Insurance, Medicare, Life and Dental insurance. There is an epidemic in our state; the inability for over 75,000 of our residents to afford Health Insurance should be more than cause for concern. As an agent only serving Idaho, the hardest part of my Job is leaving a meeting with an individual I cannot help.

Paired with our States strict definition of Disability, it has been my experience that these individuals whom fall below 100% of the FPL are the ones most in need of Healthcare. These are our 55-64 year old baby boomers whom can't work 8 hour days because of their medical conditions. These are our Millennial populations with chronic disease. Most importantly, they are our Family, Friends, & Neighbors who have their medical costs passed along to collections furthering them from the American Dream and bombarding them with crippling debt. Hospitals, clinics, and physicians can only do so much before a patient in the gap realizes they cannot afford their treatment. In many cases, aliments are left untreated and can lead to death. At the very least, Prescriptions are never picked up, specialist referrals are not followed up on and a patient's care goes from Compromised to Jeopardized.

The State has a hard financial decision to make here. When it comes to the health and well being of Idahoans the decision is an obvious one. We are one of only a handful of States in the Union to not be exercising all aspects of the Affordable Care Act. The enrollment numbers for the ACA in Idaho are staggering as it has allowed a huge segment of the population to finally afford Insurance. I have many wonderful success stories from Parents telling me they could finally afford a surgery their Child needed to Cancer Patients being able to afford their treatment without having to worry about taking food off their families tables. While the future of the ACA is uncertain in this Election Year, one thing is for certain, the expansion of Medicaid will save lives!

Thank you Mr. Senator for introducing these bills and to the committee for your time today; I think you see in all communities throughout Idaho, We the People are embracing these laws.

The SHOSHONE-BANNOCK TRIBES

FORT HALL INDIAN RESERVATION
PHONE (208) 478-3700
FAX # (208) 237-0797

FORT HALL BUSINESS COUNCIL
P.O. BOX 306
FORT HALL, IDAHO 83203

February 01, 2016

To Whom It May Concern,

The Shoshone- Bannock Tribes support passing bills introduced by Idaho Senator Schmidt, (S1204 and S1205). Too often in the debate regarding Medicaid expansion, politics are put ahead of lives, we ask the Idaho legislature and this committee to look at the big picture instead of the origin of the expansion opportunity. We are asking for this bill to be passed and ask the legislature to separate the issue from the Affordable Care Act. It should be considered on its own merits and how it would benefit Idaho.

This bill impacts the health and economic opportunity of those Idaho citizens living at poverty levels, increasing their health and wellbeing is good for Idaho because this translates to more productivity, more taxes paid, and reduced chance for communicable disease outbreaks (called "herd Immunity"). Expanding Medicaid makes everyone in Idaho healthier, not just those covered by the expansion. Better health care helps lift people out of poverty which then reduces the drains on related resources such as food stamps and cash assistance.

The governor's own workgroups have said to expand Medicaid. Per Milliman's study, whose data considered health care dollars alone, the expansion would save Idahoans $173 million over ten years. As tax payers we support saving millions of dollars, this makes sense for Idaho.

Another fact to consider is that services provided to Native Americans at Indian Health Services or tribal facilities are at 100% FMAP, which means the federal government reimburses the state for their care at 100%. Since the Medicaid expansion would impact tribal people, this makes the cost savings even greater than what the Milliman firm calculated. It will cost the State nothing to expand Medicaid to our Native peoples. This not due to the Affordable Care Act, this FMAP rate is set by other legislation. Again, thank you for this time allowing me to speak on behalf of the Shoshone-Bannock Tribes.

Respectfully,

Lee Juan Tyler

Lee Juan Tyler, Acting Chairman
Fort Hall Business Council

To: Senate Health & Welfare Committee
From: Aaron Wilson, CEO, CHAS Health
Re: Support for SB 1204 & SB 1205

February 2, 2016

Dear Chairman Heider and Members of the Committee,

CHAS Health operates two federally qualified health center sites in North Idaho: Latah Community Health in Moscow and Lewis & Clark Health Center in Lewiston. Our staff work with Idahoans on a daily basis who are struggling to make ends meet. Over 1,500 individuals served at our two sites annually are uninsured.

The overwhelming majority of our uninsured patients have income below 100% of the federal poverty level. The state has left these residents in a gap, where they make too much to qualify for Medicaid, but not enough to qualify for a tax subsidy through Your Health Idaho.

Each of our sites employs an in-person assistor to help patients navigate Your Health Idaho and sign up for health insurance. Since the state's health insurance marketplace opened, many of our patients have tried to obtain coverage, but they are unable to afford any of the health plan options. For example, during the last six months of 2015 our staff assisted 165 consumers through Your Health Idaho, but only 2 individuals signed up for a health plan.

In September 2015, the Idaho Association of Counties endorsed the Healthy Idaho Plan. Our county elected officials support this plan and now it is time for our state elected officials to support this plan. I urge your committee to pursue a cost-savings solution that will be achieved by implementing the Healthy Idaho Plan. Senate Bills 1204 and 1205 provide an opportunity for the state to spend tax dollars in a much more efficient, cost-effective manner. Considering the health needs of the state's most vulnerable residents and wisely spending tax payer dollars are two topics deserving of the attention of the full legislature.

Thank you for holding this public hearing and providing stakeholders the opportunity to voice support for Senate Bills 1204 and 1205.

Sincerely,

Aaron Wilson
CEO, CHAS Health

Administration 203 N. Washington, Suite 300 Spokane, WA 99201 509.444.8888 TTY 509.434.0390

CHAS.ORG

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 2, 2016

ATTACHMENT 8

Chair Heider and Vice Chair Nuxoll:

My name is Linda Anderson. I am a resident of Boise.

I greatly appreciate your giving the public a chance to weigh in on this critical issue.

Like all of you, I am one of the lucky ones. Thanks to my late husband, I have Federal employee health care for life.

If you have suspected cancer, your primary care physician orders an MRI or a CAT scan and sends you to an oncologist. If you break a bone, you are sent to an orthopedic surgeon, and if you have serious depression, you are referred to a psychiatrist. You understand what I mean.

But the hard working ladies who clean my house every two weeks don't have that luxury now and would not have it under PCAP. Under Governor Otter's proposal, the 78,000 uninsured Idahoans would not be referred to a specialist, have advanced diagnostic tests or even expensive drugs. Because it is financially within easy reach, it seems highly unfair to deny our fellow citizens the services, which we take for granted. I haven't talked to one physician who feels that the PCAP is an adequate plan.

The Idaho Legislature prides itself on being fiscally conservative. If we were talking about a budget-breaking expense, you, of course, would reject it. However, the expansion of Medicaid is expected to save our state $173 million. This is money we would otherwise be leaving on the table. Instead, you are considering spending $30 million per year, funded by tobacco and cigarette taxes, a declining source of revenue. Think of the impact those funds could make on infrastructure, education or even tax cuts.

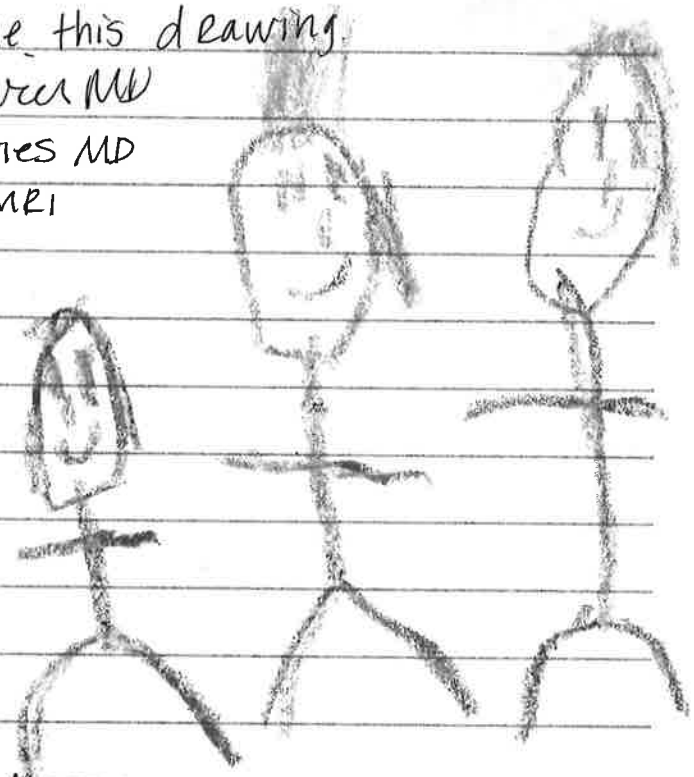
I urge you to think about your 78,000 underserved constituents and to take the humanitarian, fiscally-common-sense path of Medicaid expansion. All of Idaho will be healthier!

Thank you.

just a note

Lily told me she wished
her mom could afford
her medication so her
tummy wouldn't hurt so much
and she would smile more when
she gave me this drawing.

Danielle Davies MD
Danielle Davies MD
PGY-2 FMR1



R15-CSCS-LGNP

AMERICAN LUNG ASSOCIATION.
Fighting for Air

My name is Clella Steinke. Our daughter-in-law was Jenny Steinke of Idaho Falls. Jenny had asthma, and because she was in the coverage gap, she did not have access to medical care for asthma. On September 1st, she had a severe asthma attack, stopped breathing, and died six days later. It is painful to share this story, as our family is still grieving. I want to thank you for holding this hearing and I implore you to take action to prevent more tragedies.

Jenny was the light of our son Jason's life. She and Jason struggled to make ends meet, but they were always working. Jenny worked as a caregiver most of her life and when grandma passed, she got a part-time job. Jason struggled to find full-time employment and was thrilled when he landed a full-time job in July that would provide insurance for both of them. The insurance took effect the day Jenny went to the hospital. In the months before her death, her asthma had worsened. She was getting inhalers from a local community clinic when she could, or buying them from friends. Jenny's lack of access to comprehensive health care caused her death.

September 1, Jenny went to work. She was not feeling well when she got home. We know now that she was suffocating. She got a neighbor to drive her to the hospital. That drive took 3 minutes and 52 seconds. When they arrived, she had stopped breathing. Jason rushed to the hospital and spent every hour of the following six days with her. Jenny's son, pregnant wife and I were at her side too. We had to say good-bye to Jenny on September 6th. She never got to meet her beautiful grandbaby, born in November. In December, Jason marked Jenny's birthday and his birthday without her. He suffered through their 10-year wedding anniversary alone.

My husband and I lived in Idaho Falls for 25 years (he was a nuclear engineer at INL and I was a speech-language pathologist in the Jefferson School District #251). We moved to Wisconsin last April. We have asked a lot of what-ifs: *What if we had still been in Idaho? What if we had realized how severe her condition was?* Nothing will bring Jenny back. We want to make sure this does not happen to another family.

We know you are considering a primary care plan for Idahoans like Jenny. This may have helped. It is not the same as health insurance. Jenny needed prescriptions and an asthma specialist. She needed coverage, just like thousands of Idahoans with medical issues not being addressed with primary care.

When Jenny died, I was struck by the contents of her purse. You can tell a lot about what someone is going through by what they carry. She had a dollar bill, two inhalers, an oxygen meter and an advertisement from the local paper. This is what "Death by Poverty" looks like.

This should not happen in our great State. I ask you to find a complete solution to the coverage gap and pass the Healthy Idaho Plan.

Respectfully Submitted,

Clella Steinke

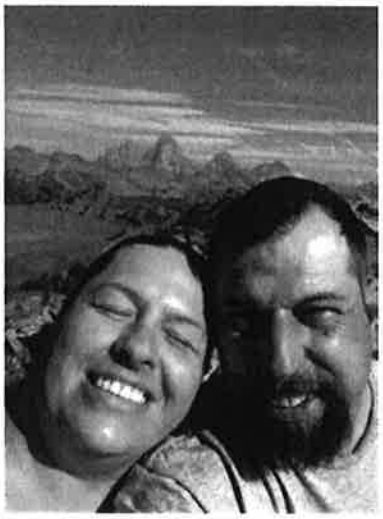
Remembering Jenny Steinke

Jenny with her son James at his wedding, August, 2015

Dear Chairman Heider and members of the Senate Health and Welfare Committee:

My name is Clella Steinke. My daughter-in-law was Jenny Steinke of Idaho Falls. Jenny had asthma, and because she was in the coverage gap, she did not have access to the correct kind of inhalers. As a result, on September 1st 2015, she had a severe asthma attack, stopped breathing, was declared brain-dead 5 days later and became an organ donor. It pains me to share this story, as our family is still dealing with so much grief, but I am writing to thank you for holding a hearing on the Healthy Idaho Plan and to implore you to take action to close the coverage gap in Idaho.

I wish I could be there in person today. My husband and I lived in Idaho Falls for 25 years (he was a nuclear engineer at INL and I was a speech-language pathologist in Jefferson School District #251), but we moved to Wisconsin last April. I deeply appreciate you taking the time to learn more about our beloved Jenny and I hope that you can prevent a tragedy like this from happening to another Idaho family.



Jenny and Jason August, 2015

Jenny was the light of our son Jason's life. She was a deeply caring and compassionate person. Jenny was born in poverty and lived her life in poverty. Jenny and Jason had struggled to make ends meet for years, but they were always working. Jenny earned her GED in Idaho Falls, and worked as a caregiver, most recently, her grandmother. When grandmother passed, Jenny got a part-time job at U-Haul late August. Jason had struggled to find full-time employment and was thrilled when he landed a full-time job in July that would provide insurance for him and Jenny. The insurance took effect the day Jenny went into the hospital. However, in the months before Jenny's death, her asthma had worsened and without access to a specialist to treat her asthma, she was getting inhalers from a local community clinic when she could, or buying them from friends. Jenny and Jason did not realize that those inhalers were actually worsening her condition. Jenny's lack of access to comprehensive health care caused her death. I told Dr. Krell, the attending physician, her death certificate should read "Death by Poverty."

Jason saying Goodbye

Jenny's granddaughter born November, 2015

On the day Jenny died, she went to work in the morning, came home after lunch and was not feeling well. We know now that she was suffocating—her inhalers had stopped working. She was able to get a neighbor to drive her to the hospital. That drive took 3 min and 52 seconds. By the time they arrived, she had stopped breathing. When the hospital called my son at work, he rushed to her side. He spent every hour of the following six days with her.

I flew from WI. Jenny's son and pregnant wife flew from OK. Jenny's family drove from CA. We had to say good-bye to Jenny on September 5th. She never got to meet her beautiful grandbaby that was born this last November. In December, my son marked Jenny's birthday without her. A few days later, he suffered through their 10-year wedding anniversary alone and his birthday without her.

The onesie of her soon-to-be-born granddaughter

In the months since Jenny's death, my husband and I have asked a lot of what-ifs: *What if we had still been in Idaho - could we have done something? What if Jason and Jenny had realized how severe her condition was? What if she had had health insurance earlier?* Nothing will bring Jenny back. Now we are doing all we can to make sure this doesn't happen to another family. Jenny and Jason worked hard, they contributed to their community and they were loved by family and friends. We loved them, just as you love your children and grandchildren.

We have heard that the legislature is considering a proposal to offer primary care to Idahoans like Jenny. We hear that maybe this would have helped her. However, access to primary care is not the same as access to health insurance. Jenny needed prescriptions and an asthma specialist—Jenny needed health care coverage. There are tens of thousands of other Idahoans with serious medical issues that cannot be addressed in a primary care setting only. We ask that you please provide a complete solution to the coverage gap and pass the Healthy Idaho Plan.

After Jenny passed away, I was struck by the contents of her purse. You can tell a lot about what someone is going through by what they carry with them. All she had in her purse was a dollar bill, two inhalers, an oxygen meter and an advertisement from the local paper. This is what "Death by Poverty" looks like. This should not happen in this great country or in our great State of Idaho. Thank you for listening to our story. Please close Idaho's coverage gap.

The contents of Jenny's purse when she passed away

Respectfully Submitted,

Clella Steinke

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, February 03, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Docket No. 16-0501-1501	PENDING RULE: Use and Disclosure of Department Records	**James Aydelotte** Division of Public Health
Docket No. 16-0319-1502	PENDING FEE RULE: Rules Governing Certified Family Homes	**Tamara Prisock** Division of Licensing and Certification
Docket No. 16-0309-1501	PENDING RULE: Medicaid Basic Plan Benefits - Update and Align School-Based and Therapy Services	**Matt Wimmer** Division of Medicaid

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, February 03, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate health and Welfare Committee (Committee) to order at 3:02 p.m.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Nuxoll to conduct the rules review.
DOCKET NO. 16-0501-1501	**Rules of the Department of Health and Welfare Relating to the Use and Disclosure of Department Records**. **James Aydelotte**, State Registrar and Chief of the Bureau of Idaho Records and Health Statistics, Division of Public Health in the Department of Health and Welfare (Department), presented this docket.

Mr. Aydelotte stated that the Department's use and disclosure rules govern who has access to vital records and deems such authorized individuals to have a "direct and tangible interest" in the records. In 2015, the Idaho Legislature amended Idaho Code § 54-1142, which designates who has the right to control the disposition of a decedent's remains in the absence of a pre-arranged funeral plan. Specifically, Idaho Code § 54-1142, as amended, clarifies that individuals granted this authority will have a "direct and tangible interest" in the death record. **Mr. Aydelotte** said that the purpose of this docket is to make the Department's use and disclosure rules consistent with Idaho statute by amending the definition of who has "direct and tangible interest" in vital records. **Mr. Aydelotte** stated that there is no fiscal impact for this pending rule. He stated that no negotiated rulemaking was conducted and no comments were received during the public comment period.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Martin asked who is eligible to receive the information, like a death certificate, for someone who has passed away. **Mr. Aydelotte** answered that typically family members request that information through the funeral home.

Vice Chairman Nuxoll asked if the rule prevents disputes over obtaining the death certificate for a person who has passed away. **Mr. Aydelotte** replied in the affirmative. This rule aligns the list of people who can arrange funerals with those who are allowed to obtain a death certificate.

MOTION: There being no further questions, **Senator Schmidt** moved to approve **Docket No. 16-0501-1501**. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0319-1502

Rules the Department of Health and Welfare Relating to Certified Family Homes. **Tamara Prisock**, Administrator, Division of Licensing and Certification in the Department, presented this docket.

Ms. Prisock stated that a certified family home allows individuals to remain in a family-styled living arrangement, usually within their own communities. These homes provide shelter for elderly individuals and individuals who have a mental illness, developmental disabilities, physical disabilities or other conditions that prevent them from living alone, and whose mental, emotional and physical condition can be met by a care provider. A certified family home provider typically cares for between 1 and 4 residents in the provider's own home. There are more than 2,300 certified family homes in the State. **Ms. Prisock** reviewed Idaho's certified family home statistics, summarized how certified family home providers are paid, and discussed the role of the Certified Family Home Program within the Division of Licensing and Certification (see attachment 1).

Ms. Prisock stated that Idaho Code § 56-264(6)(f) requires the Department to implement licensing fees to cover the costs of initial certification and recertification of certified family homes (see attachment 2). In March 2012, the Department implemented an initial fee of $150 for inspection, orientation and consultation for a new certified family home. Additionally, a monthly certification fee of $25 is invoiced quarterly. **Ms. Prisock** indicated that the revenue from these fees is not adequate to cover all operating costs of the Certified Family Home Program (see attachment 3). Certified Family Home Program costs for FY 2015 were approximately $87,000 more than the revenue generated from fees. The Department is proposing to increase the initial certification fee from $150 to $175 and to increase the monthly certification fee from $25 to $30. Next, **Ms. Prisock** indicated that this rule change will require certified family home providers complete a "Basic Medications Awareness" course instead of a general course given by Idaho's Professional and Technical Education Department (IPTED). The new course, specifically designed for certified family home providers, will cost the provider $60 instead of $75.

Ms. Prisock stated that the Department held negotiated rulemaking sessions in three locations across Idaho. During these rulemaking sessions, the Department presented two dockets: these fee-related rules and rules related to substantive certified family home program changes. Additionally, both dockets were placed on the Department's website for certified family home providers and both dockets were presented to the Community Care Advisory Council for comments. **Ms. Prisock** indicated that five providers shared concerns about proposed fee increases during the comment period. She noted that the Department did not negotiate with the providers about the amount of the increase because the increase is just enough to cover program costs. The second docket related to substantive certified family home program changes was pulled in September to allow the Department more time to work with providers.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Comparing the three obligations set forth in Idaho Code § 5656-264(6)(f) with the twelve responsibilities set forth in the Department's certified family home information sheet (see attachment 1), **Senator Hagedorn** asked if the additional responsibilities included on the information sheet were set for in another section of Idaho Code. **Ms. Prisock** answered that Chapter 35 of Idaho Code Title 39 sets forth the Department's responsibilities regarding certified family home providers. **Senator Hagedorn** asked why the Division of Licensing and Certification has staff located in ten regions instead of the typical seven geographic regions. **Ms. Prisock** replied that the staff members are located in the seven geographic regions, but regions 3, 4 and 7 have two staff members to accommodate the population.

Senator Lee asked if the proposed "Basic Medications Awareness" course would be required in addition to the current IPTED course. **Ms. Prisock** answered that the proposed course would be an option for certified family home providers; providers may take either course. **Senator Lee** inquired whether the Department had worked with IPTED to add specialized certified family home training to the existing course before deciding to create a separate course. **Ms. Prisock** answered that the Department did have conversations with IPTED, but they wanted the course to remain relevant to a wide range of health care providers, instead of including specialized certified family home training.

Senator Harris asked for clarification regarding the fees discussed during the comment period. **Ms. Prisock** stated that the Department did inform stakeholders about the fee increases, but did not negotiate the amounts of the fee increases.

Senator Schmidt asked if the responsibilities of the Certified Family Home Program are established by the State or the federal government. **Ms. Prisock** answered that this is a State-only program and all requirements come from the State in statute and administrative rule. **Senator Schmidt** asked for clarification regarding the purposes of the annual recertification fees and the monthly fees. **Ms. Prisock** stated that both fees are used to inspect certified family homes annually. **Senator Schmidt** asked if the Department had a full-time personnel (FTP) count. **Ms. Prisock** stated that the FTP count for the program is twelve; ten specialists, one program manager and one administrative assistant. **Senator Schmidt** asked if the Department contracts any certified family home inspections to third-party inspectors. **Ms. Prisock** replied that the Department does not contract for third-party inspections.

Senator Hagedorn asked if all FTP positions in the Division of Licensing and Certification were filled last year. **Ms. Prisock** answered that there was a specialist position vacancy and an administrative assistant position vacancy, which were both filled within a few months. **Senator Hagedorn** asked what comments the Department received from the Community Care Advisory Council regarding the fee increases. **Ms. Prisock** replied that none of the certified family home providers serving on the Community Care Advisory Council supported the fee increases.

Senator Lodge asked Ms. Prisock to describe the inspection process for certified family homes. **Ms. Prisock** indicated that the inspections related to the safety of the physical environment, medication management and resident activities. Additionally, inspectors review the adequacy of resident admission agreements and resident fund management. **Senator Lodge** asked if measuring windows was part of the annual inspection. **Ms. Prisock** answered that she does not know if each of the specialists measure the windows annually, but she noted that there is a width requirement for windows. **Senator Lodge** stated that a comment she had received indicated that window measuring was a waste of time and money if the windows have not changed over the years. **Ms. Prisock** commented that the ongoing substantive review of program rules is intended, in part, to address how the Department could streamline inspections.

Senator Schmidt asked if there have been problems in certified family homes that are addressed by the inspections. **Ms. Prisock** answered that there are problems that need to be addressed by inspections. There is a spectrum of good homes and bad homes across the 2,300 certified family homes in the State.

Senator Schmidt asked Senator Lodge whether the intent of the original legislation was to have certified family homes to pay for the costs of their own inspections. **Senator Lodge** replied that the intent of the legislation was for providers to pay for the costs of their inspections. The legislature wanted to reduce cost to taxpayers related to the cost of certified family homes doing business. **Senator Hagedorn** commented that Idaho Code § 39-3501, enacted in 2005, expressly states the legislative intent. The provision does not suggest that certified family home providers be self-sustaining. However, he stated that Idaho Code Title 56 Chapter 2, enacted in 2011, does require that fees cover certification costs. Therefore, **Senator Hagedorn** suggested that costs not related to certification were to come from sources other than fees. **Ms. Prisock** requested that Dave Taylor, Deputy Director and Chief Financial Officer, Support Services of the Department, address this issue. **Mr. Taylor** stated that funds that were originally allocated to the certified family homes program were reverted to the General Fund. The funding split at the time of the reversion was 50/50. He indicated that this docket was proposed because the Department believed that State statutes required the Certified Family Home Program to be self sufficient. He stated that the Department has covered the cost of the Certified Family Home Program with other Department funds.

Vice Chairman Nuxoll asked how much the providers are paid per day to take care of their clients. **Mr. Taylor** replied that Medicaid pays providers $53 per day for medical services. **Vice Chairman Nuxoll** asked what other payments the certified family home providers receive. **Mr. Taylor** replied that the certified family home providers may negotiate to receive a portion of their clients' Supplemental Security Income (SSI); provided that each client retain at least $100 per month for personal expenses. If SSI pays a client $733 per month, then the provider can negotiate with the client to be paid up to $633 per month.

MOTION: There being no further questions, **Chairman Heider** moved to approve **Docket No. 16-0319-1502**. **Senator Martin** seconded the motion.

DISCUSSION: **Senator Schmidt** indicated that of the 2,300 people in the program, 1,600 are cared for by family members. He stated that this was the goal of the program. He indicated that he is uncomfortable saying to providers that they are a business, even though the Committee has to look at it like a business. He stated his opposition to this docket. **Senator Lodge** commented that she supported the docket because the inspections are needed to ensure that certified family homes provide a safe environment for their clients. **Senator Lee** indicated that her constituents indicated that they do not want an increase in fees. She stated that the relationship between inspectors and providers needs to be improved. She stated her opposition to this docket. **Senator Hagedorn** commented that the State was trying to do the right thing by allowing people the opportunity to receive care in a home environment. He stated that the funding issue for the Certified Family Home Program has been confused by statutory changes by the Legislature. He commented that statute needs to be changed rather than rules to address the funding issues. He recommended that the Legislature work with the Department to revise the relevant statutes to reflect an intentional funding structure. He stated his opposition. Acknowledging the benefits of certified family homes, **Vice Chairman Nuxoll** indicated that she wants the program to be self-funded.

ROLL CALL VOTE: **Vice Chairman Nuxoll** called for a roll call vote. **Senator Lodge**, **Senator Martin** and **Chairman Heider** voted aye. **Vice Chairman Nuxoll**, **Senator Hagedorn**, **Senator Lee**, **Senator Harris**, **Senator Schmidt** and **Senator Jordan** voted nay. The motion failed.

Chairman Heider suggested that each Committee member visit a certified family home. He praised the work that is done in the certified family homes and stated that Idaho needs this program. **Chairman Heider** introduced Joyce Broadsword, former Idaho Senator. **Senator Schmidt** commented that his vote was not a reflection of unwillingness to fund the Certified Family Home Program. He stated that his issue was related to the funding structure; providers should not have to pay for their own inspections. **Senator Lee** commented that she has been in certified family homes; her vote was also not a reflection of unwillingness to fund the Certified Family Home Program. **Vice Chairman Nuxoll** reiterated her desire to see the program be self-funded.

DOCKET NO. 16-0309-1501 **Rules of the Department of Health and Welfare Related to Medicaid Basic Plan Benefits to Update and Align School-Based and Therapy Services**. **Matt Wimmer**, Deputy Administrator for Policy for the Division of Medicaid in the Department, presented this docket.

Mr. Wimmer stated that much of the concern raised in previous testimony suggested that section 733.01.a.i-iii created a new requirement for schools. He stated that the provisions do not create a new requirement for schools, but rather create some flexibility for providers. The purpose of this rule is to allow therapists the opportunity to write up a specific plan of care and let the physician sign off on it for treatment and billing purposes. **Mr. Wimmer** stated that the Department has proposed modifications to their Provider Handbook to address the concerns raised by testimony earlier in the week. **Mr. Wimmer** stated that the Department will continue to work with providers.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Lodge indicated her concern that previous testimony identified that some districts have nurse practitioners sign off on medical services for children they have not seen. **Mr. Wimmer** stated that the Department has concern regarding this practice as well. He stated that this was not the intent of the rules. Over 98 percent of the children have a primary care physician (PCP) assigned to them. Medicaid pays the PCP to look at records and perform care management. **Mr. Wimmer** acknowledged that the Department needs to address this issue in future rules.

TESTIMONY: **Vice Chairman Nuxoll** invited testimony.

Lisa Hettinger, Administrator of Medicaid Benefits in the Department, testified that this rule does not change the requirement to obtain physician orders; this rule only addresses the timing for those orders.

Senator Martin asked what the IEP team is. **Mr. Wimmer** answered that IEP stands for individualized education plan. The team consists of a child's family and providers. **Senator Martin** asked who controls what services the child receives. **Mr. Wimmer** responded that the IEP team has a central role in determining the needs of the child.

Referencing the language in section 733.01.a.iii, **Senator Schmidt** asked Mr. Wimmer to clarify whether billings may include services that were provided prior to when the bill was submitted. **Mr. Wimmer** responded yes; he commented that the specific language Senator Schmidt referred to is not intended to indicate that services will not be reimbursed.

Karen Echeverria, Executive Director, Idaho School Boards Association (ISBA), confirmed the ISBA's rejection of this section. She said that school districts do not and will not get paid for services rendered under this rule until the dated referral or IEP is signed by the physician. She indicated that the Department interprets the federal signature requirement to mean only the signature of a physician, physician assistant or a nurse practitioner. Several surrounding states interpret the federal signature requirement broadly. **Ms. Echeverria** reviewed regulations in Washington, Oregon, Colorado and Montana. The ISBA would like to see the expansion of the federal practitioner of the healing arts definition to include different types of therapists and psychologists in the school setting. **Ms. Echeverria** indicated that it is hard for rural districts to comply with the requirement that a physician sign for every service. She stated that many school districts do not bill for services because of the strict requirements. A sample analysis of 20 school districts showed that between $10 million and $40 million are not claimed from federal moneys per year. Addressing Senator Lodge's concern regarding billing for unnecessary services, **Ms. Echeverria** stated that in the last two years there has been more consistent and ongoing training for school medical service providers; additionally, the Department conducts regular audits. She reiterated the ISBA's recommendation to reject section 733.01.a.i-iii.

Senator Lee asked Ms. Echeverria to explain the schools' process for obtaining physician orders if the Committee rejects this section at issue. **Ms. Echeverria** replied that schools will still have to get a physician signature. She commented that the physician signature requirement is present throughout the rule and the addition of it in this section made the problem worse.

Senator Lodge asked how many school districts do not bill or only partially bill Medicaid for services provided. **Ms. Echeverria** answered that she did not have the exact numbers, but districts who do not bill, do not bill at all. There is no partial billing. **Senator Lodge** redirected her question to Mr. Taylor. **Mr. Taylor** responded that 120 school districts billed for school-based services in 2015. The total amount paid was $32.2 million; school districts paid $9.1 million of the total and the federal government paid $23.1 million.

Senator Schmidt asked Mr. Taylor if smaller districts submitted billing. **Mr. Taylor** answered that there are some smaller school districts who bill Medicaid. He stated that he would provide a list to the Committee.

Senator Hagedorn asked Ms. Hettinger why a handbook is needed to clarify the rules. **Ms. Hettinger** replied that the provider handbook has existed for many years as a procedural-level clarification for the rules and is always more specific than rule. She commented that section 733.01.a.iii relaxes the requirements on the billing of services before having the official signed order. She indicated that services rendered within the 30 days awaiting a returned signed order from physician may be billed once the order is received.

Senator Lee asked Ms. Hettinger if schools would not get paid for services rendered within the 30 days if the Committee rejects section 733.01.a.i-iii. **Ms. Hettinger** stated that Senator Lee's statement was correct and would also affect community providers as well.

Senator Martin asked Mr. Wimmer if the Department was open to a dialogue with stakeholders. **Mr. Wimmer** replied that the Department is always open to having a dialogue and are always committed to work with providers in minimizing their burden.

MOTION: There being no further questions, **Senator Hagedorn** moved to approve **Docket No. 16-0309-1501**, but strike section 733.01.a.i-iii. **Senator Harris** seconded the motion.

ROLL CALL VOTE: **Senator Martin** called for a roll call vote. **Vice Chairman Nuxoll**, **Senator Hagedorn**, **Senator Lee** and **Senator Harris** voted aye. **Senator Lodge Senator Martin**, **Senator Schmidt**, **Senator Jordan** and **Chairman Heider** voted nay. The motion failed.

MOTION: **Senator Martin** moved to approve **Docket No. 16-0309-1501**. **Senator Lodge** seconded the motion.

SUBSTITUTE MOTION: **Senator Schmidt** moved to approve **Docket No. 16-0309-1501** and direct the Department to continue provider negotiations. **Senator Lee** seconded the motion.

ROLL CALL VOTE ON THE SUBSTITUTE MOTION: **Vice Chairman Nuxoll** called for a roll call vote on the substitute motion. **Senators Lodge Senator Hagedorn**, **Senator Martin**, **Senator Lee**, **Senator Harris**, **Senator Schmidt**, **Senator Jordan** and **Chairman Heider** voted aye. **Senator Nuxoll** voted nay. The substitute motion carried. No vote was taken on the original motion.

PASSED THE GAVEL: Vice Chairman Nuxoll passed the gavel back to Chairman Heider.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:31 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Michael Jeppson
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, February 3, 2016

ATTACHMENT 1

Certified Family Homes
Information for the 2016 Legislature
February 2016

Information About Homes and Residents	
Total number of certified family homes *Note: 25 of these homes currently have no residents* 3305 beds, 2851 currently occupied, 454 currently empty	2361
Number of homes that care only for family members	1644
Number of homes that care for a mix of family and non-family	77
Number of homes that care for non-family members only	615

Information About Payment Sources	
Number of Homes that care for only Medicaid participants	2213
Number of homes that care for a mix of Medicaid and private pay residents	56
Number of homes that care for only private pay residents	67

How Certified Family Home providers are paid:

The CFH provider and the resident enter into an admission agreement that covers the rent, utilities, food, and care/services the provider will deliver as well as the monthly amount the resident will pay for living in the home.

For a single private pay resident, the amount varies quite a bit based on where the homes are located. In some of the more rural areas of the state, a typical monthly charge for a private pay resident is about $2,500. In the more urban areas, average monthly charges vary between $3,000 and $4,000, with a few homes charging $5000. The resident pays with his/her own income, which can be Social Security or retirement benefits, or the monthly charge is paid by the resident's family.

For residents who are eligible for Medicaid, the provider cannot charge the resident for health-related services that Medicaid covers. For rent, utilities, and food, the provider negotiates the monthly charge with the resident as part of the admission agreement. Certified family home rules prohibit the provider from charging the full amount of a resident's income for rent, utilities and food. The provider must leave the resident at least $100 as a personal needs allowance. For example, a typical resident in a certified family home who qualifies for Medicaid receives $733 in Supplemental Security Income (SSI) as his/her only income. The provider can negotiate a monthly charge for rent, utilities and food up to $633, leaving the resident with $100 for personal needs.

Certified Family Home Program – Division of Licensing and Certification

The Certified Family Home Program in the Division of Licensing and Certification is charged with monitoring and enforcing the compliance of certified family homes with the statutes and rules that outline requirements for operation. Certified Family Homes are one of 17 facility types the division licenses or certifies

The program is staffed with ten Certified Family Home Specialists located in seven geographic regions of the state and one Program Manager, who works out of the DHW Pocatello field office.

This program maintains a current workload—there are no overdue surveys or complaint investigations. Actually, that is the case with 14 of the 17 facility types the division works with.

All of the work performed by the Certified Family Home Program relates to the certification and recertification of homes and includes the following tasks:

- Complete initial inspections to certify new certified family homes
- Conduct initial orientation and training for new certified family home providers
- Provide ongoing training, consultation, and technical assistance to providers
- Approve placements in certified family homes
- Investigate complaints made about certified family homes and determine whether results of the investigation will impact the provider's certification
- Conduct annual recertification inspections
- When necessary, take enforcement actions against certificates, such as revocation of the certificate or issuance of a provisional certificate
- Monitor plans of correction to correct deficiencies and complete follow-up inspections to ensure corrections are implemented
- Relocate residents, when conditions of the home pose an immediate risk to residents' health or safety.
- Collaborate with certified family home providers on proposed changes to rules, practices, training, or forms.
- Communicate regularly with providers about certification issues
- Maintain a website and Facebook page for providers as well as a provider manual and other educational resources.

Reducing staff or funding for this program would likely have the following consequences:

- Overdue inspections and complaint investigations
- Lower quality of inspections
- Less time and opportunity for Certified Family Home Specialists to provide training and consultation to providers

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, February 3, 2016

ATTACHMENT 2

TITLE 56
PUBLIC ASSISTANCE AND WELFARE
CHAPTER 2
PUBLIC ASSISTANCE LAW

56-264. RULEMAKING AUTHORITY. In addition to the rulemaking authority granted to the department in this chapter and elsewhere in Idaho Code regarding the medicaid program and notwithstanding any other Idaho law to the contrary, the department shall have the authority to promulgate rules regarding:

(1) Medical services to:

(a) Change the primary case management paid to providers to a tiered payment based on the health needs of the populations that are managed. A lower payment is to be made for healthier populations and a higher payment is to be made for individuals with special needs, disabilities or are otherwise at risk. An incentive payment is to be provided to practices that provide extended hours beyond the normal business hours that help reduce unnecessary higher-cost emergency care;

(b) Provide that a healthy connections referral is no longer required for urgent care as an alternative to higher cost but unnecessary emergency services; and

(c) Eliminate payment for collateral contact;

(2) Mental health services to:

(a) Eliminate administrative requirements for a functional and intake assessment and add a comprehensive diagnostic assessment addendum;

(b) Restrict duplicative skill training from being provided by a mental health provider when the individual has chosen to receive skill training from a developmental disability provider. Mental health providers may not provide training for skills included in the individual's developmental disability plan, but may provide services related to the individual's mental illness that require specialized expertise of mental health professionals, such as management of mental health symptoms, teaching coping skills related to mental health diagnosis, assisting with psychiatric medical appointments and educating individuals about their diagnosis and treatment;

(c) Increase the criteria for accessing the partial care benefit and restrict to those individuals who have a diagnosis of serious and persistent mental illness;

(d) Eliminate the requirement for new annual plans; and

(e) Direct the department to develop an effective management tool for psychosocial rehabilitation services;

(3) In-home care services to:

(a) Eliminate personal care service coordination; and

(b) Restrict duplicative nursing services from a home health agency when nursing services are being provided through the aged and disabled waiver;

(4) Vision services to:

(a) Align coverage requirements for contact lenses with commercial insurers and other state medicaid programs; and

(b) Limit coverage for adults based on chronic care criteria;

(5) Audiology services to eliminate audiology benefits for adults;

(6) Developmental disability services to:

(a) Eliminate payment for collateral contact;

(b) Eliminate supportive counseling benefit;

(c) Reduce annual assessment hours from twelve (12) to four (4) hours and exclude psychological and neuropsychological testing services within these limits;

(d) Reduce plan development payment from twelve (12) to six (6) hours and reduce requirements related to adult developmental disabilities plan development;

(e) Restrict duplicative skill training from being provided by a developmental disabilities provider when an individual has chosen to receive skill training from his mental health provider. The individual may receive skill development services from a developmental disability provider only for skills that are not addressed by the mental health service provider's plan and that relate directly to the individual's developmental disability, such as skills related to activities of daily living and functional independence;

(f) Implement changes to certified family homes pursuant to chapter 35, title 39, Idaho Code, to:

(i) Create approval criteria and process for approving new certified family homes;

(ii) Recertify current certified family homes; and

(iii) Develop applicant and licensing fees to cover certifying and recertifying costs; and

(7) Institutional care services to discharge individuals from institutional settings where such services are no longer necessary.

History:

[56-264, added 2011, ch. 164, sec. 15, p. 473; am. 2012, ch. 107, sec. 12, p. 295; am. 2012, ch. 190, sec. 2, p. 513.]

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, February 3, 2016

ATTACHMENT 3

CERTIFIED FAMILY HOMES - PROGRAM EXPENSES FOR SFY 2015

Description	Amount	
PERSONNEL		
EMPLOYEES SALARIES	$ 539,737.90	
GROUP INSURANCE - LIFE	$ 3,590.76	
GROUP INSURANCE - HEALTH AND ACCIDENT	$ 125,657.35	
WORKER'S COMPENSATION	$ 4,981.04	
WORKER'S COMPENSATION AUDIT ADJUSTMENT	$ 0.06	
WORKER'S COMPENSATION CREDIT	$ (0.22)	
EMPLOYER RETIREMENT CONTRIBUTIONS	$ 61,154.12	
RETIREMENT - SICK LEAVE	$ 3,508.40	
PERSONNEL COMMISSION	$ 1,649.59	
EMPLOYMENT SECURITY	$ 864.73	
F. I. C. A.	$ 38,914.41	
TOTAL PERSONNEL EXPENSES		**$ 780,058.14**
POSTAL AND MAIL	$ 13.60	
CELL PHONE VOICE/DATA SERVICE	$ 7,969.33	
TRAINING	$ 542.36	
NEW EMPLOYEE DRUG TESTING	$ 97.00	
ADVERTISING AND LEGAL NOTICES	$ 100.00	
PRINTING AND BINDING	$ 367.25	
TRAVEL EXPENSES	$ 18,212.50	
OFFICE EQUIPMENT AND SUPPLIES	$ 1,152.38	
TRAVEL REIMBURSEMENT FOR COMMUNITY CARE ADVISORY COUNCIL MEMBER (REIMBURSEMENT IS LEGISLATIVELY MANDATED)	$ 767.54	
AWARDS AND RECOGNITION	$ 58.87	
RULE PROMULGATION	$ 1,550.00	
TOTAL OPERATING EXPENSES		**$ 30,830.83**
TOTAL PROGRAM EXPENSES		**$ 810,888.97**
TOTAL REVENUE FROM FEES		**$ 723,900.00**
DEFICIT		**$86,988.97**

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, February 04, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Docket No. 15-0202-1501	PENDING RULE: Vocational Rehabilitation Services	**Dr. Mike Walsh** Idaho Commission for Blind and Visually Impaired
Docket No. 16-0601-1501	PENDING RULE: Child and Family Services	**Stephanie Miller** Division of Family and Community Services
Docket No. 16-0602-1501	PENDING RULE: Rules Governing Standards for Child Care Licensing	**Michelle Weir** Division of Family and Community Services
RS24054	RELATING TO THE COUNCIL ON DEVELOPMENTAL DISABILITIES: Amending Idaho Code § 67-6704 to revise provisions regarding council membership.	**Christine Pisani** Idaho Council on Developmental Disabilities
RS23976	RELATING TO THE DEPARTMENT OF ENVIRONMENTAL QUALITY: Amending Idaho Code § 39-107C to provide that certain moneys shall be held in the environmental protection trust, to provide for the payment of costs and expenses, to revise provisions relating to the investment of surplus moneys and to revise provisions relating to the payment of interest received.	**Orville Green** Waste Management and Remediation Division

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, February 04, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Nuxoll.
DOCKET NO. 15-0202-1501	**Rules of the Office of the Governor - Commission for the Blind and Visually Impaired Relating to Vocational Rehabilitation Services**. **Dr. Mike Walsh**, Rehabilitation Services Chief for the Idaho Commission for the Blind and Visually Impaired (Commission), presented this docket.

First, **Dr. Walsh** stated that the changes in the pending rules are necessary to keep up with increasing costs associated with the provision of vocational rehabilitation services. **Dr. Walsh** explained that, over the last two to three years, several exceptions have been made in the payment policy for clients due to rising tuition, training and medical costs. Second, **Dr. Walsh** stated that changes in the pending rules update policy terminology to be consistent with federal oversight.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Martin asked Dr. Walsh to explain what it means for the Commission to assist clients with an advanced degree, based on the client's needs. **Dr. Walsh** explained some of the Commission's clients, who already have an undergraduate degree, may have employment goals that require an advanced degree. In these situations and if the employment goal is congruent with the client's skills and abilities, the Commission supports an advanced degree in the client's vocational plan.

Referring to the eligibility provisions, **Vice Chairman Nuxoll** asked Dr. Walsh to explain disability priorities. **Dr. Walsh** responded that, if necessary, the specified categories prioritize clients with the most significant disabilities to receive services before clients with no significant disability. **Vice Chairman Nuxoll** asked if the specified categories were defined by the Commission. **Dr. Walsh** replied yes.

Senator Harris asked when fees were last raised by the Commission. **Dr. Walsh** responded that the last revision of the policy manual was in 2013.

MOTION: There being no more questions, **Senator Martin** moved to approve **Docket No. 15-0202-1501**. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0601-1501 **Rules of the Department of Health and Welfare Relating to Child and Family Services**. **Stephanie Miller**, Permanency Program Specialist for the Division of Family and Community Services in the Department of Health and Welfare (Department), presented this docket.

Ms. Miller stated that the pending rules will have a positive impact on Idaho children and their families by providing clarification and continuity of services in three areas: siblings, guardianship and adoption. First, the pending rule defines the term "sibling" as a child's full or half-sibling through blood or adoption. Second, the pending rule allows a child, whose relative guardian has died or become incapacitated, to continue to receive guardianship assistance benefits in the home of a successor guardian without having to re-enter the foster care system. Third, the pending rule deletes an adoption assistance benefit rule; the removal of this provision in State rules will allow Idaho to continue to receive federal funds. **Ms. Miller** stated that these rule changes will bring the Department into compliance with the Social Security Act and the Preventing Sex Trafficking and Strengthening Families Act.

Ms. Miller stated that the Department did not conduct negotiated rulemaking because the changes are non-controversial and beneficial to Idaho families. No negative feedback was received during the public comment period.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Vice Chairman Nuxoll inquired what year the Social Security Act was modified to mandate that states cannot make adoption assistance benefits subject to the appropriation of state funds. **Ms. Miller** answered she did not have that information available but, to her understanding, the mandate was stated at the time the Adoption Assistance Program was created in the Social Security Act.

Senator Martin asked Ms. Miller to confirm that the term "sibling" was not previously defined by statute or rule. **Ms. Miller** confirmed. **Senator Martin** asked Ms. Miller to confirm that if either parent disrupts the relationship between the siblings, the children would still be considered siblings under this rule. **Ms. Miller** stated Senator Martin's understanding was correct.

Regarding transfer of guardianship, **Senator Lee** asked if the successor guardian would be subject to the same rules and procedures as the original guardian. **Ms. Miller** stated that the original relative guardian would select a successor guardian to be named in the guardianship assistance agreement. The proposed successor guardian would be required, at minimum, to go through a criminal history background check. **Ms. Miller** stated that upon the death or incapacitation of a relative guardian, the successor guardian would be able to seek formal guardianship from the courts. Once the courts finalized the guardianship, the successor guardian would be able to receive guardianship assistance from the Department.

MOTION: There being no more questions, **Senator Harris** moved to approve **Docket No. 16-0601-1501**. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0602-1501 **Rules of the Department of Health and Welfare Relating to Standards for Child Care Licensing**. **Michelle Weir**, Child Welfare Policy Unit Program Manager for the Division of Family and Community Services in the Department, presented this docket.

Ms. Weir stated that the pending rules focus on improving the experiences and opportunities of children and youth in foster care by providing them with typical day-to-day life experiences and normalcy. **Ms. Weir** stated that the pending rules bring the Department into compliance with Title IV-E of the Social Security Act as outlined in the Preventing Sex Trafficking and Strengthening Families Act by aligning Idaho's rule with the federal requirements for foster care. First, the pending rules will allow foster parents and caregivers to apply the reasonable and prudent parent standard when making decisions about a child's participation in daily activities. Second, the pending rules define the reasonable and prudent parent standard and identify training requirements for caregivers. Third, the pending rule will require all licensed child care facilities to designate an on-site official to apply the reasonable and prudent parent standard when necessary.

Ms. Weir stated that the Department did not conduct negotiated rulemaking because of the nature of the rule change. The Department did not receive any responses or negative comments during the public comment period. **Ms. Weir** stated there is no anticipated fiscal impact on the General Funds. The proposed rule changes were shared with foster parents across the State and the Department received positive feedback and support.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Jordan asked if the Department provides caregivers with examples of conduct that meets the reasonable and prudent parent standard. **Ms. Weir** answered that the Department is putting together policies, guidelines and training materials that will be delivered to the State's foster parents and to Department staff to ensure the reasonable and prudent parent standard is clear. **Senator Jordan** asked if the Department is confident that, if a question arose, it would be quite clear to a foster parent whether they may allow a child to participate in certain activities or whether they must obtain additional approvals from the Department. **Ms. Weir** said the Department currently has a foster care recreation standard and it defines a lot of activities.

MOTION: There being no more questions, **Senator Lodge** moved to approve **Docket 16-0602-1501**. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

PASSED THE GAVEL: Vice Chairman Nuxoll passed the gavel to Chairman Heider.

RS 24054 **Relating to the Council of Developmental Disabilities**. **Christine Pisani**, Executive Director of the Idaho Council on Developmental Disabilities (Council), presented this RS.

Christine Pisani stated that the RS will amend Idaho Code to revise provisions regarding council membership. Individuals applying for certain council positions would no longer be restricted because they work for a State agency or local organization that receives funds for or provides services to persons with developmental disabilities, except as limited by federal laws. **Ms. Pisani** stated that the proposed changes will improve the Council's recruiting efforts.

MOTION: There being no questions, **Senator Martin** moved to send **RS 24054** to print. **Senator Lee** seconded motion. The motion carried by **voice vote**.

RS 23976 **Relating to the Department of Environmental Quality. Orville Green**, Administrator for the Waste Management and Remediation Division in the Department of Environmental Quality (DEQ), presented this RS.

Orville Green stated that this RS will amend Idaho Code to give the DEQ the option to invest certain funds within the existing environmental protection trust fund, with the concurrence of the Director of the DEQ, the Treasurer's Office and the endowment fund.

Chairman Heider asked how much money is in the environmental protection trust fund and what is purchased with these funds. **Mr. Green** said there are several million dollars in the trust fund. A significant portion of the money is being used in the Coeur d'Alene basin. **Mr. Green** said the funds support water treatment, repositories and the institutional controls program.

MOTION: There being no more questions, **Senator Schmidt** moved to send **RS 23976** to print. **Senator Jordan** seconded the motion. The motion carried by **voice vote**.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:35 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Kara Machado
Assistant

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, February 08, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
RS23988	EMS Personnel Licensure Interstate Compact	**Wayne Denny** Department of Health and Welfare
Presentation	Annual Report and Summary of Work with the Idaho State Healthcare Innovation Plan (SHIP)	**Caroline Keegan** and **Megan Williams** Idaho Academy of Nutrition and Dietetics
Presentation	Evaluation Report: Design of the Idaho Behavioral Health Plan	**Lance McCleve** and **Ryan Langrill** Office of Performance Evaluations

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Monday, February 08, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:06 p.m.

RS 23988 **Relating to the Emergency Medical Services Personnel Licensure Interstate Compact. Wayne Denny**, Bureau Chief of the Bureau of Emergency Medical Services and Preparedness for the Division of Public Health in the Department of Health and Welfare (Department), presented this RS.

Mr. Denny stated that the proposed RS pertains to the licensure of Emergency Medical Services (EMS) personnel. More specifically, it's an interstate compact for the licensure of EMS personnel, much like the existing compacts that Idaho has joined for physicians and nurses. **Mr. Denny** stated that Idaho recognizes four levels of EMS providers: Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced EMT and Paramedic. Many states have moved to recognize these four levels of EMS licensure. To remove frustration regarding state-to-state EMS licensure requirements, the National Association of State EMS Officials drafted the Recognition of EMS Personnel Licensure Interstate Compact Agreement (REPLICA). **Mr. Denny** provided the Committee with an Overview of the provisions of REPLICA, including (i) purpose, (ii) definitions, (iii) home state licensure requirements, (iv) privilege to practice, (v) conditions of practice in a remote state, (vi) relationship of compact to disaster declarations, (vii) commitment to veterans and their spouses, (viii) complaint and investigation processes, (ix) relationship between the member states regarding adverse actions, (x) establishment of the interstate commission, (xi) establishment of a coordinated database, (xii) rulemaking, (xiii) oversight dispute resolution and enforcement, (xiv) date of implementation, withdrawal and amendment. **Mr. Denny** reviewed the general benefits of Idaho's participation in REPLICA.

Chairman Heider asked the Committee members if they had any questions.

Senator Hagedorn asked if the rulemaking procedures set forth in REPLICA are consistent with the rulemaking procedures in Idaho. **Mr. Denny** stated that the interstate commission established by REPLICA is required to write rules to implement the compact, and such rules would have to be in compliance with the Department's rules.

Senator Nuxoll asked if enactment of this RS would establish Idaho's membership in REPLICA, or whether additional steps would need to be taken by the Department. **Mr. Denny** answered for Idaho to become a member of REPLICA, it must be enacted in Idaho Code. REPLICA does not come into effect until ten states have enacted it into law. Utah and Virginia are in the process of enacting the compact, and Colorado and Texas have already done so.

MOTION: There being no more questions, **Senator Lee** moved to send **RS 23988** to print. **Senator Nuxoll** seconded the motion. The motion carried by **voice vote**.

PRESENTATION: **Annual Report for the Idaho Academy of Nutrition and Dietetics** (Academy). **Caroline Keegan**, President of the Academy and **Megan Williams**, President-Elect of the Academy, made this presentation before the Committee (see attachment 1).

Ms. Keegan introduced herself as President of the Idaho Academy of Nutrition and Dietetics (Academy) and introduced Ms. Williams as the Academy's President Elect. **Ms. Williams**, later added that she is a registered and licensed dietician and a certified diabetes educator. The two spoke before the Committee as a follow-up from last year's presentation, to maintain a presence and to inform the Committee of activities the Academy is involved in to improve health care (see attachments 2 and 3).

Ms. Keegan stated that one of the purposes of presenting this report to the Committee is to build awareness of registered dietician nutritionists' (RDNs) contributions to Idaho's health care systems. **Ms. Keegan** discussed: (i) RDN qualifications, (ii) RDN commitments, (iii) obesity statistics and (iv) RDN's educational efforts to solve the problem of preventable conditions and diseases that lead to diminished quality of life and higher morbidity and mortality rates. **Ms. Keegan** reported that RDNs across Idaho are participating in the State Healthcare Innovation Plan (SHIP). Additionally, RDNs held a conference on diabetes and they continue to update the Idaho Diet Manual.

Ms. Williams reported on the progress RDNs have made during the last year to improve the health of Idahoans. **Ms. Williams** discussed the Governor's appointment of a dietician to the Idaho Healthcare Coalition, the entity charged with executing the SHIP and transforming Idaho's health care delivery system. She noted dieticians' involvement with the transition of primary care practices into patient-centered medical homes (PCMHs). Finally, **Ms. Williams** reviewed data and studies that evidenced the impact of dieticians on the health of Idahoans (see attachment 1).

Chairman Heider commented that some health care providers do not discuss nutritional, diabetic or dietetic issues with their patients. **Ms. Williams** said that this is something that Idaho needs to change.

Chairman Heider asked the Committee members if they had any questions.

Senator Schmidt asked Ms. Williams to describe the business model for advancing RDN services. **Ms. Williams** replied that PCMHs provide for a viable business model, with RDNs being paid for chronic care management. **Ms. Williams** noted that RDN services improve patient care.

Senator Nuxoll inquired about the costs to obtain RDN services in a PCMH. **Ms. Williams** replied that she did not have specific cost approximations at this time, but noted that it is difficult to collect fees to meet the costs of services provided.

Noting that the State needs to find ways to provide RDN services on a wider scale, **Senator Hagedorn** asked if RDN services are currently being provided via telehealth. **Ms. Williams** responded that the Academy has been exploring the potential of telehealth. She stated the Academy would bring more specific data regarding telehealth as part of next year's presentation to the Committee.

PRESENTATION: Evaluation Report Relating to the Design of the Idaho Behavioral Health Plan. **Lance McCleve**, Principal Evaluator of the Idaho Legislature's Office of Performance Evaluations (OPE), and **Ryan Langrill**, Senior Evaluator of the OPE, made this presentation before the Committee (see attachment 2).

Mr. McCleve stated that the Idaho Behavioral Health Plan is the effort by the Department of Health and Welfare (Department) to move a portion of the behavioral health medicaid program to managed care. **Mr. McCleve** stated that the OPE evaluation report considered (i) whether the factors affecting the success of the behavioral health plan were related to how the Department designed the plan or how Optum carried out the contract and (ii) whether the Idaho Behavioral Health Plan was affecting other areas of the behavioral health landscape. The Department is aware of and working to address the issues identified in the final evaluation report. **Mr. McCleve** reviewed the data sets and processes used to complete the evaluation. **Mr. McCleve** noted that general outcomes data are not available.

Discussing the Behavioral Health Plan, **Mr. Langrill** stated that the transition to managed care provided the Department with the opportunity to obtain sufficient oversight and implement changes in the behavioral health service array. In particular, **Mr. Langrill** noted the Department's struggles with psychosocial rehabilitation. He reviewed the three key strategies the Department used to negotiate the behavioral health managed care contract, including requesting value added services from providers, setting a cap on funds available for administrative costs and establishing financial holdbacks and incentives. **Mr. Langrill** discussed the Department's Medicaid spending trends on psychosocial rehabilitation. He summarized the lessons learned and general recommendations of the OPE to continue developing the plan and to improve communication.

Senator Hagedorn asked how the number of patients served in 2013 compared to the number of patients served in 2015. **Mr. Langrill** stated that the number of patients has increased; however, there has been a slight decline in the proportion of patients served in the program from 8.8 percent to 8.7 percent as a result of enrollment growth. He added that the reduction in spending does not indicate a reduction in people receiving behavioral health services.

Discussing potential improvements for Idaho's Behavioral Health Plan, **Mr. McCleve** stated that (i) a well-developed program design is needed before contracting for future services, (ii) differences between the Department's plan for services and a vendors products and capabilities should be expected and (iii) collaboration with vendors is important for filling gaps in services.

Chairman Heider asked Mr. McCleve to specifically address the concerns of the Committee related to outcomes, best practices and costs. **Mr. McCleve** stated that the report did not evaluate the Behavioral Health Plan based on health outcomes; the plan was evaluated based on the distribution of services. Regarding costs, **Mr. McCleve** stated that costs are currently fixed per member per month. **Chairman Heider** asked if the patients are getting better. **Mr. McCleve** indicated that health outcomes are not currently measured at an appropriate level to determine if people are getting better in aggregate.

Senator Hagedorn asked if the Department set metrics for success in the managed care contract with Optum, or whether the State relied on the understanding that evidence-based services will produce better outcomes. **Mr. McCleve** responded that the contract does include broad level metrics for identifying problems, and confirmed that the Department did generally rely on evidence-based practices improving outcomes.

Senator Martin asked about the trend in the number of providers delivering behavioral health services. **Mr. McCleve** stated he was not able to provide that information as a result of the way the evaluation data are kept. **Senator Martin** asked if the number of providers providing psychosocial rehabilitation services has increased or decreased. And, he inquired whether the dollars paid by the State for such services has increased or decreased. **Mr. McCleve** responded that there are fewer psychosocial rehabilitation services being provided.

Senator Schmidt asked if the institution of managed care was an attempt to solve a lack of capacity and oversight or was it to address some other need. **Mr. McCleve** responded that the institution of managed care was geared toward addressing capacity.

In closing, **Mr. McCleve** reviewed the OPE recommendations to the Department (see attachment 2).

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:26 p.m.

_____

Senator Heider
Chair

_____

Karen R. Westbrook
Secretary

_____

Kara Machado
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Monday, February 8, 2016

ATTACHMENT 1

IDAHO ACADEMY OF NUTRITION & DIETETICS

Health & Welfare Committee Presentation

CAROLINE KEEGAN, MBA, RDN, LD
MEGAN WILLIAMS MDA, RDN, LD, CDE

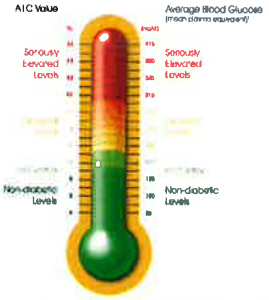
2016

Our Commitments

- Improve the health and well-being of Idahoans
- Progressive leadership and training in partnership with fellow health care professionals
- Health care cost reduction.

Estimated diabetes costs in the United States, 2007	
Total (direct and indirect)	$174 billion
Direct medical costs	$116 billion After adjusting for population age and sex differences, average medical expenditures among people with diagnosed diabetes were 2.3 times higher than what expenditures would be in the absence of diabetes.
Indirect costs	$58 billion (disability, work loss, premature mortality)

Medical expenses for people with diabetes are more than two times higher than for ***people without diabetes.***



Idaho RDN Data 2015

- Of the 90 patients we have data on:
  - The average drop in A1c was 1.03%.
  - 20% of patients went from an A1c above 7% to an A1c below 7%
  - 75% of patients saw a decline in their A1c after RDN intervention.
- Cost savings $820 from a 1% drop in A1c.

Actual Savings: **$76,014**

Average drop (1.03) x $820 X 98,977 Idahoans with Diabetes

$83,595,974 projected cost savings

RDN in Primary Care

- 14 patients with 2 hours + with the RDN:
  - Average A1C drop from 10.2 to 7.1

3.1% decrease x $820 x 14 patients =

$35,588

Weight loss

145 patients:

5.5# average weight loss state-wide

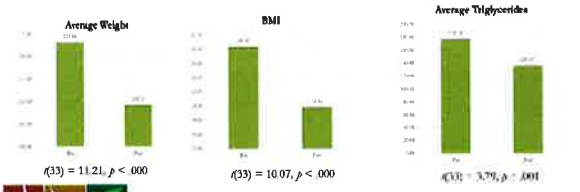
Idaho RDN's

1. MC, 62 y/o female, down 117 lbs. from 318 to 201. DM improved, A1c lowered.
2. JB, 59 y/o female, down 38 lbs. A1c decreased from 6.7 to 5.4. Off BP meds
3. PA, 61 y/o female, A1c down from 10.7 to 6.3.
4. KS, 62 y/o female, from 260 – 236 lbs. Triglycerides 314 to 143.
5. PP, from 235 - 218 lbs, A1C from 12.1 to 5.8 (no longer on BP medication)

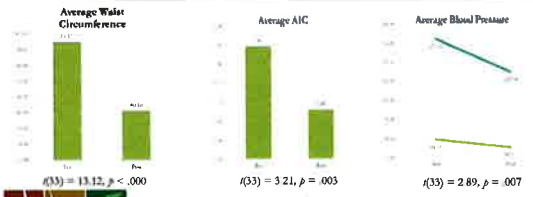
Metabolic Syndrome Prevention Clinic Project

- **St. Luke's Employees w/ Met Syn**
  - **Total of 5 men, 29 women: 2 cohorts**
- **12 Weeks**
- **Inter Disciplinary Staff**
  - Physician Directed
  - Exercise Physiologist
  - Licensed Clinical Social Worker
  - Registered Dietitian
- **Individual Intake with Each Discipline**
- **Twice a week (24 sessions)**
  - Group Education
    - Support Group format
  - Supervised Group Exercise with individualized exercise prescription

Met Syn Project Outcomes



Met Syn Project Outcomes



SENATE HEALTH & WELFARE COMMITTEE
Monday, February 8, 2016

ATTACHMENT 2

Design of the Idaho Behavioral Health Plan

Report highlights

January 2016

The Legislature and the Department of Health and Welfare have successfully addressed concerns about the overreliance on psychosocial rehabilitation. The department now needs to make significant improvements to mental health program planning before taking its next steps.

The plan

Idaho wanted to reform outpatient behavioral health for Medicaid patients.

The department planned for changes to policy, service criteria, and oversight to bring services in line with department intent.

Changes were implemented through a 3-year contract estimated at $300 million.

Results

A substantial decline in PSR.

An increase in other services: most notably family therapy. Despite increases in other services, total spending is down.

Savings has not come from a reduction of members served.

Intentional changes negatively affected some providers.

Investing savings in the community has proved more difficult than planned by the department.

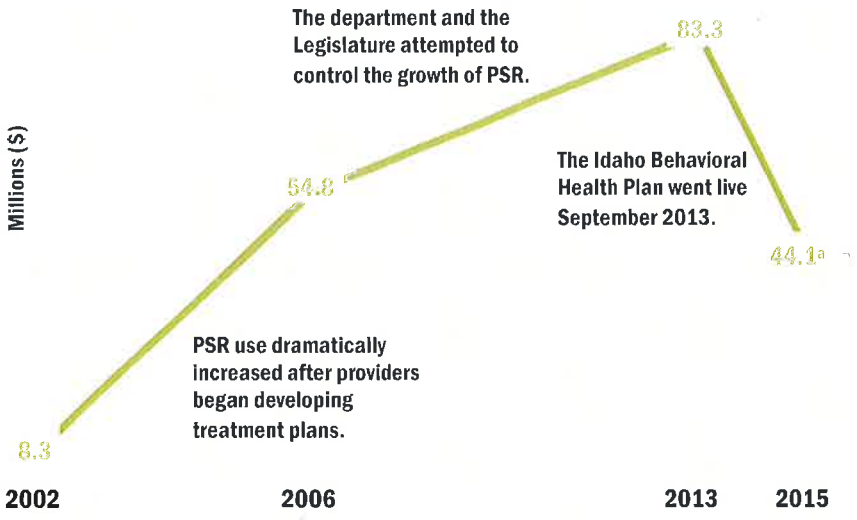
Lessons

Clearly communicate plans and choices for new programs.

Program design should be well developed before going to contract.

Ensure sufficient expertise to align program design and vendor capabilities.

Medicaid spending on psychosocial rehabilitation (PSR) increased through 2013, a trend reversed by the behavioral health plan.



a. 2015 data extrapolated from Optum claims data. Changes in spending also reflect the department's redefinition of the service to community-based rehabilitation services in 2013.

Recommendations

The department needs to continue taking steps to build capacity and services in the community.

The department should formally evaluate the merit of including inpatient services in the behavioral health plan.

The department should also use independent third-party expertise for assistance in evaluating the merit of including inpatient services. If it decides that including inpatient has merit, independent expertise would also be valuable for planning and designing the transition.

View the report: www.legislature.idaho.gov/ope/

Office of Performance Evaluations ope Idaho Legislature

Promoting confidence and accountability in state government

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, February 09, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
RS24241	RELATING TO THE PRACTICE OF PHARMACY: Amending Idaho Code § 54-1704 to provide that pharmacists may prescribe immunizations for persons who are six years of age or older.	**Pam Eaton** Idaho State Pharmacy Association
RS24053	RELATING TO PUBLIC ASSISTANCE: Amending Idaho Code § 56-209h to revise provisions regarding civil monetary penalties for providers.	**Steve Bellomy** Department of Health and Welfare
RS24052	RELATING TO BACKGROUND CHECKS: Amending Idaho Code § 56-1004A to remove obsolete language regarding a federal pilot project.	**Fernando Castro** Department of Health and Welfare
Presentation	Behavioral Health in Idaho	**Tom Hanson** and **Kathie Garrett** National Alliance on Mental Illness - Idaho **Ross Edmunds** Department of Health and Welfare **Dennis Boughman** Lifeways

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, February 09, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:02 p.m.
RS 24241	**Relating to the Practice of Pharmacy**. **Pam Eaton**, Executive Director of the Idaho State Pharmacy Association (ISPA), presented this RS.

Ms. Eaton stated that pharmacists are currently authorized to prescribe and administer immunizations to individuals who are 12 years of age or older. This proposed legislation amends Idaho Code to provide that pharmacists' may prescribe and administer immunizations for individuals who are six years of age or older. **Ms. Eaton** discussed three primary reasons for modifying this age limit: (i) to increase immunization rates in Idaho, (ii) to decrease the waivers for immunizations based on convenience and (iii) to increase access to flu shots for children. **Ms. Eaton** clarified that this proposed legislation would not require immunizations.

Chairman Heider asked the Committee members if they had any questions.

Vice Chairman Nuxoll asked if obtaining immunizations from pharmacists would cost less than obtaining immunizations from physicians. **Ms. Eaton** answered that it depends on the type of immunization the patient is receiving. Currently, physicians obtain immunizations required for school for free and pass cost savings along to the patients. Pharmacists are eligible to enroll in the same program to obtain the immunizations for free. If the pharmacists do not enroll in the program, then immunizations would be more expensive. **Vice Chairman Nuxoll** asked if pharmacists are require to provide patients with the same information as physicians and obtain the parental consent. **Ms. Eaton** replied that pharmacists must distribute the same information that a physician distributes at the time of immunization. Pharmacists also encourage patients who receive immunizations through them to follow-up with their physician. **Vice Chairman Nuxoll** asked again about parental consent. **Ms. Eaton** responded that parental consent is required before administering an immunization to a minor.

Senator Lodge commented that, in her experience, obtaining a flu shot from a pharmacist was less expensive and more convenient than scheduling an appointment with a physician.

Senator Harris asked why the age of six was chosen instead of another age. **Ms. Eaton** answered that some states have the age limit at six and others go down to age two. Age six was chosen because that is primarily the age of a child when they start grade school.

Senator Schmidt asked if pharmacists record immunizations in the State database. **Ms. Eaton** replied that some pharmacists do record the information and others do not. Those who did not input the information into the State database either did not know they were required to record immunizations or they did not know how record immunizations in the database. She indicated that there is an campaign underway to train pharmacists to input immunization information to the State database.

MOTION: There being no more questions, **Senator Harris** moved to send **RS 24241** to print. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

RS 24053 **Relating to Public Assistance**. **Steve Bellomy**, Bureau Chief of Audits and Investigations in the Department of Health and Welfare (Department), presented this RS.

Mr. Bellomy stated that the proposed legislation amends Idaho Code to revise provisions regarding civil monetary penalties (penalties) for providers. The legislation proposes three main changes: (i) to allow the Department to make rules regarding how and when penalties are applied, (ii) to reduce the minimum penalty from 25 percent to 10 percent and (iii) to modify how the Department applies penalties to providers who fail to obtain required background checks on employees. **Mr. Bellomy** commented that fiscal note represents the impact of this legislation on the General Fund if all penalties were reduced to the minimum 10 percent. However, this is a worst case scenario and the Department does not anticipate a current or future need for funding. **Mr. Bellomy** reviewed the specific language for the proposed changes.

Chairman Heider asked the Committee members if they had any questions.

Senator Hagedorn asked Mr. Bellomy to clarify how the Department would determine if a background check is "not timely performed." **Mr. Bellomy** answered that in some cases, a background check is required before the first day of work; in other cases, a background check is required if the employee is supervised. Therefore, the Department intentionally used this broad language to accommodate different rule requirements for different categories of service.

Senator Schmidt requested that the Department be prepared to discuss how many civil monetary penalties have been applied to school districts. **Mr. Bellomy** stated that he would answer that question at the hearing.

MOTION: There being no more questions, **Senator Schmidt** moved to send **RS 24053** to print. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.

RS 24052 **Relating to Background Checks**. **Fernando Castro**, Supervisor of the Criminal History Unit of the Bureau of Audits and Investigations in the Department, presented this RS.

Mr. Castro stated that proposed legislation amends Idaho Code to remove obsolete language regarding funding for criminal background checks. **Mr. Castro** reviewed the duties of the Criminal History Unit. Specifically, he indicated that the proposed legislation seeks to eliminate language regarding funding of a federal project that has since lapsed. The Department currently charges fees to adequately fund the program and so there is no fiscal impact to the State.

MOTION: There being no questions, **Senator Schmidt** moved to send **RS 24052** to print. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**.

PRESENTATION: **Behavioral Health in Idaho**. **Tom Hanson**, President of the Board of Directors of the National Alliance on Mental Illness – NAMI Wood River Valley; **Kathie Garrett** Vice President, National Alliance on Mental Illness – Idaho; **Ross Edmunds**, Administrator of the Division of Behavioral Health in the Department; and **Dennis Baughman**, Project Director of Lifeways, made this presentation before the Committee.

Mr. Hanson opened the presentation with a discussion regarding his son's struggle to obtain health care.

Ms. Garrett presented behavioral health priorities in an integrated health care setting. Specifically, she discussed (i) the obstacles for people with mental illness, (i) the transformation of the mental health system into an integrated system in which mental health issues are treated like any other health issue or illness, (iii) the importance of suicide prevention for mental health, (iv) the effects of trauma on mental health, (iv) national mental health statistics and (v) care issues in a primary setting (see attachment 1).

Mr. Edmunds continued the presentation by examining the system of care for behavioral health in Idaho. He discussed (i) the types of individuals that need behavioral health services, (ii) the accomplishments of the Department, (iii) the Department's current and future work related to behavioral health, (iv) the increased demand for crisis services, (v) updates regarding the establishment and operation of Idaho's community crisis centers, (vi) updates and core elements of the Jeff D. settlement agreement and (vii) updates and pathways through the redesigned public behavioral health system (see attachment 2).

Chairman Heider asked the Committee members if they had any questions.

Vice Chairman Nuxoll asked about private entities that can support those in need. **Mr. Edmunds** responded that there are entities across the State that provide housing and other support services. He stated that the regional health boards are able to become the experts in the communities they serve and help people identify and connect with different resources. He stated that there are recovery coaches and certified peer specialists to assist those who are coming out of the behavioral health systems.

On behalf of Senator Schmidt, **Senator Lee** asked how the State can provide better access to behavioral health services in rural areas. **Mr. Edmunds** replied that there is no easy solution, but technology can assist in the process. He stated that the Department started by assisting those with immediate crisis needs through the establishment of crisis centers. The Department wanted to have a more managed network of community providers so it introduced managed care into the State. He noted that the problem for not having enough behavioral health specialists is felt in all counties in Idaho. He indicated that the next major step for the behavioral health system is the integration of physical and behavioral health.

Senator Hagedorn requested that Mr. Edmunds provide information to the Committee via e-mail regarding Idaho's rank among behavioral health providers per capita. **Mr. Edmunds** answered that he would be happy to provide the information Senator Hagedorn requested. **Senator Hagedorn** asked if behavioral health services are increasing due to a population increase or if the increase is caused by other issues. **Mr. Edmunds** responded that many factors have resulted in increasing behavioral health services. He stated that more than 250,000 people suffer with some form of mental illness.

Dennis Baughman discussed Lifeways' experience as providers of comprehensive behavioral health services and stewards of public funds in both Idaho and Oregon (see attachment 3). He stated that discussions regarding a new model of delivery of behavioral health services are very timely. He provided an overview of the services Lifeways provides to Idaho and Oregon families. **Mr. Baughman** noted that managed care strategies create a better foundation for achieving the triple aims of overall health care: better care, better health and lower costs. He reviewed the benefits for individuals, hospitals and emergency departments in using a wellness and recovery model. **Mr. Baughman** highlighted research that demonstrates that early intervention, prevention and community based services are more effective for children and youth with severe emotional disturbance, as well as with individuals who have severe and persistent mental illness.

Chairman Heider asked about Lifeways' presence in Idaho. **Mr. Baughman** answered that there are Lifeways offices in Fruitland and Caldwell. **Senator Lee** recognized the innovation Lifeways brings to Fruitland and Caldwell.

Chairman Heider asked if Lifeways had plans to expand further into Idaho. **Mr. Baughman** deferred the question to Lifeways Chief Operating Officer, Ray Millar. **Mr. Millar** responded that Lifeways plans to expand in Idaho as a comprehensive behavioral health provider and share the lessons the company has learned in Oregon.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:24 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Michael Jeppson
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 9, 2016

ATTACHMENT 1

Behavioral Health Priorities in an Integrated Health Setting

January 18, 2016

Kathie Garrett

2003 The President's New Freedom Commission
Achieving the Promise: Transforming Mental Health Care in America

"Our country must make a commitment. Americans with mental illness deserve our understanding and they deserve excellent care."

April 29, 2002, President George W. Bush

2003 The President's New Freedom Commission
THREE OBSTACLES

- Stigma that surround mental illness.
- Unfair parity in health insurance coverage.
- Fragmented mental health service delivery system.

TRANSFORMATION?

Transformation is:

- Changing the way we think about mental illness
- Changing the way mental health services are delivered.
- Transformation is revolutionary and at times scary. It implies profound change-not at the margins but at the very core.

Why is Transformation important

- Behavioral health is an essential part of health;
- Prevention works;
- Treatment is effective; and
- People can recover from mental illness

No Health Without Mental Health

- People with serious mental illness (SMI) die on average between age 53-56. 2/3 of premature deaths are due to preventable/treatable medical conditions
- 70% of individuals with significant MH/SUD had at least 1chronic health conditions, 30% have 3 or more.
- (SAMHSA)

No Health Without Mental Health

- 12 million visits annually to ERs by people with MH/SUD (SAMSA)
- One out of every five community hospital stays today involves a principal or secondary diagnosis of mental illness. (NAMI 2010)

Medical issues

- "An cautious estimate places the direct and indirect financial cost associate with mental illness in the United states at well over $300 billion annually and it ranks as the third most costly medical condition in terms of overall heath care expenditure, behind only heart condition and traumatic injury."

(Dr. Thomas Insel, M.D. Director of NIMH, Jan. 24, 2013)

Primary Care: A Crucial Setting for Suicide Prevention

- Up to 45% of individuals who die by suicide have visited their primary care physician within a month of their death.
- And yet 81% do not seek prior psychiatric help.
- At any given time, between 2-4% of patients in a primary care setting are having thoughts of suicide.

(Suicide Prevention in Primary Care/SAMHSA/HRSA and Suicide Prevention Toolkit for Rural Primary Care)

Why Trauma Matters in Primary Care Trauma is Common

- 59% of men and women experience at least one adverse childhood experience in their life and 9% experience five or more.
- 35.6% of men and 14.5% of women witness someone being badly injured or killed.
- 18.9% of men and 15.2% of women are involved in a fire, flood or other natural disaster.
- 25% of men and 13.8% of women experience life-threatening accident/assault.

(National Council for Behavioral Health December 2015)

Mental Health Statistics

- Each year 1 in 4 adults and 1 in 5 children experiences a mental health disorder
- 1 out of every 17 people lives with a serious mental illness
- That means approximately 54,000 adults and 18,000 children in Idaho live with mental illness

Children's Mental Health

- Half of all mental illness emerges by age of 14 and three quarters by age 24.
- In the US, there is an average lag of 8 to 10 years between the onset of a mental health condition and the start of treatment.
- While nearly 1 in 5 American youth live with a mental health condition, less than half receive any services.
- (NAMI, December 2015)

"Today, recovery is the expectation for people who experience mental illness. We know that treatment works—if you can get it. However, there is an average delay of eight to 10 years between onset of mental illness and when people typically get treatment."

(NAMI, *January 2011*)

The good news is that

- Today, for people with mental illness recovery is a real possibility
- Treatment outcomes for people with even the most serious mental illnesses are comparable to outcomes for well established general medical or surgical treatments for other chronic diseases.

Integrated healthcare

- "…in essence integrated health care is the systematic coordination of physical and behavioral health care. The idea is that physical and behavioral health problems often occur at the same time. Integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served."

(Hogg Foundation for Mental Health, Connecting Body & Mind: A Resource Guide to integrated Health Care in Texas and the U.S.)

Seeking behavioral health care in primary care

- Most people seek help for BH problems in primary care settings
- ½ of all care for common psychiatric disorders happens in a primary care settings
- Uninsured or underinsured
- Limited access to public mental health services
- Cultural beliefs and attitudes
- Availability of MH Services, especially in rural areas.

(Understanding Primary and Behavioral Healthcare Integration, Mental Health America and National Council)

Care issues in a primary setting

- Mental health problems often go undetected and untreated.
- When detected mental health problems tend to be undertreated.
- Are less likely to receive preventive services.
- Behavioral Health consumers report difficulties in establishing relationships with primary care providers.

(Understanding Primary and Behavioral Healthcare Integration, Mental Health America and National Council)

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 9, 2016

ATTACHMENT 2

IDAHO Department of Health and Welfare

Behavioral Health Update
Division of Behavioral Health

Ross Edmunds
Division Administrator

Senate Health & Welfare Committee
January 19, 2016

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO Department of Health and Welfare

Behavioral Health System of Care

Who needs services?

Three categories...

1. Individuals dealing with a mental health crisis; typically short term, often life threatening, need immediate intervention.
2. Individuals with chronic, severe mental illness; typically lifelong and debilitating, require intensive long-term management and support.
3. Individuals with serious mental illness that need ongoing maintenance; i.e. medication, checkups, brief assistance when minor challenges manifest.

IDAHO DEPARTMENT OF HEALTH & WELFARE

2

IDAHO Department of Health and Welfare

Behavioral Health System of Care

What have we accomplished...

1. **Crisis centers** to more effectively and efficiently assist people experiencing a BH crisis.
2. **Crisis Intervention Teams (CIT)** statewide in partnership with law enforcement.
3. **Regional BH Boards** to provide leadership in communities and establish/manage recovery support services.
4. **A network of specialty BH providers** consistently managed by contractors, BPA Health and Optum.
5. **Recovery centers** to support people in recovery from BH disorders remain in recovery.

IDAHO DEPARTMENT OF HEALTH & WELFARE

3

IDAHO Department of Health and Welfare

Behavioral Health System of Care

What we are working on...

1. **Safe and stable housing** for adults with chronic mental illness who may never be able to live independently, Adult Residential Treatment Homes (ARTH).
2. Better access to ongoing **healthcare** for people with BH disorders, which is integrated with physical health into seamless delivery.
3. A more **effective BH system** to intervene with **children and families** as early as possible to reduce the impact of BH illnesses later in life.

IDAHO DEPARTMENT OF HEALTH & WELFARE

4

IDAHO Department of Health and Welfare

Behavioral Health System of Care

What we need to work on next...

1. We need **better access** to ongoing effective mental health and substance use disorders specialty treatment services.
2. Better access to effective treatment for offenders in the **criminal justice system**.
3. Opportunities to access services in **rural communities**, possibly through **technology**.
4. **More highly trained providers**; particularly psychiatrists, mid-level practitioners & psychologists.
5. Treatment for dealing with **trauma**.
6. Possibly most importantly, a **cultural shift** in the way we view BH illnesses and how we treat people with BH disorders.

IDAHO DEPARTMENT OF HEALTH & WELFARE

5

IDAHO Department of Health and Welfare

Behavioral Health System of Care

Who needs services?

Three categories...

1. **Individuals dealing with a ~~mental~~ health crisis; typically short term, often life threatening, need immediate intervention.**
2. **Individuals with chronic, severe ~~mental~~ illness; typically lifelong and debilitating, require intensive long-term management and support.**
3. **Individuals with serious ~~mental~~ illness that need ongoing maintenance; i.e. medication, checkups, brief assistance when minor challenges manifest.**

IDAHO DEPARTMENT OF HEALTH & WELFARE

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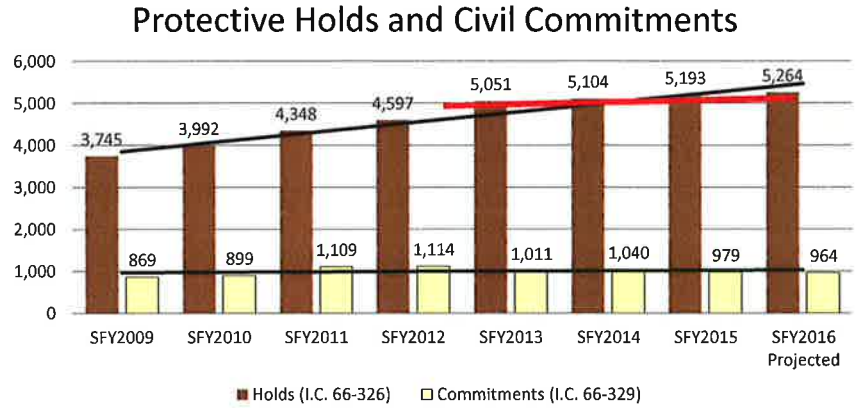
IDAHO Department of Health and Welfare

Increased Demand for Crisis Services



IDAHO DEPARTMENT OF HEALTH & WELFARE

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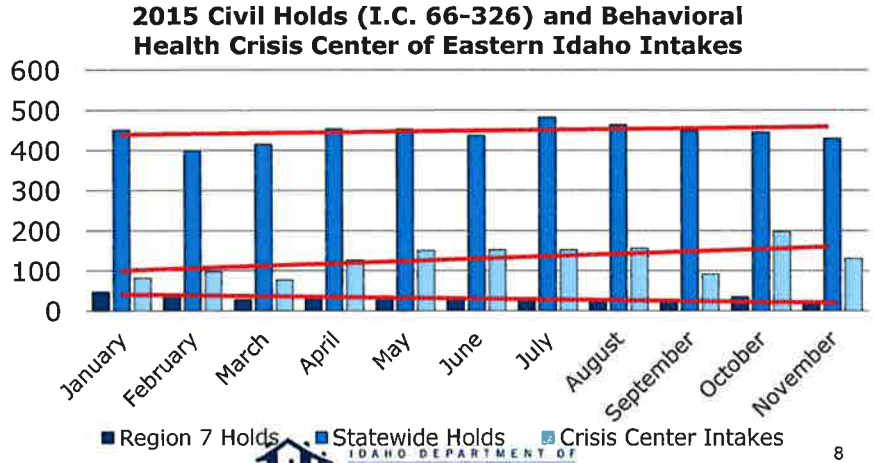
IDAHO Department of Health and Welfare

Community Crisis Centers Update



IDAHO DEPARTMENT OF HEALTH & WELFARE

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IDAHO Department of Health and Welfare

Community Crisis Centers Update

Eastern Idaho Crisis Center (opened 12/2014) :

- 2,349 Patients served
  - 1,536 admissions and 813 assessment and referral
- 259 Law enforcement referrals
  - Estimating nearly 1,200 hours of saved time
- 228 Hospital referrals/138 diversions from hospitalization
  - $280,000 estimated savings in Emergency Dept costs
  - $450,000 estimated savings in hospitalization
- 14 hours 39 minutes, average level of stay for admissions

Northern Idaho Crisis Center (opened 12/2015):

- 66 Patients served
- 8 Law enforcement referrals
- 4 Hospital referrals

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IDAHO Department of Health and Welfare

Jeff D. Update

Timeline to Dismissal

- Settlement agreement accepted by the Federal Court (June, 2015).
- Currently developing implementation plan (due end of March, 2016).
- Four years to implement the plan (2020).
- Two to three years of monitoring following implementation (2024).
- Joint motion of dismissal, provided successful implementation (2025 expected resolution).

IDAHO DEPARTMENT OF HEALTH & WELFARE

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IDAHO Department of Health and Welfare

Jeff D. Update

Core Elements of the Settlement Agreement

- **Medicaid will serve as the backbone for the system.**
- **Research suggests 5 to 7% of general population (approximately 9,000) of children <18 years have serious emotional disturbance, with less than half accessing services.**
- **Better cross-system coordination.**
- **Access to an effective continuum of services.**
- **Focus on better case/care management, particularly for the most severe.**
- **Families as full partners in their own care and in the system design, delivery, and evaluation.**

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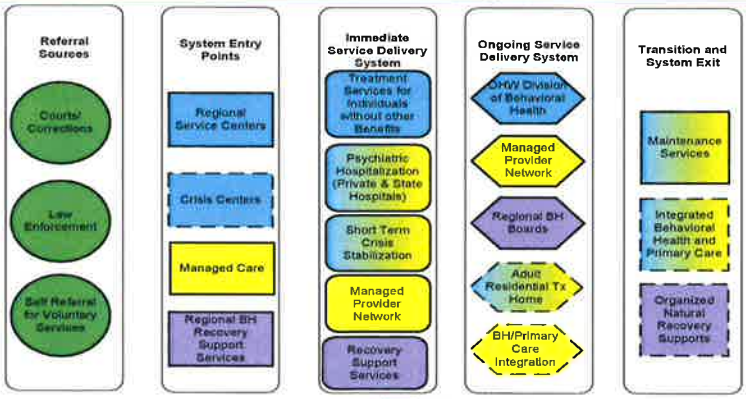
Public Behavioral Health System Redesign



Current System Resource
Under Development

Referring Sources
DHW Division of Behavioral Health (BH)
Shared Responsibility (BH & Managed Care)
Managed Care Network
Regional BH Recovery Support Services

IDAHO DEPARTMENT OF HEALTH & WELFARE

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IDAHO Department of Health and Welfare

Division of Behavioral Health

Ross Edmunds
edmundsr@dhw.idaho.gov
208.334.5726

IDAHO DEPARTMENT OF HEALTH & WELFARE

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HEALTH & WELFARE

Defining Behavioral Health Crisis Centers vs. Recovery Community Centers

What is a Behavioral Health Crisis Center?

Behavioral Health Crisis Centers are an unrealized component of the Idaho Behavioral Health System. Once established, these centers will be accessible to all citizens on a voluntary basis. Established as a brick and mortar facility, these centers operate 24/7/365 and are available to provide evaluation, intervention and referral for individuals experiencing a crisis due to serious mental illness or a co-occurring substance use disorder.

Key Points:

- An episode of care at a behavioral health crisis center is no more than 23 hours and 59 minutes.
- Crisis centers are voluntary. Working with law enforcement, these centers are a resource for individuals who are willing to seek services but lack the essential resources. These centers help individuals in crisis get the assistance they need without going to the emergency room or being taken to jail.
- Eligibility for the centers: a) be at least eighteen (18) years of age, b) demonstrated impairment and or symptom(s) consistent with a DSM-V diagnosable condition, c) be medically stable, and d) be in need of frequent observation on an ongoing basis.
- The staff of the center are comprised of three levels of behavioral health professionals: a) Certified Peer Specialists, b) Clinicians, & c) Nurses
- Capacity: The estimated need is approximately 1 bed for every 10,000 Idahoans in the community. As pilot sites launch we will be evaluating the need, capacity and outcomes achieved to help inform additional project outcomes.
- We anticipate local centers leveraging local partnerships once established to assist in the ongoing operation and service needs of those served (for example: donated meals, laundry service).
- There are currently two crisis centers operating in Idaho, one in Idaho Falls and one in Coeur d'Alene. The Department of Health and Welfare is requesting one additional Crisis Center in the 2016 Legislative session to be located in Southwest Idaho. The actual location will be determined through a competitive process.

What Is a Recovery Community Center?

Recovery Community Centers provide a meeting place for those in recovery from alcohol or drug addiction and act as a face for recovery to the community as a whole. Building meaningful and healthy relationships is key to successful recovery and these centers offer the venue for that to happen. Ideally, the centers are located as close to the heart of a community as possible, and are very visible. The center doesn't need to be large to have a huge impact on those who use it.

A variety of activities can originate at the Recovery Community Center:

- A center is a welcoming meeting place where others can be counted on to provide support when an individual's recovery is feeling shaky.
- Reliable information is made available on services needed by those new to recovery, such as housing and transportation assistance.
- Computers with internet services are made available to enhance recoverees' computer skills as well as to provide them with the connectivity that may be needed to do job searches or to stay in touch with family and friends.
- Classes are provided to enhance recoverees' ability to live their lives clean and sober and can cover areas such as job skills and how to socialize with others without getting high.
- Phone banks are provided for volunteers to make requested check-in calls to people in recovery. Knowing someone is going to call every week to see how they are doing may be what it takes to keep an individual in recovery.
- It is a place to give back. These centers rely heavily on volunteers to function. Experience tells us that giving back is as powerful to the person volunteering as it is to the recoveree receiving the help.
- It can become an information source for those who are seeking help for themselves or those they care about.

A Recovery Community Center should not be confused with a 12-step clubhouse, and it is not a drop-in center. It isn't meant to be a place to hang out, but is meant to be a place where a person can go to work on improving their life and that of those around them. It could also be expected to take on the personality of the people who use it and the community that is its home.

Behavioral Health Crisis Center of East Idaho

Referral Source

Hospital 228

Law Enforcement 259

Self 862

2,359 Clients

1,536 regular clients + 813 short-term clients

For example, short-term clients may only come in for a referral to a community resource and do not need a nursing assessment.

1,165 Law Enforcement Time Savings

259 Law Enforcement Referrals × 4.5 hours = 1154.5 Estimated law enforcement time saved.

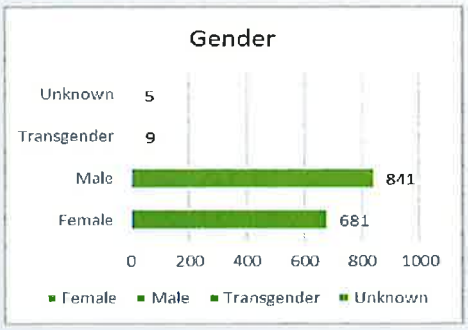
Per law enforcement, 47 people would have been taken to the ER by law enforcement if the Crisis Center were not available.

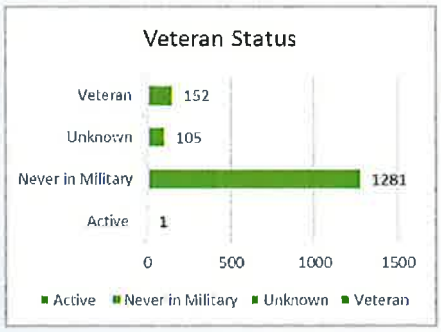
$281,124 Hospital ER Savings

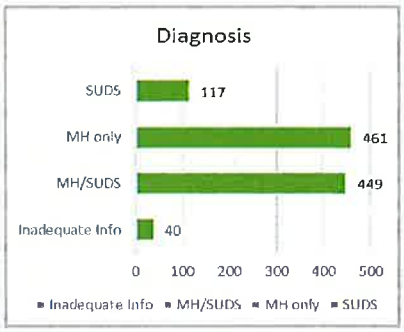
228 referrals from hospitals × $1,223 (average ER visit cost) = $281,124 Estimated Savings.

$483,000 Inpatient Hospitalization Savings

138 diverted inpatient hospitalization = (138 admissions X avg. 5 days) X $700 daily rate = $483,000







Data 12-12-2014 through 12-31-2015

There are a number of clients with multiple episodes. Nearly all of those clients have chronic conditions such as schizophrenia and bipolar disorder. Some clients with substance use disorders have had multiple episodes due to readmission after a relapse.

Number of Days with (x) number of Clients										
# of Clients	1	2	3	4	5	6	7	8	9	10
# of Days	50	63	51	52	53	41	25	17	9	6

14 Hrs 39 Min

Average Length of Stay

Client County	
County Name	Total
ADA	2
BANNOCK	49
BINGHAM	86
BONNER	2
BONNEVILLE	1230
BUTTE	3
CASSIA	1
CUSTER	3
FRANKLIN	3
FREMONT	20
JEFFERSON	40
LEMHI	4
MADISON	36
NEZ PERCE	2
Out of State	40
TETON	9
TWIN FALLS	3
POWER	1
BOUNDARY	1
GOODING	1
Grand Total	**1536**

behavioralhealth crisis center of east idaho
welcoming empathic hopeful

The Crisis Center has:

- **Diverted 138 people away from inpatient hospitalization.**
- **Received 228 people from community hospitals.**

"The crisis center has empowered law enforcement to take an active role in addressing mental health issues in our community."

Officer Zeb Graham , Bonneville County Sheriff's Office

IDAHO DEPARTMENT OF HEALTH & WELFARE

Division of Behavioral Health

Approximately 1 in 5 Idahoans will experience a diagnosable mental illness in any given year.

Most will talk to friends and family, seek assistance from their primary care provider, or meet with a counselor, and life continues. They may not even consider that what they are feeling might be a mental illness and will chalk it up to feeling a little down or overwhelmed. Even so, many people suffer from chronic, severe mental illness that can be debilitating.

Mental illness can cause difficulty attaining and maintaining employment, housing, and relationships. People who suffer from mental illness may end up in psychiatric hospitals for short stays or need long-term supportive housing. Others can live successfully on their own with the support of their loved ones and the care and treatment of Idaho mental health providers.

For several years, the challenge has been finding an efficient and effective living situation for people with a Serious Mental Illness (SMI) without the ability to live on their own. They require near constant supervision to ensure they eat, take their medication, manage their other health needs, etc. Currently, many live in Residential Assisted Living Facilities, or RALFs. While the owners and staff at these facilities do the best work they can for their residents, it isn't a model precisely designed for this population.

There has been significant legislative, provider, and state interest in appropriate levels of care for people with chronic and serious mental illness. As a result, a work group of providers, advocates, stakeholders and Department of Health and Welfare (DHW) representatives has been formed. The work group is co-chaired by Trista Wolfe (chair of the Idaho Small Providers Association) and Ross Edmunds (DHW Administrator over Behavioral Health). The work group has taken a fresh start on the issue by researching models from around the country and developing an Idaho-specific solution.

By working collaboratively, the work group is developing a solution for Idahoans with serious mental illness that require long-term support to remain stable and out of expensive hospitals. The model is being called an Adult Residential Treatment Home.

Survey Estimates 500-600 Idahoans Affected Statewide

- **500-600 Idahoans** suffering from a severe mental illness currently live in Residential Assisted Living Facilities (RALFs) because they are unable to live on their own, according to a survey conducted by the **Idaho Small Provider Association**.
- RALFs, while not designed for this population, are the least expensive long-term setting for citizens suffering from a mental illness who are unable to live on their own.
- The RALF provider base is quickly eroding because of an ill-fitting licensing structure, by both regulation and reimbursement.
- RALFs are an inexpensive community safety net. By nature of the setting, providers can closely monitor and ensure patients are compliant with psychiatric treatments and medications.

Alternative Environments For This Population

- **Skilled Nursing Facilities**
- **Nursing Home**
- **Publicly Funded System**
  - Emergency Rooms/Hospitals
  - Jail/Prison
  - Homeless

Elements of the Model

- Should be as close to a home environment as possible.
- Will have 16 beds or fewer.
- Designed for people with Serious Mental Illness (SMI) without the ability to live independently.

Objectives

1. More cost effective treatment than currently financed by the state to support Idahoans with serious mental illness that cannot live independently.
2. Adequately reimburse providers for the treatment and support of Idahoans with serious mental illness to save the state more expensive treatment elsewhere.
3. Develop and implement appropriate governance bodies to ensure patient safety and eliminate conflict with current state and federal guidelines.

Steps Taken To-Date

- The work group has established co-chairs to organize and convene the stakeholders.
- A target population/ population description has been developed and is in final stages of approval.
- The work group recognizes the need to fully articulate the model, including requirements, access points, funding mechanisms, treatment modalities, etc.
- The work group also understands the importance of looking at short-term solutions, as many current RALF providers are struggling financially under the current requirements and needs of the patients to the point of going out of business.

YOUTH EMPOWERMENT SERVICES

Implementation of the settlement agreement in the Jeff D. lawsuit

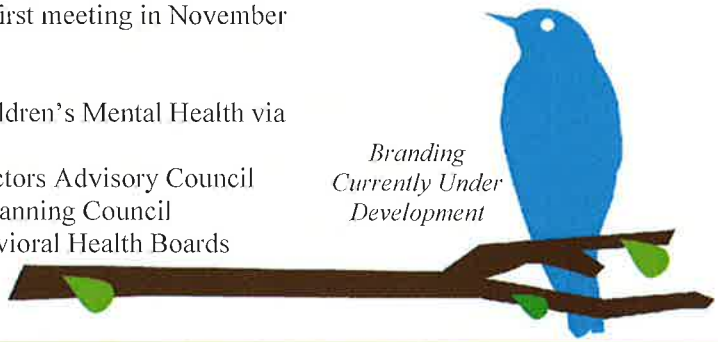
BACKGROUND

- Class action lawsuit from 1980 stemming from allegations of abuse of children who were co-mingled with adults at State Hospital South (SHS), lack of appropriate educational and treatment services at SHS, and lack of community-based mental health services.
- After many hearings over 30 years, the Court encouraged a mediation process to occur in order to identify solutions - occurred 9/13-12/14.
- Mediation resulted in proposed Settlement Agreement which is the result of more than a year of negotiations among key community stakeholders representing parents, advocates and private providers, representatives from DHW, the Idaho Department of Juvenile Corrections, the Idaho State Department of Education and attorneys representing the class members.
- The Settlement Agreement is a high-level description of what the state agrees to do to have the lawsuit dismissed

Pre-Implementation Status Report (milestones achieved and currently in development)

- Branding for new identity to be announced in November
- New state website with shared ownership with partners in development: November launch
- Draft Idaho Implementation Plan developed and scheduled for review and input by partners 10/19/15
- Child Adolescent Needs & Strengths (CANS) Tool developed and in approval process
- Quality Management Improvement & Accountability (QMIA) Workgroup is meeting and is designing a statewide quality review and oversight plan
- Workforce Development Workgroup recruited and invitations to first meeting in November announced
- Speaking engagements:
  - **June:** Presentation to Idaho Federation of Families on Children's Mental Health via webinar
  - **September, 2015:** Presentation to Special Education Directors Advisory Council
  - **October, 2015:** Presentation to Behavioral Health State Planning Council
  - **March-May, 2016:** Presentations to seven Regional Behavioral Health Boards

9,000 Idaho children have been identified as Class Members



Pre-Implementation Milestones on the Horizon

- IDJC, Child Welfare and DBH participating in Georgetown University Multi-System Integration Program
- DBH and Child Welfare attending CANS Conference to address implementation strategies
- Exploring how to automate CANS & associated costs
- Reducing the utilization of higher-cost services through the expansion of respite
- CANS Workgroup to develop profile for Class Membership and develop criteria for Intensive Care Coordination level of care (January)

See Back of Page
Detailing commitments of the settlement agreement with exit criteria and cost implications.

IDAHO DEPARTMENT OF HEALTH & WELFARE

Agreement Commitments (scope of work with implication for costs)

Work Objectives in Development	Exit Criteria	Implications for Changes in System Infrastructure, Processes and Products
Continuum of care development	A service package is developed and implemented in sufficient quantity to meet the annual service utilization by Class Members and is delivered to identified Class Members based on Class Members' strengths, needs and medical necessity.	• Medicaid waiver would leverage federal dollars — otherwise reliance on general fund dollars increases • Calls for integration across child-serving agencies/units to ensure smooth transitions and eliminate duplicative efforts • Need staff resources to design and operate new methodologies for cross-system integration • Redefining of roles/responsibilities
Adoption of new ideology	Agencies and providers in the new system of care demonstrate fidelity to the Principles of Care and Practice Model in the delivery of services and supports.	• Switch from medical model (currently the Optum/Medicaid model) to recovery model that eliminates "fail first" approach to authorization of services • Relies on child/family team model of decision-making • Need to adjust printed materials and other communications to reflect new ideology
Creating Access	Class Members are identified, assessed and served using the specified models and tools. This process and informative materials are communicated statewide to the community, stakeholders, and families.	• Creation of screening tool & assessment to identify Class Members • Adoption of CANS tool • Automation of CANS tool • Training staff and community stakeholders to CANS tool • Adoption of evidence-based Wrap Around practice
Workforce Training and Development	Agency staff, providers, and other community and system partners use and follow the Access Model, Practice Model, Practice Manual and CANS tool as appropriate and with sound fidelity.	• Workforce capacity to be assessed • Gaps in access and quality performance to be addressed • Development of Practice Manual • Must train staff and community stakeholders on Practice Manual
Due Process	Class Members', their families, and caregivers' concerns, related to their dissatisfaction with a process, provider or agency action, will be addressed. Such process and associated outcomes will be documented and tracked for continuous quality improvement. This information is made available through reports.	• Development and operation of complaint and grievance process that functions to be responsive in a timely manner and corrective of problems cited by complainant and plaintiffs. • Continuous quality improvement activities • Development of data reporting system
Governance	The identified child-serving agencies establish and use an Interagency Governance Team (IGT) including adoption and use of operational guidelines for the purpose of coordinating and overseeing implementation of the Agreement. The IGT includes specific membership as described in the Agreement.	• Resources: Staff time
Quality, Management, Improvement, & Accountability	The identified child-serving agencies conduct reviews, publically report the outcomes of the reviews and demonstrate the ongoing maintenance and improvement of the quality of the system and client outcomes.	• Department workforce to conduct oversight and quality improvement activities on a large scale statewide • Development of automation processes • Reports to be generated for public information on system and client outcomes and the state's adherence to lawsuit requirements
Implementation Plan: Sustaining the new system of care	The identified child-serving agencies develop an Implementation Plan that meets the requirements set by the Agreement, gain approval of the Plan from the District Court, execute the Plan within four years and sustain the Plan for a three year period.	• Staffing resources to be determined

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 9, 2016

ATTACHMENT 3

LIFEWAYS
HELPING PEOPLE

We help people in our communities
achieve and maintain
emotional well-being.

LIFEWAYS
HELPING PEOPLE

MISSION STATEMENT

We will help people in our communities achieve and maintain emotional well-being.

Our Staff:

To accomplish this mission, we maintain a qualified and professional staff, including psychiatrists, therapists, skills trainers,and case managers, who are trained to assess and respond to the individual needs of our clients. We provide our staff with knowledge through ongoing training, and broad and intensive opportunities for professional growth and advancement. We strive to maintain a friendly and efficient workplace that supports staff in providing creative, committed, and effective service to our clients.

Our Services will be...

EFFECTIVE

Mental Health Services at Lifeways are based on the latest advances and best practices in the art and science of psychiatry, psychology , and mental health. We encourage professional excellence by providing our staff with ongoing opportunities for training and study necessary to remain abreast of new developments and best practices. We maintain a rigorous quality assurance and quality improvement process to ensure that our clinical practice is appropriate, effective, and in line with accepted national standards and the state of the art.

ACCESSIBLE

We provide our clients with appointments and services in ways and at times that are convenient for them. We are committed to responding to all new requests for services with appointments within two weeks of an initial request. We maintain a walk-in clinic to ensure that clients experiencing acute distress receive immediate care. Mental health crisis assessment and intervention services by qualified mental health professionals are available twenty-four hours a day, seven days a week.

AFFORDABLE

We provide our clients with appointments and services in ways and at times that are convenient for them. We are committed to responding to all new requests for services with appointments within two weeks of an initial request. We maintain a walk-in clinic to ensure that clients experiencing acute distress receive immediate care. Mental health crisis assessment and intervention services by qualified mental health professionals are available twenty-four hours a day, seven days a week .

ETHICAL

The Mental Health Services staff of Lifeways adheres to the highest standard ethical professional conduct. Our Code of Ethical Conduct is designed to protect clients from harm and to ensure that they receive the services they need in ways that respect their human dignity and individual rights. A copy of the Code of Ethical Conduct is available at the reception desk.

LIFEWAYS
HELPING PEOPLE

OUR SERVICES

At Lifeways, we meet the person right where they are, sometimes in response to crisis, but often just to help get them get back on track. We know life deals many challenges and obstacles, some of which can be debilitating and threatening to your job and relationships. Our holistic approach to mental health is built around a caring, compassionate professional team, with all the skills necessary to assess your challenges, and to collaborate with you on a plan for care to get you on track, back to functioning at your best.

All counseling begins with an assessment and development of a plan with agreed upon goals. Inclusion of the family and supports is encouraged and built in when possible. At Lifeways we treat all aspects of mental and behavioral health.

Our treatment is based on research and is client centered; we develop your plan of care with you.

Areas of expertise include but are not limited to;

- Attention and Hyperactivity Disorders
- Autism Spectrum Disorders
- Mood and Depressive Disorders
- Obsessive-Compulsive Disorders
- Personality Disorders
- Impulse Control Disorders
- Post-Traumatic Stress Disorder
- Schizophrenia
- Substance Abuse

We will help people in our communities achieve and maintain emotional well-being.

LIFEWAYS ONTARIO	LIFEWAYS PENDLETON	McNARY PLACE	LIFEWAYS HERMISTON	LIFEWAYS FRUITLAND	LIFEWAYS CALDWELL
702 Sunset Drive	331 SE 2nd Street	290 Willamette Street	595 N.W. 11th Street	1611 N. Whitley Drive	2609 S. 10th Ave. Ste. 102
Ontario, OR 97914	Pendleton, OR 97801	Umatilla, OR 97882	Hermiston, OR 97838	Fruitland, ID 83619	Caldwell, ID 83605
(541) 889-9167	(541) 276-6207	(541) 922-0880	(541) 567-2536	(208) 291-1020	(208) 454-2766

LIFEWAYS
HELPING PEOPLE

MEDICAL STAFF

Si Steinberg, MD, is Double Board Certified in Adult and Child and Adolescent Psychiatry and Neurology. He attended The University of Michigan Medical School. He then attended UCLA for the first two years of his psychiatry residency with the remainder of his residency training at Dartmouth-Hitchcock Medical Center in New Hampshire where he obtained his Child and Adolescent Psychiatry Fellowship.

Currently, Dr. Steinberg is the Medical Director at Lifeways in Malheur and Umatilla Counties in Oregon. He is also the consulting psychiatrist at Cherry Gulch Therapeutic Boarding School and Novitas Therapeutic High School, both in Emmett, Idaho. In addition he serves as the prescriber's supervisor for several group homes for adults and children with developmental disabilities.

Dr. Steinberg regularly conducts trainings for prescribers, other mental health professionals and the general public in the areas of diagnosis and treatment of mental disorders with particular emphasis on differential diagnosis, childhood trauma, Post-traumatic Stress Disorder, and medication management.

Amy Boudreau, MD, Ph.D., is Board Certified in Psychiatry and Neurology. She completed her residency at UCLA Semel Institute for Neuroscience and Human Behavior.

Dr. Boudreau attended Rosalind Franklin University of Medicine and Science where she earned a Doctorate of Philosophy with Distinction in Neuroscience and a Doctor of Medicine. Additionally, she has spent years in research and therapy in the fields of addiction and geriatric treatment.
Currently Dr. Boudreau practices in Umatilla County, Oregon.

Sandy Lare, DO, is Board Certified in Psychiatry and Neurology. She graduated Cum Laude from the University of Richmond in Virginia. She attended The University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine and awarded the Outstanding Pediatric Award.

Dr. Lare completed her internship and residency in Psychiatry at the Medical University of South Carolina. While at MUSC she was Chief Resident. Dr. Lare has worked in public mental health clinics in California and North Carolina. In North Carolina she served as a Medical Director and owned her private practice The Wilmington Wellness Group.

Currently Dr. Lare practices in Umatilla County, Oregon.

John Bates, MD, is Board Certified in Psychiatry and Neurology. He began his career with an associate degree in Nursing from Treasure Valley Community College and earned his bachelor's degree from Albertson College of Idaho. He graduated medical school and his residency training at Oregon Health & Sciences University in Portland, Oregon.

Dr. Bates has extensive experience with treating chronic mental illnesses, patients in psychiatric crisis, providing psychoeducation, psychiatric medication management and treatment of patients under the PSRB (Psychiatric Security Review Board).

Currently Dr. Bates is the Residential Medical Director with Lifeways Recovery Center and provides outpatient care in Lifeways facilities in Idaho.

We will help people in our communities achieve and maintain emotional well-being.

LIFEWAYS ONTARIO	LIFEWAYS PENDLETON	McNARY PLACE	LIFEWAYS HERMISTON	LIFEWAYS FRUITLAND	LIFEWAYS CALDWELL
702 Sunset Drive Ontario, OR 97914 (541) 889-9167	331 SE 2nd Street Pendleton, OR 97801 (541) 276-6207	290 Willamette Street Umatilla, OR 97882 (541) 922-0880	595 N.W. 11th Street Hermiston, OR 97838 (541) 567-2536	1611 N. Whitley Drive Fruitland, ID 83619 (208) 291-1020	2609 S. 10th Ave. Ste. 102 Caldwell, ID 83605 (208) 454-2766

LIFEWAYS
HELPING PEOPLE

MEDICAL SERVICES

The Lifeways Medical Department is committed to excellence in mental health, beginning with a thorough assessment and ongoing assistance in every aspect of psychiatric medication management. Our success is evident in our many patients who daily, find relief from depression, gain control over behaviors, or are able to sustain recovery from a range of psychiatric conditions. At Lifeways we integrate science-based treatments, utilizing leading research and compassionate, personalized care. Seeking assistance with a psychiatric difficulty can be frightening.

With that in mind, here is some of what you can expect from the Medical Department:

- Assessment and careful consideration of your needs
- Review your history of what has worked and what has not
- Treatment Plan we can agree on that ensures your best chance of success
- Adjustments to your medication when needed and tools to help you manage
- Compassionate professionals who treat you with respect and commit to your care

Last year our Medical Department team served 667 patients led by our Psychiatrist, along with several Physician Assistants and Registered Nurses, and provided more than 3,500 service contacts.

We know we are making a difference because our patients tell us so:

"For the first time in my life medication is really working well for me. I am productive again and held the same job for almost two years."

"I am happy for the first time ever! I am so thankful for the caring staff at Lifeways, they figured out what I needed and encourage me at each step along the way."

We will help people in our communities achieve and maintain emotional well-being.

LIFEWAYS ONTARIO	LIFEWAYS PENDLETON	McNARY PLACE	LIFEWAYS HERMISTON	LIFEWAYS FRUITLAND	LIFEWAYS CALDWELL
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RESIDENTIAL SERVICES BY LOCATION

ONTARIO:

Lifeways Recovery Center: 35 bed
Adult Addiction Treatment Facility

North Oregon: 5 bed
Women's Transition Residential Addiction Treatment

Burdic House: 5 bed
Supported Housing

Riverstone: 8 bed
Premier Addiction Treatment Center

1st Street House: 8 bed
Men's Transition Residential Addiction Treatment

4th Avenue: 5 bed
Psychiatric Security Review Board Facility

UMATILLA:

McNary Place: 16 bed
Non Hospital Acute Secure Residential Treatment Facility

HERMISTON:

Aspen Springs: 16 bed
Projected opening 2016
Acute Psychiatric Hospital

PENDLETON:

Hilltop House: 5 bed
2 Psychiatric Security Review Board
3 Residential Treatment

McKay House: 5 bed
Supported Housing

We will help people in our communities achieve and maintain emotional well-being.

LIFEWAYS ONTARIO	LIFEWAYS PENDLETON	McNARY PLACE	LIFEWAYS HERMISTON	LIFEWAYS FRUITLAND	LIFEWAYS CALDWELL
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Ontario, OR 97914	Pendleton, OR 97801	Umatilla, OR 97882	Hermiston, OR 97838	Fruitland, ID 83619	Caldwell, ID 83605
(541) 889-9167	(541) 276-6207	(541) 922-0880	(541) 567-2536	(208) 291-1020	(208) 454-2766

LIFEWAYS
HELPING PEOPLE

PREVENTION

Lifeways has a Prevention Specialist who will come to your school or organization and present a program adapted to the audience.

Prevention Services are a proactive approach to substance abuse in our community. We pay extra attention to the younger population, because that will have the greatest impact on the largest number of people.

Children and teens face incredible obstacles to resisting substances. Movies, television, magazines, music, friends, and even some adults promote smoking, alcohol and drug use. There are substances available to them now that were not available several years ago, and those substances are much more dangerous and addictive.

Treatment is late in the game — our best treatment is prevention. There are many articles and links on this site, and contacting us will provide answers to your questions.

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MENTAL HEALTH TREATMENT

At Lifeways, we meet the person right where they are, sometimes in response to crisis, but often just to help get them get back on track. We know life deals many challenges and obstacles, some of which can be debilitating and threatening to your job and relationships. Our holistic approach to mental health is built around a caring, compassionate professional team, with all the skills necessary to assess your challenges, and to collaborate with you on a plan for care to get you on track, back to functioning at your best.

All counseling begins with an assessment and development of a plan with agreed upon goals. Inclusion of the family and supports is encouraged and built in when possible. At Lifeways we treat all aspects of mental and behavioral health.

Our treatment is based on research and is client centered; we develop your plan of care with you.

Areas of expertise include but are not limited to;

- Attention and Hyperactivity Disorders
- Mood and Depressive Disorders
- Personality Disorders
- Post-Traumatic Stress Disorder
- Substance Abuse
- Autism Spectrum Disorders
- Obsessive-Compulsive Disorders
- Impulse Control Disorders
- Schizophrenia
- Eating Disorders

What some of our clients say about treatment:

"I didn't believe counseling would work for me. Last year I was hopeless but my counselor patiently led me out of the darkness and helped me feel like I really matter."

"When my wife died I lost control of my life and did not have anyone to turn to. I learned new ways of coping and after a lot feet dragging joined the Grief Group. Life isn't perfect but I am doing so much better."

"As a veteran and a senior I didn't have mental health problems. Being in treatment mostly helped me tell myself the truth about my life and the fact that I need people. My family has really seen the difference."

"My son has learned to identify his emotions and ask for help when he starts losing control. As a family we are no longer hopeless, we now have the tools to help him get through the rough times."

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PROBLEM GAMBLING SERVICES

There are many forms of problem gambling. If any kind of gambling is interfering with your life and relationships, chances are you or your loved one is a problem gambler. . .

A problem gambler might exhibit one or all of the following warning signs:

- Preoccupied with gambling and unable to stop
- Restless and irritable when not gambling
- Borrowing money for gambling
- Has frequent unexplained absences
- Losing work time because of gambling
- Jeopardizing a significant relationship or job by gambling
- Bragging about gambling, exaggerating wins & minimizing losses
- Gambling to "feel better"
- Lying to hide time spent gambling or unpaid debts
- Chasing losses (gambling to win back losses)
- Doing something illegal to get money for gambling

When Their Problem is Your Problem:

If you are the spouse or family member of a problem gambler, it is important for you to take care of yourself, stay in touch with your feeling and realize that you are not responsible for the gambler's behavior. There are specific things you can do to help you bring up the subject when you want to talk to someone about their gambling problem. **Call 889-9167 for the support and education you need. It's free.**

Responsible Gambling Guidelines:

Has the game become more than just a game for you? If you're playing for more than fun, try using these guidelines to moderate your play.

- Think of the money you lose as the cost of your entertainment. Consider any money you win a bonus.
- Set a dollar limit and stick to it.
- Set a time limit and stick to it.
- Leave when you reach your limit, whether you're winning or losing.
- Understand that you'll probably lose, and accept the loss as part of the game.
- Don't borrow money to gamble.
- Don't let gambling interfere with or become a substitute for family, friends or work.
- Don't chase losses. Chances are you'll lose even more trying to recoup your losses.
- Don't use gambling as a way to cope with emotional or physical pain.
- Know the warning signs of problem gambling.

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LIFEWAYS
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ELDERLY SUPPORT SERVICES

The mental health needs of seniors are often quite vague and different from the needs of younger populations; and their mental health problems are often complicated by increasing difficulties with physical health and loss of mental acuity.

Seniors Treatment Services can address these concerns and differences and, therefore, has a service delivery system that is able to utilize all the other agency components, as well as individualized services that enhance a person's care and/or independence in the community.

Lifeways works with many partner agencies in the community, such as Aging and People with Disabilities (APD), hospitals and assisted living.

Lifeways is an approved Medicare provider.

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LIFEWAYS
HELPING PEOPLE

INSURANCE

Will My Insurance Cover Treatment?

There are many providers of alcohol and drug treatment insurance. At Lifeways we want to make sure you have the best solution for your unique clinical needs. When inquiring about our premier services, we have qualified experts that work hard with your provider to ensure that you receive the maximum benefit available.

We know insurance can be confusing and complicated. We want to help you navigate through understanding what your insurance benefits are. We are here to walk with you through this process. Please call us at **541-889-2490** so we may begin to work with you on what your insurance carrier will do for you or a loved one. With your permission we are happy to contact your provider for you.

Lifeways addiction treatment programs promote quality of life for people through integrated healthcare services focused on prevention, intervention and wellness. Our holistic services are based on solid research and evidence based practices.

Our core philosophy is based on the recognition of addiction as a progressive and debilitating condition that has been scientifically proven to be overcome through treatment. Our highly trained professional staff at Lifeways use proven state of the art treatment approaches. We operate from a strength based model in conjunction with motivational interviewing to insure that everyone we treat gets the individualized program to meet their needs.

Call us any day, any time to ask questions or to begin the admission process.
541-889-2490

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CRITICAL INCIDENT STRESS DEBRIEFING

Critical incidents, which are threatening, overwhelming, or potentially traumatizing are an unfortunate part of some of the work we do, regardless of the industry we work within. Their occurrence can impact staff emotions, productivity, and cause turnover in highly taxing situations. Critical Incident Stress Debriefing (CISD) is a well-known and widely used process to reduce the emotional trauma individuals experience in these situations offered within the broader framework of Critical Incident Stress Management (CISM). CISM offers a variety of interventions to effectively respond to particular situations or group needs. The cornerstone of CISM is the stress debriefing process. Using the straight forward, non-therapeutic debriefing process in a timely manner following an incident can greatly reduce post-traumatic stress that individuals may experience after an incident. CISD seeks to enhance resistance to stress reactions, build individuals' resiliency or the ability to "bounce back" from a traumatic experience, and facilitate both a recovery from traumatic stress and a return to normal, healthy functions.

In the past year, Lifeways has made an effort to expand the number of trained staff able to provide Critical Incident Stress Debriefing and plans to offer the service free of charge to the communities within the Treasure Valley and Umatilla regions. Response time is important and each region has a complement of trained staff able to respond to a request for debriefing within 48 to 72 hours of the incident.

Our agency would like to further develop our CISD response teams by including trained individuals from a variety of community agencies. Individuals trained in CISD usually do not have mental health training but are part of a professional group such as police, fire, education, emergency services, medical, and the like. This provides a multidisciplinary, peer-led context to the stress debriefing, improving effectiveness. Training is offered by the International Critical Incident Stress Foundation at various sites throughout the year. If your organization would like to develop an individual to respond to critical incidents within and outside of your agency, I would hope that you would contact us with your interest. You can find further information about the CISD foundation at www.icisf.org.

If your organization would like to receive CISD services, these are accessed through our crisis line (Ontario 541-889-9167, Pendleton 541-276-6207). Please contact us as soon as possible after the incident occurs. We are pleased to be able to help.

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DEVELOPMENT DISABILITIES SUPPORT

Lifeways, Inc. serves adults and children in Malheur County who have disabilities attributable to mental retardation, Autism, Cerebral Palsy, Epilepsy, Asperger's, Traumatic Brain Injury, Fetal Alcohol Syndrome/Effect, Fragile X, Rhett's Disorder, Prader Willy, Tourette's Disorder, or any other neurological handicapping condition which requires training or support similar to that required by individuals with Intellectual Disability.

Eligibility and Services

Developmental Disability services are best secured while the client is a minor, because there are more records available when they are still in school. However, clients whose condition originated before age 22, can apply for services any time. Eligibility criteria are established by Federal and State law. Remember that these services are in addition to services you may be receiving from Social Security and are not based on income.

There is an application form on this site for you to print and submit to the DD program for review. There may be an eligibility screening, additional testing, and additional documents gathered. You can get more information by e-mail or by calling Lifeways at (541) 889-9167.

Once eligibility is established, the client is assigned a case manager who will assist with coordination of all services available through our program and other community programs, including advocating for those services and supports:

- Residential Services
  (including Group Homes and Adult Foster Homes)
- Vocational Services
  (supervised work experience, based on the individual's need)
- Family Support
- Crisis Diversion
- Protective Services
- Brokerage services
- Skills Training
- Personal Care Services

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SUPPORTED EMPLOYMENT PROGRAM

Supported Employment is an evidenced-based practice that helps people with psychiatric and/or substance disorders, find and maintain competitive jobs of their choice. Supported employment helps people find jobs in their communities with rapid job search, assistance with placement, integrated service support, personalized benefits planning and time un-limited support. Eligibility for this program is based upon client choice. No one is excluded because of prior work history, hospitalization history, substance use, symptoms, and personal decisions about medications, personal appearance, missed appointments with Mental Health Practitioner or other factors. Every person is encouraged to think about employment, and all interested people are referred to the SE Program at Lifeways.

Supported Employment Services:

- Develop Resources
- Assist in keeping the job
- Treatment Team Services...
- Assist in finding a job
- Recovery Oriented Treatment

Develop resources for consumer employment:

- Nurture community partnerships and potential agency resources
- Engage the community at large in the supported employment concept
- Develop competitive job opportunities

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COMMUNITY SUPPORT SERVICES

Community Support Services (CSS) is an outreach based team serving the seriously mentally ill adult population. Services include supported housing, supported employment, homeless outreach, intensive case management, outreach, psychiatric and nurse medication management, therapy, skills training, case management, daily structure and support, dual diagnosis treatment, peer-run programs, and a variety of therapy groups including Dialectical Behavioral therapy. CSS follows an evidence-based practice model which promotes empowering our consumers to realize their full potential and to recognize that recovery is possible for everyone.

Severe Mental Illness Support

Community Support Services

"CSS" is a longstanding Lifeways program of wraparound services for persistently and severely mentally ill people. The Malheur County Lifeways program is renowned in the state as being a model for other counties. Wraparound services are anything that a specific client needs and may include financial management, medication management, supported employment, or daily living tasks such as shopping, cooking and cleaning, family education, and housing.

You can contact the CSS Program Manager by e-mail or by calling your regional office.
This is also a good starting place if:

- You are a family member who needs support/education for your loved one's mental illness;
- You want to attend a monthly provider meeting, to learn more about caring for mentally ill people;
- If you are interested in becoming a personal care provider or adult foster home provider

We encourage you to visit our online Resource Center for specific information about mental illness.

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PEER SUPPORT SPECIALIST PROGRAM

The peer support specialist program is a program designed to help clients in all stages of recovery. We have first-hand experience with mental illness and the challenges that come with it. Despite those challenges we have come to know the reality of wellness. We believe recovery is possible for everyone and our hope is to reach out to our peers.

As Peer Support Specialists, we help clients develop their own recovery by recognizing personal strengths and setting goals. As clients, we too have gone through this process and now share a unique empathy and perspective.

Peer Support Specialist can help with:

- Appointments
- Assistance with paperwork
- Cooking classes
- Employment search assistance
- Housing resource
- Life skills building
- Outreach services
- Recreational activitieS
- Art and music activities
- Benefits acquisition
- Education on recovery
- Goal setting
- Interpersonal skill-building
- Orientation to mental health center
- Pathways to recovery
- Socialization

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LIFEWAYS
HELPING PEOPLE

CHILD PARENT PSYCHOTHERAPY
C P P

Child-Parent Psychotherapy is a treatment for children **age 0 to 5** who have experienced a traumatic event (abuse, exposure to domestic violence, sudden or traumatic death of someone close) and/or are experiencing mental health, attachment, or behavioral problems, including PTSD.

GOALS OF CPP:

- Support & strengthen relationship between child & caregivers in order to improve child functioning,
- Help caregivers understand how the child's and caregiver's experience with trauma may affect the child's functioning and development.

The Child and Adolescent Services Program at Lifeways offers a number of options for struggling families.

Call 541-889-9167 to schedule an assessment with a mental health specialist who will help you identify the right program for your family.

How do I find out more about PCIT and CPP in my area?

Call **Lifeways at 541-889-9167** and request that a **PCIT or CPP** therapist contact you by phone.

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PARENT CHILD INTERACTION THERAPY
PCIT

Parent Child Interaction Therapy is an evidence based treatment for children **age 2 to 7** experiencing emotional and behavioral problems.

KEY FEATURES:

- We work with parents and children together to improve the quality of daily interactions.
- We provide parents with direct coaching during live practice managing their child's behavior.
- We work with parents, foster parents, grandparents; anyone in a caregiving role.

GOALS OF PCIT:

- Improve family relationships,
- Increase caregiver self-confidence and reduce parenting stress,
- Improve child listening & minding, self-esteem, social skills, and attention skills,
- Improve child's ability to handle frustration and other strong emotions,
- Services available in English and Spanish.

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ASSERTIVE COMMUNITY TREATMENT

Assertive Community Treatment (ACT) is an Evidence-Based Practice Model designed to provide treatment, rehabilitation, and support services to individuals who are diagnosed with a severe mental illness, and whose needs have not been well met by more traditional mental health services.

The ACT team provides services directly to an individual that are tailored to meet his or her specific needs. The ACT team is multi-disciplinary and include members from the fields of psychiatry, nursing, psychology, social work, substance abuse and vocational rehabilitation. Based on their respective areas of expertise, the team members collaborate to deliver integrated services of the recipients' choice, assist in making progress towards goals, and adjust services over time to meet recipients' changing needs and goals.

The staff-to-recipient ratio is small (one clinician for every ten recipients), and services are provided 24 hours a day, seven days a week, for as long as they are needed.

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LIFEWAYS INTEGRATION FOR TREATMENT
LIFT

Living well with chronic medical issues while recovering from mental illness is a difficult task. We understand that achieving wellness means a person's physical and mental health must both be cared for in a thoughtful and individualized manner. Our bodies and minds work together in complex ways, and the professionals caring for you should too. Guided by a care coordinator, the LIFT Demonstration Project brings together your mental health and physical health care providers to create a plan for your care.

Your goals are important to us, so you are a critical part of this team.

In the LIFT project, you should expect:

- To set and achieve goals leading to positive outcomes in your mental and physical health
- Access to preventative and community based services to help you achieve wellness
- A team individually created to fit you and your family's healthcare needs; your care team is made up of people who you choose to invite to participate
- Professional help from registered nurses, physicians, dentists, pharmacists, dieticians, drug & alcohol, and mental health professionals
- To actively participate in LIFT Team meetings to identify your needs and concerns, and develop a plan with you at the center
- Consistent support from your LIFT Team members to help you progress in your plan of care.

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SUBSTANCE ABUSE TREATMENT

People needing to access Alcohol and Drug Treatment Services can walk-in Monday through Thursday, 9am to 3pm to complete the intake process and be seen by an Alcohol and Drug Counselor for the purposes of completing an Assessment. Appointments can also be made for an Assessment, if needed, after the intake process has been completed.

Alcohol and Drug Treatment consists of but is not limited to Individual Counseling, Group Counseling, and Monitoring of abstinence from mood altering chemicals through random testing and Case Management Services with referral sources with the written permission of the client.

Lifeways Prevention & Recovery Services are certified by the State of Oregon to provide a wide range of Alcohol and Drug Treatment Services. We provide education and treatment in the effects of Drugs and Alcohol. Cognitive change as it relates to the use of drugs and alcohol and Relapse Prevention Planning. Intensive Outpatient Treatment is also offered 5 days per week.

DUII Treatment Services for those needing to satisfy a court requirement for treatment for Driving Under the Influence of Intoxicants in the State of Oregon are also provided. Lifeways Prevention & Recovery Services provides services in both English and Spanish.

Lifeways has funding to underwrite a sliding fee for treatment for Oregon residents allowing the cost of treatment to become more affordable. Application for reduced fees is required to be completed in order to qualify for reduced fees.

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Lifeways
Rebuilding Lives

When an individual, couple or family wishes to make positive changes in their life, they may need the assistance of an experienced professional to help guide them in making those changes. A counselor can help ease this process by getting to know the background(s), personality and goals. Additionally, he or she can help to uncover and determine factors or traits that keep individuals from achieving and completing the necessary steps in order to be successful.

You are who you are. By the time a person comes to counseling, they most likely have developed habits, thoughts and ideas over the course of their lifetime. Because these have affected their life over a long period of time, carefully planned counseling needs to slowly occur in order to find permanent solutions and determine ways to make healthy changes.

Counseling can, with commitment and hard work, be a very effective tool to improve countless lives for those dealing with dysfunctional relationships, addictions, trauma, anxiety, depression, troubled marriages or compulsions.

Are you ready to move in a new direction with your life? Let us help you discover your true potential and acquire the skills, attitudes, and resources necessary to pursue a productive and satisfying life.

LIFEWAYS HELPING PEOPLE

702 Sunset Drive | Ontario, Oregon 97914
Phone (541) 889-9167 | Fax (541) 889-7873
www.lifeways.org

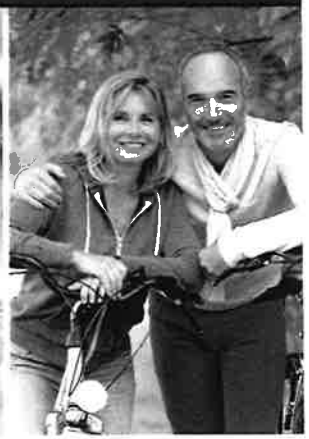
Lifeways is the largest behavioral health care provider in the region with nearly 250 employees at all locations. Lifeways is licensed to serve in Idaho and is certified to provide mental health and addiction services by the State of Oregon. The agency holds a Certificate of Credentialing from Greater Oregon Behavioral health Inc., and is a member of the National Council of Community behavioral Health Care as well as the National Association of County Behavioral Health Care.

Medical & Psychiatric Providers

- Amy Boudreau, MD & PhD
  Hermiston
- Si Steinberg, MD
  Medical Director
- John Bates, MD,
  Lifeways Recovery Center
  McNary Place & Caldwell
- Morris Smith, MD
  Lifeways Recovery Center
- Alexander E. Horwitz, MD
  Telepsychiatry
- Sandra Lare, DO
  Umatilla County

"We will help people in our communities achieve and maintain emotional well-being."

Welcome To Lifeways



Comprehensive Mental Health and Addiction Services

Servicios de trandicción (Español)

LIFEWAYS HELPING PEOPLE
www.lifeways.org

OUR SERVICES

Outpatient Mental Health Services:

- Assertive Community Treatment (ACT)
- Adult Foster Home – six state licensed homes
- Community Support Services (CSS)
- Developmental Disabilities (DD)
- Employee Assistance Program (EAP)
- Early Assessment Support Alliance (EASA)
- Forensics Case Management & Treatment
- Intensive Outpatient Counseling
- Lifeways Integration For Treatment (LIFT)
- Medication Management
- Psychiatric Security Review Board Services
- Supported Employment (SE)
- Transportation Services – Umatilla

Outpatient Addiction Services

- Alcohol and Drug Prevention Services
- Gambling Treatment Services
- Prevention Services
- Mental Health Services
- DUI

Children and Adolescence Services

- School Based Services
- Mental Health Services
- Addiction and Mental Health Services
- Child Parent Psychotherapy (CPP)
- Parent Child Interaction Therapy (PCIT)

Community Services

- Critical Incident Stress Debriefing (CISD)
- Mental Health First Aid

RESIDENTIAL SERVICES

McNary Place: *Umatilla*
16 bed non-hospital Acute Secure Residential Treatment Facility

Pendleton Stabilization Unit:
23 hour Crisis Stabilization & Observation

Hilltop House: *Pendleton*
5 bed; 2 Psychiatric Security Review Board; 3 Residential Treatment

McKay House: *Pendleton*
5 bed Supported Housing

Lifeways Recovery Center: *Ontario*
35 bed Adult Addiction Treatment Facility

Riverstone : *Ontario*
8 bed Premier Addiction Treatment Center

North Oregon: *Ontario*
5 bed Women's Transition Residential Addiction Treatment

1st Street House: *Ontario*
8 bed Men's Transition Residential Addiction Treatment

Aspen Springs: *Hermiston*
16 bed Projected opening 2016
Acute Psychiatric Hospital

Burdic House: *Ontario*
5 bed Supported Housing

4th Avenue: *Ontario*
5 bed Psychiatric Security Review Board Facility

OUTPATIENT SERVICES

ONTARIO **541-889-9167**
702 Sunset Drive
Ontario, OR 97914
Toll Free: 800-995-9169

PENDLETON **541-276-6207**
331 SE 2nd Street
Pendleton, OR 97801
Toll Free: 866-343-4473

HERMISTON **541-567-2536**
595 NW 11th Street
Hermiston, OR 97838
Toll Free: 866-343-4473

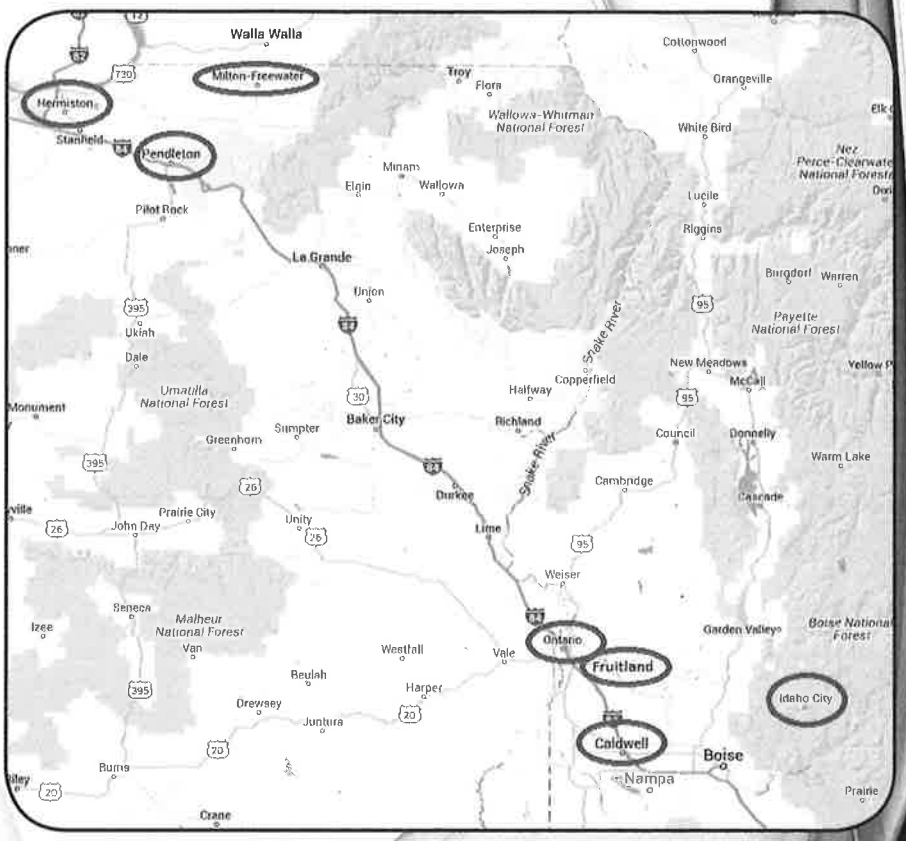
MILTON-FREEWATER **541-276-6207**
299 N. Columbia
Milton-Freewater, OR 97862
Toll Free: 866-343-4473

FRUITLAND **208-291-1020**
1611 N. Whitley Drive # 7
Fruitland, ID 83619

CALDWELL **208-454-2766**
2609 S. 10th Ave. Ste. 102
Caldwell, ID 83605

WEISER MEMORIAL HOSPITAL **208-291-1020**
645 E. 5th Street
Weiser, ID 83672

IDAHO CITY **208-454-2766**
100 Centerville Road
Idaho City, ID 83631



LIFEWAYS
HELPING PEOPLE

LIFEWAYS ONTARIO
702 Sunset Drive
Ontario, OR 97914
(541) 889-9167

LIFEWAYS PENDLETON
331 SE 2nd Street
Pendleton, OR 97801
(541) 276-6207

McNARY PLACE
290 Willamette Street
Umatilla, OR 97882
(541) 922-0880

LIFEWAYS HERMISTON
595 N.W. 11th Street
Hermiston, OR 97838
(541) 567-2536

LIFEWAYS FRUITLAND
1611 N. Whitley Drive
Fruitland, ID 83619
(208) 291-1020

LIFEWAYS CALDWELL
2609 S. 10th Ave. Ste. 102
Caldwell, ID 83605
(208) 454-2766

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, February 10, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Docket No. 16-0715-1501	PENDING FEE RULE: Behavioral Health Programs	**Jamie Teeter** Division of Behavioral Health
Docket No. 16-0720-1501	PENDING RULE: Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs	**Jamie Teeter**
Docket No. 16-0717-1501	PENDING RULE: Alcohol and Substance Use Disorders Services	**Jamie Teeter**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, February 10, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the Senate Health and Welfare Committee (Committee) meeting to order at 3:02 p.m.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Nuxoll to conduct the rules review.
DOCKET NO. 16-0715-1501	**Rules of the Department of Health and Welfare Relating to Behavioral Health Programs**. **Jamie Teeter**, Bureau Chief of the Division of Behavioral Health in the Department of Health and Welfare (Department), presented this docket.

Ms. Teeter noted that she was making this presentation to the Committee to provide follow-up testimony regarding a previous presentation about this docket. **Ms. Teeter** stated that this docket establishes a new chapter of rules entitled "behavioral health programs" and the purpose of the new chapter is to move toward an integrated behavioral health system of care that includes both mental health and substance use disorder providers. Two weeks ago, the Committee directed the Department to collaborate further with the Idaho Association of Community Providers (IACP). Today, they are united. **Ms. Teeter** reported that the Department is committed to working with all stakeholders to establish a long-term solution to provider certification. **Ms. Teeter** stated the importance of the docket is threefold: (i) it establishes an integrated behavioral health certification for mental health and substance use disorder providers, (ii) it streamlines an already existing required process for substance use disorder providers to obtain State approval and (iii) it opens a voluntary pathway for mental health providers to obtain State approval.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Martin asked Ms. Teeter to refresh his memory regarding the proposed fee increase. **Ms. Teeter** responded that the rule established a $100 fee for each treatment provider/facility. She reminded the Committee that the existing rule also included a $50 fee for recovery support providers, but noted that, under the pending rules, recovery support providers were not required to pay this fee.

TESTIMONY: **Vice Chairman Nuxoll** invited testimony.

Greg Dickerson, Mental Health Director of Idaho Association of Community Providers, Inc. (IACP), testified in support of this docket. **Mr. Dickerson** stated that he had voiced IACP's opposition to the pending rules during a Committee hearing earlier this session. As a result of an agreement with the Department to address IACP's concerns through negotiated rulemaking, the IACP now supports the pending rules. The Department and IACP will address such issues as cost, time lines, substance abuse service integration and access.

Amy Jeppesen, Substance Use Disorder Director of IACP, testified in support of this docket. **Ms. Jeppesen** stated that the rules will create better access to health care in Idaho. **Senator Schmidt** asked Ms. Jeppesen to explain why she feels the redesign of the pending rules will improve access. **Ms. Jeppesen** responded that the substance abuse and the behavioral health rules provide an easier pathway for providers to be credentialed, thereby reducing administrative work and giving providers more time to spend with patients.

Darren Richman, Owner of Ascent Behavioral Health Services, LLC, testified in support of this docket. **Mr. Richman** stated that he believes the pending rules will streamline the current certification process for providers.

MOTION: There being no more questions, **Senator Martin** moved to approve **Docket No. 16-0715-1501**. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0717-1501 **Rules of the Department of Health and Welfare Relating to Alcohol and Substance Use Disorders Services**. **Jamie Teeter**, Bureau Chief of the Division of Behavioral Health in the Department, presented this docket.

Ms. Teeter stated that the pending rules have two main purposes: (i) to provide participant eligibility criteria, application requirements and an appeals process for services administered under the Department's Division of Behavioral Health and (ii) to establish requirements for the quality of substance use disorders treatment, care and services provided by behavioral health and recovery support services programs. Ms. Teeter reviewed the detailed changes made in this docket. **Ms. Teeter** noted that this pending rule meets the directive of the Alcoholism and Intoxication Treatment Act by establishing requirements for the quality of substance use disorders treatment, care and services provided by behavioral health providers.

Ms. Teeter stated that the Department held negotiated rulemaking in June 2015 in three locations across Idaho: Idaho Falls, Boise and Lewiston. In addition to the on-site meetings, the Department arranged for individuals in locations outside of the meeting areas to participate via teleconference. **Ms. Teeter** reported that the feedback from negotiated rulemaking was overwhelmingly positive. She said there is no fiscal impact to the General Fund.

Vice Chairman Nuxoll asked the Committee members if they had any questions.

Senator Schmidt asked if providers, who provide care in a methadone treatment program, are required to enter data into the Idaho prescription monitoring program. **Ms. Teeter** stated that federal regulations do not require entry into that system.

Senator Jordan asked why the section on criminal history and background checks has been deleted. **Ms. Teeter** replied that the section was deleted because it duplicated existing rules related to criminal history background checks.

Regarding eligibility for substance use disorder services, **Vice Chairman Nuxoll** asked Ms. Teeter to explain how the Department would limit or prioritize services by "imposing income limits." **Ms. Teeter** responded because of limited funding, the Department has to set income parameters for people eligible to receive substance use disorder services.

Senator Lee asked why the definition of a child was removed in the pending rules and adolescent was redefined as anyone 18 years of age or younger. **Ms. Teeter** responded that these changes were made based on a recommendation received from the Idaho Department of Juvenile Corrections to address certain gaps in treatment service coverage.

Vice Chairman Nuxoll noted that staff training for adolescent residential treatment services must include cultural, sensitivity and diversity training. She asked Ms. Teeter to clarify what was meant by "cultural sensitivity and diversity." **Ms. Teeter** replied that there's a movement in the behavioral health community to make sure services are provided in a culturally sensitive manner. She stated that treatments may differ across cultures. **Vice Chairman Nuxoll** asked Ms. Teeter to explain how a treatment could be different. **Ms. Teeter** responded that services may vary based upon a person's socio-economic status, race, ethnicity and age.

MOTION: There being no more questions, **Senator Schmidt** moved to approve **Docket No. 16-0717-1501**. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0720-1501 **Rules of the Department of Health and Welfare Relating to Alcohol and Substance Use Disorders Treatment and Recovery Support Services, Facilities and Programs**. **Jamie Teeter**, Bureau Chief of the Division of Behavioral Health in the Department, presented this docket.

MOTION: There being no questions, **Senator Martin** moved to approve **Docket 16-0720-1501**. **Chairman Heider** seconded the motion. The motion carried by **voice vote**.

PASSED THE GAVEL: Vice Chairman Nuxoll passed the gavel back to Chairman Heider.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:33 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Kara Machado
Assistant

AMENDED AGENDA #2

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, February 11, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
RS24072C1	Relating to Epinephrine Auto-Injectors	**Chairman Heider**
RS24456	Relating to Suicide Prevention	**Senator Fred S. Martin**
S 1231	RELATING TO CHIROPRACTIC PRACTICE: Amending, Section 54-704, Idaho Code, to revise restrictions relating to prescribing, dispensing, independently administering, distributing, directing or suggesting to patients certain drugs, substance or products.	**Roger Hales** Attorney, Bureau of Occupational Licenses
Presentation	Idaho's Community Health Centers	**Yvonne Ketchum** Idaho Primary Care Association **Mike Baker** Heritage Health **Heidi Traylor** Terry Reilly Health Services

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, February 11, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:02 p.m.
RS 24072C1	**Relating to Epinephrine Auto-Injectors**. **Chairman Heider** presented this RS.
	Chairman Heider reviewed the history of bills relating to epinephrine auto-injectors. **Chairman Heider** stated that there is no mechanism in current statute for individuals to buy epinephrine auto-injectors without a doctor's prescription. This legislation would allow pharmacists to prescribe and sell epinephrine auto-injectors to those in need.
MOTION:	There being no questions, **Vice Chairman Nuxoll** moved to send **RS 24072C1** to print. **Senator Martin** seconded the motion. The motion carried by **voice vote**.
RS 24456	**Relating to Suicide Prevention**. **Senator Martin** presented this RS.
	Senator Martin recognized Senator Schmidt for his drafting assistance. This legislation proposes that suicide prevention services be added to statute as part of the mission of the Department of Health and Welfare (Department).
	Chairman Heider asked the Committee members if they had any questions.
	Senator Schmidt asked about the fiscal impact of the legislation. **Senator Martin** answered the Department is currently providing some suicide prevention services. He stated his hope for eventual appropriations from the State to expand suicide prevention services in Idaho.
MOTION:	There being no further questions, **Senator Harris** moved to send **RS 24456** to print. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.
S 1231	**Relating to Chiropractic Practice**. **Roger Hales**, Administrative Attorney for the Idaho Board of Chiropractic Physicians (Board) in the Bureau of Occupational Licenses, presented this bill.

Mr. Hales recognized in attendance: Dr. Mary Jo White, Chairman of the Board; Alex Adams, Executive Director of the Idaho Board of Pharmacy; and Berk Fraser, Deputy Executive Director of the Idaho Board of Pharmacy. First, **Mr. Hales** stated that this bill clarifies the prohibition against chiropractors' use of legend or prescriptive drugs in their practice. The bill set forth specific prohibited acts by chiropractors, including prescribing, dispensing, independently administering, distributing, directing or suggesting to patients the use of legend or prescriptive drugs. The language updates make clear which substances are legend or prescription drugs. Second, **Mr. Hales** stated that the bill adds "Rx only" to the labeling provisions used to identify legend or prescriptive drugs. Third, he stated that the statute is being amended to clarify that the prohibition applies to not only prescriptive products, but also prescriptive drugs and substances.

Mr. Hales noted that the Board held several open meetings to discuss the proposed changes. The current language of the bill was approved by the Board in July 2015. The Board sent a final letter in January 2016 to all licensees stating the Board's intention to propose this bill.

Chairman Heider asked the Committee members if they had any questions.

Senator Harris asked whether the Board received comments in opposition to these changes, and if so, what were the comments. **Mr. Hales** answered that chiropractors expressed concerns with this bill. He stated that the bill closes potential loopholes in the current statute regarding the use of legend or prescriptive drugs. **Mr. Hales** stated that there is a process for chiropractors to obtain rights to dispense legend or prescriptive drugs under the law. **Mr. Hales** reiterated that the intent of this bill is simply to eliminate confusion regarding chiropractors' use of legend of prescriptive drugs in their practice.

Senator Schmidt asked if the current language of the statute has resulted in the Board being unable to enforce the law. **Mr. Hales** replied that chiropractors have raised the issue of whether or not they have statutory authority to use legend or prescriptive drugs. There are several Attorney General opinions that indicate the statute does not support the use of legend or prescriptive drugs by chiropractors.

Senator Hagedorn asked if there is a formulary for chiropractors in Idaho Code. **Mr. Hales** responded that there is not a formulary under the current act. **Senator Hagedorn** asked if the Board intended to create a formulary for chiropractors in the future. **Mr. Hales** answered that the Board is charged with protecting the public, and currently does not have plans to create a chiropractic formulary. Typically, **Mr. Hales** stated that expansion of the scope of practice is usually left to professional associations.

TESTIMONY: **Chairman Heider** invited testimony.

Dr. James Hollingsworth, chiropractic physician, testified in opposition to the proposed bill. He has been a practicing chiropractic physician for 34 years. Addressing the questions regarding a chiropractic formulary, **Dr. Hollingsworth** stated that there have been attempts in the past to establish such a formulary. **Dr. Hollingsworth** stated that chiropractors began using vitamin B12, folic acid and other substances in a variety of forms when they were not labeled "Rx only." And he discussed the change in federal law that redefined "Rx" to include the substances mentioned above. **Dr. Hollingsworth** informed the Committee that there is a clinic in Pocatello that sees hundreds of patients and administers these types of injections. There has never been a problem. **Dr. Hollingsworth** stated that this proposed bill would limit his ability to properly advise his patients. He indicated that within the last two years he has administered approximately 650 vitamin B12 injections. He commented that there has to be something better than this proposed bill.

Senator Lee asked if he believed the existing statutory language authorized chiropractors to direct and advise patients, as well as give certain injections. **Dr. Hollingsworth** answered by reading Idaho Code § 54-704(1). He commented that the phrase "clinical nutritional methods" is not limited to oral or topical medicines.

Senator Martin asked if the changes in the proposed bill meant that Dr. Hollingsworth would not be able to administer the injections he currently administers. **Dr. Hollingsworth** responded that changes in the federal statute resulted in questions about a chiropractor's authority.

Senator Schmidt read Idaho Code § 54-704(2)(b) and commented that he believes the language clearly prohibits chiropractors' use of legend or prescriptive drugs. **Senator Schmidt** stated his support for the bill.

Dr. Mary Jo White, Chairman of the Board, testified in favor of the proposed bill. **Dr. White** reviewed the legislative and rulemaking histories related to the prohibition against chiropractors' use of legend or prescriptive drugs. Referencing earlier testimony that there have never been complaints regarding chiropractors' use of injectables, **Dr. White** reported that the Board has received complaints. Also, questions arose whether or not chiropractors were authorized to buy injectables. Given the problems and questions surrounding this issue, the Board was compelled to clarify the chiropractor's scope of practice. She noted that many chiropractors do not support this change. She acknowledged that this was not an easy decision, but it is a good decision.

Senator Hagedorn commented that in the past, chiropractic training included some naturopathic training and now there are naturopathic physicians. He asked if current chiropractic training includes naturopathic training. **Dr. White** answered that in the core chiropractic education, which is standardized and accredited, there is no naturopathic training. She noted that this training is offered in advanced degrees.

Molly Steckel, Idaho Medical Association, testified in support of the proposed bill. She stated that complaints have been received by physicians whose patients have had problems with these types of treatments. **Ms. Steckel** stated that providers need clarification regarding this issue and this bill provides that clarification.

Ryan Fitzgerald, Idaho Association of Chiropractic Physicians (IACP), testified regarding the proposed bill. He stated that the Board should consider chiropractors' current practices when revising their scope of practice. Preventing chiropractors from doing what they have always done will restrict patient access. **Mr. Fitzgerald** expressed his disappointment that the companion bill to this piece of legislation will not be considered by the Senate. **Mr. Fitzgerald** reiterated his belief that this legislation will restrict patient choices and access and expressed his desire to continue working with the Board and the Legislature to find a solution to this issue.

Senator Schmidt asked if Mr. Fitzgerald opposed the proposed legislation. **Mr. Fitzgerald** responded that the question was impossible to answer because there are patients who will be negatively impacted by this bill, but he understands the need to regulate the practice.

CLOSING: In conclusion, **Mr. Hales** stated that the Board is trying to clarify the statutory prohibition. He stated that this bill is not the right vehicle for addressing scope of practice changes.

Vice Chairman Nuxoll commented that the Affordable Care Act caused the current conflict. She noted that she voted to send this bill to print if the companion bill was also advanced. The Idaho House has decided not to hear the companion bill. She felt that this bill, by itself, restricted patient choice and patient access and is a restraint of trade. She noted that the Committee just passed a bill regarding epinephrine auto-injectors, but yet a bill that would allow chiropractors to give injections cannot pass. She indicated that she has a personal interest in this legislation because of her daughters' circumstances.

MOTION: There being no more questions, **Vice Chairman Nuxoll** moved to hold **S 1231** in Committee until the companion bill is advanced. **Senator Harris** seconded the motion.

SUBSTITUTE MOTION: **Senator Lee** moved to send **S 1231** to the floor with a **do pass** recommendation. **Senator Hagedorn** seconded the motion.

Senator Hagedorn stated that the problem has existed for many years and this proposed bill is a first step in addressing this problem. He acknowledged that, in the future, the Legislature can revise the scope of practice and set training requirements for injectables. He does not believe this bill restricts patients' access because they can obtain these types of services from other physicians.

The substitute motion carried by **voice vote**. **Vice Chairman Nuxoll** and **Senator Harris** asked to be recorded as voting nay. No vote was taken on the original motion. Senator Lodge will carry the bill on the floor of the Senate.

PRESENTATION: **Idaho's Community Health Centers**. **Yvonne Ketchum**, Chief Executive Officer of the Idaho Primary Care Association, **Heidi Traylor**, Chief Executive Officer of Terry Reilly Health Services and **Mike Baker**, Chief Executive Officer of Heritage Health, made this presentation before the Committee (see attachments 1 and 2).

Ms. Ketchum presented an overview of Community Health Centers (CHCs) in Idaho. **Ms. Ketchum** discussed (i) the services provided by CHCs, (ii) the transformation of CHCs into patient-centered medical homes, (iii) the value of providing care to the uninsured in Idaho and (iv) the locations of CHCs across Idaho (see attachment 1).

Ms. Traylor continued the presentation. She provided the Committee with an overview of Terry Reilly Health Services (TRHS). **Ms. Traylor** discussed TRHS's (ii) history, funding and certifications, (ii) strategic goals, (iii) patient demographics and (iv) behavioral health integration (see attachment 1).

Mr. Baker continued the presentation. He discussed CHCs in northern Idaho. **Mr. Baker** stated that CHCs are responsive to people that matter the most: the patients. He commented on Heritage Health's ability to work pro-actively to connect with patients. **Mr. Baker** recognized the Kroc Center in Coeur d'Alene and discussed the center's successes (see attachment 1).

Chairman Heider asked the Committee members if they had any questions.

Senator Martin asked Ms. Traylor to describe who Terry Reilly was as a person. **Ms. Traylor** commented that he was the founder of the Terry Reilly health organization. He started a clinic in his home in Nampa. Mr. Reilly was the first to receive federal funding to start a CHC in Idaho. Mr. Reilly was a State Senator.

Senator Lodge asked what NCQA Level III recognition is. **Ms. Traylor** responded that NCQA is a national organization that accredits primary care practices as patient-centered medical homes. There are three levels of accreditation based on many standards, including patient access, patient-centeredness, complexity of services offered and the ability to track referrals. Level III is the highest level of accreditation.

Senator Schmidt asked if access to services is limited based on the insurance status if its patients. **Mr. Baker** answered that patients cannot be turned away, regardless of insurance status. He stated that the organization must operate under a viable model and that is why a balanced payer mix is important. **Senator Schmidt** asked how CHCs maintain a balanced mix of payers. **Mr. Baker** replied that the clinics need to provide really great services. He stated that the expansion of services has helped Heritage Health attract new patients.

Senator Hagedorn asked how well-coordinated the CHCs are across Idaho. He also asked if the services offered by CHCs are comparable throughout the state. **Ms. Ketchum** responded that the Idaho Primary Care Association is a membership organization. The Idaho Primary Care Association connects CHCs together to problem solve and share information. **Mr. Baker** stated that the relationships between the CHCs and the local hospitals is critical.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:31 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Michael Jeppson
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Thursday, February 11, 2016

ATTACHMENT 1

Yvonne Ketchum-Ward , CEO
Idaho Primary Care Association

Heidi Traylor, CEO
Terry Reilly Health Services

Mike Baker, CEO
Heritage Health

IDAHO'S COMMUNITY HEALTH CENTERS

SENATE HEALTH AND WELFARE COMMITTEE

February 11, 2016

IPCA
IDAHO PRIMARY CARE ASSOCIATION

WHO ARE IDAHO'S COMMUNITY HEALTH CENTERS?

Community Health Centers (CHCs) are a Tremendous Value to Idaho

- In 2014 served 156,651 patients (nearly 1 in 10 Idahoans)
- 72 clinic sites in 47 communities
- Health services available on a sliding fee or nominal fee
- Recognized patient centered medical homes
- High quality primary medical, dental & behavioral health services
- Pharmaceuticals are accessible at a discounted rate
- Have an ongoing Quality Improvement/Quality Assurance (QI/QA) program

COMMUNITY FOCUSED SERVICES

- CHCs are all community-based nonprofit organizations
- They deliver essential medical, dental and behavioral health services to everyone, including those without insurance, residents of rural and underserved areas, and Medicare, Medicaid and private insurance patients
- Each CHC is governed by a community board, a majority of whom are patients of the CHC, assuring a strong community voice in determining how healthcare services are designed and delivered

IPCA
IDAHO PRIMARY CARE ASSOCIATION

HIGH QUALITY PRIMARY CARE

Idaho's Community Health Centers deliver coordinated primary care that:

- Is the foundation of Idaho's healthcare system
- Is focused on wellness, prevention and chronic disease management. CHCs serve their local communities by providing a wide range of basic healthcare needs
- Reduces disease through treatment and prevention, reduces the economic costs of poor health, and reduces the use of emergency and hospital visits
- Helps manage the control of routine illnesses and increases patient compliance of medical treatments

IPCA
IDAHO PRIMARY CARE ASSOCIATION

LEADING PATIENT CENTERED MEDICAL HOME TRANSFORMATION

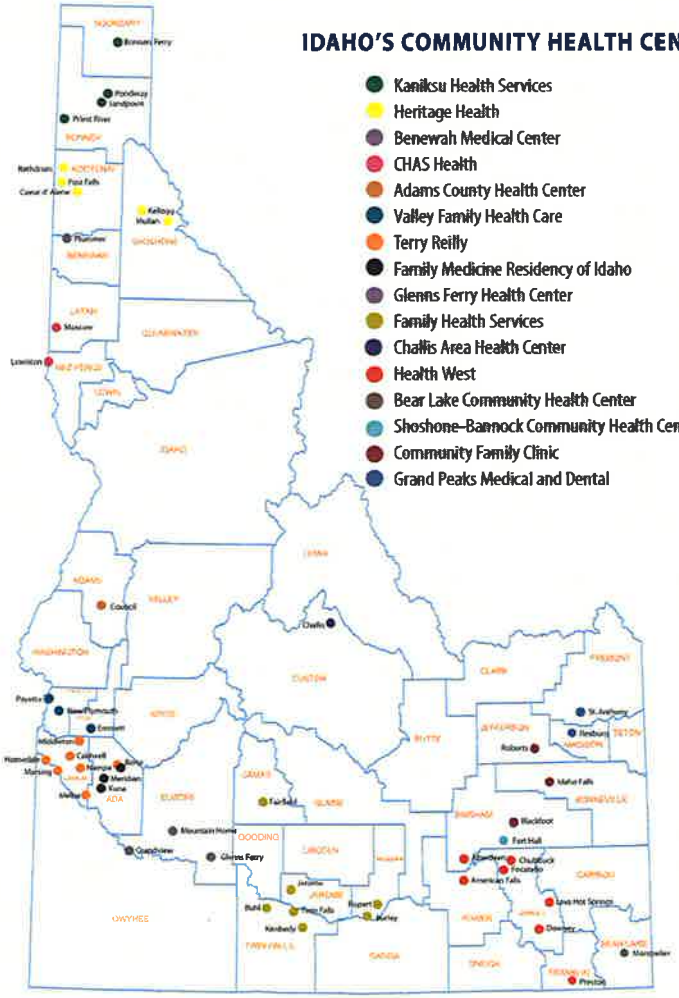
- CHCs are rapidly preparing for the future Idaho healthcare environment by transforming their practices into patient centered medical homes (PCMH)
- PCMH is team-based care focused on prevention, managing chronic illness and better coordination across the delivery system to improve quality and reduce costs
- This model promotes a close relationship with the primary care provider and their care team, while maximizing the use of health information technology

IPCA
IDAHO PRIMARY CARE ASSOCIATION

THE VALUE OF PROVIDING CARE TO THE UNINSURED IN IDAHO

- The cost arising from lack of health insurance coverage – increased morbidity and mortality, reduced financial security, lost productivity – is borne by families, employers and society generally
- This cost burden is shifted to others – including county and state indigent care programs, charity care, and more. CHCs reduce cost-shift by providing the uninsured with high quality care that is coordinated, prevention focused, and supports consistent management of chronic illness

IPCA
IDAHO PRIMARY CARE ASSOCIATION



IDAHO'S COMMUNITY HEALTH CENTERS

- Kaniksu Health Services
- Heritage Health
- Benewah Medical Center
- CHAS Health
- Adams County Health Center
- Valley Family Health Care
- Terry Reilly
- Family Medicine Residency of Idaho
- Glenns Ferry Health Center
- Family Health Services
- Challis Area Health Center
- Health West
- Bear Lake Community Health Center
- Shoshone-Bannock Community Health Center
- Community Family Clinic
- Grand Peaks Medical and Dental

TERRY REILLY

Your Health. Our Mission.

Integrated Care

Heidi Traylor, CEO

Who is Terry Reilly

Community Health Clinic since 1971

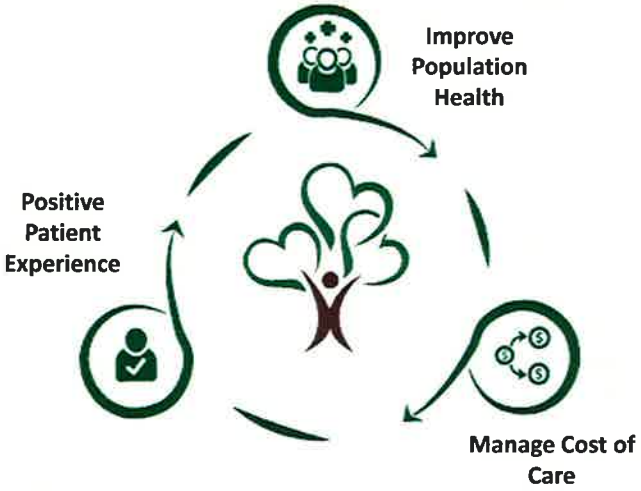
- A Community Health Center located in Southwest Idaho in operation for 45 years
- Funded as a:
  - Community Health Clinic
  - Migrant Health Center
  - Health Center for the Homeless
- Service area includes:
  - Ada, Canyon and Owyhee Counties
- Joint Commission Accredited
- NCQA Level III Recognized
- Over 300 employees and $24 million in annual operations

Strategic Goals

Building for today, designing for tomorrow

Today
- Cross-disciplinary team based care
- Seamless referral and care coordination
- Proactive outreach and disease management

Future
- Transition of care teams
- Patient engagement, education and wellness
- Enhanced use of technology



Today
- Data driven, high quality health care
- Multi-disciplinary, integrated services
- Chronic, Acute and Preventative Care across Life Cycle
- Targeted special population activities

Future
- Clinical Pharmacy
- Enhanced patient management
- Expanded integration of care

Today
- Active Outreach and Enrollment efforts
- Sliding Fee Discount
- 340 B Pharmacy

Future
- Expanded partnership with hospitals and health departments
- Alternative delivery models including telehealth

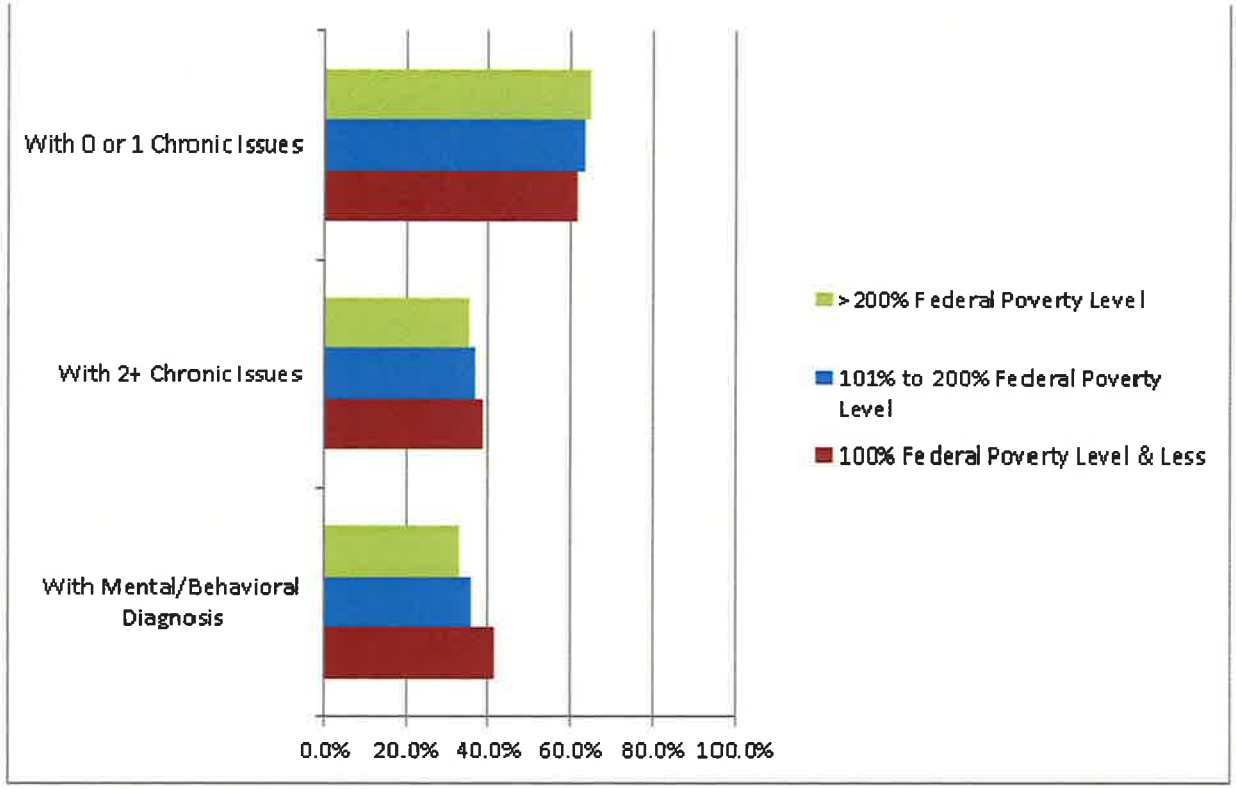
Who We Serve

Primary Care, Oral Health, Behavioral Health

- Over 30,000 unique patients seen in CY 2015
- Income status:
  - 59% 0 - 100% FPL (18,000)
  - 18% 101 – 150% FPL
  - 19% 150% - 200% FPL
  - 4% +200% FPL
- 56% (17,000) are uninsured
- 30 % Public Insurance
  - 22% Medicaid (56% 0-17)
  - 8% Medicare
- 9% Agriculture Workers
- 10% Homeless
- 3% Veterans

Health Status of our Patients

Mental Health and Chronic Disease



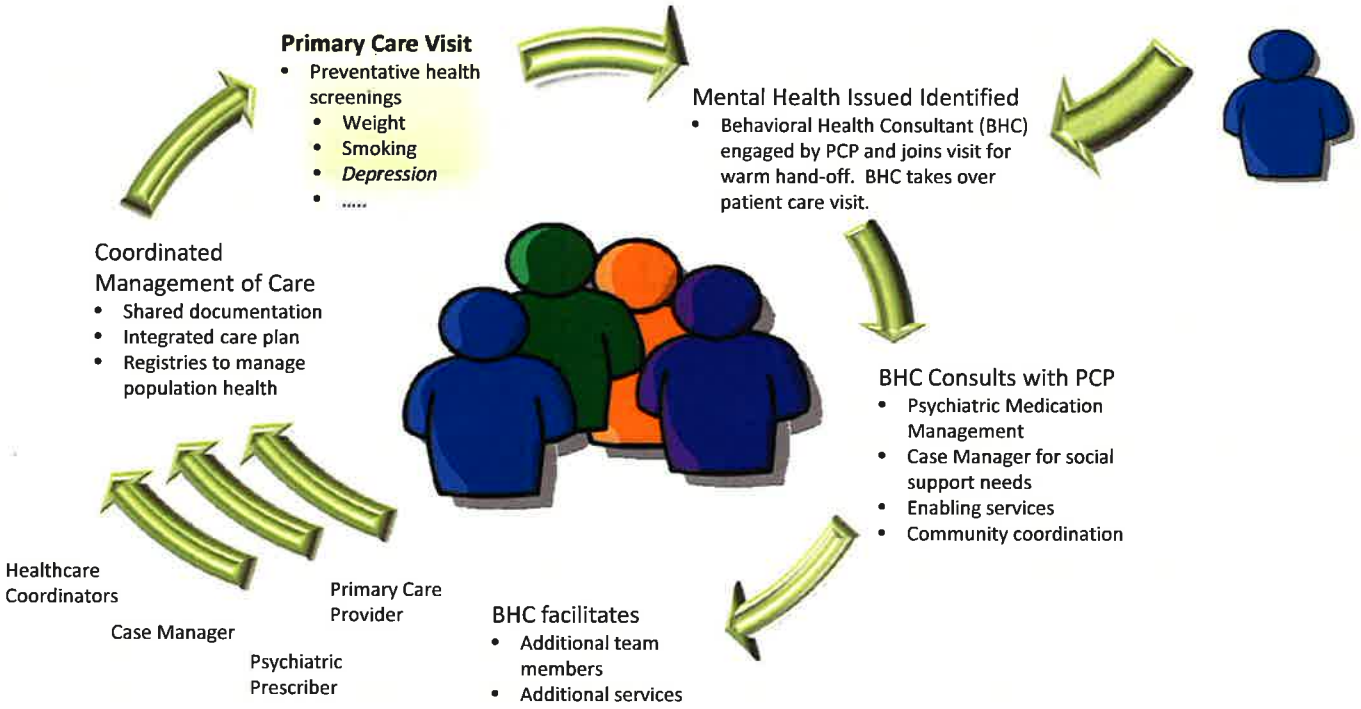
Focusing on a Solution

Integrated Care

- Team Based Care
- Primary Care, Behavioral Health, Oral Health integrated EMR
- Behavioral Health Screenings
- Expanded capacity to manage psychotropic medications
- Behavioral Health Consultants
- Allumbaugh House
- SANE SOLUTIONS
- PAP and 340B for medications

Behavioral Health Integration

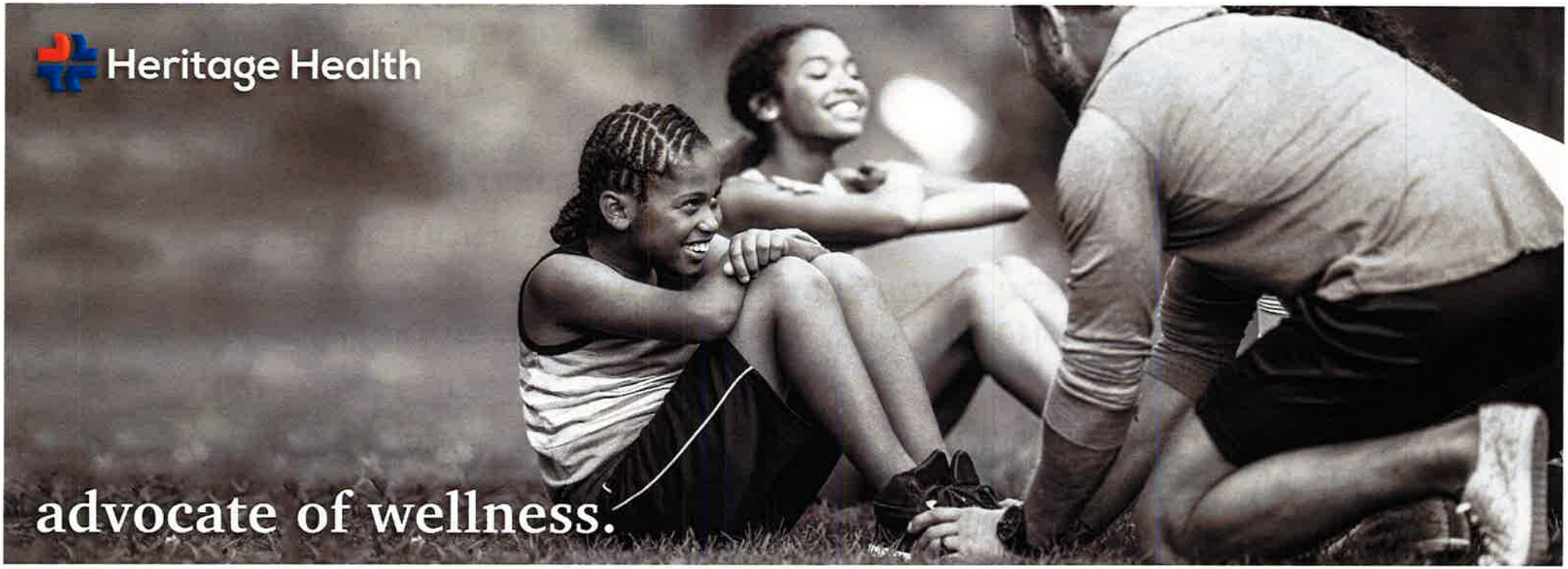
A model of excellence



Mental Health Infrastructure

Opportunities to build on

- Expand capacity of Behavioral Health Consultants
  - address all patient visits, not just mental health visits.
- Transition of Care Team
  - a team who closely manage patients who are at risk or rising risk of hospitalization or who are transitioning from a hospital setting.
- Patient Education and Activation
  - medication adherence, symptom management, wellness and safety planning, chronic disease management.
- Clinical Pharmacy
  - Ensuring patients are taking medications and understanding their medications.


Heritage Health
advocate of wellness.

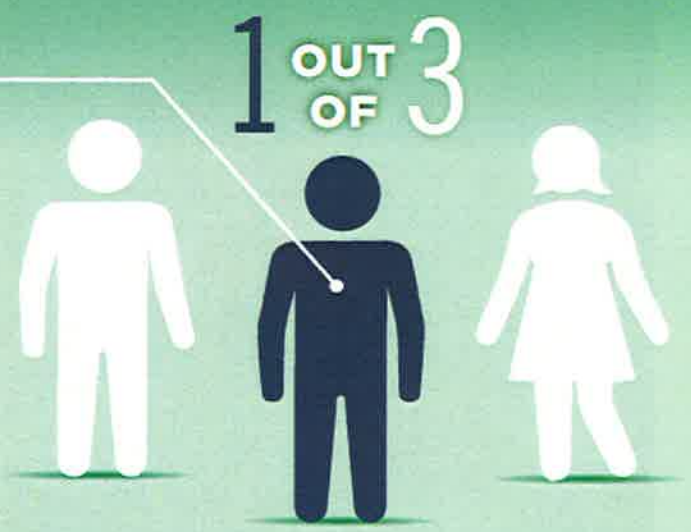
PREDIABETES

COULD IT BE YOU?

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

86 MILLION

86 million American adults—more than 1 out of 3—have prediabetes



CHECK

The cost of diagnosed diabetes in 2012 was $245 billion

Source: American Diabetes Association

People with diagnosed diabetes have health care costs **2.3 times higher** than if they didn't have the disease

1 of 3

December 2015

Live Well CdA

celebrating healthy lifestyles

Heritage Health's Chief Medical Officer, Dr. Joseph Abate begins an innovative partnership with the Kroc Community Center to treat diabetes.

Heritage Health

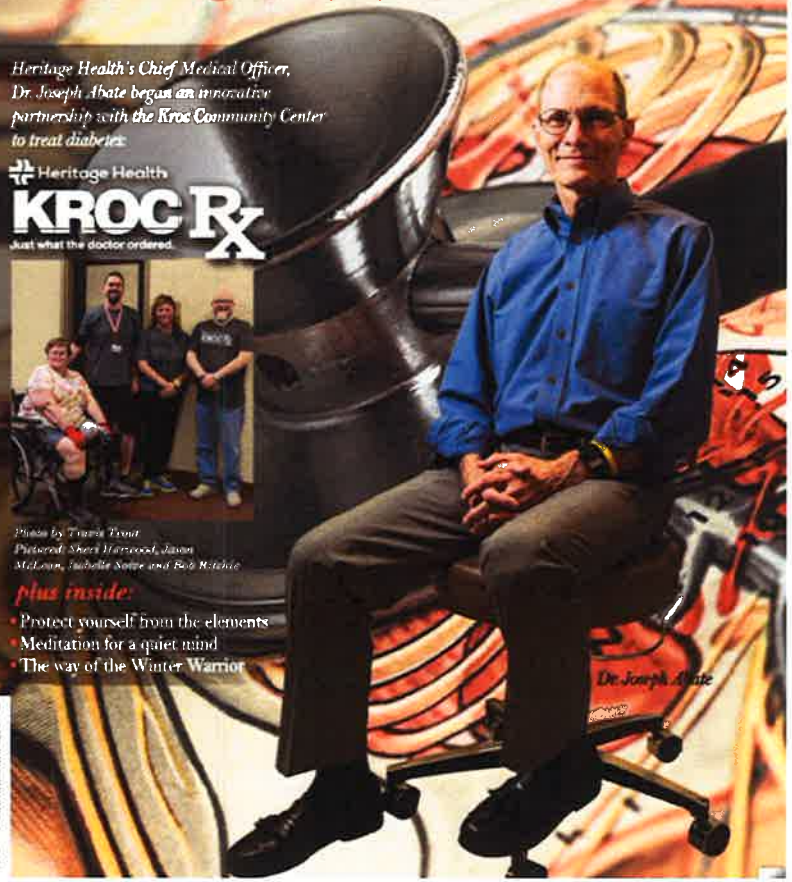
KROC Rx

Just what the doctor ordered.

Photos by Travis Trout
Pictured: Sheri Hartcook, Jason McLean, Isabelle Sotto and Bob Mitchie

plus inside:

- Protect yourself from the elements
- Meditation for a quiet mind
- The way of the Winter Warrior



$4.00

Heritage Health
be inspired.

Heritage Health
heal.

Heritage Health
we are Heritage.

RAY & JOAN KROC CORPS COMMUNITY CENTER

KROC
CHURCH
KROCRx

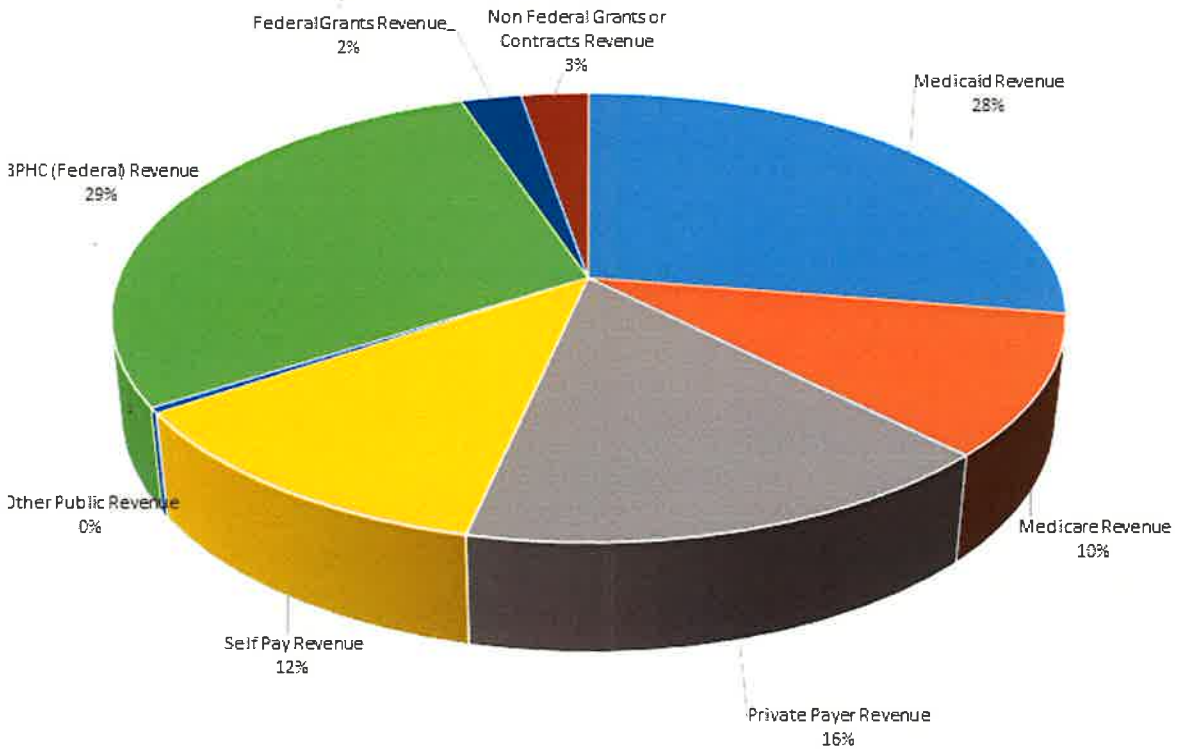
Heritage Health
find encouragement.

Questions?

- Yvonne Ketchum-Ward, CEO – Idaho Primary Care Association
- Heidi Traylor, CEO – Terry Reilly Health Services
- Mike Baker, CEO – Heritage Health

IPCA
IDAHO PRIMARY CARE ASSOCIATION

COMMUNITY HEALTH CENTER REVENUE (2014)



IPCA
IDAHO PRIMARY CARE ASSOCIATION

SENATE HEALTH & WELFARE COMMITTEE
Thursday, February 11, 2016

ATTACHMENT 2

IDAHO'S COMMUNITY HEALTH CENTERS

CARING FOR PEOPLE, BENEFITING COMMUNITIES

A TREMENDOUS VALUE TO IDAHOANS

Idaho's 16 community health centers (CHCs) provide patient-centered primary healthcare that lowers costs and improves health outcomes. CHCs provide essential medical, dental, and behavioral health services to everyone, based on a sliding fee scale. CHCs are often the only source of primary and preventive care in rural Idaho.

CHCs are community-based nonprofit organizations. Each CHC is governed by a community board, a majority of whom are patients of the CHC, assuring a strong community voice in determining how healthcare services are designed and delivered.

CHCs serve patients covered by Medicare, Medicaid, and private insurance, and those who are unisured.

156,651
PATIENTS SERVED

Nearly **1** in **10** Idahoans in 2014

DELIVERING HIGH-QUALITY PRIMARY CARE

Primary care is the foundation of Idaho's healthcare system. Idaho's CHCs deliver coordinated primary care that is focused on wellness, prevention, and chronic disease management. CHCs serve their local communities by providing a wide range of basic healthcare services.

Primary care reduces disease through treatment and prevention, reduces the economic cost of poor health, and reduces emergency and hospital visits. Additionally, it helps manage the control of routine illnesses and increases patient compliance with medical treatments.

LEADERS IN HEALTHCARE TRANSFORMATION

In 2010, Governor Otter issued Executive Order No. 2010-10 establishing the Idaho Medical Home Collaborative to implement a patient centered medical home (PCMH) model of care in Idaho. This executive order cited the importance of decreasing healthcare costs and increasing efficiency, as well as addressing the process of transforming Idaho's healthcare system to a PCMH model.

A PCMH practice makes efficient use of a physician's time, allows the team to provide comprehensive and cost-effective care to a patient, and maximizes the use of health information technology. This model promotes a closer relationship between the patient and their provider and care team.

Idaho's community health centers (CHCs) are rapidly preparing for the future Idaho healthcare environment by transforming their practices into PCMHs and participating in the State Healthcare Innovation Plan (SHIP). Of the 55 clinics in the SHIP, more than 45 percent are CHCs.

PATIENT CENTERED MEDICAL HOME

a location and a model of team-based care that incorporates primary care physicians, nurse practitioners, nurses, physician assistants, social workers and others—each working at the top of their license—to provide timely care that focuses on prevention and wellness

92% of Idaho CHCs have at least one site that has achieved **PCMH recognition**

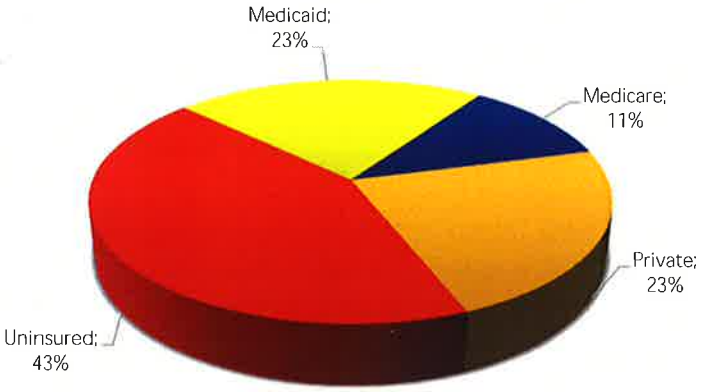
THE VALUE OF PROVIDING CARE TO All IDAHOANS

When people receive high-quality primary care that focuses on prevention and supports chronic illness management, it leads to better health outcomes, fewer missed work and school days, and a reduced healthcare cost burden.

Providing care to all Idahoans will have a positive economic impact on families, employers, tax payers, and Idaho's county and state indigent care programs.

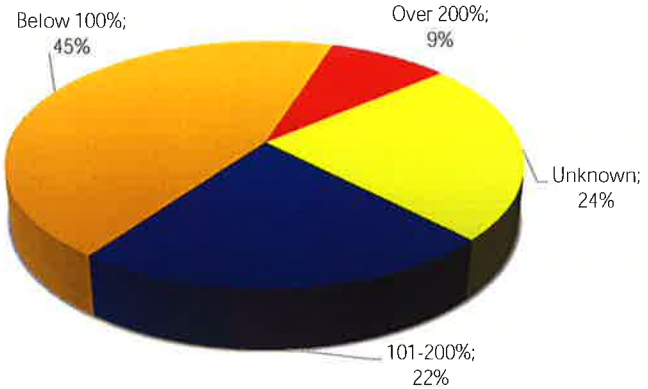
Idaho Community Health Center Data 2014*

Insurance Status



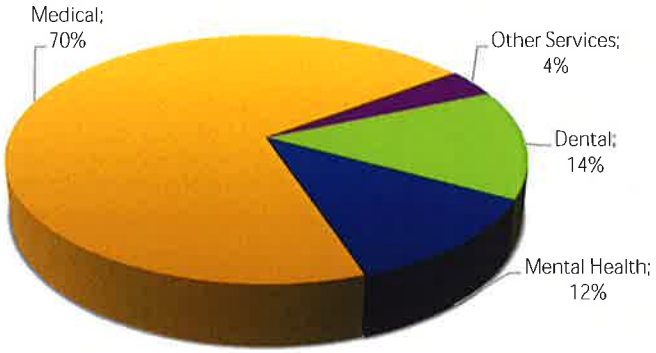
156,651 Patients

Federal Poverty Level



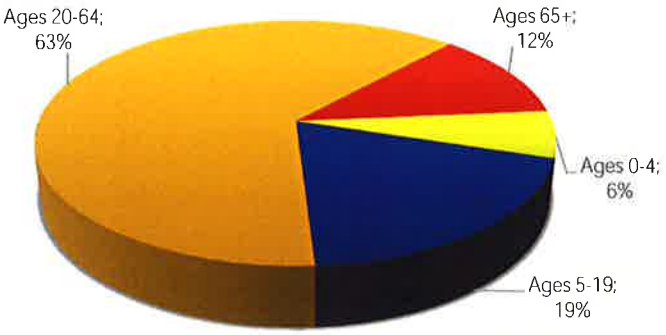
156,651 Patients

Primary Care Visits by Type



600,210 Visits

Patients by Age



156,651 Patients

*Most current data available

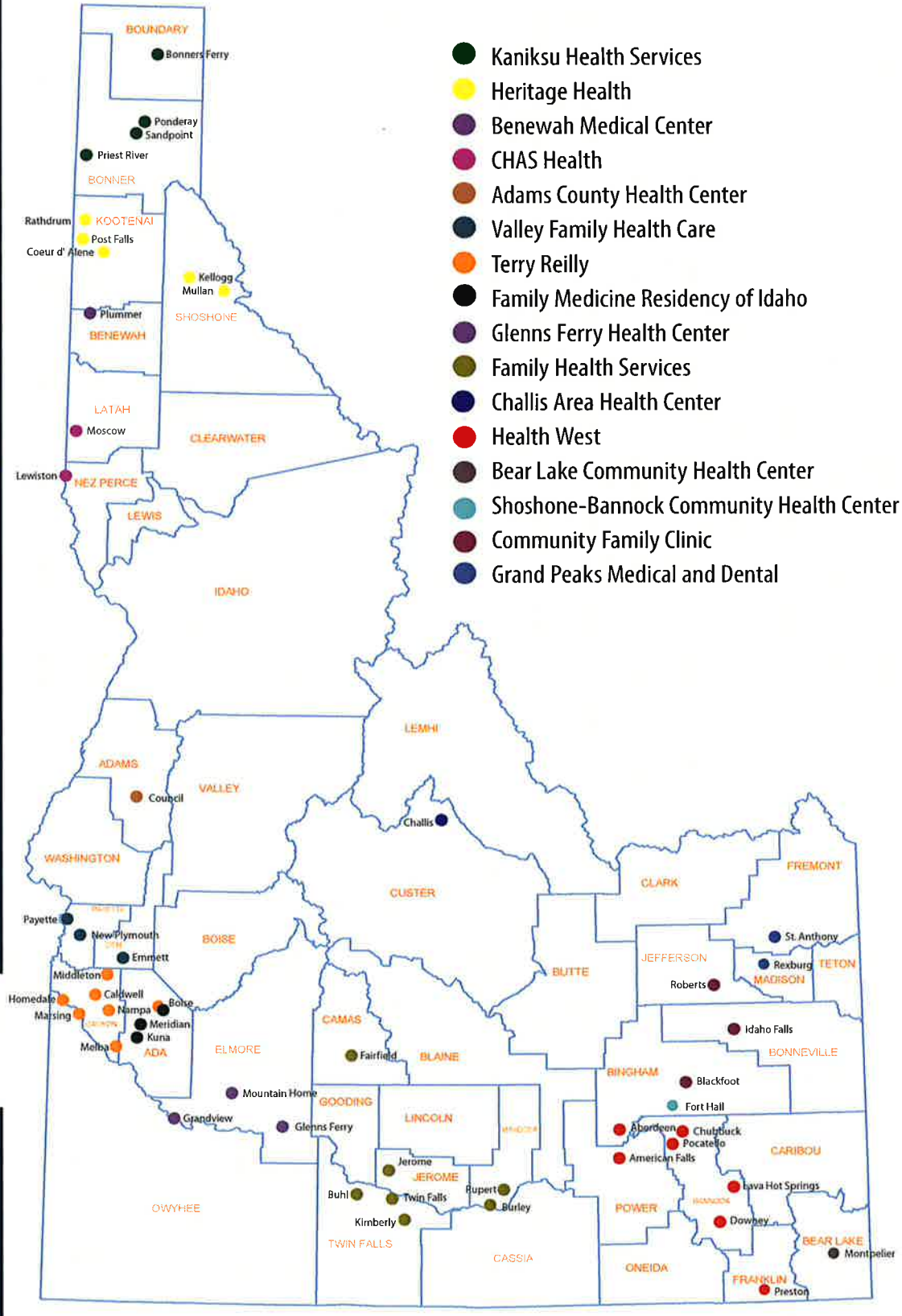
IPCA Members

- Adams County Health Center
- Benewah Medical Center
- Challis Area Health Center
- CHAS Health
- Community Family Clinic
- Family Health Services
- Family Medicine Residency of Idaho
- Glenns Ferry Health Center
- Grand Peaks Medical & Dental
- Health West
- Heritage Health
- Kaniksu Health Services
- Shoshone-Bannock Community Health Center
- Terry Reilly
- Valley Family Health Care

IPCA
IDAHO PRIMARY CARE ASSOCIATION

Idaho Primary Care Association is the membership organization that represents Idaho's 16 community health centers (CHCs) which offer high-quality, affordable primary and preventive healthcare as well as dental and behavioral services in 47 Idaho communities.

IDAHO'S COMMUNITY HEALTH CENTERS



www.idahopca.org

JOINT

SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE

8:00 A.M.
Lincoln Auditorium
Friday, February 12, 2016

PUBLIC HEARING

SUBJECT	DESCRIPTION	PRESENTER
	THE SENATE AND HOUSE HEALTH AND WELFARE COMMITTEES WILL HOLD A PUBLIC HEARING ON HEALTH AND WELFARE ISSUES.	**Chairman Heider**
	MEETING TIME IS 8:00 A.M. TO 10:00 A.M.	
	THE PUBLIC WILL HAVE THE OPPORTUNITY TO EXPRESS CONCERNS RELATED TO HEALTH AND WELFARE PROGRAMS.	
	TESTIMONY WILL BE LIMITED TO 3 MINUTES PER PERSON.	

If you have written testimony, please place one copy of it in the box next to the podium to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
JOINT MEETING

SENATE HEALTH & WELFARE COMMITTEE
HOUSE HEALTH & WELFARE COMMITTEE

DATE: Friday, February 12, 2016

TIME: 8:00 A.M.

PLACE: Lincoln Auditorium

MEMBERS PRESENT: Chairman Heider, Senators Hagedorn, Martin, Lee, Harris, Schmidt and Jordan

Chairman Wood, Vice Chairman Packer, Representatives Hixon, Perry, Romrell, Vander Woude, Beyeler, Redman, Troy, Rusche, Chew

ABSENT/ EXCUSED: Vice Chairman Nuxoll and Senator Lodge

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the joint meeting of the Senate Health and Welfare Committee and the House Health and Welfare Committee (Committees) to order at 8:02 a.m.

OPENING REMARKS: **Chairman Heider** introduced himself and Chairman Wood of the House Health and Welfare Committee. He stated that this is a joint meeting of both the Senate and House Health and Welfare Committees. He welcomed everyone in the audience and discussed the procedures for testifying during today's meeting. **Chairman Wood** thanked everyone in the audience for their attendance and discussed the House Health and Welfare Committee's schedule.

TESTIMONY: **Randy Nilson** testified, as read by Alta Dee Holsted, regarding his concerns about current Medicaid coverage in Idaho (see attachment 1). He indicated that the Medicaid "personal needs allowance" barely covers his cost of living, with no allowance for home maintenance or auto insurance. If allowed to keep more income, Medicaid participants could remain in their homes and communities.

Terri Sterling, Executive Director of the Idaho Cancer Action Network, testified in support of **S 1204** and **S 1205**. She expressed her concern that her federal tax dollars were being spent to provide medical coverage for individuals living in other states and asked the Legislature to approve comprehensive health care coverage for all Idahoans.

Ilene Kingery, mental health advocate, testified in support of improved psycho-social rehabilitation (PSR) services (see attachment 2). She said PSR services are often being denied, and when children are denied these vital services they often end up in the hospital or incarcerated.

Ken Olson testified in support of **S 1205** – the Healthy Idaho Plan. He read a statement on behalf of Clella Steinke, mother-in-law of Jenny Steinke, which related the story of Jenny Steinke's death as a result of asthma complications.

Michelle Gluch testified in support of **S 1205** – the Healthy Idaho Plan. She shared her family's story of living without health insurance. She stated that primary care alone is not a solution.

Kerry Hong, Director of Community and Family Justice Services for the Administrative Office of the Idaho Supreme Court, testified regarding the impact of **S 1204** and **S 1205** on the criminal justice populations (see attachment 3). Often offenders enter problem-solving courts with health concerns in addition to addiction and mental health disorders. Additionally, moderate and high-risk to recidivate offenders on probation and parole that have behavioral health treatment needs that may be going unmet. The proposed legislation would help meet the needs of these populations.

Amanda Hundt, Crisis Responder for the Idaho Suicide Prevention Hotline and Board Member of the American Foundation of Suicide Prevention - Idaho Chapter, testified in support of the Idaho Suicide Prevention Plan (see attachment 4). She discussed her own experience with the suicide prevention hotline and urged the Committees to support sustainable funding for the Idaho suicide prevention hotline, the creation of an office of suicide prevention, continued youth training through funding for the Idaho lives project and a public awareness campaign to reduce the stigma of mental health issues.

Sean Nixon, Licensed Clinical Professional Counselor, testified in support of funding for mental health services in Idaho. In particular, he suggested screening school-aged children and adults for trauma in order to provide mental health services for individuals before they need hospitalization.

Jennie Rylee, Volunteer for the Idaho Suicide Prevention Hotline and two-time suicide attempt survivor, testified in support of the Suicide Prevention Plan and the Healthy Idaho Plan. Individuals calling the suicide hotline are homeless, unemployed, working for minimum wage, uninsured and facing existing stigmas. She told the story of a friend that recently committed suicide. The Healthy Idaho Plan can provide appropriate treatment for these individuals.

Kathy Scott, Idaho citizen, testified in support of **S 1205** – the Healthy Idaho Plan. She suggested that if Idaho accepts federal funding to support highways, education and agriculture, the State should also accept funding for comprehensive health care coverage for our citizens.

Christie Stephenson, a foster parent, testified in support of foster care reform in Idaho. She related her story of being parent to five foster children and six biological children. She discussed the hardship that her family endured when she had to relocate to Utah after losing her job.

Jim McCauley, Idaho citizen, testified in support of foster care reform in Idaho. He discussed his experience as a counselor for adults who have been traumatized as a result of their childhood experiences in the foster care system. And he suggested that this type of trauma could be prevented if the foster care system is reformed.

Nichole Ashford, employee of ResCare HomeCare Services, testified in support of increased Medicaid reimbursement rates. She discussed the services provided by home health care professionals. Low reimbursement rates make it difficult for home health care companies to stay in business and provide personal care for their participants. She stated that increased reimbursement rates would improve the lives of caregivers and participants.

Heather Mark, a former foster parent, testified in support of foster care reform in Idaho. She stated her belief that the current foster care system does not function in the best interests of foster children.

John O'Keefe, owner of a personal care services (PCS) agency, testified in support of increased Medicaid reimbursement rates. He stated that the services PCS agencies provide allow seniors to age in place and stay in home. He indicated that PCS agencies are a low-cost alternative to nursing facilities. He said the low reimbursement rates make it difficult to find caregivers to provide PCS services.

Kevin O'Sullivan, Idaho citizen, testified in support of **S 1205** – the Healthy Idaho Plan (see attachment 5). He discussed that potential benefits of providing health care coverage for all Idahoans currently in the health care gap.

Kathleen Zielinski, representing Idaho Parents Unlimited, testified regarding the consequences of mental health service reductions for children with dual-diagnosis: developmental disabilities and mental health issues (see attachment 6). She says reductions in mental health services result in regression and rage in the home, school and community. She advocated for improved mental health services in Idaho.

Rebecca Perrenoud, Chief Executive Officer of A to Z Family Services, Inc., testified regarding the consequences of mental health service reductions (see attachment 7). She recommended (i) a simple behavioral health package funded by a flat rate, (ii) looking to other countries for guidance on health care delivery and (iii) revising the accreditation requirements for mental health providers.

Lindsey Dial, Branch Manager of ResCare HomeCare of Boise, testified in support of increased Medicaid reimbursement rates (see attachment 8). She is concerned about how little caregivers are paid and the low rates make it difficult for her company to maintain caregivers. She related a story of a quadriplegic patient who has suffered due to the lack of caregivers.

Liza Long, Board Member of the National Alliance on Mental Illness - Boise, testified in support of **S 1205** – the Healthy Idaho Plan. She related her story as a mother of a child with mental illness. Mental health treatment leads to self management, recovery and hope. Individuals with serious mental illness deserve access to lifesaving quality health care.

Jodi Fulford, a foster parent and licensed counselor, testified in support of foster care reform in Idaho (see attachment 9). She related her efforts to adopt foster children. She stated that changes need to be made to the foster care system to prevent trauma in the children the system serves.

Jim Baugh, Executive Director of DisAbility Rights Idaho, testified in support of Medicaid expansion. He discussed two main groups of people with disabilities that do not have health insurance: (i) people with severe and persistent (chronic) mental illness and (ii) people who acquire a progressive condition, like cancer, and can no longer work. These people need more than primary care; they need specialty care, hospitalization and coordinated care.

Andrew Serre, foster parent, testified in support of foster care reform in Idaho. He discussed the effects of the foster care system on his foster son. The decisions made by the Department of Health and Welfare traumatized his foster son.

Lauren Necochea, Director of Idaho Voices for Children, testified in support of **S 1205** – the Healthy Idaho Plan (see attachment 10). She stated that the health care gap forces Idaho parents earning low wages to choose between working and access to health care. She noted that the Healthy Idaho Plan would strengthen the overall health care system and focus on prevention rather than pay for expensive emergency care.

Cricket Syes, a child of the foster care system, testified in support of foster care reform in Idaho. She told her experiences as a foster child. She was never able to make significant attachments to her family. She advocated for ensuring that foster children are not left in limbo and know that they are loved.

Susanne Jamison, Executive Director of the Idaho Dental Hygienists Association, testified regarding the need for a dental hygienist mid-level practitioner license to answer the current oral health crisis and increase the number of patients receiving dental care (see attachment 11).

Dena Duncan, Idaho citizen, testified in support of **S 1205**. She suggested that Idaho should help those in the health care gap to improve their health because improved health would translate into improved families and improved communities.

Valerie Bish, foster parent and guardian ad litum, testified in support of foster care reform in Idaho. She suggested that all foster care stakeholders should be involved in the reform process, including the foster parents, health and welfare administrators and court workers.

Ardella Percy, representing the Idaho Suicide Prevention Hotline, testified in support of funding for the Suicide Prevention Plan and mental health treatment. She related a story about a hotline call she received from a young man in rural Idaho.

Frank Gallant, former school district superintendent and professor, testified in support of **S 1204** and **S 1205**. He discussed the economic benefits of Medicaid expansion. He said that the State would see an increase in sales revenue, compensation, new jobs and tax revenue.

Brian Pope, chief executive officer of the Northwest Children's Home, testified regarding three issues his residential treatment center for youth has with the Department of Health and Welfare: (i) referrals from the State have been dramatically reduced, (ii) individual education plan process is not being completed for children placed in his facility, and (iii) lower rates paid to the Northwest Children's Home (see attachment 12).

Lori Lodge, licensed professional counselor, testified in support of reform for mental health treatment in Idaho. She discussed her experiences and concerns for mental health treatment for children. She stated that **S 1204** and **S 1205** could make a big impact on children's mental health across the State.

Kathleen Keyes, foster parent, testified in support of foster care reform in Idaho (see attachment 13). She told her personal experience as a foster parent. She related her concerns with the frequent relocation of foster children and placement away from siblings.

Sylvia Chariton, representing the Idaho Chapter of the American Association of University Women, testified in support of **S 1204** and **S 1205**. Women make up 55 percent of the health care gap population and face a greater risk of insurance loss if they become widowed or divorced. Women who fall in the health care gap live lives of quiet desperation.

Representative Perry requested the written testimony of Brian (last name withheld) be entered into the record (see attachment 14).

Chairman Heider requested that the testimony of **Teri Murrison** be entered into the record (see attachment 15).

WRITTEN TESTIMONY: The following individuals and groups testified regarding Medicaid expansion (see attachment 16):

1. Erin Bennett, representing the American Heart Association / American Stroke Association in Idaho;
2. Fred Birnbaum, representing the Idaho Freedom Foundation;
3. Karleen Davis;
4. William Fowkes;
5. Audrey Gatewood;
6. Idaho Voices for Children;
7. Barbara Kemp;
8. Cay and Ron Marquart;
9. Mike McGrane, representing the Idaho Nurses Association and the Nurse Leaders of Idaho;
10. Danielle Ryals;
11. Susan Sered; and
12. Clella Steinke.

The following individuals and groups testified regarding foster care reform (see attachment 17):

1. Michelle Alden, representing Healthy Foundations;
2. Stephanie Alvarez;
3. Brian McCauley;
4. Valerie McCauley;
5. Carly Neff;
6. Lisa Nordstrom;
7. JoAnn Parkinson;
8. Jamie Taylor; and
9. Compilation of Stories, Comments and Messages (Pages i-vi and 1-86).

The following individuals testified regarding Mental Health, Behavioral Health and Optum (see attachment 18):

1. Jessica Chilcott;
2. Jamie Gibson;
3. Vanessa Johnson;
4. Matthew Montoya; and
5. Jennifer Zielinski.

The following individual testified regarding medical neglect (see attachment 19):

1. Mariah Walton.

The following individual testified regarding marijuana (see attachment 20):

1. Dr. Leanne Rousseau

CLOSING REMARKS: **Chairman Wood** commented that Idaho citizens are suffering in various areas. In particular, he expressed his concern regarding foster care reform. **Chairman Wood** thanked everyone in the audience for being in attendance and being willing to testify today. He indicated that the Committees will do their best to address the issues presented here today.

Chairman Heider stated that the Committees are trying their best to represent the citizens of Idaho. He thanked all those in attendance today.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 10:02 a.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

JOINT
SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 1

Randy Nilson 02/12/16 Randy Nilson

375-9760

Dear legislators,

I want to thank you for giving me the opportunity to speak with you today. I want to start with the things that the Idaho Department of Health and Welfare is doing right. I do appreciate the opportunity to stay in my home. You should also be commended for not having a waiting list for Medicaid applicants. The last thing that you should be proud of is the Medicaid for Workers with Disability legislation that was passed 10 years ago. That legislation allowed disabled people like myself, to continue working and stay on Medicaid while paying a reasonable premium for Medicaid services.

No one wants to have a disability. I worked for the state tax commission for 26 years 18 of those years in administration. I feel I've earned the retirement income I receive from Social Security and Persi.

The first problem I have is Medicaid is charging me over $2100 a month for my Medicaid services. When I was working the highest premium that I ever paid was $153 a month for the same Medicaid services. It has been said that my share of cost is based on federal law and there's nothing you can do about it. But that's not true because every state has the right to set the Medicaid participant's Maintenance Needs Allowance or in Idaho it's called a Personal Needs Allowance. Idaho has one of the lowest Maintenance Needs Allowances in the nation. I know you won your lawsuit that says you can pay whatever Medicaid rates you want but there has to be some justice for those who need assistance. I've been put on a budget by Medicaid that barely allows me to pay my mortgage, utilities, and groceries. I own my own home and have other expenses that are not budgeted by Medicaid. I've had to replace my furnace, water heater, roof, clothes washer, and do other general maintenance since I stopped working. I have a handicap van that allows me to go grocery shopping and to allow me to get out in the community. The problem there is there is no allowance in my Medicaid budget to pay my car insurance for the van. The Idaho Department of Health and Welfare needs to allow Medicaid participants to keep more of their income so that they can remain in their homes and is in the community.

The second problem the IDHW's Notices of Action that show an individual's share of cost do not include any indication of whether submitted expenses are approved or denied, and if an expense is denied, the basis for the denial. The department took 10 months to provide a notice of action that showed the incurred medical or remedial expenses that they denied. Even then the department did not show specific rules for each expense that was denial but did a shotgun approach with a list of rules at the end of the notice.

The third problem with Idaho Medicaid has to do with incurred medical or remedial care expenses that can be deducted from a participant's share of cost. The department has chosen not to define these terms even though other states have defined incurred medical or remedial care expenses. On top of that the Department has failed to provide a list of limitations for incurred medical or remedial care expense deductions in the Idaho's A & D waiver application as required by the Centers for Medicare and Medicaid Services for CMS.

The fourth problem is the IDHW employees deny federally mandated medical or remedial expenses by using the same standard for state plan funding of covered Medicaid services, thus creating an impossible "Catch 22" barrier to approvals for expenses.

The fifth problem is exercise and transportation is not included in the Universal Assessment Instrument.

The sixth problem is individuals who take care of their own relative and are only paid fifty dollars a day or two dollars an hour.

I've been told by both chairman's of the health and welfare committees last year that the federal government is bankrupt and we cannot increase Medicaid spending. I believe the best place for a person to stay is there home or apartment. The state of Idaho spends $.30 on the dollar for increases for participants on the A & D waiver program. I think the state could invest a little bit more of its money to keep people in their homes and not be institutionalized in a nursing home.

This could happen to you or a relative.

1. The IDHW fails to provide any standards for determining if an expense qualifies as medical or remedial.
2. The IDHW fails to consider expenses incurred by individual home owners necessary to maintain that home.
3. The IDHW has denied expenses on the basis that Medicaid should or could be funding that expense without informing the participant, assuming responsibility for payment of the expense, or determining that the service is actually available through Medicaid.
4. The IDHW failed to correct a denial of an expense based upon erroneous information it provided in Appeal No. 2014-1008.
5. The IDHW denied certain expenses using a basis it knew to be tenuous and without verifying any facts.

JOINT
SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 2

Ilene Kingery
ilenekingery@Gmail.com
Facebook.com/IdahoParents for Mental Health

02/12/16
Ilene Kingery

My children and I are "member's" of Optum and I am also an advocate for Mental Health.

Last year I was here telling you of my concerns about my son losing PSR services due to the fact he wasn't taking any medications. He has since been on medication and still was denied PSR services last fall. Luckily last month he was reinstated because our provider never gave up. Unfortunately in 2 months the chances of him losing PSR again is very high. 3 months of PSR is too short of time for any body. In order for PSR to begin being effective it would take at least 9 months.

I have heard the reason why PSR services are being cut is because Idaho uses this service more than any other state. The reason why we use it more is because Idaho doesn't offer any other services besides counseling, med management, and case manigment. On Optums website they advertise that they offer Family Support Services when in fact Family Support services is not readily available. Optum also claims

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that they offer Peer Support, but in reality there are only a handful of people who are certified for Peer Support and Idaho no longer provides classes to become certified. As you can imagine ones who are certified are booked solid with clients.

It has been proven time and time again PSR services are vital in the success of mental health cases. Especially to children. Because PSR services are being denied children are being admitted to hospitals or end up incarcerated. Where the conditions of the facilities are horrific. From feces on the walls to molestation and rape.

Last year I asked to see the statistics of how many mental Health cases end up in incarceration and in hospitals. Something that should be available to the public. One year later and Optum still has not released these numbers. I think that it is important to know how much it is costing the state to incarcerate or hospitalize these children (and adults for that matter) vs giving them the services they need and deserve. It is to my understanding

Ilene Kingery
ilene kingery@gmail.com
facebook.com/Idaho Parents for mental health

that the Jeff D lawsuite is coming together with new laws, regulations, and services for mental health cases. But it's going to be about another 5 years befor they are finalized and implemented. In the meantime I as a mother/advocate/and client I highly recomend that PSR services are approved and reinstated as advised by a certified clinition or a psychiatrist who has examined the client face to face. This intern will lower the cost of hospitalizations and incarcerations for the state, guaranteed.

Thank you.

JOINT
SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 3

02/12/16
Kerry Hong

2/2/2016

K. Hong Testimony Re: SB 1205

Chairman Heider and members of the committee,

My name is Kerry Hong. I serve as the Director of Community and Family Justice Services Division for the Idaho Supreme Court. I am here today upon invitation from Sen. Schmidt to speak to the potential impact of this proposed legislation on criminal justice populations, specifically to offenders participating in Idaho's problem solving courts.

The Judiciary is respectful of the policy domain of the Legislature and I take no position on the ultimate question of whether this bill is good policy, but the courts do have an interest in behavioral health issues as they pertain to reducing recidivism, protecting our communities and rehabilitating offenders.

Problem solving courts use a team based approach, led by a judge, to supervise and treat offenders in the community that have high risk to recidivate and have behavioral health issues. These courts provide an evidence based alternative to costly incarceration. There are 69 problem solving courts spread throughout Idaho's 7 judicial districts, serving approximately 2,500 offenders in FY2015.

Often, offenders come into PSC with primary health concerns in addition to addiction and mental health disorders. It is not uncommon to hear from offenders and their treatment providers that their use of illegal substances was connected to self-medication for chronic health conditions or unmanaged mental health disorders. These offenders frequently have poor employment history and limited financial resources. However, our PSC coordinators have reported that only about 9% of these offenders are currently eligible for services through Medicaid. We anticipate that Medicaid eligibility for adults up to 138% of federal poverty level would significantly increase this percentage and may help meet the needs of this population.

In addition to offenders in PSC, there are thousands of moderate and high risk to recidivate offenders on probation and parole that have behavioral health treatment needs that may be going unmet. The JRI Gap analysis submitted to the legislature this year by the Department of Correction and the Department of Health and Welfare estimates a gap nearly $15 million to provide substance abuse and mental health treatment to all moderate and high risk to recidivate offenders who may need it. This estimate is for felons and doesn't measure the needs of the misdemeanants who are also being supervised in the community. Expanded eligibility to Medicaid may provide many these offenders with access to care and assist with their rehabilitation.

Thank you for the opportunity to provide this testimony. I now stand for any questions.

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ATTACHMENT 4

02/12/16
Amanda Hundt

Testimony of Amanda Hundt
February 12, 2016
Joint Health & Welfare Committee

My name is Amanda Hundt, and I have been volunteering as a crisis phone responder at the Idaho Suicide Prevention Hotline for the past two years. I am also a member of the Board for the Idaho Chapter of the American Foundation for Suicide Prevention.

I have come here today to express my deep concern about the level of mental health care provided in the State of Idaho. Over my two years at the Hotline, I have spoken with individuals from all corners of the state, who were experiencing mental health crises. These individuals cover a wide variety of demographics, but they all have one thing in common: they are reaching out to the Hotline in desperation, not knowing how to turn their lives around. They are reaching out to the Hotline because they have very few options to access mental health care, and they have no where else to go.

Be it the gaps in health insurance coverage, the inaccessibility of medical professionals in rural areas, or the stigma surrounding mental illness, Idahoans have extreme difficulty in accessing and receiving quality mental health care.

Idaho has consistently been among the top ten suicide rates in the nation. Our citizens, our people are in pain, isolated, and choosing to end their own lives out of hopelessness. We've seen this continue for far too long, and it's time for Idaho to get off that top ten list.

I stand before you today, a survivor of my own suicide attempt over a decade ago. I know the hopelessness and isolation that comes from poor mental health. I know the fear and the stigma that comes with accessing what help there is. And I know, first hand, that access to quality mental health care does prevent needless death as it prevented mine. I know, first hand, that the Hotline saves lives, as it saved mine.

I urge you, as myself, as a volunteer crisis counselor, and on behalf of the board of AFSP-ID to move forward on the recommendations presented by Dr. Polk and the Suicide Prevention Core Team, with particular emphasis on: sustainable funding for the Idaho Suicide Prevention Hotline; creation of an office of suicide prevention; continued youth training through funding for the Idaho Lives Project; and a public awareness campaign to reduce the stigma of mental health issues.

Thank you for your time.

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ATTACHMENT 5

02/12/16
Kevin O'Sullivan

The Politics of Life

ISIS and Medicaid Expansion

With the presidential primaries under way, the politics of life, terrorism and security cause unscrupulous politicians to stir up voters' fears. The horiffic deaths of 14 Americans in San Bernadino at the hands of ISIS followers was pure evil but politicians in Idaho allow hundreds of working Idaho citizens, to die each year at a high cost to taxpayers, for purely political reasons. Who should "we the people" fear more: ISIS or these politicians?

Governor Otter's Milliman report referenced reduced mortality as shown by the New England Journal of Medicine (herewith) for people on healthcare insurance, as 1 life saved for every 176 people added to the healthcare insurance rolls. For the 78,000 uninsured Idaho people in the gap, this equates to 443 lives saved each year. You should save these lives even if there is no $173 million bonus benefit to Idaho (which there is over 10 years) and use it to fix other problems like education, or cut taxes and provide better healthcare to veterans and their families. You can do many things if you forget about your [redacted] politics and focus on the people who sent you here.

Just close the gap with the Healthy Idaho Plan. Not to do so is [redacted] to be 100 x worse than ISIS. The Governor's PCAP plan is mere political pap that lacks common sense and further insults the working poor and taxpayers.

Thank you for your time. Kevin O'Sullivan Statehouse Feb 12- 2016

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ATTACHMENT 6

02/12/16
Kathleen Zielinski

Kathleen Zielinski

Habiliative Support Staff

My name is Kathleen Zielinski,

I am a Habiliative Support Staff at a Developmental Disability Agency here in Idaho.

I am also a Grandmother representing my adoptive granddaughter, a child who came from Idaho's Foster Care system, due to neglect and abuse. She now has significant mental health disorders.

I work with and see children everyday with duo diagnosis of Developmental Disability and Mental Health diagnosis.

I am here to ask, **Why.**

Over the last year our children have been dealing with significant reduction in their Mental Health Services.

Along with this reduction in services comes regression and rage in the home, school and in the community.

It is because of this reduction in services that I see more anxiety, depression, self- harm, physical aggression, suicidal tendencies, trauma behaviors and the lack of social & emotional skills.

I want to see changes and improvements made in our Behavioral Health Managed Care System, Optum of Idaho.

I want to see an array of treatment services specifically designed for our children with Mental Health Disorders.

These children deserve more services and we can become a team working together to insure that we do the right thing by them. We are there voices.

Do not, Optum of Idaho, leave these children to sink in the sea of circumstances.

Do not leave them behind and forgotten.

Thank you

Kathleen Zielinski

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AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 7

02/12/16
Rebecca Perrenoud

Statement Senate Health and Welfare Committee

2-12-16

A warm thank you Mr. Chairman Heider and members of the committee, for your leadership, your dedication to our beautiful state of Idaho, our home land, and holding this hearing. My name is Rebecca Perrenoud; I live in Blackfoot, Idaho and am the CEO of A to Z Family Services, Inc. I recognize the privilege speaking in this forum where in other nations may be punished. I wish to represent the Little, the Lost, and the Lonely. I was asked by someone of influence, "What do you think the problem is; what is the struggle." I replied, "There is nowhere to go. Churches uses to be unlocked for us to enter and seek solace, now our churches are locked. There are few safe places of refuge; this along with the belief that no one understands, no one cares, and it won't get better, is creating a sense of hopelessness and desperation that often present as illness." I have been taught by my parents not to complain, therefore, I bring 3 solutions for consideration. I do not have all of the remedies, but together we do.

1. Let's consider a simple behavioral health package of services consisting of Clinical Therapy, Peer Support, Case Management, CBRS or an alternative replacement, funded by a flat rate vs. billable hour rate reimbursement. Let's consider discontinuing the lengthy documentation UM authorization process to acquire CBRS and include it as part of the simple health package. This could potentially reduce our cost for a contracted health care management company to regulate and monitor, saving valued resources for the vulnerable. This may reduce incorrect claims, reduce fraud, reduce our governmental expenditures of health care managing company contracts, reduce governmental tedious audits, and reduce health care providers' administrative load, leading to increased attention to what really matters, ...people.

2. Let's consider looking to other countries for guidance for our health care delivery. My understanding France and Germany are two of the leaders in health care delivery. We may wish to consider implementing the use of a health information smart card. This card holds all health care data of an individual, the card is brought to the health professional of choice, the health professional is able to see past treatment and medications, then adds to the health care record, the individual takes the card with them. This remedies the need for cumbersome document sharing amongst professionals, protects against confidentiality breach, maintains individuals investment in their own care, reduces possible duplicability, while reducing burden of health care long term storage.

3. Let's consider allowing providers to choose between CARF accreditation or the proposed IDAPA rules for quality of care. Allowing providers' a choice, would allow the goal of high quality services to bet met by all sizes and capacities of agencies, while reducing the governmental burden of quality oversight. Simplicity is the ultimate sophistication. *Leonardo daVinci*

I am honored to be part of the solution of protecting the Little, the Lost, and the Lonely.

I'm Taking A Stand...

Lost

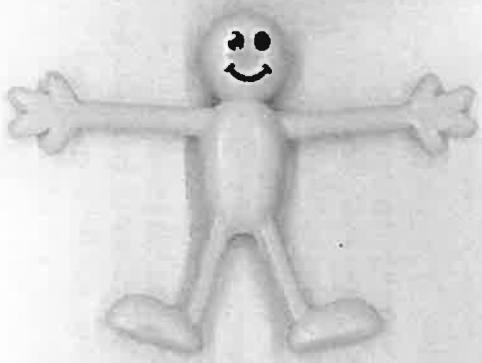
Little

Lonely

NCADV

TAKE A STAND AGAINST DOMESTIC VIOLENCE

#tasncadv
#takeastand
#STANDwithNCADV



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ATTACHMENT 8

02/12/16
Lindsey Dial

Lindsey Dial

Rescare Home Care Boise

During my time working in the homecare field I have made it a point to get to know my caregivers and clients very well. I want them to know I am available to them and I am their biggest support. Not only have I developed a relationship with my clients through quarterly house visits, but I have also worked many shifts with them. I also know their cares very well. I get to see firsthand how hard my care givers work to take care of my clients. My concern comes with watching the amount of work my care givers do for how little they are paid.

I have a caregiver that is living out of her car with her two little dogs. She knows we cannot pay her what she really deserves, but does this job because she knows these clients need the help. These passionate care givers can be hard to come by because of the low rates.

The cost of living in the Boise area continues to increase. With this increase the minimum wage stays at $7.25 which is throwing people into poverty. This in turn is costing the state of Idaho more money on welfare. According to Forbes, a family of four to live comfortably in the state of Idaho needs to make $56,491 per year, in the rural area, a family of four needs to make $58,071 per year. We are forcing people to live off the government.

The low rates Medicaid has set for the care we provide for our clients is asinine. We cannot keep caregivers staffed because they have to leave to make more money to live. For the care givers that do stay working for us we are forced to cut them to 40 hours per week, to avoid overtime. For clients that are authorized 56 hours per week, we are only able to service 40 of those hours because we cannot stay in business if we pay overtime so these clients go without the additional 16 hours they need.

This brings me to my next point; I have a client that is a quadriplegic. He was in a car accident 3 years ago with his wife and three kids. They were heading to a family reunion over towards Mountain Home. The car flipped and landed on the father while the rest of the family walked out with some bumps and bruises. The father was paralyzed with a broken neck. This father was 24 yr old at the time of the accident. Now at the age of 27, he has been with several different agencies because they could not keep him staffed due to the lack of caregivers and due to their inability to afford overtime wages. This has forced his wife who carries a full time job to stay home to do his catheter, ROM, bowel care, and all the other cares he cannot go without. Eventually these working spouses lose their jobs because we cannot staff their hours and now their entire family is forced to live off of welfare so she is able to take care of her husband. Medicaid's guidelines state that a spouse cannot be hired on to care for the client so we have a client who is finally be served the hours he needs but a family who lives entirely off the system. These families who are trying to do the right thing and keep a job to support their families can't because the health and welfare won't help the agencies who are trying to give them those opportunities.

Since we don't have the caregivers for our clients, are we to just let it get to the point where they are now in the hospital and worse off? Or they have to go to a facility where it would cost Health and welfare more money? Where these people who have worked so hard for their homes and belongings to have to move into a facility where they are uncomfortable and confused. Where would you want your parents or loved ones to go? Would you like your wife or husband to be able to still live at home with you and their dementia, and have a caregiver come in to help take care of them? A person with dementia is better off in a place they are familiar with and with people they know. These caregivers are sometimes the only form of communication these clients have.

Raising the reimbursement rates would allow us to increase the pay for our caregivers, it will allow us to pay over time if needed, to make sure these clients receive the care they need. No one asks to be bed bound or have to rely on someone else to help them get dressed or bathed. Let these clients keep the little dignity they have left and stay in their homes, independently.

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ATTACHMENT 9

Jodi Fulford - pg. 1

02/12/16
Jodi Fulford

Foster Care Reform Hearing

In November 2013, health and welfare called our adoption agency looking for an adoptive family for a group of siblings. The children had been in the system for 18 months and parental rights were expected to be terminated within a few months and we would be officially selected as the adoptive family at that time. Unfortunately, it took 9 months until parental rights were finally terminated and then we were informed that a relative had come forward to adopt them. Even though the case workers felt it was not an appropriate placement, they needed to allow ~~time for~~ them to complete a home study and there was no deadline for this to happen. At the same time, the department decided to try and reunite the children with other siblings who they had separated and placed into another pre-adopt home because of the immense needs of all of these children. They believed chances were slim that they would find a capable family but felt the need to pursue it anyway. In February 2015, after almost a year and a half of bonding with these children, working with multiple therapists and counselors to help them attach to **us**, and treating them as our own children, the department decided to move them to another pre-adopt home also separate from their siblings.

We were told not to say anything to the children until they found a new family but then one day, the case worker pulled our foster child out of class by herself, with no other support people around, to tell her the traumatizing news that she was going to be moving to a new family. They then sent her back to class with a hand written note of what the transition schedule would be. That is how fast the decision was made that the case worker did not even have time to type up a letter. There is much more to our story but the summary of it is that they picked up the children from their school the next day and moved them to the new family without informing us beforehand. They told us to pack their stuff up and bring it to the department. We ~~also~~ escalated the issue to the top of the department and met with several managers. They repeatedly told us there were no safety concerns in our home. They admitted to us that it was not handled appropriately and that changes had been made to their processes ~~based on our case~~ but that nothing could be done about our children at that point. We were allowed to see the children to say goodbye but have not been ~~able~~ allowed to maintain contact with them. We don't know what they told the children and can only imagine that they feel abandoned by us and unloved which is the furthest thing from the truth. We will always love these children and consider them a part of our family.

Since then, we have given up our dream of adopting and our only daughter will never have a sibling because of this situation. The only siblings she has ever known were ripped from her life. The emotional trauma this has caused our family has been immense but the trauma on the children is so much worse. The children were not given an opportunity to say goodbye to any of their friends and professional services they received while in our home were abruptly ended.

Changes need to be made immediately. The court system needs to have oversight. The judge in our case recommended that the department leave the children in our home and not pursue the other relative placement but they did it anyway. The judge told us she did not have jurisdiction to decide placement decisions. I believe that most of the case workers are good people who get into this job to help children but they are dealing with high stress, huge case loads and difficult situations. I am a trained counselor and have helped many adults and children suffering from the effects of trauma. In my professional opinion, many of the case workers are suffering from secondary trauma which they pass on to the foster parents and

children on their case load. When soldiers come back from war, they are evaluated by medical and mental health professionals to help them debrief and see if they are able to go back to the front lines. The same thing cannot be said about our foster care social workers. They need to be overseen by psychologists and evaluated on a regular basis for burnout and counter transference.

In addition to the changes already recommended, there needs to be a protocol for informing children of traumatizing information. The dept ~~They~~ need to be held accountable for following their own recommendations for transitions and there needs to be more urgency in permanence. It took 3 ½ years for these children to finally find permanency. If changes are not made, it will be a disservice to all those involved in the foster care system, but especially the children.

Jodi Fulford - pg. 2

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ATTACHMENT 10

02/12/16
Lauren Necochea

Testimony to the Joint Health and Welfare Listening Session

February 12, 2016

Lauren Necochea
Director, Idaho Voices for Children

Mr. Chairman, members of the joint committee, my name is Lauren Necochea and I direct Idaho Voices for Children. Thank you for holding this listening session.

We know Idaho families are working hard to build a future for their children and we all want to see them be successful, but many are in the precarious situation where an illness or medical emergency can pull the rug out from under them.

It's critical for families that we close Idaho's coverage gap. The gap hits families in two ways that are in conflict with Idaho values honoring families and work. First, the coverage gap carries a penalty for parents compared to childless Idahoans. Second, it forces sick Idaho parents earning low wages to choose between working and access to health care.

Today, you could have two workers working the same job at the same low wage. If the first worker is childless, he or she will earn enough money to go on the health exchange and find an affordable plan with a tax credit. If that other worker has children, the family size increases, and even at the same income level, the family is now below the poverty level, and therefore ineligible for a tax credit in the exchange. We have a system in Idaho today where the childless low-wage worker gets assistance with health insurance and the mother or father doesn't.

Currently, only Idaho parents with extremely low incomes can qualify for Medicaid. That sometimes means we force Idaho parents in the coverage gap to choose between work and healthcare. I met a mom in Canyon County who had access to care and medication for a serious condition while she was out of work during the recession. Her eyes lit up when she told me about how she'd secured an $8/hour job that allowed her put food on the table for her daughter. Even this modest wage meant she was no longer eligible for Medicaid. She was rationing her medication and worrying about keeping her job while facing life-threatening risks.

The only way she could get coverage again would have been to stop working. She didn't want to do that, but a crisis was looming.

There are great fiscal and economic reasons to close the coverage gap. We could also eliminate $12-$18 million in unnecessary tax penalties for businesses. We could strengthen the overall health care system and focus on prevention, rather than pay for expensive emergency care. These are great reasons. There are 78,000 more and they would very much appreciate your consideration.

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ATTACHMENT 11

02/12/16
Susanne Jamison

MISTER CHAIRMAN....MEMBERS OF BOTH THE HOUSE AND THE SENATE WELFARE COMMITTEES.
MY NAME IS SUSANNE JAMISON AND I AM THE EXECUTIVE DIRECTOR OF THE IDAHO DENTAL HYGIENISTS' ASSOCIATION.
FIRST, DENTAL HYGIENISTS ARE LICENSED HEALTH PROFESSIONALS WITH A WEALTH OF KNOWLEDGE AND SKILLS TO SHARE WITH IDAHO CITIZENS. THERE ARE OVER 1800 DENTAL HYGIENISTS AND OVER 1200 DENTISTS LICENSED IN IDAHO. THERE ARE FOUR DENTAL HYGIENE EDUCATION PROGRAMS IN IDAHO, ONE OF WHICH HAS A MASTER OF DENTAL HYGIENE PROGRAM THAT IS ONLINE.

I COME BEFORE YOU TODAY TO URGE YOU TO CONSIDER THE CREATION OF A DENTAL HYGIENE MIDLEVEL PRACTITIONER POSITION IN THE STATE OF IDAHO. MIDLEVEL PROVIDERS ARE COMMON IN OTHER HEALTH PROFESSIONS. NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS ARE EXAMPLES. DENTAL HYGIENE MIDLEVEL PRACTITIONERS EXIST IN OTHER STATES SUCH AS NORTH DAKOTA AND WASHINGTON. THEY PERFORM PREVENTIVE AND SIMPLE RESTORATIVE PROCEDURES SUCH AS CLEANINGS AND SEALANTS. THEIR EDUCATION IS ECONOMICAL BECAUSE DENTAL HYGIENISTS ALREADY HAVE A DEGREE, ARE LICENSED INDICATING COMPETENCY, AND WOULD NEED VERY LITTLE ADDITIONAL EDUCATION.

HERE ARE SOME QUICK ORAL HEALTH FACTS ABOUT IDAHO:

- 42 COUNTIES, OR ALMOST ALL OF IDAHO, IS DESIGNATED AS A DENTAL HEALTH PROFESSIONAL SHORTAGE AREA - THAT DOESN'T MEAN THERE'S A SHORTAGE OF DENTISTS IN ALL AREAS...IT JUST MEANS DENTAL PRACTICES TEND TO CONGREGATE IN POPULATED AREAS...WHILE OTHER AREAS GO UNSERVED.
- 21% OF CHILDREN 6 TO 9 YEARS OLD HAVE UNTREATED DENTAL DECAY
- 50% OF PREGNANT WOMEN HAVE BLEEDING GUMS, INDICATING INFECTION
- 65% OF PEOPLE WITH DIABETES HAVE HAD ONE OR MORE TEETH REMOVED
- 69% OF THOSE WITH CORONARY HEART DISEASE HAVE TOOTH LOSS
- 70% OF ADULTS 65 YEARS AND OLDER DO NOT HAVE DENTAL INSURANCE
- 55% OF 18 TO 24 YEAR OLDS DO NOT HAVE DENTAL INSURANCE AND
- AMONG IDAHO ADULTS 65 AND OLDER, ONE IN FOUR HAS LOST ALL THEIR TEETH.

IDAHO IS IN AN ORAL HEALTH CARE CRISIS...BUT THERE IS AN ANSWER...CREATION OF THE DENTAL HYGIENE MIDLEVEL PRACTITIONER.
AS THINGS STAND TODAY, THE DENTAL HYGIENIST IS ONE OF THE MOST UNDER-UTILIZED PROFESSIONALS IN OUR STATE. OTHER STATES HAVE FOUND THAT INCREASING THE RESPONSIBILITIES OF HYGIENISTS HAS RESULTED IN

INCREASED EFFICIENCES, IMPROVED ACCESS TO ORAL CARE AND LOWERED COSTS TO PATIENTS.

UNFORTUNATELY THERE ARE SOME POWERFUL FORCES THAT MIGHT OPPOSE THIS PROPOSED CHANGE BECAUSE NAYSAYERS SAY THIS MIDLEVEL PROVIDER IS UNNEEDED AND UNSAFE. HOWEVER, THERE IS NO EVIDENCE OF EVER HARMING A PATIENT BECAUSE OF THIS PROVIDER. IN FACT, NUMEROUS STUDIES HAVE SHOWN JUST THE OPPOSITE. ORAL CARE IS OF HIGH QUALITY AND CAN EVEN INCREASE REVENUE FOR DENTISTS, ORAL SURGEONS, PERIODONTISTS, AND VARIOUS OTHER MEDICAL PROFESSIONALS. IN MINNESOTA, THIS PROVIDER HAS INCREASED THE NUMBER OF MEDICAID PATIENTS SEEN, AND RAISED REVENUE WHILE DECREASING WAIT TIMES.
I HOPE YOU WILL AGREE THAT IT'S PERPLEXING WHY ANYONE WOULD OPPOSE A POTENTIAL SOLUTION THAT COULD PROVIDE SIGNIFICANT BENEFITS TO IDAHO CITIZENS. THE DENTAL HYGIENE MIDLEVEL PRACTITIONER EXISTS IN AT LEAST 14 STATES ALREADY, WITH OTHERS MOVING TOWARD THIS MIDLEVEL PROVIDER. A JOINT TASK FORCE OF ORAL HEALTH PROFESSIONALS AND OTHER STAKEHOLDERS COULD BE ASSEMBLED TO DEVELOP THE MODEL THAT WORKS FOR IDAHO. LET'S NOT LEAVE IDAHO CITIZENS BEHIND WHEN IT COMES TO ORAL HEALTH CARE, ESPECIALLY THE UNSERVED AND UNDERSERVED.

IN CLOSING HERE IS AN EXCERPT FROM THE 2014 GOVERNORS REPORT:

"Dental hygienists often are at the center of proposed strategies to increase access to oral health care. Such strategies include changing supervision rules and reimbursement policies so that dental hygienists are able to provide preventive services outside of dentists' offices or creating advanced-provider models that involve educating hygienists to perform under new titles with an expanded scope of practice and less supervision. Some of the barriers to access for underserved populations will be the same, regardless of whether services are provided by a dentist or a dental hygienist. Those barriers include low health literacy, low reimbursement rates for the publicly insured, and high administrative burdens for reimbursement from public payers."

RESOURCES

THE BURDEN OF ORAL DISEASE IN IDAHO 2014, IDAHO ORAL HEALTH PROGRAM, DEPARTMENT OF HEALTH AND WELFARE, DIVISION OF PUBLIC HEALTH.

THE NATIONAL GOVERNORS ASSOCIATION REPORT. THE ROLE OF DENTAL HYGIENISTS IN PROVIDING ACCESS TO ORAL HEALTH CARE. JANUARY 2014.

FACTS ABOUT THE DENTAL HYGIENE WORKFORCE IN THE UNITED STATES. AMERICAN DENTAL HYGIENISTS' ASSOCIATION, JANUARY 2016.

American
Dental
Hygienists'
Association

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www.adha.org

Facts about the Dental Hygiene Workforce in the United States

Dental Hygienists are Primary Providers of Oral Health Care Services

The dental hygienist is the member of the oral health care team focused on preventing oral disease and identifying and treating oral disease while it is still manageable. Dental hygienists are primary care oral health professionals who administer a range of oral health services including prophylaxis, sealants, fluoride treatments, oral cancer screenings, oral health education, and in many states dental hygienists play an active role in placing restorations.[1]

Dental hygienists are licensed health care providers in each of the 50 states and the District of Columbia. In order to become licensed as a dental hygienist, an individual must graduate from one of the nation's 335 accredited dental hygiene education programs and successfully complete both a national written examination and state or regional clinical examination. The average entry-level dental hygiene education program is 84 credits, or about three academic years, in duration.[2] Approximately 6,700 dental hygienists graduate annually from entry level programs that offer a certificate, or an Associate's or Bachelor's degree. There are currently 21 Master's degree dental hygiene education programs in 16 states. In 48 states and the District of Columbia, dental hygienists are required to undertake continuing education as part of the licensure renewal process to maintain and demonstrate continued professional competence.[3]

Dental hygienists work in a host of settings to deliver clinical care and work under varying levels of supervision, depending on the state practice act. States are increasingly recognizing the importance of increasing direct access to dental hygiene services. In 1995, five states allowed direct access. Currently, 38 states have policies that allow dental hygienists to work in community-based settings (like public health clinics, schools, and nursing homes) to provide preventive oral health services without the presence or direct supervision of a dentist.[4] These states recognize that dental hygienists are primary care providers who are an essential entry point to the health care system.

Dental Hygienists' Impact on Access to Care

The dental hygiene profession with its continuing growth offers a cadre of competent and licensed providers who can deliver comprehensive primary care services in an increasing array of settings. Direct access to dental hygiene services is especially critical for vulnerable populations like children, the elderly, and the geographically isolated who often struggle to overcome transportation, lack of insurance coverage, and other barriers to oral health care. Today, 17 states (Arizona, California, Colorado, Connecticut, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, Oregon, Rhode Island, Washington and Wisconsin) recognize and reimburse hygienists as Medicaid providers.[5]

HRSA's National Center for Health Workforce Analysis developed the Dental Hygiene Professional Practice Index (DHPPI) to document the dental hygiene profession across the 50 states and assess the impact of dental hygienists on access to care for underserved

populations.[6] The findings of the study suggest that expanding the professional practice environment of dental hygienists improves access to oral health services, utilization of oral health services and oral health outcomes. Indeed, the study noted that "more can be done to increase the impact of these professionals [dental hygienists] on improved access and quality of care and reduced costs of care. More can be done to align DH [dental hygiene] scope of practice with demonstrated DH clinical skills and competencies."[7]

Dental hygienists throughout the country have demonstrated their ability to reach patients in alternative settings, thus drawing those who are currently disenfranchised from the oral health care system into the pipeline for care. In South Carolina, a school-based program brings dental hygienists directly to low-income students in 413 schools in 45 targeted school districts. Importantly, the program has 20 restorative partners, dentists who agree to see referred children in their private offices, thus promoting the receipt of comprehensive services. Data from the state has demonstrated that in the first five years the program was effectively in place; sealant use for Medicaid children increased while the incidence of untreated cavities and treatment urgency rates decreased for that population.[8] The 2007-2008 Needs Assessment showed that there were no disparities between black and white third grade children for sealant use in South Carolina.[9]

A program in Michigan, Smiles on Wheels, run by three dental hygienists, applied more than 1,360 sealants to children in schools in a one year period. The same program also brings care directly to patients living in nursing homes who are not able to travel for dental care.[10] For more than a decade, California has recognized "Registered Dental Hygienists in Alternative Practice" who provide unsupervised services in homes, schools, residential facilities and in Dental Health Professional Shortage Areas. A study of RDHAPs in California found that "alternative care delivery models such as RDHAP are *essential* to improving oral health and reducing health disparities."[11] These are just a few examples of innovative models and programs that maximize utilization of the experience, education and expertise of dental hygienists, many more can be found throughout the country.

Oral Health is Vital to Total Health and Most Dental Disease is Preventable
Research is continually emerging that demonstrates the link between oral health and total health. The Centers for Disease Control has noted the relationship between periodontal disease and health problems like diabetes, heart disease, and strokes.[12] The tragic death of 12 year old Deamonte Driver who died in 2007 as a result of complications from a brain infection that was brought about by an abscessed tooth was an unfortunate demonstration of the impact of untreated oral disease. In 2012, Kyle Willis, a 24-year-old father died from a tooth infection because he couldn't afford the antibiotics he needed, offering a sobering reminder of the importance of oral health and the serious-even fatal consequences- that people without access to dental care suffer. Lack of access to dental care forces too many Americans to enter hospital emergency rooms seeking treatment for preventable dental conditions, which emergency rooms are typically ill-equipped to handle.

Most oral diseases are completely avoidable with proper preventive care; however, in spite of this proven prevention capacity, oral disease rates among children and adults continue to climb.[13, 14] Preventing oral disease can positively impact total health and is also cost effective. Research indicates that low-income children who have their first preventive dental visit by age one incur dental related costs that are approximately 42 percent lower ($262 before age one, $449 between ages two and three) over a five year period than children who receive their first preventive between the ages of two and three.[15] Preventive care can diminish the need for more costly restorative and emergency care, saving valuable health care dollars in the long-run.

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[2] American Dental Hygienists' Association. *Dental Hygiene Education: Curricula, Program Enrollment, and Graduate Information.* American Dental Hygienists' Association [Internet]. 2014 Oct 21 [cited 2014 Feb 2]. Available from: http://www.adha.org/resources-docs/72611_Dental_Hygiene_Education_Fact_Sheet.pdf

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[4] American Dental Hygienists' Association, *Direct Access States Chart*, Chicago, IL, 2013. http://www.adha.org/resources-docs/7513_Direct_Access_to_Care_from_DH.pdf

[5] American Dental Hygienists' Association, *States Which Directly Reimburse Dental Hygienists for Services Under the Medicaid Program*, Chicago, IL, 2013. http://www.adha.org/reimbursement

[6] Health Resources and Services Administration, *The Professional Practice Environment of Dental Hygienists in the Fifty States and the District of Columbia, 2001*, National Center for Health Workforce Analysis, Bureau of Health Professions, Rockville, MD, 2004.

[7] *Ibid.*

[8] South Carolina Rural Health Resource Center, 2007-2008 South Carolina Oral Health Needs Assessment Data, 2008.

[9] *Ibid.*

[10] Smiles on Wheels Data, Jackson, Michigan. 2009.

[11] Mertz, E., "Registered Dental Hygienists in Alternative Practice: Increasing Access to Dental Care in California," University of California, San Francisco, Center for the Health Professions, May 2008, p. 44.

[12] U.S. Centers for Disease Control and Prevention. *Links between Oral and General Health*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2004.

[13] U.S. Centers for Disease Control and Prevention. *Links between Oral and General Health*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2004.

[14] Dye BA, Tan S, Smith V, Lewis BG, Barker LK, Thornton-Evans G, et al. National Center for Health Statistics. *Trends in oral health status: United States, 1988–1994 and 1999–2004. Hyattsville, MD. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 2007.*

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[16] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2014-15 Edition*, Dentists, Washington DC, 2014. http://www.bls.gov/ooh/healthcare/dentists.htm#tab-6

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JOINT
SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 12

02/12/16
Children's NW Home

NORTHWEST CHILDREN'S HOME
CONTRACTS

68 BEDS TOTAL
49 BEDS FULL CURRENTLY
72% CAPACITY

WASHINGTON
KIDS

40 CURRENTLY
82%

OREGON
KIDS

1 CURRENTLY

IDAHO
CHILD WELFARE
KIDS

QUEST = 1
QEWETT = 2
6%

IDAHO
CHILDREN'S
MENTAL
HEALTH
KIDS

QUEST = 1
QEWETT = 5
12%

IDAHO
DEPARTMENT
OF
QUVENILE CORRECTIONS
KIDS
(IDJC)

0

PROGRAMS

QEWETT
HOPPER
QUEST
VISION
SYRINGA: CLOSED
12/31/2016

* IDAHO RATE IS 25% - 35%
LESS PER DAY
THAN WASHINGTON, OREGON OR IDJC RATES

Admission Criteria for Northwest Children's Home--

Attributes Accepted:

1. Must have a full scale IQ of 60 or greater
2. Must be within the ages of 6 and 18
3. Currently not able to benefit from less restrictive setting and treatment
4. Currently need 24 hour care
5. Currently must be able to be safely managed in an open facility (does not require a locked facility)
6. If psychotic, must be amendable to treatment using psychiatric medications
7. DSM-IV Diagnosis including, but not limited to: Conduct Disorder, ADHD, Bipolar Disorder, Depression, Schizophrenia, ODD, OCD
8. History of sexual, physical, or emotional abuse
9. History of sexual offending/sexually aggressive behavior
10. Manageable medical conditions including diabetes, special dietary needs, encopresis, enuresis, Seizure disorder
11. Serious family dysfunction
12. Lack of immediate family resources

For Hopper Program Only

13. Must be identified as having sexually aggressive/abusive behavior.

Admission Criteria for Extensive Evaluation--

1. (*) History of fire setting
2. (*) Sexual acting-out behavior
3. (*) Severe personality disorders
4. (*) Current high risk to self or others
5. (*) Severe Elopement Behavior
6. (*) Special Medical/Physical Conditions

Exclusion From Admission--

1. Pregnancy
3. Significant, untreated substance abuse as a primary treatment issue
4. Current History of extreme violence

NCH Admission Criteria Checklist

Admission Criteria:	1	2	3	4
IQ	100 and above	80-99	61-79	Below 60
Settings:	Hx of home based care only unsuccessful	Hx of home based care and group homes unsuccessful	Hx of prior Residential treatment	Unsuccessful history in detention, secure, or hospital setting
Runaway history	None in past year (age 6-10 last 6 months)	Has had occasional day time runs with no criminal behaviors	Has had overnight runs or frequent day time runs with no community victims and up to occasional drug use	Has had runs with community victims through theft, assault, property damage, etc. or frequent drug use
Diagnostic	Mental health diagnosis no treatment history	Mental Health diagnosis has history with compliance and demonstrated efficacy	Mental Health Diagnosis has treatment efficacy with some resistance	Mental health diagnosis and non-compliant/ Oppositional or unresponsive with multiple attempts.
Sexual behaviors present	None	Some behaviors present/No victims established	Victims established/Non Violent acts	Violent attempts of sexual assault
Medical Needs	Minimal	Some needs such as glasses, braces, temporary injury	Medium needs manageable by nursing that can be carried out by RTS staff members	Life threatening ongoing needs with high travel requirements or beyond the training of staff members during evenings and weekends
Fire Setting Behaviors	Not present in history	Present on one occasion with item unattainable and no run history	Present over 2 years ago, no other attempts noted	Present within last two years with obtainable items or run history tied with any fire setting behaviors
Assault	Not present	Present, but not in residential care	Present without injury or risk of major injury	Current history of extreme violence (leading to or causing major injury)
Drug Use	No history of use of narcotic drugs	Treated with no recent use of narcotics	Untreated, occasional use, may be present in diagnosis	Primary issue of drugs and alcohol, clear addiction established in documentation.
Self Harm	No history of self harm in the past year	A couple of incidents of Superficial Self Harm in the past year	Repeated efforts of superficial self- harm, or accidental injury as a result, suicidal discussion possibly with plan.	Purposeful life threatening suicide attempts, or thoughtful planning of suicide attempt that is life threatening
Property Destruction	No history of property destruction in past year	Minor property destruction (low value items, agency property or personal property)	Major property destruction (doors, windows, tv's not used as a weapon)	Extreme Property Damage (cars, thousands of dollars of property destruction

08. Interstate Compact on Out-of-State Placements. Where necessary to encourage all possible positive contacts with family, including extended family, placement with family members or others who are outside the state of Idaho will be considered. On very rare occasion the Department may contract with a residential facility out of state if it best serves the needs of the child and is at a comparable cost to facilities within Idaho. When out-of-state placement is considered in the permanency planning for a child, such placement will be coordinated with the respective interstate compact administrator according to the provisions of Section 16-2101, et seq., Idaho Code, the "Interstate Compact on the Placement of Children." Placements must be in compliance with all state and federal laws. (5-8-09)

Idaho Admin. Code r. 16.06.01.030

11) At any time the department is considering a placement pursuant to this chapter, the department shall make a reasonable effort to place the child in the least restrictive environment to the child and in so doing shall consider, consistent with the best interest and special needs of the child, placement priority of the child in the following order:
(a) A fit and willing relative.
(b) A fit and willing nonrelative with a significant relationship with the child.
(c) Foster parents and other persons licensed in accordance with chapter 12, title 39, Idaho Code.

Idaho Code Ann. § 16-1629 (West)

(8) The department having been granted legal custody of a child, subject to the judicial review provisions of this subsection, shall have the right to determine where and with whom the child shall live, provided that the child shall not be placed outside the state without the court's consent. Provided however, that the court shall retain jurisdiction over the child, which jurisdiction shall be entered on any order or petition granting legal custody to the department, and the court shall have jurisdiction over all matters relating to the child. The department shall not place the child in the home from which the court ordered the child removed without first obtaining the approval of the court.

Idaho Code Ann. § 16-1629 (West)
The child's placement and care are the Department's responsibility. The child must live in a licensed foster home, licensed institution, licensed group home, or in a licensed relative's home. (3-30-01)
01. Interstate Placements. In interstate placements, a child may be placed with an approved unlicensed relative when delaying the placement would be harmful to the child's well-being. In those cases, a subsequent request for foster care licensure will be made through the Interstate Compact on the Placement of Children. (3-30-07)
02. Intrastate Placements That Become Interstate Placements. If a foster care placement that was initially intrastate becomes an interstate placement because the family with whom the child is placed relocates to another state, a request for foster care licensure will be made through the Interstate Compact on the Placement of Children immediately upon the decision to move the child. If the state to which the family has moved accepts the family's Idaho foster care license as effective, the placement is considered licensed until a determination is made that the family is in

compliance with the licensing and other applicable laws of the state to which the family has moved. (3-30-07)

Idaho Admin. Code r. 16.06.01.428

ARTICLE VI. INSTITUTIONAL CARE OF DELINQUENT CHILDREN

A child adjudicated delinquent may be placed in an institution in another party jurisdiction pursuant to this compact but no such placement shall be made unless the child is given a court hearing on notice to the parent or guardian with opportunity to be heard, prior to his being sent to such other party jurisdiction for institutional care and the court finds that:

(1) Equivalent facilities for the child are not available in the sending agency's jurisdiction; and

(2) Institutional care in the other jurisdiction is in the best interest of the child and will not produce undue hardship.

Idaho Code Ann. § 16-2102 (West)

Subject: Determining Educational Settings for Youth Placed in the Department's Legal Custody Pursuant to the Child Protective Act: Public School vs. Private School		FACS Administrative Directive: 13-001
Effective Date: 9/1/13	**Supersedes: N/A**	**Approved by:** 9-6-13 **Date (signed):**
Annual Review Date: September 1	**Annual Reviewer:** Miren Unsworth	**Technical Support Contact:** Miren Unsworth
Location:	**Total Pages: 3**	**Attachment(s): form, page 3**
Programs Affected: Children and Family Services		

Whenever, and at all times possible, children and youth shall be provided education in the least restrictive, most normative environment possible. It is the policy of the Division of Family and Community Services (FACS) to ensure that children are provided with the same opportunities and experiences as all children regardless of their placement circumstances. By federal law, all youth, including those served by FACS, are entitled to a free and appropriate public education in accordance with the requirements of *Section 504 of the Rehabilitation Act of 1973, (Pub.L. 93–112, 87 Stat. 355, enacted September 26, 1973), codified at 29 U.S.C. § 794, the Americans with Disabilities Act of 1973, 42 U.S.C. Section 12131 et seq., and implementing regulations at 34 C.F.R. Part 104.*

IEP Authority

The right to an education in the least restrictive environment is also guaranteed by Idaho law (I.C.33-201, 33-1404, 33-2002, and 33-2004). In particular, Section 33-1404 states "Nonresident pupils who are placed by court order under provisions of the Idaho juvenile corrections or child protective acts and reside in licensed home, agencies and institutions shall be received and admitted by the school district in which the facility is located without payment of tuition." See also: Attorney General Opinion, "Funding for Education of Juveniles placed in Private Residential Facilities," Dated December 19, 1996. As such, it is clear that local school districts have the responsibility for educating youth in residential care settings and for the identification and evaluation of children in need of special education in those settings. Department staff shall participate in team meetings and reviews regarding education of youth in residential care settings.

All children in the care of the Department are expected to receive a free and appropriate public education through existing public education services. In rare instances a child may be placed at a non-public accredited school on a time-limited basis. The Department will make that determination, based upon best interests and clinical needs of the child. In addition to best interests and clinical needs, the Department will consider parental preference as the cost of non-public education may impact the parent's child support obligation to help defer the costs of care. Examples justifying an exception to public education may include: prior expulsion; habitual truancy; incorrigibility; or when a child poses a serious immediate threat to safety or health of self or others which cannot be reasonably controlled in a public school environment.

IEP? TEAM

Child's Name:
Case Manager's Name and Work Station:
Child's Current Placement:

Summary of Best Interests and Clinical Need for Placement of Child in a Non-public Accredited School *(to be completed by the youth's worker).*

Pursuant to the Administrative Directive regarding placement of youth in non-public accredited schools, I have reviewed the details of this case and concur that it is in the child's best interest and that this placement would best meet the child's clinical needs.

At the point one of the following approvers disagrees, the request is considered void and the request is terminated.

5 APPROVAL STEPS

Supervisor	Date
Lead Chief or Chief of Social Work	Date
Program Manager	Date
Division Administrator	Date

IDAHO DEPARTMENT OF HEALTH & WELFARE

EDUCATIONAL INFORMATION FOR ALTERNATE CARE

Effective July 1, 2013

DBH-0522 (6/13)

Child's Name: _____

Name of Current School: _____ Current Grade: _____

My child has ☐ an Individualized Education Program (IEP), ☐ a 504 Accommodation Plan, or ☐ neither of these. (Check one)

The following has worked well academically, behaviorally, and socially for my child at school: (for example – teacher's aide, text books at home, frequent breaks, lunch buddies, etc.)

The following has not worked well academically, behaviorally, and socially for my child at school: (for example – sticker charts, seated in front row, unstructured time, etc.)

My child's strengths at school are:

During the time my child is in alternate care, subject to IEP Team approval: (Check one)

☐ I would prefer my child be educated through the public school system, or

☐ I would prefer my child be educated through the alternate care program's accredited school program, if one is available. *I understand that any additional costs for educating my child are considered costs of out of home care and are part of my financial obligation under Idaho Code Section 16-2406(3).*

Please explain the reasons for your preference and how it will benefit your child:

The anticipated educational setting for my child when he/she returns home is:

Additional information about my child that would be helpful in planning for his/her educational needs:

_____ _____

Parent's/Guardian's Signature Date

FOR REGIONAL OFFICE USE:

Educational costs for an accredited non-public school in an alternate care setting is hereby

☐ Authorized ☐ Not Authorized ☐ Not Applicable.

_____ _____

Program Manager or Designee Signature Date

Lewiston Campus

October 2015

Neighborhood Block Party

Big Thank you to everyone involved in the event on October 8th. Over 60 attendees enjoyed a tour of our 22 acre campus and enjoyed baked goods from our dining room. A facility like the Children's Home in a neighborhood environment is lucky to be able give our children a sense of community. We currently own Jewett Park and lease it to the city for $1/year. This is the local park and both our kids and neighbors enjoy it immensely. There were lots of questions about NCH from the neighbors.

Special THANK YOU to:
Ida Vend Broadcasting, Community Bank, Troy Insurance, Lewiston Tribune

Upcoming Events:

NCH tree at Locomotive Park "Winter Spirit"
Our Children will decorate a tree that will be lit up during the holiday season

November is Non-Profit Month

Red Stocking Campaign– Annual giving Campaign November– December Look for opportunities to give to the kids at Happy Day Locations, Joe Hall Ford and Kendall motors locations. Donations can be made online or at our admin office.

Coffee with the Girls– December 4th 10am
Clarkston Event Center, Clarkston
Community Women celebrating the strengths of women while enjoying speakers, entertainment and silent auction and raffle items.
Tickets available now $25. Donations needed.

Thank you to the Friends of Northwest Children's Home

Thank you to the Friends of Northwest Children's Home Vision Classroom will receive books, book displays, bags for books to be taken back their rooms, comfy beanbag chairs and fun carpet for the library area. These funds were given by the Lewiston School District LIFE grant. Clearwater Paper Corporation approved a grant for $3500 to purchase Trauma Informed Care Therapy items for all 4 of the programs at Northwest Children's Home. The therapists at NCH will have more options when working with our children. FLOR Flooring Company is donating carpet squares from recycled carpets, plastic bottles, and fishing nets. They have put together rugs for each room in the Vision house. This is a great way to cozy up the spaces for the kiddos. Thank YOU Friends and supporters of our KIDS.

Thank YOU Friends and supporters of our KIDS.

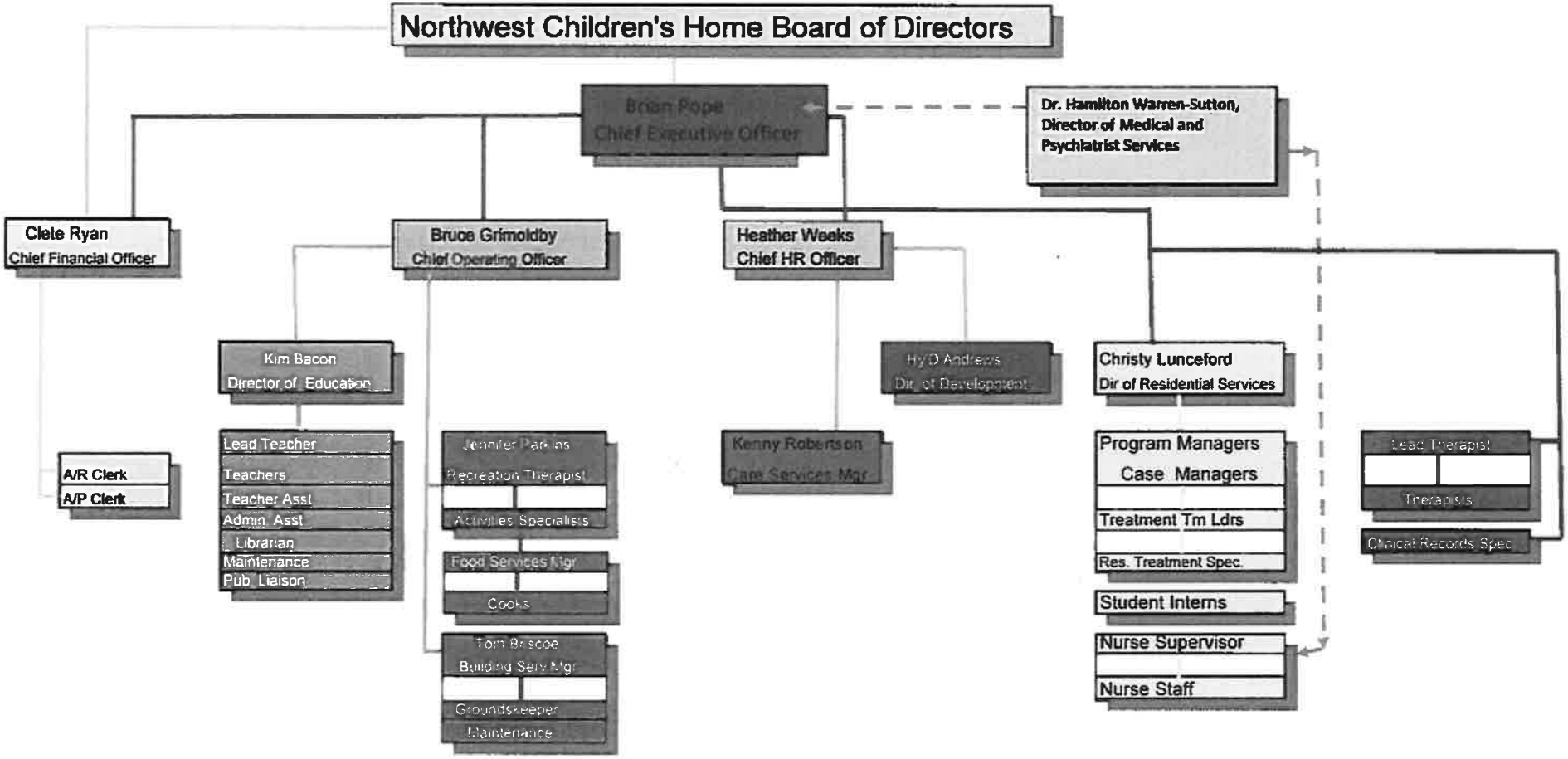
Fund a Case:

We are in need of new or slightly used roller blades for the Vision boys. This is their favorite activity and some new wheels would make the fun times keep rolling!!!
If you are interested in donating blades, skates or a donation toward wheels
please contact 208-743-9404 ext. 205

New to the North Slope of Campus

Northwest Children's Home's Lewiston campus sits on 22 acres in the heart of the city's Reno Addition. Approximately 12 of those acres accommodate our four residential cottages, various support-services buildings (dining, education, maintenance, nursing, recreation, etc.), and recreational fields, sports courts and gardens. Adjacent to our campus is Jewett Park, which we lease to the city (for $1.00 per year!); it occupies about three acres. The remaining 7-or-so acres have, for many years, played host to an assortment of native grasses and noxious weeds. This year we decided to put that area to a more productive use. With generous help from our community partners, we mowed about 90% of this ground, plowed it, and are planting a cover crop of alfalfa. Greening up this "north slope" will fix nitrogen in the soil, preparing it for more vegetable gardens, fruit and ornamental trees, and future 4-H projects, not to mention bike and roller blade trails. We are very excited about this endeavor. In addition to beautifying our campus, it will enhance our children's experiences and, true to our motto, brighten their futures.

Revised February 2016



JOINT
SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 13

pg 1 of 2
02/12/16
Kathleen Keyes

Name: Richard & Kathleen Claire Keyes

- We had 2 half sisters placed with us for 15 months
- H&W determined 1 would be adopted the other they hoped to reunify
- H&W told us we could adopt the 1 girl
    - social workers got reports from the school, counselor, lawyer and the guardian ad litem; all supported us adopting her
- The plan for over 2 months was for us to adopt
- At the regular court review Judge Minder ruled the we could adopt the 1 and H&W needed to move the other due to the situation. In the courtroom everyone agreed to keep both girls in the Boise area to continue contact between them and extended family.
- Then all of a sudden we received a call saying the social worker would be picking the kids up the next day and to pack their belongings that evening
- The girls were quickly moved to what the social worker called a temporary placement
- We asked to keep the girls until we figured out what was going on but we were not allowed
- We were assured we could continue contact with the girls, the girls were told we could visit - we were not allowed to contact them once they left our home
- We asked to appeal the decision -
- We had a meeting with the social workers and their managers - we specifically asked why the girls were moved and if there were safety concerns? They said there were no safety concerns they wanted to keep the girls together
- The girls were moved in June
- H&W said we did not have the grounds to appeal
- we asked who made that decision and we were told the same workers that made the decision to move kids determined we did not have the grounds to appeal
- We continued to try to appeal the move, we reached out to the governor's office and had a meeting with H&W in the statehouse

Name: Richard & Kathleen Claire Keyes

- Nothing changed
- In the fall the 1 girl to be adopted was a Wednesday's child - we applied to adopt even finding a foster home for the other girl until reunification and signing a contract with the other parents that we would keep girls in counseling together and they would see each weekly
- We were not chosen, they moved her to Tennessee over Christmas break
    - this placement lasted less than 10 days, she returned before break was over
- In the late spring she was Wednesday's child again - again we applied - again we were not chosen
    - this placement is in Kentucky - she has no contact with extended family and extremely limited contact with her sister
    - the sister was visiting but now she is aging out of foster care (was never reunified)
- If the 1 girl had stayed in our home she would have been adopted within 18 months of going into foster care and only had 1 placement - our home
- Because of H&W disregard for the professionals advise, our desire, the girls desire (she was 11 and voiced her desire to stay with us), and disregard to Judge Minder's order to move only 1 girl - she was moved 5 times and not adopted for over 2 years
- ever since the girls were moved we have been blacklisted because we went up against them

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SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 14

Representative Christy Perry

From: Brian
Sent: Thursday, February 11, 2016 10:38 PM
To: Representative Christy Perry
Cc:
Subject: Foster Care

Importance: High

Hon. Rep. Perry:

We spoke on the telephone last night and this is our story.

October 2008. My wife and I made the decision to get involved with the foster care program. We made a conscious decision not to have more biological children, but felt that adoption was an viable option. So, we went through the licensing process and training program; interested in long-term placements.

May of 2009. We obtained our foster care license, with our first placement being two girls age 5 and 13, Alexandra and Alyssa. The girls were from a rough home were methamphetamine was trafficked and Alyssa had been abused. From the first moment we had the girls, we knew that it was going to a rough go, but we pushed through it. As the months passed, it became clear that the girls were not going back with the parents and were going to candidates for adoption. During this time, we had become a family....blood relatives or not.

Through the court process, it became clear that IDHW was not interested in allowing us to adopt the kids and were actively working to place Alex and Alyssa elsewhere. During this time, Alyssa turned 14, and was given the opportunity to have input on her future; she made it clear she wanted to stay with us, as a family. However, the biological mother was going to Federal prison and was insistent that Alex be placed with her husband's brother in California. This "uncle" was someone that Alex had never met. As the court process continued, the Guardian ad litem, psychologist, court appointed attorney, and other biological family members all recommended that BOTH Alex and Alyssa be placed permanently with us. They believed that the kids needed to stay together, and since we (wife and I) had developed personal relationships with the kids' biological aunts and uncles, it was win-win for everyone involved.

We continued to fight the State of Idaho Health and Welfare on this issue, to include catching the IDHW attorney in an untruth in court; then having the kids' attorney notify the judge. The result? I was banned from all future court proceeding concerning the children. My wife was allowed to continue, however, I was not. Then IDHW came to my home and threatened to revoke our foster care license and take both Alex and Alyssa from us.

December 2009. At this point, we were working on permanent legal guardianship and/or adoption of Alyssa. We were stuck, and IDHW knew it. We had to make a choice, letting Alex be taken from us in order to keep Alyssa. We were crushed, and felt like the government had just run roughshod over us. Moreover, we had to explain to Alyssa that we had to quit fighting for Alex; and that she (Alyssa) was going to have to accept the fact that her sister was going to be placed with the "uncle" in California.

March 2010. Alexandra was placed with the family in California. Alyssa was given little to no opportunity to keep in contact with her sister. Phone calls on birthdays and holidays. The bright spot was that the uncle and his family spent time in Mexico during Christmas. The State of CA would not allow them to take Alex to Mexico, so we were able to take her during the break. Which was wonderful. Christmas 2010 was one we will not forget, as it was the last time we were together as a family.

September 2011. We completed the adoption of Alyssa. Both our children are our shining stars, I love them dearly. My daughter became a very strong woman and is just like her mother. She overcame a tremendous amount of adversity to

become a well-adjusted adult, and happy. Today, Alyssa is a dental hygienist for a dental surgeon in Las Vegas, NV. My wife and I are very proud of her.

October 2015. Alexandra had been adopted by the uncle a few years prior. Virtually all communication with Alex had ceased, as the uncle would not allow it. During October, Alyssa was notified by bio-family that Alex had been placed into foster care with different aunt. Alex had divulged that her new parent (uncle) had been sexually abusing her for the last 3+ years. In addition, Alex had sustained injuries consistent with this type of abuse. The State of CA acted immediately and placed her into a new foster home. As of today, Alex is in a safe environment and she is now able to visit with Alyssa on a more frequent basis. However, Alex has been significantly damaged by this process and will require a tremendous amount of therapy and love to overcome it.

This situation was wholly avoidable, if IDHW had just listened to those people that knew better. Alex would still be in a loving home, with safety, security and the means to be a well-adjusted child in Idaho. Instead, she is now a victim. A statistic. Just another child in the revolving foster care system. This story is sad and unacceptable, and it must change for future children.

I will tell you that being foster parents was a way for my wife and I to give back to our community. For many years, I have been responsible for removing children from a violent and/or unsafe home, placing them in the custody of IDHW in the hope the agency would do the right thing. In my person experience with IDHW, I now have no faith in the agency or the fact they will do the right thing for the children in their care. IDHW has become a bureaucracy of monstrous proportions and uses this to gain power and then leverage control over their foster parents and foster kids. The agency is a bully. My wife and I have discussed going back to being foster parents, we will **not** under the current system. IDHW must change its policies and behavior; become a champion for their children and parents (not a bully), listen to those with knowledge and experience, ***then to the right thing***.

Thank you for your time and interest. My wife, Alyssa and I are sincerely encouraged by your crusade to help these children. I sincerely hope our story helps you in your quest for change within that agency....Godspeed.

Brian

JOINT
SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 15

02/12/16
Teri Murrison

Karen Westbrook

From: Teri Murrison [terimurrison@gmail.com]
Sent: Friday, February 12, 2016 11:35 AM
To: Karen Westbrook
Subject: Testimony of Teri Murrison re Foster Care, 2/12/2016

Chairman Heider and Committee Members,

Thank you for this opportunity to submit my last minute written testimony in lieu of being the final speaker in this morning's hearing.

I was not planning to speak, but I have a unique perspective to add to the testimony already heard this morning in support of Representative Perry's draft legislation on foster care. I appreciate being called upon.

My name is Teri Murrison. I am speaking as a private citizen of the great State of Idaho.

In 2004 I was a member of an agricultural leadership program that visited San Quentin Prison as part of a seminar on the development of the criminal mind in general, and serial murderers specifically. We studied criminals such as Ted Bundy, Scott Peterson, and others similarly infamous.

Eric W. Hickey, renown criminal justice professor from Fresno State University (http://www.fresnostate.edu/socialsciences/criminology/faculty/hickey.html) assigned us to read his book *Serial Murderers and Their Victims*, 2013, 6th ed., (Thompson-Wadsworth-Cengage Publishers). It's frequently used as a teaching tool in universities and by law enforcement in studying the nature of violence, criminal personalities and victim-offender relationships.

During the visit to San Quentin, Dr. Hickey made a very strong case for the connection between children who fail to securely attach - bond - to their primary caregivers, and the development of adults who have limited capacity to form meaningful relationships. The impacts range from mild to severe. They can be like those Cricket told you about this morning: her life was ruined by others' actions many years ago, but even now her inability to trust and constant state of self-protective vigilance make life very painful. Others become sociopaths like Ted Bundy and go on to commit heinous crimes with no remorse.

Our class toured the many and various levels of security lock up and the death chamber and Dr. Hickey told us that our prisons are full of men and women who do the things they do because of the start they got - good, bad, and horrific. This made a big impression on me, but what happened next, even more so.

He showed us a video that some of you may have seen before. In the old black and white video, a baby monkey is separated from his mother from birth and kept in isolation from humans and other monkeys. He is introduced to a healthy, secure monkey which reaches out to the baby. The baby, in a confined space and unable to get away, shrieks and jumps around the cage as if he is in boiling water. The next scene shows children in a Romanian orphanage. They are rocking back and forth rhythmically in an effort to comfort themselves and self-soothe. The video makes the connection between early rearing practices and their bizarre behavior.

Watching it, I began to cry. Embarrassed, I noticed that I too was rocking.

I spent the next three days researching Romanian children and learned that many of them suffer from a condition that Dr. Hickey hadn't mentioned, Reactive Attachment Disorder. That's the medical term for some children's response to trauma and abandonment. And as I learned more, I recognized many of its symptoms:

failure to trust, failure to establish deep and meaningful relationships, a history of multiple short disrupted relationships in high school, and fear of being known at any level deeper than the surface.

As I looked back at my life and the things I had been told about myself, it all finally made sense. My birth mother gave me up for adoption at birth. She was not married to my birth father and her husband (not my father) wouldn't sign the paperwork for me to be relinquished for some time. At two months old, I had a life threatening medical episode that required lengthy hospitalization. When at 6 months I was finally placed with adoptive parents, my foster mother sent along a note cautioning them not to hold me too much since that would spoil me.

For a brief year I was the joy and sole focus of two very loving parents. For a child who had been deprived of the nurture an infant needs, that must have been wonderful. But then they adopted another child who had seemingly greater needs, and my mother's focus was diverted. She later told me she put me in my crib a lot because I seemed to like to be there. It was a life long pattern that continued through my parents' passing several years ago.

Over the past decade I have come to terms with and learned how to overcome my first tendency to withdraw and not trust. But how many, many children and adults have not? At the macro level, San Quentin is full, as are other prisons. We're running out of room and it's costing us dearly. At the micro level, there are so many of us like Cricket and me who have to make daily conscious decisions to overcome how we learned to deal with the world at an early age.

I believe that we as parents, leaders, and members of society have a moral imperative to address this widespread condition in society. I believe the solution lies in ensuring that all children are able to securely bond with their primary caregivers. Some of those are blood relatives, but many, many others are foster and adoptive parents. Disrupting fragile children engaged in trust-building relationships only compounds the harm. The task is huge, but we have to start by touching the lives we can - the lives you can.

I urge the Committee to hear and support Representative Perry's legislation to help traumatized children who may just be beginning to trust for the first time in their lives.

Thank you so much for this opportunity to tell you in writing what you ran out of time to hear this morning. You have a very difficult job and I appreciate each and every one of you.

Teri Murrison
PO Box 471
Eagle, Idaho

JOINT
SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 16

American Heart Association | American Stroke Association
life is why

Joint Health and Welfare Committee
February 11, 2016

American Heart Association / American Stroke Association
Erin Bennett, Government Relations Director, Idaho Division
Testimony in Support of SB 1205

Mr. Chairman and Members of the Committee,

For the record, my name is Erin Bennett, and I am the Government Relations Director for the American Heart Association / American Stroke Association in Idaho. We are a nonprofit, nonpartisan organization that supports evidence-based policy solutions that prevent and eliminate cardiovascular disease and stroke as leading causes of death in the United States. I want to thank you for the opportunity to provide input on these important issues, and encourage your support of Senate Bill 1205.

We are working in local communities and across the state to support healthy, active lifestyles to reduce the risks for cardiovascular disease and stroke. Unfortunately, we know that in Idaho, heart disease and stroke are still 2 of the top 5 leading causes of death[i]. We also know that those without insurance diagnosed with heart disease are less likely to seek and receive timely medical care, those who suffer from a stroke often experience greater neurological impairment and longer hospital stays, and both suffer worse medical outcomes[ii]. Currently, those without health care coverage often over-utilize emergency rooms and require indigent care funds to cover costs. This costs taxpayers' money, without providing efficient or effective health care.

In our current system, we all pay the costs for the 78,000 Idahoans that fall in the coverage gap, through tax dollars going to catastrophic care, higher insurance premiums, and higher service costs through inefficient use of the health care system. SB 1205 provides a unique Idaho solution to ease the financial burden on taxpayers, and provide those diagnosed with heart disease, stroke, or other chronic conditions the critical medical care they need. Senate Bill 1205 is the best path forward to effectively and efficiently improve the health of all Idahoans, and we urge your support.

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[i] Source: Vital Statistics, Idaho Division of Public Health, Bureau of Vital Records and Health Statistics.
[ii] Duru OK, Vargas RB, Kerman D, Pan D, Norris KC. Health Insurance status and hypertension monitoring and control in the United States. Am J Hypertens 2007;20:348-353.
Rice T,LaVarreda SA,Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. Med Care Res Rev 2005; 62(1): 231-249.
McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare coverage. JAMA. 2007; 298:2886 –2894.

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02/12/16

IDAHO FREEDOM FOUNDATION

POLICY MEMO 2016-2

Medicaid expansion

By Fred Birnbaum

Senate Bill 1205 changes to fiscal impact from 2015 to 2016

Medicaid expansion currently contemplated under Senate Bill 1205, was first presented in 2015 as saving Idaho $173 million over 10 years.[1] This estimate was based on a 2014 report by Milliman, an actuarial firm.[2] A recent revised estimate from Milliman now shows expansion would cost Idaho taxpayers $187 million.[3] Both reports analyze Healthy Idaho, presented in Senate Bill 1205, which is called Option 3.5 in the Milliman reports. Milliman updated its cost estimate in January 2016 and the savings evaporated and morphed into burden on the state budget. The negative-cost swing is $361 million. The updated report started with the state's fiscal year 2017 for the revised estimates. Below, a summary table compares the expansion's prior and updated cost estimates.

Comparison of Milliman Medicaid expansion estimates
$ millions

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	FY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	SFY 2026	Total
State Funds, 11/14 est.	12.1	29.2	51.5	60.9	78.6	93.8	97.6	101.7	106	110.6		742
State and County savings, 11/14	76.8	79.7	82.8	86	89.2	92.7	96.4	100.1	104	107.9		915.6
Net costs to Idaho, 11/14	(64.7)	(50.5)	(31.3)	(25.1)	(10.6)	1.1	1.2	1.6	2.0	2.7		(173.6)
State Funds, 1/16 est.		24.7	45.4	55.1	73	89.4	95.5	102.1	109.2	116.9	125.2	836.5
State and County savings, 1/16		55.9	57.6	59.5	61.5	63.6	65.7	67.9	70.2	72.6	75.1	649.6
Net costs to Idaho, 1/16		(31.2)	(12.2)	(4.4)	11.5	25.8	29.8	34.2	39.0	44.3	50.1	186.9
Change in state funds	-12.1	-4.5	-6.1	-5.8	-5.6	-4.4	-2.1	0.4	3.2	6.3	125.2	94.5
Change in savings	(76.8)	(23.8)	(25.2)	(26.5)	(27.7)	(29.1)	(30.7)	(32.2)	(33.8)	(35.3)	75.1	(266.0)
Change in net costs	64.7	19.3	19.1	20.7	22.1	24.7	28.6	32.6	37	41.6	50.1	360.5

Notes:

1. Net costs to Idaho are shown as negative values when general fund and county dollars are saved, () = positive outcomes.
2. Numbers differ slightly from "Healthy Idaho" presentation due to rounding.
3. For comparison in change rows, positive numbers are shown as increases or worse outcomes, negative numbers are better outcomes
4. The biggest driver of the change was not the one year delay, but lower estimates of savings for the state and counties.
5. Milliman forecasts a 15 percent increase in participants in its 2016 estimate
6. There was no change in the FMAP rates, except that SFY 2016 assumes a 100% federal match, the subsequent years use the same rates; 90 percent from 2021 on.
7. The change in federal funds to Idaho is not materially different in the new estimate, less than 1 percent difference cumulatively.

Summary

The state fiscal impact of Senate Bill 1205, which would put into law the "Healthy Idaho" Medicaid expansion plan outlined by Idaho Health and Welfare Director Richard Armstrong, has experienced an estimated negative-cost swing of $361 million since Mr. Armstrong presented it in February 2015. The savings in the fiscal note only represent *initial* savings and do not factor in net costs that now begin in SFY 2020 and accumulate indefinitely at an accelerating rate.

Idaho Freedom Foundation
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Media@idahoFreedom.org

Notes:

1. "Healthy Idaho," presented by Idaho Health and Welfare Director Richard Armstrong, pp. 16-17, Feb. 5, 2015
2. Milliman Client Report, "Revised Financial Impact Review of the Patient Protection and ACA on the Idaho Medicaid Budget including State and County Cost Offsets," Nov. 7, 2014
3. Milliman Client Report, "2015 Financial Impact of the Medicaid Expansion on the Idaho Medicaid Budget including state and County Cost Offsets," Jan. 8, 2016

02/12/16
Karleen Davis

Good morning Senator Heider, Representative Wood, and Committee Members,

My name is Karleen Davis. I live in Boise, and I am here, representing myself and my husband.

First, we want to thank you for holding this hearing. We are grateful that you are focusing on this issue, and we hope that all parties will be able to come together to help our friends and neighbors who are suffering without access to adequate healthcare.

I am here today because my husband and I are landlords and we care about the well-being of our neighbors and community. We rent at the lower end of the market and most of the people we rent to are in the coverage gap. They are honest, hard-working people – because, of course, we don't rent to people who are dishonest and unemployed.

For our renters in the coverage gap, a medical misfortune can be a disaster. A trip to the emergency room after an accident on the basketball court, or treatment for food poisoning after a bad sandwich, or a suspicious spot on a face that should be checked by a dermatologist for cancer — any of these quickly leads to large medical bills, missed work, delayed rent payments, and worse.

This is tremendously expensive for Idaho. A couple years ago, we became involved in a renter's struggle to get help paying his bills through the county indigent programs. He was a mason, and had become ill, to the point of hospitalization. He lost work and couldn't afford housing here in Boise, so he moved back home with his family in Twin Falls. We became involved because of the battle between Ada County and Twin Falls County regarding who should pay the medical bills.

We don't know what the final outcome was, but we took the opportunity to learn more about healthcare assistance for low-income folks in Idaho. We were stunned at the enormous administrative overhead of these county indigent medical care programs. Idaho needs something better.

It's difficult to talk to friends and colleagues about the Coverage Gap in Idaho. I have come to expect that first look of total disbelief. How can it be that a working couple loses their insurance subsidy when they have a child? How can it be that, in Idaho, we provide disincentive for having children? In order to be believed I have to provide a short history of healthcare legislation in the U.S., because that is the only way it makes any sense.

I listened to the director of Your Health Idaho explain that thousands of Idahoans, tens of thousands of Idahoans, tried to obtain insurance through Your Health Idaho, but were turned down because they didn't have high enough income to qualify. They are baffled by this situation as well, I am sure.

My husband and I think that Senate Bill 1205 and the Healthy Idaho Plan is a good solution to the Coverage Gap. It requires personal responsibility on the part of patients, while it will relieve the administrative burden associated with the county indigent programs and the Idaho CAT program. It will save us all money, reward hard work, and strengthen our families and communities.

We hope you will be able to support for Senate Bill 1205.

Thank you for your attention.

Karleen Davis & Eugene Turley
1318 Ranch Road
Boise ID 83702

02/12/16
William Fowkes

Healthy Care Plan Coverage +
Disability waivered services +

We are here as a community because we expect decisions to be made. Communities have a sense of belonging by finding common ground with attitudes and choices.

When we realize the duties and responsibilities of the Department of Health and Welfare and Medicaid, and by extension the shared moral and fiscal responsibilities of citizens have to do with the survival and wellbeing of the often weak, helpless, and disadvantaged in Idaho, we realize that this may be an exploration of what I will call Sacred decision making.

When it comes to decisions for Medicaid expansion for working people who cannot afford health insurance under current economic structures, and face the crushing reality of not getting health care when it is needed, or face the crushing debt that may follow uninsured care, one realizes these legislative initiatives are born of compassion. These initiatives come from a communities knowing that is not enough for some people to be well and free from suffering, it is a heroic response of community saying that together we can help insure that everyone has the right to health care. Without insurance most people get crushed by the inequalities and structures of life that they alone can do nothing about. That's what I mean about weak and helpless.

Each one of us came into this world physically weak and helpless. Unless we die abruptly, almost every one of us will grow weak and grow helpless as we are dying. We've all had help in these early circumstances, and we're all likely to need help in the future. And so, for those of us in the in between times, and who have not yet found ourselves currently weak and helpless, it might be appropriate in our relative strengths at this time to be supportive ~~of the weak and the helpless in Idaho.~~

I also know something about, and am supportive of the waivered disability programs of Supported Living Agencies and their appropriate reimbursement rates. My daughter Eva who has a severe brain injury is not weak in her spirit by any means, but she is weak and helpless to survive without Intense Level of Care assistance provided by her care agency and administered by H & W and Medicaid funding. We are grateful for the assistance of everyone involved and the community of tax payers in Idaho and beyond. This is deeply honorable, and we thank you. Without this greater community response of what I will call Sacred decision making, she and her mother and I would be lost and crushed under unmanageable circumstances.

We in this room seek to create and encourage heroic leadership in the Statehouse and in our Idaho communities through conversation, commitment, and mutual effort. I ask that that each of us reach for the hero within us. I am asking for a vote to decide on these matters for others, that which we would hope for ourselves.

William Fowkes – 3011 Taft, Boise ID 83703 208-343-9812

Audrey Gatewood
860 W. Sherwood St #301
Boise, ID 83706
208.906.9653

02/12/16
February 2, 2016
Audrey Gatewood

Audrey Gatewood's Testimony

Support of SB1205

My name is Audrey Gatewood. I am a full-time student at Boise State University, a student affiliate of AAUW, and a full-time single mother of two. Me and my daughters live here in Boise.

Thank you Chairman Heider and the committee for giving us this opportunity and for your willingness to hear us today regarding the Healthy Idaho Plan. We are overwhelmed with appreciation for the opportunity to speak at this hearing today.

Being an advocate for Senate Bill 1205 comes from my current daily struggles. I never expected to be on Medicaid. I never expected to become injured to a point it was disabling. Everyday I am in fear of not having health care coverage because I might make just too much. I have chosen at times to reduce the hours I put in for my part-time income to avoid being kicked off of medicaid and potentially being left with having zero health care coverage.

The medications I need access to are anticonvulsants and could cause me severely negative effects if I were not able to get these medications. Without having health care coverage I would not be able to afford these medications. I have two daughters that rely on me to take care of them and I would not be able to efficiently provide or care for them without access to these medications.

Some days I do not know how I will afford things as simple as shelter, clothing, or normal daily goods such as soap. Having such a limited income and ability to purchase the basics for my family causes me stress but the stress of potentially ending up in the hospital with no health care coverage causes me intense apprehensions in making just too much.

Hearing all of this hard work being put into health care in Idaho has been tremendously inspiring to me and I cannot tell you enough how grateful I am and how grateful we all are for this opportunity to be here today. We will respect any decisions made but I implore this committee to support the Healthy Idaho Plan and close the coverage gap.

02/12/16

The Healthy Idaho Plan Helps Kids and Families

The Healthy Idaho Plan—A Real Solution

One of the best ways to make sure Idaho children grow up in families that are healthy and financially stable is for their parents to be able to get medical care when they need it.

Too often today that isn't the case. Fortunately there's a solution: the Healthy Idaho Plan, proposed by a working group named by Governor Otter, would cover 78,000 adults who can't afford health insurance.

An estimated 63% of people in the coverage gap are parents or primary caregivers of children.[i] When moms and dads have their health care needs met they are better prepared both physically and mentally for the demands of parenting. And affordable medical care not only keeps families healthy, it also helps them avoid the financially devastating costs associated with serious health issues. Plus, parents with health insurance are more likely to make sure their kids are covered too – for example, through the Idaho children's insurance program. [ii]

The Healthy Idaho Plan addresses the critical needs of Idaho parents whose jobs don't offer the health insurance needed to maintain a healthy, safe, stable, and financially secure environment for their children.

Income Levels to Qualify for Tax Credit to Purchase Health Care

Household Size	100%
1	$11,770.00
2	$15,930.00
3	$20,090.00
4	$24,250.00
5	$28,410.00
6	$32,570.00
7	$36,730.00
8	$40,890.00
For additional person, add	$4,160.00

Source: healthcare.gov

An estimated 63% of people in the coverage gap are parents or primary caregivers of children

These parents are in what's called the "coverage gap." As they struggle to make ends meet they find their incomes are just below the eligibility level for subsidies on the Idaho health insurance exchange and just above what qualifies for Idaho Medicaid.

The Healthy Idaho Plan—Important Benefits for Families

- **Dismantles the Medicaid Parent Penalty**
  Today, working parents who struggle to make ends meet are penalized. A single, childless worker earning minimum wage qualifies for help to purchase insurance in Idaho's health insurance exchange. But if that worker is a parent and the sole earner for the family, the family doesn't receive any help. In this scenario, if that parent quits their job, he or she could receive Medicaid. Under the Healthy Idaho Plan, single parents no longer would have to choose between working and receiving health care through traditional Medicaid.

- **Promotes Health Insurance Coverage for Children**
  Research shows that when parents have insurance, kids are more likely to have it too.[i] As of 2013, 8.9% of children in Idaho are uninsured, which is above the national average of 7.1%.[ii] That means over 38,000 Idaho children do not have the health care they need. Whether they have something treatable, such as strep throat, or a more complicated long-term or chronic illness, these kids are more likely to be enrolled in the Children's Health Insurance Program (CHIP) if their parents are insured.

- **Provides the Full Range of Care for all Households**
  The Healthy Idaho Plan is the only solution to Idaho's health care issues that would provide comprehensive health care to those in the coverage Gap. Instead of families having to wait for emergency room care, they would be able to see a doctor regularly for preventive care. The Healthy Idaho Plan would provide access to care from specialists to treat chronic illnesses, cover emergency room visits, hospitalizations, access to lifesaving medication and the screening and diagnostic tools that will lead to early detection and treatment. That means healthier families.

  Healthy Idaho is a public/private, or "hybrid" plan. Income eligibility would vary by family size. A family of four earning up to $32,913 per year would get help purchasing private coverage. Families of four making less than $24,250 a year could get coverage through care management provided by the Idaho Department of Healthy and Welfare.

  And, Healthy Idaho includes provisions to encourage good health and personal responsibility, such as minimum co-pays and incentives for preventive care.

The Healthy Idaho Plan is Cost Effective for the State, Localities, and Families

- It brings our tax dollars home. Right now our taxes are funding health care in other states. There would be no additional tax on families.
- It saves state and local governments money by eliminating the need for our antiquated and expensive state and county indigent care funds.
- It will spur economic growth. Families will have more money in their pockets to spend at local businesses.

Thousands of our friends and neighbors who can't get health insurance today would be covered – making our state stronger and Idahoans healthier.

Notes:

i. Idaho Department of Health and Welfare, Self-Reliance Data, 2015. Approximately 51,808 Idahoans are in the coverage gap according to IDHW. IDHW's estimate is a count of all the people who:1) applied for and were denied Health Coverage Assistance because their income fell below 100% of the federal poverty threshold and/or 2) receive Supplemental Nutrition Assistance Program benefits and do not qualify for Health Coverage Assistance. This is a subset of the statewide estimate of approximately 78,000 Idahoans in the coverage gap, the rest of whom do not receive public benefits have never applied for them through DHW. People in this group are considered parents or caregivers if they have at least one child living in the home.

ii. Alker, Joan and Chester, Alice, Georgetown University Health Policy Institute, Center for Children and Families, "Children's Coverage at a Crossroads: Progress Slows," November 2014.

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IVC IDAHO VOICES FOR CHILDREN

02/12/16
Barbara Kemp

Karen Westbrook

From: CenturyLink Customer [pinkerton5@q.com]
Sent: Friday, February 12, 2016 10:04 AM
To: Karen Westbrook
Subject: S1204

Please pass my testimony to members of the Senate Health @ Welfare committee who are currently listening to testimony regarding this bill.

I strongly urge committee to print the bill to expand Medicaid in Idaho and send to full Senate with a do-pass recommendation. I'll try to be brief: Without access to full range of medical benefits that Medicaid expansion would provide, thousands of individuals will continue to die, some quickly and some in a longer, slower descent. I want to emphasize that the families of the individuals suffer daily, too, and they also are not able to live well, stably, or to contribute positively in their communities. Untreated mental and physical health difficulties tear apart the fabric of families and their ability to function. The ripple effect spreads: all of Idaho is becoming weaker as a result. Think short-term, please, but also long-term. How many chronically ill people will we have in 5 years if we don't stanch the bleeding now.

Please print 1204, send to full Senate with a do-pass recommendation.

Thank you
Barbara Kemp
3314 Camrose Lane
Boise, ID 83706

02/12/16
Cay & Ron Marquart

February 12, 2016

Dear Senate Health and Welfare Committee Members:

Our 44 year old son was diagnosed with schizophrenea over 20 years ago. He is a gentle soul and is highly intelligent. He was born with many talents in music, art, and sports. The illness has robbed him of these special talents. Thank goodness, he still loves to read and you can find him in the University Library nearly everyday. He has lived at home with us all these years and will do so until we no longer exist. We are very fortunate that we have the means to support and take care of him. This is not the case with many people suffering from severe mental illnesses. The Healthy Idaho Plan would help so many of these people who do not have the support like our son has. We just recently lost a homeless man in a Boise park who was mentally ill. That could have easily been our son. I often wonder if this man would still be alive today if we would have expanded Medicaid. Please pass the Healthy Idaho Plan—it would help poor people and the mentally ill.

Thank you for your service to the State of Idaho.

Sincerely,

Cay Marquart
Ron Marquart

Cay & Ron Marquart (mnimages@hotmail.com)

3300 E. Red Stone Drive

Boise, Idaho 83712

Telephone: 208-344-4012

02/12/16
Mike McGrane

Testimony before the Joint House and Senate Health and Welfare Committee on behalf of the Idaho Nurses Association and the Nurse Leaders of Idaho

February 12, 2016

Chairman Heider, Chairman Wood, Members of the Committee,

Thank you for allowing me to address the Committee. My name is Mike McGrane. I represent the Idaho Nurses Association and Nurse Leaders of Idaho.

55,000 nurses are licensed in Idaho. They practice in a variety of settings including public health, community health, rural clinics, homes, schools and universities, industrial settings, nursing facilities and hospitals, in addition to many, many other areas. The Idaho Nurses Association represents the broad spectrum of nurses across our state.

Nurse Leaders of Idaho is an association of nurse executives and managers, nursing program directors, deans and professors, and leaders from public health, industry, and advanced practice.

As nurses we are the backbone of providing healthcare. Healthcare professionals and the public look to nurses as the trusted guardians of our health. We are the ones on a daily basis who screen and monitor patients, coordinate care, instruct wellness and assure compliance. Nurse Practitioners fulfill a necessary role in providing care in Idaho's rural communities. Nurses have the upmost concern for the health of Idaho's citizens and Idaho communities.

The Idaho Nurses Association and Nurse Leaders of Idaho strongly support the Healthy Idaho Plan (Senate Bill 1205) as the right choice for the 78,000 uninsured Idaho residents to gain appropriate, comprehensive healthcare coverage to include preventative care, prescription coverage, and access to specialty and inpatient care. While much is unknown about the impact of any of the proposed plans, what we do know it that early intervention, preventive measures, care coordination and care management reduces reliance on emergency care and hospitalization and ultimately reduces cost. This was most recently demonstrated in savings to the catastrophic fund from those enrolled in the Healthcare Exchange. We are all paying the high cost of uncoordinated, inappropriate and unnecessary healthcare by having no plan to address the uncovered. The Healthy Idaho Plan provides access and coordination for those who find themselves barely making ends meet and unable to access private healthcare. It also extends the Health Insurance Exchange, through reliance on the private health insurance market for those who otherwise do not qualify for coverage. It provides access and personal responsibility that relies on existing programs. The Idaho Nurses Association and Nurse

Leaders of Idaho urge you to adopt the Healthy Idaho Plan as the best option for coverage of those falling in the gap.

That being said, we applaud the Governor and Director Armstrong for proposing an initial alternative, the PCAP program. Although the program is very limited and will create barriers to providing equal and adequate care to all participants due to the significant coverage gaps it includes, it does capture elements of personal responsibility, the Medical Home model, prevention and early management of chronic illness. It is better than the current situation of no coverage. If the vote is PCAP or nothing, we would support voting "Yes"on PCAP.

As nurses we have no financial stake in one plan over another. What we care about is providing access to necessary, cost effective healthcare for Idaho's citizens.

Thank you again for allowing me to address you.

Michael McGrane, RN

Idaho Nurses Association and Nurse Leaders of Idaho

02/12/16
Danielle Ryals

Testimony of Danielle Ryals
347 East North Street, Albion, ID 83311
To present to Senate Health and Welfare, Feb 12, 2016

Thank you Chairman Heider, Chairman Wood and members of this committee for allowing testimony to be presented today. My name is Duane Goodner, and I will be reading a testimony on behalf of Danielle Ryals, of Albion, Idaho. Danielle is unable to be here today ~~*because she recently got a part-time job and could not miss a day of work to drive to Boise*~~ for work and medical reasons. *Danielle is* ~~*still*~~ *in the coverage gap, and these are her words:*

My husband and I fall into the coverage gap, and we are concerned about our lack of access to affordable health insurance. While we appreciate the governor's recent initiatives regarding closing the healthcare gap, the Primary Care Access Plan is not enough. We need affordable access to full healthcare coverage.

My husband works on a nearby farm and I run the household, take care of my three young children, and recently got a part-time job—but it does not pay well. I used to work as a Certified Nursing Assistant but had to quit that job when a respiratory infection went untreated. My husband has high-blood pressure but we can't afford the medication for it. Last year, I fell down the stairs and broke a rib. If we saw a cardiologist, we would need to pay for a visit in full and we can't afford to visit a specialist and pay for food and clothes for our kids. More recently, my husband broke his finger and we can't afford to get that fixed either.

My family is not looking for a government hand-out. What I most want to convey to you today is that closing the coverage gap would be one of the most important things you could do to make my family, and other families like mine, healthier and more productive. Being in the gap makes it harder to work. By helping us access affordable healthcare coverage, we will be more productive and able to support our family without government assistance. We hope you will support Senate Bill 1205, thank you for your time and consideration.

02/12/16
Susan Sered

Uninsured in Idaho: Policy Brief (February 2016)

Contact Information:

Susan Sered, PhD

Department of Sociology, Suffolk University

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This brief is offered as a contribution to current deliberations regarding Medicaid expansion and healthcare reform in the Idaho state legislature.[1]

Research Findings

In 2003 I conducted in-depth interviews with uninsured individuals and families in northern Idaho, south-central Illinois, Texas, Mississippi and Massachusetts. All 37 Idahoans – at the time – were in the work force, though many were struggling to maintain a level of health sufficient to allow them to continue working and caring for their families. As I wrote in *Uninsured in America: Life and Death in the Land of Opportunity* (University of California Press, 2015), I was struck by the "rugged Idahoans" who shared with me stories of swallowing handfuls of Ibuprofen each day in order to manage pain, using a pocketknife to shave off bone spurs from their feet, turning to friends who worked as aides at nursing homes for help bandaging wounds, and confronting medical bills of $100,000 or more in the wake of an accident or health crisis.

In 2015 I returned to Idaho and the other four states in which I had carried out research in 2003.

- In Idaho I looked for 37 people and was able to re-interview 20 of the 37.
- Five of the 37 were dead: all five had passed away prematurely (in their 40s, 50s or early 60s).

One of the dead, who passed away at the age of 58, had worked in the mines his entire life. He left behind a wife and children.

- Five are now recipients of SSI or SSDI by virtue of having become too disabled to continue working.

Jane used to work at three jobs: cleaning houses, doing laundry in a nursing home, and waitressing at a café. "Eventually I cut back to just the café job because it was my social life," she explained, "but finally I couldn't do it anymore. I even kept working through double pneumonia because I had to pay my bills, but eventually I had to stop because of my legs – you see my feet and ankles hurt and then turned black." When she was finally diagnosed with diabetes at a free clinic she was told that she most likely already had diabetes for seven to ten years, but it had never been diagnosed or controlled. The staff at the free clinic would give her free samples of

[1]Idaho did not accept the ACA Medicaid expansion. As a consequence, Medicaid is only available to children, pregnant women, parents of children under the age of 19, disabled people and the elderly. Even within those categories not many meet the Medicaid criteria: A family of 4 must earn less than $650 / month to qualify. http://www.healthandwelfare.idaho.gov/FoodCashAssistance/ApplyforAssistance/Applyforservices/Whoiseligible/tabid/1556/Default.aspx

her medication whenever they had it available, but that was not a consistent source. At age 57 Jane was granted Disability (SSDI), but then had to wait two more years to become eligible for Medicare. By 2015 was able to access care through Medicare and Medicaid, but it was too late. She now is housebound.

- Five now receive insurance through their employers [2]. None of the five are able to cover their dependents through their employers.

Marla and Peter, parents of three young children, were uninsured when I met them in 2003 and remained uninsured until a year or so ago. This was challenging because Peter has a blood disorder, ulcerative colitis and glaucoma. Throughout his adult life he has worked steadily for a company that he likes and likes him, but does not provide health insurance. When their kids reached school age Marla took an office job, but it did not provide health insurance. To take care of her family's health needs, Marla drove them to doctors all over the northern part of the state – sometimes putting hundreds of miles on the car. At each office she would accumulate a manageable bill that they tried to pay off over time. Typically, the doctor would not see them again until they fully paid the bill. Knowing they needed healthcare coverage, Marla began to work for another small business owner who agreed to pay half of their monthly health insurance premium. But the remaining half was so high that after it was deducted from her salary she ended up taking home about $5 / hour. In 2015 she moved to a job with somewhat better insurance. Her premium now is $250 / month, but the deductible is $3000 per person and there are hefty co-pays and co-insurance.

- Three purchased insurance on the Exchange. All three were only able to afford the lowest premium plans / highest deductible plans which often end up costing the poorest Americans more than higher premium plans.[3] Still, all three were happy to have insurance.

Al, a farmer in his early 60s, was embarrassed to admit to liking "Obamacare." But he certainly has benefitted from expanded healthcare access. Diagnosed with lung cancer a number of years ago, he had not been able to obtain health insurance before the ACA because of his pre-existing condition. During those years, hospital bills were as high as $300,000 annually, leaving him in horrendous debt. Now he pays $12 / month for insurance through the Exchange and his doctor is satisfied that "there are no new tumors."

- Four had moved out of state, primarily in order to access healthcare in Washington or other states that have expanded Medicaid under the ACA. No one in Idaho was receiving Medicaid in 2015.

Chris and Brittany, a vivacious couple in their thirties, moved from Idaho to Washington several years ago after Chris injured his leg on a construction job and the workers compensation ran out before the surgeries he needed were completed. While Chris was out of work Brittany took a job at a restaurant in order to tide them over. With her salary they earned too much for Chris to qualify for Medicaid and get his leg fixed. But without that salary they couldn't survive. Today, they both are healthy and productively employed in the state of Washington, where they are raising their children and waiting for the day when it will be possible for them to return home to Idaho.

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[2] Approximately 95% of Idaho businesses employ less than 50 workers, exempting the businesses from the ACA mandate to provide health insurance. Idaho Department of Labor, QCEW 2013

[3] Susan Sered and Marilyn Delle Donne Proulx. 2011. "Lessons for Women's Health from the Massachusetts Reform: Affordability, Transitions and Choice," *Women's Health Issues* 21(1): 1-5.

Policy Recommendations

- Senate Bill No. 1204, an act that proposes expanding Medicaid eligibility to persons under age 65 whose modified adjusted gross income is one hundred thirty-three percent (133%) of the federal poverty level or below is an excellent first step towards allowing all Idahoans access to appropriate healthcare services and thus the ability to maintain better health.
    - Those with incomes below 133% of the federal poverty level cannot afford to pay for appropriate medical services. As a consequence, their health deteriorates and/or they amass medical bills that eventually are passed on to the counties or the state.
    - Idaho hospitals and clinics, for the most part, already accept Medicaid payments. Thus, the infrastructure is in place and implementation of this expansion should not involve additional costs or bureaucratic complications.

- The Primary Care Access Program (PCAP) is unlikely to substantially improve access to healthcare for Idaho's low income residents.
    - While primary care is the core of any healthcare system, the reality of today's complex medical world is that primary care visits alone are rarely sufficient for diagnosing or treating serious illness. For primary care providers it is frustrating not to have the capacity to send patients for tests, procedures or specialist care. Patients will find themselves in the frightening position of being told by a primary care provider that they need certain treatments but that the primary care program does not cover them.
    - There is no evidence that access to primary care alone, without parallel access to other medical services, improves the health of populations.
    - According to the published description, "The program requires payment for services on a sliding scale fee, which encourages greater personal responsibility for the patient's own health." Given that this program is aimed at people with very low incomes, it is more likely that fees will function as deterrents to care rather than as an encouragement of personal responsibility.
    - In my research in Idaho I have never spoken with a single individual who can afford healthcare but irresponsibly chooses not to seek it. The most common reasons for not seeking care are: uninsurance, deductibles that are too high to meet, lack of transportation to healthcare centers, inability to take off time from work during clinic hours.
    - By limiting access to healthcare to specific health centers, this proposal fails to address the needs of many Idahoans who do not live near any of the specified health centers.

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Acknowledgments: In addition to the uninsured and formerly uninsured individuals whom I interviewed, I spoke with Terri Sterling, ICAN; Charlotte Ash, Snake River Community Clinic; Ken Whitney, Jr., Mayor of Troy; Dr. Richard Thurston, St Maries Volunteer Clinic; Donald Duffy, Panhandle Health District; Moriah Nelson, Idaho Primary Care Association; Pam McBride, Clearwater Valley Hospital, Orofino; Ashley Piaskowski, Heritage Health, Coeur d'Alene; Dr. Ted Epperly, Idaho Healthcare Coalition and Family Medicine Residency of Idaho; Stephen Weeg, Board Chair, Idaho Health Insurance Exchange. I thank all of these people for taking the time to share their expertise with me. All opinions and errors are my own.

02/12/16
Clella Steinke

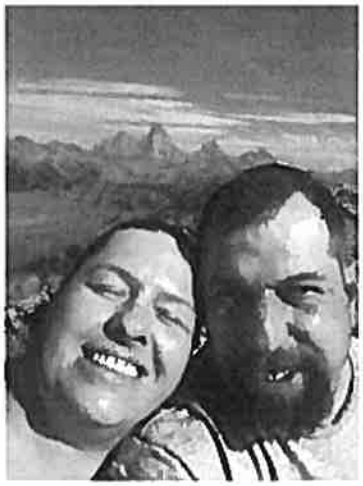
Remembering Jenny Steinke

Jenny with her son James at his wedding, August, 2015

Dear Chairman Heider and members of the Senate Health and Welfare Committee:

My name is Clella Steinke. My daughter-in-law was Jenny Steinke of Idaho Falls. Jenny had asthma, and because she was in the coverage gap, she did not have access to the correct kind of inhalers. As a result, on September 1st 2015, she had a severe asthma attack, stopped breathing, was declared brain-dead 5 days later and became an organ donor. It pains me to share this story, as our family is still dealing with so much grief, but I am writing to thank you for holding a hearing on the Healthy Idaho Plan and to implore you to take action to close the coverage gap in Idaho.

I wish I could be there in person today. My husband and I lived in Idaho Falls for 25 years (he was a nuclear engineer at INL and I was a speech-language pathologist in Jefferson School District #251), but we moved to Wisconsin last April. I deeply appreciate you taking the time to learn more about our beloved Jenny and I hope that you can prevent a tragedy like this from happening to another Idaho family.



Jenny and Jason August, 2015

Jenny was the light of our son Jason's life. She was a deeply caring and compassionate person. Jenny was born in poverty and lived her life in poverty. Jenny and Jason had struggled to make ends meet for years, but they were always working. Jenny earned her GED in Idaho Falls, and worked as a caregiver, most recently, her grandmother. When grandmother passed, Jenny got a part-time job at U-Haul late August. Jason had struggled to find full-time employment and was thrilled when he landed a full-time job in July that would provide insurance for him and Jenny. The insurance took effect the day Jenny went into the hospital. However, in the months before Jenny's death, her asthma had worsened and without access to a specialist to treat her asthma, she was getting inhalers from a local community clinic when she could, or buying them from friends. Jenny and Jason did not realize that those inhalers were actually worsening her condition. Jenny's lack of access to comprehensive health care caused her death. I told Dr. Krell, the attending physician, her death certificate should read "Death by Poverty."

Jason saying Goodbye

Jenny's granddaughter born November, 2015

On the day Jenny died, she went to work in the morning, came home after lunch and was not feeling well. We know now that she was suffocating—her inhalers had stopped working. She was able to get a neighbor to drive her to the hospital. That drive took 3 min and 52 seconds. By the time they arrived, she had stopped breathing. When the hospital called my son at work, he rushed to her side. He spent every hour of the following six days with her.

I flew from WI. Jenny's son and pregnant wife flew from OK. Jenny's family drove from CA. We had to say good-bye to Jenny on September 5th. She never got to meet her beautiful grandbaby that was born this last November. In December, my son marked Jenny's birthday without her. A few days later, he suffered through their 10-year wedding anniversary alone and his birthday without her.

The onesie of her soon-to-be-born granddaughter

In the months since Jenny's death, my husband and I have asked a lot of what-ifs: *What if we had still been in Idaho - could we have done something? What if Jason and Jenny had realized how severe her condition was? What if she had had health insurance earlier?* Nothing will bring Jenny back. Now we are doing all we can to make sure this doesn't happen to another family. Jenny and Jason worked hard, they contributed to their community and they were loved by family and friends. We loved them, just as you love your children and grandchildren.

We have heard that the legislature is considering a proposal to offer primary care to Idahoans like Jenny. We hear that maybe this would have helped her. However, access to primary care is not the same as access to health insurance. Jenny needed prescriptions and an asthma specialist—Jenny needed health care coverage. There are tens of thousands of other Idahoans with serious medical issues that cannot be addressed in a primary care setting only. We ask that you please provide a complete solution to the coverage gap and pass the Healthy Idaho Plan.

After Jenny passed away, I was struck by the contents of her purse. You can tell a lot about what someone is going through by what they carry with them. All she had in her purse was a dollar bill, two inhalers, an oxygen meter and an advertisement from the local paper. This is what "Death by Poverty" looks like. This should not happen in this great country or in our great State of Idaho. Jenny's death was a "preventable death." Thank you for listening to our story. Please close Idaho's coverage gap.

The contents of Jenny's purse when she passed away

Respectfully Submitted,

Clella Steinke

JOINT
SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 17

02/12/16
Michelle Alden

My name is Michelle Alden, and I am a licensed professional counselor. I specialize in working with adoptive families, families with difficult and challenging children, and children who struggle with attachment and trauma related emotional and behavioral issues. I am also an adoptive mom. I adopted my 14 year old son from foster care here in Boise last year. Perhaps what has led me to this work, and created a desire to help adoptive families is that I too was adopted at the age of 6 from foster care in California. My older brother, who was to be adopted with me but was later placed with our maternal grandparents, struggled his entire life-into adulthood, with effects from our early childhood trauma, multiple placements and disruptions. Now, some forty years later, I have been reconnected with my birth family. I can honestly say that I look at adoption from all sides and I have come to appreciate the struggles my adoptive family had as well as the deep struggles and challenges our kids face everyday.

Clearly there are no easy solutions, but the research is overwhelming in how losses and lack of permanence in a child's life can and often does cause great difficulty for the child throughout childhood, adolescence and even into adulthood. One study stated that the more changes in caregivers [redacted] children in foster care experience the more likely they are to exhibit oppositional behavior, crying and clinging as well as reactive attachment disorder in which the child then exhibits severe disturbances in relationships with future caregivers (Gean, Gillmore & Dowler, 1985). The impact of these experiences on the development of the child can be devastating.

Former foster children are likely to have higher numbers of teen pregnancies, more marriages to spouses who failed to provide emotional support, and greater social isolation than the general population. Further findings suggest that the risks of these outcomes are reduced through a nurturing and stable foster family care experience and adoption. A stable, nurturing family environment can protect foster children against the negative effects of trauma and loss.

The importance of a child's close relationship with a caregiver cannot be overestimated. Through relationships with stable and secure caregivers, children learn to trust others, regulate their emotions and interact with the world. And it is up to the child welfare system, the policymakers, practitioners and the courts to ensure safe and stable family environments for these children even if it means changing the way things are currently being done. There will always be questions as to "what is best for a child" how we decide this needs to reformed. I believe

changes need to be made in way these decisions are made. We are failing our most vulnerable children, and from the stories I have heard from those asking for reform, I would say we are failing our best resources for healing that these children may have—the families that are willing to adopt, who have stepped in when no one else would and who are able to meet not only the physical needs but the emotional needs for these children.

Michelle Alden, LPC, MFT

Healthy Foundations

208-860-7828

02/12/16
Stephanie Alvarez

Chairman Wood and committee,

I came to observe todays hearing, not prepared to testify, not thinking I had anything of value to contribute. After listening to several speakers, if I may add my 2 cents to this topic.

I am retired from the United States Air Force, with 23 years active duty service. My husband also retired. I chose to keep my 5 children here in Idaho, in little Kuna, a safer place than our last assignment near Washington, DC. People, in general, are much nicer here in Idaho. :)

I want to thank you for your service, as well.

Currently, I am a professional counselor (LAMFT, LPC, NCC) with a non-profit agency, Methodist Counseling Center (MCC) in Kuna. I am in the counseling profession now, because I care for hurting people. I ask for Foster Care reform in what's best for the child, utilizing Attachment Theory, & ask for Dept Health & Welfare rules to be reviewed. →

Thank you for your service.

Stephanie Alvarez

- KAD (Kuna Against Drugs), President.
- Idaho Marriage + Family Counseling Association (iDAMFC), President.
- Mother of 5.
- My son-in-law, deployed for 2 years in Navy, leaving his 4 year old + 2 year old twins, he entered Idaho's Foster Care system.

From Brian McCauley

02/12/16
Brian McCauley

Mr Chairman, Members of the Committee-

I stand to speak today in favor of Reform to the Idaho Foster Care System which we have written with the help of **Rep Moyle and Perry**. This **bill will not solve all the problems**, but it is a start. It is the beginning of a **multi-year plan** we have developed to fully change and overhaul the foster care system.

I hold in my hand a **portion of the compiled stories** we have received in just the past 4 days.

3 Common Themes

1- Department **Violates State and Federal Laws**, we are a nation of laws, but **laws are of no use if they're not enforced**. This is the role of the courts and they are not doing it.
2- Idaho law **defines how long a birth family has to qualify** to have their child returned, but **sets no limit on how long extended family has to qualify**. This allows the Dept to pull foster children from a foster home after they have lived there for years. This is **not in the child's best interest.**
3- Department can **move a foster child whenever and for whatever reason they choose**. And they do. This is in clear **violation of their own policy**. But the Department still does it.

Our proposed legislation will

1) Reassert the COURTS authority to **ACCEPT, REJECT, MODIFY plans to meet the child's best interest**
2) Set a **TIMEFRAME in which relatives of a foster child have priority** to adopt
3) Protect the **STABILITY OF FOSTER PLACEMENT** by requiring the Department to **gain approval from the court prior to removing** a foster child except for reasons of immediate safety

I truly believe these solutions should be welcomed by the Department because it will allow them to. This should be collaboartive

1) Speed up the process of PLACING KIDS IN PERMANENT HOMES

2) Thus LIGHTENing CASELOADS

3) They will be able to BETTER MEET THE NEEDS OF FOSTER FAMILIES AND CHILDREN

4) Provide a SAFE ENVIRONMENT FOR FOSTER FAMILIES

This is a win for everyone, most of all the foster children

I encourage you to hear and support our Idaho Foster Care Reform Bill

02/12/16
Valerie McCauley

Valerie McCauley, Eagle Idaho, ~~Address foster care reform~~

Our goal for ~~foster~~ reform is to help change a system we have come to realize is broken. Many foster parents no longer want to participate in a system that does not support them or the children they are called to protect.

For most part,
Good foster know what they are getting into. They know that is very likely that they will have to say goodbye to a child they have cared for and loved. They also recognize that ~~it is likely they will~~ they may not be the best option for the child. But good foster parents are also wise enough to recognize when the department is motivated by something other than the best interest of the child. As we began to tell our story we realized we are not alone. One woman said it well, "there has been a crack in the dam." These past 5 days we have seen this crack grow and the eruption of stories has flooded social media.

-We have been foster parents for 3 years now. Our first foster experience was rewarding. We instantly fell in love with our foster son. The case unfolded how I believe the system was intended to function. The communication was strong and focused on this little boy. He was reunited with his family and we felt privileged to have loved him. Our last case did not go as smoothly. It was far more complicated and we recognize the challenge the department must have faced, but this particular case revealed to us that there are serious problems that need to be addressed.

What FP want?

~~Foster parents~~ They want to be a part of the collaborative process to help bring about the best interests of the child. When a case is subject to judicial review there is safety. The Courts have not been allowed their lawful oversight of the Department. In order for foster parents to be a team player with the Department and the courts, they must be heard and their perspectives must matter. ~~We KNOW these children~~. We are the department's finest resource to help them understand the child, but the department is accustomed to shutting us out and we cannot have this if this system is to survive.

What are we asking for the Department to change? We are pleading with them to obey the laws of the State of Idaho. After our foster son was removed from our home, we instantly began to educate ourselves on the laws and the policies guiding the department and our state. We were amazed at how well these laws protected children. But these laws, in many cases, are completely ignored. We are trying to bring forth legislation that is intended to clarify the laws and provide specifics where in the past there has been ambiguity.

What do we want the department to understand about foster parents? Like any parent, foster parents feel the natural instinct to protect those in their care. We are not an institution or a business, we are loving families who don't stop doing our job of caring just because we didn't birth these children.

When our foster son was abruptly removed from our home and placed in another foster home, without any warning, after 14 months, we were in a state of shock. How could anyone believe that this was the right thing to do? To the department, it made things less complicated, to our foster son it will complicate the rest of his life.

We have no expectation that ~~these efforts will bring~~ our foster son will come back to our home. We have agonized for the suffering he has gone through and cannot change what happened to him but what is in our power is to make sure this doesn't happen to another. I spoke to a ~~woman~~ former foster mom on the phone yesterday who said, "If these changes can come, I'm coming back. I want to come back and help children but I've been afraid."

I plead with you to support the Idaho Foster Care Reform bill that will be coming as a first step in a long process for needed change.

02/12/16
Carly Neff

Good Morning,

My name is Carly Neff. My husband Shaun and I became foster parents to 4 children in March 2015. After 14 months in care, H&W chose to place the children with their birth mother despite strong objections from us as well as the Guardian ad Litem and biological relatives including the children's father. As a licensed social worker myself, I expressed both my personal and professional concerns which were dismissed by the department. In fact, we were twice threatened to "learn our place or have the children removed from our home". In January 2016, 5 days before court, we received a phone call, which we recorded, from H&W informing us that regardless of the judge's ruling, the children would not be allowed to stay with us despite the negative consequences that decision would have on them. The department stated "we know this decision will add additional trauma to the children". Furthermore, H&W refused to provide an explanation as to why they had made that decision. At the following court proceeding, we were informed by the Guardian ad Litem that they did not support the department's decision and recommended the children stay in our home. However, H&W told the Guardian ad Litem they had 2 choices to endorse: either extended home visits or split the children up into new foster homes, essentially tying their hands. What the department has done and is continuing to do is a disgrace and is detrimental to vulnerable children. We strongly urge this committee to take action and give a voice to those who cannot speak. Thank you.

02/12/16
Lisa Nordstrom

2/12/16

Comment on Foster Care Reform

I had hoped to personally convey my concerns about current child protection practices at this morning's hearing but hope you will consider legislation to improve outcomes for children in foster care.

I am not a foster parent. I am a former child protection county prosecutor and have practiced child protection Act-related cases pro bono for the last 8 years. As a volunteer attorney representing court appointed special advocates (CASA), I have personally represented the interests of more than 50 children in foster care in more than 25 cases in Ada County.

I am concerned that permanent placement decisions are made in Idaho without any opportunity for judicial review. While I generally believe social workers have good intentions and the best interests of children at heart, there have been too many troubling placements statewide to conclude that a review process is unnecessary.

Judges in Ada County have told me several times in courtroom proceedings that they do not have the statutory authority to review the Department of Health and Welfare's permanent placement decisions inside Idaho's boundaries.

As a legal practicioner, I find it troubling that an executive agency acts as a law unto itself without any of the checks and balances typically found in our state systems. Judicial review of in-state permanent placement decisions for foster children ensures that the State of Idaho is protecting the best interests of the children within its custody as envisioned by the Child Protection Act codified in Idaho Code Title 16.

Please clarify Title 16 to explicitly authorize judicial review of in-state permanent placements of foster children. No other avenue exists currently for reconsideration of the Department's decisions that can prevent additional trauma to these vulnerable children (even if unintentional).

Please contact me if I can be of further assistance.

Lisa Nordstrom
Idaho State Bar # 5733
mobile: 208-344-2045
email: idahopowergirl@yahoo.com

Foster Reform JoAnn Parkinson 02/12/116

I've been a foster parent for 2 children. I was summoned to court every 3 mos for 2 yrs. I was the only person in the courtroom that represented with a court appointed atty.

The mother had a public def. The father had a public def. H&W had their atty.

The guardian ad litum was an atty and had an atty representing her. (I wasn't told the children could be represented - I had to find out on my own and request an ad litum)

I was given no instruction on my rights as a foster parent, Frankly I had few. I asked if I could make a statement then was excused to leave the court. I was caring for 2 foster children 24/7 and missed pr ty to hear the proceeding.

We had 5 CPS workers in 19 mos. One accused me of letting the children see their mother when there was a no-contact order and threatened legal reprecussion. It was completely false.

One of our foster kids, H&W recommended parental rights be terminated. The judge gave custody back to the mother - because of her disinterest we were eventually allowed to seek guardianship. Our other child went to her father who had never had custody and went kicking & screaming.

When will the best interest of the child be the driving force in our foster system.

02/12/16
Jamie Taylor

Our family recently joined the ranks of foster parents in the State of Idaho. We had only one respite case under our belts when we were asked to transition a child from their former foster home to an out of state relative for permanency.

Our relationship with our case worker started out well. However, we were told limited information about the child, and were not given access to the former family in order to get vital information pertinent to their special needs. Thankfully, the child's Guardian ad litem served as an invaluable resource to us during the first few difficult weeks.

This child was hastily removed from a situation and was not allowed to say goodbye to the only family they had known for their entire life. The child was sad, sullen, and generally displayed a flat affect. We assumed that this was their typical personality.

After several times of trying to get information on this child's former foster family, I finally reached the foster mom through Facebook. She was able to help me with vital information to the child's care.

After 3 weeks of no contact with the child's former foster family, they were permitted a visit. When the family walked through the door, this child's demeanor changed completely. Suddenly they were running around with a huge grin, squealing with joy, and their eyes were lit up in a way we had not seen.

The former foster family had been told that they should maintain contact with this child if they wanted to continue to be a permanency option should the out of state placement fall through. For that reason, they continued visits with the child each week. At one point this child had 4 different "moms." Birth Mom, Out of state family member (who visited monthly), former foster mom, and myself. The confusion and frustration was evident on this child's face every week. There were moments of anger, tantrums, sleepless nights, etc. These behaviors happened no matter who the child was visiting.

With dedication, I worked tirelessly to help this child form an attachment to me and our family. I would hold them close and rub their back. I would encourage frequent eye contact. I would meet all their needs as quickly as possible, so that they would feel secure. Many nights I would find myself rocking this child in the middle of the night as they sobbed in frustration.

After many months, I have seen a change in this child. They have a sparkle in their eye. They are able to regulate their emotions (which is what foster parents are there to help them do). This child does struggle with trusting new people who come into their life, but part of that is age appropriate.

What I see in hind-sight, is that foster families *are* capable of crossing a line. Of wanting a child to be part of their family so desperately that they will do anything to stand in the way of what the Department of Health and Welfare thinks is best. And in such cases, it is probably best for a child to be moved. However, as much as possible, the Department should do everything they possibly can to keep the child in a secure environment. What I have witnessed is tragic, and has taken extreme intentionality to undo. Not every foster parent is going to work that hard to help a child "re-attach" when they have been so traumatized.

Jamie Taylor
2/12/16

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Idaho Foster Care Reform 2016

February 12, 2016

Compilation of Stories, Comments, Messages and Petition Comments Received in the past 5 days

Via Facebook and Email

Since Saturday February 6, 2016

1341 Facebook "Likes"

250+ Stories

Over 500 signers of the Idaho Foster Care Reform Petition

02/12/16

SUMMARY OF "FOSTER CARE REFORM" PROPOSED LEGISLATION (2016)

There seems to be a myth in some child welfare offices that attached children can be moved with the assumption that the future placement will be a reflection of the past. Every time we move children who show the courage to attach, we teach them that attachments are ultimately painful....[1]

Idaho Department of Health and Welfare currently has an express, standard practice of choosing distant, out of state relatives for permanent placements for children in foster care over the child's long term foster care placement, regardless of the individual needs of the child and, most importantly, the child's attachment to foster caregivers. Relatives are selected as the permanent placement so long as the relative meets the State's definition of "fit and willing." No other permanent placement option will be considered unless any potential relative option is first "ruled out" under this standard, which is the minimal threshold of having a home study approved in the state in which the relative resides.

Because of this policy, foster children are often removed from what have become their families (and in many cases the only family they have ever known having been placed from birth), and placed with unknown "relatives." Foster families watch as their happy, thriving young foster children experience intense emotional and physical pain from the literal disappearance of their family – just as children who have been removed from abusive or neglectful homes. But in these cases, there was no abuse or neglect—just a State policy that a blood relative placement—no matter how remote—is "better in the long run." And these decisions run contrary to everything these foster parents have been trained about the best interests of children, and well established principles of attachment and trauma.

Foster families who then ask questions about these relative placements, or express disagreement with these decisions, are told that if they do not support the placement decision, the foster children will be removed from their home to a new foster home better able to "transition" the child into yet another home....Foster parents know well that such a move would cause even more trauma to these children. Foster parents become afraid and have no ability to advocate for the children because they are told they are "not a party to the child protection case," or regardless, the Department has "sole authority" over these decisions under Idaho law and there is nothing even the court can do to change to course of that child's future.

These are not isolated incidences; they are routine decisions based on a formal IDHW policy preferring relative permanent placements. The pervasiveness of this policy statewide is promoted by the child protection community's belief for over a decade that

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[1] Training of Dr. Deborah Gray for the Idaho Department of Health & Welfare on June 24, 2011, page 1. Dr. Gray is an author, educator, therapist and former foster parent, and a leader in the field of attachment and adoption. She is the founder of Nurturing Adoptions, and the author of Attaching in Adoption, Practical Tools for Today's Parents (2002; 2009) and Nurturing Adoptions, Creating Resilience after Neglect and Trauma (2007).

under Idaho law, the Department is the "sole authority" over placement decisions and not subject to any judicial oversight or review even when the best interests of the child are legitimately disputed.

Aside from the undisputed emotional devastation that a young child undergoes from being abruptly removed from his or her primary attachments, and the chilling effect this policy has on the ability to recruit caring foster families, these practices run afoul of numerous federal mandates regarding children's rights under federal child welfare laws.

1. Idaho's indefinite timeframe within which relatives can come forward to become a permanent placement violates that child's right to timely permanence.

Federal laws set the minimal standards with which Idaho's child protection laws must comply in order for this state to receive federal matching funds for its child and family services programs. In 1997, the Adoption and Safe Families Act (ASFA), P.L. 105-89, was enacted to promote significant reform to national child welfare standards with respect primarily to the safety of children, acceleration of permanency and promotion of adoptions. Major provisions of ASFA relevant to permanent placement of children include:

- Clarifying that in making reasonable efforts regarding the permanent goal for a child, the health and safety of the child shall be paramount, 42 U.S.C. 671(a)(15);
- Requiring states to terminate parental rights when children are in foster care 15 out of 22 months, unless an exception applies, 42 U.S.C. 675(5)(E);
- Allowing children to be free for adoption without reunification efforts in "aggravated circumstances," such as extreme physical or sexual abuse, murder of another child, involuntary termination of another child and other extreme circumstances.42 U.S.C. 471(a)(15)(B);
- Requiring shorter time limits to make permanent placement decisions by holding the permanency hearing at 12 months (instead of 18 months) from the date the child comes into foster care . 42 U.S.C. 675(5)(C);
- Clarifying that efforts toward finalizing an alternate placement plan do not violate a state's obligation to make reasonable efforts toward reunification with a birth family. 42 U.S.C. 671(F).

More recently, "a description of the activities that a state has undertaken to ***reduce the length of time children who have not attained 5 years of age are without a permanent family. . .***" was added to states' 5-Year Child and Family Services Plan (CFSP) reporting requirements that are necessary for the receipt of federal funding. Child and Family Services Improvement and Innovation Act, P.L. 112-34 Section 101, 42 USC 622 (2011). Notably, in the current CFSP for Idaho, the only description of an apparent ongoing activity to reduce time in care for children under five (5) years of age is the use of concurrent planning stating:

> A concurrent plan is developed for all children who come into the custody of the Department. *Many infants are adopted by the family (both relatives and non- relatives) with whom they are placed at the time of removal.*

The IDHW Concurrent Planning Standard recognizes the importance of these attachments and that there is a time frame within which relatives should be considered for permanent placements because of these attachments:

> Relatives should be instructed that due to the bonds of attachment the child forms with their caregivers, it may not be found in the child's best interest to change placement to a relative who shows interest in being a placement resource later on in a case. Relatives should be made aware that when relatives wait to come forward until it is clear that their relative child cannot return home, and the child is in another stable permanent resource placement, the Department might not consider the relative a possible placement resource as it may not be in the best interest of the child to place with his/her relative at that time.[2]

Idaho Department of Health & Welfare, Concurrent Planning Standard (rev. 12/15). Nonetheless, the Department rarely rejects a relative for permanent placement, regardless of the child's attachments because of the "relative permanent placement preference" policy and practice.

Delaying permanency for children while waiting for relatives to be found or approved is inconsistent with actual federal mandates and policy that children, particularly those under five years of age, as emphasized by the Child and Family Service Improvement and Innovation Act, need permanency as quickly as possible, and that it is in their best interests to give a deadline to even their biological families. Our state practice of giving relatives indefinite grace periods is clearly contrary to the letter and spirit of the federal laws which were adopted based on valid, peer reviewed research and sound policy.

2. Idaho's position that the IDHW has "sole authority" over permanent placement decisions is not in the best interests of children and is inconsistent with federal provisions requiring permanency hearings to be heard by a reviewing body that is independent of the agency receiving federal funds, and to consider all placement options, both in and out of state.

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[2] "Time is the definitive factor. Bonding is possible after three months, probable after six months, and almost certain after 12 months. At some point the child's right to permanence and emotional stability must come before the rights of the biological parents. Recognizing that a year is a very long time in the life of a developing child, ASFA requires that the state file a termination of parental rights within that time period. Continuing delay, even to grant biological parents extra chances, is destructive to the child."
J. Kenny, PhD and L. Groves, MMFT, BONDING AND THE CASE FOR PERMANENCE, PREVENTING MENTAL ILLNESS, CRIME AND HOMELESSNESS, AMONG CHILDREN IN FOSTER CARE AND ADOPTION (2010) (fn omitted).

For over a decade now, the IDHW has successfully relied upon the Supreme Court decision *IDHW v. Hays*, 137 Idaho 233 (2002), for its position that it has unfettered, unreviewable authority in placement decisions. In *Hays*, deciding a grandparent's right to intervene in an adoption proceeding, the Idaho Supreme Court stated, in *dicta*, that because the IDHW must consent to an adoption as the appointed guardian of a foster child under the Idaho's adoption consent statute, only the Department has authority to decide who will adopt the child. This narrow ruling has been since extrapolated to insulate the Department from oversight in all matters relating to child placement decision.

42 U.S.C. 675(5)(C) provides that "in the case of a child who will not be returned to the parent, the hearing *shall consider in-State and out-of-State placement options*, and, in the case of a child described in subparagraph (A)(ii), the hearing shall determine whether the out-of-State placement continues to be appropriate and in the best interests of the child." *See also* 42 U.S.C. Sec. 671 (a)(E)(i). Under the federal regulations:

> The permanency hearing must be conducted by a family or juvenile court or another body appointed or approved by the court which is not a part of or under the supervision or direction of the title IV-E agency.

45 CFR 1355.20. Independence in the reviewing body is important to ensure that permanency decisions are based on the best interests of children, and not driven by funding reporting. Resigning all authority over permanent placement decisions to the IDHW is contrary to the federal requirements of independent judicial review and ensuring that decisions are made in the best interests of children. The position that Idaho courts have no authority over placement decisions is also inconsistent with the mandate that permanency hearings, before an independent decision-maker, include consideration of both in and out of state placement options.

3. Idaho's practice of not allowing foster parents to meaningfully participate in permanency hearings violates a child's right to have the court consider foster parents' input in making permanency decisions.

ASFA also added the provision mandating that foster parents be "provided with notice of, and an opportunity to be heard in, any review or hearing to be held with respect to the child," 42 U.S.C. 675(5)(G). The purpose of the provision was the recognition that foster parents providing daily are for foster children are uniquely situated to provide the courts with information on the bests interests of children in permanent planning decisions and otherwise. The implementing regulations defining "permanency hearing" expressly exclude any proceeding not "open to the participation of the foster parents" from the definition of a "permanency hearing":

> Paper review, ex parte hearings, agreed orders, or other actions or hearings which are not open to the participation of the parents of the child, the child (if of appropriate age), the foster parents or preadoptive parents (if any) are not permanency hearings.

45 CFR 1355.20. Idaho's current practice of allowing foster parents to appear and speak regarding the status of the children in their care, but otherwise exclude them from the hearing, and deny them any relevant information about the placement options being considered, is inconsistent with the federal regulation defining a permanency hearing, and the child's rights to have the court consider the foster parents' input in permanency decisions.

4. Federal guidance regarding "relative placements" emphasize early engagement of relatives for foster care for better outcomes for children, not permanent placement in lieu of attachments to foster care-givers.

With regard to placing children with relatives, ASFA directs:

> ***"Consider giving preference to an adult relative over a nonrelated caregiver when determining placement for a child, provided that the relative caregiver meets all relevant State child protection standards." 42 US.C. Sec. 671(a)(19). Placement refers to placing a child in the home of an individual other than a parent or guardian or in a facility other than a youth services center.***

https://www.childwelfare.gov/pubpdfs/majorfedlegis.pdf

The term "placement" refers to foster care. All research and policy on "kinship care" refers to kinship foster care, which makes sense given the studies and the reasons that the outcomes for children placed in foster care with relatives would be better. This is not disputed. Families who are in a position to provide kinship foster care are more likely to have had a prior relationship with the child, or the child's parents, are supportive of reunification efforts with the parents and in local proximity which causes less disruption to the child and less trauma.

Consistent with the research on relative or kinship foster care placement, *early engagement of relatives* is promoted by federal mandates and incentives. Federal law provides that the State is to exercise due diligence to identify and provide notice to relatives "within 30 days after the removal from the custody of the parent or parents of the child..." 42 U.S.C. Sec. 671(29). Federal grants are offered to states to start or expand current family finding programs.

There is no argument that efforts to notify and involve relatives are to occur early in a child protection case precisely because children placed with non-relative caregivers can and do form strong bonds of attachment such that removing the child is likely to cause trauma. The one mandate in federal law regarding relatives and "placement," added by the Fostering Connections Act, P.L. 110-351(2008), is that the State must provide written notice within 30 days of removal of a child to relatives that a child is in care and that they have a right to be a caregiver for the child. 42 U.S.C. 671(a)(28). The relatives must be informed that if they do not come forward in response to the notice, their right will be waived. This is further evidence of the overall federal policy that relative engagement must be early, and that late coming relatives may not be considered due to the child's

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attachments to current caregivers. (This is also expressly stated in the IDHW policy as discussed above.)

5. Moving children from foster homes because of placement disagreements is harmful to children.

It is undisputed that moving children from foster care homes is harmful to children with long term consequences. However, when the Department's placement decisions are challenged, children are often removed from the potential adoptive foster home without good cause and contrary to the indisputable, generally accepted information regarding the damage children suffer from foster care moves. Under current Idaho law or practice, the Department has no oversight in its decisions to move children under these circumstances, or otherwise, and foster parents have no means to object in court or provide information to the court on the decision to have a child moved.

The intent of the bill is to address these issues by asking the legislature to:

- Clarify that under Idaho law and consistent with federal law, the relative placement preference applies in foster care placement decisions early in the child's stay in foster care, and that permanent placement decisions always must be governed by the best interest of the child and consider the child's attached bonds.
- Clarify that under Idaho law and consistent with federal law, the Court has the duty and responsibility to pre-approve permanent placements both in and out of state as being in the best interest of the child.
- Clarify that under Idaho law and consistent with federal law, the Department's authority to consent to an adoption is subject to judicial approval as being in the best interest of the child.
- Create timeframes for the investigation of and notification of relatives for foster care placement to put an end to the current practice of giving relatives an indefinite grace period to come forward to be considered for placement and adoption.
- Clarify that under Idaho law and consistent with federal law, foster children have a right to have foster parents given fair notice of a hearing and the opportunity to be heard on the issues presented in the hearing.
- Recognize that moves in foster care create significant trauma to foster children with long-term consequences to the child's well-being, and clarify that under Idaho law that removal from a foster home must be shown to be for good cause, and in the best interest of the child, and give foster parents the right to be heard in court on the removal of a child from their home.

Story 1

In 2009, I decided to take the next steps in doing something I had wanted to do for some time, become a foster parent. It was a six month process in which every bit of my life was raked over with a fine tooth comb and took classes to learn how to best welcome a child into my home; the process was long, tiring, and tedious. Finally, in September, I received the official word that I had been approved, but I figured it would be some time before I was actually called to take in a child.

Much to my surprise, just one short week later, the phone call came: a five year old boy needed a place. I returned the call to the caseworker only to find that the little boy had been placed, BUT a little 8 month old girl had JUST been brought into the office, and would I be willing to take her. Of course I would! Over the next couple of hours, I scrambled to prepare for an infant, and picked her up from the caseworker. Her giant blue eyes and her little pink overalls are two things I will never forget about that day. Little did I know, that day, October 7, 2009, would be the day would be change the rest of my life. No class, no social worker, no nothing could have prepared me for the journey that little girl and I would take together. For the first six months she was with me, I was told she would be going home to her mother any day, but those months turned to a year, and then another year, and yet another year of promises she would be going home to her mother. In addition, FOSTER CHILD was considered an Indian child, so the parameters of the ICWA likely applied to her, and she would have to "legally" be placed with an Indian family. However, over those first few years, her tribe could not take jurisdiction of the case, and they offered very little involvement in the process, and what involvement they did have was limited and sporadic, often times failing to appear at court hearings, leaving IDHW to make decisions about her placement. In the meantime, in fall of 2010, the biological mother had another child, a boy. I was more than willing to take in FOSTER CHILD's brother, but my inquiries and attempts to discuss this option with my caseworker were left unanswered until the baby was born. It was then IDHW placed him at birth with another foster home (against their own policies) stating that the baby would be "better with a stay at home mom" (also not a valid reason according to their own policies). The other foster mom and I worked as best we could to facilitate a relationship between the siblings. After YEARS together, it goes without saying that two human hearts cannot help but become bonded and in love with one another. There was minimal involvement with the biological mother, absolutely ZERO involvement with the father, and very little, if any, interest from ANY other biological family member my little FOSTER CHILD really only knew me as her mother. Eventually, in 2012, the biological mother voluntarily terminated her rights to both children because she was led to believe that FOSTER CHILD and her brother would be adopted by the foster mothers that had raised them for years. The biological father's rights were going to be involuntarily terminated according to the ICWA guidelines, and I too was under the impression I would become FOSTER CHILD's adoptive home because not only were parental rights being terminated, but there were no other viable relative options that could be found, or no option that was willing to remove FOSTER CHILD from my home where she had been most of her life. However, the moment mom's rights were terminated, IDHW completely changed their tune, and told me I would most likely NOT be FOSTER CHILD's permanent placement despite having been her home for nearly 2.5 years. They said because of the ICWA, they HAD to keep looking for an Indian placement; I would always hear that "Boise" says we have no choice but to find a new placement for her. At this time, IDHW decided to look for a biological father for the little brother (again over a year after the baby brother had been born; not best practice). They did find a father verified through a DNA test. It turned out that FOSTER CHILD and her brother came from related fathers, and therefore the brother's family would need to be given first

opportunity to adopt FOSTER CHILD as well, not only because of the sibling relationship but because the family was and Indian home and would meet the demands of ICWA. It is important to note that these family members, who lived in the same city, were aware that FOSTER CHILD was in foster care, they were present with the biological mother at her court hearings when FOSTER CHILD was first taken into care, and they had said they did NOT want to be a placement for FOSTER CHILD (all of this was verified through court and CASA records). For all the years that FOSTER CHILD was with me, they had no interest in her, did not ever have a visitation with her, and were wholly uninterested in her. The family was definitely interested in the baby brother because his relation them was as grandson, while FOSTER CHILD was a niece. They were given custody of the brother within six months time. During this time, they were still uncertain as to whether or not they were interested in adopting FOSTER CHILD. IDHW meeting was arranged with an attachment specialist to discuss what would be the ramifications of removing FOSTER CHILD from a home that she had lived in for years at this point. The specialist, without hesitation, stated that "the move would be one of the most devastating events in her life from which she would never recover." At this point, the family said they did not want to do this to FOSTER CHILD, so they would not seek custody of her. The department then started to move forward in making me FOSTER CHILD's adoptive mother. However, the family members then changed their minds fearing that I would keep her from them and never allow them to know her because Idaho is a closed adoption state. IDHW then changed their plan and began to prepare the family to take custody of FOSTER CHILD. IDHW spent the next months working with the attachment specialist to develop a transition plan that would best help FOSTER CHILD transition from my home to the relatives after so much time. At this point, IDHW was adamant that they would do what was best for FOSTER CHILD, and do everything they could to minimize the inevitable trauma that FOSTER CHILD would experience. The transition plan was very detailed and required the family and I to work together closely and spend as much time as possible together because that would be best for FOSTER CHILD. Around this time I decided to hire an attorney, even though I knew foster parents had no rights in the state of Idaho, because I was determined to do all that I could to help ensure FOSTER CHILD's rights were being met. IDHW did not openly oppose me on this and allowed both my attorney and I to attend all court hearings. One big piece my attorney was able to get into the case was questioning whether or not the Indian Child Welfare Act actually applied to FOSTER CHILD's case. CASA had also hired an attorney because they did not agree with IDHW's decision in regards to it being in line with policy and with FOSTER CHILD's BEST INTERESTS. Together my attorney and CASA's attorney were able to present evidence to get the judge in the case to rule that the ICWA did not apply to FOSTER CHILD, and therefore IDHW DID NOT have to place FOSTER CHILD with the Indian family members. However, IDHW decided (not in line with their policies) that they needed to follow the "spirit of ICWA" and place her with the family members anyway. However, the family would not go along with the transition plan because it would have been too much of a burden on them timewise. IDHW, who had been so adamant, also retracted their decision, and declared such detailed transition plan was not really necessary after all, so it was scratched, and they began to transition FOSTER CHILD. Their reasoning was that FOSTER CHILD being placed with family was so much more important to a child's well-being than a transition plan would be. It is important to remember that FOSTER CHILD was over 4 years old at this point. She had been in my home since the age of 8 months. Not only did the department start a transition, they also refused to share with FOSTER CHILD any information as to what was happening to her or why she was expected to build a relationship with people she didn't really know. I was forbidden from answering her questions and truly was expected to lie to her convince her that her fears and questions were wrong. In November of 2013, to help speed up the process (because

FOSTER CHILD was not responding well to developing a relationship with the family) IDHW hired a woman to provide care for FOSTER CHILD so she could continue to work on a relationship with the family, outside of my presence. FOSTER CHILD spent her days at the woman's home where the family would come spend time with her or take her on outings. FOSTER CHILD's mental health began a huge decline; she began having toilet accidents, harming herself, having tantrums, withdrawing, harming others. IDHW's response was that I must be doing something to her on my end to cause her the problems. Not once did they acknowledge that removing her from the only home and mother she knew could be the cause (at this point FOSTER CHILD is nearly 5 years old). The caregiver expressed her concerns, gave her honest opinions about what was happening, yet the response was only to speed up the process. One day in March of 2014, I dropped FOSTER CHILD off at the caregiver's home. Later that day I was called and told I would not be able to return to pick her up because the transition plan had been completed. I was not able to say goodbye to her, she and I never even got talk about what was happening, or to have any closure. She left my home that day with only the clothes on her back and a few of her personal things, never knowing she would never return to the home, the room, the pets that she had called hers since she was 8 months old. She was removed from the person she considered her mother, and she was told that I was never her mother and never her family. The other important family and friends FOSTER CHILD had also never had a chance to tell her goodbye. One week later I was offered at "goodbye" visit with FOSTER CHILD to be held at the IDHW office under STRICT supervision. I felt like a prisoner. I was not able to address with FOSTER CHILD what was happening or why I was there or where I had been the last week. I was told not to upset her, to pretend that everything was okay, and that she was JUST FINE. I spent 2 hours with FOSTER CHILD at the H&W office, the IDHW supervisor sitting 2 feet from us at all times. At the end of two hours, FOSTER CHILD was pulled from me screaming and crying and begging me to not leave her and wanting to know why I was leaving her. All of this, I was told by IDHW, was "BEST" for her because she was going to live with her "real" family. At age 5, after 4 ½ years of raising her, FOSTER CHILD and I were forcibly and cruelly separated, and I have never seen her again. I can only imagine what goes through her mind on a daily basis, and what she is thinking about where all of her friends and foster family went; she was not provided the proper help in processing what happened to her. There were so many other scenarios that could have happened so that FOSTER CHILD could have maintained all of her important relationships, minimized the trauma she inevitably experienced, and allowed her to still develop meaningful and significant relationships with biological family.

Story 2

My husband and I have been foster care parents since March 2015. At that time, we received four (4) children, all siblings. We have known the mother of the children for twenty (20) years and therefore were considered "kinship". At first, we didn't have any problems with the department other than not receiving responses to emails and phone calls for day, even weeks (even though the department standard is 24 hours). However, our case worker went on maternity leave earlier than expected and we received a new case worker. All of our interactions with him and his supervisor have been negative. Immediately after he was assigned the case, the children began overnight visits with their birth mother. The case had been open two (2) weeks shy of a year when he took over and the children were still having twice weekly supervised visits with their birth mother. This was due to the fact that she had submitted multiple dirty UAs for methamphetamine and was not living in adequate housing. Each Sunday evening when the children came home from their visits, there were issues. The youngest child

(whom turned five (5) on Christmas) regressed due to the changes in their schedule. When she would come home, she would be covered in dried urine as well as the clothes she had worn at her mother's over the weekend. I reported it to our case worker, and he ignored the health issue. One weekend, three (3) out of the four (4) children came home with a rash all over their faces, arms, backs, and chests. Their mother refused to seek medical attention all weekend. I took them to the doctor the following morning and it was determined the rash was due to a severe case of bed bugs from their mother's home. I reported this to the case worker, and again he did nothing. The children then disclosed to us that there was physical abuse occurring in their mother's home. She lives with a transsexual who has three children of his/her own. Our foster children informed us that he/she gets angry with his/her sons and "chokes them and throws them on the floor really hard". The children also told us about a "game" they play with their mother in which they slap her as hard as they can in the face and then she slaps them in the face. This "game" was witnessed by the mother's sister and reported to us. I reported these concerns to the case worker, and again he did nothing.

Despite the mother not completing multiple tasks on her case plan, the department chose to return the children to her. Per her case plan, she was to maintain housing and employment for a minimum of six (6) months. She obtained housing a few weeks before the year review hearing in November 2015 and at that time, still was not employed. The housing she is in is not sufficient as it is a 3-bedroom home of which she has one room and her roommate has the other. This leaves one (1) bedroom for her four (4) children and her roommate's three (3) children. The department determined this was adequate. She also does not have a driver's license due to failing to pay child support for her other two (2) children. When the department was questioned about this issue, they reported that they "don't care if she drives illegally with the children in the car" stating that it's a "poverty issue" rather than a safety concern. After all of this, the department asked us if we supported reunification. I responded that I did not support reunification at that time due to the fact that she had not completed the case plan created by the department when the kids were removed. Our case worker's supervisor then told me to "learn my place" and if I didn't, they would take the children away from us. Unfortunately, they chose to follow-through on their threat. A couple of days before our final court hearing in January 2016 to determine if extended home visits would be granted, the department called us and informed us that despite the ruling in court, the children would not return to our custody. They reported "we know you have created a great home and the kids are well taken care of. We know the kids love you and will be greatly traumatized if we remove them and split them up, but that's what we are going to do". When asked to explain why they were making that decision, their response was either silence, or to say "that's just what we decided". Despite all of the biological family members of the children, as well as the Guardian ad litem, voicing their concerns with the children returning to their birth mother, the department chose to recommend it to the judge. They gave the Guardian ad litem the options of either supporting extended home visits or supporting that the children be split up and sent to different foster homes. Therefore, the Guardian ad litem had no choice but to support a return to the birth mother.

Story 3

When the boys came to live with me they had already been in foster care for eight months. Their father was in prison for physically abusing their older brother, another brother had been permanently removed from the family for sexually abusing their sisters. In fact, all of the children had been sexually abused by members of their extended family. In spite of this, the boys were generally cheerful children, and they had been happy and comfortable in their first foster home. They were removed from that placement

because of an accusation against their foster parents by their mother. The accusation was probably unfounded, but they were taken from that home with only a few hours' warning, and they were told at the time that the move was expected to be temporary.

As a result of the move, the second grader changed schools – to his third school in three years. I took him to say goodbye to his teacher, but he missed the friends he had made in his old school for a long time. Although he loved his new teacher and spoke well of his classmates, it was months before he dropped his guard enough to make real friends. By the next fall, he was thrilled to have close friends to proudly invite to his birthday party. With stability and structure, this child who had been in the extended resource room a year before was able to access his amazing potential and improve his academics so much that he was dismissed from special education. For the first time in his life he realized that he had talents and abilities, and he began to take pride in them. He learned what an engineer is and hoped to become one – the first time he'd ever dared to imagine a future.

While his brother moved to a new school, the preschooler remained at his previous school at his mother's insistence. This meant leaving the house at 6:30 in the morning so that he could catch the Head Start bus, as well as a move to a new after-school daycare. This little boy was so sweet and smart, but he *hated* the daycare. He cried every single morning for four months when he remembered that he had to go, but my repeated pleas to the case workers to consider a change in his interest fell on deaf ears. It wasn't until summer finally came and he could be home or go with his brother to our family sitter that he finally felt happy.

Both boys were wonderful, bright, good-natured children, but they came to me with a history of betrayal. The older boy was quieter, wary. He turned his anxiety inward and against himself. Early in their time with me, he pulled his own tooth out long before it was ready to come out, and for months he managed anxiety by picking at his skin or scratching himself. Changes in his routine led him to run to his room and hide under his blankets, and there were weeks when I had to change his sheets every morning because he had wet the bed. It took at least six months before he truly trusted that he could come to me and get the help he needed. The younger boy turned his stress outward. In the first months, he would burst into tears or fly into rages that seemed inexplicable. After many months of holding and hugging him through the tears and screams, he finally believed he was safe. Life settled into a calm, comfortable, loving routine.

Until the case workers decided that members of the extended family should adopt the boys.

Parental rights had been terminated a few months earlier, and the department had asked me if I would be willing to adopt the boys. They pointed out that the boys were thriving in my home, and the boys told case workers they wanted to stay there. Of course I was delighted to adopt them, and we all began to anticipate our futures together and talk about the things we would do. But after the boys had been in

foster care for a year and a half, case workers convinced relatives to pursue adopting them. Although asked by case workers, these relatives refused to take in the boys when they were first removed from their home, and they refused again when they were removed from their first foster home, in spite of seeing them regularly at supervised visits. These relatives were also 70 and 75, meaning they will be close to 90 when the boys reach adulthood. Given their current health problems, however, it is unlikely they will live that long. I pointed out to social workers that they were nearly guaranteeing that these boys would face more losses, but they continued to pursue the relatives as adoptive parents and began unsupervised visits with them. During these visits the boys were exposed to extended family with severe emotional and behavioral problems, histories of perpetrating physical and sexual abuse, unsupervised contact with the parents who had lost custody of them, and unsupervised play in dangerous situations, including around firearms. The older boy began wetting his bed again. He began lying, and stealing. He became openly skeptical of all adults and their motivations. The younger boy's rages returned. He began to have nightmares about being kidnapped from our home by strange men. When I expressed concern about this to case workers, I was told that the nightmares and rages and sobbing fits were normal. I pointed out that none of those things were normal experiences for a 4-year-old, but case workers literally shrugged and told me that "biology is best".

Three days before Christmas, the boys were moved to their new home with their great-aunt and uncle. We celebrated the holiday together before they left, and on the day I packed boxes and boxes of toys and clothes and books – the accumulated evidence of our lives together – into a van and watched them drive away. The social workers who had forced that moment upon us weren't there to witness it, just like they weren't there when I told the boys it would happen, and held them as they sobbed.

It's been two years since they were placed with their relatives. They have attended at least two schools in that time. Because the relatives who adopted them move frequently, they will undoubtedly attend many more. Their potential will likely remain untapped – no one in the family has attended college, and the family's culture does not encourage achievement. The choice of an adoptive home was made entirely on the basis of a fairly distant biological relationship. "They always go back to their families, anyway," I was told. Meanwhile, their sisters were returned to their mother because, at ages 11 and 12, they were "basically old enough to raise themselves". When social workers say things like that, it's clear that decisions are being made because of misguided policies and not in the best interests of vulnerable children.

Story 4

It would be so simple to start this letter with all the factual information surrounding how RAD, or Reactive Attachment Disorder occurs and how it impacts the children involved. I want to give you a more personal look at what trauma actually does to a child, family and community. Eleven years ago, I was a younger mama with a four year old and a two year old. These two boys were our joy and they were best buddies. It was about this time that we decided to expand our family through adoption. Our little boys we so excited to learn they would be getting a new brother. With their young minds, they assumed a new baby brother would bring more of the fun and joy that they brought to each other. A new buddy to play with. As parents, we naively thought this would be the case as well.

We learned that our new son came into the Foster Care system at the age of ten weeks suffering from severe abuse that left him with a bone that had been purposely broken. By this time our son was approximately seventeen months old and very bonded to his foster parents. The Judge had just terminated parental rights and we would now be allowed to bring him to his forever home. So after fifteen months in foster care, he came home to us. We were thrilled, our older boys were beyond excited. After six months we were anxious to be able to formally adopt him and give him our name and assure our older boys that we were going to be able to keep their baby brother. At this point he had now been in foster care for a total of twenty one months, as we were still not legally his parents. At this time, our first big surprise came in the form of notification from our caseworker that at the last minute, the birth mother had brought up the possibility of our son having some Native American heritage. This is where we became very familiar with ICWA – the Indian Child Welfare Act. So in a matter of days, we went from being so anxious to adopt our son to the very real possibility that he could be taken from our home due to the fact that we could not prove and Native American heritage was present in either myself or my husband. We waited almost another six months as tribe after tribe denied any interest in our son. Finally, after a twenty seven months in foster care, we were able to legally adopt our son. By this time he was approaching the age of three and it was becoming evident that his emerging behaviors once thought to just be the "terrible twos" were not going away. In fact, they were increasing and becoming at times frightening.

By the time he was three and a half, we sought help from the department. I contacted our case worker and explained to her what was going on and was told that he "must just not be sleeping" and to give him melatonin. We were also referred to Family Connections. After six months of in home counseling, parental support and Love and Logic training, the behaviors continued to escalate with no end in sight. We were desperate. Our two other boys grew increasingly estranged from their brother and were afraid to play with him. Once again, I reached out to the department requesting more intensive help. We started therapy and medication. All to no avail.

By the time our son was five years old, he attacked me with the wooden closets rods designed to hold clothes. We again, sought help and his current therapist suggested residential. There are very few facilities that will accept a five year old. Another hurdle at that time was Medicaid, as they stated they do not pay for residential services for Idaho. I ended up in the emergency room at St. Alphonsus being questioned by CPS workers and talking about possible pediatric psych. hospital admittance. It was determined that due to his age, we would take him home with a prescription for a medication that melts on his tongue so he cannot spit it out and will sedate him when he rages.

This was the first big crack in my armor. Continued weekly therapy and medication management seemed to do nothing. One time while driving to Grandma and Grandpa's house, he assaulted me so bad in the car I had to pull into the parking lot at the grocery store and get my other three children out of the car for safety. It was freezing outside, but there was nothing I could do as he pulled my hair from behind and punched me in the face. Once free, I was able to call my husband and the police. By the time

he was seven years old and in first grade, he had several physical altercations where he kicked and punched the principle, other kids, the special ed. Teacher and the continued physical abuse myself and my other children endured every time my son would rage. It was at this time that he committed his first felony against an officer, threatening to "take her gun and shoot her in the head."

I will never get the picture out of my mind of my tiny seven year old in hand cuffs. His wrists were so small, both arms fit in one side of the cuffs and left the other side to dangle behind him. My son is now ten years old. He has been let go by several therapists who all suggested residential for my son. I fought Medicaid, Optum, and more paperwork than I can remember to obtain these services for my son. This process took over a year. My son is currently in a specialized school setting with three teachers in a fully contained classroom. He has a minimum of three assault and battery charges within the first four months of the 2015-2016 school year. He has enough charges to be locked up for a year and a half. He was not with us the last two Christmases. The first one, he was in residential in Texas, the second one, he was in detention. We continue weekly therapy and monthly medication management, coupled with the ongoing services we are seeking through children's mental health, and his bi-weekly parole visits and frequent court dates. I am not able to work due to the time involved in managing his care. My marriage has become at times, just managing our son's rages, arrests and constant supervision. We cannot use babysitters, or leave him with very many people. Vacations and any change in routines is a sure recipe for a rage and anxiety. Our entire family now suffers from PTSD. My other children will need counseling to process all they have been though and had to give up. My boys who once used to be best buddies are now guarded to each other due to all the hurt and violence they have witnessed. They are embarrassed to have friends over in case they witness a rage. Our home has been vandalized by our son and our furniture has been destroyed by scissors, our animals have been hurt, and so far we have thousands of dollars in repairs to his room and furniture. He completely punched and kicked all the way through his bedroom door several times. Full sheets of drywall had to be replaced in his room as he punched and kicked holes in the walls, and then urinated and defecated inside those holes and his heater vent in the floor of his room. These are just some of the very real things that we have endured in the last ten years due to this horrible thing called Reactive Attachment Disorder.

PART 2:

I wanted to share our story about the adoption/foster process concerning our fourth son. He is our second adoption through the department. There are also some references to the struggles of our 10 year old son due to his adoption story as some of the challenges overlap. Often times, when one child is triggered, it will set off the other son. This does not include at all the MANY challenges that my older two children have endured due to the fact that trauma affects the entire family. Trauma comes in many forms.

In December of 2008 when our son was about nine months old, we received a call from the department inquiring if we would be interested in adopting a baby boy. After hearing a brief summary regarding the

details of his case, we learned that he had been born meth affected and that at this time the long term challenges were not clear. We decided that we would in fact, love to adopt this little boy.

At this time, we were already licensed foster parents and could easily transition a child into our home. As we waited to hear back from the department, the days turned into months and we weren't sure if or when this little boy would be joining our home. Five long months passed before we were able to bring him into our home.

By this time he was fourteen months old and becoming very bonded to his foster parents and his foster brother and sister. We were very nervous about this due to the fact that we had a previous adoption where our son was with his foster parents for sixteen months and was struggling with severe attachment issues. After our son joined our home, we worked very hard to help him with attachment while maintaining a bond to his now "aunt, uncle and cousins" who were previously just his "foster family".

Although this adoption went much more smoothly overall than our first, I have to question why he was allowed to remain in a foster care situation for five more months once a suitable, willing, and licensed home was found. In May of 2016 he will have been with us for seven years. While he is a very well-adjusted child and has bonded to us as his parents and his three brothers, he is not without challenges that stem from the adoption process.

As with our son, it is not uncommon for him to refuse to be away from me. I never know when his emotions will overwhelm him and he will feel that all too familiar anxiety that mama might not come back. Experiences outside of the home must be very thought out and regimented. What this looks like in "real life" is that the routine for transitioning to anything where I will not be present continually must always be made familiar and safe. This includes going to school in the mornings, trips to the grocery store, church attendance, the use of babysitters, etc. This does not include the challenges that most parents don't have to consider, for instance a dental appointment can be very challenging until the practice proves to be safe, and predictable. This would not normally seem like a big deal, but to a child who deals with this kind of anxiety even going back to the dentist chair alone, or going into a grocery store is a big deal.

There are always the questions of "will someone take me?" The door bell ringing at home can trigger anxiety and often full dysregulation accompanied by a significant meltdown as the child processes through the fear of who is coming to the house? Are they safe? Will they take me? What will I do if they hurt mama? There are also the concerns as a parent, that often these children are desensitized to "stranger danger" as they are taken by social workers, police, doctors, etc. as they come in to the care of the department and are having visitations. Having said this, it is not uncommon for one of my adopted

boys to try to leave with anyone who tells him their name. To him, that translates to "I know this person since I know their name." I have had to stay hyper-vigilant any time we are in a social setting.

My other adopted son on the other hand is so fearful of the intentions and outcomes of being around strangers, even ones that mom and dad say are "safe and ok." He will often become so deregulated that typically a rage ensues and it is not uncommon for him to have to take medication to completely calm him down. There are challenges with vacations, going to his brothers' baseball games and just routine days at the park or the swimming pool.

Trauma turns everything normal into a challenge both for the children and their caretakers. Nothing is simple or easy. You cannot just suddenly announce a surprise trip to ice cream because that will trigger anxiety. The child must know where we are going, how long will we be gone and the worst question "will we all be coming back home?" I could cite so many more daily challenges that exist in our home, but this has become our "normal" and while I would not change it for the world, I know we can do better. Not just for these kids but for our society that will be impacted for better or worse as these children either heal or sadly, end up taking their "hurts" out into society that continues to misunderstand the far reaching effects of childhood trauma.

Story 5

My husband and I have been foster parent for 3 years, we have welcomed 17 children into our home from respite care to emergency placements, and long term placements. These are a few of our stories. We would like to continue fostering, but at the same time our choices are to do whatever the workers tell us to do, or stop fostering. We also know if we stand up to the workers we risk losing the foster children in our home.

Part 1:

When the twins were first place with us at 9 months old, the Dept didn't know how long the children had been left in a single crib before the police found them. We had the babies for a year and 4 days before they went to their Grandmother for permanency. In this case, I do not want to argue whether or not the babies should have stayed as much as the awful transition the workers arranged. We knew the transition was pending, and we were waiting for the "ok" to move forward. The worker emailed us, said they would like to do a transition in the next month, she asked us to check our schedules and let her know what worked, we had also had a transition meeting about a month prior with Grandma, where we both stated, we didn't have specifics we as adults needed, as long as it was best for the twins. I received the email, and in the Skype visit that night (Grandma lived out of state) I told her that we had received an email to discuss dates that morning, so I asked her what worked for her. Grandma replied "Oh, the worker already sent us our plan tickets we will be there next weekend (10 days) to pick up the twins" After emails later with Grandma, we had discovered the Worker had not asked the Grandma either about the schedule, as the Grandma was in the middle of a remodel project..... So not only did Grandma end up with the twins abruptly, she also had new to her toddlers, in the middle of a house remodel and her husband would be out of town for work for 3 weeks. The worker had told us there would be a 4-7 day transition period during our transition meeting, but in reality, we had 1/2 day. Grandma flew into

town late on a Friday, we had time together with them and the boys on Saturday, and their flight left very early Sunday morning. These boys, who knew us as mom and dad for a year, were passed off in one day, never to see us again. I believe if the workers had followed through with what they had told us- letting us pick the transition dates, as well as followed through with a 4-7 day transition plan it would have been better for the twins. When we buckled those boys in to their Grandmother's rental car, they looked so confused. They were 21 months old. I can only pray that they do not have lingering issues with abandonment, as they already had lost relationship with their birth parents, then they had their second parental relationship severed without a proper, and promised transition.

Part 2:

Two days before Christmas 9 year old N arrived. She had originally came into care in August, and had been living with a step mother on an extended home visit when it was decided she needed a safer home. Initially we were told it would be a 2 week respite situation..... it turned into 10.5 long months. Out of state family had already been contacted and working the ICPC paperwork. In the meantime N had weekly visits with her Grandfather, a sexual predator the Dept was aware of, but insisted the family bond was more important than the risk. The safeguards put in place were that he had to do visits out in the community, and have another adult with him. 8 months into the case, birth mom found out which relative was going to be the permanent option for N, and birth mom was unhappy, this relative had adopted 2 of 3 previous children she had lost rights to. Birth mom insisted she would now start her case plan, 8 months late, and in the meantime tried to get her own mother to get certified to get N (in other words, she didn't want N, she just didn't want the other relative to adopt her) The worker supported birth mom, instead of pushing for early permanency. At the 12 month review, N wrote a letter to the judge stating she wanted to live with the out of state relative. Birth mom did not have place to live, or had been appropriate enough to obtain unsupervised visits- all conversation had to be within earshot of the visit tech. Even still, the worker asked for an extension for birth mom's case plan. At the 12 month point, this poor child, did not want to live with her mother, she had the strength to tell the Judge and had the opportunity to be moved to a relative, and be reunited with her sisters. Instead the worker dragged out the case, N was forced to remain unsettled for another 3 months, start another school she knew she wouldn't be able to attend a full school year at instead of being with her adoptive placement and start the bonding, and attachment necessary to her healing. Every time we went to court and the Judge and Worker agreed to continue working with birth mom, N's heart would be crushed. All she wanted was to be with the family that wanted her.

Part 3:

T came to us in November, he is 2.5 years old, and we are his 4th foster home and he has been in Foster Care for 2 years. A year ago DHW decided to terminate the Parental Rights of his parents. A permanent home has yet to be selected for T, they are still searching for a relative placement for T. Three times the Dept. has had scheduled TPR Trial dates in 2015, none of which proceeded for different reasons. In the meantime, there is no end game plan for T to get a family. There is no guarantee the Judge will proceed with the next TPR trial, there is no set date for a selection committee to pick out an adoptive home (relative or non-relative) for T, there is no deadline the Dept is holding to stop searching for a

relative placement and seek out an adoptive home so T can have a family. So we wait and see. We are willing to be an adoptive placement for T and although we understand the relative placement policy, how long will they search before saying this child's need for a family now, for attachment now, for his healing now, is more important?

Story 6

I was placed with FOSTER CHILD at two days old April 28, 2013. He tested positive for methamphetamine. FOSTER CHILD's biological mom was inconsistent in her visits. After only four or five visits in his first five months she disappeared. FOSTER CHILD was not a typical foster. He did not leave our home several times a week for visits. FOSTER CHILD had a handful of visits with his biological father in January 2014 before he decided he did not want to pursue reunification. During his first year the department looked into family placements in Utah (maternal) and West Virginia (paternal). I had contact via email, phone and in person visits with FOSTER CHILD's aunt in Utah who decided not to pursue adoption of FOSTER CHILD because he already had a strong attachment with our family. In late April, early May 2014 I was informed by the department the Aunt in West Virginia did not want to adopt FOSTER CHILD. In May 2014 FOSTER CHILD's half sister was born and placed with our family, she also tested positive for methamphetamine. FOSTER CHILD and Jodie are 12 months and 3 weeks apart in age. There was an immediate and intense bond between these two babies. May 2014 also brought termination of parental rights in FOSTER CHILD's case and an adoption committee meeting was held to select our family for adoption. In September 2014 I received a phone call from the department that FOSTER CHILD was possibly Native American and we would now have to wait to hear from the Indian tribes before proceeding with his adoption. They also informed me they had contacted the Aunt in West Virginia and was told she now wanted to pursue adoption of FOSTER CHILD. At this point, FOSTER CHILD was 17 months old and had only known one family and one mother. He was completely bonded and attached to our family including my son, NATURAL SON as his sibling, and our extended family. One week later the department called and said central office had decided they would not allow the family in West Virginia to complete an ICPC as FOSTER CHILD's adoption selection had already been complete and he had been in one family for his entire life. In November 2014 on a conference call with several department workers I was informed the department had changed their minds and was requesting an ICPC from FOSTER CHILD's aunt in West Virginia. I was told there was no avenue to fight this decision. At this time FOSTER CHILD was 19 months old and had never had any contact with this family. One week later FOSTER CHILD and Jodie were removed from my home and placed for two months with another amazing foster mom. During our separation FOSTER CHILD stopped talking and signing. He was sad, anxious and confused and tried to self soothe with food. He often moaned and cried when with others. Upon their return to my home January 2015 FOSTER CHILD quickly returned to his happy self. The department funded four trips to Boise for FOSTER CHILD's Aunt. Every visit created more stress for FOSTER CHILD, especially when the department would restrict all contact between FOSTER CHILD and our family, and insisted we start calling him James. FOSTER CHILD became physically ill during or after each visit. In late November 2015 I was told FOSTER CHILD would be moving to West Virginia before Christmas. The department created a short five day transition between FOSTER CHILD's only home and family he had ever known and a hotel room with his Aunt. During Skype visits he has asked to come home. He asks repeatedly for Jodie, NATURAL SON, Grandma and other family members. He has gone from testing out of the infant toddler program to weekly speech therapy due to regression from the trauma caused by removing him from his family. FOSTER CHILD has no contact with his maternal

biological family and the department no longer requires the aunt to continue contact between FOSTER CHILD and NATURAL SON and I, his family since birth.

Story 7

To: Those helping to bring change to the Idaho Foster Care system

Our foster son was brought to our home at 2 months old. We fostered him for 25 months. During this time, we worked with multiple visit techs and safety/case/adoption workers from the Department of Health and Welfare.

Communication with our case worker was almost none existent. Between visits, needing vouchers, signatures for medical care, court dates, not to mention checking on how the child is doing, communication is important. Over 90% of our phone calls/emails to our case worker were NEVER returned. I reported to calling and emailing the supervisor, of all those times, I only received one call back. How are we supposed to care for this child well, when we cannot even get a call returned from his case worker? Vouchers could take up to 4 weeks after we requested them, case worker didn't show up to a specialist Dr appointment we needed him at, and we couldn't get him on the phone. It is our understanding foster parents we can come to court and have a couple minutes to update the judge on how the child is doing. The first time we went, we sat in the hall waiting (after talking to case worker) and were never called in. According to our CASA worker, who was in court, case worker never told the judge we were there.

Our foster son's pediatrician was recommending treatments that we knew were not suitable (we have past medical experience with other children). It took 4 months of horrible care before our case worker would agree to let us change Dr's. Bio Mom never came to a Dr visit or had a special interest in staying at this particular Dr. Visits that are hard. We understand the importance of visits, if reunification is going to happen, but by this time, when the visits were becoming traumatizing, neither parent were working their plan and the child had been in care for well over a year. Countless times I would get a phone call demanding I bring our foster son to the department within 15 minutes because Mom requested a visit. This would be after I was told visits would be on hold until parent met with the case worker due to 4-5 missed visits in a row. As our foster son got older and grew healthy attachments, when his Mom would have a visit he would be literally be torn from my arms, screaming. I asked that the visitation tech take him from me, as he transitioned from me to the tech better than me to bio mom, but my requests were denied and bio mom was brought with the tech when she came to pick up our foster son, causing undo stress for the child. This process can effect his attachments for years to come. After being in our family for 14 months, and meeting his bio dad, for the first time, for a 30 minute meeting, our foster son was forced to go to prison. He was taken to prison, by a social worker whom he had never met. The worker, who was a complete stranger to this 16 month old child, took him to a facility where he was patted down/searched and taken to visit a man whom he had no previous relationship with. This went on sporadically for 4 months. These visits caused trauma to this child that he couldn't voice, being 16-20 months old, but it was evident in his demeanor and emotional state. It is obviously traumatic to take a child away from his only consistent, safe place, but then add being taken by a person he has never met, in a car he's never been in, to a person he had no previous relationship with... it was no wonder that his behaviors were abnormal, aggressive and dramatic for 5-7 days after each visit. He would cling to me and not let me out of his sight, not sleep well, become paranoid, and scared of everything. Even others outside of our family (occupational therapists, friends who regularly see us) noticed the changes in him

days after visits. I'll never forget when we had to get a rental car. As we approached the car and got in he started screaming in terror. He thought we were sending him away. Each time his case worker/permanency worker came for their monthly home visit, as soon as he saw them (once he learned how to say 'no') he would say 'no no no' and cling to me, afraid they were going to take him away.

Story 8

My husband and I became foster parents in 2012. After participating in PRIDE training, we were so excited to become a part of something much bigger than ourselves, especially since the training emphasized that we would be part of a team that would work together for the well being of children in foster care. PRIDE also emphasized the importance of continuity, stability, and permanence for these especially vulnerable children.

The following year we fostered an infant. He came to us as a newborn, directly from the hospital. Several months went by and a woman from Oregon came forward, saying she wanted Baby D. She had previously adopted two (of eight) of Baby D's biological siblings. We voiced our concerns to the department, which included the fact that Baby D had bonded to us, as well as the fact that the family in Oregon had five children in the home, two of whom were under the age of five and both had FAS (one with severe handicaps requiring constant medical attention and multiple therapies) as did Baby D. We were concerned that his needs could not be adequately met. The GAL assigned to the case began to express similar concerns to the department, as did the county prosecutor. At that point, the department completely turned on us. They were openly rude and disrespectful to us, though we had only ever politely, respectfully tried to talk through our concerns with them. They refused to work with the GAL at all; the situation became so difficult that the GAL was given an attorney to represent him in hearings. During that time, we did everything the caseworker asked us to do, including extremely difficult interactions with the family in Oregon. When we asked the caseworker to please help us facilitate appropriate visitations with the other family, she told us to 'figure it out ourselves since we were adults'.

When Baby D was nine months old, the courts granted the department's request to have him placed in the home in Oregon; however, since it was over state lines, the department could not actually move Baby D to their home until another hearing could be scheduled to get approval for an out-of-state placement. Workers on the case were so angry and frustrated by that time, and their treatment of us became a terrible reflection of that. They grew tired of waiting for the out of state approval to move Baby D, so they abruptly removed him from our home and placed him in a foster home hours away from us. He had never met that foster family. He had only ever lived with us and was absolutely and completely attached to us. There was zero attention given to how this would affect this little person, to one day just be removed from his family and never see them again, and be placed with total strangers, all for expediency! The department would only to have waited two-three weeks, and Baby D could have at least been spared what must have been exceptionally painful and frightening. All I have been able to think about in the two years since, is how utterly abandoned he must have felt. My heart is forever broken for him, and the unnecessary pain he has suffered.

We did not continue as foster parents afterwards, even though many in the department said we were

among the best foster parents they had, and they wanted us to stay. We could no longer participate in a system that bullied its way over foster families, court appointed guardians, and the very children they claimed to care for.

Story 9

Our son was placed in our home at 4 months of age. His mother had passed away that day and his family asked to have him placed in foster care. Within a short time a family from out of state expressed interest in adopting him. The department worked hard to make the move. He went to live with them after being in our home for 5 months. Three months later I received a call from the adoptive family saying they were not going to adopt him and were bringing home back to Idaho in a few days. I stated, he is coming home to us. This is when I was told the department had found another adoptive family. I was stunned that this was the first I was hearing this. I promptly called the case worker. She informed me that indeed another family had been chosen. I asked why we had not been asked if we would like to adopt. She said she had spoken to our licensing worker and understood that we never intended to adopt. I explained that we did not go in to foster care with that intent. However, given the situation we would like the opportunity to adopt him. I was told the decision was already mad and it was too late. My heart was broken. My husband and I discussed the situation that evening and decided I would call our licensing worker in the morning. We both felt strongly that he needed to be with us. We couldn't stand the thought of him having to go to another home. I called our worker. I expected her to know why I was calling. She seemed confused. I explained what had taken place. She told me that she had not talked to the case worker. At that point she offered to take our case to her boss and above. Over the next day and a half meeting were had. I received a call from the case worker saying he could come home to us. BUT...not to think that it means we will be allowed to adopt him. I expressed how happy I was he didn't have to go to another home. She told me he wouldn't remember us. She even asked if we had any animals. I said, yes a dog. She said, good he will remember the dog.

Two days later our son came home. As soon as he saw me he reached for me. My daughter and I gave him a bath that night. When I took him out of the bathtub he said "mama" for the first time. Remember he is a year old! He had never said that before. I knew then he knew who I was.

The first time the case worker came to the house after our son came home she dropped a bomb that he has 12 year old half-brother. This had never come up the five months he was with us before. She explained that if we didn't agree to visits they probably would not allow us to adopt him. This was the tone for the next 9 months until the adoption was final.

Now to do my best to explain the impact this has had on our son and family. When he came back home he had skin issues that he did not have prior. He had an open sore the size of a quarter on his back that the other family was treating with steroids. It would not heal. Our dermatologist said that it was due to stress/anxiety. We now have three different kinds of creams to use when he has flares. It took about a year to resolve the initial skin issues. Now the pop up here and there.

The biggest thing we noticed when he came home was there was no light in his eyes. (this is where it gets hard to explain on paper) He had no emotions. Our friend, who has a child with RAD looked at him

and said she would not allow anyone to touch him. She explained he needed to attach. We limited him being around people other than our immediate family for six months. If we were going out I always wore him in a carrier. We didn't let anyone else hold him. I did all of his care. It was exhausting. This was very difficult given the fact that our other two children were teenagers. Going to school, church, and other events as a family was a thing of the past. The results were slow. He did not start showing emotion until he was 3.

Our son was enrolled in the infant toddler program until he aged out at three. At that time they said he would not qualify for the preschool at the school. We agreed and sent him to a private preschool. This is when we saw his attachment issues. The preschool was not able to understand or deal with his "quirks". In order to feel secure, he attaches himself to objects. He would always want the same car. Therefore, they hid his favorite car which took his security away. This had snowball effect. We decided to take him out of preschool and seek professional help. He began seeing play therapist once a week. The therapist recommended that we had a neuropshych test done. The therapist worked with me and our son on teaching him emotions. He could not tell you how he felt. He always said he was happy. And he had no idea that other people had emotions other than happy. We also worked on correct behavior with strangers. He would ask to get in strangers cars. And touch people at the grocery store. He still struggles with strangers. She explained to me that he is emotionally half his chronological age. We worked on what that looks like and how to deal with that in daily life. We saw this therapist for 1 ½ years.

In that time when he was 4 we enrolled him in different preschool. This preschool only had six children. There were two teachers. It was difficult for the teachers with him. They were understanding with him and made it work. He is now in kindergarten. He is doing better than I expected. Yet, he is on a 504 and is defiantly not emotionally with the other children. He often does not want me to leave because he doesn't think I will come back. It is heart breaking. I reassure him that mommy always comes back.

Daily life is so different. Going to the store he needs to know he will be safe and I will not leave him there. He has to know when will daddy be coming home. Are brother and sister ever going to come back from college? When we take a trip he asks if we are going to leave him there? Or is someone else going to be living in our house when we get home? He has often told me he didn't like being a baby that it was scary. When his siblings have friends over he tells them he loves them and cries when they leave. (this is getting better, still a work in progress) He asks me daily wh0 parent helper will be in his classroom. (he always needs to be reminded he is safe).

Family vacations go like this: the way there he wants to go home, the first night he doesn't sleep, the next day he doesn't want to leave the room, that night he throws up before going to sleep. If the trip is longer than two-night he doesn't want to go back home.

Story 10

We got the call to take 2 ½ year old, identical twin boys in to our foster home in May 2007. Approximately 3 months later the caseworker asked us to consider adoption as the biological parents were failing to meet their goals on the case plan. After family discussions and prayer our family was excited to say "yes" to being the boys' permanent placement. However, at about 15 months in to the case it was decided that the boys would be reintroduced and transitioned to their biological parents. Right from the beginning of a visitation schedule, we knew things weren't right. We suspected drug use

and reported it. However; 17 months later they were placed back with the biological parents, along with their little brother who had been in the same foster home since birth and was now 22 months old (he knew no other parents). They also had an older sister who was also living in the home. My husband and I forged a relationship with the biological parents determined to mentor them for the better of the boys and their siblings. Sadly within months they were evicted from their apartment. We got word that drugs were still an issue. The parents allowed us visits and even asked us to babysit and do a few overnight visits on some weekends. We bought food, clothes, and shoes for the boys, hoping to improve the situation. The mother seemed increasingly mentally unstable and we suspected spousal abuse based on stories the boys would tell us when staying with us and the injuries their mother had such as bruises, black eyes, and knocked out tooth. Their trailer smelled of feces, as there apparently was issue with their septic. The twins entered kindergarten and they missed so much school that they had to be transferred to a special class because they had gotten so far behind. Apparently getting them to school by noon for ½ day of school was too much for the parents who complained they were overwhelmed. Finally 14 months after being placed back with the parents we got word that they were being placed back into foster care with us. I already was babysitting them that night at my home. The judge was to sign the order the next day and they would reenter into foster care at our home. However, the biological grandmother saw me the boys at the store, and took them out of my cart and left with them, angry that I was being allowed to babysit. The caseworker told me that she would go get them the next day after the order was signed and bring them to us. That never happened. The caseworker decided to place with biological grandparents despite the fact that she previously had allowed visitation with the parents without the approval of the department and had a previous arrest record for injury to a child. In addition, the department hired an attachment specialist to see where they had parental attachment and it was found they had attachment with us, none the less they were placed with the grandparents and adoption was to take place December 2010. They lived with the biological grandparents for a full year before she was arrested on DUI charges with a child in the car who was not belted (not one of the twins or little brother). The DUI charges came five day prior to the final adoption court date. They were finally placed back with us following the arrest and later adopted. However, the department's handling of the case left as many emotional and mental scars on the children as what the parents had done!! They are now 11 years and still struggle with nightmares and abnormal fears for boys their age. One of them struggled to self regulate requiring counseling. The other one pulled his hair and eyelashes out due to anxiety. They both have had counseling as a result of the trauma of the department forcing a sibling bond by placing them all together for 2 years with the end result of them being back in the foster homes they started at and the sister still living with the biological grandparents. They were very behind in school because of all the missed kindergarten and lack of help while with the grandparents. It took 3 years of hard work to get them up to grade level. During their time with the parents they witnessed and can recall, drugs use, drug manufacturing, the selling of drugs, and domestic violence. During their time with the grandparents they were locked in the basement for punishment, the biological mother was allowed to come and go as she pleased, leaving them very insecure about when they would see her next. At one point she lived in the basement of the grandparents house, though the boys were told not to tell anyone. One of them has memories of pornography movies being played in the homes. All of this could have been prevented by requiring the parents to follow every part the case plan and following up to make sure it was truly being done. At one court date the father lied about the mom completing drug rehab (which she had left before completing) and lied on why he was unable to keep a job. The facts were easy to follow up on but yet the department chose not to present

the fact or follow up on said stories. It sickens me to know that these beautiful twin boys had to endure so much beyond what they had already gone through just because the department was so determined to reunify and then later place with biological family. Obviously the decisions made WERE NOT in the best interest of any of the children in this case and there it has left scars. Please call me with any further questions on our case. I am happy to do whatever it takes to assist in changing the laws as to reduce the amount of trauma kids must endure.

Story 11

We got a call from the Department of Health and Welfare when C was about two weeks old. They informed us that he was in the NICU and born addicted to drugs. For the next two and half weeks we visited the NICU every day spending hours holding and helping him feel nurtured and safe. The nurses were astounded at how quickly he began to show improvement. "All he needed was a little love," they told us. Home health nurses would visit our home the next few months of his life monitoring his progress. They credited his rapid recovery to a safe, loving, and nurturing home. We felt good about the service we were able to render this little boy. C made a full recovery and within two weeks after coming to our home was off the drug-weaning medication.
Early on it was reported to us that an out of town relative had been selected to adopt C in the event that his mom's rights were terminated. While we would have loved to adopt C, we were in support of the relative. We facilitated multiple skype visits each week as well as monthly visits when the relative would come into town.

While C was an infant, these week -long visits at the hotel worked well. As the child got older he began to return from these visits more and more disturbed and aggressive. We reported these reactions to the caseworker with the hope that a modification to the visits would be explored to better ease C through the transition process. The department ignored our request and concerns. After firmly stating the need for them to evaluate how they were conducting the visits our case -worker threatened to remove C from our home if we couldn't support the department's decisions. We felt alarmed that the department was unwilling to make minor adjustments to accommodate C's changing needs.

Shortly afterwards, when C was 14 months old he went to his usual visit with his birth mom. When we said goodbye to him that morning we had no idea the grief we would experience that day. At the time he should have returned from his visit we were informed that he would not be returning to our home but was to be placed in another foster home. We were sick inside. Sick for what C was thinking. Where was he? Was he scared? Was he confused? Did he think that we did not care about him? What was going through his mind? These questions haunted us. While he was not our literal son, we felt as much concern for him as we would one of our own children.

After 14 months of living with the people he believed to be family, the department knowingly, purposefully, and premeditatively severed that bond. We found out later, that a week before they removed C from our home, a group of supervisors met and decided to remove him without any notice to us, the birth mom, or the guardian. They did that knowing full well, in violation of their own research and internal protocols, how devastating it is on a child to have those bonds disrupted.

From the Idaho Child Protection manual it states, "We now know that multiple moves can break the bonds of trust and attachment formed by the child. Consequently, mutliple moves harm the child. Multiple moves compound the original trauma of abuse and neglect, often leading to long term adjustment and attachment difficulties." And knowing all this, they removed C to another foster home.

In the months following, the reasons they gave for taking C from our home changed many times. We met with the department after this decision pleading with them to place the child back in our home for C's own sake, which they rejected. Through facebook the new foster mom contacted me wondering how to care for C and his special needs. She shared how he was feeling and doing and described a boy that we did not recognize; inward, sad, empty, sullen, withdrawn. Those words did not describe the boy we knew. C was vibrant, cheery, goofy, fun loving, happy and excited about life. Everyone that knew him called him the happiest baby they had ever seen. He was always smiling and full of energy.

Even though the department has removed C from our home, C still feels and thinks that we're his family. It is the height of arrogance that a bureaucracy thinks they can terminate a meaningful relationship with an order. Just because they made that relationship end didn't mean it ended for C. He has suffered and continues to suffer because of it. C is still in the state and still living with his other foster family. We have been privileged to get to know them. As wonderful as they are, C knows who we are and continues to feel a strong connection to us. These bonds are real and when they are broken there are real consequences. We currently continue to support C the best we can. For the last five months, once or twice a week we take C for a day. My husband takes work off, the kids forego their usual schedules and we spend that entire day with C. We drive him back in the evening, hand him to the foster family, and have to look into his eyes as he cries and reaches for us.

And then we walk away.

Story 12

Sadness, confusion, and melancholy marked our foster son's mood after he was abruptly moved from his original foster family. For three weeks, we wondered if the flat affect we were witnessing was his true personality. The day we saw him reunited for a quick visit with his former family was one that told us the true story of his disposition. His face lit up and his eyes boasted a sparkle we had not yet seen. The unbreakable bond we witnessed between them brought tears to our eyes, and a lump to our throat.

Breaking these important bonds is damaging to a child's psyche. We witnessed this first hand. We watched our foster son lash out with tantrums, experience sleepless nights as he tried to adjust, and struggle to establish a trusting relationship with our family.

We were privy to information through his former family that gave us insight into the type of toddler he had been before coming to our home, and we were shocked at what we were witnessing. A little boy was taken from a loving, safe environment, for reasons that were important to the Department of Health and Welfare. And, all we could see was the pain and bewilderment on our foster son's face. He didn't ask to be removed abruptly from the only family he had known. He didn't understand the reasons given to us by his Caseworker. He didn't get a say in his surroundings. And it showed.

I am able to report that our foster son is adjusting to our family, and has formed an attachment to us after 5 hard months. We have had to work overtime to help those vital connections form. I see distrust in his eyes when we introduce him to new people, as if he is wondering who will take him next. I have held him as he cried in confusion during the night. I have observed him fall to the floor and hit his head repeatedly in extreme frustration. And, in these moments, I have worked to encourage healing and attachment. We now see a sparkle in his eye when we walk in the room. When his chubby little hands hold our own, and he snuggles into our neck, we breathe a huge sigh of relief. It hasn't been perfect; in fact, it's been a tragic experience. But, we are committed to loving him back to a place of normalcy. - What is astounding is that when his former foster family comes in the room, it's almost as if we don't exist. The bond they share is incredible, and I know he misses them terribly.

We are unsure what the rest of his life looks like, but we hope we have helped to lessen the horrible effect that his abrupt removal might have on him down the road.

Story 13

My story is heartbreaking, as so many are:

My husband and I have been married almost twenty years we have five boys ages 8 to 18.

Three years ago thru much thinking and talking to the kids and really having a heart for our community we decided to become foster parents in Idaho, we really had a desire to bring a baby girl in, in hopes to adopt.

In July of 2013 we received a call about a baby girl R , little R had been taken from her grandmother at two weeks old who had her since birth, she did not comply with state rules I was told, grandma was also raising three other grandchildren.

Little R was born into the system to a mother who knew she would not get her to take home due to drug use and other things, this baby was the result of an affair the mother had on her husband, she had three siblings that were from both the same mom and dad.

I picked her up and I took her home, the next three months I adjusted to being a mom of a precious baby girl that we took as one of our own, during this time she had a bio logical father who would be allowed with his mother to visit once a week at the office, I drove her to and from these appointments never asked for money anything, I had a great relationship with this dad and her mother, they loved this baby but they knew she was happy and healthy and the most bright eyed little girl, they both desired to have her stay with us, the grandmother wanted to be a part of her life but wasn't capable of raising her, the father was unstable and moved around a lot as well as had a drug addiction so he wasn't able to take her or care for her., at about the three month mark the biological mother decided to have a one hour visit with her, this continued for a couple visits and then she didn't show for many more months, she moved out of state and then moved back, very unstable not moving forward with trying to conform to the rules to get her child back. She saw her approximately 5 to 7 times for one hour each time the first year of her life. The father had told the state workers that he wanted our family to keep her, the grandmother saw the great bond and realized we were her family and wanted us to keep her.

There was an issue, the grandparent on the mothers side , they wanted to place her and were bound to place her with a blood relative, mind you, the whole time that we had baby R this grandmother and grandfather had not showed interest, I had taken her on a visit once in that year on thanksgiving day to see them and spend two hours there, I picked her up and life continued as normal, she very much was our little rose our beautiful baby girl, she met her milestones and was so happy and healthy, it was two weeks before her first birthday we were informed she would be leaving, be transitioning to her grandmother, the one who had three others that were siblings, the family that she did not know. I had never left this baby in the almost year I had had her, I was her mama, and my boys where her siblings, we started with a day care type schedule I'd drop her off and I'd pick her up, she went there five days a week, she was very distraught when I would leave her and pick her up, she started to really with drawl I saw it, she had a blank stare, she started waking at night instead of sleeping thru the night, she would holler mama mama and I'd have to hold her to sleep, she was sad and looked lost, it broke my heart. They this process I had talked to my case worker as well as the head people about my concern, we had a group meeting and basically said are u going to follow our plan or not, they didn't once listen to our concern for this baby girl, they instead accused us of not setting up visits to her grandparents, they told us that in that almost year they thought she was seeing her grandparents and was having visits, there was so many lies, they treated us as garbage and disregarded anything we said, I watched as they would do things right before court dates so that the judge would not know what was going on. It was awful.

A week after her first birthday I packed up her beautiful pink nursery in her brand new house we had built to send her to an uk own place and leave her, to say goodbye forever, I had to take her to the grandparents house and drop her off with all her things and say my goodbye and watch her face as she knew something was wrong she started biting her lip all the time and the bright eyes were now sad eyes, I said my goodbye and handed her over and I will never forget that feeling of knowing that I had to leave my baby, she didn't understand why she would never agin see her mama, everything she lived and knew was gone and I will never get over it, the effects it had on not only her but on our family and my boys was everlasting to this day, it caused so much heartbreak.

My prayer is that this broken system would once again place the child's best interest in mind as the choices they make have lasting attachment issues for these children, foster parents are the only voice that they have. We need to be able to be heard. Our children are more then a number that looks good on paper when reunified with a blood relative, what about the best interest in that child.

This is just one of the heart breaking stories we have.

Story 14

The date you received the child. How long the child remained with you? - We were called by our social worker on November 28, 2007 to take him in at the age of 1 day. Child was in the hospital where we visited each day until he was able to come home with us at 9 days old. He stayed with us until one month before his second birthday.

The date the child was removed from your home. - He remained in our home until October 30, 2009, when the department gave us 3 hours to deliver him to his "new family". We then drove him to H&W in CDA where we delivered him to complete strangers and were given one hour to give the new family information about "our baby" and then were asked to leave.

The reason the department gave for removing the child. - The department told us that another family had been chosen to adopt him at the adoption selection committee. One month prior to the adoption selection committee meeting we attended his parental termination hearing and were asked under oath if it was our intention to adopt him. This was absolutely our intention and our understanding as we moved forward. This was also the plan the department had given us.

Did you receive the child back into your care? If so, why? If not, why not? Yes, we received the child back in our care exactly one day short of 6 months later. We were told the other family were having personal issues and were unable to continue with adoption. Moving him back into our home was not what we expected. During the time he was gone we filed motions to have him returned, we went to the media including several radio stations, 3 local newspapers and a local television station. During this time the department was given a gag order and both the department and CASA refused to talk to us. We were also turned away several times when trying to renew our home study.

Are you aware of any repercussions that have come to the child because of the actions of the department. - He suffers ADHD, PTSD, and RAD, all of which come with many repercussions of their own. CHILD struggles at school and socially.

Where is the child today? Is there any information about the child that would help us understand how they have been affected? - He is in our home since the other family gave him back to the department, although the other family was unaware he would be moved back into our home. Attached testing and plan from counselor.

Story 15

I am so thankful someone is trying to take a stand for foster parents. I was a foster parent for about 9 years for just over 20 kids. However, after experiencing a non-caring attitude from so many case workers and department heads, I wasn't able to continue. I could not stand back and watch them NOT care for my foster children. Anytime the kids needed something, they wouldn't respond. When abuse was suspected and reported to the Dept, I couldn't believe they never did anything about it. Time after time, month after month, child after child, I watched the Dept destroy these kids. It broke my heart! I so wish I could have continued being a foster parent. After a grueling two years, many promises made and broken, and by the grace of God, I was finally able to adopt my first foster placement. He is the joy of my life. I just wonder how many others could have turned out the same way if things would have been different. I could never be a foster parent again and that's sad. We have so much to offer to a child. We need change!

Story 16

As being raised in foster care,living with several different families through out the years, there were good experiences, but then some very bad ones! I learned how to adjust to different aspects of life, as each family has different dynamics, expectation, food, ect..... Then on top of that, you always wonder how long you will be there. You learn not to keep anything as you can not take much with you. The greatest desire is to be loved and accepted, no matter what, but so many of the foster parents do not know exactly what kind of behaviors they will have to deal with..... And instead of helping the child, they choose to move them out..... So as that result, the child learns once again not to trust.....,now years later, I have learned it is OK to have material things, I still have trust issues and relationship issues.

I did have a couple of families that wanted to adopt me....my birth mother and father refused to allow the adoption to happen.

The most important thing you could do for the children placed in foster care..... Is security!!! The only reason for a child to be moved out is abuse of any form! Never because the social worker decides that there is to much of a connection.... We need these kids to come out of a horrible situation as healthy, physically and mentally healthy adults!.

Story 17

Foster care reform,

I recently had the opportunity to speak with one of you representatives who encouraged my to write my story, to bring to light the damages caused by State Institutions and Foster Care. I am sorry for the extent and nature of this matter. I also know that together as a body in Christ, this will be reformed.

When I was a young child, my mother was involved in a fatal car accident. With nowhere else to turn I was placed into the custody of Idaho Department of Health and Welfare, splitting up my siblings. As the years went by and the houses kept changing, I was left to wonder, why does this keep happening? Doesn't anyone care? With all these questions running through my mind and the continual change in locations, I was left to believe that I must be the reason for all this movement or relocations. While in the custody of IDHW, around age 16 I was placed into a foster home which was to be the location where I would "age out." While in this final home I was involved in a major car accident and suffered a severe brain injury. After months in the hospital and to my surprise, I was returned to the same foster home I was previously placed (the best thing to have happen) To make a very long and hard story a bit more bearable, I have firsthand knowledge and am the result of continual damage of being relocated and not having the security of being kept with a family, to build a family connection, to feel accepted and loved. The results are unbearable still to today, over 20 years later.

If I can be of any more assistance please feel free to contact me. Thank you and God bless.

Story 18

Please keep my name and phone number confidential . The date I received the 4 out of 6 children was [redacted] 2012, They were with us for 18 and half months . They took them away [redacted] 2013. I have seen the state do a lot of bad choices for children in the 8 years we were foster parents ! I know what you are going through I had 4 children that the state told me and the 4 kids that my home was going to be there forever home ! also we had done the home study and all the adoption paper work to make this happen . They took them on [redacted] 2013 and gave them to a unsafe Family environment due to this family isn't blood but they had adopted there brother the last time the kids were in foster care . this family they placed my kids with never tried to get them from day one when they came into care this time . the family knew the night these kids came into care and never contacted the state to try and get them . The permanency social worker contacted them [redacted] 2013 and that is when our nightmare started . the department even went against the judges orders that they could not consider that family for permanency. I had my four for 18 and half months . I need to Add that the 4 foster children I had Three of the 4 where removed Twice a few years ago when they were in care another time From the family they have placed them with also that family sent one of the three away

twice because they did not want him because they could not keep him under control . the reason the fourth child wasn't removed from them was because she wasn't born yet . would you please get a hold of me when you have time . I would be happy to help there is a lot more to my story that I have not shared .

Story 19

We met with the Department and they really can't tell us why they took the children from our home and placed them in a home where they are sure to endure a life of abuse and neglect. We loved them and cared for them for two years, ten months, and seven days. We were promised we would be allowed to adopt them, but that never happened. The head of IDHW can't possibly conceive that the case workers made an error as he stated he has been up and down this state and none of his social workers would ignore children on their case loads. My claim was no one has ever talked to these children about how they are, what they want, or even knew them. The Department would not make such a horrific mistake. He feels our experience is not typical of how people feel about the department. He said he knew the workers involved personally and they would never harm children. We were promised so many things and we did everything asked of us. The children ages 3 and 6 knew us as their family. They were told by the caseworker we would be adopting them, but it didn't happen because Supervisors who never met the children decided a distant cousin should adopt the kids. We reached out to the dept heads, the governor otter, his wife, senators, and lawyers. No one could help us the state went against the Judges ruling to not remove the children, but that didn't matter to the dept. the CASA was also in our side, but hi opinion didn't matter either. We got one visit with the children they begged to come home, I can still feel my little boys sobs on my chest as the case worker told him no. My little girl asked if I would go to the cemetery and put flowers on her grave to remember her. I later ran into her at school she asked me if I was still trying to bring her home, and that her new Mom and the department told her we were the bad guys and she couldn't hug me anymore. Later that week I got a letter from the department that I was not allowed to have any contact. When we see their sad faces at Walmart we have to look away, just because we didn't agree with the department to change their permanency plan. The children are doing poorly in school and are treated poorly by their new family, but the department doesn't care. They have no interest in doing what is best for children. Case workers told me if they disagree with a supervisor they could lose their jobs. There are no checks and balances, new legislation protecting our most vulnerable is long over due. Not a day goes by, that I don't think of those children and what that little boy was thinking when he begged me not to give him away. I didn't have a choice.

Story 20

they took my grandson from my daughter, he was born with feeding issues and put on feeding tube and then took him straight from the hospital for what they called "failure to thrive" then they put the mom on a child neglect registry which gets her fired from her job she worked at for 3 years and now cant find a job because of it, and because of that they say shes unstable and gave the baby to her ex. so CPS does take kids away from perfectly good parents for NO GOOD REASON. and IF we could afford an attorney she would of won this case but its all about whos got the $ to fight it and he did and won. THIS WHOLE TITLE IV FUNDING is the whole reason CPS exists. it needs to be overhauled and kids given back to the good parents. if you want more info ill be glad to step up and tell the story. so will my daughter. dont even get me started with the corruption in that department. its been 2 years since ive seen my grandbaby and they left it up to her ex to give her supervised visits till the baby is 18 but its up to him when its convenient for him to let her see him which will prob be never frown emoticonhow sad they have that power.

Story 21

The complete story of how I ended up in foster care is lengthy but will try and explain in a shorter version. If you feel you need additional information please contact me. I have been speaking out for years but has always fell on deaf ears. When I was about a year old my father obtained full custody of both my sister and I. She was about two and half. We moved several hundred miles away for work. He worked rotating shifts because of the work he did. Two weeks each, days, nights and graveyard. Due to this schedule he met a family that was willing to help him take care of us. They set up an arrangement where us kids would stay with this family during the week and with our dad on the weekends and he could visit whenever. This arrangement worked well and continued for about five years until we were seven and nine and he died in a work related accident. According to the court documents I've obtained, an aunt decided she wanted us and within a month and a half CPS opened and closed our case granting her full guardianship with the exception that we would get to spend part of our summers with the other family. Our new gaurdian took it upon herself not to follow the court order after the first summer visit. We were told they didn't want us to come any

more and that they didn't love us but only wanted us for our trust funds. Also, in the document from CPS it clearly states they had no intention of following up on us after the guardianship was granted. I began running away within the first year of placement and was returned several times by police and told to be a good girl and that I should be thankful I had such a caring family that loved me and a beautiful house to live in. They like so many others wouldn't listen to me, I was just a child and didn't know what was best for me. Even at age seven I knew I didn't like to listen, watch or be the target of the abuse that when on in that house. Even at a young age I knew it wasn't a healthy environment. My sister and I never experienced that kind of behavior with our father or the other family we lived with. It wasn't until several years later that CPS agreed to become involved again, which seemed to take an act of congress. My sister ran away and reached out to the other family for help and they stepped up knowing they could get in trouble with the law. They drove hundreds of miles to pick her up and then filed for custody for both of us. When we went to court the judge CHOSE reject all of our alligations toward our guardian and her family even though she admitted to them in court or at least she admitted to it after she tried to down play everything. According to the court document, she stated that refused to let us live with this other family and if we did not want to live with her she would allow us to be placed into foster care but also stipulated to the court only if it was in the ADA county court jurisiction. We still chose not to live with her so the judge granted her wish and punished us by placing us into separate foster homes with her guidelines of it being in ADA county. We never lived together again and the separation separated us to a degree. However, I must note that though we were now in the states custody she retained guardianship over our trust funds which meant we never escaped her because we had to go to her for anything, lunch money, school clothes, etc.

I forgot to add that due to their spite and unwillingness to state the fact that they were wrong about where they placed us. They not only punished us by placing us in foster care but it also took two spots away from two other children who needed them. Also, I inherited several documents which is how I know some of the things that I am sure wasn't meant for me to ever see.

Sahred via Facebook Comment:

Cricket Syes

I was a foster child. I will spare you and my cell phone the Kleenex & tears of my up bringing and the final straw that resulted me being a ward of the state.
I was placed October 1980, I was 12 years old. Came from a house of mentally, physical, and sexual abuse. This was my second time in foster care, first time I was in CO, as an infant to toddler. 35+ years later I'm dealing with issues resulting from the choice H&W made for me.
I didn't realize how raw the pain was until I talked yesterday for the first time about my experience. I then started to read all these similar stories. I am so sorry to those that didn't get one home placement or the love of great foster parent. My heart goes out to you. I am one of the few & far between children of IDHW system that was left in one home. I was told end goal was to reunite me with birth mother, but I was never given an end date from what I remember. I was never sent back home, and my foster family wanted to adopt me. It was denied!!!With everything my foster family did to treat me as one of their own, there was always limitations & restrictions on me set by the state. My foster parents hands were tied by does & don'ts set by ID H&W. The simplest thing of spending the night at someones house, or

going on a trip with them had to get approval. After 6 years with my foster family I never really felt like I belong there, was a part of their family. Believe me they tried. I always felt like I was in limbo.... I never knew if I was coming or going, there was always court hearing & meeting. I'm assuming I timed out of

the system about the time I walked away from the home. I rebelled and started my long path of life hard knocks. I always had this deep gut feeling of being loved, wanted, belonging.... My own family.

Finally, I understand why Ive felt this deep down feeling all these years. It's not just me.

Name withheld

I hope that this stays anonymous, but I want this situation to be heard about and fixed for the kids of the future...The bad news was that I was a drug addict who lost her son to Idaho Foster Care. The day I was in court in regards to my custody of him, I had a case worker for H&W walk up to me before court and tell me that the only way my Mom would be able to keep in contact with the family would be for me to sign over my rights. The lady left the court room before the judge arrived for court. I was hysterical when the judge was walking me through the proceedings. H&W had filled the adoptive parents heads with lies that I was on drugs during my pregnancy of him and that's why he supposedly behaved the way he did. (I started using when my son was 6 months old). They never tried talking to his father. They had no interest in finding him either.

Due to the lies and pulling my son from one family to another, he has been diagnosed with reactive attachment disorder and sociopath behavior. In fact, Channel 7 had his story of his disappearance from a group home in Marsing. He had left there because the family that had adopted him, had left him at the group home and went back to S. Carolina without him. The state convinced the family to bring him to S.C. with them about 6 months after leaving him.

The adoptive parents asked me for advice on helping him with his anger issues about and towards me. When I suggested that he and I meet in a controlled environment, they told me that their advisors said it would only hurt him more.

The good news is that I have been clean and sober since 2002 and I am married (to a Correctional Officer). I turned my life around.

I am scared of what the Foster Care may have created within my son, whom will be 18 years old in April of this year. I am slightly concerned that he is going to come looking for me for the wrong reasons..... ALL THANKS TO THE IDAHO FOSTER CARE SYSTEM.....

Debbie Wood

I know foster parents want rights but why don't we get the whole Idaho System changed. We need laws to make the Judges of Idaho do their jobs and not let CPS be the sole deciding party in these cases. A social worker for CPS should not be able to decide a case .We need to get Idaho to have open family court. We need to get Idaho to have lawyers to represent the kids instead of this joke of a system they have in place now with Family Advocates/Guardian at litem.

Desirée Hennessey

This happened to us here in Utah..
We passed a bill hb170 in 2010 so foster kids could not be removed after they achieved family relationships unless there was abuse or to return them to their bio family.
I'm so sorry.

Candee Gilbertson Whiting

My heart has been broken again reading these heart wrenching stories of these babes being abused again and again by the health and welfare..... The social workers, the courts, the foster parents all know if a biologic parent is reformable or not!!!! Protect these children and stop the abuse!

Joan Simmons

Idaho's foster care system definitely needs reform.

The goal is finding children homes not ripping them from the only home they know unless there are reasons that the foster family broke law. The kids aren't pawns in a chess game.

I write this with a heavy heart. It is difficult to attempt to summarize my family's experience with the Idaho Foster Care System. We became foster parents three years ago. I worked full time at a Boise psychiatric hospital on the adolescent girl's unit. This was how I came to know about the problem in our society of teenage girls with behavioral and mental health issues having absolutely no where to go. I was astonished to discover that teenage girls were the most difficult to place in foster care. Basically, no one, not even foster families would take them. This became heavy on my heart and after discussing it with my husband we decided to become part of the solution. This was our motivation in becoming foster parents.

Subsequent our first placement of a seventeen year old girl we decided to go to work for a company called PATH. PATH foster parents are the highest level of foster care. It is a full time job that I became very passionate about. I gave up my job at the hospital and became a full time foster parent for up to two girls at a time. Throughout this time we had seven different girls placed with us from anywhere from a few days to permanently.

In July 2014 I met the sixteen year old girl that would change my life. My husband and I have three grown children and four grandchildren and had no intention whatsoever of adopting. This young lady who I will call Leilani, blew into our world with all of her behaviors, emotional turmoil, mentall illnesses and the world's most beautiful laughter. and she stole our hearts. I went to every therapy session with her, every doctors appointment, every social worker meeting, every court hearing, (and there were many because she frequently broke the law by running away and stealing) yet through it all I saw how deeply she needed us. Her biological

mother was given over five years to get her back and failed on all accounts. I remember her last hearing regarding this and she asked the judge if she could speak to me. She stated in front of everyone how grateful she was to have me as her "Mom".

Leilani had run away six times. Each time she would assure the police that she had a wonderful home life but sometimes she just had to run. We understood and hung onto her. At one point my husband was rather burnt out from all the running away and two social workers sat in our living room and basically begged us to to take her back. We did. I remember the social worker saying to me, "You wouldn't give up on your birth child would you?"

cynlimary@gmail.com

We were submitted and approved as the adoptive family. We even had the judge chosen to do the adoption. Judge "O" in Caldwell who is a magnificent man.

The last 8 months or so we have had some marital issues. I know now that having a teenage girl with such issues can wear on a family. But that was ok, she was still our daughter to us. Regardless, at one point we were considering a separation and spoke openly about this to Leilani and the social worker. We were told the department of Health and Welfare would not take her from us. In November 2015 Leilani ran away again. A few days later I received a call from her social worker that Leilani was to be removed from our home. Apparently there had been a meeting which we were not invited to be a part of, and the decision was made. All that was told to me as a reason was that she had accused me of being a drug addict (I have 18 sobriety) and that my husband had warrants. Both of these accusations are easily enough checked out. However, I was instructed that when she came home I was to call him and he would move her to another home. I still remember the look on her face when she opened her bedroom door and asked, "Am I going to another home?" Instant despair.

Subsequent our foster daughter being removed, I called the social worker and was in tears. I stated, "You took my daughter." He replied rather indignantly, "You are not her mother. She is not your daughter. You are her therapeutic foster mother." I was devastated. My question to the department of health and welfare would be, "When do I become her mother? If you so easily dismiss us as her family, how is the foster child ever supposed to know that we are truly her parents and family?" Today this precious young lady is listed as an endangered run away. Although she has runaway multiple times, I hold the department responsible for her situation. Rather than make her face the natural consequences of lying about your parents (which many teenagers do), the social workers simiply placed her in another home. She will be eighteen in August 2016 and will have no legal parents other than the state. I miss her everyday and I know that we are the only family that she has truly bonded with. In particular, her relationship with my husband, whom she calls 'Dad' is the saddest part of this. She has never known a father that would love her unconditionally and not abuse her. When the state took her she not only lost her parents, but also two sisters, a brother and three nephews and a niece who all adored

her. There was no closure for us as a family. Once she was taken we were treated like some type of social untouchables without ever knowing why. We poured our time, money, emotional and mental energies into being her family and in one quick phone call it was all taken away.

Mrs. Cynthia Limary

I have a long extensive history with the Department. I adopted two children from foster care who had been in 17 home by the time we got them, (they were 3 and 5). I also worked for the Department as a child protection case for seven years, and most recently I am a certified Adoption Professional and I do adoption home studies. At times I do home studies for families who are adopting through Health and Welfare. I did a home study a few years ago for an adoption. The children were placed with "fictive kin". The maternal grandfather of the children, lived with a woman who was going to adopt. The grandfather had significant health issues and couldn't adopt the children. This couple, lets call them Mary and George had been married for years and in fact had two grown children. George was married to someone else after his marriage to Mary and had a daughter with the other woman. It was the children of this daughter that were the subject of the adoption. George and Mary were not currently married but were living together. The marriage between these two ended partly because of domestic violence issues and in fact, George and Mary both had a criminal histories with domestic violence as well as child protection cases when their own children were growing up. Now Mary is licensed to provide foster care for these children and George is living in the basement of the home. George is a vet and gets benefits and is contributing to the house hold income. He just had heart surgery and had recently been diagnosed with cancer, so he was terminal and it was unclear how long he had. When the children came into care they were placed with George and Mary and have been with them for about 18 months. I did the home study and was appalled. Frankly if these people had been a random couple looking to adopt they never would have been approved. They both had criminal backgrounds including domestic violence. They had prior child protection cases. The only source of income for Mary was George and the foster care payments. So essentially no income and she would rely on the subsidy to support the house hold. It was just not a good situation. I called the Adoption people in Boise and explained my concerns and said that I didn't feel like I could approve this woman for adoption. The adoption workers said they would get back to me. They called a few days later after speaking with the case worker. I was told to approve the adoption. Again I stated that I was not okay with approval, it was my name and my license on the line and I couldn't do it. So we finally agreed on how to word the recommendation, so

that I didn't recommend this woman for adoption. It was basically stating that Mary was fictive kin, the children had been placed with her for two years, and she had an approved foster care home study and license and by her adopting these children they would remain with family. Unbelieveable. I did that and the state signed off on my home study and on the adoption. On adoption day in November I was in court with several families to finalize adoptions and Mary was there, and the Department finalized her adoption on that day.

I have another family that I have completed two or three home studies for. They have adopted three girls and in the process through life, had six of their own children. This is an incredible family. They have a big home, a stay at home mom who home schools some of the children. The children have chores, and responsibilities. I have talked extensively with the girls they adopted. The girls are happy, well adjusted and have done very well. The parents, Sarah and Troy have done an incredible job with these girls. The girls are all off meds, and are very successful. The oldest one graduated from High school last spring and is attending college. Their own children are well behaved, nice kids. Some of the children want to go to public school and their parents are supportive of that. The ones in public school are excelling, good grades, good behavior, no issues. Troy and Sara are very young under 40 but are truly amazing parents. They have no criminal records, no history of domestic violence, their references are glowing. They are active respected members of the community. These are people I would leave my own children with. Recently Sarah called me and said that they have been feeling like they are missing someone. They began looking at children in foster care and found a boy in Washington State. I updated their home study (which Health and Welfare signed off on by the way) and they began working with Washington to facilitate the adoption. The child "John" was involved in selecting Troy and Sarah and their family. They have been to Washington to meet with him, and he has been to Idaho a few times. These visits have all gone well and John did an extended visit with the family over Christmas. Every thing was planned to move forward, until Idaho Foster care got involved. Washington state required a home study done by the state. So we thought this would be simple, right. Use my already approved home study, the foster care worker do a home visit and they would be good to go. I got a call after the home visit from Sarah who was sobbing hysterically. She said that the worker came out, and basically said that there was no way they would approve anything, they already had too many children. The worker then went on to state that Troy and Sarah are basically young uneducated parents and they really shouldn't have any more children. It was a horrible experience for the entire family. Now again let me say these people have nine children, and John will make 10. There are not many people with that many children I would recommend for

adoption, but these truly are wonderful people. It's an amazing family with the capacity to love and support all their kids. The children are loved and well cared for. They are being taught values, and manners. They have chores, help care for the animals and do school work. I honestly would leave my own children with them. But some social worker made a value judgement about this family and decided they can't adopt.

So compare the two families. Mary, criminal and child protection history, Sarah and Troy none, Mary-Child protection history, Troy and Sarah-None. Mary's children-in and out of detention as teens and jail as adults, Troy and Sarah's children-no criminal activity one in college. And the family the state approves to adopt is Mary. I wouldn't leave my cat with Mary (and I don't really like my cat most days!) Something is completely wrong here. Also, the state didn't seem to care that John has selected Troy and Sara and family, and formed a relationship with them. Nope they aren't approving the home study or the ICPC because Troy and Sarah have too many kids and are young parents.

In my opinion and having an insiders view, I believe that Health and Welfare have too much power. Every day they make and break families. They meet as a committee and decide where children will go and who they will live with. They basically get to create families. So I think they believe they are equal with the only person who can create families.....God! It's very scary when a small group of people have so much power over so many.

I don't care to remain anonymous, you may use my name any time, and can contact me any time. Please let me know how I can help and if there is something else I can do. I am so glad you are doing this. I have talked to Senator Wood about this and got no where with him. Thanks again, and I want to help anyway I can.

Shannan Mayer, LSW, Ed.S.
1313 G Street
Rupert, ID 83350
208-312-1204

Where do I start.

We went into foster care with the intent to adopt a child. We took our foster care classes and signed up in August 1994. By October 25th, we had our first placement. The social worker told us that they usually want the child to reunite with the birth parent(s), but in this case that just wasn't going to happen. She told us we would be able to adopt this child once parental rights were terminated.

When they asked if we could take this child, we didn't hesitate. This was a young boy, 23 months old. It was my understanding that this child had been in just one foster home. However, I found there was at least one other foster home and maybe another one prior to that. Two to three home before they placed him with us for what we were told "A permanent-adoption placement". We had a couple of visits at the current foster home and then we were told to go ahead and take him home with us.

We were so excited to have this little boy into our family. We even had a baby shower for him with all out family and friends in attendance. We were told that the birth mom's rights would be terminated and they located the person listed as the father on the birth certificate, and he had terminated his rights. Within 4-5 months later, we were told that they weren't sure if we were going to be able to adopt him. They had located, who they thought was the birth father. DNA tests were done and it was found that he was in fact the birth father. Then we were told that even if the father decided not to take him, that his parents could possibly want to adopt him. We were told if they wanted him, they could have him. Months passed. Every day got a little harder, not knowing if he would truly be ours to adopt.

The Department of Health and Welfare set up a meeting with the grandparents and us. They were very nice people. They said they felt it was in this child's best interest to be adopted by us. As you could imagine, we were relieved. They told us that neither birth parent was in a position to take care of him at that time in their life. They also felt since he had already been with us for about a year that it wouldn't be fair to him if he was taken from us.

Our road was cleared for adoption or so we thought. There were times that the social worker told us that she didn't know if the parents were going to terminate their rights. The department could have terminated their rights, but chose not to. Each time we asked about it, we were shunned by the department and especially by the social worker. Eventually the social worker "had it in for us" or at least that's how we felt. She would yell at me and say she never promised we could adopt him. She may not have promised anything, but she definitely told us from day one that we should be able to adopt him and even called it a "Foster-Adopt Placement" on the first phone call.

Month after month went by. Threats of removing him from our home continued. I fought back. It was like a rollercoaster of emotions. Once minute he was ours and the next he wasn't.

I was one of the fortunate ones that actually came out on top. After endless meetings with the department, the removal of the social worker, and me telling them I was going to the state senator and to the media, that it did happen.

Eight days shy of two years, my son was legally adopted.

We continued to do foster care. We had a certain age and stated only one foster child at a time. However, the department seemed to have a way of talking us into a different age and two at a time. We fostered about 20 kids in all.

When our foster children needed something, I would contact Health and Welfare. It was like pulling teeth to get anything for my kids. When I needed someone to sign for a doctor appointment or in some cases a hospital (ER) visit, they seemed very mad that they had to go in and sign. It clearly states foster parents cannot sign any forms, but the social workers would always say – "Go ahead, it's no big deal." Yes it is a big deal, it's against the rules.

When we asked if we could take the kids on vacation, we were told we couldn't take them out of state. So much for making them feel like they were a part of our family. However, trying to get the department to find a respite home for us so we could go on vacation was very hard. One time we were scheduled to fly out in the morning. We had submitted our respite care request about five months earlier. We finally got the respite care approval the night before we were to leave.

Once there was an instance where I heard a foster child screaming, not the scream from a child throwing a fit, but a child that was screaming in pain. I reported it to the department and I was told it was my issue, the child was fine, and not to worry about it. They never checked into it. That's when I had them pull my license.

Renee S.

This is our story. We are not the traditional foster family as we were brought in under Code X which is a family member brought in without the traditional background check first, etc.

My story begins July 15, 2014. I received a call from my son saying that they were removing his son from the home for alleged abuse. We were named as Code X foster parents and my grandson was brought to our house that evening. He was upset and scared. He wanted to go home to his daddy but I had to tell them that he was brought to our house and that daddy knows that he is there. At this time, I won't go into the details of the case but suffice it to say from the beginning I asked them to truly seek the truth because I could not believe that my son would abuse my child. To this day, I still firmly believe that and have seen nothing that changes my mind.

The next day, I had to take my grandson to CARES where I was completely in the dark again. When they finally called my grandson's name, I went to go back with him and the nurse held up her hand and said that they were just taking him to get his weight. He didn't come back for 30 minutes or so and I was told he was all done.

From there, there was confusion about where to take my grandson for daycare and what to do. At this time he was also having visitation with his mother as well. This went on and we just started to develop a routine when my grandson was removed from our home and visitation with his mother was stopped because of suspicious bruises again. It was determined that the marks may have come from daycare so he was removed from there.

I continued to press the social workers to seek the truth and then finally on August 12th with no notice, they removed my grandson from our home. I contacted the primary social worker about why and they couldn't really give me a reason. When pressed long enough they finally agreed that it could have been handled better and notice could have been given to allow for a smoother transition. My grandson became upset every time he had to switch homes when it was unplanned and he wasn't prepared. My husband and I were not allowed visitation with our grandson either. We were not told why and had no clue as to what was going on.

Late in September, we received a letter dated September 23, 2104 that on August 12th my husband and I were named in a referral of child neglect, abuse or abandonment. It was determined that the report was unsubstantiated. We had no idea that we had been investigated or why we were investigated.

I had reported my concerns and frustrations to Richard M. Armstrong's office on several occasions. While I did receive a call back, I was told that they would investigate but as usual, received no answers or information. Just the standard response that "Due to confidentiality laws, I am unable to provide you detailed information about the outcomes of the review without a written, notarized release, signed by both of the child's parents." My son tried to find out the outcome but received no information either.

I did meet one social worker who I really felt had the best interests of the child and our family at heart. She was present during some of the questions I asked of the social workers but because she tried to help us, she was shut out of discussions held inside of the H&W team. I thank her for her work.

I believe that our grandson was removed from our home because we continued to press them to look for the truth. We would ask for what policies and procedures that they followed. We got nothing. They would respond that they were just following judge's orders. I know for a fact that they led the judges and dictated how things would go. According to the judge's guide, the process is also supposed to be one judge for the entire process. This did not happen. In the beginning of this case, there were 3 different judges. The final judge stayed with the case until the end.

You can contact me at 208-919-2977, if you wish. I do plan to be at the hearing tomorrow as well.

Ruth Taylor

Boise, ID

Victoria Pack <packvict@isu.edu>

I worked as a Para BI, in Idaho schools. My kid I was assigned age 12 was unable to care for themselves. They lived with their adoptive parents who were at an advanced age. They originally got the child as a foster. In another state. The child often came to school dirty and smelling of rotting formula. Often in a broken wheel chair that was not his and several sizes too small. After talk to the parents about it they claimed he was becoming to heavy and too hard for them to manage. They also claimed to be trying to get him a lift and that they did have a live in care provider that comes in for their respite. After this meeting the child was taken to the doctor for rashes and appearing to being in pain during feeding. This lead to a surgery on his feeding port. Which became infected and was being rejected by the child's body. I called and wrote everything out for 1 month before the school finally decided to step in and call child services. They agreed to meet us and see the child. After this meeting, the parents were called and told to fix the rashes and get the child immediate medical care. With the promise of in house visit from Child Services. After the in home visit the parents were approved and even offered to foster a baby, because the foster care system is so overwhelmed. The lady assigned the child's case spoke to me about it when she came to check on the child a week later. After asking her how could they leave the child in that situation when it was clear the child was being neglected and even if the parents had good intentions they could not provide the proper care the child needed. She said, " The foster system in Idaho can't afford to take on a child with special needs. No one will want to take and would cost too much to care for the child through the state."

Thank you for sharing your story. I am so sorry that you had to go through that especially seeing that if we had done what you are doing back in February of 2015, you might not have gone through it as well. Our story is so similar to yours except that we were never Plan B. Our children had been in the foster care system for 18 months when we got a call from our adoption agency looking for an adoptive placement for a group of siblings. Parental rights were expected to be terminated within a few months and we would be officially selected as the adoptive family and be legal guardians of these children within a year. We were told there was a biological father of one of the children who had not been identified but that they were not planning to pursue that. After 9 months of having these children in our lives, parental rights were finally terminated and we were informed that the father had been found and his whole side of family needed to be researched. A relative came forward to adopt them and even though the case workers felt it was not an appropriate placement, they told us they needed to allow them to complete a home study. There was no deadline for when this home study needed to be completed. On top of that, we were told the department had decided they needed to try and reunite the children with other siblings who were in another pre-adopt family. Because of the immense needs of all of these children, they believed chances were slim that they would find a family capable of caring for all of them but that they were "required by law" to pursue that option. In February 2015, after almost a year and a half of bonding with these children, working with multiple therapists and counselors to help them attach to us, and treating them as our own children, the department decided to move them to another pre-adopt home.

Again, similar to your story, it wasn't THAT they moved them but HOW they moved them. There is much more to our story but the summary of it is that they picked up the children from their school and moved them to the other family without informing us. They told us to pack their stuff and bring it to the department. Our case workers acted in an unprofessional manner with us, the foster children and the other professionals involved in these children's lives on so many instances that I cannot even begin to write it here. The worst one being when they pulled our foster child out of class by herself, with no other supporting people around her, to tell her the traumatizing news that she was going to be moving to a new family. They then sent her back to class to continue learning with a hand written note of what the transition schedule would be. That is how fast the decision was made that she didn't even have time to type up a letter. (Again there were NO safety concerns.)

We also escalated the issue to the top of the department and had many meetings with several managers. They repeatedly told us there were no safety concerns in our home. They admitted to us that it was not handled appropriately and that changes had been made to their processes based on our case but that nothing could be done about our children at that point. We were allowed to see the children to say goodbye but have not been able to maintain contact with them. We don't know what they told the children or the new family about us and can only imagine that they feel abandoned by us and unloved which is the furthest thing from the truth. We decided not to fight the system as you are doing because we didn't want the children to have to move again. They had already been through so much and we didn't want them to be uprooted again, even if it was to be returned to us. The children have since been adopted so we feel it is time to speak out. We have stopped our fight to adopt and our only biological daughter will never have a sibling because of this situation. The only siblings she has ever known are out of her life and she is not even able to write them letters. As you can imagine, the emotional trauma this has caused our family has been immense. This affected not only our family but our family friends, classmates and their families, teachers, counselors; all of whose communication was cut off completely. The children were not given an opportunity to say goodbye to any of them and professional services they received while in our home were abruptly ended.

Changes need to be made immediately. The court system needs to have oversight. The judge in our case recommended that the department leave the children in our home and not pursue the other relative placement but they did it anyway. The judge told us she did not have jurisdiction to decide placement decisions but just that she was there to make sure the department did their due diligence in finding permanency for the children. I am a trained counselor who has helped many adults and children who are experiencing trauma and Post-Traumatic Stress Disorder but I did not know about the level of dysfunction within the foster care system until we became a foster family. I believe that most of the case workers are good people who get into this job to help children but they are dealing with high stress, huge case loads and difficult situations. So many of them are dealing with secondary trauma and that is passed on to the foster parents and children on their case load. When our soldiers come back from war, they are evaluated by medical and mental health professionals to help them debrief and see if they are able to go back to the fighting. The same thing cannot be said

about our foster care social workers. Most of them have only bachelor's level degrees. They need to be overseen by psychologists and evaluated on a regular basis.

In addition to the changes you are recommending, there needs to be a protocol for informing children of traumatizing information. Transition recommendations from their own classes need to be followed, there needs to be oversight for case workers to make sure they are not too burnt out or having counter-transference issues and there needs to be more urgency in permanence. If changes are not made, it will be a disservice to all involved in the foster care system, but primarily the children.

Jessie Jackson 208-484-4165

Hello my name is Jessie, I am a grandparent who is raising her grandson. My grandson went into the system 9-11-2014 and I've had him for most of his life, he was 6 months old and is now 35 months old.. We are currently in process of going to termination the end of this month. My son didn't do his case plan and the Mom is a drug user and is currently in jail for probation violation. The parents did agree to let my lawyer do an intervention and consented to me being my grandsons guardian, the judge signed off and gave me full and sole legal custody. Health and Welfare won't accept the judges decision. Also at a cost of 7000.00 dollars so far. I used my 401k .

My husband and I have finally been approved to adopt our grandson,but we're not there yet. H&W want me to testify against my son and my grandson's mother in court at the trial. I don't want to do that but I do want to keep my grandson and I don't want him placed with somebody else. I have lived in fear the whole time we have been a foster parent that they will take our grandson away from us. Grandparents have no rights to their grandchildren. We have been to court many times and have never gotten to have our say to the judge, we have not had anyone truely represent our grandson in court, we see new faces every time we go to court ,how can new faces know what is best for my grandson? They are given the file and they just read what someone else reported. Even if the children have representation, what ever H&W recommends is what happens. No checks and balances in the courtroom and if there was H&W doesn't have to agree with them. How can they have so much power? I like being a foster parent, I love children and feel all children deserve a chance to a normal, loving,stable and safe family. My husband is afraid that this is going to take away our chances of getting our grandson for - Adoption. I so hope he is wrong.

In the beginning of October 2014 we got a phone call from my daughter telling us about Christian Alex Brown, he was born June 29, 2014, which he is a cousin to our kids, Christian was removed from his mother and father Christine and Daniel Brown, On August 2, 2014 he was removed from the home and he was in foster care and had been taken out of one and put in another, we were told that he was in and out of the hospital, he got his leg broke and would we become foster parents, so my husband and I did all the necessary steps to become a kin foster family, the licensing agent came into our home and checked everything out, she asked us if we would like to bring in more children, at that time we did not, So on October 9, 2014 Christian came to live with us.

In the beginning there were no visitation with the parents, then I took him to the health and welfare so he could have supervised 2 hour visits, It was a hit and miss with the mother showing up for visits, then one visit the police showed up and arrested them both, the mother Christine's boyfriend bonded her out, however Daniel is still in jail, the mom had moved into a 2 bedroom subsidized apartment with her boyfriend Dean Kester, who was only 17 at the time and was still living with his parents and 2 brothers and a sister and dogs, snakes and mice to feed the snakes in Wilder, she started getting visits out there February 6, 2015, he was picked up from our house at 11 and dropped back off at 2. It started getting harder and harder to see him go. He kicked and screamed not wanting to go. Then we found out she was pregnant again with her 6th child, then she got a monitored ankle bracelet from some of her wrong doings with the law, So a woman hired by the state came to pick Christian up and drive him out to visit, this went on for 3 months while she was on house arrest. Then the state started giving her overnight visits, when he came back from his visits, he was filthy, not bathed, and starving. Christine canceled visits about every other week, then they all got kicked out of their apartment. They moved into approximately a 16ft camp trailer with no running water and a portable electric heater, there is only enough room to get to their bed that is a table or the couch. They have a basinet in there in front of the sink for the new baby Sam, Christian sleeps on another bed, there is no room to play, he is now 19 months old, here he had his own room, lots of toys, lots of room to run, he had his own T V where he liked watching Mickey mouse clubhouse, Sesame street, Sid the science kid. We read books, we taught him everything he knows, We understand the state is for Unification, however how can the state and the social workers say this is a safe secure home?

Christine lost 3 older children, one of which is totally disabled, due to neglect. Daniels parents adopted them, and moved to Oregon, they have tried everything to get Christian to live with them, there's another concern, they live in a single wide trailer with 3 adults and three children, they live off the money they receive for the children, neither on of them are working outside the home, the 4th child died in the hospital at birth. We have taken Christian to all the doctors appointments, which Christine was told about yet she showed no interest in attending any of them. Our biggest concern is for the children, it doesn't seem like a good living conditions, in the last 2 court sessions, the Social worker said the police were called out every week. Then she started getting 48 hour visits.

During the 14 1/2 months that Christian was with us we rarely saw a social worker. We had to constantly call her when we needed something. As for a Guardian ad litum, Christian did not get one until he was

here for 6 months. We saw her twice at the house and then never saw her again. After numerous attempts to contact to contact her we were finally told that we had another one. We saw her one time and never heard from her again.

We don't understand how the State can say that the mother was doing everything that she needed to do. She never got a job, a stable safe home to live in, a secure environment. She lost her drivers license and still drives with the children in the vehicle. All she did was hook up with a teenage boy whos only source of income is McDonalds, and got pregnant for the sixth time in her life.

Why is it that the parents don't have to abide by the laws. Why is it that they don't have to take classes and meet the same criteria as the Foster parents do? Why is it that the State workers turn a blind eye to the necessary steps that parents should take to care for their children? Why is it that they minimize the concerns or Foster Parents? Where is the PRIDE?

We petitioned the Judge to allow us to adopt Christian and he told us there was nothing he could do without petitioning the State.

Our hearts are broken for this young bright boy.

Thank you,

James and Judy Socwell

Judy Cel# 208-371-8008

James Cel# 801-458-8201

Candee <candeew64@gmail.com>

As being raised in foster care,living with several different families through out the years, there were good experiences, but then some very bad ones! I learned how to adjust to different aspects of life, as each family has different dynamics, expectation, food, ect..... Then on top of that, you always wonder how long you will be there. You learn not to keep anything as you can not take much with you. The greatest desire is to be loved and accepted, no matter what, but so many of the foster parents do not know exactly what kind of behaviors they will have to deal with..... And instead of helping the child, they choose to move them out..... So as that result, the child learns once again not to trust.....,now years later, I have learned it is OK to have material things, I still have trust issues and relationship issues.

I did have a couple of families that wanted to adopt me....my birth mother and father refused to allow the adoption to happen.

The most important thing you could do for the children placed in foster care..... Is security!!! The only reason for a child to be moved out is abuse of any form! Never because the social worker decides that

there is to much of a connection.... We need these kids to come out of a horrible situation as healthy, physically and mentally healthy adults!

Hi Brain and Val , I hope my story will help the case for reform . My full Name is Ginger Kreiter My phone number is 429-8263 . please keep my name and phone number confidential . The date I received the 4 out of 6 children was May 25 2012, They were with us for 18 and half months . They took them away December 15th 2013. I have seen the state do a lot of bad choices for children in the 8 years we were foster parents ! I know what you are going through I had 4 children that the state told me and the 4 kids that my home was going to be there forever home ! also we had done the home study and all the adoption paper work to make this happen . They took them on December 15th 2013 and gave them to a unsafe Family environment due to this family isn't blood but they had adopted there brother the last time the kids were in foster care . this family they placed my kids with never tried to get them from day one when they came into care this time . the family knew the night these kids came into care and never contacted the state to try and get them . The permanency social worker contacted them July of 2013 and that is when our nightmare started . the department even went against the judges orders that they could not consider that family for permanency. I had my four for 18 and half months . I need to Add that the 4 foster children I had Three of the 4 where removed Twice a few years ago when they were in care another time From the family they have placed them with also that family sent one of the three away twice because they did not want him because they could not keep him under control . the reason the fourth child wasn't removed from them was because she wasn't born yet . would you please get a hold of me when you have time . I would be happy to help there is a lot more to my story that I have not shared . Thank you for your time Ginger Kreiter

My name is Jennifer Zielinski and I have been married to my husband, Kevin for almost 20 years, and we have four children. We reside right outside of Boise, Idaho in a city called Eagle. Chelsea, our third child, was welcomed into our home as a foster child at the age of two and adopted at age three. As a product of neglect and a family history of mental illness, intellectual and developmental disabilities, Chelsea has multiple diagnoses. My son, Dillon is 19 years old, my daughter Amanda is almost 16, Chelsea is 10, and my youngest, Roxanne, is four. As a Program Coordinator for Idaho's parent training and information center and family to family health information center (IPUL), I work hard to ensure that parents of children with disabilities receive training and information on their rights, responsibilities, and protections under the individuals with disabilities education act (IDEA). My passion is to help sustain the health and well-being of families who have children and youth with special health care needs through family centered care and create better awareness, supports, interventions and access to a quality mental health system.

Seven years ago Kevin and I were sitting in church listening to a guest speaker who talked about how many children in foster care were in need of foster parents. At that time it seemed to be the perfect idea as we had the space and means to do so. Though the process to become a certified foster parent was easy; I look back and realize that we had no proper training on attachment and/or trauma. The naïve notion that we would bring in a child, shower him/her with love and

security and then live happily ever after was not only a fairy tale, but could not be farther from the reality of a very flawed system. The moment Chelsea was dropped off at our house, by her current foster parent; we knew that there were significant problems. The first year raising Chelsea was full of juggling visits with her biological mother, which caused trauma over and over on a weekly basis, as well as working through significant feral like behaviors related to developmental and social delays. This seemed appropriate and acceptable by the social workers and anyone else we worked with at the Department of Health and Welfare (DHW). Kevin and I worked hard to create a relationship with Chelsea's biological mother; it became clear that she too was dealing with mental health disorder(s) and possibly an intellectual disability.

When we were able to adopt Chelsea a year later, we decided to seek specialists for answers. Her pediatrician, who has known Chelsea from birth and was her biological mom's primary care provider, became our biggest ally. It was very clear to him that Chelsea was dealing with far more than just the environmental aspects of neglect. Chelsea's first diagnosis of Reactive Attachment Disorder (RAD) came as a huge shock because we really did believe that we could just love her and everything would be fine. Her severe food addiction became our biggest struggle, especially with judgment and accusations. Later, she was diagnosed with PDD/NOS, AD/HD, Anxiety disorder, OCD, intellectual disability, and a developmental disability. These new diagnoses were in addition to her RAD and food addiction, all of which were not identified or supported by the DHW when they were still involved with the foster/adoption process. This created a huge barrier, as Kevin and I were accused of creating these issues with Chelsea by the foster care system, even though it became clear later that mental illness runs in both of her biological parents as well as some of their other family members.

When parental rights were terminated, Chelsea was eligible for adoption. What came as a huge surprise was the difference between the foster care system, where we immediately became the "problem". During this process we were discouraged from getting diagnoses, assessments and evaluations done for Chelsea because the department said that she would be just fine. So many children with trauma and attachment issues have significant struggles with food. We had no idea what we were dealing with, except that Chelsea would gorge, shake, scream, eat until she would vomit, steal, lie, beg strangers for food, anytime she was around food. Because we voiced concern over Chelsea's food addiction, the social worker decided that someone would need to come to our house on a daily basis and watch us eat with Chelsea. It didn't take her long before she realized that this was not a family issue, but in fact due to Chelsea's neglect and abuse. When the home study was conducted, we immediately became a target. Our house was too clean, Chelsea should be able to eat all she wants, and I was targeted as having a food issue myself because of my thin body type, implying that I might be starving her. We immediately found ourselves fighting the system for this child who came to us feral, unloved, unlovable, with little to no social and emotional skills, and severe behaviors. We knew that if we didn't adopt Chelsea, that her life would be in more danger with such a broken system. We were eventually chosen to adopt Chelsea and had no idea that we would soon become a target from child protection services.

The first time someone, the (school psychologist), made a false accusation against us was during her Kindergarten year, everyone wanted to hide the serious stealing, hording, and binging food issues. Chelsea was very good at telling stories and getting people to give her food or tangible items. I would get calls from other parents asking me if Chelsea is getting fed and informing us that she steals others kids food and begs for food on the playground. That investigation went nowhere, but the social worker denied that Chelsea has reactive attachment disorder and suggested that Chelsea see a nutritionist. We knew that if the nutritionist did not understand mental health, trauma, and attachment that this would trigger all of Chelsea's behaviors. No one realized that food took the place of Chelsea's mother. It brings her love, security, joy, even euphoria.

Chelsea's behaviors were increasingly getting worse as she was getting older. She was mastering the ability to superficially charm people, triangulate to get people to question us as her parents, and to manipulate people to get things from them. Her daily rages would last up to four hours a day, while punching walls, trying to break windows, and throwing things. Our youngest daughter was born into a family where she watched her sister physically attack me on a daily basis and would scream for me to run because Chelsea was coming for me. My oldest kids could no longer bring friends over and our family and friends were struggling to believe this was really happening.

Chelsea was hospitilatized for a mental breakdown at St. Alphonsus Behavioral Health at the recommendation of her psychiatrist. They immediately stripped her of her medications and during a counseling session Chelsea told the developmental specialist that I shove hot food in her mouth (something I would never do). He reported that Chelsea was in imminent danger to child protection services. The social worker and sheriff showed up at our house, Chelsea answered the door in her princess dress. The accusations were regarding my neglect to feed Chelsea, which was the opposite of the original claim. The foster care social worker was quoted saying that I have Munchausen Bi-Proxy and that I have made up all of Chelsea's diagnoses. They had ME go to counseling for nine months and then closed the case. They reported me non-compliant because I did not allow them to talk with Chelsea or have her go to a nutritionist. I have been begging for treatment and real comprehensive mental health services. I have yet to find a nutritionist who understands significant mental health issues related to neglect and abuse.

Chelsea's updated diagnoses is reactive attachment disorder (RAD), schizoaffective disorder, ADHD, and Anxiety. All of which the Department of Health and Welfare denied during the foster care and adoption process.

Chelsea's nightmare didn't end there. We have been bullied by the Department since we started the adoption process and tagged as the reason for Chelsea's behaviors. Her rage and the risk of false accusations were tearing our family apart so we had to place Chelsea in a residential care facility. Chelsea's behaviors were proven not to be isolated to just our family and home as the care facility was struggling to support her. About six months into her stay, we got a call from an investigator that Chelsea's care givers have been arrested for sexual abuse. We are now involved in this investigation as Chelsea was one of the victims.

There is so much to our story and the bottom line is that the foster and adoption care system in Idaho, failed Chelsea. They failed our family.

Jennifer Zielinski

Eagle, Idaho

208-830-2963

There are workers in this system that feel that the children are actually the last to be considered. They chose to remain silent because they hope by continuing to they can try and advocate for the children because H&W or Ad Litem do not. I know of some. But even so they often times can't anyways. I hope this system is resolved and you are able to make some type of change and that when H&W begins to provide their "evidence" of the good doings even someone on the other side of the argument, the people who have had the children removed can see even if they are brave enough to state they can't parent and the foster parent should it falls on deaf ears. Or children that shouldn't be given back to parents are. Even though I did get my children returned I was cognizant to see even that side. It must be a screwed up system if this is the same argument for all sides and if there were anyway to help it would be through my attorney who has the complete files on the case years ago showing the flip flopping and absurdity that the Dept works with. Your group is welcomed to the actual files and reports to see how the Dept words and works things if your argument get to a point where that may become helpful. I hope your group's voice is heard and change happens.

To whom it may concern,

I read about your plight on KTVB and so supportive of your efforts. Reform is so needed! I am a former Guardian Ad Litem and adopted my daughter from Foster Care. My daughter was adopted at 12 and she has been diagnosed with Reactive Attachment Disorder. I am a huge advocate of attachment parenting.

Through my years of experience as a GAL, I have seen families reunite and one in which parental rights were terminated. I remain in touch with the family that terminated and it's been 2 years.

I'd like to see a peer support network to be built for birth parents. It's difficult and overwhelming to navigate the system when their children are removed. As a GAL, I have had difficulty contacting case workers; the birth parents usually have a harder time and lack the skills to push.

I'd like to see more with reducing the caseloads and reducing staff turn over. I would like to see a

cultural shift in providing a high quality customer service experience. Being polite goes a long way.

I'd like too see more access for respite care. More education and emphasis on promoting attachment. More planning and investment in meeting the children's educational needs in regards to planning for college. I'd like to see the education voucher, currently only available for children in care for 90 days after their 16th birthday, expanded to all children in care for more than 18 months.

I could go on and on ☺

If you need anything, I'm happy to help.

Thank you,

Loni Wood
Ljwood79@gmail.com
208-861-2380

Cricket Syes

I was a foster child. I will spare you and my cell phone the Kleenex & tears of my up bringing and the final straw that resulted me being a ward of the state.
I was placed October 1980, I was 12 years old. Came from a house of mentally, physical, and sexual abuse. This was my second time in foster care, first time I was in CO, as an infant to toddler. 35+ years later I'm dealing with issues resulting from the choice H&W made for me.
I didn't realize how raw the pain was until I talked yesterday for the first time about my experience. I then started to read all these similar stories. I am so sorry to those that didn't get one home placement or the love of great foster parent. My heart goes out to you. I am one of the few & far between children of IDHW system that was left in one home. I was told end goal was to reunite me with birth mother, but I was never given an end date from what I remember. I was never sent back home, and my foster family wanted to adopt me. It was denied!!!With everything my foster family did to treat me as one of their own, there was always limitations & restrictions on me set by the state. My foster parents hands were tied by does & don'ts set by ID H&W. The simplest thing of spending the night at someones house, or

going on a trip with them had to get approval. After 6 years with my foster family I never really felt like I belong there, was a part of their family. Believe me they tried. I always felt like I was in limbo.... I never knew if I was coming or going, there was always court hearing & meeting. I'm assuming I timed out of the system about the time I walked away from the home. I rebelled and started my long path of life hard knocks. I always had this deep gut feeling of being loved, wanted, belonging.... My own family.

Finally, I understand why Ive felt this deep down feeling all these years. It's not just me.

Name withheld

I hope that this stays anonymous, but I want this situation to be heard about and fixed for the kids of the future...The bad news was that I was a drug addict who lost her son to Idaho Foster Care. The day I was in court in regards to my custody of him, I had a case worker for H&W walk up to me before court and tell me that the only way my Mom would be able to keep in contact with the family would be for me to sign over my rights. The lady left the court room before the judge arrived for court. I was hysterical when the judge was walking me through the proceedings. H&W had filled the adoptive parents heads with lies that I was on drugs during my pregnancy of him and that's why he supposedly behaved the way he did. (I started using when my son was 6 months old). They never tried talking to his father. They had no interest in finding him either.

Due to the lies and pulling my son from one family to another, he has been diagnosed with reactive attachment disorder and sociopath behavior. In fact, Channel 7 had his story of his disappearance from a group home in Marsing. He had left there because the family that had adopted him, had left him at the group home and went back to S. Carolina without him. The state convinced the family to bring him to S.C. with them about 6 months after leaving him.

The adoptive parents asked me for advice on helping him with his anger issues about and towards me. When I suggested that he and I meet in a controlled environment, they told me that their advisors said it would only hurt him more.

The good news is that I have been clean and sober since 2002 and I am married (to a Correctional Officer). I turned my life around.

I am scared of what the Foster Care may have created within my son, whom will be 18 years old in April of this year. I am slightly concerned that he is going to come looking for me for the wrong reasons.....
ALL THANKS TO THE IDAHO FOSTER CARE SYSTEM.....

Debbie Wood

I know foster parents want rights but why don't we get the whole Idaho System changed. We need laws to make the Judges of Idaho do their jobs and not let CPS be the sole deciding party in these cases. A social worker for CPS should not be able to decide a case .We need to get Idaho to have open family court. We need to get Idaho to have lawyers to represent the kids instead of this joke of a system they have in place now with Family Advocates/Guardian at litem.

Desirée Hennessey

This happened to us here in Utah..
We passed a bill hb170 in 2010 so foster kids could not be removed after they achieved family relationships unless there was abuse or to return them to their bio family.
I'm so sorry.

Candee Gilbertson Whiting

My heart has been broken again reading these heart wrenching stories of these babes being abused again and again by the health and welfare..... The social workers, the courts, the foster parents all know if a biologic parent is reformable or not!!!! Protect these children and stop the abuse!

Joan Simmons

Idaho's foster care system definitely needs reform.

The goal is finding children homes not ripping them from the only home they know unless there are reasons that the foster family broke law. The kids aren't pawns in a chess game.

I write this with a heavy heart. It is difficult to attempt to summarize my family's experience with the Idaho Foster Care System. We became foster parents three years ago. I worked full time at a Boise psychiatric hospital on the adolescent girl's unit. This was how I came to know about the problem in our society of teenage girls with behavioral and mental health issues having absolutely no where to go. I was astonished to discover that teenage girls were the most difficult to place in foster care. Basically, no one, not even foster families would take them. This became heavy on my heart and after discussing it with my husband we decided to become part of the solution. This was our motivation in becoming foster parents.

Subsequent our first placement of a seventeen year old girl we decided to go to work for a company called PATH. PATH foster parents are the highest level of foster care. It is a full time job that I became very passionate about. I gave up my job at the hospital and became a full time foster parent for up to two girls at a time. Throughout this time we had seven different girls placed with us from anywhere from a few days to permanently.

In July 2014 I met the sixteen year old girl that would change my life. My husband and I have three grown children and four grandchildren and had no intention whatsoever of adopting. This young lady who I will call Leilani, blew into our world with all of her behaviors, emotional turmoil, mentall illnesses and the world's most beautiful laughter. and she stole our hearts. I went to every therapy session with her, every doctors appointment, every social worker meeting, every court hearing, (and there were many because she frequently broke the law by running away and stealing) yet through it all I saw how deeply she needed us. Her biological mother was given over five years to get her back and failed on all accounts. I remember her last hearing regarding this and she asked the judge if she could speak to me. She stated in front of everyone how grateful she was to have me as her "Mom".

Leilani had run away six times. Each time she would assure the police that she had a wonderful home life but sometimes she just had to run. We understood and hung onto her. At one point my husband was rather burnt out from all the running away and two social workers sat in our living room and basically begged us to to take her back. We did. I remember the social worker saying to me, "You wouldn't give up on your birth child would you?"

cynlimary@gmail.com

We wer submitted and approved as the adoptive family. We even had the judge chosen to do the adoption. Judge "O" in Caldwell who is a magnificent man.

The last 8 months or so we have had some marital issues. I know now that having a teenage girl with such issues can wear on a family. But that was ok, she was still our daughter to us. Regardless, at one point we were considering a separation and spoke openly about this to Leilani and the social worker. We were told the department of Health and Welfare would not take her from us. In November 2015 Leilani ran away again. A few days later I received a call from her social worker that Leilani was to be removed from our home. Apparently there had been a meeting which we were not invited to be a part of, and the decision was made. All that was told to me as a reason was that she had accused me of being a drug addict (I have 18 sobriety) and that my husband had warrants. Both of these accusations are easily enough checked out. However, I was instructed that when she came home I was to call him and he would move her to another home. I still remember the look on her face when she opened her bedroom door and asked, "Am I going to another home?" Instant despair.

Subsequent our foster daughter being removed, I called the social worker and was in tears. I stated, "You took my daughter." He replied rather indignantly, "You are not her mother. She is not your daughter. You are her therapeutic foster mother." I was devastated. My question to the department of health and welfare would be, "When do I become her mother? If you so easily dismiss us as her family, how is the foster child ever supposed to know that we are truly her parents and family?" Today this precious young lady is listed as an endangered run away. Although she has runaway multiple times, I hold the department responsible for her situation. Rather than make her face the natural consequences of lying about your parents (which many teenagers do), the social workers simiply placed her in another home. She will be eighteen in August 2016 and will have no legal parents other than the state. I miss her everyday and I know that we are the only family that she has truly bonded with. In particular, her relationship with my husband, whom she calls 'Dad' is the saddest part of this. She has never known a father that would love her unconditionally and not abuse her. When the state took her she not only lost her parents, but also two sisters, a brother and three nephews and a niece who all adored her. There was no closure for us as a family. Once she was taken we were treated like some type of social untouchables without ever knowing why. We poured our time, money, emotional and mental energies into being her family and in one quick phone call it was all taken away.

Mrs. Cynthia Limary

I have a long extensive history with the Department. I adopted two children from foster care who had been in 17 home by the time we got them, (they were 3 and 5). I also worked for the Department as a child protection case for seven years, and most recently I am a certified Adoption Professional and I do adoption home studies. At times I do home studies for families who are adopting through Health and Welfare. I did a home study a few years ago for an adoption. The children were placed with "fictive kin". The maternal grandfather of the children, lived with a woman who was going to adopt. The grandfather had significant health issues and couldn't adopt the children. This couple, lets call them Mary and George had been married for years and in fact had two grown children. George was married to someone else after his marriage to Mary and had a daughter with the other woman. It was the children of this daughter that were the subject of the adoption. George and Mary were not currently married but were living together. The marriage between these two ended partly because of domestic violence issues and in fact, George and Mary both had a criminal histories with domestic violence as well as child protection cases when their own children were growing up. Now Mary is licensed to provide foster care for these children and George is living in the basement of the home. George is a vet and gets benefits and is contributing to the house hold income. He just had heart surgery and had recently been diagnosed with cancer, so he was terminal and it was unclear how long he had. When the children came into care they were placed with George and Mary and have been with them for about 18 months. I did the home study and was appalled. Frankly if these people had been a random couple looking to adopt they never would have been approved. They both had criminal backgrounds including domestic violence. They had prior child protection cases. The only source of income for Mary was George and the foster care payments. So essentially no income and she would rely on the subsidy to support the house hold. It was just not a good situation. I called the Adoption people in Boise and explained my concerns and said that I didn't feel like I could approve this woman for adoption. The adoption workers said they would get back to me. They called a few days later after speaking with the case worker. I was told to approve the adoption. Again I stated that I was not okay with approval, it was my name and my license on the line and I couldn't do it. So we finally agreed on how to word the recommendation, so that I didn't recommend this woman for adoption. It was basically stating that Mary was fictive kin, the children had been placed with her for two years, and she had an approved foster care home study and license and by her adopting these children they would remain with family. Unbelieveable. I did that and the state signed off on my home study and on the adoption. On adoption day in November I was in court with several families to finalize adoptions and Mary was there, and the Department finalized her adoption on that day.

I have another family that I have completed two or three home studies for. They have adopted three girls and in the process through life, had six of their own children. This is an incredible family. They have a big home, a stay at home mom who home schools some of the children. The children have chores, and responsibilities. I have talked extensively with the girls they adopted. The girls are happy, well adjusted and have done very well. The parents, Sarah and Troy have done an incredible job with these girls. The girls are all off meds, and are very successful. The oldest one graduated from High school last spring and is attending college. Their own children are well behaved, nice kids. Some of the children want to go to public school and their parents are supportive of that. The ones in public school are excelling, good grades, good behavior, no issues. Troy and Sara are very young under 40 but are truly amazing parents. They have no criminal records, no history of domestic violence, their references are glowing. They are active respected members of the community. These are people I would leave my own children with. Recently Sarah called me and said that they have been feeling like they are missing someone. They began looking at children in foster care and found a boy in Washington State. I updated their home study (which Health and Welfare signed off on by the way) and they began working with Washington to facilitate the adoption. The child "John" was involved in selecting Troy and Sarah and their family. They have been to Washington to meet with him, and he has been to Idaho a few times. These visits have all gone well and John did an extended visit with the family over Christmas. Every thing was planned to move forward, until Idaho Foster care got involved. Washington state required a home study done by the state. So we thought this would be simple, right. Use my already approved home study, the foster care worker do a home visit and they would be good to go. I got a call after the home visit from Sarah who was sobbing hysterically. She said that the worker came out, and basically said that there was no way they would approve anything, they already had too many children. The worker then went on to state that Troy and Sarah are basically young uneducated parents and they really shouldn't have any more children. It was a horrible experience for the entire family. Now again let me say these people have nine children, and John will make 10. There are not many people with that many children I would recommend for adoption, but these truly are wonderful people. It's an amazing family with the capacity to love and support all their kids. The children are loved and well cared for. They are being taught values, and manners. They have chores, help care for the animals and do school work. I honestly would leave my own children with them. But some social worker made a value judgement about this family and decided they can't adopt.

So compare the two families. Mary, criminal and child protection history,

Sarah and Troy none, Mary-Child protection history, Troy and Sarah-None. Mary's children-in and out of detention as teens and jail as adults, Troy and Sarah's children-no criminal activity one in college. And the family the state approves to adopt is Mary. I wouldn't leave my cat with Mary (and I don't really like my cat most days!) Something is completely wrong here. Also, the state didn't seem to care that John has selected Troy and Sara and family, and formed a relationship with them. Nope they aren't approving the home study or the ICPC because Troy and Sarah have too many kids and are young parents.

In my opinion and having an insiders view, I believe that Health and Welfare have too much power. Every day they make and break families. They meet as a committee and decide where children will go and who they will live with. They basically get to create families. So I think they believe they are equal with the only person who can create families.....God! It's very scary when a small group of people have so much power over so many.

I don't care to remain anonymous, you may use my name any time, and can contact me any time. Please let me know how I can help and if there is something else I can do. I am so glad you are doing this. I have talked to Senator Wood about this and got no where with him. Thanks again, and I want to help anyway I can.

Shannan Mayer, LSW, Ed.S.
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Where do I start.

We went into foster care with the intent to adopt a child. We took our foster care classes and signed up in August 1994. By October 25th, we had our first placement. The social worker told us that they usually want the child to reunite with the birth parent(s), but in this case that just wasn't going to happen. She told us we would be able to adopt this child once parental rights were terminated.

When they asked if we could take this child, we didn't hesitate. This was a young boy, 23 months old. It was my understanding that this child had been in just one foster home. However, I found there was at least one other foster home and maybe another one prior to that. Two to three home before they placed him with us for what we were told "A permanent-adoption placement". We had a couple of visits at the current foster home and then we were told to go ahead and take him home with us.

We were so excited to have this little boy into our family. We even had a baby shower for him with all out family and friends in attendance. We were told that the birth mom's rights would be terminated and they located the person listed as the father on the birth certificate, and he had terminated his rights. Within 4-5 months later, we were told that they weren't sure if we were going to be able to adopt him. They had located, who they thought was the birth father. DNA tests were done and it was found that he was in fact the birth father. Then we were told that even if the father decided not to take him, that his parents could possibly want to adopt him. We were told if they wanted him, they could have him. Months passed. Every day got a little harder, not knowing if he would truly be ours to adopt.

The Department of Health and Welfare set up a meeting with the grandparents and us. They were very nice people. They said they felt it was in this child's best interest to be adopted by us. As you could imagine, we were relieved. They told us that neither birth parent was in a position to take care of him at that time in their life. They also felt since he had already been with us for about a year that it wouldn't be fair to him if he was taken from us.

Our road was cleared for adoption or so we thought. There were times that the social worker told us that she didn't know if the parents were going to terminate their rights. The department could have terminated their rights, but chose not to. Each time we asked about it, we were shunned by the department and especially by the social worker. Eventually the social worker "had it in for us" or at least that's how we felt. She would yell at me and say she never promised we could adopt him. She may not have promised anything, but she definitely told us from day one that we should be able to adopt him and even called it a "Foster-Adopt Placement" on the first phone call.

Month after month went by. Threats of removing him from our home continued. I fought back. It was like a rollercoaster of emotions. Once minute he was ours and the next he wasn't.

I was one of the fortunate ones that actually came out on top. After endless meetings with the department, the removal of the social worker, and me telling them I was going to the state senator and to the media, that it did happen.

Eight days shy of two years, my son was legally adopted.

We continued to do foster care. We had a certain age and stated only one foster child at a time. However, the department seemed to have a way of talking us into a different age and two at a time. We fostered about 20 kids in all.

When our foster children needed something, I would contact Health and Welfare. It was like pulling teeth to get anything for my kids. When I needed someone to sign for a doctor appointment or in some cases a hospital (ER) visit, they seemed very mad that they had to go in and sign. It clearly states foster parents cannot sign any forms, but the social workers would always say – "Go ahead, it's no big deal." Yes it is a big deal, it's against the rules.

When we asked if we could take the kids on vacation, we were told we couldn't take them out of state. So much for making them feel like they were a part of our family. However, trying to get the department to find a respite home for us so we could go on vacation was very hard. One time we were scheduled to fly out in the morning. We had submitted our respite care request about five months earlier. We finally got the respite care approval the night before we were to leave.

Once there was an instance where I heard a foster child screaming, not the scream from a child throwing a fit, but a child that was screaming in pain. I reported it to the department and I was told it was my issue, the child was fine, and not to worry about it. They never checked into it. That's when I had them pull my license.

Renee S.

This is our story. We are not the traditional foster family as we were brought in under Code X which is a family member brought in without the traditional background check first, etc.

My story begins July 15, 2014. I received a call from my son saying that they were removing his son from the home for alleged abuse. We were named as Code X foster parents and my grandson was brought to our house that evening. He was upset and scared. He wanted to go home to his daddy but I had to tell them that he was brought to our house and that daddy knows that he is there. At this time, I won't go into the details of the case but suffice it to say from the beginning I asked them to truly seek the truth because I could not believe that my son would abuse my child. To this day, I still firmly believe that and have seen nothing that changes my mind.

The next day, I had to take my grandson to CARES where I was completely in the dark again. When they finally called my grandson's name, I went to go back with him and the nurse held up her hand and said that they were just taking him to get his weight. He didn't come back for 30 minutes or so and I was told he was all done.

From there, there was confusion about where to take my grandson for daycare and what to do. At this time he was also having visitation with his mother as well. This went on and we just started to develop a routine when my grandson was removed from our home and visitation with his mother was stopped because of suspicious bruises again. It was determined that the marks may have come from daycare so he was removed from there.

I continued to press the social workers to seek the truth and then finally on August 12th with no notice, they removed my grandson from our home. I contacted the primary social worker about why and they

couldn't really give me a reason. When pressed long enough they finally agreed that it could have been handled better and notice could have been given to allow for a smoother transition. My grandson became upset every time he had to switch homes when it was unplanned and he wasn't prepared. My husband and I were not allowed visitation with our grandson either. We were not told why and had no clue as to what was going on.

Late in September, we received a letter dated September 23, 2104 that on August 12th my husband and I were named in a referral of child neglect, abuse or abandonment. It was determined that the report was unsubstantiated. We had no idea that we had been investigated or why we were investigated.

I had reported my concerns and frustrations to Richard M. Armstrong's office on several occasions. While I did receive a call back, I was told that they would investigate but as usual, received no answers or information. Just the standard response that "Due to confidentiality laws, I am unable to provide you detailed information about the outcomes of the review without a written, notarized release, signed by both of the child's parents." My son tried to find out the outcome but received no information either.

I did meet one social worker who I really felt had the best interests of the child and our family at heart. She was present during some of the questions I asked of the social workers but because she tried to help us, she was shut out of discussions held inside of the H&W team. I thank her for her work.

I believe that our grandson was removed from our home because we continued to press them to look for the truth. We would ask for what policies and procedures that they followed. We got nothing. They would respond that they were just following judge's orders. I know for a fact that they led the judges and dictated how things would go. According to the judge's guide, the process is also supposed to be one judge for the entire process. This did not happen. In the beginning of this case, there were 3 different judges. The final judge stayed with the case until the end.

You can contact me at 208-919-2977, if you wish. I do plan to be at the hearing tomorrow as well.

Ruth Taylor

Boise, ID

Victoria Pack <packvict@isu.edu>

I worked as a Para BI, in Idaho schools. My kid I was assigned age 12 was unable to care for themselves. They lived with their adoptive parents who were at an advanced age. They originally got the child as a foster. In another state. The child often came to school dirty and smelling of rotting formula. Often in a broken wheel chair that was not his and several sizes too small. After talk to the parents about it they claimed he was becoming to heavy and too hard for them to manage. They also claimed to be trying to get him a lift and that they did have a live in care provider that comes in for their respite. After this meeting the child was taken to the doctor for rashes and appearing to being in pain during feeding. This lead to a surgery on his feeding port. Which became infected and was being

rejected by the child's body. I called and wrote everything out for 1 month before the school finally decided to step in and call child services. They agreed to meet us and see the child. After this meeting, the parents were called and told to fix the rashes and get the child immediate medical care. With the promise of in house visit from Child Services. After the in home visit the parents were approved and even offered to foster a baby, because the foster care system is so overwhelmed. The lady assigned the child's case spoke to me about it when she came to check on the child a week later. After asking her how could they leave the child in that situation when it was clear the child was being neglected and even if the parents had good intentions they could not provide the proper care the child needed. She said, " The foster system in Idaho can't afford to take on a child with special needs. No one will want to take and would cost too much to care for the child through the state."

Thank you for sharing your story. I am so sorry that you had to go through that especially seeing that if we had done what you are doing back in February of 2015, you might not have gone through it as well. Our story is so similar to yours except that we were never Plan B. Our children had been in the foster care system for 18 months when we got a call from our adoption agency looking for an adoptive placement for a group of siblings. Parental rights were expected to be terminated within a few months and we would be officially selected as the adoptive family and be legal guardians of these children within a year. We were told there was a biological father of one of the children who had not been identified but that they were not planning to pursue that. After 9 months of having these children in our lives, parental rights were finally terminated and we were informed that the father had been found and his whole side of family needed to be researched. A relative came forward to adopt them and even though the case workers felt it was not an appropriate placement, they told us they needed to allow them to complete a home study. There was no deadline for when this home study needed to be completed. On top of that, we were told the department had decided they needed to try and reunite the children with other siblings who were in another pre-adopt family. Because of the immense needs of all of these children, they believed chances were slim that they would find a family capable of caring for all of them but that they were "required by law" to pursue that option. In February 2015, after almost a year and a half of bonding with these children, working with multiple therapists and counselors to help them attach to us, and treating them as our own children, the department decided to move them to another pre-adopt home.

Again, similar to your story, it wasn't THAT they moved them but HOW they moved them. There is much more to our story but the summary of it is that they picked up the children from their school and moved them to the other family without informing us. They told us to pack their stuff and bring it to the department. Our case workers acted in an unprofessional manner with us, the foster children and the other professionals involved in these children's lives on so many instances that I cannot even begin to write it here. The worst one being when they pulled our foster child out of class by herself, with no other supporting people around her, to tell her the traumatizing news that she was going to be moving to a new family. They then sent her back to class to continue learning with a hand written note of what the transition schedule would be. That is how fast the decision was made that she didn't even have time to type up a letter. (Again there were NO safety concerns.)

We also escalated the issue to the top of the department and had many meetings with several managers. They repeatedly told us there were no safety concerns in our home. They admitted to us that it was not handled appropriately and that changes had been made to their processes based on our case but that nothing could be done about our children at that point. We were allowed to see the children to say goodbye but have not been able to maintain contact with them. We don't know what they told the children or the new family about us and can only imagine that they feel abandoned by us and unloved which is the furthest thing from the truth. We decided not to fight the system as you are doing because we didn't want the children to have to move again. They had already been through so much and we didn't want them to be uprooted again, even if it was to be returned to us. The children have since been adopted so we feel it is time to speak out. We have stopped our fight to adopt and our only biological daughter will never have a sibling because of this situation. The only siblings she has ever known are out of her life and she is not even able to write them letters. As you can imagine, the emotional trauma this has caused our family has been immense. This affected not only our family but our family friends, classmates and their families, teachers, counselors; all of whose communication was cut off completely. The children were not given an opportunity to say goodbye to any of them and professional services they received while in our home were abruptly ended.

Changes need to be made immediately. The court system needs to have oversight. The judge in our case recommended that the department leave the children in our home and not pursue the other relative placement but they did it anyway. The judge told us she did not have jurisdiction to decide placement decisions but just that she was there to make sure the department did their due diligence in finding permanency for the children. I am a trained counselor who has helped many adults and children who are experiencing trauma and Post-Traumatic Stress Disorder but I did not know about the level of dysfunction within the foster care system until we became a foster family. I believe that most of the case workers are good people who get into this job to help children but they are dealing with high stress, huge case loads and difficult situations. So many of them are dealing with secondary trauma and that is passed on to the foster parents and children on their case load. When our soldiers come back from war, they are evaluated by medical and mental health professionals to help them debrief and see if they are able to go back to the fighting. The same thing cannot be said about our foster care social workers. Most of them have only bachelor's level degrees. They need to be overseen by psychologists and evaluated on a regular basis.

In addition to the changes you are recommending, there needs to be a protocol for informing children of traumatizing information. Transition recommendations from their own classes need to be followed, there needs to be oversight for case workers to make sure they are not too burnt out or having counter-transference issues and there needs to be more urgency in permanence. If changes are not made, it will be a disservice to all involved in the foster care system, but primarily the children.

Jessie Jackson 208-484-4165

Hello my name is Jessie, I am a grandparent who is raising her grandson. My grandson went into the system 9-11-2014 and I've had him for most of his life, he was 6 months old and is now 35 months old.. We are currently in process of going to termination the end of this month. My son didn't do his case plan and the Mom is a drug user and is currently in jail for probation violation. The parents did agree to let my lawyer do an intervention and consented to me being my grandsons guardian, the judge signed off and gave me full and sole legal custody. Health and Welfare won't accept the judges decision. Also at a cost of 7000.00 dollars so far. I used my 401k .

My husband and I have finally been approved to adopt our grandson,but we're not there yet. H&W want me to testify against my son and my grandson's mother in court at the trial. I don't want to do that but I do want to keep my grandson and I don't want him placed with somebody else. I have lived in fear the whole time we have been a foster parent that they will take our grandson away from us. Grandparents have no rights to their grandchildren. We have been to court many times and have never gotten to have our say to the judge, we have not had anyone truely represent our grandson in court, we see new faces every time we go to court ,how can new faces know what is best for my grandson? They are given the file and they just read what someone else reported. Even if the children have representation, what ever H&W recommends is what happens. No checks and balances in the courtroom and if there was H&W doesn't have to agree with them. How can they have so much power? I like being a foster parent, I love children and feel all children deserve a chance to a normal, loving,stable and safe family. My husband is afraid that this is going to take away our chances of getting our grandson for - Adoption. I so hope he is wrong.

In the beginning of October 2014 we got a phone call from my daughter telling us about Christian Alex Brown, he was born June 29, 2014, which he is a cousin to our kids, Christian was removed from his mother and father Christine and Daniel Brown, On August 2, 2014 he was removed from the home and he was in foster care and had been taken out of one and put in another, we were told that he was in and out of the hospital, he got his leg broke and would we become foster parents, so my husband and I did all the necessary steps to become a kin foster family, the licensing agent came into our home and checked everything out, she asked us if we would like to bring in more children, at that time we did not, So on October 9, 2014 Christian came to live with us.

In the beginning there were no visitation with the parents, then I took him to the health and welfare so he could have supervised 2 hour visits, It was a hit and miss with the mother showing up for visits, then one visit the police showed up and arrested them both, the mother Christine's boyfriend bonded her out, however Daniel is still in jail, the mom had moved into a 2 bedroom subsidized apartment with her boyfriend Dean Kester, who was only 17 at the time and was still living with his parents and 2 brothers

and a sister and dogs, snakes and mice to feed the snakes in Wilder, she started getting visits out there February 6, 2015, he was picked up from our house at 11 and dropped back off at 2. It started getting harder and harder to see him go. He kicked and screamed not wanting to go. Then we found out she was pregnant again with her 6th child, then she got a monitored ankle bracelet from some of her wrong doings with the law, So a woman hired by the state came to pick Christian up and drive him out to visit, this went on for 3 months while she was on house arrest. Then the state started giving her overnight visits, when he came back from his visits, he was filthy, not bathed, and starving. Christine canceled visits about every other week, then they all got kicked out of their apartment. They moved into approximately a 16ft camp trailer with no running water and a portable electric heater, there is only enough room to get to their bed that is a table or the couch. They have a basinet in there in front of the sink for the new baby Sam, Christian sleeps on another bed, there is no room to play, he is now 19 months old, here he had his own room, lots of toys, lots of room to run, he had his own T V where he liked watching Mickey mouse clubhouse, Sesame street, Sid the science kid. We read books, we taught him everything he knows, We understand the state is for Unification, however how can the state and the social workers say this is a safe secure home?

Christine lost 3 older children, one of which is totally disabled, due to neglect. Daniels parents adopted them, and moved to Oregon, they have tried everything to get Christian to live with them, there's another concern, they live in a single wide trailer with 3 adults and three children, they live off the money they receive for the children, neither on of them are working outside the home, the 4th child died in the hospital at birth. We have taken Christian to all the doctors appointments, which Christine was told about yet she showed no interest in attending any of them. Our biggest concern is for the children, it doesn't seem like a good living conditions, in the last 2 court sessions, the Social worker said the police were called out every week. Then she started getting 48 hour visits.

During the 14 1/2 months that Christian was with us we rarely saw a social worker. We had to constantly call her when we needed something. As for a Guardian ad litum, Christian did not get one until he was here for 6 months. We saw her twice at the house and then never saw her again. After numerous attempts to contact to contact her we were finally told that we had another one. We saw her one time and never heard from her again.

We don't understand how the State can say that the mother was doing everything that she needed to do. She never got a job, a stable safe home to live in, a secure environment. She lost her drivers license and still drives with the children in the vehicle. All she did was hook up with a teenage boy whos only source of income is McDonalds, and got pregnant for the sixth time in her life.

Why is it that the parents don't have to abide by the laws. Why is it that they don't have to take classes and meet the same criteria as the Foster parents do? Why is it that the State workers turn a blind eye to the necessary steps that parents should take to care for their children? Why is it that they minimize the concerns or Foster Parents? Where is the PRIDE?

We petitioned the Judge to allow us to adopt Christian and he told us there was nothing he could do without petitioning the State.

Our hearts are broken for this young bright boy.

Thank you,

James and Judy Socwell

Judy Cel# 208-371-8008

James Cel# 801-458-8201

Candee <candeew64@gmail.com>

As being raised in foster care,living with several different families through out the years, there were good experiences, but then some very bad ones! I learned how to adjust to different aspects of life, as each family has different dynamics, expectation, food, ect..... Then on top of that, you always wonder how long you will be there. You learn not to keep anything as you can not take much with you. The greatest desire is to be loved and accepted, no matter what, but so many of the foster parents do not know exactly what kind of behaviors they will have to deal with..... And instead of helping the child, they choose to move them out..... So as that result, the child learns once again not to trust.....,now years later, I have learned it is OK to have material things, I still have trust issues and relationship issues.

I did have a couple of families that wanted to adopt me....my birth mother and father refused to allow the adoption to happen.

The most important thing you could do for the children placed in foster care..... Is security!!! The only reason for a child to be moved out is abuse of any form! Never because the social worker decides that there is to much of a connection.... We need these kids to come out of a horrible situation as healthy, physically and mentally healthy adults!

Foster care reform,

I recently had the opportunity to speak with one of you representatives who encouraged my to write my story, to bring to light the damages caused by State Institutions and Foster Care. I am sorry for the extent and nature of this matter. I also know that together as a body in Christ, this will be reformed.

When I was a young child, my mother was involved in a fatal car accident. With nowhere else to turn I was placed into the custody of Idaho Department of Health and Welfare, splitting up my siblings. As the years went by and the houses kept changing, I was left to wonder, why does this keep happening? Doesn't anyone care? With all these questions running through my mind and the continual change in locations, I was left to believe that I must be the reason for all this movement or relocations. While in the custody of IDHW, around age 16 I was placed into a foster home which was to be the location where I would "age out." While in this final home I was involved in a major car accident and suffered a severe brain injury. After months in the hospital and to my surprise, I was returned to the same foster home I was previously placed (the best thing to have happen) To make a very long and hard story a bit more bearable, I have firsthand knowledge and am the result of continual damage of being relocated and not having the security of being kept with a family, to build a family connection, to feel accepted and loved. The results are unbearable still to today, over 20 years later.

If I can be of any more assistance please feel free to contact me. Thank you and God bless.

Jon Nobles
208-919-0454
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Hi Brain and Val , I hope my story will help the case for reform . My full Name is [redacted] My phone number is [redacted] . please keep my name and phone number confidential . The date I received the 4 out of 6 children was May 25 2012, They were with us for 18 and half months . They took them away December 15th 2013. I have seen the state do a lot of bad choices for children in the 8 years we were foster parents I I know what you are going through I had 4 children that the state told me and the 4 kids that my home was going to be there forever home I also we had done the home study and all the adoption paper work to make this happen . They took them on December 15th 2013 and gave them to a unsafe Family environment due to this family isn't blood but they had adopted there brother the last time the kids were in foster care . this family they placed my kids with never tried to get them from day one when they came into care this time . the family knew the night these kids came into care and never contacted the state to try and get them . The permanency social worker contacted them July of 2013 and that is when our nightmare started . the department even went against the judges orders that they could not consider that family for permanency. I had my four for 18 and half months . I need to Add that the 4 foster children I had Three of the 4 where removed Twice a few years ago when they were in care another time From the family they have placed them with also that family sent one of the three away twice because they did not want him because they could not keep him under control . the reason the fourth child wasn't removed from them was because she wasn't born yet . would you please get a hold of me when you have time . I would be happy to help there is a lot more to my story that I have not shared . Thank you for your time Ginger Kreiter

My name is Jennifer Zielinski and I have been married to my husband, Kevin for almost 20 years, and we have four children. We reside right outside of Boise, Idaho in a city called Eagle. Chelsea, our third child, was welcomed into our home as a foster child at the age of two and adopted at age three. As a product of neglect and a family history of mental illness, intellectual and developmental disabilities, Chelsea has multiple diagnoses. My son, Dillon is 19 years old, my daughter Amanda is almost 16, Chelsea is 10, and my youngest, Roxanne, is four. As a Program Coordinator for Idaho's parent training and information center and family to family health information center (IPUL), I work hard to ensure that parents of children with disabilities receive training and information on their rights, responsibilities, and protections under the individuals with disabilities education act (IDEA). My passion is to help sustain the health and well-being of families who have children and youth with special health care needs through family centered care and create better awareness, supports, interventions and access to a quality mental health system.

Seven years ago Kevin and I were sitting in church listening to a guest speaker who talked about how many children in foster care were in need of foster parents. At that time it seemed to be the perfect idea as we had the space and means to do so. Though the process to become a certified foster parent was easy, I look back and realize that we had no proper training on attachment and/or trauma. The naïve notion that we would bring in a child, shower him/her with love and security and then live happily ever after was not only a fairy tale, but could not be farther from the reality of a very flawed system. The moment Chelsea was dropped off at our house, by her current foster parent; we knew that there were significant problems. The first year raising Chelsea was full of juggling visits with her biological mother, which caused trauma over and over on a weekly basis, as well as working through significant feral like behaviors related to developmental and social delays. This seemed appropriate and acceptable by the social workers and anyone else we worked with at the Department of Health and Welfare (DHW). Kevin and I worked hard to create a relationship with Chelsea's biological mother; it became clear that she too was dealing with mental health disorder(s) and possibly an intellectual disability.

When we were able to adopt Chelsea a year later, we decided to seek specialists for answers. Her pediatrician, who has known Chelsea from birth and was her biological mom's primary care provider, became our biggest ally. It was very clear to him that Chelsea was dealing with far more than just the environmental aspects of neglect. Chelsea's first diagnosis of Reactive Attachment Disorder (RAD) came as a huge shock because we really did believe that we could just love her and everything would be fine. Her severe food addiction became our biggest struggle, especially with judgment and accusations. Later, she was diagnosed with PDD/NOS, AD/HD, Anxiety disorder, OCD, intellectual disability, and a developmental disability. These new diagnoses were in addition to her RAD and food addiction, all of which were not identified or supported by the DHW when they were still involved with the foster/adoption process. This created a huge barrier, as Kevin and I were accused of creating these issues with Chelsea by the foster care system, even though it became clear later that mental illness runs in both of her biological parents as well as some of their other family members.

When parental rights were terminated, Chelsea was eligible for adoption. What came as a huge surprise was the difference between the foster care system, where we immediately became the "problem". During this process we were discouraged from getting diagnoses, assessments and evaluations done for Chelsea because the department said that she would be just fine. So many children with trauma and attachment issues have significant struggles with food. We had no idea what we were dealing with, except that Chelsea would gorge, shake, scream, eat until she would vomit, steal, lie, beg strangers for food, anytime she was around food. Because we voiced concern over Chelsea's food addiction, the social worker decided that someone would need to come to our house on a daily basis and watch us eat with Chelsea. It didn't take her long before she realized that this was not a family issue, but in fact due to Chelsea's neglect and abuse. When the home study was conducted, we immediately became a target. Our house was too clean, Chelsea should be able to eat all she wants, and I was targeted as having a food issue myself because of my thin body type, implying that I might be starving her. We immediately found ourselves fighting the system for this child who came to us feral, unloved, unlovable, with little to no social and emotional skills, and severe behaviors. We knew that if we didn't adopt Chelsea,

that her life would be in more danger with such a broken system. We were eventually chosen to adopt Chelsea and had no idea that we would soon become a target from child protection services.

The first time someone, the (school psychologist), made a false accusation against us was during her Kindergarten year, everyone wanted to hide the serious stealing, hording, and binging food issues. Chelsea was very good at telling stories and getting people to give her food or tangible items. I would get calls from other parents asking me if Chelsea is getting fed and informing us that she steals others kids food and begs for food on the playground. That investigation went nowhere, but the social worker denied that Chelsea has reactive attachment disorder and suggested that Chelsea see a nutritionist. We knew that if the nutritionist did not understand mental health, trauma, and attachment that this would trigger all of Chelsea's behaviors. No one realized that food took the place of Chelsea's mother. It brings her love, security, joy, even euphoria.

Chelsea's behaviors were increasingly getting worse as she was getting older. She was mastering the ability to superficially charm people, triangulate to get people to question us as her parents, and to manipulate people to get things from them. Her daily rages would last up to four hours a day, while punching walls, trying to break windows, and throwing things. Our youngest daughter was born into a family where she watched her sister physically attack me on a daily basis and would scream for me to run because Chelsea was coming for me. My oldest kids could no longer bring friends over and our family and friends were struggling to believe this was really happening.

Chelsea was hospitilatized for a mental breakdown at St. Alphonsus Behavioral Health at the recommendation of her psychiatrist. They immediately stripped her of her medications and during a counseling session Chelsea told the developmental specialist that I shove hot food in her mouth (something I would never do). He reported that Chelsea was in imminent danger to child protection services. The social worker and sheriff showed up at our house, Chelsea answered the door in her princess dress. The accusations were regarding my neglect to feed Chelsea, which was the opposite of the original claim. The foster care social worker was quoted saying that I have Munchausen Bi-Proxy and that I have made up all of Chelsea's diagnoses. They had ME go to counseling for nine months and then closed the case. They reported me non-compliant because I did not allow them to talk with Chelsea or have her go to a nutritionist. I have been begging for treatment and real comprehensive mental health services. I have yet to find a nutritionist who understands significant mental health issues related to neglect and abuse.

Chelsea's updated diagnoses is reactive attachment disorder (RAD), schizoaffective disorder, ADHD, and Anxiety. All of which the Department of Health and Welfare denied during the foster care and adoption process.

Chelsea's nightmare didn't end there. We have been bullied by the Department since we started the adoption process and tagged as the reason for Chelsea's behaviors. Her rage and the risk of false accusations were tearing our family apart so we had to place Chelsea in a residential care facility. Chelsea's behaviors were proven not to be isolated to just our family and home as the

care facility was struggling to support her. About six months into her stay, we got a call from an investigator that Chelsea's care givers have been arrested for sexual abuse. We are now involved in this investigation as Chelsea was one of the victims.

There is so much to our story and the bottom line is that the foster and adoption care system in Idaho, failed Chelsea. They failed our family.

Jennifer Zielinski
Eagle, Idaho
208-830-2963

There are workers in this system that feel that the children are actually the last to be considered. They chose to remain silent because they hope by continuing to they can try and advocate for the children because H&W or Ad Litem do not. I know of some. But even so they often times can't anyways. I hope this system is resolved and you are able to make some type of change and that when H&W begins to provide their "evidence" of the good doings even someone on the other side of the argument, the people who have had the children removed can see even if they are brave enough to state they can't parent and the foster parent should it falls on deaf ears. Or children that shouldn't be given back to parents are. Even though I did get my children returned I was cognizant to see even that side. It must be a screwed up system if this is the same argument for all sides and if there were anyway to help it would be through my attorney who has the complete files on the case years ago showing the flip flopping and absurdity that the Dept works with. Your group is welcomed to the actual files and reports to see how the Dept words and works things if your argument get to a point where that may become helpful. I hope your group's voice is heard and change happens.

To whom it may concern,

I read about your plight on KTVB and so supportive of your efforts. Reform is so needed! I am a former Guardian Ad Litem and adopted my daughter from Foster Care. My daughter was adopted at 12 and she has been diagnosed with Reactive Attachment Disorder. I am a huge advocate of attachment parenting.

Through my years of experience as a GAL, I have seen families reunite and one in which parental rights were terminated. I remain in touch with the family that terminated and it's been 2 years.

I'd like to see a peer support network to be built for birth parents. It's difficult and overwhelming to navigate the system when their children are removed. As a GAL, I have had difficulty contacting case workers; the birth parents usually have a harder time and lack the skills to push.

I'd like to see more with reducing the caseloads and reducing staff turn over. I would like to see a

cultural shift in providing a high quality customer service experience. Being polite goes a long way.

I'd like too see more access for respite care. More education and emphasis on promoting attachment. More planning and investment in meeting the children's educational needs in regards to planning for college. I'd like to see the education voucher, currently only available for children in care for 90 days after their 16th birthday, expanded to all children in care for more than 18 months.

I could go on and on ☺

If you need anything, I'm happy to help.
Thank you,

Loni Wood
Liwood79@gmail.com
208-861-2380

FACEBOOK COMMENTS

Foster Care Reform

Kookoo Jacobs These poor kiddos who spend their entire lives with foster parents and then are placed with biological parents or relatives are just traumatized and it has such long reaching impact. It's got to be changed!

Liberty Shepard Signed and donated and shared to over a 100 people on FB. Marissa Ferguson who was my foster sister is now on the National Center for Missing and Exploited Children. They just dismissed her disappearing as "another run away" it wasn't until our family who was trying to adopt her kept pursuing and calling outside resources and contacting her previous social worker who actually cared that this has now become a serious issue. Children's lives matter no matter what their behavioral issues. We still consider her part of our family even though they showed up and just took her away without warning. And we will fight until we find her.

Anonymous: A story from a foster parent:

Please keep my name and phone number confidential . The date I received the 4 out of 6 children was XXXX 2012, They were with us for 18 and half months . They took them away XXXX 2013. I have seen the state do a lot of bad choices for children in the 8 years we were foster parents ! I know what you are going through I had 4 children that the state told me and the 4 kids that my home was going to be there forever home I also we had done the home study and all the adoption paper work to make this happen . They took them on XXXX 2013 and gave them to a unsafe Family environment due to this family isn't blood but they had adopted there brother the last time the kids were in foster care . this family they placed my kids with never tried to get them from day one when they came into care this time . the family knew the night these kids came into care and never contacted the state to try and get them . The permanency social worker contacted them XXXX 2013 and that is when our nightmare started . the department even went against the judges orders that they could not consider that family for permanency. I had

my four for 18 and half months . I need to Add that the 4 foster children I had Three of the 4 where removed Twice a few years ago when they were in care another time From the family they have placed them with also that family sent one of the three away twice because they did not want him because they could not keep him under control . the reason the fourth child wasn't removed from them was because she wasn't born yet . would you please get a hold of me when you have time . I would be happy to help there is a lot more to my story that I have not shared

Another story from a former foster child:

This one was shared by a former foster child:

As being raised in foster care,living with several different families through out the years, there were good experiences, but then some very bad ones! I learned how to adjust to different aspects of life, as each family has different dynamics, expectation, food, ect..... Then on top of that, you always wonder how long you will be there. You learn not to keep anything as you can not take much with you. The greatest desire is to be loved and accepted, no matter what, but so many of the foster parents do not know exactly what kind of behaviors they will have to deal with..... And instead of helping the child, they choose to move them out..... So as that result, the child learns once again not to trust.....,now years later, I have learned it is OK to have material things, I still have trust issues and relationship issues.
I did have a couple of families that wanted to adopt me....my birth mother and father refused to allow the adoption to happen.

The most important thing you could do for the children placed in foster care..... Is security!!! The only reason for a child to be moved out is abuse of any form! Never because the social worker decides that there is to much of a connection.... We need these kids to come out of a horrible situation as healthy, physically and mentally healthy adults!.

I am so thankful someone is trying to take a stand for foster parents. I was a foster parent for about 9 years for just over 20 kids. However, after experiencing a non-caring attitude from so many case workers and department heads, I wasn't able to continue. I could not stand back and watch them NOT care for my foster children. Anytime the kids needed something, they wouldn't respond. When abuse was suspected and reported to the Dept, I couldn't believe they never did anything about it. Time after time, month after month, child after child, I watched the Dept destroy these kids. It broke my heart! I so wish I could have continued being a foster parent. After a grueling two years, many promises made and broken, and by the grace of God, I was finally able to adopt my first foster placement. He is the joy of my life. I just wonder how many others could have turned out the same way if things would have been different. I could never be a foster parent again and that's sad. We have so much to offer to a child. We need change!

Demetre Gennette I can't bring myself to press "like" but I remember talking about Miss Chelsea years ago with you and Angela, and I just cannot believe the extent of the hell you've gone through.

Stacy McAlpine Manning Jenny THANK YOU for being so brave and telling your story..you are not alone in the hell you have lived. Society does not understand that your story is all too common. You and your husband are amazing. All the best to you

Valerie McCauley So much of that never had to happen. My greatest prayer is that as the system is repaired, care and genuine concern for each child will replace the current apathy that exists from the department.

Stacy McAlpine Manning Jenny THANK YOU for being so brave and telling your story..you are not alone in the hell you have lived. Society does not understand that your story is all too common. You and your husband are amazing. All the best to you.

Becky Novak Thank you for sharing, Jennifer. Prayers for your family as you continue with the current challenges you are facing.

Richard Keyes Well I can confidently say that Idaho health and welfare has retaliated against my wife and I. We have been black flagged from Idaho health and welfare for some years now. Because we fought them on an issue and took it all the way to the governor's office.

This story is not first-hand, but should be shared. Here it is as provided to us:

Hi! First I want to say I am so glad to see this page! My story is this: about 3 years ago my 2 nieces were taken from their biological parents and went into the system. At the time nobody else in our family was able to take custody of them. So they remained at a foster home for a short time before the state began their push for permanent placing and adoption. A couple who knew the foster parents from church had fallen in love with the girls and decided to just attend the permanent placing meeting and ended up leaving being that placement. Shortly after the meeting the girls were moved and have been living with this family since. I want to say it has been over 2 years just since being with their permanent family. This couple is such a great couple and the youngest of the girls barely being 3 when they were taken only recognizes them as mom and dad. They attended all the meetings and had even attended meetings that they were told were for the adoption process. The official court date for adoption was to be end of January. Well just before the court date the state informed them that the girls would be removed from the home. No reason given. So the couple has gotten an attorney and is trying to fight this, but at court they were basically told the judge couldnt do anything.. so they will be going to another court this week with their attorney and also a judge appointed representative for the girls aside from guardian at litem. We are all confused and lost at why the girls were taken and the states plan is to put them back into foster care.. I know this is a long message but I reach out for advice and also for support to stand with your cause! They are hurting kids that already have been through too much! Thank you!

Anna Blackford Unfortunately, they don't have to tell why they were moved. This is just another story about how broken this system is. Praying that there is change and praying for the hearts and minds of these children.

Annette Knebel This is a great thing to be happening,,, its a lie when she said kid's are only removed because of the foster family. Not true they lie and take them.

Renea Killgore Yes they do the system is horrible just horrible

Liberty Shepard. Marissa Ferguson who was my foster sister is now on the National Center for Missing and Exploited Children. They just dismissed her disappearing as "another run away" it wasn't until our family who was trying to adopt her kept pursuing and calling outside resources and contacting her previous social worker who actually cared that this has now become a serious issue. Children's lives

matter no matter what their behavioral issues. We still consider her part of our family even though they showed up and just took her away without warning. And we will fight until we find her.

VAL MC CAULEY - I can hardly take it anymore. Val and I have spent the ENTIRE day reading your stories, talking to you on the phone and responding back as best we could to posts and messages. Even now it is past 1:15 AM. The quantity of stories and the amount of pain we have collected today from you is beyond comprehension. CHANGE MUST COME. Pray for our legislators, pray for the policy makers and most of all, pray for the little foster children that are unnecessarily hurting. Then, GET UP AND DO SOMETHING ABOUT IT. Call you legislators, come to the hearing on Friday morning at the Capitol Building. In a civil and educated way, DEMAND change. Our foster kids deserve better than this.

Heather Gee Davis When we planned to move to another state for college for 2 years, the state of Idaho told us they would just place our foster son in another family and give him back when we got back. Children are not furniture or potted plants!

Shannon Vandever The kids needs have to come first not the parents!

Hillarie Hagen This is so great they are looking at reform, but one word of advice... Contact your legislators directly, tell them you are in support and why. Call them, write them, schedule a visit with them. Or even email them! Let them know you personally are in support of this, it will have a much larger impact! Don't know who your legislators are? Google it, it will bring up the website and you can look at a map to find your district and legislators. They WANT to hear from you.

Idaho Foster Care Reform Absolutely right. Nothing can replace personal contact. Thanks Hillarie Hagen

Kookoo Jacobs These poor kiddos who spend their entire lives with foster parents and then are placed with biological parents or relatives are just traumatized and it has such long reaching impact. It's got to be changed!

Richard Keyes Same thing happened to us I cant wait to go to the hearing Friday the 12th 8:00 am this must be stopped. Sounds like this is standard operating procedure them.

Richard Keyes Who in the world ever gave them complete authority they are the judge and jury. They overruled a judge that we were in front of. The judge said keep the kid in our home and we could adopt her so health and welfare moved her out in fact they moved her 5 times and move her out of state away from her sister, family and friends.

Andrea Kartchner I have a question: I like the idea of all changes for foster kids going through court, but do we have the kind of judges that would have common sense and not just view to the department's wishes?

Annaandjohnahrnsbrak Ahrnsbrak This story brought me to tears, so happy for her but the feeling of lose watching this for I never got that happy ending with my baby girl.

Stacey Hoffman Interesting that she had been a foster parent for 3 years and never had gotten even a single call though there is a foster parents shortage!!!! This is video was done for her adoption party so it was meant to leave many of the experiences out because it was a happy occasion. I hope she will post the rest of the story.

Kathy Wood Idaho is far behind in this area. In California we have open court and the children are represented by real lawyers. Get with this Idaho and get on board !!!!

Debbie Wood I know foster parents want rights but why don't we get the whole Idaho System changed. We need laws to make the Judges of Idaho do their jobs and not let CPS be the sole deciding party in these cases. A social worker for CPS should not be able to decide a case .We need to get Idaho to have open family court. We need to get Idaho to have lawyers to represent the kids instead of this joke of a system they have in place now with Family Advocates/Guardian at litem.

Another story from a former foster child:

Foster care reform,

This one was shared by a former foster child:

As being raised in foster care,living with several different families through out the years, there were good experiences, but then some very bad ones! I learned how to adjust to different aspects of life, as each family has different dynamics, expectation, food, ect..... Then on top of that, you always wonder how long you will be there. You learn not to keep anything as you can not take much with you. The greatest desire is to be loved and accepted, no matter what, but so many of the foster parents do not know exactly what kind of behaviors they will have to deal with..... And instead of helping the child, they choose to move them out..... So as that result, the child learns once again not to trust.....,now years later, I have learned it is OK to have material things, I still have trust issues

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Anna Blackford Unfortunately, they don't have to tell why they were moved. This is just another story about how broken this system is. Praying that there is change and praying for the hearts and minds of these children.

Richard Keyes The state does whatever they want to do if you saw one of my other messages they can overrule a judge's ruling they do not have to abide by a judge's ruling that is how much power they have they do whatever the hell they want weather it makes sense or not.

Judy Love My husband and I were fostering a 18 month old, we got him when he was 3 months old with a broken leg, he is a kin to our children, he was returned to his mother January 12, 2016, The social worker has told the court system that she was working her plan, we are totally dumb founded to this, she is still married, she is living with her boyfriend in a trailer that has no running water, they live on property of some friends. She has sense had another child and has had 3 adopted before our little guy came to us, we gave him a wonderful life, lots of room to run, lots of toys, lots of love, we care deeply and have a real bond with the child and now he is gone, we are devastated, she is now working and the boyfriend has a somewhat job. We saw a guardian ad litum twice in the 15 months we had him, we were the ones that was up all night with him when he got sick, she never showed up to one of his doctor appointments, our whole family love him, we saw him in court, he stunk, like he hadn't been bathed, he dug through my purse and ate some candy like he was starving, we were told they were dealing drugs, and none of that was checked out. The social worker stopped working with us. We would love to see something happen to help us and all the children that are not being treated right. Judy and Jim

Elle Gersema "This case is unique," was the main phrase I received. When in reality each case is. I was repeatedly told this as a child when I questioned the courts and caseworkers about how they were handling my living situation. I hope a lot of children who have aged out speak up about the trauma they have endured while being bounced from home to home. In my case I had a family willing to take us permanently who we had previously lived with for years, but because a busy body relative the system opted to separate us into two separate foster homes. We needed each other.

Lachelle Larson Prieto Judy Love this sounds similar to the Robert Manuel story. H&W dropped the ball plain and simple. Just wondering how many children will have to pay for the mistakes they make. Seems like they make decisions off of emotion, NOT what is actually best for these kids. Hear stories like this and worse all through the system.

Heather N Joseph Soelberg We have been foster parents for approximately 7 years now, with 14 children being part of our family during this time. Being a foster parent is so difficult. Although the heartache is painful, it is out weighted by the reward we receive from loving these children, even if it is for the briefest of moments. BUT, the struggles dealing with The Dept. of Heath and Welfare ("H&W") makes being a foster parent almost unbearable! H&W's claim they are doing what is in the child's best interest is far from the truth. It has been our experience they take the road that is the easiest for them, the one that will give them the least amount of resistance, and allow the case worker to have this child removed from their case load.

H&W says children need an opportunity to bond and build healthy relationships. Then it is H&W that breaks the healthy bonds these children and foster parents have fought so hard to build.

The damage foster children suffer is beyond what many of us can imagine. The damage these children continue to be inflicted with when ripped from the arms of yet another "parent" makes no sense. How is this in the best interest of a child?

We have seen the return of the same child to the system more then once. We have seen a birth parent granted multiple chances to be a parent (I'm not saying they don't deserve an opportunity). When does the child's safety truly become a priority? When does the child's guardian ad litem become more of a focal point of the court proceedings? When does the conflict of interest of H&W's appointed attorney not be the same attorney representing the State?

A foster child is not just a number which is compiled into a statistic. A foster child is a human being that needs more then just a case worker who checks off a quarterly visit, a guardian ad litem that rarely spends even a moment getting to know them, a pro bono attorney whose report means nothing to the Court, and whose foster parent's experience/interaction with a birth parent has no merit. Children in Foster Care deserve more! They deserve a chance! Foster Children deserve the love of a parent(s) who knows that blood is thicker then water, but actually has a love stronger then any strand of DNA could ever be.

Melanie Durham Jones The case workers know for a fact that bouncing a child from home to home cause attachment disorders, and yet with the cruel hearts that they have they do it. They cause their own turmoil on these children on top of what their own bio parents do. Idiots at their finest.

Richard Keyes One interesting thing about Idaho health and welfare is they will preach to people they do not take kids out of homes the police take kids out of homes that is BS they do take kids out of homes because they've taken kids out of my perfectly good home for no good reason.

Connie Rudolph they took my grandson from my daughter, he was born with feeding issues and put on feeding tube and then took him straight from the hospital for what they called "failure to thrive" then they put the mom on a child neglect registry which gets her fired from her job she worked at for 3 years and now cant find a job because of it, and because of that they say shes unstable and gave the baby to her ex. so CPS does take kids away from perfectly good parents for NO GOOD REASON. and IF we could afford an attorney she would of won this case but its all about whos got the $ to fight it and he did and won. THIS WHOLE TITLE IV FUNDING is the whole reason CPS exists. It needs to be overhauled and kids given back to the good parents. if you want more info ill be glad to step up and tell the story, so will my daughter. dont even get me started with the corruption in that department. its been 2 years since ive seen my grandbaby and they left it up to her ex to give her supervised visits till the baby is 18 but its up to him when its convenient for him to let her see him which will prob be never frown emoticon how sad they have that power.

Michelle Nordin-Mills I was in foster care at several different homes and it is very frightening not knowing when you'll be going to the next home or who will be taking care of you. After awhile I just kinda shut down and didn't get close to anyone or trust them and came off as a bitter, unloving child.

Chelsea Goodwin Idhw on foster and bio fam makes the worst decision with no explanations just excuses
They need to be investigated and cases handled correctly and best interests of the children kept in minds at all times

Angela Gross I also have a child with RAD that came out of a terrible situation with his biological mother and whom was placed in foster care for 8 months before cps would release him to his biological father and myself. It's very difficult and these little lives will suffer their entire lives dealing with RAD issues. I feel for you and your family.

Ce Price Thats any state! Ive dealt with that myself! I was hoing to adopt and they told me after having a child for 3 yrs that I was too old to be a permanent placement and my children were too! Because we had older children and

he was a baby! Good emough for foster care but not for permanent! I got an attorney... I think they are better now days but thats just wrong! These kids do bond with families! And if they can bond with any one after what theyve been through then its meant to be! Wish theyd think about humans instead of cases!

Annaandjohnahrnsbrak Ahrnsbrak I feel so much your pain, for this is all to familiar, my baby girl was ripped away to a grandparent she did not know after a year of raising her since birth, it broke my heart , to this day I remember dropping my one ur old little girl of to say good by forever and the look in her face as I had to say goodby, she didn't understand why her mom and dad and brothers were leaving her, I think of this often she must have felt so

abandoned.

Patricia E. Shuman The department does not care about the welfare of the child as it states on the front page of it's website. Children 1st is what it says. Many friends and relatives I know have been destroyed emotionally and financially trying to fight for the protection of an innocent child. Idaho courts have an advocate that works with Foster Parents, Families, H&W and Judges. These people are usually volunteers and give there recommendations to the courts. In my experience this person is completely ignored if they do not agree with H&W. Many just give up and quit when they see the broken system. A person has to ask themselves? If Foster Families all over the nation are all wrong or is the H&W system broke?

Christy Amos Williamson Completely unacceptable and cruel. Someone in that department is Power hungry and wants to usurp their control. It really makes me sick. Thank you for caring.

Carrie Hull I am very interested in understanding this bill and support foster care reform. As foster parents we have had experience with this personally. Who do I contact, what do I do to help change the system to support children

and focus on their best interest.

Sarah Hines I back this 100% !! Anything i can do to help! I am currently STILL going through the process of becoming a foster parent!
When i applied the 1st time, the woman who did my home inspection made fun of me to my face for trying to become a foster parent as a single mother, even though i had EVERYTHING lined up, including income... It really made me second guess my decision... But now i am re-applying ... And this Bill would change a huge flaw that i have seen in the system!

Spencer N Megan My husband and I started the process to become foster parents in Idaho a few years ago, but after hearing countless horror stories like this we decided not to continue. We had to take into consideration the trauma that could fall on our current children and the future problems that would entail, as well as the trauma a foster child would go through. Being a foster parent is always something I've wanted to do, but it seems like such an emotional risk to our family. I completely support Foster Care reform in Idaho.

Angela Baldwin This is why we stopped being foster parents. The system hurts the children worse than being with broken parents. Awful.

Christina Hatley I know this family who opened their hearts and their home. This truly was an u justice for this family and this baby girl. I agree the system is disfunctional. It is because of this I have restrained from becoming a foster parent. There's many more families that I believe would open their homes if the system wasn't so broken. Children are removed for a reason and in this case this little girl should have remained with her foster family her family who loved her and protected her.

Kelly Jo Pitcher Andresick Idaho foster care workers were awful in this case! Ignoring the foster mom and lying and placing blame. I foster adopted in WA. While not perfect, I was appalled at the behavior of these workers and what they put this family through.

Julia Torrey This makes my heart ache, the department definitely doesn't always make the best decisions in regards to these children. I truly hope that will change.

Jessie Jackson A lot of foster parents stay silent because they fear of loosing their children and don't want to make waves, reform needs to take place and judges should have the power to decide what happens to the the child and their authority should be all.How does health and welfare have so much power? there should be checks and balances in place. Health and welfare makeup their own rules as they go along and don't let foster parents know anything . It shouldn't be a crime to ask questions and because you do you loose your foster child. Good parents ask questions and have a hard time being silent because they don't want to see anyone else go through this anguish, sometimes the fosterparent is the only person who truely cares about them. Guardian adlitieum sometimes never even meet the child or foster parents and then they all meet in court, all they know is what health and welfare tell them or a report they read. They are just volunteers and have a lot on their plate but why aren't there more paid people for this position? So many flaws in this system.... Nothing is ever perfect but some things are plain as day and still go on as if everything is ok. I am very concerned about this subject.

Richard Keyes Oh and for those of you who don't know t Idaho health and welfare can disregard a judge's order that is part of what happened to us. A judge layed down an order in our favor and they ignored it health and welfare went ahead and did their own thing even though the judge told health and welfare not to. Idaho health and welfare can overrule a judge that is outrageous that is the power that they have.

Candee Gilbertson Whiting As a person that was raised in foster care for 7 years, 15 homes..... Some were very good, others not so much! I will say that any form of foster care I recieved was better than what I came out of!!! I just wanted to say, that you might want to check out the state of Texas policies and procedures,... My niece was a foster parent there for a few years, sounds as if it so much better than Idaho's program.... As a adult I was going to provide foster care, but then the policy was to return the child/ children back to the blood parents as soon as possible..... In my view this can and has proven to be a disaster!!! Also , we are to bring these kids into our home, love, nurture, provide protection, food, clothing ect. Just as our own child..... And as most foster parents do, then have the child/ children moved out in the drop of a hat, not only is divenstating to the child, who then learns to never connect to people, have trust issues and a mariad of other issues, I also does the very same to the foster parents and other siblings! Sorry this is so long.... But I am so excited that you are standing up for the rights of foster kids and parents!

Davina Spafford Stuart i so agree with you Candee. We're in Alaska and have been fostering for a few years.. main goal is _always_ reunification.. even if it should be flat out obvious that is not a good idea.. we have 2 kids right now that we had a bit over a year ago... they have been in and out of care now for about 5 years.. they first came to us in sept of 2014. they were living w. bio mom (had been 6 months since she got them back that time...) in a shelter when she od'd.. we had to go pick them up middle of the night. we had them for 6 months then they were sent back on "trial placement" again... because the only way mom could get into the treatment program she wanted was if she had her kids with her... (so not only mom is living in the treatment center, so are the kids... this is a thing....) we had worked hard with those kids, saw so much improvement.. then, they left, went back, and massive backslides. not only that.. but 6 months later, again the kids were pulled from mom.. they tried placing with great grand parents.. that lasted 2 months.. couldn't handle them.. so back to us.. behavior problems have skyrocketed.. kids are now 6 and 8. the 8 yr old is home today due to a suspension because she has so many issues at school and yesterday she hit another student. We love these kids to pieces, and would have adopted them last year if they'd allowed it.. yet, there are still no plans in the works for tpr. thankfully she will be starting therapy, but that's not til next month, but boy does she need it and we just hope they can get through to her... but, there is just no way at all they should have been allowed to go back to mom's care a year ago when they did.. she was not "ready" and the kids certainly weren't.. they didn't want to leave

Annaandjohnahrnsbrak Ahrnsbrak There needs to be a time period there is such strong attachment in the first year of a child's life

Anna Blackford Unfortunately, they don't have to tell why they were moved. This is just another story about how broken this system is. Praying that there is change and praying for the hearts and minds of these children.

Richard Keyes The state does whatever they want to do if you saw one of my other messages they can overrule a judge's ruling they do not have to abide by a judge's ruling that is how much power they have they do whatever the hell they want weather it makes sense or not

Kari Wardle Oh my gosh!!! I'm so happy to hear about this! [The Foster Care Reform] I tried contacting my own legislature in regards to her similar issues and was told that it won't matter because in the state of Idaho even if there was a bill before the legislature it wouldn't pass and that was the end of it!!! He wasn't even willing to try. I've been doing foster care for a year and a half and I have some stories!!
Heather Gee Davis When we planned to move to another state for college for 2 years, the state of Idaho told us they would just place our foster son in another family and give him back when we got back. Children are not furniture or potted plants!
Hillarie Hagen This is so great they are looking at reform, but one word of advice... Contact your legislators directly, tell them you are in support and why. Call them, write them, schedule a visit with them. Or even email them! Let them know you personally are in support of this, it will have a much larger impact! Don't know who your legislators are? Google it, it will bring up the website and you can look at a map to find your district and legislators. They WANT to hear from you.
Another amazingly sad and infuriating story:
We met with the Department and they really can't tell us why they took the children from our home and placed them in a home where they are sure to endure a life of abuse and neglect. We loved them and cared for them for two years, ten months, and seven days. We were promised we would be allowed to adopt them, but that never happened. The head of IDHW can't possibly conceive that the case workers made an error as he stated he has been up and down this state and none of his social workers would ignore children on their case loads. My claim was no one has ever talked to these children about how they are, what they want, or even knew them. The Department would not make such a horrific mistake. He feels our experience is not typical of how people feel about the department. He said he knew the workers involved personally and they would never harm children.
We were promised so many things and we did everything asked of us. The children ages 3 and 6 knew us as their family. They were told by the caseworker we would be adopting them, but it didn't happen because Supervisors who never met the children decided a distant cousin should adopt the kids. We reached out to the dept heads, the governor otter, his wife, senators, and lawyers. No one could help us the state went against the Judges ruling to not remove the children, but that didn't matter to the dept. the CASA was also in our side, but hi opinion didn't matter either.
We got one visit with the children they begged to come home, I can still feel my little boys sobs on my chest as the case worker told him no. My little girl asked if I would go to the cemetery and put flowers on her grave to remember her. I later ran into her at school she asked me if I was still trying to bring her home, and that her new Mom and the department told her we were the bad guys and she couldn't hug me anymore. Later that week I got a letter from the department that I was not allowed to have any contact. When we see their sad faces at Walmart we have to look away, just because we didn't agree with the department to change their permanency plan. The children are doing poorly in school and are treated poorly by their new family, but the department doesn't care. They have no interest in doing what is best for children.
Case workers told me if they disagree with a supervisor they could lose their jobs. There are no checks and balances, new legislation protecting our most vulnerable is long over due. Not a day goes by, that I don't think of

those children and what that little boy was thinking when he begged me not to give him away. I didn't have a choice.

This one was shared by a former foster child:
As being raised in foster care, living with several different families through out the years, there were good experiences, but then some very bad ones! I learned how to adjust to different aspects of life, as each family has different dynamics, expectation, food, ect..... Then on top of that, you always wonder how long you will be there. You learn not to keep anything as you can not take much with you. The greatest desire is to be loved and accepted, no matter what, but so many of the foster parents do not know exactly what kind of behaviors they will have to deal with..... And instead of helping the child, they choose to move them out..... So as that result, the child learns once again not to trust.....,now years later, I have learned it is OK to have material things, I still have trust issues and relationship issues.
I did have a couple of families that wanted to adopt me....my birth mother and father refused to allow the adoption to happen.
The most important thing you could do for the children placed in foster care..... is security!!! The only reason for a child to be moved out is abuse of any form! Never because the social worker decides that there is to much of a connection.... We need these kids to come out of a horrible situation as healthy, physically and mentally healthy adults!.
I am so thankful someone is trying to take a stand for foster parents. I was a foster parent for about 9 years for just over 20 kids. However, after experiencing a non-caring attitude from so many case workers and department heads, I wasn't able to continue. I could not stand back and watch them NOT care for my foster children. Anytime the kids needed something, they wouldn't respond. When abuse was suspected and reported to the Dept, I couldn't believe they never did anything about it. Time after time, month after month, child after child, I watched the Dept destroy these kids. It broke my heart! I so wish I could have continued being a foster parent. After a grueling two years, many promises made and broken, and by the grace of God, I was finally able to adopt my first foster placement. He is the joy of my life. I just wonder how many others could have turned out the same way if things would have been different. I could never be a foster parent again and that's sad. We have so much to offer to a child. We need change!

CHANGE.ORG COMMENTS

I have seen the system take a child away from loving, devoted foster parents in the only home he has ever known and given to another family because he was bonding with the first family. It has broken all of their hearts and will cause permanent damage to the child. Something is very wrong with a system that would do that to a child! It was definitely not for the benefit of the child!
KAREN WRIGHT, EAGLE, ID7 minutes ago

I have personally felt and observed the damaging effects on foster children and well meaning adults trying to help foster children under the current rules and regulations. These need to reformed so that they are helpful to those who can help and not causing serious long term psychological problems with foster children.
Thank you for inviting comments.
Ronald Clark, Eagle, ID33 minutes ago

I have seen many families affected by their foster children being taken away and placed back in detrimental situations. It doesn't seem to me that the children's best interest is considered.

Marisa Lamm, Eagle, ID35 minutes ago

I'm signing because I watchedmnmy parents struggling for many years when fostering children and saw the hardship it caused on the children as well as the fostering parents!
Stephanie Veach, Nampa, ID5 minutes ago

I've adopted and experienced that world. I've watched some things happen in families with their foster kids where it is not for the good of the child. Let's please reform and do what's best for the child and nothing else!
justin nielsen, Eagle, ID58 minutes ago

Reform and judicial oversight needed!!!
Kelly Hunemiller, Boise, ID59 minutes ago

My friends sister has been abducted and needs to be found.
Ashleigh Easley, Reno, NV hour ago

We have need of some foster care change
Tim Fortin, Kuna, ID hour ago

THere needs to be best interest standard for children regarding placement. Foster Parents need to have more input into the court system.
valerie bish, Boise, ID hour ago

I am signing because I personally know that the current laws do not protect the foster children of Idaho.
Bonnie K Clark, Eagle, ID hour ago

I have been a foster parent for 5 years and I have seen this happen over and over again. They children are caught in the middle and there needs to be a voice for them.
Kea Loveland, Nampa, ID hour ago

I support reform. Children first
Jennifer Mikel, Middleton, ID hour ago

I believe early childhood development is a crucial part of raising healthy adults who then contribute to a healthier society. And I believe in checks and balances, especially when it comes to children and their welfare.
Mila Gaulrapp, Sandpoint, ID hours ago

I am an advocate for children.
Don Brinton, Eagle, ID hours ago

I've seen many friends and family who are foster parents have their hearts broken when children who have been with them for a long time and offered to them for adoption removed and sent to live with relatives that were deemed not appropriate in the middle of adoption for no real reason other then they can. The pain this causes have stopped many from providing a stable and loving home for children who badly need it.
LESLIE HATT, Eagle, ID hours ago

It's so cruel to take a child from a loving foster home because they are forming a strong attachment with the foster parents, which is what has been happening in Idaho lately!!
Deanna Terry, Grain Valley, MO hours ago

As a foster parent, adoptive parent and educator, I have seen such disregard for the emotional needs of children...straight from those in charge. They have title, but no heart.
Teola Sheldon, Nampa, ID hours ago

The system needs to change!!!
Jenny Needles, Meridian, ID hours ago

Reform is essential for the Idaho foster program
Carolyn Kiesel, Boise, ID hours ago

I plan to foster/adopt in Idaho in the future. I've seen the absurd situations that have happened to friends in the foster world, and so I too desperately want for these kids to have as much consistency, attachment, and advocacy in their lives as possible.
Rebecca Whiting, Nampa, ID hours ago

Regulatory departments and agencies must be accountable to the courts at the very least.
Paul Johnson, Eagle, ID hours ago

I am in support of Idaho Foster Care reform to protect ALL children to a stable, nurturing home and time frame decisions be made in a timely manner in order to add to the security and a loving home environment that is a right to all children.
Deb Winward, Star, ID hours ago

I agree, some of the laws should be re written
Laura Denney, Boise, ID hours ago

I was a guardian ad Litem for Ada county and I've seen first hand one of the horror stories!
Terri Reno, Kuna, ID hours ago

I'm signing because I'm pro-life and that means taking care of all children
Devanie Christensen, Rexburg, ID hours ago

Have seen first hand the trauma that the current system inflicts upon children and foster families.
Rhonda Quinn, Middleton, ID hours ago

Foster children need better protection.
katie smith, Garden City, ID hours ago

I am signing because we need to look out for the best interests of children, not adults!
Chris Warren, Sandpoint, ID hours ago

Every child life should be up help to the highest priority
Lisa Holligan, Abernathy, TX3 hours ago

Foster children need to feel secure. Their lives are difficult anough!
Cheryl Dias, Wendell, ID3 hours ago

I love children and believe that bonding is critical to the children. They deserve to feel loved and cared for.

Rolane Gibbons, Nampa, ID3 hours ago

Three main reasons I am signing - One to support my friend who has had to deal with the devastation of this system because she cared enough to do what she could to be a great foster parent. The second reason is because although I was not in foster care prior to living with my dad I should have been. No one did anything until I decided to take matters into my own hands and save myself by contacting my other parent (who had no idea due to divorce and distance of residence, how bad it was). Up until then I was afraid to "tell". Even after that it took my stable parent countless appearances in court giving my unstable parent the opportunity to try to keep me, luckily the unstable parent never showed up. My step parent was a murder, abuser, etc. We lived in a trailer in the woods with no electricity, no hot water, etc. I never understood why anyone would give my unstable parent a chance, had I been sent back, I would have ran away, my life would have been completely different than it is today. My husband and I also applied to be foster parents for my husbands step children (his step children from a prior relationship). We had them every other weekend, and sometimes for a week at a time as it was, and whenever mom called and couldn't handle it anymore. Their mom had not been taking care of them and we already had bought them their own clothes, scooters, dressers, etc at our house so when they came they had everything they needed. Although kids were taken from mom, her preference was a leader in her church. Because he was told by mom that she knew of no one else who would take them, he applied immediately and he got chosen right away. Their biological dad wanted us to have them while he was trying to get custody after the kids being removed and the kids wanted to be with us, they called my husband "dad" since they were toddlers. It made no sense at all that mom had any say and that they would place the children with someone they didn't know like they knew us and who they didn't have bonds with like they did us. Terrible experience, definitely not focused on what was best for the kids. Those kids are now adults and have thanked us for doing what we did to get them to a better place with their dad, we were one of the calls that turned mom in for neglect and abuse. It took multiple calls from different people who ed their situation and visits with many chances to change before they removed the kids from that situation. Very sad....
Wendy Mason, Garden City, ID3 hours ago

I know first hand the damage the dept can do to a child who has formed bonds and has anticipated permanency with a foster parent.. And then the dept expecting a mother to choose between a bio and a foster child who she both loves and supports completely..
lisa andersen, Post Falls, ID3 hours ago

I'm a foster parent who has had terrible experiences.
Karl Wardle, Heyburn, ID3 hours ago

As a previous foster parent and someone whose family has taken in a lot of children I have seen first hand how the system has failed dozens of times. My mother was in the process of adopting Marissa Ferguson when they showed up and took her. Now she is missing and they didn't even notify her, she found out online. She is like my sister and Marissa is like her daughter. And we're the only people who have adamantly been searching for her. The system just dismisses these kids when they behave negatively, they dismissed her as just another run away but my mom and I fought hard and now she is on the national center for missing and exploited children. Just because she isn't our blood doesn't mean she's not family!!!
Liberty Shepard, Reno, NV3 hours ago

When something is broke we need to fix it.
John Mark, Meridian, ID3 hours ago

Our foster system is broken if children are taken away from loving, caring families because "they have bonded too much" or simply because it hits the 8 month mark. Children need love AND stability!

Cynthia Peterson, Caldwell, ID3 hours ago

I am signing because we have kids adopted via the foster system. I know their stories. We have also done some foster care. I have friends that have done foster / adopt as well and some of their stories are much much worse than mine.
Sharon Butterfield, Mountain Home, ID3 hours ago

I have had a first hand look at how broken the foster care system is. It seems to me that the needs of the biological parents are put first. ...and what is best for children a distant second. Change is desperately needed.
Kimberly Barton, Nampa, ID3 hours ago

I'm signing because I would like some review on whether the policies in place focus on the best for each child AND whether those policies are being followed.
Jennifer Butler, Eagle, ID3 hours ago

Children and the compassionate people trying to help them deserve better.
Elizabeth Lane, Eagle, ID4 hours ago

I'm signing in support of my friend Jamie who had her family ripped apart. It needs to stop. These children need to be protected and allowed to live with families that love them.
Marci Pokorney, Meridian, ID4 hours ago

I care about all children, and I have felt the foster system needed reform for a long time. We need to give children the best chance to be successful!
Jenny Guthrie, Logan, UT4 hours ago

I believe that if the bonds of attachment are solid with the foster home and the child feels comfortable and is safe and all of their needs are met . That child shouldn't be moved from that home
Virginia Lubovich, Meridian, ID4 hours ago

I don't want the children to suffer by being pulled out of loving homes. They're biological families have caused these children enough suffering.
Alison Hucks, Meridian, ID4 hours ago

Children should have a stable, loving home and they shouldn't have to wait until their parents get their act together to have it.
Tiffaney Harris, Caldwell, ID4 hours ago

Foster kids need people to look out for their best interests. They are not just numbers in a system, but people whose lives are impacted by these decisions forever. Please sign this petition for essential reforms.
Jennifer Black, Eagle, ID4 hours ago

I witnessed the effects of a child pulled in and out of a good home. Tragic and Sad don't begin to describe the impact to the child and the family.
Michael Hunter, Eagle, ID4 hours ago

I care about the future of the children of Idaho, and want them to have a loving family.
Dave Thames, Meridian, ID4 hours ago

I'm signing because treatment is not working in favor of the kids in this system. It seems to favor the biological family/parents. I think what's best for the child is most important but the state is failing miserably to be their advocate and ensure their well being. I also think that in order to keep good foster homes, their needs and desires need to be addressed. They are the people who know these kids the best. They have the hands on experience with them. The foster care program was set up to protect these volatile children. Now let's actually do it!
Trina Browning, Caldwell, ID4 hours ago

I care about protecting the welfare of children in Idaho!
Liv Christianson, Eagle, ID4 hours ago

I care about the children of Idaho having a good life.
Dave Thames, Meridian, ID4 hours ago

I say YES to Idaho Foster Care Reform.. The children need a voice, stability, and not moved around from place to place....
Kim Felix, Caldwell, ID4 hours ago

I was a foster parent for about 9 years and had multiple issues with the Department of Health and Welfare. I asked them to pull my license. I told them since they don't care what happens to these children, I cannot be a part of that. I ed a suspected abuse of a child, and I was told that the child is fine and that it was my issue and I just needed to let it go. Change is needed immediately. Someone needs to speak up for these children. Foster parents should be considered one of the department's most valuable resources for these kids, but all they do is push us away. They treat us like we don't know anything about the children, even though we are the ones who care for them 4 hours a day. Foster parents should have a voice when it comes to all the unnecessary moves, disruptions, and lack of resources that are provided for each child. I am delighted to sign this petition.
J Renee Swanson, Meridian, ID4 hours ago

My very good friend is trying to adopt
melissa porter, Vernal, UT4 hours ago

My husband and I were foster parents for seven years and agree that the parents' rights seem to come before the foster children. This needs to change!
Wendi Ballard, Rexburg, ID4 hours ago

I have friends who provide foster care that need this petition supported!!!
Becky Burnham, Nampa, ID4 hours ago

Administrative agencies both federal and state do NOT know better than the citizens. All administrative agencies must be reigned in. The Constitution of the United States gives power to the citizens, not the government. Administrative agencies have through the passing of many laws obtained the power that the Constitution gives to the citizens. This is invalid and unconstitutional activity and must be stopped.
Stace Lee, Eagle, ID5 hours ago

i was in foster care for 5 years
amanda clampitt, Boise, ID5 hours ago

I have been affected by this as a teenager and know that the children's best internet is truly not the top priority, when kids are left in horrible environments because biological relations speak louder than what is in the best interest of the child.

Kara Steik, Eagle, ID5 hours ago

I am an advocate for children in the foster care system. There is a need for better education throughout the foster care system to maintain the best interest of these children to develop into healthy and adapted adults.
Elizabeth Loyd, Boise, ID5 hours ago

I did daycare for a wonderful foster mom, and watched as the state, first made promises and the changes the rules. The kids were doing so well with her and made so much progress. Everyone they went to visit their real family they slid backwards. Sadly after the parents were declared unfit, they found distant relatives the kids didn't know and who had criminal records to take in the kids. Blood isn't always in the best interest of the child.
Kim Day, Kuna, ID5 hours ago

I am a foster parent
Sandra Brostrom, Twin Falls, ID5 hours ago

The Dept is totally and completely out of control. They have no oversight and if you disagree with them or try to do things that are best for the children they will retaliate.
The are proof the power corrupts and absolute power corrupts absolutely.
George Satter, Boise, ID5 hours ago

I was a foster parent for years. The system is broken. It needs to be adjusted so that the rights of the children are considered.
Heather Mark, Eagle, ID5 hours ago

My family and I were somen of the people that were affected by these laws first hand. It was awful!
Gwendelyn Vergobbi, Kingston, ID5 hours ago

Health and Welfare is violating its own rules. No agency should be able to operate without question or oversight. This agency should be putting children first and not getting caught up in its own bureaucracy. When that occurs, the first thing to disappear is humanity, along with humanity and compassion.
Marlisa Keyes, Sandpoint, ID5 hours ago

My experience as a foster parent was a horrible one and I believe that change is not only needed but necessary.
Ruth Taylor, Boise, ID5 hours ago

We moved away from Idaho because of the corrupt system. I'm so excited to finally see some substantial outrage at the ineptness of the system.
Laurie Moyer, Yelm, WA5 hours ago

I was a foster child and the number one thing these kids need is security and trust
Lisa Lint, Nampa, ID5 hours ago

I really want to foster, but based on the horror stories I've read about the system in Idaho I've been hesitant to get involved. I want to know that someone is looking out for these kids and their best interest. These kids didn't choose this life, and they deserve not only some stability and security, but a chance to actually bond with their foster families. A chance at a LIFE. There should be no reason to remove them unless abuse is suspected, or there is permanent placement available.
Shannon White, Kuna, ID5 hours ago

I'm signing because I was born in Pocatello, Idaho where the presence of dysfunctional families was prevalent. The importance of foster care children finding safe, loving homes cannot be overstated. The bonds that some of these children have with their foster families should not be broken either.
Nakita Santiago, Austin, TX5 hours ago

I was born and raised in Idaho, have seen the effects of poorly-managed foster care system, and would like to see children given better, more considered (and compassionate) treatment.
Jana Light, Honolulu, HI5 hours ago

I think changes need to be made that put the focus more on the needs of the child not the department or others involved.
Scott Stewart, Meridian, ID5 hours ago

I was a foster child and didn't stay long at the foster homes. It was traumatizing and I just shut down after awhile because I didn't know when I'd actually get a home to live in. I to this day get separation anxiety.
Michelle Nordin, Boise, ID5 hours ago

I hope to become a foster parent in the future and I want the laws to protect the children's rights to be given the best care possible!
Rachel Parrish, Boise, ID5 hours ago

Because we fostered and adopted our so and we know first hand the effects he has because of decisions that were made while he was in care.
Jenn Skeesick, Wapato, WA5 hours ago

My Wife and I were taken advantage of and lied to by Idaho's foster program after a child was taken from us two years after we received him form birth and told we would adopt him no problems.
Adam Mark, Eagle, ID5 hours ago

We were foster parents for over years and adopted 6 children. Idaho needs to change and make the kids come first not the parents!
Shannon Vandever, Rathdrum, ID5 hours ago

Idaho's children are worth it and if we want great foster parents we need a better system.
Sara Hansen, Star, ID6 hours ago

My husband and I as Foster parents had the same thing happen to us. Two sisters removed because we we're bonding. Getting too attached. We never had a voice and neither did the girls. It should change!
Terri Mudd, Nampa, ID6 hours ago

They have too much power!! It's like they are above the law. They don't care about your opinions. And they don't or care about certain issues about the children you are living with. They think they know it all. And I don't believe their idea that it's whats best for the child. No way.
Jane Keyes, Star, ID6 hours ago

There needs to be a change!!!
Raeanne Blackner, Nampa, ID6 hours ago

I was a foster child nd went through hell 5 foster homes 3 group homes from age 4-8

anngie munoz, Caldwell, ID6 hours ago

My family and foster children experienced gross abuse perpetrated by IDHW foster care workers and their superiors.
Christie Stephenson, Lehi, UT6 hours ago

stability for foster children
Sherri Randall, Eagle, ID6 hours ago

In support of a loved one who had their foster baby taken away and given to someone else to foster without warning. They had him since he was born. He was 4 months. SAD!
Stephanie Higgins, Nampa, ID6 hours ago

Bonding and attachment are critical to a child's development and mental health. To move them around is inexcusable without very good reason.
Melanie Prescott, Brainerd, MN6 hours ago

We have personally seen this impact of this in our very good friend's lives.
Marilyn Smith, Eagle, ID6 hours ago

Children deserve happiness especially when their life is not that great to start with. Why remove them if things are going amazingly? !
Jennifer White, Twin Falls, ID6 hours ago

This system is broken and has lost their mission to help children
melody watts, Meridian, ID6 hours ago

I have been witness to capricious decisions by the Department that adversely impact the children for whom they are chartered to care. I have witnessed the same Department decisions sustained by legal maneuvers to avoid court scrutiny of their decisions. I have witnessed caring foster parents with no rights to participate in Department decisions that adversely impact children they have nurtured.
Gary Gwin, Eagle, ID6 hours ago

I'm signing because things need to change. My cousin and his wife fostered many children and tried to adopt. They genuinely love the children they have invited into their home and hearts! The child they tried to adopt was moved out of their home, but she will never leave their hearts. Why was this family torn apart? Why was all this pain inflicted? Things need to change-now!
Tamara Tanner, Cumming, GA6 hours ago

I know a few families and children in the treasure valley that have had huge struggles with the system the way it is now.
Deborah Hillesland, Nampa, ID6 hours ago

My foster son was one of the many effected by poor decision making in his best interest, which in turn cause undue stress and trauma.
Andrew Sertr, Boise, ID6 hours ago

This needs to happen!!
Victoria Pack, Mountain Home, ID6 hours ago

I support the changes that need to reform the foster care program! I think it is in the children's best interests! I am a foster parent and believe these changes need to be made to keep the Department of Health and Welfare accountable and help the children have a healthier and happier experience while in their care.
MeDynn Call, Boise, ID6 hours ago

I hope something changes.... I am currently fighting for guardianship of a lil 4m old girl that the system won't help or even look into what I have proof of. The Judge didn't grant my emergency temp guardianship cause I had the baby for the whole month and as soon as the parents found out they called the cops wanted the lil girl back. The officer made me give her to mom cause my court case is all pending. Wouldn't even look at any evidence of the neglect or other facts. Told me fallow thru with trying to get her, to call cps if I get new info and that he made a referral to cps yet see nothing done. I've filed another affidavit for emergency guardianship after talking to the judge's clerk she told me the judge won't review it till the child has a guardian ad litem. I then tell her that the child was no longer with us, and still nothing. Going on wks now and don't have intake/interview till the 3rd for her guardian ad litem. Been so sick to my stomach and worried about the baby.
So much info and stuff that I would be typing for hours.
amanda hopper, Boise, ID6 hours ago

The best interest of the children is not being served.
Jill Eells, Nampa, ID6 hours ago

Our current foster care program needs reform. I would also like to see a citizens review committee formed with regards to the adoption process of children in the foster care system.
kim cowley, Eagle, ID6 hours ago

The children deserve better!
Jason Saadi, Eagle, ID6 hours ago

It is our duty to support the best interest of the children in foster care! They need us to be their voice and we need to speak on for the BEST INTERESTS to be at the forefront of every decision that is made for them!
JInjue Serre, Boise, ID6 hours ago

Kids need to have their best interest served.
Melanie Lewis, Nampa, ID6 hours ago

We need Foster Care Reform, these children are not being taken care of by the Idaho Department of Welfare, Their best interest are not a priority in most cases that they are in charge of the foster parents voice is not heard nor are the voices of the children THIS NEEDS TO CHANGE
Sandra Neff, Cascade, ID6 hours ago

I have witnessed the devastating affect of Idaho's poor policy on foster children and those trying to provide loving secure environments for these children.
Hoyt Hagens, Boise, ID6 hours ago

I agree the foster care system needs reform for the sake of our kids and families
Michelle Alden, Boise, ID6 hours ago

The pendulum of power has swung too far in favor of the Department of Welfare. There needs to be a check and a balance in making decision for the future of foster care children

James McCauley, Eagle, ID6 hours ago

I am very concerned for the welfare of children in the current foster system.
Roberta Honn, Eagle, ID6 hours ago

As a licensed foster parent in Idaho I saw first hand the negative outcomes the current system has on children in care. My story although far worse than most is not uncommon. Children shuffled from home to home. After numerous placements the children detach and the effects are horrific. Kallen was 5 when he came to live with me. 36 placements. After just 5 weeks in my home his honeymoon period ended and he burned two buildings to the ground causing nearly a million dollars in damages. The state knew of his potential for violence. When he would become aggressive in a home instead of allowing Foster parents to appropriately discipline him the state simpl moved him. They created a monster. I now live each day in fear of him and others that have gotten lost in the system of hurt. Kallen was in he system from until 5 and never adopted. Shuffled from home to home. I use his name because he was tried and sentenced as an adult because of the extreme nature of his crime. When his trial occurred the state came to support him, but did not offer me any support. The instead sent me a check for $, to cover damages. The slap in the face that no one wants.
Sherry Scheline, McCall, ID6 hours ago

I'm signing because foster care should be about what is best for the child and not what is best for the parent (s) that caused the child to be in foster care.
Randi Loveless, Twin Falls, ID6 hours ago

I've seen too many cases where the foster child has been harmed by being moved too many times. Short of the child being in a dangerous situation, they should be allowed to bond with a family who cares and has their best interest at heart.
Peggy Gilbert, Nampa, ID7 hours ago

I work in the foster care system and believe that these children deserve better than being moved around without being listened to or consulted.
Jessica Kelly, Caldwell, ID7 hours ago

The interest of the children should always be the first priority.
Pat Wilde, Eagle, ID7 hours ago

I'm signing because I have personally worked on CPA cases where the kids have been moved and moved. I as the guardian ad litem did not feel it was in the best interest of the child, but did not have much say on where the child is placed.
Yazmin Rich, Star, ID7 hours ago

I have experience both as a foster parent and working with foster children. Reform is needed to ensure the best interest of the children.
Kathyn Stucker, Boise, ID7 hours ago

This needs to end.
Mike Clark, Boise, ID7 hours ago

I am in favor of Idaho foster care reform.
Dana McNatt, Eagle, ID7 hours ago

I am signing because I am concerned about the blatant disregard of laws and policies by the Department of Health and Welfare and the negative impact it is having on Idaho's foster children and all those associated with them.
Christine Dunn, Eagle, ID7 hours ago

We are currently in the process of becoming foster parents in another state. Idaho is home to us and we hope to return someday. When we do it would be lovely to become a foster family in Idaho as well. Hoping change will happen much much before then.
Karen Heaton, Harlem, GA7 hours ago

I support foster care reform
Tucker Johnson, Eagle, ID7 hours ago

I have been a foster parent and experienced first hand the frustrations of dealing with under-qualified, overworked social workers.
Deborah Hoopes, Eagle, ID7 hours ago

I am signing this petition because I am in favor of foster care reform. Thanks for your support.
David Palfreyman, Boise, ID7 hours ago

These three points will help to protect foster children from added emotional trauma. Trauma brought about by nonviable placement practices in the Idaho foster care program.
Gary Anderson, Eagle, ID7 hours ago

This is about the kids,,it need's to be reformed to give them there Best shot in life.
Annette Knebel, boise, ID7 hours ago

All children should matter in the state and their best interest should always be the number one concern.
Allison Patterson, Eagle, ID7 hours ago

I'm signing because I have seen so much unnecessary harm done to kids in the foster system over the past 3 years.
Kimberly Rutland, Eagle, ID7 hours ago

There needs to be a change so that we can keep good, honest, trustworthy families as foster care families!
Nicole Coates, Nampa, ID7 hours ago

Health and Welfare has been out of control for along time, they do not put the welfare of children first. When did it all come to be about them. They choose the job of being a advocate for the children, these children have already been abused. They look to these people that have taken them from their home to be their advocate not their second abuser.
Gerrie Ozmer, Horseshoe Bend, ID7 hours ago

I am a foster parent and decisions are made based on department rules not state laws. We have asked the question, "Is that a department decision or state law?" and never get a straight answer. This among many reasons are why I'm signing this petition.
melissa williams, Star, ID7 hours ago

The system is broken and needs fixing (oversight). Children are adversely affected as a result. Let's focus on the children
Brian McNatt, Eagle, ID7 hours ago

I watched or foster son be given back to his family just before the year deadline was up. His Mom wasn't ready for him. His Dad didn't want him, and called me the night before the hearing, completely intoxicated, and told me that. I told the case worker, and they still opted to give him to his Dad. I saw him several years later, when he was not quite 8... he had dropped out of high school, was on his nd kid with the nd girl, and was so intoxicated, he could hardly communicate with us. I would've happily raised him until there was somewhere stable to go, or forever, for that matter. He has been in jail several times, been involved in violent crimes, and that sweet little 9 year old, that we taught how to read, would have clearly been better off staying with us and our 4 children.
Kyndal Fondren, Nampa, ID7 hours ago

I truly believe this need's to be reform.
Annette Knebel, boise, ID7 hours ago

I agree reform is needed. The children's best interest needs to come first.
cricket Syes, Meridian, ID7 hours ago

I'm signing this petition because my family has been personally effected by H&W's choice to remove a nine month old baby we cared for since birth from our home to another foster home with no regard for the child's best interest or well-being in mind.
Brad Wilson, Meridian, ID7 hours ago

The system is broken and family that have opened there heart and homes are be torn apart
Trinity kautz, Boise, ID7 hours ago

This is something that is currently affecting my brother and his wife right now. They have had the pleasure of having amazing foster girls in their care for a yr and a half. and have been going through the steps to adopt them, which was to be finalized this month when the state out of the blue has told them that the decision had been made to replace the girls into a different home. The state refuses to return their calls or to give them a reason why the adoption will not proceed. Lawyers have been called on behalf of the girls, as well as to represent my brother and his wife to no avail. Apparently it is the state's sole discretion to make this decision even if the girls counselors, teachers, pastors, and their Casa advocate all say that it is a mistake to remove the girls from this home. the system is flawed and something needs to change before another family is destroyed.
Melanie Pope, Garden Valley, ID7 hours ago

As a current foster parent, we see first hand then need for change.
Joe Soelberg, Cascade, ID8 hours ago

Because social workers have to much control. Supervisors don't consider family/child's best interests. They only listen to social workers attachment is critical to a child's development.
Dawn Maglish, Star, ID8 hours ago

Change needs to happen. The case workers know that if you keep moving children from home to home, it is going to cause damage, and yet they keep doing it. Look at our society as a whole. It would be better for them to have hearts and do things right. Constantly moving children damages them, it does not help them. Shame on them. You would think they would know better.
melanie jones, Caldwell, ID8 hours ago

I'm a close friend with a family who's lives have been directly effected by the messed up way that Idaho handles their foster children. This needs to change for the sake of the children without a voice of their own.

Andrea Levora, Sandpoint, ID8 hours ago

I have personally seen the rights and welfare of the child take a back seat to every other possible concern in the foster care system in Idaho.
Heather Davis, Eagle, ID8 hours ago

I had Grandchildren in the system and did not like how things were handled.
Laraine mika, Sandy, UT8 hours ago

I believe in the best interest of the children. Let's make a positive change for their future.
Leah Obenchain, Meridian, ID8 hours ago

The needs of the child needs to come before numbers for funding for the department
Ellie Ibarra, Weiser, ID8 hours ago

I am in favor of Foster Care Reform. I wish to see the bill come before the legislature during the 6 session.
Arlene McCauley, Eagle, ID8 hours ago

My adopted grandson has been damaged by all things mentioned in the petition. Diagnosed with Teams, PTSD, ADDHD, Attachment disorder. Not one more child should suffer.
Alice Holt, Kootenai, ID8 hours ago

I'm signing because children need stability, safety, and love. As a foster parent, I have seen how many rights birth families have while the kids seem to have very few. This needs to change!
Samantha Sundquist, Boise, ID8 hours ago

health and welfare will take foster kids out of homes for no good reason. that is the very short reason have a long story of what the scumbags did to us and the kids.
Rich Keyes, Horseshoe Bend, ID8 hours ago

This very much needs to change, as a family who was directly effected by this system of things, it's wrong to move an attached child after all they only know is your family for the first year of there life, or any long term placement of a child who has formed healthy attachment. it's wrong to not have any support from the very people who placed that child, these children need to have the right to have stability and to be able to have lasting relationships and bonds , foster parents need to be heard, who know that child more then the one who cares for them day in and day out, this is why we need to petition
Anna Ahrnsbrak, Athol, ID8 hours ago

I feel compassion for the rights of children in foster care and finding them a good home.
Jennifer Chadwell, Hayden, ID8 hours ago

It is necessary for changes. The Dept. does not recognize or acknowledge judicial order as to what is in the best interest of each unique child.
Nikki Kiesel, Marsing, ID8 hours ago

I support this. The "System" is so broken. They want you to treat foster children as if they were your own!!! But they don't want you to love them. I was a foster parent for 8 years and I adopted my son through the State 9 years ago, it was tough but we fought and WE WON!
Vicki Wagner, Twin Falls, ID8 hours ago

I support this. The "System" is so broken. They want you to treat foster children as if they were your own!!! But they don't want you to love them. I was a foster parent for 8 years and I adopted my son through the State 9 years ago, it was tough but we fought and WE WON!
Vicki Wagner, Twin Falls, ID8 hours ago

The reform needs to happen, the same thing happened to the children in our care for 3 years
Corinne Larsen, Nampa, ID8 hours ago

I care about the well-being of children.
Cynthia Garrick, Farmington, UT8 hours ago

The protect the lives of foster kids.
Anna Blackford, Ponderay, ID8 hours ago

I am a foster parent and know first hand about all of the practices the Department does to the kids and the foster parents. We desperately need checks and balances in place and accountability.
Jessie Jackson, Marsing, ID8 hours ago

I strongly support the proposed legislation to begin bringing reform to our foster care system in Idaho.
Sarah Wilson, Mountain Home, ID8 hours ago

I want to see change. Too many children are being hurt in the current system. The needs of the child need to come FIRST.
Luann Kirkham, Rathdrum, ID8 hours ago

I would like to be a foster parent, but am concerned by the way things are currently handled in the system. A change needs to happen to encourage more families like ours to participate in fostering kids.
Elizabeth Olacsi, Kuna, ID8 hours ago

I am signing this because I was a foster parent and there needs to be huge changes for the children that are in the foster-care system . The System is very broken .
Ginger Kreiter, Boise, ID8 hours ago

I believe these changes will better serve the children in the foster care system and the foster parents who love them and want what is best for these children.
Robyn Winget, Eagle, ID9 hours ago

I have seen the foster care system from all angles, I have adopted foster children, I was a child protection case worker and I now do adoption home studies for families who want to adopt. I adopted two children from foster care who had been moved over 5 times and they were 3 and 5. I am a social worker and was involved with the child protection system as a case worker. I am now doing adoption home study and have been appalled at some of the adoptive placement that have and have not been made by the department. They have way too much power. They choose families to adopt children, so in a real sense they are creating families. The only person who creates families is God. So the department has the power to create families. They have gone way over board their scope of practice.
Shannan Mayer, Rupert, ID9 hours ago

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JOINT
SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 18

02/12/16
Jessica Chilcott

February 13, 2016

Chairman Heider, Chairman Wood, Members of the Committee

I want to thank you for this opportunity to speak to you today. And to thank all of you who assisted in prompting the evaluation of the Idaho Behavioral Health Plan by the Office of Performance Evaluations and to commend the office for their work.

I would like to take this opportunity to provide an additional perspective on some of the statements.

It was noted that the Department of Health and Welfare was concerned about the rising costs of psychosocial rehabilitation (PSR) services and that "PSR was sometime inappropriately used to replace missing social services" (p.19). I am uncertain what social services that PSR would have been replacing. However, I can, with confidence, state that in the communities in which I practice additional services have not appeared. The roll out of the Idaho Behavioral Health Plan in 2013 promised the addition of peer and family support services. These services are still mostly nonexistent in Region 1.

It was noted that in the fee for service payment model the payment amounts "are determined by a fee schedule set by the state" At this juncture it is unclear how the reimbursement rates are determined. I will note that the rates are inadequate to cover the cost of doing business. The administrative burden created by the utilization management process has been financially devastating for some, particularly the small rural, agencies. Meanwhile, agencies are told that they need to "alter their business practices." It is not clear what this means however, the two simplest methods for reducing the financial impact would be for agencies to eliminate CBRS or to pay their direct service staff less. The elimination of CBRS is undesirable from an access perspective. I would hope that it would be unnecessary to explain why paying staff less is undesirable.

Beyond questions of whether or not PSR and CBRS are the same service (they are not). And whether or not case managers should be fairly compensated for their work (they should). I have larger concerns. **I am concerned because we have hundreds of Idahoans with mental illness who are not able to access the services that they need because their recovery goal is not in line with Optum's recovery goal for them, or because Optum does not recognize CBRS as a valid treatment for their diagnoses. Or their CBRS hours have been reduced but none of the "value added" services have appeared to assist. A full continuum of care should have been ready to implement before clients began losing the few services that they did have access to.**

I am further concerned by the fractured state of the Idaho Behavioral Health System. I am concerned because the providers have such an enormous level of distrust in Optum and the Department. This distrust has been built from intentional miscommunication from both the Department and Optum. It has been built from the apparent opacity when attempting to have questions answered. It also comes from what we have observed as the outcome in other jurisdictions where Optum administers the funds. This distrust has been built from seeing damage done to our clients, people we care about, as they are unable to access the help that they need.

Moving forward I would suggest that the Divisions of Medicaid and Behavioral Health communicate with each other and stakeholders prior to changes in services regarding a shared vision for what we as Idahoans want for our behavioral health system. It has become apparent in communicating with both the Division of Medicaid and the Division of Behavioral Health that they do not have the same goals. Managed care may have saved the State money but, I fear that we have not yet seen what those dollars will cost us.

I would also ask that a rate study be completed to examine the current fee structure for services. Provider reimbursement rates have been largely stagnant for the last 15 years. More to the point we saw several rates drop with the roll out of managed care. Current rates are not sufficient to cover the costs of doing business even from the most generous inflationary perspective. No amount of "altering business practices" is going to make the rent, utilities, and insurance cost less.

Suggestions for use of the $28 million dollars include: increasing the baseline authorization for CBRS from 3 months to 6 months. This would give providers enough time to try to develop a therapeutic alliance with the client while at the same time reducing the administrative costs to agencies because of the hours long process of completing the utilization management forms required to access CBRS. Restore case manager's ability to receive appropriate compensation for their work: including an appropriate rate for case management activities completed over the phone. Provide a mechanism for reimbursement for care coordination activities. Providers have long recognized the value of ongoing communication with a client's other providers including their doctor, school, and psychiatrist. This coordination of care is a corner stone of the medical home models gaining popularity in Idaho, provide a mechanism for providers to be paid for this time.

Thank you,

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Jessica.chilcott@gmail.com

P.S. Please take the opportunity to send SB 1204 or SB1205 to the floor with a "do pass"

02/12/16
Jamie Gibson

First, thank you for taking the time to learn a little about my son Michael and the difficulties that he faces every day. I could write literally hundreds of pages about him, but I do not wish to take more of your time than is necessary. To give you a little background on Michael, he just celebrated his 10th birthday last Sunday. He has always had difficulty in many areas, but is usually a fairly happy child. He is currently in the third grade at Edgemont Gardens Elementary in Idaho Falls. He attends school in a general education classroom and receives supports from the special education department in math, reading, and testing. He also receives speech therapy and occupational therapy in the school once per week.

In addition to the supports and therapies that he receives at school, he also receives private speech therapy and occupational therapy once per week and counseling sessions twice per week. As you can see, he is a busy boy.

In March 2014, we requested a referral for counseling from Michael's Healthy Connections provider. At the time he was showing aggressive tendencies and we wanted to address the problem before it became a larger issue. At the time we were unsure if the aggression was a result of mental health issues or a side effect of the seizure medication that he was taking. Our best guess is that it was a combination of both.

In April 2014 we met with David Spencer at Pearl Health Clinic in Ammon, ID. He did a CDA on Michael and made the recommendation for weekly Individual Therapy and CBRS. He also requested additional psych testing to make a more definitive diagnosis than PDD-NOS.

In May 2014, Michael began seeing David Spencer weekly for Individual Therapy. We also met with Matt Bishop from Pearl Health Clinic to begin the process of CBRS. Michael was approved for 3 hours a week of CBRS for 90 days with a singular diagnosis of PDD-NOS. Michael also received in depth psych testing.

In June 2014 we met with Dr. Daniel McGrath at Pearl Health Clinic to receive the results of the testing. Michael received a primary diagnosis of ASD and a secondary diagnosis of Borderline Intellectual Functioning.

In July 2014 we sent a reauthorization for CBRS beginning in August 2014. The service was approved, but Optum made the recommendation to transition to DD services. We did the research and determined that DD services would not be as beneficial as the services that he was currently receiving.

In October 2014 we sent a reauthorization for CBRS beginning in November 2014. The service was approved. Michael also began using Neurofeedback in place of the traditional Individual Therapy he had been receiving. It has proven beneficial in both treating some mental health issues and decreasing the frequency of Michael's seizures. This was done at the recommendation of his

counselor and with the approval of his Neurologist.

In January 2015 we sent a reauthorization for CBRS beginning in February 2015. The service was approved.

In April 2015 we sent a reauthorization request for CBRS beginning in May 2015. The service was denied. When Michael's case manager/ CBRS worker spoke with the agent at Optum that denied the request he was told that Autism is a cognitive impairment, not a mental health impairment and Optum would not pay with only an ASD diagnosis. When he provided proof that the treatment had been effective, he was told "They did not care." At the time we chose to withdraw the request and do more testing. We felt that there were more issues, but to that point they had just been included under the ASD umbrella.

In May 2015 we entered into a private pay contract with Pearl Health Clinic. Michael has built a trusting relationship with his current worker over the last year. We felt that removing the service would cause a definitive regression in the progress that we had seen. We agreed to pay $25 an hour for services. This contract has been in place since May 12, 2015. As a result the number of hours has been reduced due to financial constraints. Michael also received additional psych testing.

In June 2015, the psych testing had been completed and his diagnosis had changed. Michael's primary diagnosis was changed from ASD to OCD. He was also diagnosed with Anxiety Disorder, Major Depressive Disorder, and Attention Deficit/ Hyperactivity Disorder. We submitted a request for services on June 15, 2015 for services to begin June 22, 2015. The request was denied and we requested a review of the denial. Michael's case manager called it a peer to peer review. Optum called Pearl Health Clinic after hours on June 25, 2015 to state that the request was still denied and that a letter would be sent. The letter was dated June 30, 2015. I received the letter July 8, 2015. We submitted a request for a Fair Hearing by email on Friday July 10, 2015.

A Fair Hearing was held October 13, 2015. The hearing officer found that Optum's decision would be upheld because the information that was provided to them at the time of the initial determination would lead to denial of services. We obtained the services of an attorney that specializes in cases of people with disabilities, she is appealing the decision.

At her recommendation, we again submitted for services in November of 2015. In the authorization request, we were careful to make sure that we addressed all of the issues that had been brought up in the preliminary order from the Fair Hearing. The authorization was denied again. This would not have been an issue, except that the decision was made in less than 24 hours. When Michael's case manager spoke with Julie Dephue at Optum (the person that made the determination) her only answer was that the State Attorney General's office had already decided that he did not qualify. She did not even read the authorization to the best of our knowledge, but made a determination based on non medical reasons.

We have also chosen to appeal this decision and it is currently being handled by Michael's attorney. It has been combined with the previous appeal, and we are anticipating a determination soon.

I know that when it comes to deciding what treatments are correct for a child, the input of the parents is often discounted because they are not professionally trained to treat or diagnose mental health conditions. This is a terribly flawed approach because a parent is the person that knows their child better than any professional. A parent is the one that deals with the behaviors caused by mental health issues every day, they are the ones that receive calls from schools, they are the ones that can see the minor changes daily. Up to this point, other than the treating professionals that work with my son, no one has listened to my input. I, as a parent, have been denied the right to advocate for my child and paint the entire picture, instead, a clinician that has never met my child has made a decision based on a 13 page form. This form contains numerous boxes to check(many of which do not apply to the service we are requesting), places to quote best practice guidelines, and basic information such as age and address. Less than 25% of the form is specific to what the needs are and how they will be addressed.

There have been many recommendations made as to what my son needs, but all of these are coming from individuals that have never met or treated him. All the professionals that work with him are in agreement as to what has been effective. We know that CBRS services have been effective, because we as a team have worked with him and understand him at a level that cannot be achieved by reading a form or even medical records. We understand Michael, and because of that, the opinions of his treatment team should be placed above the opinions of any other clinician. This team is comprised of professionals from multiple disciplines, including education, Occupational Therapy, Speech Therapy, and mental health services, working together to reach the best overall outcome. There is not a single person on the team that has treated or worked with him for less than a year. This is important to understand, because he is a unique individual, with unique challenges and needs. A decision should be based on what will provide the best outcome for him as a person, not just in one specific area.

We have reached a point that he has lost most, if not all, of the progress that he made learning to cope with the symptoms of his mental health issues. The reason for this is obvious to anyone looking at the entire picture, that services were terminated before he was ready. At the time of his initial denial in June, our guess was that he would only need 6 months at the most to be ready to graduate. The fact is that the treatment for mental health is not something that we can put a clock on, it is something that each person will achieve in their own way and time.

We have been told time and again that he needs Developmental Disability (DD) Services. No one could tell us what services he needed from DD, just that DD was a better fit for him. I finally got an answer from someone at the Department of Health and Welfare on January 20, 2016. I was told that what he needed was Habilitative Intervention. I understand the HI is a life saver for many families that have children on the spectrum, I have even researched it myself. The truth is that the behaviors often associated with his autism are being adequately addressed through other means. The issues that we are dealing with are the mental health symptoms. He has obtained the functional skills that HI could provide for him. Due to a medical condition, some skills must be modified or observed, but he does possess them.

The clinician that contacted me on January 20, explained to me the difference between a symptom and a behavior, the way I understand it, a behavior is the result of a symptom. HI services are stated to treat behaviors. From the DD services handout found on the department website:

> *1. **Develop Functional, Adaptive Skills.** When goals to address skill development are identified on the plan of service, the intervention must provide for the acquisition of functional skills such as riding the bus, cooking, banking, dressing, keeping a schedule and community safety skills.*
>
> *2. **Diminish Maladaptive Behaviors.** When goals to address maladaptive behavior are identified on the plan, the intervention must include the development of replacement behavior/skills rather than merely the elimination or suppression of maladaptive behavior that interferes with the child's overall general development, community and social participation.*

That is not what he needs, he needs the skills to cope with the symptoms of his mental health issues, he was learning those skills in CBRS. If HI is used the way that it is stated, he will not gain those skills, he would just learn to use a more appropriate behavior. HI services will never address the root cause of the behaviors in the way that CBRS has been able to do.

Another important issue that has never been addressed, but should be when discussing my son's mental health is that he is fearful of new people and new routines. Is this something that we are working on? Of course it is, but it would do him a disservice to force him into both and pull the support that he is comfortable with at the same time. It took Michael a significant amount of time to build a relationship of trust with his former CBRS worker, and that is not always a relationship that Michael is capable of building. We have kept the relationship active through weekly Case Management Services, though not providing the same service as before, it allows Michael the ability to see that the routine and people have not changed, even if what they do has changed. It is one step in the path to the goal. The fact that this relationship has been built is important to Michael's mental health treatment, and not a relationship that is guaranteed with an new service provider.

HI is also a much more time consuming treatment, my understanding from an unscientific poll of people I know that use HI, it is on average 5 to 8 hours a week. There is also Habilitative Supports, a separate service that works in addition to HI. When this is added to the two session a week of counseling that he is required, the session of speech therapy, and the session of occupational therapy that he needs every week, he is never given the time to just be a kid. He spends all of his waking hours in school or therapy. Regardless of the fact that he has different needs, he still needs the time to be a kid and do that things that he enjoys doing. To take that rest and relaxation time from him would do as much damage as not providing him with services at all.

The final recommendation that has been made is that he seek medication to deal with his mental health issues. This is part of the reason that a full understanding of the whole individual is important. Michael has epilepsy. It is a simple statement that I feel is glanced over by all of the professionals making recommendations to treat his mental health. The fact that he has epilepsy with an unknown cause is a game changer. He currently takes large doses of two different medications to attempt to stop his seizures. This combination has been the most effective of any that we have tried, yet

he is still having seizures and the frequency, duration, and intensity of the seizures is escalating. He currently has a service dog in training because his seizures have become severe enough that he needs constant support and monitoring. Within the last two weeks, he has had two seizures that have caused him to stop breathing. He had one two days ago and vomited during the seizure. The reason that this is important is because both the medications that are used to treat his epilepsy and the medications that could be used to treat any of the mental health issues that he has affect brain chemistry, that is how they work. There is no way to know how a combination of medications will affect both his medical and mental health. When you look at possible interactions between his current anti-seizure medications and all possible mental health medications, there is not a single combination without moderate interactions, and many have severe interactions. That is a risk that I am not willing to take with my child, especially since it has been empirically proven that his mental health issues can be effectively treated without medication.

There is no choice when it comes to medication for his epilepsy, without the medication, he seizes so frequently that he is not able to function. There is no surgery that will fix the problem. We have learned that he is more likely to seize when his anxiety levels are too high. This is becoming an issue, and I fear for his physical safety if we are not able to get him the skills he needs, and was building until services were removed. When he is anxious, he gets nauseous, he gets dehydrated, all of these cause him to have more seizures. The more seizures that he has, the more anxiety he has, and it is a cycle that may one day be deadly. It may seem that I am over reacting, but this is a reality within my life and his. If for one second I thought that a treatment plan other than what we were requesting would be effective, I would jump on it.

Again, thank you for your time. I know that Michael is not the only child that is being forced to suffer because he is being denied access to the treatments that work for him. It affects not only him and his quality of life, but his family and their quality of life. It is a matter of more than just dollars and cents, the decisions that you are charged to make have real life consequences for Idaho families.

Jamie Gibson

February 11, 2016

02/12/16
Vanessa Johnson

February 12th 2016

RE: Health and Welfare Programs

Chairman Heider, Vice Chair Nuxoll, and Esteemed members of the health and welfare committee.

Good Morning and Thank you for giving me the opportunity to speak today.

My name is Vanessa Johnson, I graduated from Boise State University in 2006 and have worked in our community serving our citizens who have been diagnosed with a severe mental illness for the past 10 years, currently I am the director of community based services at Access Behavioral Health and I am a graduate student at Simmons College out of Boston.

Community Based Services for individuals with a mental illness has been served for years under a program called Psychosocial Rehabilitation (PSR) and when managed care became effective this service's name was changed to Community Based Rehabilitation Services (CBRS). This service has been drastically cut, I was here a couple weeks ago and listened to the OPE report of Optum Idaho and am glad it has finally been clarified that decreasing community based service costs was a top priority of Health and Welfare in implementing managed care. Optum has successfully decreased the costs of providing this service stating that it is ineffective and not evidence based practice. However, as this service has declined rates of hospitalizations, psychiatric holds, police interventions, and homelessness have risen. I am not sure if you would call that a cost savings.

I would like to take a step back and explain that Psychosocial rehabilitation is a model of service delivery, which provides an umbrella of interventions which can fall beneath the model. Many evidence based practice interventions fall under this umbrella, such as social skills training,

psychoeducation, and supported education. SAMHSA refers to PSR as an evidence based practice, as does multiple research studies across several countries. Boston uses a tailored model of PSR for their community based service delivery, this is a state which ranks amongst the highest in mental health system performance and service delivery.

Psychosocial rehabilitation is an evidence based model, however the restrictions that have been placed on this service model over the years, not just through our current managed care provider, have prevented the full utilization of this evidence based model of treatment. Psychosocial rehabilitation became the catch all service in Idaho because there was no other community based service to provide, now this service has been renamed to something that does not have any evidence base and denied to clients based on claims that the service is not evidence based and does not meet medical necessity. Medical necessity guidelines are not posted or available, however the adopted best practice guidelines from the American Psychiatric Association and the American Academy of Child & Adolescent Psychiatry have links posted for provider to use under the Guidelines/Policies/Manuals section.

On the American Psychiatric Association page it states:

"In accordance with national standards, including those of the Agency for Healthcare Research and Quality's National Guideline Clearinghouse, these guidelines can no longer be assumed to be current." http://psychiatryonline.org/guidelines

Outdated are all diagnosis listed except eating disorders and OCD.

On the American Academy of Child & Adolescent Psychiatry page it states:

"AACAP practice parameters are not intended to define the sole standard of care. As such, the parameters should not be deemed inclusive of all proper methods of care, nor exclusive of other

methods of care directed at obtaining the desired results."

http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx

" In accordance with national guidelines, AACAP practice parameters are considered to be current if published within the past five years. Parameters older than five years (asterisked in the list below) may not reflect current knowledge and practice and as such should not be considered current until they are updated."

http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx

Outdated infromation includes child diagnosis such as ADHD, Anxiety disorders, Bipolar disorder, Conduct disorder, ODD, Stimulant medications, substance use, suicidal behavior and many others.

The only other service that has been added as a community based service is Peer Support Services, a wonderful service, but only 25 people per region, per year are trained. Many of these individuals find themselves unable to work after the training, or do very well working for 10 to 20 hours per week. Two of the significant leaders in Boise for Peer Support services committed suicide last year and a system to fully support this service has not been implemented.

CBRS or PSR whichever you prefer to call it cannot be a catch all service, however neither can peer support services, or the counseling and medications regiment Optum requires in some unwritten mandate.

PSR and Peer Support services policies should be written and supported in a way that captures their evidence based models. The current system of restrictions on community based services is

having a detrimental effect on those who live with a mental illness and out community as a whole.

Attached to my written testimony you will find a list of articles and web sites that I have referenced.

Thank you,

Vanessa Johnson

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Vanessa@accessbhs.com

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https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/bpg.html

02/12/16
Matthew Montoya

Good morning, my name is Matthew Montoya. I have been a billing specialist for Access Behavioral Health Services for over three years. My first introduction to Medicaid billing came at a time when Molina Medicaid Solutions was still dealing with the difficult and drawn out transition that had begun in June of 2010. During this time, providers statewide were having problems getting reimbursed for Medicaid services; our agency was not immune to this problem, even though we had participated in the pilot program. One of the primary roles I undertook at that time was sifting through the pages of remittance advice statements that showed all our paid, denied, pended, and reversed claims. Considering the volume of claims our agency submits, these were pages of information that had to be manually combed through, looking for minor discrepancies in payment. Throughout the next couple years, we would encounter multiple ongoing claim issues that ended up costing a lot of administrative time to correct. Even though we have had ongoing issues, ranging from claims processing to implementing and complying with CMS guidelines, we had finally come to a comfortable relationship and understanding of what to expect between the state and the administering of claims by Molina. We still submit claims to Molina as all services were not part of the new managed care system. One problem we continually encounter with the Department of Health and Welfare is the lack or confusing billing guidelines for the various Medicaid programs that exist. This problem has only become greater with the addition of another vendor administering Medicaid claims. Now, faced with the decision by the Idaho State Legislature, to award the managed care contract to an out-of-state business, Optum/United Behavioral Health, we are again facing claim issues that are preventing reimbursement for mental health services. Since September, I have spent a considerable amount of time dealing with the specifics of Optum's billing guidelines, that they themselves have created for their commercial products, some of which was discussed during the provider trainings prior to the go live date, and some of which I have learned along the way and continue to learn as new issues arise.

Prior to the go live date, we submitted a provider roster to Optum on multiple occasions. However, even after receiving this information, they failed to include one of our nurse practitioners. This resulted in the denial and delay of this provider's claims for well over a month. Even though we continued to provide all necessary information to have this provider added to our practice, it still took a month for Optum to correctly load this provider into their system so that claims would not be denied. It took more than a month after that to sort out and reprocess all of these denied claims. This is just one example of no matter how much we tried to prepare for this transition, in educating ourselves, repeatedly making inquiries, and complying the best we could with their billing guidelines, something that could have been prevented was not, and the time it took for Optum to respond was borderline negligent. It has been routinely brought up that we should have adjusted our business model in preparation of this transition, but how do you prepare for something that is entirely out of your hands? Now that the grace period has come and gone, I am still getting denials on claims that we are trying to reprocess with dates of services going back to September. Yet, instead of reprocessing these claims, they are being denied yet again, for timely filing. Even though we had submitted these claims on time, it has taken us this long to identify all the claims that were originally incorrectly denied. Does it seem reasonable that claims during this grace period should be exempt from this 90 day timely filing rule? Furthermore, why has a 90 day timely filing rule been instituted when the national standard for timely filing is one year from the date of service?

Perhaps the biggest short coming for me as a biller, has been Optum's claims processing system, a system that has had many technical drawbacks and has been spread across a wide range of products under the Optum brand that makes up the system as a whole. I could not begin to describe the challenges a single claim has in even entering into the processing system specific to Idaho, since the product they use is based on a national system for the processing of not only Idaho's Medicaid claims, but their entire commercial and Medicare supplement claims nationwide. Optum's claims web portal, Provider Express, lacks many of the features providers have grown to rely on for timely adjudication and processing of claims, as well as accurate information, which doesn't seem to be reflected across all of Optum's different healthcare claim systems. There seems to be a huge disconnect between the system Optum has set-up for Idaho and these various other systems that operate under the Optum brand.

There have been multiple occasions where the information reporting on the electronic remittance advice statements does not match the information found on the provider portal. Additionally, information found on Provider Express does not match up with the remittance advice statements that they generate. It's yet another example of poor communication between Optum/United Behavioral Health's own systems that are in conflict with one another. Even talking to the customer service agents, they too have agreed that the information will vary from Provider Express to the information found on the remittance advice. I have yet to get an answer as to why these discrepancies exist. My frustration goes back to always being told, that Optum does not have any control over the handling or technical issues that take place with Provider Express. Instead I am referred to calling a different number specifically for this website, working with a service department that has no knowledge about how Idaho Medicaid claims should be handled.

Although I could attest to the many instances individual claims may be denied, pended, or otherwise held for payment, I would like to highlight some areas that are still of concern to us as a provider and to me in doing my job as a biller.

There are members that have incorrect eligibility information being reported, or not reported to Optum. In such cases, we can confirm with Health and Welfare that these members should be active. However, we have to call Optum's customer service department and ask them to submit an eligibility request to the State, which may take up to five business days for a response. In some cases, the information coming back does not report original effective dates. If a member should not be covered for a month while eligibility information is being verified, and an original effective date is not loaded correctly, then neither us nor Optum can pull up previous claim history on that member. Right now, I am waiting to hear back on one such member. All of the December claims have been denied. Although after submitting an eligibility request and now finding this member active, we cannot reprocess any of the December claims because these claims are nowhere to be found since the effective date is January 1st. We also cannot resubmit these claims on our own, as they would deny for duplicate services. I am still waiting on a response as to when this issue will be corrected.

Authorizations have been nothing short of a nightmare. I'm sure many here could speak about all the frustrations in even trying to obtain an authorization, but again, as a biller, when I see a denied claim because of no authorization, even though we have submitted a valid authorization with the claim,

it's nothing short of astonishing that a company this size with as many resources as they have, cannot even process a simple claim with its corresponding authorization. To Optum's credit, they know this is an issue and have helped in the reprocessing of a vast amount of claims that denied at the beginning of December. However, this is an ongoing issue that still has no resolution. Subsequently, our issues with the authorizations have only begun, as this is only the first round we have gone through in obtaining the majority of category 3 authorizations. We now have to deal with the fact that a majority of these authorizations are all set to expire around the same time. This has led to problems in authorizations for the same member, same service, overlapping with the dates these authorizations are valid. That means that there may be two valid authorizations for the same service. How do we then determine which authorization we should be billing with if both are showing as active and valid? We are not sure, but we are having claims denying when there are two valid authorizations on file.

Lastly, if this contract remains in place, I would hope that through these testimonies, that some effort will be made to improve the relationship between Optum and Idaho's providers. I would encourage Idaho's legislature, to make the following changes:

- Continue to make enhancements to the online web portal, to allow for better and concise access to eligibility, authorizations, claims, and payments.
- Build upon the relationship with Optum and providers to develop a billing model that works for everyone, which may include adopting rules that were in place with Molina and were outlined in IDAPA.
- Change the 90 day timely filing to a year from the date of service.
- Engage the providers in more in-depth trainings that could range on a variety of topics, but include best billing practices, not best business practices in favor of Optum.
- Streamline the authorization process, hire more staff to deal with reviews, and treat our staff that has been on hold for hours with the courtesy of professionalism.

Thank you for your time today in your careful consideration of improving a relationship that has been strained. We are putting our trust into you to make logical and reasonable decisions that truly affects the quality of care our patient's deserve.

02/12/16
Jennifer Zielinski

Joint Health and Welfare Committee
Jennifer Zielinski- 2/12/2016

My name is Jennifer Zielinski, the Program Coordinator with Idaho Parents Unlimited, Idaho's parent, training and information center as well as the family to family health information center. I come before you today representing parents of children with mental health disorders. I also represent myself as a parent of our adopted daughter, Chelsea, who came from Idaho's foster care system due to neglect and abuse. In the area of children's mental health, our 30 year old organization has never received the amount of crisis phone calls from parents searching for out of home placements for their children, like we have in past year. For the first time, we cannot report positive health outcomes for these families. We are reporting crisis, families are falling apart, their jobs are effected, their marriages impacted, there's an increase in school issues, and their other children are dealing with the stress and fear from all of the trauma. I have a stack of denial letters that Optum Idaho has sent out to parents who were seeking an average of just three hours a week for the only home and community based service Idaho offers, CBRS. The denials come back with recommendations of family therapy and medication management. ~~Most of these families who call our office are raising children are in need of treatment, which would include an array of intensive therapies and interventions.~~ Though we believe that family counseling, medication management, and individual counseling can be effective as part of an array of services, our state needs to address the need for real comprehensive treatment specific to the individual's needs, not based solely on diagnoses.

For the past eight years we have searched for treatment for Chelsea whose rage, aggressive behaviors, and social and emotional delays were increasingly getting worse. We have been through two investigations due to false accusations of neglect. Chelsea's current diagnoses are reactive attachment disorder, schizoaffective disorder, anxiety, ADHD, and social and emotional delays. One of the many times Chelsea was hospitalized at St. Alphonsus Behavioral Health center due to her ~~a~~ mental health ~~breakdown~~ they falsely accused me of harming Chelsea. That nine month investigation revolved around my going to counseling so that I could learn how to be a better parent to Chelsea. No treatment and no services appropriate to meet her individual needs. Our youngest daughter was born into a family where she watched her sister physically attack me on a daily bases. Our two older kids could no longer bring friends over for fear that they would witness Chelsea's rage. Our family was forced into isolated from our own family, friends, and community. The risks of trying to raise Chelsea without the appropriate services or treatment forced us to place her in a residential care facility. We for The nightmare didn't stop there. About six months after she had been there, we got a call from an investigator who told us that Chelsea's care givers were arrested for sexual abuse of minors. Chelsea has been victimized again! ~~She should have been able to receive treatment while living in our loving home where she was safe. Instead~~, I spent eight years being falsely accused, turned away, ignored, and left to navigate a mental health system that doesn't address the serious needs for children like Chelsea. To top it off, she is only ten years old!

JOINT
SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 19

02/12/16
Mariah Walton

Mariah Walton Testimony Feb. 11, 2016

I was born with a hole in my heart that could have been easily fixed right then But I was born at home to parents who didn't believe in using doctors, and throughout my childhood they ignored daily, obvious signs that something was seriously wrong.

I had a hard time breathing. I would turn blue and pass out frequently. I coughed non-stop. I had little energy and was sometimes foggy-headed.I begged and begged to be taken to a doctor but never was. The day I turned eighteen I went on my own, and it was a scary thing to see doctors with alarmed looks making phone calls to get me more serious help.

Help was hard to get, too, because I had no birth certificate, no Social Security, nothing – because my parents didn't believe in that either. Or in sending me to school. I've never been.

I ended up in Spokane, then Boise, then Salt Lake City where teams of cardiologists, pulmonologists - and more - ran tests and experimented with medicines to keep me alive – I was that close. In Boise, there was a period where I was on full life support for eleven days and the family was called to come to say goodbye to me. I was airlifted to Salt Lake where it was touch and go for a month after that.

Today, life is pretty hard. I'm on full time oxygen and a medication line into my chest that is painful. I have little energy and I can never be alone – never – and one of my sisters, Eliza, is my fulltime caregiver. If the doctors can get me to grow stronger, I'll be eligible for a heart-lung transplant, which I will need to survive.

As you can imagine I am angry and upset at how I was neglected. I wouldn't want anyone to have to go through what I am enduring. I feel it is not okay for people to be allowed to ignore modern science that saves lives. I had no vote and no power over my parents and they were legally allowed to let me get to this point.

It's just wrong. You only need to look at me to see that. Thank you for listening.

JOINT
SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 20

Region I Behavioral Health Board
Fact Sheet on Marijuana Legalization

Myth: Marijuana is safe
Fact: Tetrahydrocannabinol or THC, the psychoactive ingredient in pot, increases heart rate and risk of heart attack and interferes with attention, motivation, memory, and learning. Smoking pot can lead to lung problems and suppresses the immune system. [1] [2]
THC appears to cause increased cravings for other drugs such as opiates. This effect may be passed epigenetically on to offspring even if the parent is not using at the time of conception. It is addictive. It causes an irreversible IQ drop of up to 8 points in youth who use it regularly. Addiction in youth is highest in states with "medical marijuana" programs and youth exposed to medical marijuana ads are twice as likely to use or intend to use the drug according to a California survey of 6th through 8th graders. [3] [4] [5] [6] [7] [8] [9]
THC may cause psychosis or precipitate schizophrenia in vulnerable people. It alters brain development, impairs neural connectivity and can cause depression, anxiety, agitation, hallucinations and paranoia.
Marijuana in the 60's was between 3-9% THC, but today's is between 8-16% THC. The process of "dabbing", creating a resin from the plant containing upwards of 90% THC has caused explosions and fires when people try to make it their homes using butane. Poisonings and exposures to children through candy-like edibles and other marijuana infused products increase over 600% in states that have legalized marijuana. ¾ of the victims were under 3 years old. [10]

Myth: Marijuana helps you relax and perform better
Fact: Studies have repeatedly shown marijuana diminishes productivity and performance, lowers GPAs of student users [11]and increased DUIs in states where it is legal. It is the most prevalent illegal drug in impaired drivers, fatally injured drivers and crash victims[12]

Myth: Medical marijuana is safer because the THC is removed
Fact: So-called CBD products tested in other marijuana-legal states revealed some contained as little as .1% CBD and as much as 18% THC. Some products claiming to be low in THC have 5% THC. 5% THC is high. Cannabidiol or CBD is being studied to help epilepsy and other disorders, but THC induces seizures and does not have any known health benefits.[13] [14]

Myth: Marijuana smoke is safer than cigarette smoke
Fact: Marijuana smoke contains the same tars and carcinogens as cigarette smoke but pot smokers inhale and hold the smoke which increases their exposure. For immunocompromised people there is additional risk of exposure to aspergillus, a mold contaminant in marijuana plants.[15] [16] [17] [18] [19] [20]

Myth: If we legalize marijuana and tax it, it will pay for itself
Fact: The cost of substance abuse in the US, including loss of productivity, health and crime-related costs is over $600 billion/year including $235 billion for alcohol, $193 billion for tobacco and $181 billion for illicit drugs of which marijuana is the most prevalent. Taxes for alcohol and tobacco only cover a small percentage of the cost they impose on society. We will not recover our societal costs by taxing marijuana. [21] Based on other states' experiences we can expect increases of 200-400% in drug addiction and mental health treatment costs,[22] [23] [24] [25]law enforcement costs due to impaired driving, motor vehicle accidents, increased crime rates,[26] [27] and other societal costs related to inability to self support such as joblessness and homelessness.

[1] National Institute on Drug Abuse. www.drugabuse.gov
[2] The Marijuana Report.Org
[3] Reference: Adverse Health Effects of Marijuana Use, by Nora D. Volkow, M.D., Ruben D. Baler, Ph.D., Wilson M. Compton, M.D., and Susan R.B. Weiss, Ph.D., published online June 4, 2014 in The New England Journal of Medicine
[4] Szutorisz, H.; DiNieri, J.A.; Sweet, E. et al. Parental THC exposure leads to compulsive heroin-seeking and altered striatal synaptic plasticity in the subsequent generation. *Neuropsychopharmacology*. 39(6):1315-1323, 2014.
[5] Cerda, M. et al. (2011). Medical marijuana laws in 50 states: investigating the relationship between state legalization of medical marijuana and marijuana use, abuse and dependence. *Drug and Alcohol Dependence*. Found at http://www.columbia.edu/~dsh2/pdf/MedicalMarijuana.pdf; and Wall, M. et al (2011).
[6] Adolescent Marijuana Use from 2002 to 2008: Higher in States with Medical Marijuana Laws, Cause Still Unclear, *Annals of epidemiology, Vol* 21 issue 9 Pages 714-716.
[7]Substance Abuse and Mental Health Services Administration (SAMHSA), State Estimates from the 2008- 2009 National Surveys on Drug Use and Health
[8] Wagner, F.A. & Anthony, J.C. (2002). From first drug use to drug dependence; developmental periods of risk for dependence upon marijuana, cocaine, and alcohol. *Neuropsychopharmacology, 26*, 479-488.
[9] The National Center on Addiction and Substance Abuse (CASA) at Columbia University. CASA white paper, *Non-Medical Marijuana II: Rite Of Passage Or Russian Roulette?* 2008.
[10] Letter from Amy Brooks-Kayal, MD President, American Epilepsy Society, Chief and Ponzio Family Chair, Children's Hospital Colorado, Professor of Pediatrics and Neurology, University of Colorado School of Medicine, to Representative Matthew Baker, Chair, Pennsylvania House of Representatives Health Committee.
http://www.legis.state.pa.us/cfdocs/legis/TR/transcripts/2015_0040_0001_TSTMNY.pdf Accessed May 16, 2015.
[11] *Substance Abuse and Mental Health Services Administration's (SAMHSA), 2010 National Survey on Drug Use and Health (NSDUH).*
[12] National Highway Traffic Safety Administration, 2010.
Office of Traffic Safety, California, 2010. Press Release: **"Drug Use Rises in California Fatal Crashes".**
[13] Bill Briggs. "Colorado Marijuana Study Finds Legal Weed Contains Potent THC Levels." NBC News, March 23, 20-15.
http://www.nbcnews.com/storyline/legal-pot/legal-weed-surprisingly-strong-dirty-tests-find-n327811
[14] White House Office of National Drug Control Policy, Marijauna Facts, page 2.
https://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/marijuana_fact_sheet_jw_10-5-10.pdf.
[15] National Institute on Drug Abuse. DrugFacts: Marijuana
[16] Volkow ND, Baler RD, Compton WM, Weiss SRB. Adverse health effects of marijuana use. N Engl J Med. 2014;370(23):2219-2227
[17] Hoffmann D, Brunnemann KD, Gori GB, Wynder EL. On the Carcinogenicity of Marijuana Smoke. In: Runeckles VC, ed. Recent Advances in Phytochemistry. Springer US; 1975:63-81.
[18] Wu T-C, Tashkin DP, Djahed B, Rose JE. Pulmonary hazards of smoking marijuana as compared with tobacco. N Engl J Med. 1988;318(6):347-351.
[19]Howden ML, Naughton MT. Pulmonary effects of marijuana inhalation. Expert Rev Respir Med. 2011;5(1):87-92.
[20] Polen MR, Sidney S, Tekawa IS, Sadler M, Friedman GD. Health Care Use by Frequent Marijuana Smokers Who Do Not Smoke Tobacco. West J Med. 1993;158(6):596-601.
[21] ***Office of National Drug Control Policy, 1992 – 2002 Report, The Economic Costs of Drug Abuse in the United States. Available at:*** *https://www.ncjrs.gov/ondcppubs/publications/pdf/economic_costs.pdf*
[22] SAMHSA,□"2010□Annual□Survey□on□Drug□Use□and□Health",□October□2011□
[23]SAMHSA,□"National□Household□Survey□on□Drug□Use□and□Health"□State□Estimates□on□Substance□Use,□2006□07□ Washington□State□Healthy□Youth□Survey,□2010□
[24]*Annals□of□Epidemiology,□*"Adolescent□Marijuana□Use□from□2002□to□2008;□Higher□in□States□with□Medical□Marijuana□Laws",□2011□
[25] Washington□State□Treatment□Assessment□Report□Generation□Tool□(*TARGET*),□November□2011□
[26] Office of Nation Drug Control Policy (ONDCP) report May 2013. Marijuana is most common drug found in systems of individuals arrested for criminal activity.
[27] Colorado DOT data: Fatalities involving drivers testing positive for marijuana increase 114% between 2006-2007

Other sources:

- **American Society of Addiction Medicine: http://www.asam.org/docs/default-source/publicy-policy-statements/marijuana-cannabinoids-and-legalization-9-21-2015.pdf?sfvrsn=0 This is a very recent and well-done position statement**
- **American Lung Association**
- **Northwest High Intensity Drug Trafficking Areas: www.mfiles.org**
- **Drug Free Action Alliance: www.DrugFreeActionAlliance.org**
- **Community Anti-Drug Coalitions of America**
- **National Families in Action (Excellent background paper prepared for Georgia legislature which asks good questions for legislatures to consider in terms of enforcement and hidden costs of legalization): www.nationalfamilies.org**

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, February 15, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
RS24507	Relating to Supplemental Nutrition Assistance Program Fraud Prevention	**Teresa Molitor**
RS24513	Relating to Residential Care Facilities Citations	**Senator Martin**
S 1250	RELATING TO NURSES: Amending Idaho Code to enact the advanced practice registered nurse compact	**Sandra Evans** Idaho State Board of Nursing
S 1251	RELATING TO NURSES: Amending Idaho Code to enact the nurse licensure compact	**Sandra Evans**
S 1252	RELATING TO NURSES: Amending Idaho Code to revise the definition of "practice of nursing"	**Sandra Evans**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Monday, February 15, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:02 p.m.

RS 24507 **Relating to Supplemental Nutrition Assistance Program (SNAP) Fraud Prevention**. **Teresa Molitor**, a Boise-based lobbyist representing the Foundation for Government Accountability, presented this RS.

Ms. Molitor stated that the proposed RS: (i) creates an optional program to affix photos to electronic benefit transfer (EBT) cards, (ii) requires the Department of Health and Welfare (Department) to cross-check SNAP benefit recipients with lottery winners; and provides a procedure for the Department to interview and investigate SNAP recipients who frequently request replacement EBT cards. **Ms. Molitor** stated that the total fiscal impact of this RS would be approximately $200,000 to $400,000.

Chairman Heider asked the Committee members if they had any questions.

Senator Schmidt asked if Ms. Molitor had cost estimates for the Department to conduct lottery cross-checks and EBT replacement card investigations. **Ms. Molitor** responded that Department staffing costs were not included in the fiscal note. The fiscal note only includes the costs of implementing the photo program for EBT cards. She indicated that additional costs to the Department would be minimal.

Senator Martin asked who could use a recipient's EBT card. **Ms. Molitor** said it is her understanding that cards may be transferred among family members. **Senator Martin** asked about the process of affixing photos to the EBT cards. **Ms. Molitor** stated that the process was not addressed in this bill; it could be addressed in rule. **Chairman Heider** asked why cards haven't had pictures in the past. **Ms. Molitor** noted that the federal government prohibits mandatory photo programs, and this is the first optional photo program to be considered in Idaho.

Questioning whether there was enough of a need for photos on the cards to justify spending between $200,000 and $400,000, **Senator Jordan** asked why this request came from the Foundation for Government Accountability and not from the Department. **Ms. Molitor** responded that she was hesitant to speak for the Department. Regarding enforcement, **Senator Jordan** asked, if the pictures are put on the cards, would there be a way to require that they be checked. **Ms. Molitor** replied it would probably be up to the retailers. **Senator Lodge** commented that she has discovered that there really isn't any benefit to having photos on the cards; there's an enormous cost to do it and anyone can still use the card. As for replacement cards, Idaho has a very low rate of replacement cards compared to some other states. Also, Idaho has a very stringent monitoring system in place to identify and refer the fraudulent activities. **Senator Lodge** concluded that, at this time, she couldn't support this RS.

MOTION: There being no more questions, **Senator Hagedorn** moved to send **RS 24507** to print. **Senator Harris** seconded the motion.

Chairman Heider asked if there was further discussion. **Senator Jordan** said this is the first time she is questioning whether to send something to print. She said she thought sending an RS to print would be a good way to advance the conversation on the topic, but that she found this RS very troubling and without a lot of data to back it up, so she would not be able to support the motion.

ROLL CALL VOTE: **Chairman Heider** called for a roll call vote. **Vice Chairman Nuxoll**, **Senator Hagedorn** and **Senator Harris** voted **aye**. **Senator Lodge**, **Senator Martin**, **Senator Schmidt**, **Senator Jordan** and **Chairman Heider** voted **nay**. **Senator Lee** was not present for the vote. The motion failed.

RS 24513 **Relating to Residential Care Facilities Citations**. **Senator Martin** presented this RS.

Senator Martin stated that the purpose of this RS is to provide clarity and to assure that residential and assisted-living facilities are only cited for violations that are specified in an applicable law or rule.

MOTION: There being no questions, **Senator Hagedorn** moved to send **RS 24513** to print. **Vice Chairman Nuxoll** seconded the motion. The motion passed by **voice vote**.

S 1250 **Relating to the Advanced Practice Registered Nurse Compact**. **Sandra Evans**, Executive Director Idaho Board of Nursing, presented this bill.

Ms. Evans stated that this bill adopts the Advanced Practice Registered Nurse (APRN) Compact, an interstate compact providing for multistate APRN licensure, which facilitates cross-border practice (APRN Compact). An APRN is a registered nurse (RN) with graduate or post-graduate education in nursing, who is prepared with advanced knowledge and skills to practice in the roles of certified nurse midwife, clinical nurse specialist, nurse practitioner or registered nurse anesthetist. Discussing the model of mutual recognition, **Ms. Evans** stated that Idaho previously adopted the Nurse Licensure Compact for RNs and licensed practical nurses (LPNs); this compact has proven to be an effective way of reducing unnecessary regulatory barriers to health care delivery. APRNs are not included in the Nurse Licensure Compact. **Ms. Evans** stated that the APRN Compact would allow an APRN to have one multistate license that permits practice in other APRN Compact member states. She noted, however, that each member state would retain regulatory autonomy through its standards of conduct for practice within its borders. The APRN Compact supports patient safety by creating and maintaining a comprehensive national database to facilitate information sharing between states, including information about licensure, investigations, discipline and alternatives to discipline. She discussed the features of the database.

Ms. Evans reviewed the 11 articles of the APRN Compact, including (i) the purpose, (ii) the definitions, (iii) the uniform provisions, (iv) applications for licensure, (v) the authorities invested in licensing boards, (vi) the licensure information system, (vii) the establishment of interstate commission, (viii) rulemaking, (ix) oversight, dispute resolution and enforcement, (x) the effective date, withdrawal and amendment and (xi) construction and severability.

Ms. Evans stated that the APRN Compact provides an effective nationwide solution to interstate APRN practice in response to concerns raised by Congress related to regulatory barriers that interfere with the practice of telehealth. **Ms. Evans** stated this APRN Compact will have minimal fiscal impact on the dedicated fund maintained by the Board of Nursing.

Chairman Heider asked the Committee members if they had any questions.

Senator Harris asked if it would be difficult for a nurse from a state not in the APRN Compact to be hired in a state within the APRN Compact. **Ms. Evans** indicated the unlikeliness of that scenario. **Ms. Evans** added that it is possible that an organization with more than one corporate campus might prefer nurses coming from APRN Compact states, if that's where the corporate campuses are located.

Senator Hagedorn asked where disputes with the interstate compact commission (Commission) would be adjudicated. **Ms. Evans** said the logical venue for the Commission would be in Chicago, which is the home base for the National Council of State Boards of Nursing. She referred the question to the Idaho Board of Nursing's attorney, Roger Gabel. Referring to article IX of the APRN Compact, **Mr. Gabel**, an attorney with the Attorney General's office, stated that there would first be an attempt to resolve the issue through the Commission. If these discussions did not resolve the issue, the parties would pursue arbitration. Then, if the issue was not resolved through arbitration, and as a final resort, a party may initiate legal action in the U.S. District Court of the District of Columbia.

Noting that the Commission is authorized to collect annual assessments from member states, **Senator Hagedorn** asked if there was a limitation on that assessment and inquired how it would be controlled. **Ms. Evans** said the Commission is made up of the administrator of the Board of Nursing from each member state, and she indicated that protections are inherent in the membership of the Commission.

Noting that nurses registered in member states would be automatically recognized and authorized to practice in Idaho, **Senator Schmidt** asked if there is much difference among the states' licensure requirements and processes. **Ms. Evans** said states are more alike than they are different. However, there are some nuances for licensure, such as continuing education requirements or some very specific educational preparation requirements.

MOTION: There being no more questions, **Senator Martin** moved to send **S 1250** to the floor with a **do pass** recommendation. **Senator Harris** seconded the motion. The motion carried by **voice vote**. Senator Hagedorn will carry the bill on the floor of the Senate.

S 1251 **Relating to the Nurse Licensure Compact**. **Sandra Evans**, Executive Director Idaho Board of Nursing, presented this bill.

Ms. Evans stated that the purpose of this bill is to adopt the enhanced Nurse Licensure Compact (Nurse Compact) to replace the current compact. She said the enhanced compact is an amended version of the existing compact, of which Idaho has been a member of since 2001. **Ms. Evans** stated that an interstate compact is a statutory agreement between two or more states intended to remedy a particular problem of multistate concern; the concern for the existing compact was the emerging practice of telehealth. **Ms. Evans** stated that the Nurse Compact creates a regulatory process that permits nurses to practice freely among participating states on the license issued by their primary state of residence without the need to hold additional licenses in those other states.

Ms. Evans discussed the successes of the current Nurse Compact, but noted that membership had stalled at 25 states. Enhancements were made to the current compact to encourage adoption by more states and thereby increase access to quality nursing care nationwide. **Ms. Evans** reviewed eight significant policy changes included in the enhancements of the Nurse Compact: (i) incorporation of uniform licensure requirements, including grandfathering nurses who hold a multi-state license at the time of transition to the enhanced compact, (ii) authority for states to obtain and submit fingerprints for national criminal background checks, (iii) requirements for prompt reporting of investigative or disciplinary actions, (iv) establishment of the interstate commission, (v) clarification of the rulemaking processes based on provisions of the Model Administrative Procedures Act, (vi) improved oversight and enforcement of the compact, (vii) revised threshold for effectiveness and (viii) provisions for withdrawal from the existing compact. Reviewing the benefits of the existing compact, Ms. Evans stated that adoption of this bill would have no negative impact on these existing benefits.

Ms. Evans stated that this enhanced Nurse Compact will have minimal fiscal impact on the dedicated fund of the Board of Nursing.

Chairman Heider asked the Committee members if they had any questions.

Senator Hagedorn asked why the new Nurse Compact would be better. **Ms. Evans** responded that key elements were identified that needed to be implemented in order to make this Nurse Compact more attractive to states that previously would not or could not join the current one.

Senator Schmidt said his understanding of the value of the Nurse Compact for Idaho was that it may encourage nurses to practice in Idaho. He asked if this was the outcome of the current compact and inquired why some states did not want to join the current one. **Ms. Evans** said some states were not interested in joining the current compact and other states tried to join but were unsuccessful in getting legislation passed in their states. Much of the opposition came from collective bargaining units in those states that were fearful the current compact would enhance strikebreaking. **Ms. Evans** stated that the enhanced Nurse Compact is more attractive because the uniform requirements are set forth in statute instead of in administrative rules that may be modified more easily. As for whether or not Idaho has experienced a greater workforce as a result of the compact, **Ms. Evans** stated that the number of practitioners has grown, but she could not say that the current compact was the reason for that growth.

MOTION: There being no more questions, **Senator Martin** moved to send **S 1251** to the floor with a **do pass** recommendation. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**. Senator Martin will carry the bill on the floor of the Senate.

S 1252: **Chairman Heider** said that due to time constraints, the Committee would hear **S 1252** on a future date.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:56 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Kara Machado
Assistant

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, February 16, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
H 0335	RELATING TO CONTROLLED SUBSTANCES: Amending Idaho Code to revise the list of schedule II uniform controlled substances	**Alex Adams** Idaho State Board of Pharmacy
H 0336	RELATING TO THE BOARD OF PHARMACY: Amending Idaho Code to remover officer term limits and increase board member compensation	**Alex Adams**
H 0337	RELATING TO PRESCRIPTIONS: Amending Idaho Code to provide that medical examiners or coroners may have access to information in the prescriptions database under certain circumstances	**Alex Adams**
H 0338	RELATING TO LEGEND DRUGS: Amending Idaho Code to clarify which persons may possess legend drugs	**Alex Adams**
H 0339	RELATING TO CONTROLLED SUBSTANCES: Amending Idaho Code to clarify that controlled substances shall be stored in accordance with applicable law and rule	**Alex Adams**
H 0340	RELATING TO CONTRACEPTIVES AND PROPHYLACTICS: Repealing certain Idaho Code provisions regarding regulation of contraceptives and prophylactics	**Alex Adams**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

Sen Martin

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, February 16, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Hagedorn, Martin, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	Senators Lodge and Lee
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
INTRODUCTION:	**Alex Adams**, Executive Director of the Idaho State Board of Pharmacy (Board) informed the Committee that he will be presenting six bills for their consideration. He noted that all six bills presented in this meeting were deliberated in a public meeting in October 2015 and were posted on the Board's website 21 days in advance.
H 0335	**Relating to Controlled Substances**. **Alex Adams**, Executive Director of the Board, presented this bill. **Mr. Adams** stated that this bill reflects the Board's statutory requirement to regularly update the State's controlled substance list as the Drug Enforcement Administration (DEA) makes changes to the federal controlled substances list. The DEA recently removed ioflupane from the federal controlled substances list. Ioflupane is a radiopharmaceutical used by nuclear medicine physicians to diagnose Parkinson's disease. This bill mirrors the DEA's action on ioflupane. **Chairman Heider** asked the Committee members if they had any questions. **Senator Martin** asked what ioflupane is. **Mr. Adams** answered that it is a radiopharmaceutical to assist in diagnosing Parkinson's disease.
MOTION:	There being no more questions, **Senator Schmidt** moved to send **H 0335** to the floor with a **do pass** recommendation. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**. Senator Martin will carry the bill on the floor of the Senate.
H 0336	**Relating to the Board of Pharmacy**. **Mr. Adams**, Executive Director of the Board, presented this bill. **Mr. Adams** stated that this bill addresses the term limits of Board officers. He explained the difference between Board members and Board officers. Board members serve five-year terms and can be reappointed to one consecutive term. Board officers are the chairman and vice chairman. The statute currently limits these officers to a one-year consecutive term. **Mr. Adams** noted that a survey of other boards within the State revealed that the Board is one of two boards with term limits for officers. This bill would remove the statutory term limits for Board officers.

Additionally, **Mr. Adams** indicated that this bill clarifies Board member compensation. Idaho Code § 59-509 sets the honorarium for Board members. This bill will increase Board member compensation from $50 to $100 a day. He indicated that the compensation has not changed since 1982. Another reason for the change is that some of the Board members are small business owners who have to close their business for a day when attending to Board duties. This bill has a fiscal note of $6,700, which would be drawn from the pharmacy regulatory fund. **Mr. Adams** noted that the fiscal note covers the honorarium and Federal Insurance Contributions Act (FICA) taxes for Board members.

Chairman Heider asked the Committee members if they had any questions.

Chairman Heider asked if Board members receive a per diem in addition to the $100 per day honorarium. **Mr. Adams** responded that Board members do receive an additional per diem, as well as travel compensation if they travel from out of town.

MOTION: There being no more questions, **Senator Harris** moved to send **H 0336** to the floor with a **do pass** recommendation. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**. Senator Schmidt will carry the bill on the floor of the Senate.

H 0337 **Relating to Prescriptions**. **Mr. Adams**, Executive Director of the Board, presented this bill.

Mr. Adams stated this bill allows coroners and medical examiners to access the State prescription monitoring program for the purpose of determining causes of death.

Chairman Heider asked the Committee members if they had any questions.

Vice Chairman Nuxoll asked why coroners and medical examiners are added to the list of those able to access the database. **Mr. Adams** replied the Idaho Coroner Association requested access to the database. He mentioned that he sees public health merits in allowing access to help determine causes of death. He noted that he does not know why these individuals were not originally included.

Senator Schmidt asked if this bill would require medical examiners or coroners to enroll in the State prescription monitoring program. **Mr. Adams** answered that statute only requires mandatory enrollment for prescribers, except veterinarians. Therefore, enrollment would be optional for coroners and medical examiners. **Senator Schmidt** asked how medical examiners and coroners would get access to the database if they were not enrolled. **Mr. Adams** responded that there are various levels at which individuals can access the prescription monitoring data. Medical examiners and coroners would register for an account and search for a patient, but, just like law enforcement personnel, these individuals would have to request the Board manually release the personal record. Only prescribers and pharmacists have real-time online access to the database. **Senator Schmidt** inquired about Health Insurance Portability and Accountability Act (HIPAA) compliance. **Mr. Adams** replied that he believed requests from coroners and medical examiners were exempted from HIPAA because the patient is deceased. Explaining his concerns regarding HIPAA compliance, **Senator Schmidt** suggested that a query in the database might return multiple people with the same name, some of which may not be deceased. However, he stated his concern was alleviated because the Board has to approve each specific request.

MOTION: There being no more questions, **Senator Schmidt** moved to send **H 0337** to the floor with a **do pass** recommendation. **Senator Harris** seconded the motion. The motion carried by **voice vote**. Senator Schmidt will carry the bill on the floor of the Senate.

H 0338 **Relating to Legend Drugs**. **Mr. Adams**, Executive Director of the Board, presented this bill.

Mr. Adams stated that this bill will clarify who can possess legend drugs in their usual course of business. He reported that it had come to the Board's attention that midwives had been inadvertently left off the list. Midwives can dispense prescription medication, but they are not technically prescribers and were thus not covered under the statute. This bill adds midwives to the list of individuals who may possess legend drugs. Additionally, **Mr. Adams** stated that this bill also includes home health agencies and hospice agencies, who are allowed to possess legend drugs if they are using emergency kits. These kits include such medications as epinephrine pens. **Mr. Adams** clarified that this bill does not confer any new authority prescriptive or otherwise.

Chairman Heider asked the Committee members if they had any questions.

Senator Schmidt asked if Emergency Medical Service (EMS) personnel should be included. **Mr. Adams** responded that EMS usually work under a physician or hospital and thus the Board felt that these individuals were already covered under the statute.

MOTION: There being no more questions, **Senator Hagedorn** moved to send **H 0338** to the floor with a **do pass** recommendation. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**. Vice Chairman Nuxoll will carry the bill on the floor of the Senate.

H 0339 **Relating to Controlled Substances Storage**. **Mr. Adams**, Executive Director of the Board, presented this bill.

Mr. Adams stated that this bill adds drug storage requirements to statute. Federal law requires pharmacies have to keep controlled substances in a substantially constructed cabinet or safe. This bill states the expectation of the Board that pharmacies store controlled substances in accordance with federal law.

Chairman Heider asked the Committee members if they had any questions.

Senator Harris asked what constitutes a substantially constructed cabinet. **Mr. Adams** answered that this is not currently defined by the DEA or the Board. He stated that compliance officers have been tasked with taking photos of these cabinets during their inspections that do not meet the expectations. He noted that the Board intends to bring legislation next year to clarify this definition.

MOTION: There being no more questions, **Senator Harris** moved to send **H 0339** to the floor with a **do pass** recommendation. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**. Senator Harris will carry the bill on the floor of the Senate.

H 0340 **Relating to Contraceptives and Prophylactics**. **Mr. Adams**, Executive Director of the Board, presented this bill.

Mr. Adams stated that this bill repeals Chapter 8, Title 39 of the Idaho Code, which related only to the sale of non-prescription contraceptives and prophylactics. The original 1939 bill required those who sold these items to register with law enforcement. In 1949, the registration was moved under the purview of the Board. In 1982, a U.S. Supreme Court ruling struck down most of the provisions in related law in New York state. **Mr. Adams** reported that the Board has not enforced this section in at least two decades.

MOTION: There being no questions, **Senator Hagedorn** moved to send **H 0340** to the floor with a **do pass** recommendation. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**. Chairman Heider will carry the bill on the floor of the Senate.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:25 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Michael Jeppson
Assistant

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, February 17, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
S 1294	RELATING TO THE PRACTICE OF PHARMACY: Amending Idaho Code to provide that pharmacists may prescribe immunizations for persons who are six years of age or older	**Pam Eaton** Idaho State Pharmacy Association
S 1268	RELATING TO THE COUNCIL ON DEVELOPMENTAL DISABILITIES: Amending Idaho Code to revise provisions regarding council membership	**Christine Pisani** Idaho Council on Developmental Disabilities
H 0373	RELATING TO LEGEND DRUGS: Amending Idaho Code (i) to define terms and (ii) to provide that qualifying charitable clinics, regional behavioral health centers or state charitable institutions may accept donations of certain medications and dispense those medications under certain circumstances	**Ross Edmunds** Department of Health and Welfare

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 17, 2016

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Martin, Lee, Harris, Schmidt and Jordan

ABSENT/ EXCUSED: Senators Hagedorn

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:09 p.m.

S 1294 **Relating to the Practice of Pharmacy**. **Pam Eaton**, Executive Director of the Idaho State Pharmacy Association, presented this bill.

Ms. Eaton stated that this bill amends Idaho Code to provide that pharmacists may prescribe and administer immunizations for individuals who are six years of age or older; current statute authorizes pharmacists to prescribe and administer immunizations for individuals who are 12 years of age or older. **Ms. Eaton** emphasized that this bill: (i) does not take away a parent's choice as to whether or not they immunize their child, (ii) does not take away an individual's choice of who administers an immunization, (iii) does not require pharmacies or pharmacists to provide and administer immunizations, and (iv) does not require pharmacies or pharmacists to lower the age to six years.

Ms. Eaton stated that Idaho has one of the five lowest vaccination rates among states in the U.S. She noted this low rate is partly due to parental choice. **Ms. Eaton** also indicated that Idaho has a low rate for children's influenza (flu) shots; children are part of the "high risk" population for contracting the flu. The main goal of this bill is to provide easier access for parents to obtain flu shots for their children, if they wish to do so. **Ms. Eaton** noted that the change is convenient, cost effective and increases access. She stated that 41 states allow pharmacists to administer vaccines to children under 12 years of age. Of these 41 states, 30 states allow pharmacists to administer vaccines to children under six years of age, and 26 of which set no age restrictions regarding pharmacists vaccinations.

Ms. Eaton then addressed questions and concerns that have been raised regarding this bill. First, **Ms. Eaton** indicated that individuals have voiced concern that pharmacists are not reporting into Idaho's Immunization Reminder Information System (IRIS). **Ms. Eaton** stated that 65 percent of Idaho pharmacies are reporting to IRIS. Pharmacies that were not reporting to IRIS were asked why this was the case; pharmacies responded that they either (i) did not realize they should report or (ii) they never learned how to register or report. Idaho State Pharmacy Association (ISPA), the Idaho Retailers Association and the Board of Pharmacy are currently conducting an educational campaign to inform pharmacists about IRIS reporting. **Ms. Eaton** reminded the Committee that the Board of Pharmacy has established record keeping requirements (see attachment 1). Second, **Ms. Eaton** addressed a concern regarding double vaccination because a pharmacist does not have access to the child's full medical record. She stated that IRIS is meant to prevent this from happening. **Ms. Eaton** discussed potential circumstances in which physicians and

nurses may also administer a double dose of a vaccine. She indicated that if a double dose of a vaccine was administered, there is no additional danger to the patient. Third, **Ms. Eaton** spoke to the concern of parental consent. She indicated that a survey of pharmacy consent forms across the State shows each form requires a parent or guardian signature. Consent forms are required to be completed before any immunizations are administered. Under the record keeping rule, pharmacies are required to keep completed informed consent forms. Pharmacists must follow all informed consent statute.

Ms. Eaton remarked that all pharmacy graduates are highly trained in immunization techniques. The Idaho State University School of Pharmacy teaches immunization techniques and guidelines during the course of their studies. Pharmacists are required to complete one hour of continuing education (CE) credit on this topic every year. She noted there has not been a single complaint since pharmacists have been allowed to administer immunizations in Idaho. Pharmacists administer approximately 25 to 30 million immunizations each year, nationally. She reiterated that this bill does not take away choice, but it is designed to bring convenience to parents.

Chairman Heider asked the Committee members if they had any questions.

Senator Martin asked why the age of six was chosen instead of another age. **Ms. Eaton** responded that age 6 was in line with statutes in many other states and was chosen because that is when kids normally begin school. **Senator Martin** asked what types of vaccines may be offered by pharmacists. **Ms. Eaton** replied that pharmacists primarily distribute influenza (flu) shots. She stated that there is one set of vaccinations recommended for children at 10 years of age that pharmacists would be allowed to administer. **Ms. Eaton** noted that pharmacists follow Centers for Disease Control (CDC) recommendations regarding the appropriate age for administering the various vaccinations.

Vice Chairman Nuxoll commented that federal law recognize vaccines kill and disable some recipients; the U.S. Supreme Court has recognized that vaccines may cause injury or death for some recipients; the U.S. government has paid more than $3 billion dollars to victims of vaccine injury; and hundreds of thousands of individuals experience adverse reactions to vaccinations. She asked whether pharmacists make sure parents understand (i) the voluntary nature of vaccinations and (ii) the possible negative consequences from receiving vaccinations. **Vice Chairman Nuxoll** indicated that she has received comments from constituents who oppose vaccinations. She mentioned that her concern is that pharmacists may not know the medical history of the patient and may not follow-up with the patient. She reiterated her questions regarding whether parents understand the voluntary nature of vaccines and whether parents are properly notified of potential adverse effects. **Ms. Eaton** responded vaccinations are voluntary. She commented that vaccination consent forms do address Vice Chairman Nuxoll's concerns. She noted that anyone who administers an immunization is required by law to disclose the side effects of that immunization and any other risks. She stated that she believed pharmacists might do a better job of informing their patients than physicians because pharmacists are trained to counsel patients regarding medications. **Vice Chairman Nuxoll** asked what happens if there is an adverse reaction immediately upon vaccination. **Ms. Eaton** answered that pharmacists instruct the patient to follow-up with them and their physician. She noted that most people go to the same pharmacy and therefore pharmacists have more records of allergies and medication reactions than physicians. **Vice Chairman Nuxoll** asked if vaccination consent forms expressly state that vaccinations are voluntary and could result in adverse reactions. **Ms. Eaton** answered that pharmacists review those questions during the counseling portion of the treatment. She indicated that most forms have some language regarding adverse reactions. **Ms. Eaton** distributed examples of pharmacist vaccination consent forms for review by the Committee (see attachment 2).

Senator Jordan asked if the Idaho Childhood Immunization Policy Commission has reviewed this bill and if it had any recommendations. **Ms. Eaton** replied that this bill was not sent to the Commission, however the Immunization Coalition was aware of this bill. There was no specific attempt to ask any group, board or coalition for support of this bill.

Senator Harris asked when most children receive their first set of vaccinations. **Ms. Eaton** responded that most children receive their first set of vaccinations at approximately three months old. **Senator Harris** asked who administers the first set of vaccines. **Ms. Eaton** answered that, in her experience, a nurse in the physician's office administered vaccinations.

TESTIMONY: **Chairman Heider** invited testimony.

Misty Gardner stated that she was speaking on behalf of Leslie Manookian, the NVIC Advocacy, Health Freedom Idaho, Vaccination Liberation, Vax Rights Idaho, Naturopathic Doctors, Chiropractors and over 1,000 citizens who are opposed to **S 1294**. She argued that pharmacists are not following the current Idaho Code § 39-4804, requiring health workers to notify parents that vaccines are not mandatory in Idaho and that participation in IRIS is voluntary. However, she stated that the Board of Pharmacy rules do not require parents to be notified of the same. **Ms. Gardner** stated that vaccine makers and health care providers who administer vaccines have no liability for injuries and death caused by vaccines. She noted that federal and State law require all health care providers report adverse reactions to the Vaccine Adverse Reporting System (VARS). **Ms. Gardner** indicated that three pharmacists informed her that they do not report to VARS. **Ms. Gardner** illustrated her concerns by reporting that (i) the U.S. Supreme Court has recognized that vaccines are unavoidably unsafe and may cause injury or death for some recipients and (ii) the U.S. government has paid out more than $3.5 billion to the victims of vaccine injury. She told the Committee that children currently receive 69 doses of vaccines for 16 different viral and bacterial illnesses and the safety of this schedule has never been proven. **Ms. Gardner** described conversations she had with a local pharmacist who indicated that they would not report vaccinations to either her primary care physician or VARS. She reiterated her belief that pharmacists were violating Idaho Code. In conclusion, **Ms. Gardner** stated that pharmacists should not be allowed to administer vaccines to children between the ages of 6 and 12.

Recognizing Ms. Gardner's general concerns regarding vaccinations, **Senator Martin** asked Ms. Gardner to address her specific concerns with allowing pharmacists to administer vaccinations to children age 6 to 12. **Ms. Gardner** responded vaccines may cause harm and should be discussed between a patient and physician.

Also recognizing Ms. Gardner's general concerns regarding vaccinations, **Senator Schmidt** asked if Ms. Gardner has had her children immunized at a pharmacy. **Ms. Gardner** replied that the first of her four children had an averse reaction to a vaccine. She stated she is not against vaccines, but people should have choice and be properly informed to make an educated decision regarding vaccinations. Regarding Ms. Gardner's testimony that pharmacists are violating Idaho Code, **Senator Schmidt** stated that reporting to IRIS is not required unless pharmacists are using State-sponsored immunizations. He stated that, based upon specific scenarios illustrated in her testimony, it was unclear whether pharmacists in those scenarios were violating the law.

Ms. Eaton followed-up the previous testimony with a few remarks. She indicated that the act of bringing a child into a pharmacy is voluntary and thus acknowledges the voluntary nature of vaccines. She stated her belief that pharmacists are informing patients about the voluntary nature of vaccines. She reiterated that reporting to IRIS is voluntary. In conclusion, **Ms. Eaton** reiterated that there have been no problems or complaints reported since the time that pharmacists have been allowed to administer immunizations.

Chairman Heider reminded the Committee that this bill only changes the age from 12 years old to 6 years old and does not change other provisions related to vaccinations in Idaho.

With the permission of the chairman, **Senator Lodge** asked Alex Adams, the Executive Director of the Idaho Board of Pharmacy, if he knew of any reports of pharmacists violating the laws that have been mentioned. **Mr. Adams** answered that the law in question has been in place since 2011. He noted that the Board of Pharmacy's compliance staff reported to him that there have been no complaints regarding pharmacists administering immunizations. **Senator Lodge** asked if pharmacists have access to the medical history or records of patients. **Mr. Adams** replied that pharmacists are required by State statute to keep an electronic record of certain information. This information includes allergy history, medication history and other related records. He stated that the Health Insurance Portability and Accountability Act (HIPAA) would not apply because if a pharmacist is acting in the usual course of practice for patients under her care, that information could be shared from another medical professional. He noted that the informed consent forms contain a series of questions relating to allergies. The answers to these questions would filter out patients who might have adverse reactions to vaccines and would prompt further questions from the pharmacist to determine whether someone was an appropriate candidate to receive a vaccine.

MOTION: There being no further questions, **Senator Martin** moved to send **S 1294** to the floor with a **do pass** recommendation. **Senator Lodge** seconded the motion.

Vice Chairman Nuxoll commented that her questions had not been sufficiently addressed. She stated that the Idaho Department of Health and Welfare and school districts make vaccinations appear to be mandatory when Idaho Code states that they are voluntary. People do not know that these vaccinations are voluntary. She noted that there is concern among some parents. **Vice Chairman Nuxoll** reiterated her concern that less can be done if a physician is not present during an adverse reaction to a vaccine. She stated her opposition to the bill.

Senator Jordan indicated that she would be more comfortable with this change if it had been vetted by the Idaho Childhood Immunization Policy Commission and through the review process established in Idaho Code. She is concerned that the modification proposed in the bill is retail driven. She stated her preference to hold the bill until it can be properly reviewed.

SUBSTITUTE MOTION: **Senator Jordan** moved to hold **S 1294** in Committee until the proposed changes are reviewed under Idaho Code § 39-4805. **Vice Chairman Nuxoll** seconded the substitute motion. The substitute motion failed by **voice vote**.

VOTE ON ORIGINAL MOTION: **Chairman Heider** returned to the original motion to send **S 1294** to the floor with a **do pass** recommendation. The original motion carried by **voice vote**. **Vice Chairman Nuxoll** and **Senator Jordan** asked to be recorded as voting nay. Senator Martin will carry the bill on the floor of the Senate.

S 1268 **Relating to the Council on Developmental Disabilities**. **Christine Pisani**, Executive Director, Idaho State Council on Developmental Disabilities (Council), presented this bill.

Ms. Pisani began by discussing the role of the Council. This bill seeks to change Idaho Code § 67-6704 regarding Council membership. Individuals applying for certain council positions would no longer be restricted because they work for a State agency or local organization that receives funds for or provides services to persons with developmental disabilities, except as limited by federal law. **Ms. Pisani** stated that this proposed change will address the Council's current recruitment and retention issue. She indicated that the proposed changes were vetted with the Council's attorney general and the Governor's office.

Chairman Heider asked the Committee members if they had any questions.

Senator Schmidt asked why Idaho Code has a prohibition like this for membership on the Council. **Ms. Pisani** answered that the original statute was written in 1975 and the original concern was a conflict of interest. She noted that people who have experience with developmental disabilities are well suited to assist others in similar situations.

Senator Lee commented that it is difficult to find people to serve on boards. She indicated her concern regarding potential conflicts of interest. She asked if the Council had considered other outreach efforts to broaden the Council's perspective. **Ms. Pisani** replied the Council does not conduct a lot of outreach. She stated that Council members themselves are heavily relied on to recruit those who they think would be good Council members. She noted that the intent of this bill is to remove the restrictions on applications. She remarked that the Council could place language in its bylaws and rules that would limit the number of members serving on the Council and working in the field of developmental disabilities.

MOTION: There being no more questions, **Senator Harris** moved to send **S 1268** to the floor with a **do pass** recommendation. **Senator Jordan** seconded the motion.

Vice Chairman Nuxoll stated her concern that this change would make the communication with the public more difficult. She stated she was also concerned that this Council would become a board of State agency employees. She indicated she would not be voting in favor of the bill.

The motion carried by **voice vote**. **Vice Chairman Nuxoll** and **Senator Lee** asked to be recorded as voting nay. Senator Jordan will carry the bill on the floor of the Senate.

H 0373 **Relating to Legend Drugs**. **Ross Edmunds**, Administrator of the Division of Behavioral Health in the Department of Health and Welfare (Department), presented this bill.

Mr. Edmunds reviewed the prescription assistance program. This program allows the Department to match patients who utilize psychotropic medications with pharmaceutical companies that provide these medications for free based on income and certain demographics. He indicated that this program saves the State approximately $4 million dollars a year. He gave a straw man scenario as an example. He explained that this bill modifies the Legend Drug Act to allow the Department to donate leftover medications that have been maintained under Department control. This bill also allows the Department (through its regional behavioral health clinics) to receive donations of these drugs. This process does not currently comply with Board of Pharmacy regulations. The Department has worked with the Board of Pharmacy in order to get a stay from the regulations in order to put together this legislation. **Mr. Edmunds** explained that being able to donate medications to itself saves the Department and the State of Idaho $1.5 million a year.

Chairman Heider asked the Committee members if they had any questions.

Chairman Heider asked who the prescribers of these types of drugs are in this scenario. **Mr. Edmunds** answered that physicians and psychiatrists who are either employed or contracted by the Department are the prescribers, as well as the mid-level prescribers, which include physician assistants and nurse practitioners. **Chairman Heider** asked if this bill conflicts with the Board of Pharmacy regulations. **Mr. Edmunds** replied that the Department presented this bill to the Board of Pharmacy and the Board of Pharmacy approved it.

Senator Jordan asked if there is a prescribed time period in which a patient is required to pick up a prescription before it is deemed unneeded. **Mr. Edmunds** responded that there is no rule or statute for this issue. However, **Mr. Edmunds** described the typical practice of the Department and noted that approximately 60 days is allowed to pass before medication is even considered for use for another patient. **Mr. Edmunds** declared that every effort is made to contact the original patient.

Vice Chairman Nuxoll asked if the medications are contained in closed bottles. **Mr. Edmunds** replied that the medication has to be kept in its original packaging. This is most often individually wrapped.

MOTION: There being no more questions, **Vice Chairman Nuxoll** moved to send **H 0373** to the floor with a **do pass** recommendation. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**. Senator Schmidt will carry the bill on the floor of the Senate.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:15 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Michael Jeppson
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, February 17, 2016

ATTACHMENT 1

330.PHARMACIST: ADMINISTERED IMMUNIZATIONS.

02. Pharmacist Qualifications. To qualify to administer immunizations, a pharmacist must first: (3-21-12) **a.** Successfully complete an ACPE-accredited or comparable course that meets the standards for pediatric, adolescent, and adult immunization practices recommended and approved by the CDC's Advisory Committee on Immunization Practices and includes at least the following: (3-21-12) i. Basic immunology, vaccine, and immunization protection; (3-21-12) ii. Diseases that may be prevented by vaccination or immunization; (3-21-12) iii. Current recommended immunization schedules; (3-21-12) iv. Vaccine and immunization storage and management; (3-21-12) v. Informed consent; (3-21-12) vi. Physiology and techniques for administration of immunizations; (3-21-12) vii. Pre-immunization and post-immunization assessment and counseling; (3-21-12) viii. Immunization reporting and records management; and (3-21-12) ix. Identification response, documentation, and reporting of adverse events. (3-21-12)

09. Recordkeeping. For each administered immunization, the following information must be collected and maintained in the patient profile: (3-21-12) **a.** The patient's name, address, date of birth, and known allergies; (3-21-12) **b.** The date of administration; (3-21-12) **c.** The product name, manufacturer, dose, lot number, and expiration date of the vaccine; (3-21-12) **d.** Documentation identifying the VIS provided; (3-21-12) **e.** The site and route of administration and, if applicable, the dose in a series (e.g. one (1) of three (3)); (3-21-12) **f.** The name of the patient's healthcare provider, if any; (3-21-12) **g.** The name of the immunizing pharmacist and of the student pharmacist, if any; (3-21-12) **h.** Adverse events observed or reported, if any, and documentation including at least the dates of any subsequent required reporting; and (3-21-12) **i.** Completed Informed consent forms. (3-21-12)

TITLE 39
HEALTH AND SAFETY
CHAPTER 48
IMMUNIZATION

39-4804. NOTIFICATION TO PARENT OR GUARDIAN. (1) Before an immunization is administered to any child in this state, the parent or guardian of the child shall be notified that:

(a) Immunizations are not mandatory and may be refused on religious or other grounds;

(b) Participation in the immunization registry is voluntary;

(c) The parent or guardian is entitled to an accurate explanation of the complications known to follow such immunization.

(2) At the time information is initially collected regarding any child for entry into the registry created pursuant to this chapter, the parent or guardian shall be notified that:

(a) They have the right under Idaho law to submit a statement pursuant to the provisions of sections 39-1118 and 39-4802, Idaho Code, which exempts them from any requirement to have information regarding the child entered into the registry;

(b) At any time they have the right to remove any information from the registry regarding the child; and

(c) Immunizations are not mandatory and may be refused on religious or other grounds.

(3) The decision of a parent or guardian to:

(a) Submit a statement pursuant to the provisions of either section 39-1118(2) or 39-4802(2), Idaho Code;

(b) Remove any information regarding the child from the registry pursuant to the provisions of section 39-4803(4), Idaho Code; or

(c) Refuse the immunization on religious or other grounds;

shall not be used in any manner against the interests of the parent or guardian in any administrative, civil or criminal action.

History:
[39-4804, added 1999, ch. 347, sec. 3, p. 930; am. 2010, ch. 336, sec. 2, p. 890.]

TITLE 39
HEALTH AND SAFETY
CHAPTER 45
THE MEDICAL CONSENT AND NATURAL DEATH ACT

39-4504. PERSONS WHO MAY GIVE CONSENT TO CARE FOR OTHERS. (1) Consent for the furnishing of hospital, medical, dental, surgical or other health care, treatment or procedures to any person who is not then capable of giving such consent as provided in this chapter or who is a minor may be given or refused in the order of priority set forth hereafter; provided however, that the surrogate decision maker shall have sufficient comprehension as required to consent to his or her own health care pursuant to the provisions of section 39-4503, Idaho Code; and provided further that the surrogate decision maker shall not have authority to consent to or refuse health care contrary to such person's advance directives, POST or wishes expressed by such person while the person was capable of consenting to his or her own health care:

(a) The court appointed guardian of such person;

(b) The person named in another person's "Living Will and Durable Power of Attorney for Health Care" pursuant to section 39-4510, Idaho Code, or a similar document authorized by this chapter if the conditions in such living will for authorizing the agent to act have been satisfied;

(c) If married, the spouse of such person;

(d) An adult child of such person;

(e) A parent of such person;

(f) The person named in a delegation of parental authority executed pursuant to section 15-5-104, Idaho Code;

(g) Any relative of such person who represents himself or herself to be an appropriate, responsible person to act under the circumstances;

(h) Any other competent individual representing himself or herself to be responsible for the health care of such person; or

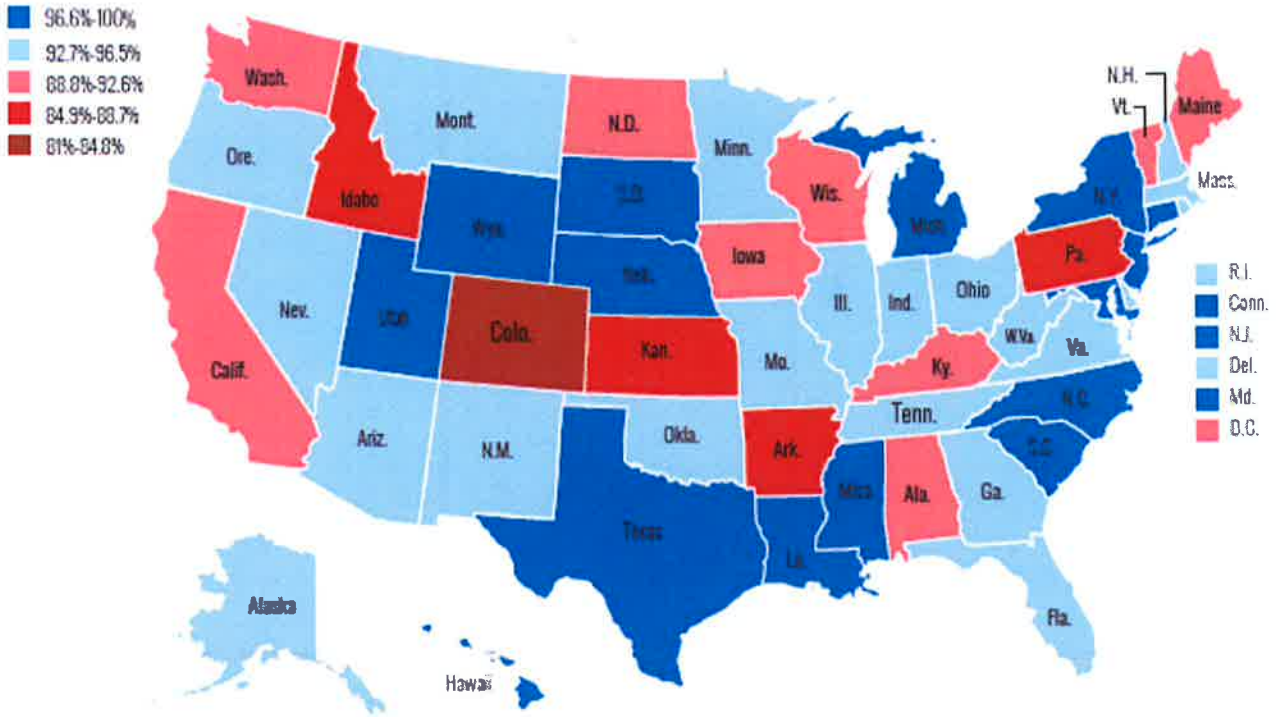
(i) If the person presents a medical emergency or there is a substantial likelihood of his or her life or health being seriously endangered by withholding or delay in the rendering of such hospital, medical, dental, surgical or other health care to such person and the person has not communicated and is unable to communicate his or her treatment wishes, the attending health care provider may, in his or her discretion, authorize and/or provide such health care, as he or she deems appropriate, and all persons, agencies and institutions thereafter furnishing the same, including such health care provider, may proceed as if informed, valid consent therefor had been otherwise duly given.

(2) No person who, in good faith, gives consent or authorization for the provision of hospital, medical, dental, surgical or other health care, treatment or procedures to another person as provided by this chapter shall be subject to civil liability therefor.

(3) No health care provider who, in good faith, obtains consent from a person pursuant to either section 39-4503 or 39-4504(1), Idaho Code, shall be subject to civil liability therefor.

History:
[(39-4504) 39-4503, added 2005, ch. 120, sec. 2, p. 381; am. and redesig. 2007, ch. 196, sec. 4, p. 581; am. 2012, ch. 302, sec. 4, p. 827.]

Percentage of kindergartners vaccinated by state, 2013-2014 school year



Note: Data for Wyoming is from the 2012-13 school year.
Source: Centers for Disease Control and Prevention

Mother Jones

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, February 17, 2016

ATTACHMENT 2

FEB 17 2016
IDAHO BOARD OF PHARMACY

DOUG

Patient Name:	Date of Birth:
Address:	Patient Phone:
Primary Doctor:	Ins ID#:

Screening Checklist for Contraindications to Vaccines

Patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your pharmacist to explain it.

	Yes	No	Don't Know
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component or latex?			
3. Have you ever had a serious reaction after receiving a vaccination?			
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?			
5. Do you have cancer, HIV, leukemia or any other immune system problem?			
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
7. Have you had a seizure, brain disorder or other nervous system problem?			
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drug?			
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
10. Have you received any vaccinations in the past 4 weeks?			
11. **Did you bring your immunization record card with you today?** It is important to have a personal record of all of your vaccinations. If you don't have one, request one from your healthcare provider.			

I agree that the person named above will receive the vaccine indicated and that this person will have a vaccine put in his or her body to prevent infectious disease. I received a copy of the Vaccine Information Sheet. I know the risks of the disease this prevents and the benefits and risks of the vaccine. I have had a chance to ask questions about the disease and vaccine. I understand a record will kept of this vaccination, and that a summary may be sent to my primary care physician, Idaho's Immunization Reminder System, daycares and schools. I voluntarily give my signed permission for this vaccine to be given. I can review this information upon request. I have received information about HIPPA.

Patient/Rep Signature:_____ Date:_____

Form reviewed by:_____ Date:_____

We just have the parent sign here as representative

Clinic –Yes ☐ No ☐

With us, it's personal.

Screening Questionnaire and Consent Form

Patient Information: (Patient to complete)*

*Patient Name: _____ *Date of Birth: _____ *Age: _____ *Phone# _____

*Address: _____ *City: _____ *State: _____ *Zip: _____

*Gender: M or F *Which vaccine(s) would you like to receive today? _____

*Medical Conditions: _____ *Enter Weight if less than 110 lbs.: _____
FOR EMERGENCY USE ONLY

*Primary Care Physician (PCP): _____ *Dr. Phone: _____

*PCP address- City _____ State_____ Zip Code_____

Email Address _____

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask your pharmacist to explain it.	**Yes**	**No**	**Don't Know**
Are you sick today?			
Do you have a long term health problem with heart disease, kidney disease, metabolic disorder (e.g. diabetes), anemia or other blood disorders?			
Do you have a long term health problem with lung disease or asthma? Do you smoke?			
Do you have allergies to medications, food (i.e. eggs), latex or any vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)?			
Have you received any vaccinations in the past 4 weeks?			
Have you ever had a serious reaction after receiving a vaccination?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (e.g. Guillain-Barre Syndrome)?			
Do you have cancer, leukemia, AIDS, or any other immune system problem? (in some circumstances you may be referred to your physician)			
Do you take prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, including antibodies?			
Are you a parent, family member, or caregiver to a new born infant?			
For children receiving FluMist®: Do you receive long term aspirin therapy or have a history of wheezing (2-4yo)?			
For women: Are you pregnant or could you become pregnant in the next three months?			
Did you bring your Immunization Record Card with you?			
Have you had the following vaccines:	**Yes**	**No**	**Don't Know**
• **Pneumococcal Vaccine-- *you may need two different pneumococcal shots***			
• **Shingles Vaccine**			
• **Whooping Cough (Tdap) Vaccine**			

Albertson's

2015-2016 Informed Consent to Receive Vaccines

List your name exactly as it appears on your Medicare or other insurance card. Provide the date of birth and street address that your insurance has on file for you. Providing incorrect information may cause your insurance to reject payment.

PATIENT INFORMATION

First Name: _____ **Last Name:** _____ **Date of Birth:**

Street Address: _____ **Age:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: (_____)_____ **Male / Female (circle one)**

Drug Allergies: _____

When did you last receive the following vaccines?

Hepatitis B	Date / /	Never/Unsure	Tetanus	Date / /	Never/Unsure
Influenza (flu)	Date / /	Never/Unsure	Whooping cough	Date / /	Never/Unsure
Pneumonia	Date / /	Never/Unsure	Other	Date / /	Never/Unsure
Shingles	Date / /	Never/Unsure			

PHYSICIAN INFORMATION

Do you have a Primary Care Physician? **Yes** **No** **(circle one)**

Physician: _____ **Physician Phone:** (_____)_____

Physician Address: _____

INSURANCE INFORMATION

Important Notice: Immunizations may or may not be covered by your insurance. We will verify eligibility under your plan and attempt to collect payment from your insurance for all immunizations. If we are unable to confirm eligibility, **you may still opt to receive it at our pharmacy and pay for it yourself** or your insurance may cover administration of the vaccine by your physician. **You are responsible for payment for products or services you receive that are not paid for by your plan.** Please provide your insurance information below.

Note for patients with Medicare: To receive the flu vaccine at no charge at the pharmacy, you must have traditional **Medicare Part B, Railroad Medicare, or select Medicare HMO plans**. If you have a **Medicare HMO plan,** it must be a plan that has contracted with the pharmacy to provide immunizations.

Insurance name (i.e. Medicare B, Aetna, etc.):

ID # (include any letters):_____ Group #:

PLEASE INITIAL THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE _____

I have read, or have had read to me, the provided Vaccine Information Statement(s) ("VIS"). I have had the opportunity to ask questions about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccine(s) requested. I understand that my receipt of this vaccination is subject to reporting, by my pharmacy or its business associate, to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Dept. of Health, if applicable, and I authorize these disclosures. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); New Albertson's Inc., Albertson's LLC and their subsidiaries and affiliates; the respective directors, officers, employees, and agents of New Albertson's Inc., Albertson's LLC and their subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability and claims that might arise from this vaccination.

Please initial that you received our HIPAA Notice of Privacy Practices

_____ (initials)

_____ _____

Patient/Parent/Guardian Signature **Date**

COSTCO PHARMACY

Immunization Consent Form

PATIENT'S LAST NAME | PATIENT'S FIRST NAME | MI | GENDER (M/F)

ADDRESS | CITY | STATE | ZIP

10-DIGIT PHONE NUMBER | MEDICARE ID NUMBER | BIRTH DATE (MM/DD/YYYY)

PRIMARY HEALTHCARE PRESCRIBER | PRESCRIBER ADDRESS | PRESCRIBER PHONE/FAX | VACCINE REQUESTED

PRECAUTIONS AND CONTRAINDICATIONS (Please check yes or no for each question.)

1. Are you sick today? ❒ Yes ❒ No
2. Do you have allergies to medications, food or vaccines? ❒ Yes ❒ No
   Allergies _____
3. Have you ever had a serious reaction after receiving a vaccination? ❒ Yes ❒ No
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? ❒ Yes ❒ No
5. Do you have cancer, leukemia, AIDS or any other immune system problem? ❒ Yes ❒ No
6. Do you take cortisone, prednisone, other steroids or anti-cancer drugs, or have you had X-ray treatments? ❒ Yes ❒ No
7. Have you had a seizure, brain or nerve problem? ❒ Yes ❒ No
8. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? ❒ Yes ❒ No
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? ❒ Yes ❒ No
10. Have you received any vaccinations in the past 4 weeks? ❒ Yes ❒ No
    If yes, what vaccines? _____
11. Are you allergic to eggs? ❒ Yes ❒ No
12. Are you allergic to latex? ❒ Yes ❒ No

ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small.

Local symptoms may include: slight tenderness, redness, itching or swelling at the site of injection.

Systemic symptoms may include: fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate presumable allergic reactions such as hives, angioedema, allergic asthma or systemic anaphylaxis occur rarely after immunization. These reactions may result from hypersensitive reactions in people with severe egg allergy, and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or any other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations.

In the case of a severe reaction such as a high fever, behavior changes or flu-like symptoms that occur after vaccination, see a doctor right away. Signs of an allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes to a few hours after the shot.

ADMINISTRATIVE RECORD FOR PHARMACY USE ONLY

VACCINE:	EXPIRATION DATE:	VACCINE:	EXPIRATION DATE:	VACCINE:	EXPIRATION DATE:
VIS VERSION:	SITE OF INJECTION:	VIS VERSION:	SITE OF INJECTION:	VIS VERSION:	SITE OF INJECTION:
MANUFACTURER:	DOSAGE:	MANUFACTURER:	DOSAGE:	MANUFACTURER:	DOSAGE:
LOT NUMBER:	ROUTE OF ADMIN:	LOT NUMBER:	ROUTE OF ADMIN:	LOT NUMBER:	ROUTE OF ADMIN:

PAYMENT INFORMATION FOR PHARMACY USE ONLY

VACCINE FEES | **TOTAL CHARGE**

"I have read the adverse reactions associated with the administration of vaccines. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named below for whom I am the legal guardian ('Ward'). My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release Costco, and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization(s). Neither Costco nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. Costco will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to you and your Ward's personal health information. I acknowledge that I have received a copy of the Notice of Privacy Practices."

SIGNATURE/LEGAL GUARDIAN | DATE OF VACCINATION/DATE VIS GIVEN

PRINT NAME | PHARMACIST/PRESCRIBER SIGNATURE

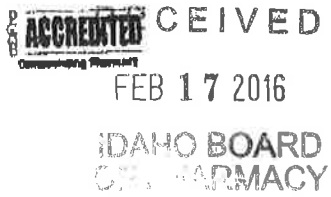
PHARMACY NAME/ADDRESS

PLEASE PROVIDE A COPY OF THIS FORM TO YOUR PHYSICIAN AND/OR HEALTHCARE PROVIDER FOR YOUR PERMANENT MEDICAL RECORDS.

WHITE – ADMINISTRATIVE COPY YELLOW – PATIENT COPY

- Prescriptions
- Compounding
- FREE Delivery

- Wellness Classes
- FREE Mailing
- Billing Arrangements



Vaccine Administration Consent Form

I have been given the opportunity to ask questions about the vaccine listed below and my questions were answered to my satisfaction. I have received the appropriate CDC Vaccine Information Statement (VIS) and have read the information or had it read to me. I have received all the information I need to give this informed consent. I have never had a history of hypersensitivity or a life threatening allergic reaction to gelatin, neomycin or to any other component of the vaccine. I have never had a history of hypersensitivity or allergic reaction to dry natural latex rubber.

I understand the benefits, risks and contraindications to this vaccine. I understand, as with all medical treatments, there is no guarantee that I will become immune. I am not immunosuppressed, on hemodialysis, breastfeeding, or pregnant. I am not taking high dose corticosteroids or other immunosuppressive therapy. I do not have active tuberculosis. I will inform my health care provider if I have any current illness, infection or elevated temperature. I understand I may need to postpone the vaccination until I have recovered. I will inform my health care provider if I have received a vaccine or injection recently.

I understand that vaccines, like any medication, can cause mild side effects including soreness/redness at the injection site, fever, headache and body aches. Other reported side effects include bruising, itching at the injection site, diarrhea, runny nose, or rash. I understand that vaccines can in rare instances cause complications, including infection, allergic reaction and death. I also, understand that the chance of serious harm is very rare and that these vaccinations are FDA approved. I agree to accept this risk to decrease my chances of contracting a serious preventable disease. I understand to seek medical attention immediately if I have any difficulty breathing, swelling of the lips, wheezing, hoarseness, fast heart beat, hives, dizziness or swelling of the throat.

Vaccine to be administered: Influenza vaccine (FluLaval, Fluvirin, Flumist, Afluria), Pneumococcal (PneumoVax), or Zostavax

Name of Patient (Please Print Clearly) _____ Date of Birth _____ AGE _____

Signature of Patient _____ Date _____

Signature of Parent/Legal Guardian _____ Date _____

Please do not write below this line. **Ladd Family Pharmacy** Authorized personnel only

FluLaval Fluvirin Flumist Afluria	Date	Manufacturer	Lot#, exp date	RD LD Injection Site	IM Route	Initials
Pneumovax	Date	Manufacturer	Lot#, exp date	RD LD Injection Site	IM Route	Initials
Zostavax	Date	Manufacturer	Lot#, exp date	RD LD Injection Site	SQ Route	Initials

P 208.947.0877
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1109 S. Broadway Ave
Boise, Idaho 83706
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INSURANCE BILLING OPTIONS FOR COMPOUNDING

Information for Health Professionals about the Screening Checklist for Contraindications To Vaccines for Adults

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references listed at the bottom of this page.

1. Are you sick today? *[all vaccines]*
There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Do you have allergies to medications, food, a vaccine component, or latex? *[all vaccines]*
If a person has anaphylaxis after eating gelatin, do not administer MMR or varicella vaccine. A local reaction to a prior vaccine dose or vaccine components (e.g., latex) is not a contraindication to a subsequent dose or vaccine containing that component. For a table of vaccines supplied in vials or syringes that contain latex, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf. For an extensive list of vaccine components, see reference 2.
An egg-free recombinant influenza vaccine (RIV3) may be used in people age 18 years and older with egg allergy of any severity who have no other contraindications. People younger than age 18 years who have experienced a serious systemic or anaphylactic reaction (e.g., hives, swelling of the lips or tongue, acute respiratory distress, or collapse) after eating eggs can usually be vaccinated with inactivated influenza vaccine (IIV); consult ACIP recommendations (see reference 3).

3. Have you ever had a serious reaction after receiving a vaccination? *[all vaccines]*
History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? *[LAIV]*
The safety of intranasal live attenuated influenza vaccine (LAIV) in people with these conditions has not been established. These conditions, including asthma in adults, should be considered precautions for the use of LAIV.

5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? *[LAIV, MMR, VAR, ZOS]*
Live virus vaccines (e.g., LAIV, measles-mumps-rubella [MMR], varicella [VAR], zoster [ZOS]) are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR vaccine is recommended and varicella vaccine should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/µL. Immunosuppressed people should not receive LAIV. For details, consult the ACIP recommendations (1, 4, 5).

6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? *[LAIV, MMR, VAR, ZOS]*
Live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1, 3). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 6. LAIV can be given only to healthy non-pregnant people younger than age 50 years.

7. Have you had a seizure or a brain or other nervous system problem? *[influenza, Td/Tdap]*
Tdap is contraindicated in people who have a history of encephalopathy within 7 days following DTP/DTaP given before age 7 years. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizure, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (IIV/LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccine, vaccinate with IIV if at high risk for severe influenza complications.

8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? *[LAIV, MMR, VAR]*
Certain live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines. (1)

9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? *[MMR, LAIV, VAR, ZOS]*
Live virus vaccines (e.g., MMR, VAR, ZOS, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive live virus vaccines should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of exposure is imminent and immediate protection is needed (e.g., travel to endemic areas). Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2nd or 3rd trimester. (1, 3, 4, 5, 7, 8)

10. Have you received any vaccinations in the past 4 weeks?
[LAIV, MMR, VAR, yellow fever] People who were given either LAIV or an injectable live virus vaccine (e.g., MMR, VAR, ZOS, yellow fever) should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at any spacing interval if they are not administered simultaneously.

References:

1. CDC. General recommendations on immunization, at www.cdc.gov/vaccines/pubs/acip-list.htm
2. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
3. CDC. Prevention and control of seasonal influenza with vaccines: Recommendations of the ACIP—2014–2015 Influenza Season at www.cdc.gov/mmwr/pdf/wk/mm6332.pdf, pages 691–7.
4. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. *MMWR* 1998; 47 (RR-8).
5. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2007; 56 (RR-4).
6. Tomblyn M, Einsele H, et al. Guidelines for preventing infectious complications among hematopoietic stem cell transplant recipients: a global perspective. *Biol Blood Marrow Transplant* 15:1143–1238; 2009 at www.cdc.gov/vaccines/pubs/hematocell-transplts.htm.
7. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001; 50 (49).
8. CDC. Prevention of pertussis, tetanus, and diphtheria among pregnant and postpartum women and their infants: Recommendations of the ACIP. *MMWR* 2008; 57 (RR-4).

Safeway

CONSENT AND RELEASE - INJECTABLE VACCINATIONS

Vaccine(s) Requested: **Injection Site:** LD RD LPLUA RPLUA

Last Name of Patient ____ First ____ Middle ____ Birth Date ___/___/___ Age (___) Gender ☐ M ☐ F

Permanent Address ____ City ____ State ____ Zip ____ Home Phone (___)___-___

Primary Insurance ____ / Insurance ID # or Medicare B Number *(Include numbers and letters)* ____ Primary Care Physician *(Please provide if you want records sent to him/her)* ____ Phone # ____

I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Safeway Inc., on behalf of its pharmacy operations in all divisions, ("Safeway") has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Safeway, either to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Safeway permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company or immunization registry, as applicable, to enable Safeway to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Safeway and its divisions and affiliates and their respective officers, directors, employees, agents and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Safeway in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.

X ____ Signature of Person to Receive Vaccine(s)/Parent or Guardian of Minor ____ Date ____ Print Name of Parent or Guardian/ Phone #

By checking this box ☐ I authorize the administration of vaccine(s) by an immunization trained student pharmacist

		Please answer these questions by checking the boxes. If the question is not clear, please ask your pharmacist.	**Yes**	**No**	**Don't Know**
Vaccine History	1	All Patients: How long has it been since your last TETANUS shot?	___ yrs		☐
	2	Please check all that apply to you: ☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Tobacco Smoker ☐ 65 years or older If you checked any of the above, have you ever received the Pneumonia Vaccine? If yes, when?	☐	☐	☐
	3	Patients 60 years of age or older: Have you ever received the SHINGLES vaccine?	☐	☐	☐
All	4	Are you sick today?	☐	☐	☐
	5	Do you have a serious allergy to ANY medications or food? (Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin). If Yes, please list:	☐	☐	☐
	6	Have you ever had a serious reaction or fainted after receiving any vaccination?	☐	☐	☐
	7	Do you have sensitivity to latex? (Example: gloves or bandages)	☐	☐	☐
	8	For women: Are you pregnant or are you considering becoming pregnant?	☐	☐	☐
Tdap	9	Do you have a seizure disorder or a brain disorder?	☐	☐	☐
Live	10	Have you received any vaccination in the past 4 weeks? Which one(s)?	☐	☐	☐
	11	Do you have cancer, leukemia, HIV, active shingles or any other immune system problem?	☐	☐	☐
	12	Do you take prednisone, oral steroids, anticancer or antiviral drugs or medications that affect the immune system?	☐	☐	☐
	13	During the past year, have you received a transfusion of blood or blood products, been given a medicine called immune (gamma) globulin, or had radiation therapy?	☐	☐	☐

----------**BELOW LINE FOR PHARMACY USE ONLY**----------

Check Box to Confirm Patient Identity Verified ☐ Check Box to Confirm Vaccine / Drug to be administered Verified ☐

Vaccine	Lot# of Vaccine	Exp Date	Manufacturer	Dosage	Site of Injection	Time	VIS Date
Influenza (Seasonal)				0.5mL	IM L / R Deltoid		July 2014
Fluzone HD® (≥65 yrs)			Sanofi	0.5mL	IM L / R Deltoid		July 2014
Zostavax®			Merck	0.65mL	SC L / R PLUA		Oct 6, 2009
Pneumovax®			Merck	0.5mL	IM L / R Deltoid SC L / R PLUA		Oct 6, 2009
Tdap				0.5mL	IM L / R Deltoid SC L / R PLUA		May 9th 2013
					IM L / R Deltoid SC L / R PLUA		

Signature of Pharmacist: ____ **RPh** ____ **Intern Initials** **Date VIS provided to patient:** ____

Date / Time Faxed to MD ____ / ____ **AM / PM** **Counseling: Accepted** ____ **Declined** ____

Initials/Date/Time _____

Patient Health Questionnaire, Consent Form, and VAR

Section A Please Print Clearly

Race / Ethnicity
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native American or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Decline to State

Gender
- ☐ Male
- ☐ Female

Mother's Maiden Name: _____

Last Name | First Name | MI | Date of Birth | Age

Medicare/Ins ID # | Rx Group # | Bin #

Home Address | City | State | ZIP | Phone #

Primary Care Physician | Physician Address | Physician Phone #

Are you covered by Medicaid? (circle): Yes No **Are you covered by Medicare Part B or D? (circle): Yes No**

Vaccine Requested (circle): Flu Pneumonia Shingles Tdap Td MMR Hep A Hep B HPV Meningococcal Varicella Other _____

Section B *The following question will help us determine your eligibility to be vaccinated today*	Yes	No
1. Is the person to be vaccinated feeling sick today or do they have a moderate to high fever? **RPH Initials: _____**		
2. Does the person to be vaccinated have allergies to medications, food, vaccine components or latex? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)		
3. Has the person to be vaccinated received any vaccination or skin tests in the past four weeks? If yes, please list the vaccination:		
4. Has the person to be vaccinated ever had a serious reaction to an influenza vaccine or any other vaccine?		
5. Has the person to be vaccinated ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome?		
6. Is the person to be vaccinated pregnant or considering becoming pregnant in the next month?		
7. Is the person to be vaccinated 65 years of age or older?		
8. Is the person to be vaccinated a smoker?		
9. Does the person to be vaccinated have a chronic condition or long term health problem such as, heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorders?		
10. If a person answers YES to question # 7, 8, or 9, have you ever had a pneumonia vaccination?		
11. Has the person to be vaccinated ever had a shingles vaccination (patients 60 years of age and older)?		
12. Is the person to be vaccinated currently on home infusions, weekly injections, steroid therapy, anticancer drugs or radiation treatment?		
13. Does the person to be vaccinated have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?		
14. Has the person to be vaccinated received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug during the past year?		

IF A PERSON ANSWERS YES TO ANY QUESTION, THEY MUST TALK TO PHARMACIST BEFORE BEING VACCINATED

Section C Consent and Waiver: *Please read each section carefully and initial in the corresponding box acknowledging that you understand and agree.*

I hereby give my consent to Walmart, as applicable, to administer the medications(s) I have requested above. I understand the benefits and risks of receiving this medication and have received, read and/or had explained to me the Vaccine Information Statement on the vaccine(s) I have elected to receive. I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that I have been advised to remain near the vaccination location for approximately 20 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs, and personal representatives, I fully release and discharge Walmart , its staff, agents, successor, division, affiliates, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising in any way related to the administration of the vaccine(s) listed above.

Initials _____

I understand the purposes/benefits of my state's immunization registry and acknowledge that, depending upon my state law, I may prevent disclosure of my immunization to the state registry with a signed Opt-Out.

Initials _____

I assign payment of authorized insurance benefits due to me to be paid to the pharmacy. I consent to the release of medical information when necessary for billing, reimbursement, and medical protocol.

Initials _____

I am aware an immunization certified student pharmacist might be administering this medication.

Initials _____

Patient Signature/Legal Guardian: _____ **Date:** _____

Section D *The following section is to be completed by* ***health care provider only.***

Immunizing Pharmacist Name (Print) _____ **Immunizing Pharmacist Signature** _____

Intern Name (Print) _____ **Administration Date/Date VIS Given:** _____

Vaccine	Lot#	Exp. Date	Manufacturer	NDC	Dosage	Site (LA/RA)	Route (IM/SQ)	VIS Date	RPh Initials
						LA RA	IM / SQ		
						LA RA	IM / SQ		
						LA RA	IM / SQ		
						LN RN	Nasal		

Authorizing Physician: Address of Authorizing Physician:

Phone : Fax :

AMENDED AGENDA #3
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Thursday, February 18, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Page Farewell	Thank you to Jared Kelly of Blackfoot, Idaho, who served as Committee Page for the first half of this Legislative Session	**Chairman Heider**
Page Welcome	Welcome to Alaire Chambers of Arco, Idaho, who will serve as Committee Page for the second half of this Legislative Session	**Chairman Heider**
Minutes Approval	Approve Minutes of January 14, 2016	**Senator Nuxoll**
	Approve Minutes of January 18, 2016	**Senator Lodge**
H 0374	RELATING TO THE CONTROLLED SUBSTANCES PRESCRIPTIONS DATABASE: Amending Idaho Code (i) to provide that delegates supervised by practitioners or pharmacists may access the database under certain circumstances, (ii) to provide that the Board of Pharmacy shall limit the number of delegates with such access and (iii) to define "delegate"	**Representative Wood**
H 0375	RELATING TO HEALTH CARE TASK FORCE: Amending Idaho Code to repeal provisions relating to the monitoring role of the task force	**Representative Wood**
S 1281	RELATING TO EMERGENCY MEDICAL SERVICES (EMS): Amending Idaho Code to enact the EMS personnel licensure interstate compact	**Wayne Denny** Department of Health and Welfare

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

Sen Martin

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, February 18, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:07 p.m. He announced that **S 1252** had been withdrawn from agenda.
PAGE FAREWELL:	**Chairman Heider** recognized and thanked Jared Kelly for his excellent work as the Committee page for the first half of the 2016 Legislative Session. **Mr. Kelly** discussed what he has learned while he has been a page and thanked the Committee for the opportunity to work with the Committee.
PAGE WELCOME:	**Chairman Heider** welcomed Alaire Chambers, who will serve as the Committee page for the second half of the 2016 Legislative Session. **Chairman Heider** asked Ms. Chambers to tell the Committee about herself. **Ms. Chambers** informed the Committee that she lives in Arco, Idaho, and attends Butte County High School. After high school, Alaire plans to attend Boise State University to study international business and marketing. She also plans to attend law school. **Chairman Heider** thanked Alaire for assisting the Committee.
MINUTES APPROVAL:	**Vice Chairman Nuxoll** moved to approve the Minutes of January 14, 2016. **Senator Jordan** seconded the motion. The motion carried by **voice vote**.
	Senator Hagedorn moved to approve the Minutes of January 18, 2016. **Senator Lee** seconded the motion. The motion carried by **voice vote**.
H 374	**Relating to the Controlled Substances Prescriptions Database**. **Representative Fred Wood** presented this bill.
	Representative Wood stated that this bill addresses the prescription monitoring program's ease of use. In order to facilitate convenient use of the prescription monitoring program, this bill: (i) authorizes a delegate program, (ii) limits the number of delegates per provider to four, (iii) defines who is eligible to be a delegate and (iv) requires registration for that delegate (which would provide each delegate with a unique identifier). **Representative Wood** stated that expenses associated with the implementation of this bill would be de minimis.
	Chairman Heider asked the Committee members if they had any questions.
	Senator Hagedorn asked if the software has the capacity to add and regulate use by all authorized delegates. **Representative Wood** responded that it is his understanding it would not be a problem.

MOTION: There being no more questions, **Senator Martin** moved to send **H 374** to the floor with a **do pass** recommendation. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**. Senator Martin will carry the bill on the floor of the Senate.

H 375 **Relating to the Health Care Task Force**. **Representative Fred Wood** presented this bill.

Representative Wood stated the this bill strikes the only reference in Idaho Code to the Health Care Task Force (HCTF) and deletes Section One of Chapter 280 of the 2006 Session Laws. **Representative Wood** reviewed the history and purpose of the HCTF and noted that the work of the HCTF was completed long ago. **Representative Wood** suggested that if the Legislature has a future need for an interim health care committee, then the Legislature should duly authorize the scope of the committee's work and the expenditure of State funds.

Chairman Heider asked the Committee members if they had any questions.

Referencing the fiscal note, **Vice Chairman Nuxoll** asked how the $3,500 savings amount was determined. **Representative Wood** answered the House fiscal officer determined the average expense for travel and other costs accrued each time the HCTF meets.

Senator Schmidt mentioned he is a member of the HCTF and supported this motion when the HCTF made the recommendation to the oversight council. However, since then, he has seen a couple of issues come to the Legislature that don't have an appropriate venue for discussion. **Senator Schmidt** he indicated that there may be a future need for a similar type of health care committee. **Representative Wood** responded that a House committee is currently drafting a House Concurrent Resolution requesting an interim committee to deal with certain insurance issues. **Chairman Heider** added if there are issues that a committee needs to investigate, discuss and bring back to the Legislature, the Speaker and Pro Tempore can always authorize and appoint members to those committees.

MOTION: There being no more questions, **Senator Hagedorn** moved to send **H 375** to the floor with a **do pass** recommendation. **Senator Harris** seconded the motion. The motion carried by **voice vote**. Senator Hagedorn will carry the bill on the floor of the Senate.

S 1281 **Relating to the Emergency Medical Services Personnel Licensure Interstate Compact**. **Wayne Denny**, Bureau Chief for the Bureau of Emergency Medical Services and Preparedness in the Department of Health and Welfare, presented this bill.

Mr. Denny stated the purpose of this bill is to enact the Recognition of Emergency Medical Service Personnel Licensure Interstate Compact Agreement, otherwise known as REPLICA in Idaho. REPLICA allows for the cross-border practice of Emergency Medical Service (EMS) in much the same way as the Nursing and Physician Licensure compacts, of which Idaho is currently a member. This bill addresses the inability of EMS personnel licensed by one state to practice in another state without obtaining licensure in the second state. **Mr. Denny** discussed the general benefits of Idaho's participation in REPLICA. To obtain an EMS license in Idaho the applicant must (i) demonstrate competency by passing a standardized exam and (ii) must pass a criminal background check. Although other states use a similar process, the depths of the exam and background checks vary significantly. In an effort to create more uniform standards, the National Association of EMS Officials drafted REPLICA. **Mr. Denny** presented the provisions of REPLICA, including (i) purpose, (ii) definitions, (iii) home state licensure requirements, (iv) privilege to practice, (v) conditions of practice in a remote state, (vi) relationship of compact to disaster declarations, (vii) commitment to veterans and their spouses,

(viii) adverse actions, (ix) relationship between the member states regarding adverse actions, (x) establishment of the interstate commission, (xi) establishment of a coordinated database, (xii) rulemaking, (xiii) oversight dispute resolution and enforcement and (xiv) date of implementation, withdrawal and amendment.

Chairman Heider asked the Committee members if they had any questions.

Chairman Heider asked Mr. Denny to confirm that REPLICA does not become effective until it is adopted by ten states. **Mr. Denny** said that is correct. **Senator Hagedorn** asked if Idaho has reciprocity agreements of any kind right now with Idaho's bordering states and whether any of those bordering states have approved REPLICA. **Mr. Denny** said Idaho currently has an interstate agreement with Utah and, until a week ago, Idaho had an interstate agreement with Wyoming. However, the Deputy Attorney General in Wyoming looked at the state's compact and realized it was not in compliance with their code, so they have severed the interstate agreement. There is an interstate agreement that allows Idaho providers, in a disaster, to work in Washington, but there isn't an agreement that allows Washington providers to work in Idaho. Utah's Legislature is currently considering REPLICA.

Senator Schmidt asked when an EMS provider would be required to get an Idaho license after moving to Idaho from a state in the compact. **Mr. Denny** said that's not specifically stated in the compact; that decision is left to the individual states. He suggested that EMS providers who move to Idaho should be given 90 days to obtain an Idaho License. **Senator Schmidt** asked about the licensure of EMS providers who travel across the Idaho border into a neighboring state as part of their daily scope of work. **Mr. Denny** responded that in most cases an ambulance service is licensed in both states. A good example would be the EMS teams that work in both Lewiston, Idaho, and Clarkston, Washington; they are licensed in both states.

Chairman Heider asked who checks to make sure the EMS providers working in the State are licensed providers from other compact member states. Describing the current process, **Mr. Denny** said when a compact EMS provider comes into Idaho, State officials have to get a list from the medical unit of where each person is from, along with their license numbers. Then that document has to be sent to the providers' state(s), with that state(s) then having to sign off on all those people who are duly licensed. However, once REPLICA is in place, the process will be much more streamlined because the licensure information for all compact EMS providers will be kept in one database.

MOTION: There being no more questions, **Senator Harris** moved to send **S 1281** to the floor with a **do pass** recommendation. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**. Senator Harris will carry the bill on the floor of the Senate.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:54 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Kara Machado
Assistant

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, February 22, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Presentation	U.S. Supreme Court Case Relating to Regulatory Boards	**Mitchell E. Toryanski** Bureau of Occupational Licenses
S 1295	RELATING TO PUBLIC ASSISTANCE: Amending Idaho Code to revise provisions regarding civil monetary penalties for providers	**Steve Bellomy** Department of Health and Welfare
S 1296	RELATING TO BACKGROUND CHECKS: Amending Idaho Code to remove obsolete language regarding federal pilot project	**Fernando Castro** Department of Health and Welfare

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, February 22, 2016

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:07 p.m. **Chairman Heider** announced that the Committee secretary will be away for three days and an assistant will take the minutes.

PRESENTATION: **U.S. Supreme Court Case Relating to Regulatory Boards**. **Mitchell E. Toryanski**, Legal Counsel for the Idaho Bureau of Occupational Licenses, made this presentation before the Committee.

Mr. Toryanski discussed the U.S. Supreme Court case of *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, which was decided by the Court on February 25, 2015 (see attachment 1). He explained that the purpose of his presentation was to provide the Committee with information about the Court's opinion, which increases the legal exposure of Idaho's regulatory boards to federal antitrust claims. First, **Mr. Toryanski** provided the Committee with an overview of U.S. antitrust laws, including purposes, statutes, the role of the Federal Trade Commission and state action immunity from antitrust laws. Second, he reviewed the facts of the case, the legal procedural history and the primary question presented to the Court. Third, he discussed the opinion of the Court and the applicable points of law resulting from the case.

Chairman Heider asked the Committee members if they had any questions.

Referring to the fact that the Governor of Idaho appoints regulatory board members, **Senator Schmidt** noted that the Senate reviews and confirms the Governor's appointments; he asked whether this confirmation process bolstered the State's oversight of regulatory boards that is now required by this case. **Mr. Toryanski** stated that the confirmation process strengthens the State's oversight of regulatory boards. **Senator Schmidt** commented that this case increases the Legislators' duty to review statutory obligations of the appointees the body confirms.

Senator Martin asked whether any of Idaho's regulatory boards required members to be a member of a professional association and, if so, does this requirement present problems based on this ruling. **Mr. Toryanski** replied there are a number of boards where the relevant professional association nominates candidates to the Governor for appointment, and the Governor is obligated to pick one of these nominated candidates. He said he is unsure if an association has to pick an association member, but in practice he feels that is what happens. **Senator Martin** noted that this ruling does not seem to directly affect associations' recommendations regarding regulatory board members, but he asked if it would be prudent for the State to review this policy. First commenting that he does not take a particular position regarding State policy, **Mr. Toryanski** said that if Legislators

wanted to strengthen State supervision over State regulators, being able to choose from a larger pool of talent and not being bound by a private association would facilitate those efforts.

Senator Schmidt commented that several years ago the Idaho Board of Medicine dealt with an issue similar to the issue raised by Senator Martin. In particular, nominees for the Idaho Board of Medicine were all coming from the Idaho Medical Association; ultimately, the Board of Medicine changed their policy to require the Idaho Medical Association to nominate nonmembers to the Governor for consideration.

S 1295 **Relating to Public Assistance**. **Steve Bellomy**, Chief of the Bureau of Audits and Investigations (Bureau) in the Department of Health and Welfare (Department), presented this bill.

Mr. Bellomy presented an overview of the organization and performance of the Bureau's various units, including (i) the Medicaid Program Integrity Unit, (ii) the Welfare Program Integrity Unit, (iii) the Criminal History Unit, (iv) the Internal Audit Unit and (v) the Fraud Analysis Unit (see attachment 2).

Mr. Bellomy stated that this bill amends Idaho Code to clarify how the Bureau intends to apply civil monetary penalties (penalties) to providers. The legislation proposes three main changes: (i) to allow the Department to develop rules regarding how and when penalties are applied, (ii) to reduce the minimum penalty from 25 percent to 10 percent and (iii) to modify how the Department applies penalties when providers fail to obtain required background checks on employees. Because he addressed the fiscal issues during the related print hearing, **Mr. Bellomy** stated that he would not provide additional comments in this presentation. **Mr. Bellomy** reviewed the specific language for the proposed changes with the Committee.

Chairman Heider asked the Committee members if they had any questions.

Referring to the minimum penalty provisions, **Senator Martin** asked Mr. Bellomy to clarify how the penalties would be determined as a percentage of "each item or service improperly claimed." **Mr. Bellomy** responded that the Bureau conducts audits on a claim-by-claim basis. Therefore, if the claim line showed a fee of $50 (the Amount paid by the Department), then 10 percent (or $5) would be the smallest penalty percentage (or lowest amount). **Senator Martin** inquired if $50 is the average claim amount investigated. **Mr. Bellomy** stated that claim amounts cross a broad range. There are many claim lines that are less than $5 and some that are $6,000. **Senator Martin** asked Mr. Bellomy to estimate the amount of penalties collected by the Bureau each year (i) when the penalty minimum was 25 percent and (ii) when the minimum penalty is modified to 10 percent. **Mr. Bellomy** responded that last year the Bureau identified claims that were subject to penalties in the amount of $700,000. **Senator Martin** asked if the 10 percent penalty will result in better compliance. **Mr. Bellomy** said the purpose of reducing the penalty to 10 percent is not to penalize more or less. He added he thinks the 10 percent penalty will result in fairer treatment of the providers.

Referring to the performance of the Welfare Program Integrity Unit, **Senator Lodge** asked how the Bureau identifies issues such as inmates receiving food stamps. **Mr. Bellomy** responded that a jail match report is generated once a month to compare welfare rolls with individuals who have been incarcerated. **Senator Lodge** inquired if food stamp benefits would be taken away from someone incarcerated for three days. **Mr. Bellomy** said that the individual would have to be incarcerated for more than 30 days before recoupment of food stamp benefits was considered. **Senator Lodge** asked Mr. Bellomy to describe what the Fraud Unit does to check food stamp fraud on all levels. **Mr. Bellomy** responded that the Fraud Unit identifies fraud by reviewing (i) complaints, (ii) jail-match reports, (iii) out-of-state usage and (iv) referrals from eligibility staff.

Vice Chairman Nuxoll asked for an explanation, in simple terms, regarding why penalty fees are being reduced from 25 percent to 10 percent. **Mr. Bellomy** responded that the minimum penalty amount is being reduced because the Bureau believed that, in the interest of fairness, certain violations should not be penalized at 25 percent. However, he reminded the Committee that the Bureau would still be able to assess higher penalties for more serious violations. To clarify, **Vice Chairman Nuxoll** asked if the minimum penalty was being lowered to give the Bureau more flexibility over the rate of a penalty, based upon the seriousness of the issue or the intention of the provider. **Mr. Bellomy** stated that although he was uncomfortable determining a provider's intent, he confirmed that the more egregious the violation the higher the penalty assessed would be.

MOTION: There being no more questions, **Senator Schmidt** moved to send **S 1295** to the floor with a **do pass** recommendation. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**. Senator Schmidt will carry the bill on the floor of the Senate.

S 1296 **Relating to Background Checks**. **Fernando Castro**, Supervisor of the Criminal History Unit of the Bureau in the Department, presented this bill.

Mr. Castro stated that proposed legislation amends Idaho Code regarding criminal history and background checks. Specifically, he indicated that the proposed legislation seeks to eliminate language regarding federal funding of Department background checks. The funding has lapsed and is no longer available. The Department currently charges fees to adequately fund its background check program and so there is no fiscal impact to the State.

Chairman Heider asked the Committee members if they had any questions.

Referring to the fiscal note, **Senator Schmidt** asked about the amount of federal funds that were lost and must now be sourced by State dedicated funds. **Mr. Castro** responded that federal funding was part of a limited-time pilot program that ended in 2007. There have not been any losses experienced since then because fees were adjusted accordingly when the pilot ended.

MOTION: There being no more questions, **Senator Hagedorn** moved to send **S 1296** to the floor with a **do pass** recommendation. **Senator Lodge** seconded the motion. The motion carried by **voice vote**. Senator Hagedorn will carry the bill on the floor of the Senate.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:59 p.m.

_____
Senator Heider
Chair

_____
Karen R. Westbrook
Secretary

_____
Kara Machado
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Monday, February 22, 2016

ATTACHMENT 2

IDAHO Department of Health and Welfare

Senate Health and Welfare Committee 2/22/16

BUREAU OF
AUDITS AND INVESTIGATIONS

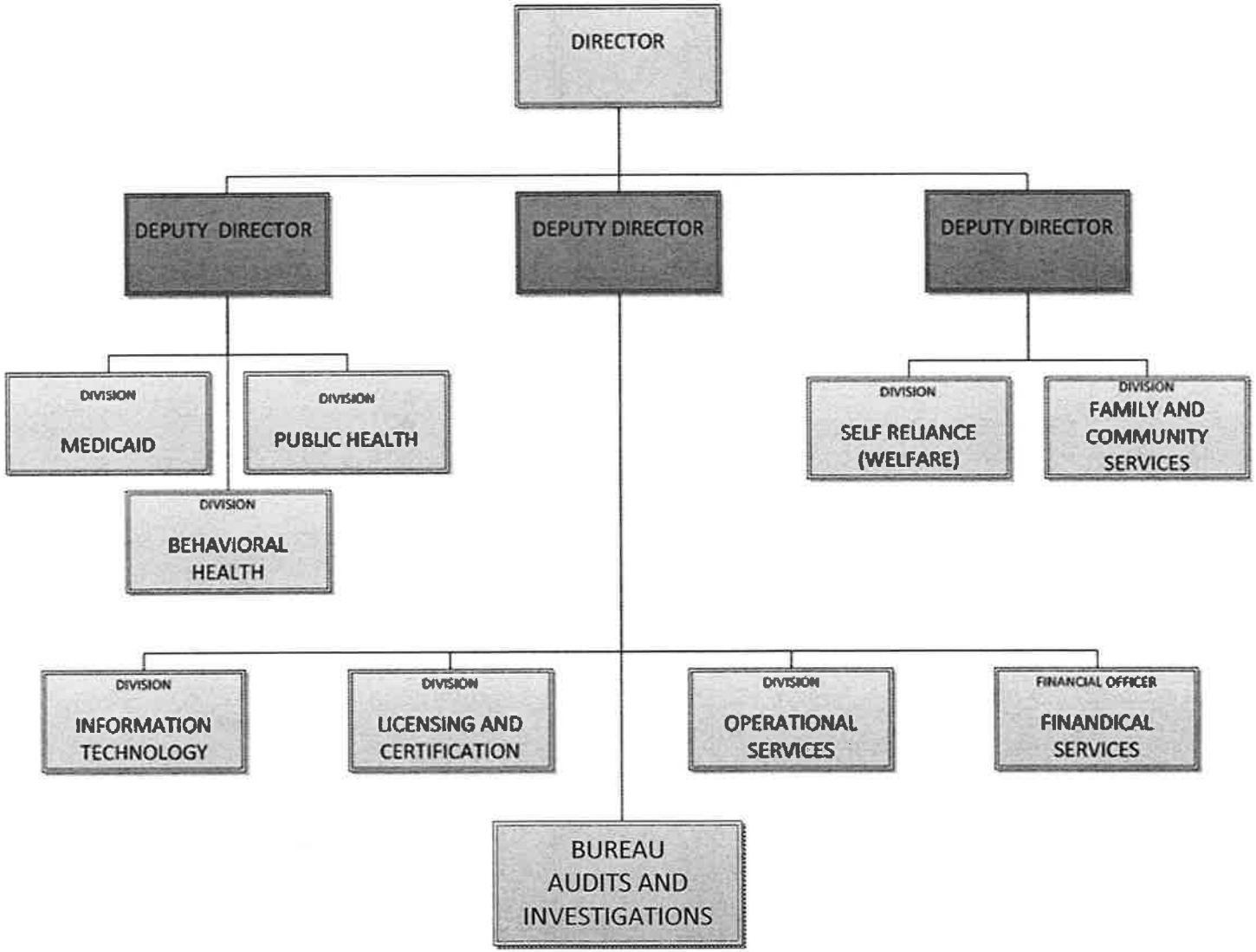
Steve Bellomy

S 1295

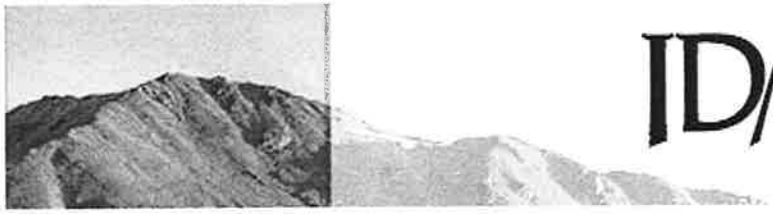
Fernando Castro

S 1296

IDAHO Department of Health and Welfare



IDAHO DEPARTMENT OF HEALTH & WELFARE



IDAHO Department of Health and Welfare

AUDITS AND INVESTIGATIONS

- Medicaid Program Integrity Unit
- Welfare Program Integrity Unit
- Criminal History Unit
- Internal Audit
- Fraud Analysis MPIU

IDAHO Department of Health and Welfare

MEDICAID PROGRAM INTEGRITY UNIT

ABOUT THE UNIT

The Medicaid Program Integrity Unit protects the integrity of Medicaid by detecting fraud, waste and abuse.

Demographics	
Medicaid Providers	44,000
Managed Care Programs	3
Medicaid Expenditures	$ 1.9 Billion
Claims Per Year	7.4 Million
Medicaid Program Integrity Staff	17

IDAHO Department of Health and Welfare

MEDICAID PROGRAM INTEGRITY UNIT

PERFORMANCE

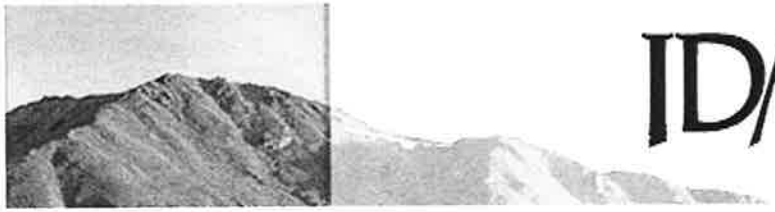
State Fiscal Year 2015		
	Cases	Dollars
No Action	283	
Identified Overpayment/Penalty	172	$ 3,196,032
Terminations and Exclusions	13	
Warning or Education	4	
Total Cases Completed	472	
Referrals For Criminal Investigation	8	

IDAHO Department of Health and Welfare

MEDICAID PROGRAM INTEGRITY UNIT

FINANCIAL

State Fiscal Year 2015	
Recovered Overpayments and Penalties	$ 2,927,470
Expenditures	$ 1,232,688
Outstanding Debt	$ 4 million



IDAHO Department of Health and Welfare

MEDICAID PROGRAM INTEGRITY UNIT

CHALLENGES

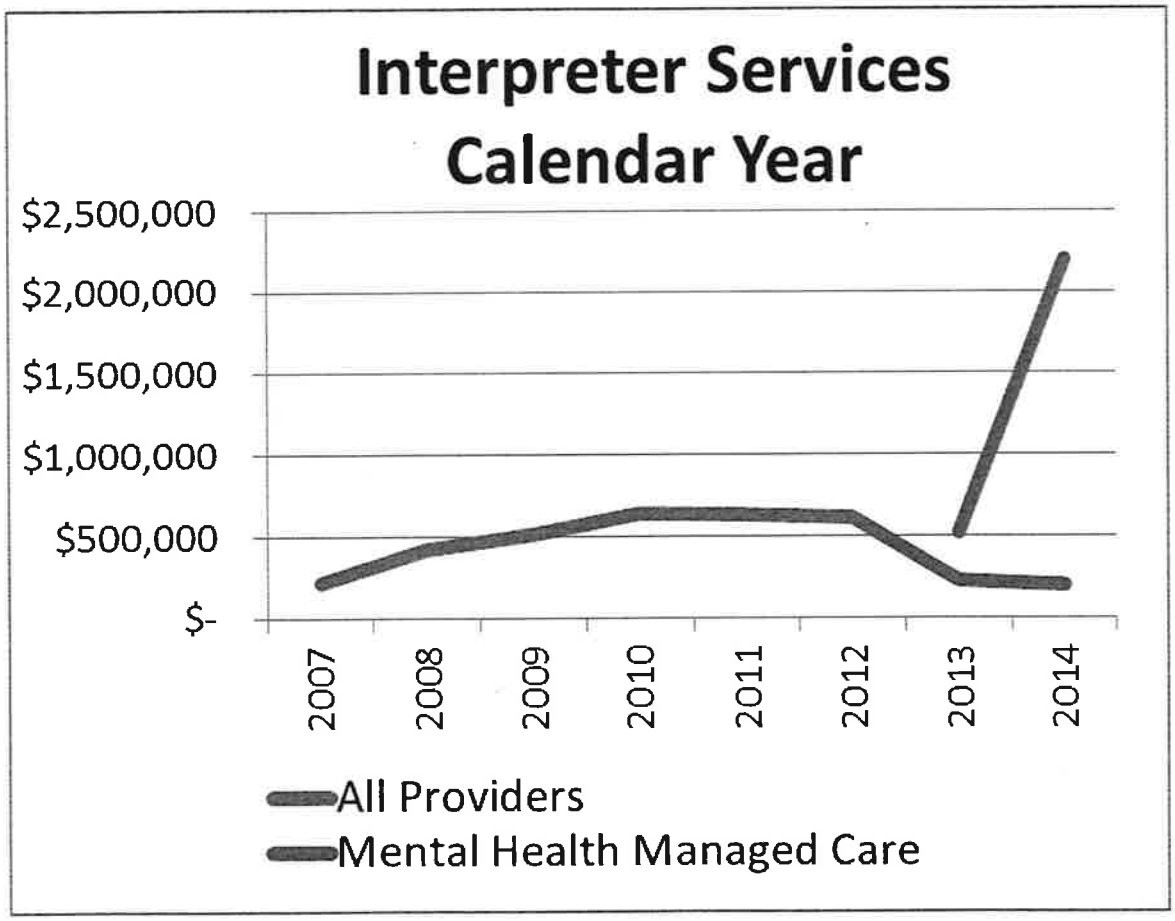
- Past Due Debts
- Managed Care
- Data Analytics

SUCCESSES

- Record Recoveries
- Exclusion Reinstatement
- Interpreter Services

IDAHO Department of Health and Welfare

MEDICAID PROGRAM INTEGRITY UNIT

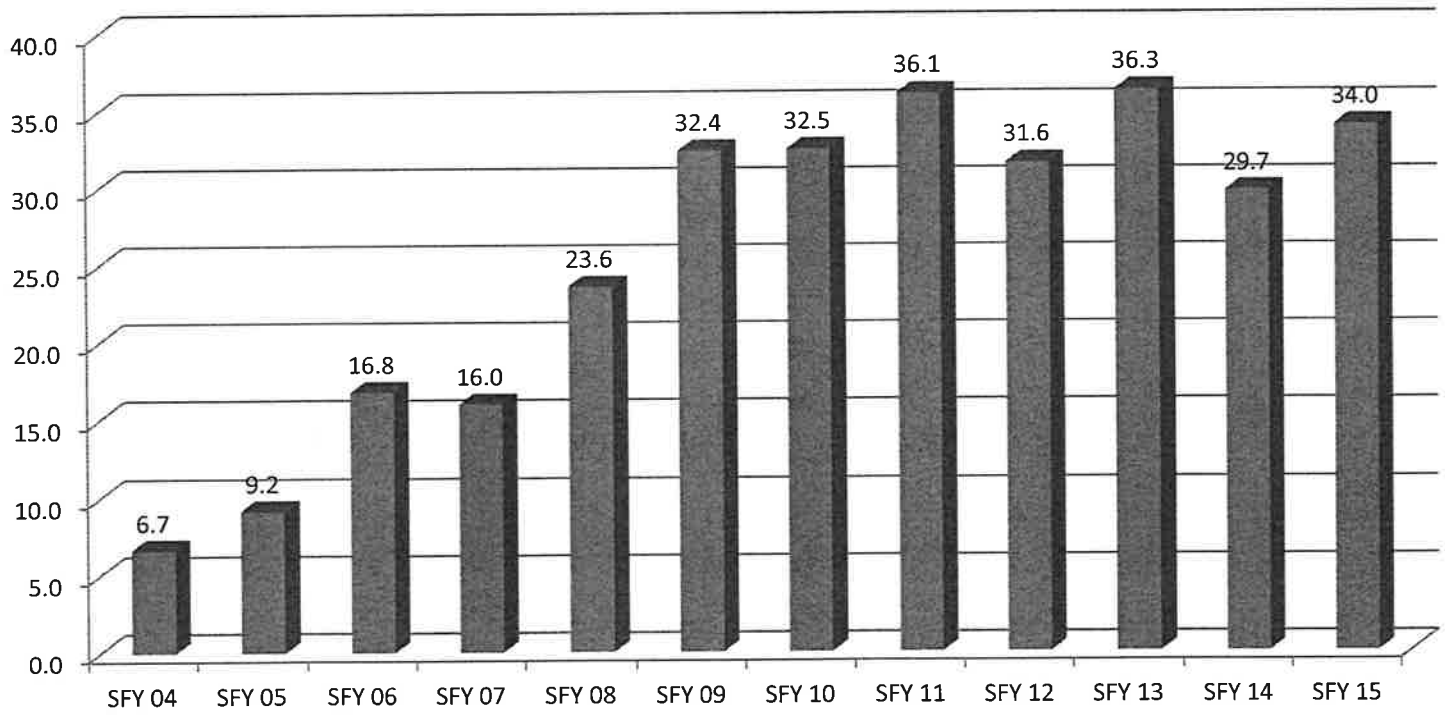


IDAHO DEPARTMENT OF HEALTH & WELFARE

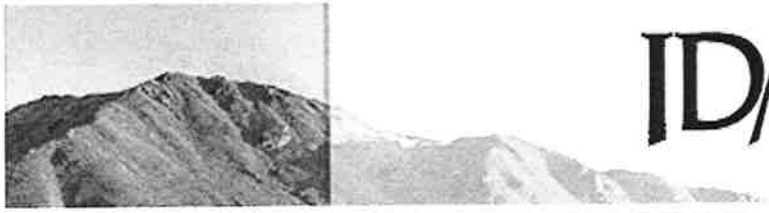
IDAHO Department of Health and Welfare

MEDICAID PROGRAM INTEGRITY UNIT
School Based Services

SFY 2004-2015 School-based Services Payments (in millions)



IDAHO DEPARTMENT OF HEALTH & WELFARE



IDAHO Department of Health and Welfare

MEDICAID PROGRAM INTEGRITY UNIT
School Based Services

Year	Audits	Audits with Penalty	Audits with Over-payment	Lowest Penalty	Highest Penalty	Lowest Over-payment	Highest Over-payment
2016	9	0	5	$ -	$ -	$ 11	$ 97,406
2015	5	0	4	$ -	$ -	$ 2,059	$ 73,892
2014	3	1	2	$ -	$ 2,890	$ 2,201	$ 10,376
2013	10	6	8	$ 28	$ 21,275	$ 111	$ 85,203
2012	29	10	23	$ 263	$ 10,813	$ 647	$ 119,089

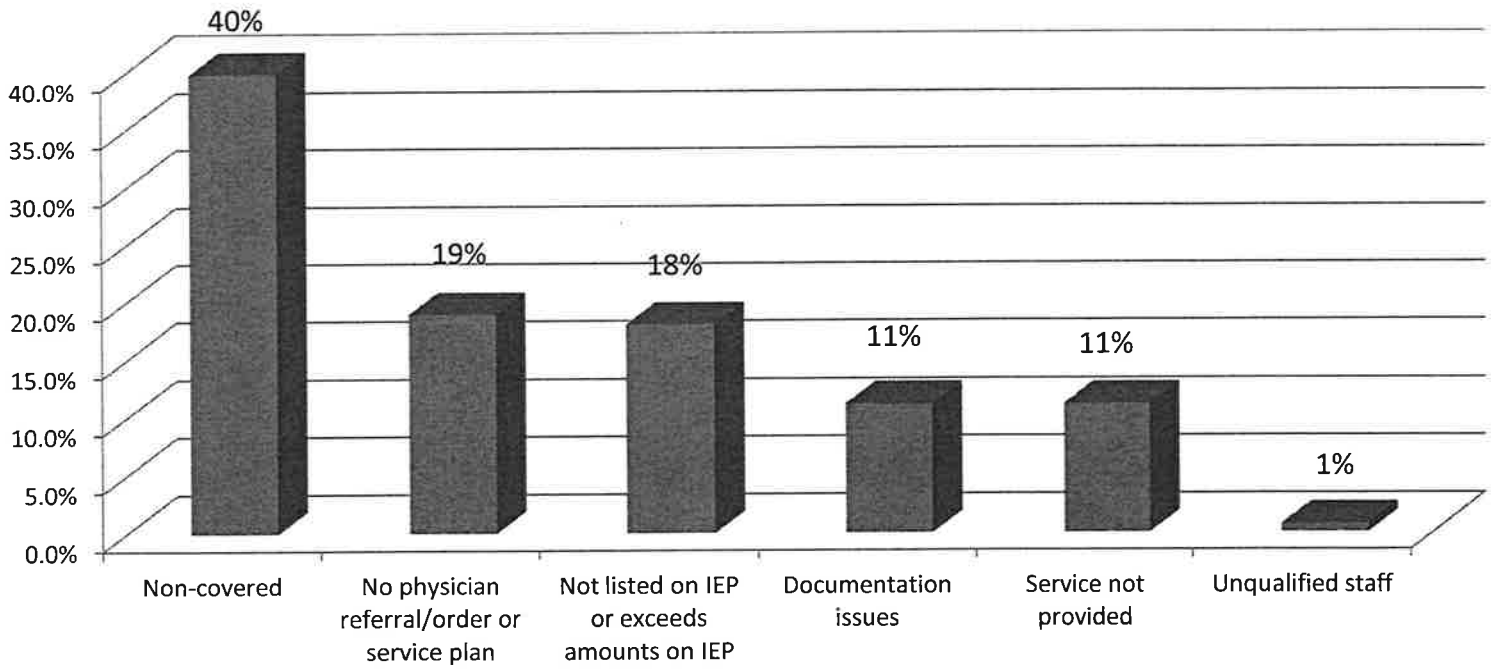
IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO Department of Health and Welfare

MEDICAID PROGRAM INTEGRITY UNIT

School Based Services

17 Sample Audits with Overpayments between $1,000 and $100,000

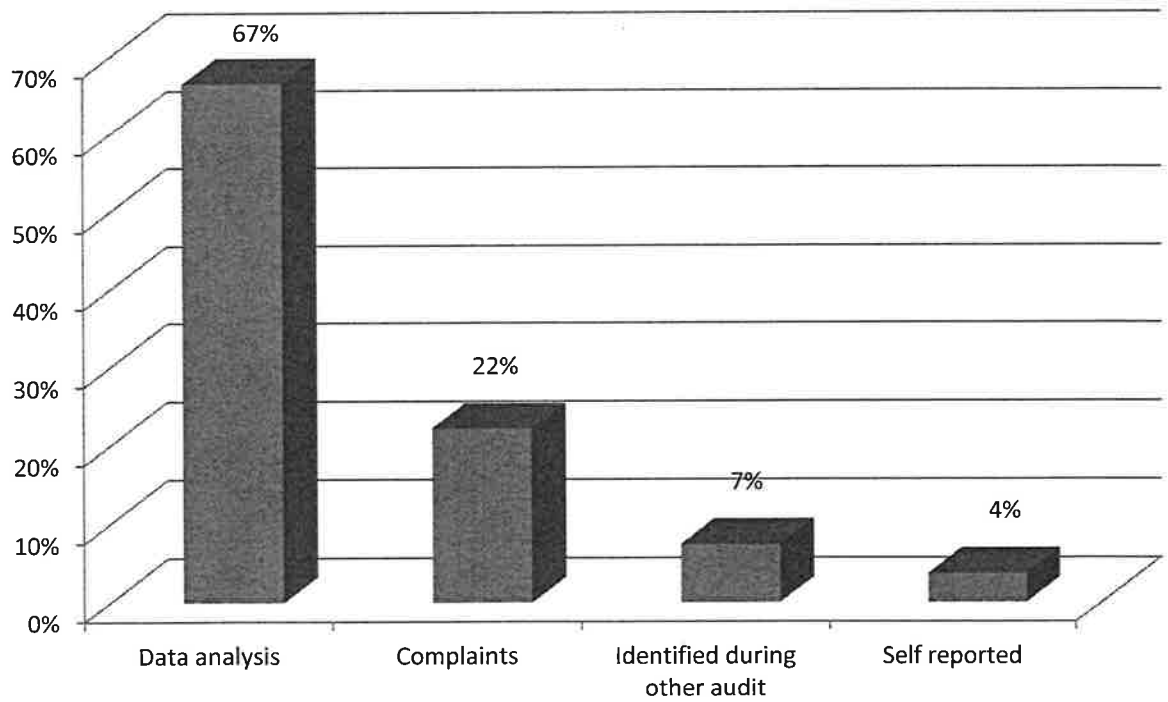


IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO Department of Health and Welfare

MEDICAID PROGRAM INTEGRITY UNIT
School Based Services

Reasons for Audit - 17 Sample Audits



IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO Department of Health and Welfare

AUDITS AND INVESTIGATIONS

- Medicaid Program Integrity Unit
- Welfare Program Integrity Unit
- Criminal History Unit
- Internal Audit
- Fraud Analysis MPIU

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO Department of Health and Welfare

WELFARE PROGRAM INTEGRITY UNIT

MEDICAID PROGRAM INTEGRITY

Programs	Benefits (Millions)	Providers	Individuals
Medicaid	$ 1,900	44,000	278,000
Food Stamp	$ 277	1,000	201,000
Child Care	$ 25	860	7,000
Women and Children	$ 17	NA	41,000
Energy Assistance	$ 10	NA	37,000
Aged, Blind and Disabled	$ 9	NA	16,000
Temporary Assistance	$ 7	NA	3,000

IDAHO Department of Health and Welfare

WELFARE PROGRAM INTEGRITY UNIT

ABOUT THE UNIT

The Welfare Program Integrity Unit investigates allegations of welfare program waste, abuse, and fraud.

Investigators	Full Time	Part Time
Field	6	
Desk	1	2
Provider	1	

IDAHO Department of Health and Welfare

WELFARE PROGRAM INTEGRITY UNIT

PERFORMANCE

State Fiscal Year 2015		
Leads		26,000
	Individuals	Providers
Investigations/Audits	2,463	20
Sanctioned or Overpayment	815	9
Prosecution	14	0
No Action	1,634	11
Overpayment/Penalties Identified	$ 898,000	$ 152,000

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO Department of Health and Welfare

WELFARE PROGRAM INTEGRITY UNIT

FINANCIAL

State Fiscal Year 2015	
Recovered Overpayments/Penalties	$ 1,030,701
Expenditures	$ 791,045

IDAHO Department of Health and Welfare

WELFARE PROGRAM INTEGRITY UNIT

CHALLENGES

- Potential Cases
- Retirements
- Program limitations

SUCCESSES

- Incarcerated
- Desk Reviews
- Highest Overpayments Recovered

IDAHO Department of Health and Welfare

AUDITS AND INVESTIGATIONS

- Medicaid Program Integrity Unit
- Welfare Program Integrity Unit
- Criminal History Unit
- Internal Audit
- Fraud Analysis MPIU

IDAHO Department of Health and Welfare

CRIMINAL HISTORY UNIT

ABOUT THE UNIT

The Criminal History Unit completes background checks of providers that care for vulnerable adults and children.

State Fiscal Year 2015	
Staff	12
Fingerprint Locations	11
Fingerprint Scanning Stations	10
Types of Service	40
Employers/Providers	3,500

IDAHO Department of Health and Welfare

CRIMINAL HISTORY UNIT

PERFORMANCE

State Fiscal Year 2015	
Background Checks	24,998
Denied/Withdrawn	303

State Fiscal Year To Date 2016		
Processing Time	Days	%
Scanned	2.8	73%
Paper Card	6.2	9%
Criminal Record	18.0	16%
Rejected Print	31.2	1%

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO Department of Health and Welfare

CRIMINAL HISTORY UNIT

FINANCIAL

State Fiscal Year 2015	Total (in thousands)
Applicant Fees	$ 1,481.0
General & Federal Funds	$ 65.4
Total Revenue	$ 1,546.4
Fingerprint Processing	$ 899.9
Personnel Costs	$ 598.6
Other	$ 47.9
Total Expenditures	$ 1,546.4

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO Department of Health and Welfare

CRIMINAL HISTORY UNIT

CHALLENGES

- Website
- Appointments
- Reduce costs and reinvest

SUCCESSES

- Increased Appointments
- Improved website – Browsers and Provider Tools
- Identified 54 Non-Compliant Providers

IDAHO Department of Health and Welfare

AUDITS AND INVESTIGATIONS

- Medicaid Program Integrity Unit
- Welfare Program Integrity Unit
- Criminal History Unit
- Internal Audit
- Fraud Analysis

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO Department of Health and Welfare

INTERNAL AUDIT

ABOUT THE UNIT

Internal Audit provides independent appraisals of the department's operations and systems of control.

Demographics	
Staff	2
Automated Systems	15
Federal Grants	89

Audit Areas

Financial Controls	Management Controls
Indirect Cost Monitoring	Credit Card Compliance
Subrecipient Audit Finding	Information Technology Controls

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO Department of Health and Welfare

FRAUD ANALYTICS

ABOUT THE UNIT

The analytics team provides data science support for the bureau.

Demographics	
Staff	1.5
Projects	
Manage Data Sources	
Analyze Trends and Mine Data for Suspect Providers, Claims, and Recipients	
Oversee Sample Extrapolations	

SENATE HEALTH & WELFARE COMMITTEE
Monday, February 22, 2016

ATTACHMENT 1

NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS
Petitioners
v.
FEDERAL TRADE COMMISSION

U.S. SUPREME COURT

Argued October 14, 2014

Decided Feb 25, 2015

PURPOSE

To provide information
about a U.S. Supreme Court Opinion
that increases the legal exposure
of Idaho's Regulatory Boards
to federal antitrust claims

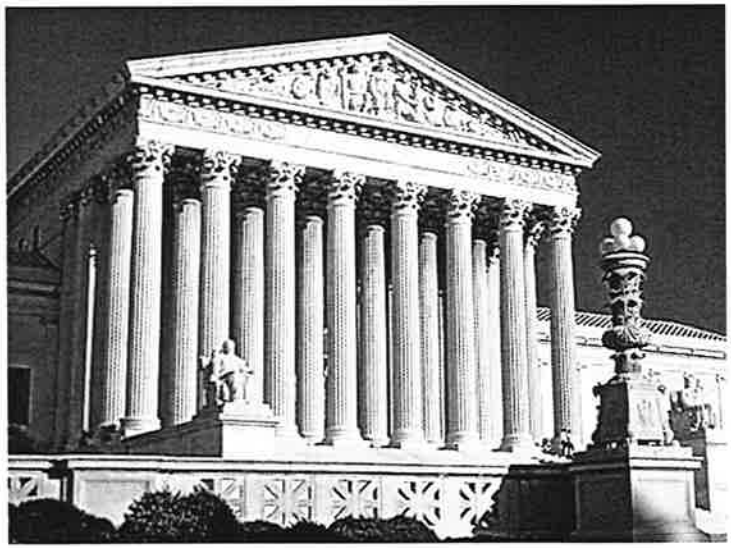
OUTLINE

INFORMATION BRIEFING

- Antitrust Overview
- Facts
- Procedural History
- Opinion
  - Majority
  - Dissent
- Issues to Consider
- Questions

RULING

If a State uses active market participants as regulators, it must provide active supervision if the board is to qualify for state-action immunity from federal antitrust laws.



FEDERAL ANTITRUST LAW

- "...is a central safeguard for the Nation's free market structures."
- "...is as important to the preservation of economic freedom...as the bill of rights is to the protection of our fundamental personal freedoms."

U.S. Supreme Court

PURPOSE OF ANTITRUST LAW

Promote competition to

- Lower prices
- Increase output
- Raise quality
- Expand innovation

ANTITRUST STATUTES

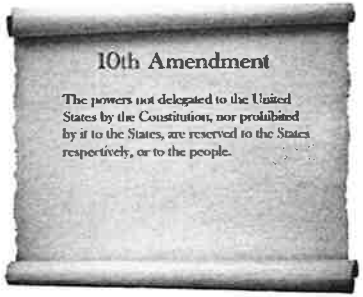
- SHERMAN ACT prohibits
  - Restraint of Trade Agreements
  - Monopolies
- FEDERAL TRADE COMMISSION
  - Unfair competition
  - Deceptive practices
- CLAYTON ACT prohibits
  - Price discrimination
  - Tying arrangements
  - Mergers/acquisitions that lessen competition

FEDERAL TRADE COMMISSION

- Agency established 1914
- Mission: Promote consumer protection and prevent anti-competitive business practices.
- 5 commissioners nominated by President and confirmed by Senate
- Responsibilities:
  - Enforce antitrust laws
  - Review proposed mergers
  - Investigate business practices

STATE ACTION IMMUNITY

- *Parker v. Brown*, U.S. Sup. Ct. (1943)
- Actions by a State are **NOT** subject to federal antitrust laws



- Local governments also immune if pursuing state's "clearly articulated policy to displace competition."
- Private entities may be immune if "actively supervised" by State

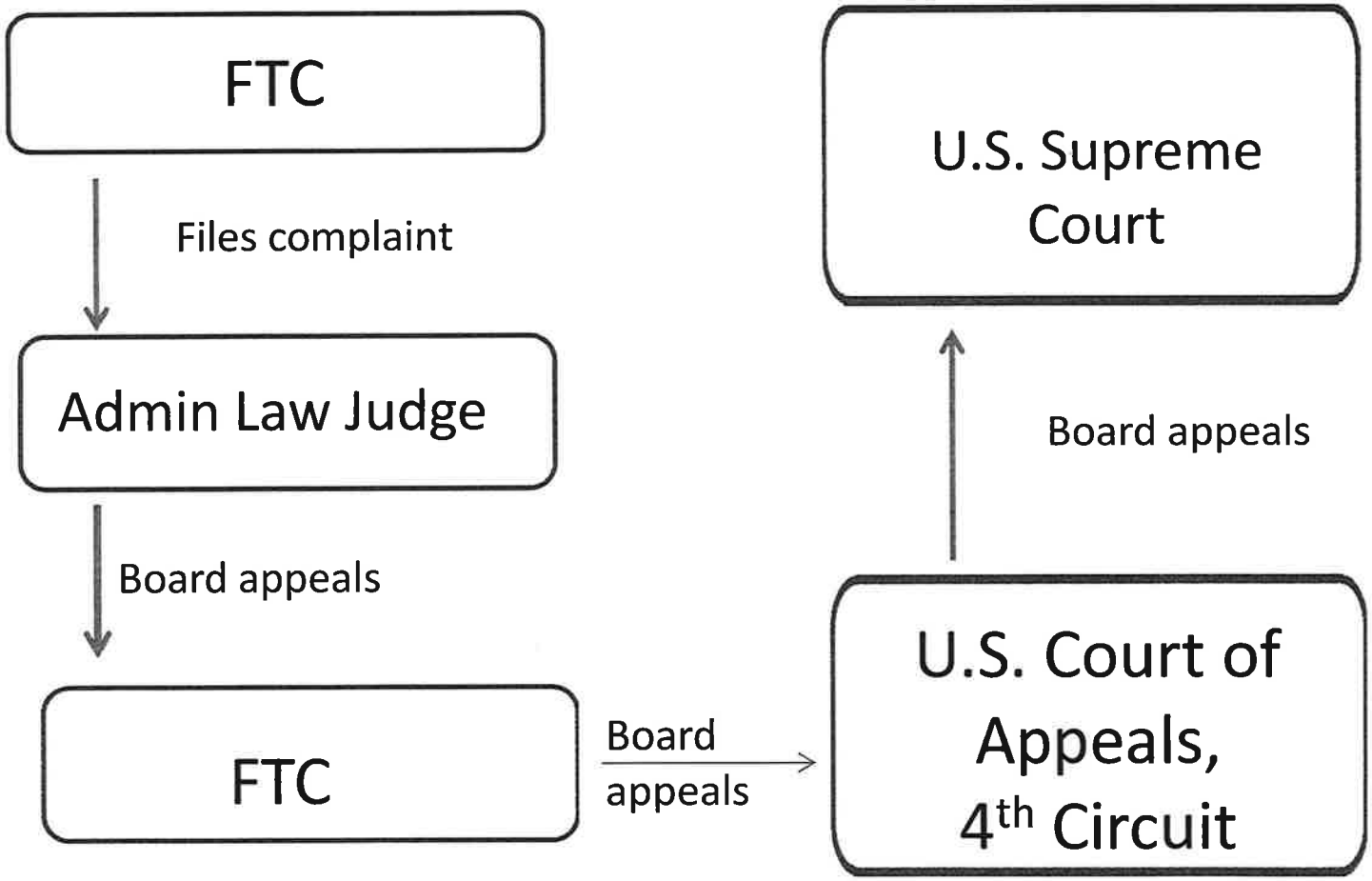
FACTS

- 1990's – North Carolina dentists (including 8 of 10 board members) whiten teeth
- 2003 – nondentists whiten teeth at lower prices – dentists complain
- Board opens investigation
- Board concludes whitening = dentistry despite whitening's omission from NC Dental Practice Act.
- Nobody takes action to amend statute or rules.

FACTS (cont.)

- 2006 – Board issues 47 cease-and-desist letters
- Letters state or imply whitening = dentistry and warn that unlicensed practice = crime
- Board send letters to mall operators re kiosks and urge eviction
- Letters to other regulatory boards

LEGAL HISTORY



PRIMARY QUESTION

- Whether active market participants, acting as unsupervised state regulators, qualify for state-action immunity from antitrust law.

OR

- Is the NC State Board of Dental Examiners truly a state agency?

OPINION

- Majority - Because "controlling number" of Board's decision makers are "active market participants," the Board is treated as a private actor and must show active State supervision.
- Dissent - North Carolina created a state agency and gave that agency the power to regulate.
- 6-3 decision (Alito, Scalia, & Thomas dissent)

POINTS OF LAW

Government character of board not enough. Must be more than mere façade of state involvement to ensure political accountability.

POINTS OF LAW (cont.)

A "nonsovereign actor", controlled by active market participants, is immune only if:

1. Anticompetitive state policy clearly articulated
2. State actively supervises policy

POINTS OF LAW (cont.)

- "state supervision" DOES NOT MEAN
  - day-to-day involvement in operations
  - micromanagement of every decision
- BUT…must be promotion of <u>state policy</u> vs. <u>personal interests</u>.

POINTS OF LAW (cont.)

- State supervisor must
  1. Review substance of anti-competitive decision, not merely procedure;
  2. Have power to veto or modify decision
  3. Not be an active market participant

- Adequacy of supervision depends on circumstances.

OBSERVATIONS
IDAHO REGULATORY BOARDS

Nearly all of Idaho's boards controlled by active market participants (AMP), but…

- Governor appoints board members;
- Executive and Legislative branch reviews appropriations, fees, statutes, and rules;
- Bureau Chief / most Executive Directors not AMP;
- Board Counsel is not AMP;
- Investigators are not AMP;
- Prosecutors are not AMP;
- Hearing officers are not AMP;
- Right to judicial review;

WHAT NOW?

- Idaho Attorney General (AG) issued Opinion 16-1.
- Governor proposing HB 480 & HB 482 to reduce exposure of boards and board members to federal anti-trust claims.

QUESTIONS

MITCHELL E. TORYANSKI

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AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, February 23, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Presentation	Report of the Idaho Family Caregiver Task Force and the Idaho Caregiver Alliance	**Sarah Toevs** Idaho Caregiver Alliance
Presentation	Report of the Collaborative Work Group on Services for Adults with Developmental Disabilities	**Christine Pisani** Idaho Council on Developmental Disabilities

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, February 23, 2016

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:03 p.m.

PRESENTATION: **Caregivers in Idaho**. **Sarah Toevs**, Director of the Center for the Study of Aging and the Idaho Caregiver Alliance (ICA), made this presentation to the Committee (see attachment 1 and attachment 2).

Ms. Toevs presented the findings of the Idaho Family Caregiver Task Force (Task Force). This Task Force, established in 2015, was charged with exploring the issues related to family unpaid caregivers. She recognized Marilyn Sword, Pam Catt-Oliason and the ICA supporters in attendance. **Ms. Toevs** stated that the mission of the ICA was to advance the well-being of family unpaid caregivers by promoting access to quality supports for these individuals. She reported that the ICA comprises more than 50 public and private organizations, with an additional 250 individual members. The ICA was established with a federal grant and is led by the Commission on Aging in collaboration with the Center for the Study of Aging at Boise State University. **Ms. Toevs** stated that family unpaid caregivers make it possible for those with disabilities to stay in their home and community. An estimated $2 billion in unpaid care is provided by these individuals every year. Most caregivers, approximately 70 percent of respondents in 2013, have a paid job in addition to their care provider duties. Family unpaid caregivers save the State resources by delaying the need for institutional care. Idaho spends more than 50 percent of its Medicaid budget on long-term care. **Ms. Toevs** stated that the Task Force was created by a House concurrent resolution and she reviewed the Task Force membership. **Ms. Toevs** reviewed the findings of the Task Force and discussed the three main recommendations from the Task Force: (i) to provide family caregiver supports, (ii) to foster community awareness and engagement and (iii) to integrate family caregivers into the health care system in Idaho (see attachment 1). **Ms. Toevs** described the actions that legislators could take to support family unpaid caregivers.

Chairman Heider asked the Committee members if they had any questions.

Chairman Heider asked how Idaho's State Healthcare Innovation Plan (SHIP) compared to other states' plans. **Ms. Toevs** answered that the SHIP grant is focused on the seven regional health districts within the State. She noted that there are models and programs across the country that the Idaho SHIP could replicate. She provided the example of the respite care registry. **Chairman Heider** asked how the caregivers are organized. **Ms. Toevs** replied that currently there is no list or network of unpaid family caregivers in Idaho.

Vice Chairman Nuxoll asked Ms. Toevs if she was familiar with a program that pays elderly people to stay with and care for other elderly people. **Ms. Toevs** responded that this program is known as the Senior Companion Program, which matches low-income, older adults with each other for community-based supports. The reimbursement for this service is approximately $3.00 per hour. She reported that there are a few Senior Companion Programs active in Idaho. She mused that this program could become even better if the State matched the federal money for this program, paying each caregiver in this program $6.00 an hour.

Senator Harris thanks Ms. Toevs for increasing awareness and supports for family unpaid caregivers.

Referencing the Task Force report, **Chairman Heider** asked how Committee members can become caregiver champions. **Ms. Toevs** answered that Committee members could recognize those who are caregivers, pay attention to them and their needs and also talk to local constituents to find out about them.

PRESENTATION: **Report of the Collaborative Work Group on Services for Adults with Developmental Disabilities**. **Christine Pisani**, Director of the Idaho Council on Developmental Disabilities (Council), made this presentation to the Committee (see attachment 3 and attachment 4).

Ms. Pisani informed the Committee that a developmental disability usually occurs at birth and will be life-long. She noted that developmental disabilities typically impact an individual in three life areas such as the ability to walk, speak or eat. No person with a developmental disability has the exact support needs of another person with a developmental disability. She described the broad spectrum of individuals requiring varying support needs. **Ms. Pisani** discussed the diversity of the collaborative work group members. This group seeks best outcomes and best use of resources for those they serve. She recognized the members of the work group in attendance. She explained that the vision for adults with developmental disabilities is to have the same rights, opportunities and freedoms their neighbors have by the year 2020.

Ms. Pisani discussed the soft direction option, including the six categories of soft direction: (i) employment support, (ii) emotional support, (iii) personal support, (iv) job support, (v) relationship support and (vi) family support. **Ms. Pisani** reviewed the findings of the work group. **Ms. Pisani** explained that the Council conducted a phone survey of more than 214 randomly selected individuals. The analysis of the phone survey will be available soon on the Council's website. It addresses the different choices and controls that participants have over aspects of their own lives. Next, **Ms. Pisani** discussed the National Core Indicator (NCI) project and the need for Idaho to become an NCI state. The purpose of the NCI project is to establish a standard set of outcome measures to track performance and contribute to data-driven decision making. She noted that, if it were to enroll as a member, Idaho will benefit from performance benchmarks, provider cost information, assistance with some waiver reporting and data to help with accountability. She reviewed the fiscal impact of enrolling as an NCI member.

Ms. Pisani discussed and showed the Committee a video about the person-centered planning process. She stated that this process identifies needs first and also empowers the participant to choose the life they want to live. **Ms. Pisani** concluded the presentation by reiterating the collaborative work group's commitment to work for improved support services, accountability and participant empowerment.

Chairman Heider asked the Committee members if they had any questions.

Chairman Heider asked if the Council's pay structure issues have been addressed. **Ms. Pisani** answered that the pay structure issues related to residential habilitation services. She indicated that a pay rate study is underway and should be completed by the end of May. **Chairman Heider** asked if a report would be issued after the study is completed. **Ms. Pisani** replied that it is likely a report will be released, but this would probably be a question for Lisa Hettinger, the administrator for Medicaid. **Chairman Heider** commented that the Committee wants to make sure that providers are being properly reimbursed for their services.

Senator Hagedorn asked about the costs to become an NCI state. **Ms. Pisani** answered that the total of $83,000 includes $13,000 a year in dues and $70,000 for the resources necessary to conduct a survey of more than 400 individuals recommended every three years.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:59 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Michael Jeppson
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 23, 2016

ATTACHMENT 1

CAREGIVERS IN IDAHO

Idaho Caregiver Alliance

Sarah Toevs
Pam Catt-Oliason
Marilyn Sword

Mission and Vision

- advance the well-being of caregivers across the lifespan by promoting collaboration that improves access to quality, responsive support across the state

- a statewide voice, convener, and catalyst for sustaining and supporting these essential providers of care

Idaho Caregiver Alliance

- more than 50 public and private organizations and 250 individual members
- launched in 2013 with support from the Administration for Community Living
- led by the Idaho Commission on Aging in collaboration with the Center for the Study of Aging at Boise State University

More than 1 in 4 Idahoans are caregivers

- make it possible for children and adults living with disabilities, long term illnesses and frailty to live in their home and community
- provide estimated $2 billion/year in unpaid care
- most juggle paid work and caregiving responsibilities

Idaho Caregivers

- Save Idaho resources by delaying need for institutional care
  - Medicaid is the primary payer for institutional care in Idaho
    - $2.4 billion expenditure in 2012
  - Over 50% of Medicaid budget spent on institutional care

Medicaid Expenditures for Long-Term Services and Supports in FFY 2012, CMS, April 28, 2014. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-2012.pdf

A Caregiver's Fear

AGING IN AMERICA

'Promise you'll never put me in a nursing home'

Many caregivers feel duty-bound to not break such a vow, despite the toll and possible danger

Feelings of failure are unwarranted, experts say, and add to stress of placing loved one in a facility

BY TARA BAHRAMPOUR
The Washington Post

Whenever Sarah Harris and her husband, Ernie, drove past a nursing home, he would say the same thing: That's where you're going to put me. That's where I'm going to be sent.

"I would say, 'No, I don't think that's going to happen,' " said Harris, of Fairfax, Va.

Her husband had been diagnosed with Alzheimer's disease at 53. She was 10 years younger and believed she could care for him until the end.

"I knew that he did not like nursing homes," she said. "His dad lived in a retirement community, and he really did not like facilities."

His fears, and her assurances, mirror conversations that are playing out increasingly between husbands and wives, children and parents, and others as the population of older Americans swells. By 2050, the number of people 85 and older is projected to triple.

"Promise you won't put me away." It is hard to say no to that request. But it often is even harder to honor it.

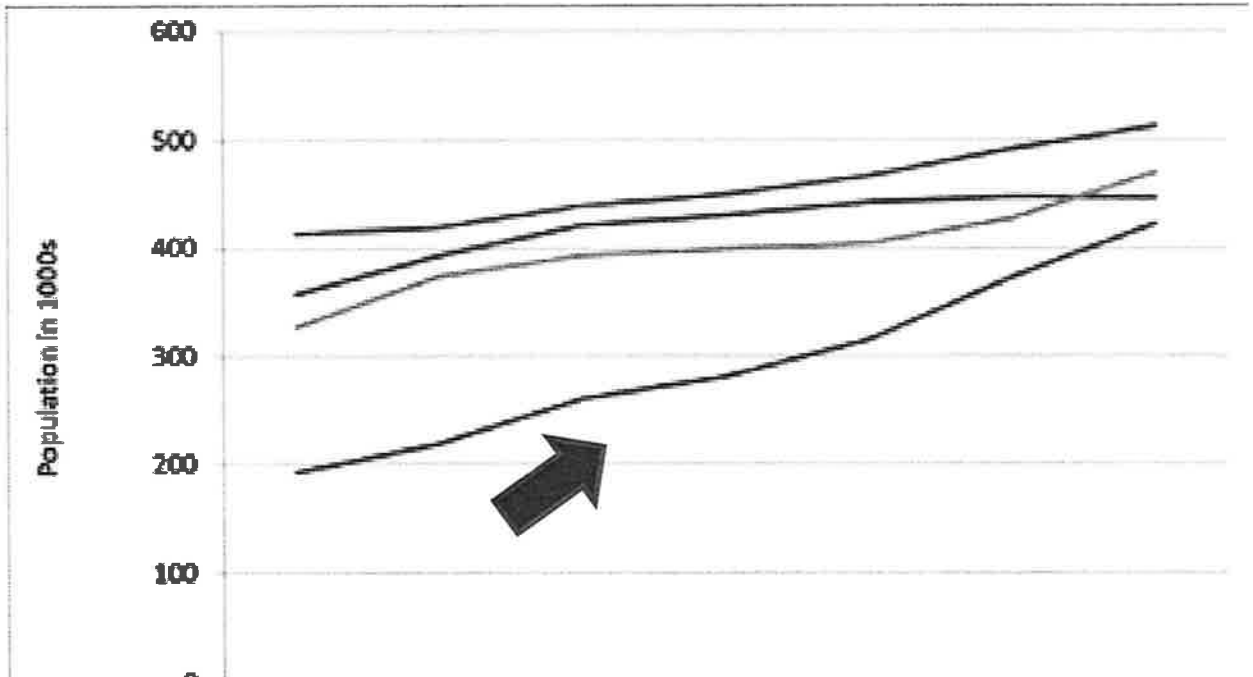
For many, the idea of being sent to a facility implies abandonment. Older Americans remember the poorhouse, where the old and infirm were hidden away to die. But many younger people also are repelled by the idea.

There's now a wider spectrum of facilities catering to different levels

> "IT WAS ONE OF THE WORST DAYS OF MY LIFE, THE DAY I PUT HIM IN A NURSING HOME.
>
> *Sarah Harris, whose husband, Ernie, had Alzheimer's*

SEE NURSING HOMES, 3C

60 + age group fastest growing in Idaho



	2000	2005	2012	2015	2020	2025	2030
0-19 years	414	419	440	450	466	491	513
20-39 years	358	394	422	431	442	448	447
40-59 years	328	375	394	400	405	428	470
60+ years	193	219	261	282	316	374	423

Source: U.S. Census Bureau, 2009 Projections

House Concurrent Resolution 24

- create a caregiver taskforce
- examine policies, resources and programs available for caregivers in Idaho and other states
- study innovative ways to support unpaid family caregivers

Caregiver Taskforce: Membership

- AARP Idaho
- Ada County Community Paramedics
- Advocates for Families/Caregivers
- Area Agency on Aging - CSI
- Blue Cross of Idaho
- Caregivers
- Caregiver Support Agencies
- Center for the Study of Aging - BSU
- Community Partnerships of Idaho
- Disability Rights Idaho
- Friends in Action
- Home Care and Hospice Agencies
- Idaho Alzheimer's Planning Group
- Idaho Area Health Education Center
- Idaho Association of Counties
- Idaho Commission on Aging
- IDHW - Behavioral Health, Public Health, Medicaid
- Idaho Health Care Association
- Idaho Hospital Association
- Idaho Parents Unlimited
- Jannus
- Living Independence Network
- MS Society
- Northwest A.D.A. Center of Idaho
- Qualis Health
- Regence Blue Shield
- Senior Health Insurance Benefits Advisors (SHIBA)
- St. Luke's, Mountain States Tumor Institute
- Treasure Valley YMCA
- Veteran's Administration

Taskforce Findings: gaps in resources

- Assistance is limited, fragmented and based mostly on the care recipient.
- Inadequate training and information for caregivers.
- Caregiver support is lacking.
- Caregiver stress has costs.
- Non-profits have not been a sustainable resource.
- Respite resources are inadequate.
- Respite support is underfunded.
- No options for pediatric respite care in Idaho.

Taskforce Recommendations

Supports For Family Caregivers

- Equip and expand a network of individuals who assist family caregivers to understand, access, and arrange complex services.
- Provide access to training for caregivers on fundamental care responsibilities and self-care strategies.

Community Awareness And Engagement

- Increase public awareness about caregiving including helping people identify as caregivers.

Taskforce Recommendations

Integration of Family Caregivers into Health Systems Transformations

- Influence health care providers to recognize family caregivers as member of the health care team.
- Build community resources with the medical-health neighborhood to support family caregivers
- Partner with SHIP Regional Health Collaboratives.
- Integrate the needs and contributions of unpaid family caregivers in other system transformation efforts.

Going Forward

We ask that you:

- ✓Learn more about the issues facing unpaid family caregivers in Idaho.
- ✓Identify the caregivers in your life.
- ✓Partner with the Idaho Caregiver Alliance to identify resources for family caregivers.
- ✓Endorse the collaboration between the Idaho SHIP and the Caregiver Alliance.
- ✓Support development of a state plan to implement the recommendations identified in this report.
- ✓Become a caregiver champion!

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 23, 2016

ATTACHMENT 2

Caregivers in Idaho

A Report from the Idaho Family Caregiver Task Force and the Idaho Caregiver Alliance

December, 2015

EXECUTIVE SUMMARY

Every day, thousands of Idahoans work 24/7, with love and dedication taking care of a family member who is elderly or has a physical or intellectual disability or mental illness. For some, caregiving lasts a few years. For others, particularly parents of children with physical or emotional disabilities, it lasts a lifetime. These caregivers are the largest workforce in Idaho and, while they find joy in their role as a caregiver, they are exhausted and burning out.

In response to this need and House Concurrent Resolution 24, passed by the Idaho Legislature in 2015, the Idaho Caregiver Alliance formed a Task Force comprised of a wide array of individuals, many of whom had not worked together before, to examine policies, resources and programs available for caregivers in Idaho and other states. The Task Force also studied innovative ways to support unpaid family caregivers.

What the Task Force discovered was that although there are well-intentioned efforts across the state, they are fragmented, siloed, and often limited to specific conditions or geographic areas. In short, **the supports for unpaid family caregivers are inadequate to meet the present and forecasted needs**. Caregivers in Idaho must manage multi-faceted and complex care on behalf of their loved one, and they must do this without the information, training, and support they need. The result of this is caregiver burnout, costly hospitalization, or institutional care for the care recipient.

Task Force Findings:

- ✓ Family caregiving impacts all aspects of a family's economic, physical, cultural, and social wellbeing.
  - Most caregivers are juggling paid work and caregiving
  - Caregiver stress has costs.
- ✓ Assistance is fragmented and mostly focused on the care recipient
- ✓ Demographics are changing; 23 % of Idaho's population will be over age 60 by the year 2030, an increase of 33 % from 2012 (US Census Bureau, 2009 Projections)
- ✓ Non-profit organizations have not been a sustainable source of support for caregivers
- ✓ Respite care is inadequate

We can and must do better. The Task Force offers the following recommendations to begin the process of supporting these caregivers. Recommendations focus on three areas of need: family caregiver supports; community awareness and engagement; and systems change.

FAMILY CAREGIVER SUPPORTS

- ***Priority #1*** ***– Equip and expand a network of individuals who assist family caregivers to understand, access, and arrange complex services.***
- ***Priority #2*** ***– Provide access to training for caregivers on fundamental care responsibilities and self-care strategies***

COMMUNITY AWARENESS AND ENGAGEMENT

- ***Priority #1*** ***– Increase public awareness about caregiving including helping people identify as caregivers.***

SYSTEMS CHANGE

- ***Priority #1*** ***- Influence health care providers to recognize family caregivers as integral members of the health care team***
- ***Priority #2*** ***- Build community resources within the medical-health neighborhood to support those in a family caregiver role through the seven State Health Innovation Plan (SHIP) Regional Health Collaboratives.***
- ***Priority #3*** ***– Integrate the needs and contributions of unpaid family caregivers in other system transformation efforts***

But this is just the beginning. Addressing the priorities identified by the Task Force will not happen without a coordinated and sustained effort. The Idaho Caregiver Alliance has made progress but developing the supports caregivers need and deserve will require the involvement of policy makers and private and public funding. We know an investment in family caregivers will save the state of Idaho money, jobs, and lives.

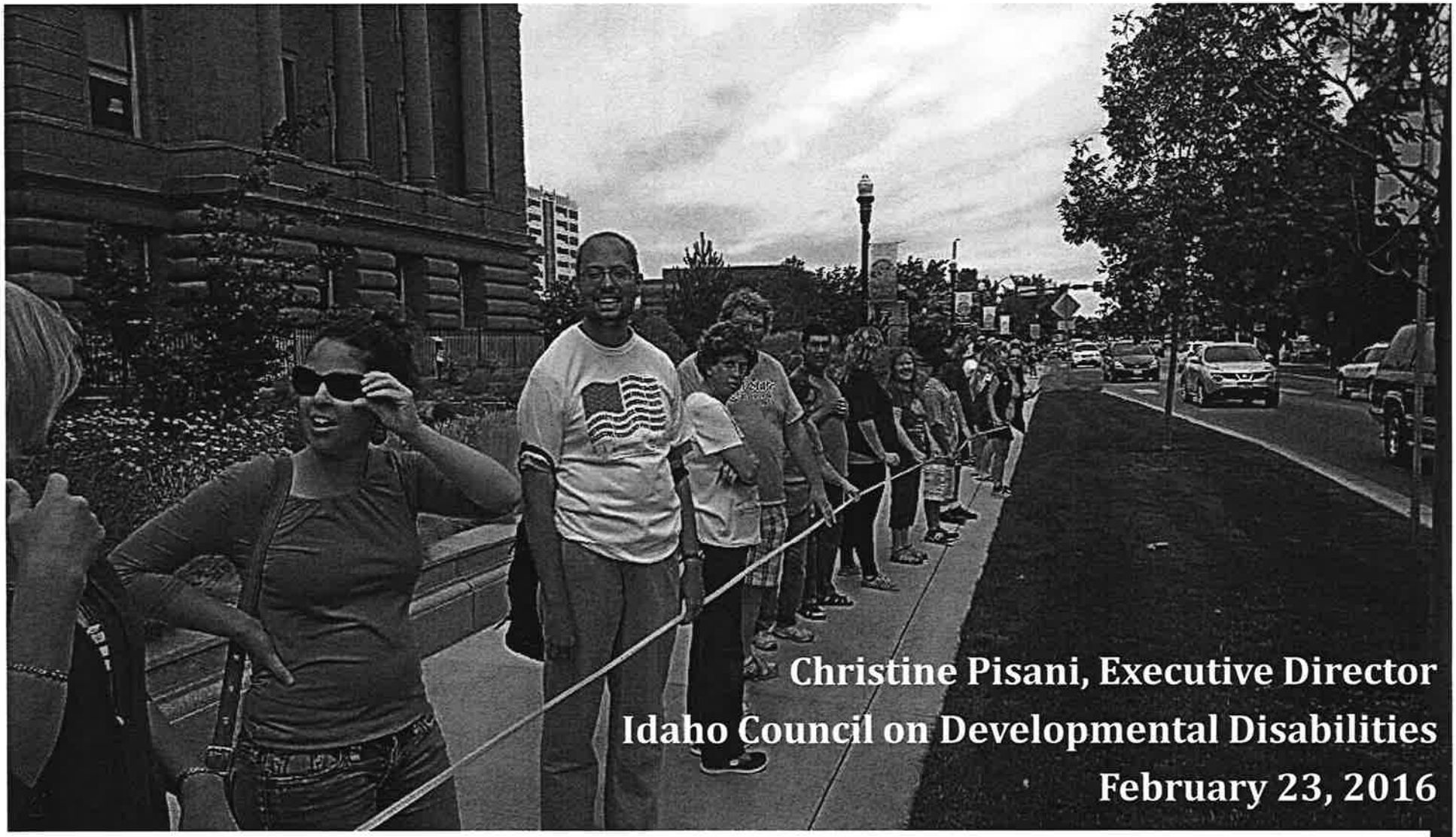
We ask that you:

- ✓ Learn more about the issues facing unpaid family caregivers in Idaho
- ✓ Identify the caregivers in your life
- ✓ Partner with the Idaho Caregiver Alliance to identify resources for family caregivers
- ✓ Endorse the collaboration between the Idaho SHIP and the Caregiver Alliance
- ✓ Support the development of a plan to implement the recommendations identified in this report
- ✓ **Become a caregiver champion!**

Supported with funds from AARP Idaho and the Idaho Caregiver Alliance (sponsored by the Idaho Commission on Aging Lifespan Respite Grant)

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 23, 2016

ATTACHMENT 3

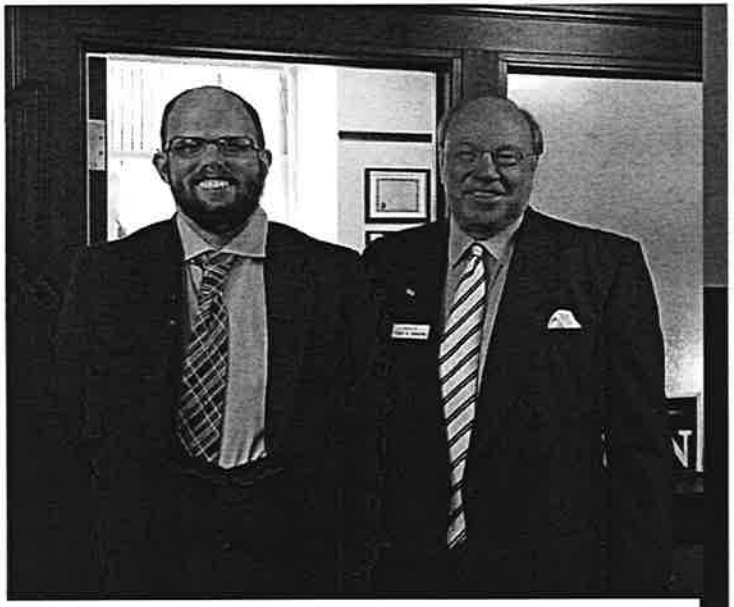


Christine Pisani, Executive Director
Idaho Council on Developmental Disabilities
February 23, 2016

COLLABORATIVE WORK GROUP ON ADULT DEVELOPMENTAL DISABILITY SERVICE REDESIGN

REPORT AND RECOMMENDATIONS

WHAT WE'RE ASKING FOR



- Your understanding
- Your support for enrollment as a NCI State for adults
- Your recognition that these programs require adequate and sustained funding
- Your support for an accountable system

DEVELOPMENTAL DISABILITY - DEFINED

Section 66-402(5) Idaho Code

- Chronic – before age 22
- Impairment (intellectual disability, cerebral palsy, epilepsy, autism or other closely related condition)
- Substantial functional limitations in three or more life activities (self-care, receptive and expressive language, learning, mobility self-direction, capacity for independent living, or economic self-sufficiency)
- Reflects the need for a combination and sequence of special interdisciplinary or generic care, treatment or other services, which are of life-long or extended duration and individually planned and coordinated.

COLLABORATIVE WORK GROUP ON SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES

- Idaho Council on Developmental Disabilities
- 2011
- Seeking best outcomes for participants
- Best use of resources
- System wide

COLLABORATIVE WORK GROUP

ACCESS Idaho	Trinity Nicholson*	Lisa Cahill
Care Providers Network of Idaho (CFHs)	Eva Blecha	Becky Solders
Center on Disabilities and Human Development (UI)	Julie Fodor	Richelle Tierney*
Council on Developmental Disabilities	Christine Pisani	Tracy Warren
Certified Family Homes	Nora Jehn	-
DisAbility Rights Idaho	Jim Baugh*	Dina Brewer
Division of Family & Community Services (crisis)	Blake Brumfield	Cameron Gilliland
Division of Medicaid	Art Evans*	Stephanie Perry
Idaho Association of Community Providers: ▪ Case Management ▪ Developmental Disability Agencies ▪ Residential Supported Living	 Joanne Anderson Maureen Stokes* Bill Benkula*	 Shaun Bills - Shelly Brubaker
Idaho Health Associations/IEFs-ID	Tom Moss	Kris Ellis
Legislature	Rep. Sue Chew	-
Legislature	Sen. Lee Heider	-
Living Independence Network Corporation	Roger Howard	-
Office of the Governor	Tammy Perkins	-
Self Advocate Leadership Network	Noll Garcia	Kristyn Herbert
Vocational Rehabilitation	Jane Donnellan	-
Vocational Services of Idaho	Kelly Keele*	-

VISION

- By 2020, adults with developmental disabilities living in Idaho enjoy the same opportunities, freedoms and rights as their neighbors. They have access to sustainable service systems that provide quality, individualized supports to meet their lifelong changing needs, interests and choices

VALUES

- Respect
- Safety
- Choice
- Quality
- Community Inclusion

THE REALITY

- Medicaid's Self-Direction Option is an important opportunity for participants
- Data informed decisions support the best, most effective, most efficient programs
- Medicaid's HCBS Rules directly support CWG Vision and Values

THE REALITY

- Person Centered Planning is the pathway to best outcomes for participants and effective resource allocation
- Employment is a priority

THE REALITY

- The right data
- The right resource allocation
- The right services and supports
- The right level of expertise
- The right outcomes for participants

…Have a Cost...

- We have to address this challenge

SELF DIRECTION

- Offers individuals the ability to direct their own services and supports
  - One of the most flexible in the Country
  - Currently services 702 adults
  - Opportunities for improvement exist in implementation of proposed HCBS rules

SURVEYS

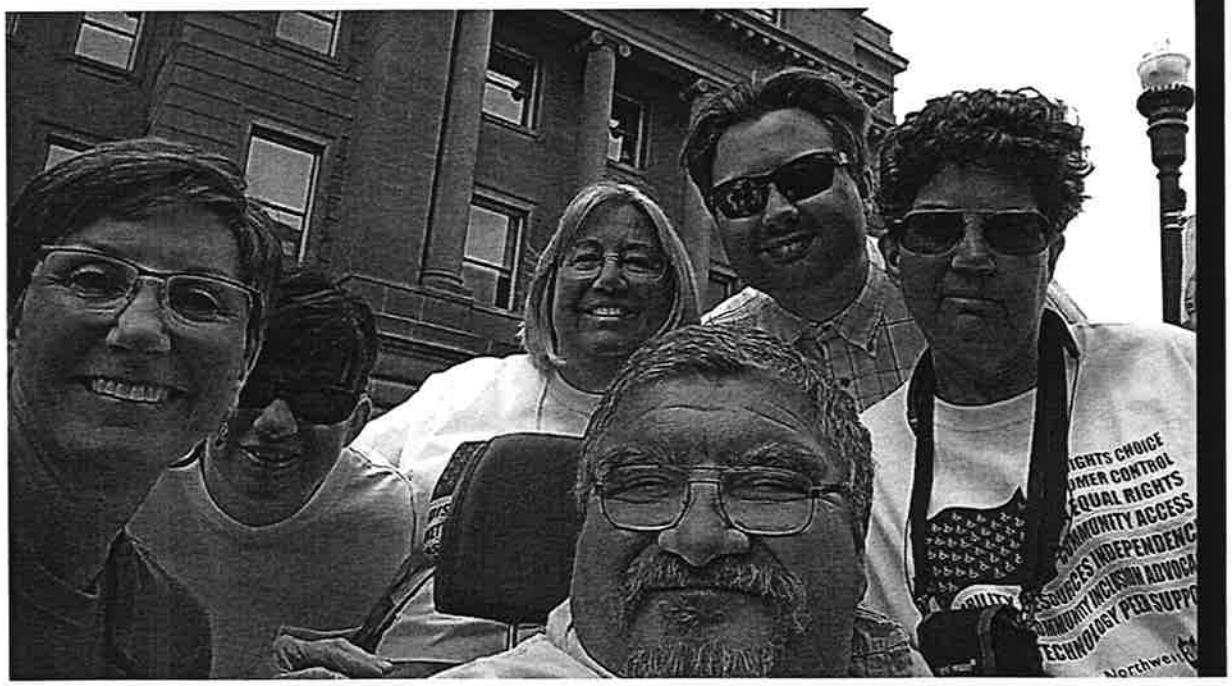
- Conducted five (5) studies to inform our understanding
  - Providers interviewed 162 participants
  - ICDD conducted 60 phone interviews
  - Online survey of 48 providers
  - 214 participated in stratified phone survey
  - HCBS Rules Based Study underway

SURVEYS

- Findings
  - Perceptions about Self Direction
  - Rationale for Choices
  - Misunderstandings regarding access
  - Whether the best outcomes are being achieved

DATA

- ICDD will have spent approximately $55,000 to secure data to inform this work
- ICDD mission more appropriately focused on training, quality assurance and advocacy



DATA

- National Core Indicators Project

  Can't manage what you can't measure

http://www.nationalcoreindicators.org

DATA

- Ensure effective, measurable implementation of HCBS Rules
- Produce meaningful performance measures
- Provides data to assist with accountability
- Prove whether we are securing the best outcomes for participants
- Make Informed Decisions
- Project enrollment

DATA: *ENROLL IN NCI PROJECT*

- Cost
  - $83,000 (every year the adult survey is conducted)
  - Just the one survey (others available)
  - Staff Resources

HCBS RULES: *COMMITTEE APPROVED!*

- THANK YOU
  - Person Centered Planning
  - Quality
  - Accountability

PERSON CENTERED PLANNING

- Person Centered Planning is key to securing best outcomes for participants

PERSON CENTERED PLANNING

- Person Centered Planning is key to achieving the best use of resources

PERSON CENTERED PLANNING

- Person Centered Planning is key to achieving our values
  - Respect
  - Safety
  - Choice
  - Quality
  - Community Inclusion

WE APPRECIATE

- Your understanding of this reality
- Your support for enrollment as a NCI State for adults
- Your recognition that these programs require adequate and sustained funding
- Your support for a accountable system

QUESTIONS

SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 23, 2016

ATTACHMENT 4

2015 Annual Report of the Collaborative Work Group on Services for Adults with Developmental Disabilities

- Findings and Opportunities Regarding the Self-Direction Option in Idaho
- CWG Recommendations for 2016
- Future Developments

February 3, 2016

2015 Annual Report of the Collaborative Work Group on Services for Adults with Developmental Disabilities

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Executive Summary

Within this Annual Report 2015, the Collaborative Work Group (CWG) presents its findings and recommendations regarding Idaho's Adult Developmental Disability Service System. This is the group's second such Annual Report. The CWG includes representatives from a diverse number of associations and organizations who have come together to constructively influence the development of the adult DD service system. Representatives bring the perspectives of people with developmental disabilities, service providers, advocates, agencies and policymakers.

Recommendations

State Legislature: Home and Community-Based Services Rules

CWG asks the 2016 Idaho State Legislature to approve the Home and Community-Based Services rules changes proposed by the Department of Health and Welfare Division of Medicaid (Medicaid). CWG notes the new rules are consistent with the values and direction the CWG has been working over the last several years, and encourages the state legislature to adopt the rule changes as proposed. On October 28, 2015, CWG delivered its specific recommendations respective to the proposed rules to the Medicaid, which urged increased emphasis on person-centered planning, including process quality and accountability and securing meaningful outcomes for participants. Medicaid incorporated those suggestions. Rules implementation will involve a collaborative effort between Medicaid and the CWG.

Idaho Department of Health and Welfare: Resource Allocation

In May 2015, the CWG generated and delivered a proposal to the Division of Medicaid that any needs assessment process selected for Idaho is strengths-based, specifically drives the allocation process (building budgets based on actual needs rather than other factors), and assumes employment is a priority for adults with developmental disabilities. That recommendation rests with Department administration for decision-making. ***CWG recommends the Department adopt its recommendation for Resource Allocation;*** CWG offers to work actively with the Division of Medicaid to assist with its implementation.

Idaho State Legislature and Idaho Department of Health and Welfare: National Core Indicator Data

Last year and again in 2015, ***the CWG recommends the State of Idaho participate in the National Core Indicators Project*** (NCI - http://www.nationalcoreindicators.org). The National Core Indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. NCI resources can, on a consistent and intentional basis, provide Idaho the kind of information CWG and ICDD seek to secure to learn about how to leverage Idaho's Self Direction Program, effectively implement HCBS rules, produce meaningful performance measures, and prove whether Idaho is, or is not, securing the best outcomes for participants.

Helping adults with developmental disabilities live meaningfully inclusive and productive lives: RESPECT

Introduction

Developmental Disabilities – Idaho's Definition

Section 66-402(5) Idaho Code defines a developmental disability as

A chronic disability of a person that appears before 22 years of age and is

- ☐ Attributable to impairment such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments.

The condition:

- ☐ Results in substantial functional limitations in three or more of the following areas of life activity: self-care, receptive and expressive language, learning, mobility self-direction, capacity for independent living, or economic self-sufficiency;
- ☐ Reflects the needs for a combination and sequence of special interdisciplinary or generic care, treatment or other services, which are of life-long or extended duration and individually planned and coordinated.

Collaborative Work Group on Adult Developmental Disabilities Services

The Collaborative Work Group (CWG) on Adult Developmental Disability (DD) Services includes representatives from a diverse number of associations and organizations who have come together to constructively influence the development of the adult DD service system. Representatives bring the perspectives of people with developmental disabilities, service providers, advocates, agencies and policymakers.

CWG seeks to influence the entire system, the core being Medicaid-paid services. CWG also seeks to influence the development of other important community and natural supports, paid and unpaid, such as employment, housing, and transportation – supports essential to helping adults with developmental disabilities live meaningfully inclusive and productive lives.

Convened by the Idaho Council on Developmental Disabilities (ICDD) in November 2011, the group aspires to achieve the following vision:

> *By 2020, adults with developmental disabilities living in Idaho enjoy the same opportunities, freedoms and rights as their neighbors. They have access to sustainable service systems that provide quality, individualized supports to meet their lifelong and changing needs, interests and choices.*

Always, the CWG work and recommendations are grounded in the following values:

- ☐ Respect
- ☐ Safety
- ☐ Choice
- ☐ Quality
- ☐ Community Inclusion

This is the CWG's second Annual Report (Report). This Report presents

- ☐ CWG findings respective to Idaho's "My Voice My Choice" (MVMC) Self-Direction waiver option and opportunities it poses to continue to provide services consistent with CWG values;
- ☐ CWG recommendations for legislation to be presented to the 2016 Idaho State Legislature respective to proposed Federal Home Based Community Services Rules;
- ☐ A summary of future work for the CWG.

More information about the CWG can be found on the ICDD website at www.icdd.idaho.gov.

CWG Members	Delegate	Alternate
ACCESS Idaho	Trinity Nicholson**	Lisa Cahill
Care Providers Network of Idaho (CFHs)	Eva Blecha	Becky Solders
Center on Disabilities and Human Development, UI	Julie Fodor	Richelle Tierney**
Council on Developmental Disabilities	Christine Pisani **	Tracy Warren
Certified Family Homes	Nora Jehn	None
DisAbility Rights Idaho	Jim Baugh**	Dina Brewer
Division of Family & Community Services (crisis)	Blake Brumfield	Cameron Gilliland
Division of Medicaid	Art Evans**	Stephanie Perry
Idaho Association of Community Providers:		
- Case Management	Joanne Anderson	Shaun Bills
- Developmental Disability Agencies	Maureen Stokes**	None
- Residential Supported Living	Bill Benkula**	Shelly Brubaker
Idaho Health Associations/ICFs-ID	Tom Moss	Kris Ellis
Legislature	Rep. Sue Chew	None
Legislature	Sen. Lee Heider	None
Living Independence Network Corporation	Roger Howard	None
Office of the Governor	Tammy Perkins	None
Self Advocate Leadership Network	Noll Garcia	Kristyn Herbert
Vocational Rehabilitation	Jane Donnellan	None

***Indicates Steering Committee Member*

Addressing key areas of concern including: SAFETY

Findings and Opportunities Regarding Self-Direction in Idaho

Medicaid and Self-Direction

Medicaid is a federal program providing a 70/30 Federal to State match funding for medical and health related services for people with low income in the United States. The Bureau of Developmental Disabilities Services (BDDS) within the Idaho Department of Health and Welfare (DHW) Division of Medicaid manages the Medicaid-paid services for adults with developmental disabilities.

Currently, approximately 3000 adults receive Medicaid waiver services in Idaho, served by approximately 100 Medicaid Providers.

The goal of the Adult Developmental Disabilities Program in Idaho "is to assist adults with developmental disabilities in getting the right care at the right place at the right cost with the right outcomes."

Medicaid also provides each state the opportunity, through a Medicaid Waiver (Medicaid Home and Community-Based Services §1915(c) of the Social Security Act), to provide an array of services that assist Medicaid beneficiaries to live independently, seek job skills, participate in their own community, and have the freedom to manage their own lives in the least restrictive environment.

Idaho's Division of Medicaid's MVMC Self-Direction waiver option offers participants the ability to direct their own services and

supports. Currently (December 2015) this option serves 702 adults.

To support the CWG activities, the ICDD conducted a number of surveys and studies to inform its understanding of the self-direction option. Table 1 provides a summary of survey efforts undertaken by the Council that are summarized as appropriate in the following pages.

	Survey Effort	Purpose	Participants	Survey Style	Survey Dates	#
1	Medicaid recipients interviewed by provider agency personnel	To determine how Medicaid waiver recipients spend their dates, what they want to do and what barriers prevent desired activities	Traditional and Self Direction Program participants	In person interview by provider	10/13 – 12/13	162
2	Pre-Survey Medicaid recipients/families interviewed by phone (no data analysis)	To determine how Medicaid waiver recipients spend their days, what they want to do and what barriers prevented desired activities	Traditional and Self-Direction Program participants	Phone survey of persons who responded to Council advertisements to volunteer for the study	08/14 – 11/14	60
3	Individual Provider online survey concerning Self-Direction	Determine if providers knew they could provide Self-Direction, and why they did not provide service when aware	Traditional DD recipients (2 TSC providers were also Support Brokers)	Online, Survey Monkey	07/14-09/14	48
4	Randomly selected names from all DD Waiver Medicaid recipients	To determine how Medicaid waiver recipients spend their days, what they want to do and what barriers prevent desired activities	Traditional and Self-Direction Program participants	Cold call phone survey. Two-four attempts made at different times.	02/15 – 01/16	214
5	HCBS Rule Based Study	Evaluate current compliance to new HCBS rules to establish a baseline	Traditional and Self-Direction Program participants	In-person interviews after initial letter and phone call	09/15 – TBD	TBD

Table 1. Inventory of Surveys

Findings and Opportunities

In comparing Idaho's MVMC program to other states, the CWG determined Idaho's program:

- ☐ Makes possible a high level of participant choice, control and flexibility within the Medicaid system;
- ☐ Can be creatively adapted to a participant's needs and preferences;

- ☐ Can be used to access services from traditional providers in a way that preserves choice and flexibility.

Summarily, CWG found this waiver option to be among the most diverse and flexible in the nation.

In two of its first three survey efforts Surveys #1, #2 and #3), one conducted by providers of participants and one directed at providers, CWG found misunderstanding and challenges related to using MVMC and to using it to its capacity, as indicated in the following table.

Table 2. Perceived challenges and opportunities related to using the Self-Direction option

	Challenges	Opportunities
Participants	▪ Availability of community support workers to meet their needs/back-up supports ▪ Workers compensation ▪ Lacked quality assurance	▪ Higher degree of choice ▪ Ability to go to agency as well as hire from community members ▪ Ability to negotiate costs
Providers	▪ Approximately 20% of provider agencies are unaware they can provide services to people on self-direction ▪ Concern the budget will not address the need ▪ Coding billing ▪ Feeling that rules and reimbursement rates of the two programs not equal ▪ Use of their employees complicates the Fiscal Employees Agent (FEA) process ▪ A specific person needs to be identified on the service plans – agencies need more flexibility ▪ Negotiation of rates ▪ Lacked quality assurance	▪ Customize services to meet participant needs ▪ Inform regarding opportunities ▪ Less paperwork ▪ Fewer Medicaid rules

To supplement the provider interviews of participants, the Council conducted a telephone survey to make more specific inquiries around the experience of using the self-direction option (Survey #4).

The University of Idaho Center of Disabilities and Human Development has analyzed the results of that survey and produced a January 2016 report entitled: The Idaho Adult Developmental Disabilities Traditional and Self-Direction Waiver Phone Survey Results. The results of the survey will soon be made available on the ICDD website at www.icdd.idaho.gov.

Table 3 provides a summary list of themes generated by the supplemental telephone survey and indicated by the level of use of the program.

CWG learned from this survey that all individuals with developmental disabilities age 18 to 22 who received family-directed services as children continued on self-directed services as they transitioned to adult services. While some individuals spent part of their budget on agency-provided (traditional) services, none who previously received family-directed services opted for traditional DD services.

The survey also showed that using the self-direction option does not necessarily mean the individual is involved in their community. For some, the lack of involvement was related to behavior, health or personal preference. Some lived in an isolated location. Others received a small budget. For others, lack of involvement appeared to relate to Community Support Worker expectations or other time commitments.

Much of this feedback came from providers rather than individuals, so the lessons learned are often filtered, accurately or otherwise, through that lens.

Some individuals on self-direction identified themselves as having a paid or volunteer job. CWG learned that in those cases, the individual's Community Support Worker often acted in the role of job coach. It appears, however, that many of these activities would not be covered under Vocational Rehabilitation or other traditional job programs.

Individual choices regarding self direction	Participant rationale for his/her choice
Individuals or families who switched to self-direction	▪ Some type of bad experience with agency centered services or group homes, such as abuse, inability of staff to handle behavior issues, frequent staff or housing changes ▪ A desire to have more community based experiences or volunteer/work experiences ▪ Having community experiences always in "groups" of people with disabilities ▪ Having to participate in activities that hold no interest to their son or daughter ▪ A lack of available and/or conveniently located agency services in rural/frontier areas ▪ The need to structure services that fit a unique setting or circumstance (the family farm, a long-term relationship between two people with developmental disabilities, certain health or behavior issues) ▪ The ability of the individual, parents or others to screen and train staff
Individuals who switched from self-direction back to traditional services	▪ The lack of availability of back-up staff ▪ The age or health of the person who had previously helped the individual to direct their services.
Individuals who considered the self-direction option but chose traditional instead	▪ The individual enjoyed the people and activities at their Developmental Disability Agency (DDA) ▪ The lack of back-up staff ▪ Self-Direction lacks regulations and monitoring ▪ Parents/guardians did not want the responsibility of hiring and supervising staff, filling out paperwork, having to cover for staff who suddenly quit or got sick ▪ Parents felt that staff at DDA's were trained and addressed their adult child's needs
Parents/guardians and individuals who were most satisfied with self-direction	▪ Families or individuals had a network of natural supports ▪ Family or friends could provide back-up services to the individual if needed (parents often reported that they did not need back-up staff as they could step in or had relatives/friends they could call) ▪ The individual was not dependent on assistance with activities of daily living or health related issues ▪ The individual and/or family could tolerate a somewhat flexible schedule

Table 3. Rationale for choices regarding self-direction

Implications for Future Work

Survey results generated the following important findings:

- ☐ A large majority of parents/guardians/Certified Family Home providers and Supported Living staff were reluctant to let us speak to the individual with a disability, both those on the self-direction and traditional programs. This was true even when the individual did not have a guardian. ICDD staff did not insist and talked instead to the parent or provider.
- ☐ Most parents and Certified Family Home providers volunteered that the person we wanted to speak with had mental or physical limitations that kept them from talking on the phone. ICDD staff sometimes knew this was not necessarily so, as staff knew a few individuals personally.
- ☐ Supported living staff sometimes refused to confirm or deny a person even lived at the residence, citing HIPPA rules. Usually they would share their agency's name and number if we insisted;
- ☐ Even when confirming we had the right number, a majority of supported living staff refused to let us speak to individuals without a supervisor's permission – even when the individual did not have a guardian.

Survey results inform CWG and Medicaid opportunities to clarify the Self-Direction option, and underscore the significance of the new federal and proposed state Home and Community Based Services (HCBS) rules.

This knowledge informs the CWG efforts and recommendations for a qualitative and quantifiable baseline on which Idaho's progress in adopting and implementing HCBS rules can be effectively measured against participant outcomes, more fully described in the following section of this report.

Providing participants the ability to direct their own services and supports: CHOICE

CWG Recommendations for 2016

Adopt Home and Community-Based Services Rules

In January 2014, the Centers for Medicare & Medicaid Services (CMS) passed new rules for Home and Community-Based Services (HCBS), which provide opportunities for waiver participants to receive Medicaid services in home and community-based settings. The rules, effective March 2014, place new requirements on states respective to how the Medicaid home and community based services program is operated. States have five years to fully implement the new requirements.

Medicaid has prepared the Statewide Transition Plan and submitted it to CMS for approval.

To meet the requirements, the Division of Medicaid presented proposed rule changes in January 2016 to the Idaho the Idaho State Legislature. CWG is pleased to note the new rules are consistent with the values and direction the CWG has been working over the last four (4) years, and encourages the state legislature to adopt the rule changes as proposed.

CWG delivered its recommendation respective to the proposed rules to the Division of Medicaid on October 28, 2015. The recommendation urged increased emphasis on person-centered planning and the quality and accountability of that process and the results it

generates for participants. A copy of the recommendation is included as Attachment A.

Rules implementation will feature a collaborative effort between Medicaid and the CWG.

To ensure adults with a range of developmental disabilities have a real voice in the implementation of the CMS HCBS rules, ICDD and the University of Idaho Center on Disability and Human Development (CDHD) worked collaboratively with the Division of Medicaid to create a face-to-face statewide study reflective of the range of participants served through DD waiver. The study intends to establish a baseline of what the service system looks like now through the eyes of adults with developmental disabilities when asked about integration, choice, control, person centered-planning, employment, and privacy through HCBS services. The baseline of this initial study will be provided to the Division of Medicaid for use in evaluating service provider compliance within the first year of implementation of the HCBS rules. The study is significant because of the intentional work to interview participants at all support levels to assure that each participant has the opportunity to provide their input.

The study began in September of this past year and will conclude by June of 2016, just before the implementation of the rules on July 1, 2016. All participants in the initial study will be interviewed a second time in 2019 to learn of their perception about how the rules impacted their ability to have more choice, control, privacy, community integration, and participation in their planning meetings.

Address Resource Allocation

Last year the CWG reported that an opportunity exists to improve the assessment and resource allocation process. While discussion and study regarding assessment tools and processes are still underway, the CWG generated and delivered, in May 2015, a proposal to the Division of Medicaid that any needs assessment process selected for Idaho is strengths-based, specifically drives the allocation process (building budgets based on actual needs rather than other factors), and assumes employment is a priority for adults with developmental disabilities. A copy of the recommendation is included as Attachment B.

With the recommendation, the CWG recognized inherent challenges the approach posed to the Division of Medicaid. CWG presented preliminary process options to help address the Division's needs to prevent abuse, project future years numbers of users and costs, and ensure allocated budgets do not exceed available funding.

CWG worked with Division staff on articulating its recommendation to Department leadership, and look forward to coordinating with the staff when the final decision is made, and supporting implementation details.

Secure Idaho-specific Data to Inform Decision-Making

In the absence of data needed to inform effectiveness, ICDD utilized approximately one-quarter of its annual project budget for data collection this year, including the phone survey and the statewide face-to-face study summarized earlier. The Council's investment of resources for this small state agency has amounted to $29,144 spent with 2,237 staff hours invested to date. It is anticipated that the study underway will cost an additional $24,000 and 240 hours over the next six months, totaling 2,477 staff hours and $53,144 in Council funds.

Even with that, the depth of the data represents only a small sample of adults with developmental disabilities in Idaho. CWG and the Council continue to seek information that is increasingly robust and meaningful.

Last year, the CWG recommended the State of Idaho participate in the National Core Indicators Project (NCI -

http://www.nationalcoreindicators.org). NCI can provide the qualitative and quantitative type of data that will guide Idaho's decision-making to secure the best outcomes for participants.

The Core Indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. Idaho is one of six states in the nation who do not use the database to inform its works with people with developmental disabilities. NCI resources can, on a consistent and intentional basis, provide Idaho the kind of information CWG and ICDD seek to help ensure effective implementation of HCBS rules, produce meaningful performance measures, leverage Idaho's Self-Direction Program, and prove whether Idaho is, or is not, securing the best outcomes for participants.

CWG recognizes participation comes at a cost to the state, but CWG maintains that participation will enable Idaho to prove and improve its performance. The move will provide accurate qualitative and quantitative data to inform decision-making by entities like the Council. Others responsible for supporting people with developmental disabilities will find the information invaluable as well. This investment will also provide the Council increased opportunities to focus on addressing other elements of the system where an existing tool does not exist–specifically providing the resources for participant advocacy as required by the HCBS rules and in perfect concert with the Council's mission.

Securing and knowing you secure the best outcomes for participants: QUALITY

Future Developments

Quality Assurance

Through a prioritization process between the CWG and the Council, Quality Assurance has been selected as the topic for study and recommendations for 2016.

In order to increase the opportunity for quality outcomes for participants, the CWG will study and, by May 31, 2016, generate recommendations on Quality Assurance with an emphasis on Person Centered Planning (PCP) as it pertains to any stakeholder or participant in the HCBS system.

Preliminarily, CWG identifies an opportunity to increase the right outcomes for participants by assessing best practice implementation of the PCP process and providing an intentional focus on training.

Idaho Employment First

CWG continues to support the efforts of the Idaho Employment First Consortium to enhance the Idaho service system to ensure employment outcomes for Idahoans with developmental disabilities. A copy of the Consortium's Recommendations for Medicaid Employment Services is included as Attachment C as an informational item.

Enjoying the same opportunities, freedoms and rights as our neighbors: COMMUNITY INCLUSION

ATTACHMENT A: CWG Recommendations on HCBS Rules

IDAHO COUNCIL ON DEVELOPMENTAL DISABILITIES

700 W. State St.
JRW Building
First Floor West
Boise, ID 83702-5868
Phone: 208-334-2178
1-800-544-2433
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C. L. "Butch" Otter
Governor

Debra Parsons
Chair

Christine Pisani
Executive Director

October 28, 2015

HCBS
Division of Medicaid
PO Box 83720
Boise, ID 83720-0009

Dear Mr. Evans:

The Collaborative Work Group (CWG) on Adult Developmental Disability (DD) Services includes representatives from a diverse number of associations and organizations who have come together to constructively influence the development of Idaho's adult DD service system. Representatives bring the perspectives of people with developmental disabilities, service providers, advocates, agencies and policymakers. The group aspires to achieve the following vision:

By 2020, adults with developmental disabilities living in Idaho enjoy the same opportunities, freedoms and rights as their neighbors. They have access to sustainable service systems that provide quality, individualized supports to meet their lifelong and changing needs, interests and choices.

Always, the CWG work and recommendations are grounded in the following values:

- Respect
- Safety
- Choice
- Quality
- Community Inclusion

More information about the CWG, can be found on this link to the ICDD website.

The CWG appreciates this opportunity to provide comments on the proposed Home and Community Based Services (HCBS) rules the Department is preparing for consideration by the 2016 State Legislature. The CWG offers the following general comments for the Department's consideration. More specific comments are included as an attachment.

1. The proposed HCBS rules respond to rules promulgated by CMS in March 2014. Idaho's proposed rules demonstrate Idaho's commitment to implement those rules. Furthermore, Idaho's proposed rules are in line with the Vision and Values the CWG adopted in 2011. While some specific comments follow, CWG supports adoption of the HCBS rules.

2. Person-Centered Planning is a service and process fundamental to providing the respect, value and choice each individual deserves. Specific attention to how those requirements are described–and how those requirements are implemented–is and will continue to be of importance to the CWG and key to the best outcomes for participants.

For this reason, these comments are presented in this letter in addition to the attachment.

- Specifically, the definition of Person-Centered Planning could be interpreted in a narrow way only requiring documentation that the team "focused" on the needs and preferences of the participant. CWG seeks to have the planning process result in specific outcomes derived from the participant, who is driving the process, and the resulting plan actually helps achieve their own goals. While the actual detail in Sections 312, 315 & 316 provide this type of direction, the definition could be misinterpreted respective to intent.
- The definition of Person-Centered planning is different in 16.03.10.721 SERVICE COORDINATION: DEFINITIONS where it says only "expressed needs" must be considered in developing the plan. CWG recommends using the CMS definition of person-centered planning, which is more expansive and reflective of the CWG Vision and Values.
- CWG recommends there be a defined process to follow if a member of the planning process does not agree with the results during and following the planning process.
- A more specific definition/distinction between a "plan monitor" and how that differs from the Department's "case manager" would be helpful, with an eye for minimizing layers of review and maintaining as much control as possible with the participant.

3. Respective to achieving the most meaningful person centered planning process, an intentional emphasis on provider education is recommended. This training should include: 1) how to conduct quality person centered planning, and 2) how to assist adults with intellectual and developmental disabilities to learn the leadership skills necessary to lead their planning meetings in an authentic way.

Thank you for your consideration of these general comments, as well as of the specific comments attached. Should you have any questions of the CWG, please let me know or come to the next full meeting of the group.

Sincerely,

Christine Pisani, Executive Director
Idaho Council on Developmental Disabilities
Collaborative Work Group on Adult Developmental Disabilities Services

RE: DRAFT DOCKET NO. 16-0310-1501

PERSON CENTERED PLANNING

Person-Centered Planning is a service and process fundamental to providing the respect, value and choice each individual deserves. Specific attention to how those requirements are described–and how those requirements are implemented–is and will continue to be of importance to the CWG and key to the best outcomes for participants. For this reason, these comments are presented in this letter in addition to the attachment.

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- A more specific definition/distinction between a "plan monitor" and how that differs from the Department's "case manager" would be helpful, with an eye for minimizing layers of review and maintaining as much control as possible with the participant.

Respective to achieving the most meaningful person centered planning process, an intentional emphasis on provider education is recommended. This training should include: 1) how to conduct quality person centered planning, and 2) how to assist adults with intellectual and developmental disabilities to learn the leadership skills necessary to lead their planning meetings in an authentic way.

Page 14 Section 312

The increased emphasis on "opportunities to seek employment and work in competitive integrated settings" is appropriate and aligns with Idaho's Employment First initiative. Even though the introductory paragraph to Section 312 HOME AND COMMUNITY BASED SETTINGS REQUIREMENTS clarifies the intent, as "participants have the same opportunities for integration . . . as individuals who do not require supports", the language in 312.01.b seems to indicate disability specific settings may remain the norm for Developmental Therapy and Adult Day health, indicating most services will be delivered in disability specific settings, which is contrary to what appears to be the intent of HCBS and certainly of the

CWG. To change the emphasis, we propose a revision to 312.01.b to read "are selected by the participant or legal guardian from among non-disability and disability specific settings, are based on the participants...."

Page 16 Section 315

03. In Plain Language and Accessible. Describe what is meant by plain language: "Plain language writing emphasizes the use of the clearest words possible to describe actions, objects and people. That often means choosing a two-syllable word over a three-syllable one, elimination of jargon, acronyms, and sometimes, several clearer words instead of one complicated word".

Page 17 Section 316

05. Individually Identified Goals and Desired Outcomes. Provide evidence of a demonstrated effort to identify participant goals and desired outcomes in the development of the person centered plan.

10. Plan Signatures. Provide clarity to all parties involved about what "signing" the plan indicates.

Page 26 Section 513

02. Plan Development. Define the term "facilitator".

Page 28 Section 513

08. Informed Consent. Consider including the following language: "The plan should include evidence of pre-planning conducted with the participant to assist them with the leadership of their person centered planning meeting."

Page 53: Section 729

There is no specific initial or ongoing training requirement for those providing Service-Coordination, which would ensure an understanding of viable Person-Centered planning processes. CWG recommends initial and ongoing uniform training for Person-Centered Plan Developers are required based on agreed-upon philosophical orientation.

RE: DRAFT DOCKET NO. 16-0313-1501

Only 16.03.10 SECTIONS 315 and 316 are required to be utilized by the Support Broker in the facilitation of the Person-Centered Planning process. The most important concepts to be included in Person-Centered Planning are found in 16.03.10 SECTION 312 HOME AND COMMUNITY BASED SETTINGS REQUIREMENTS. CWG recommends references to this section to strengthen the intent of the Person-Centered Planning process.

COLLABORATIVE WORKING GROUP FOR ADULT DEVELOPMENTAL DISABILITIES ASSESSMENT AND RESOURCE ALLOCATION: RECOMMENDATION MAY 14, 2015

The Collaborative Working Group (CWG) for Adult Developmental Disabilities met on May 14, 2015 in Boise, Idaho and generated the following proposal for the state's consideration respective to selecting an Assessment and Resource Allocation process for Idaho adults with development disabilities. CWG has been reviewing other states' systems and a variety of assessment tools, including the SIB-R, SIS and InterRAI, over the past several years. This spring their work dovetailed with that of a DHW-convened project team who also reviewed tools and generated four different options for consideration by DHW administration.

More information about the CWG, its membership, principles, processes, and its recommendations can be found in its Annual Report at the following link:
http://icdd.idaho.gov/pdf/Idaho%20CWG%20Report%20to%202015%20Legislature.pdf

The discussion CWG pursued is specific to an assessment process that produces an allocated budget to meet individual needs. This recommendation specifically does not address an assessment process that determines DD program eligibility.

RECOMMENDATION

Fundamentally, the CWG proposes that *any needs assessment process* selected for Idaho is strengths based, specifically drives the allocation process–building budgets based on actual needs rather than other factors–and assumes employment is a priority for adults with developmental disabilities.

Any assessment and resource allocation process selected by the state should feature the following characteristics:

1. The process must be transparent, easily understood, and 'welcoming' to the adults undertaking them;
2. The process specifically utilizes a person-centered planning approach as defined by CMS, recognizing each individual is unique in their needs and ensuring each plan is specifically responsive to individual conditions;
3. The process will be comprehensive in its definition of needs across all life areas, including but not limited to the individual's situation respective to:
    - Health and Medical needs
    - Mental/Behavioral Health needs
    - Independent living skills
    - Safety
    - Employment
    - Community Integration
4. Based on the individual needs generated through a person-centered approach, the process will identify the hours of support required to meet those needs and the qualifications of the personnel required to provide them;
5. With this deliverable, the allocation process will generate a budget that is fair and equitable, appropriately meeting the individual's current needs and specifically featuring the flexibility to respond to changing needs.

Ultimately, the process should serve as a pathway to help people integrate in their respective communities.

This proposal recognizes all involved parties must implement the person-center-planning process with integrity, and parties must include the active engagement of the participant and his/her best advocate. All must work toward effectively meeting needs–and not trying to merely pull down the most money or support those needs as inexpensively as possible. The approach will likely require additional training for those involved.

ADDRESSING CHALLENGES

CWG recognizes this approach is commonly called a "retrospective planning" approach – where planning occurs based on the individual's current reality and not necessarily what came before. CWG recognizes the approach causes some specific challenges for the Division of Medicaid, and seeks to help the Division address the following responsibilities:

- How to safeguard against exploitation and abuse
- Project the future year's number of users and cost of services to CMS
- Project the future year's number of users and cost of services to the state Legislature
- Ensure the state does not get itself in a situation where the allocated budgets exceed available funding.

CWG proposes a number of strategies to help address said challenges, some of which are process and others content oriented. A subcommittee of the CWG will meet with Division of Medicaid personnel in the very near future to follow up on some of these recommendations. Meanwhile, CWG submits the following suggestions for the state's consideration.

Process Proposal:
Having developed an accurate Person Centered Plan, CWG proposes the following process elements:

1. Have an independent assessor review the support plan and its justification. It is anticipated the vast majority of the plans would fall in an expected range.
2. In the event of disputes and plans falling outside the expected range, DHW care managers will review and resolve
3. DHW care managers will approve, or not, the plans
4. A review and appeal process can be utilized in the event of further dispute

The approach brings control to the process and does, in fact, utilize a 'soft cap' for implementation.

Other Process Suggestions:

- The support plan will articulate a justification for the hours and qualifications identified
- To reduce a potential inclination to inflame a budget, the plan can be outcome oriented by blocks of hours

Suggestions for Addressing Reporting Requirements:

1. Look at how supported employment was implemented to assist with avoiding exploitation of funding
2. Implement a pilot project in up to 2 regions to assess planning and budget implementation usage (R3 and Frontier)

3. Quantify the percentage of adults who are maxing out their KW budgets – this would help give a budget starting point; also look at the percentage and resources remaining from those who are not utilizing their entire budgets
4. Assess cost of people in supported employment vs. those not working
5. Ensure people have their needs met instead of utilizing all available services

CWG appreciates the Department's consideration of this proposal, and commits to continuing to work collaboratively with the Department to address challenges associated with its implementation.

CWG
Recommendation

Retrospective Budget using Person Centered Planning

Through person centered planning, the participant and their team determine the individual participant needs and identify the hours and level eeds. The resource allocation process should:

- be transparent, easily understood, and welcoming
- be comprehensive in its definition of needs
- generate a budget that is fair and equitable
- feature flexibility to respond to changing needs

Criteria for Scoring - Project & Program Objectives	
1. **Reduces complexity** of the resource allocation process.	**YES** Services and level of support are determined by the person centered planning team.
2. Allocation method can be **clearly communicated**. Understandable communication can be developed to inform DD participants about their annual benefit allocation and any changes from their previous year.	**YES** Eligibility notices would only communicate DD and/or ICF/ID level of care eligibility an that will assist in determining their annual benefit.
3. Resources are allocated **based on need** and addresses participant health & safety.	**Yes** The person centered planning team would examine needs across all life areas, includi situation respective to: • Health and Medical needs • Mental/Behavioral Health needs • Independent living skills • Safety • Employment • Community Integration
4. Resource allocation assessment is **accurate**	**Yes (N/A)** with some dependencies Participants would only receive an eligibility assessment. A separate resource allocatic utilized. Instead the person centered planning process and those involved in that pr allocate resources accordingly. Dependencies: 1) the person doing the PCP must be highly skilled if we are to insure a quality asses increase training and oversight of those doing this work and 2) the integrity of the people at the table must be high so personal interests are not

5. Resources are allocated **equitably** across members	Yes with some dependencies This model is based on needs, not equity. Dependencies: 1. It is dependent upon a quality PCP process 2. The person doing the PCP must be highly skilled if we are to insure a quality need to increase training and oversight of those doing this work 3. The integrity of the people at the table must be high so personal interests a process 4. Training and QA of PCP developers must be very good or else those partici receive more services than a participant with a less skilled planner.
5. Allocation method promotes **sustainable** service delivery (no waitlists, protections against unnecessary services, cost neutral, allows state to set a predictable budget)	Yes If the budget allocation is outside of the expected range, (not sure who assesses this (new position?) would be asked to review the needs and allocation. Should there be hierarchy would be established so health and safety needs would be supported first Dependencies: 1. Need to add the work of assessing all plans to ensure they are within the ex 2. If a plan is out of the expected range we would need to fund an independe
6. Allocation method addresses individuals who choose traditional and **Self Directed** services	No At the time of the meeting how to meet this criteria is not known.

Recommendations for Medicaid Employment Services

Employment First means that having a job in the community should be expected and planned for people with developmental, intellectual, and other disabilities. It is a national movement and many states have changed their policies, services, and systems to align with Employment First principles. The Idaho Council on Developmental Disabilities has established the Idaho Employment First Consortium (IEFC) as part of its Employment First Initiative. This Consortium has been meeting over the past 3½ years to review national and state-specific data, Idaho policy and systems and develop recommendations for needed changes to agency services/procedures and state policies.

Because adults with disabilities who experience significant barriers to employment often need additional services and supports to gain and maintain integrated employment, the Consortium has determined that enhancements to the Idaho service system for adults with intellectual and developmental disabilities are necessary to ensure employment outcomes for Idahoans with disabilities.

The Consortium proposes expanding the choice of services that support employment, as allowed by the Center for Medicare and Medicaid Services (CMS), to encourage an effective and productive use of Idaho Medicaid service dollars towards the goal of employment and enable Idahoans with disabilities to become more independent, contributing members of their communities.

The Consortium also proposes the development of specific provider qualifications related to recognized core standards for the provision of employment support services by supervisors and direct support professionals. The Idaho Council on Developmental Disabilities and members of the Consortium are committed to supporting and facilitating a coordinated effort to identify provider qualifications and develop a standardized, state-approved training curriculum for related professionals.

In addition, the group proposes implementation of rigorous quality assurance measures that include collecting data on employment outcomes of individuals receiving employment support services.

The Idaho Employment First Consortium makes the following recommendations related to the implementation of employment support services under the Idaho Medicaid service system for adults with intellectual and developmental disabilities who are eligible under the 1915c HCBS DD waiver and the 1915i DD State Plan option.

Recommendations:

1. Broaden the current exception review process to include pre-vocational and career planning services in addition to supported employment services.

2. Services and supports are considered part of a path to employment:

    a. Encourage individuals who have an employment goal to utilize a combination of services : developmental therapy, pre-vocational, career planning services and supported employment services to gain skills needed to achieve employment

b. Prevocational services are focused, time-limited and intended to help the individual make continued progress towards voluntary participation in at least part-time integrated employment

c. Prevocational services are not a pre-requisite to other employment support services

d. Career planning services utilize a more robust person-centered and community-based planning process, like Discovery, that identifies individual strengths and abilities related to employment and enables a better job match

3. Improve the person centered planning process by training service coordinators, support brokers, support personnel, participants, family members and other members of their circle of support to have the skills needed to:

   a. Engage in an employment discussion with individuals to focus on consideration of a work goal. Help individuals (and circle of support) picture a different day for themselves with a variety of services that lead to an integrated employment outcome

   b. Discuss how income from employment may affect the individual's disability-related benefits

4. Additional employment services to be included in the benefits package (see table for additional clarification of each service):

   a. Prevocational services

   b. Career Planning services

   c. Individual Supported Employment services

5. Employment services quality assurance measures

   a. Quality assurance and evaluation of services based on employment outcomes in the Adult Services Outcome Review (ASOR)

   b. Include additional data points to the employment section of the Individual Support Plan (ISP) to be considered during the plan review process

   c. Include service and employment outcomes in the provider reporting process

   d. Create a data gathering process so that outcomes can be reported

6. Engage in discussions with Vocational Rehabilitation to determine best process/protocol to enable the most effective use of both program's services and a smooth transition for the individual to ensure continuity of support in preparing for employment and in the workplace.

As Idaho moves forward to help individuals with disabilities become employed and contributing members of their community, the Consortium realizes that some policy and system changes to build capacity in our current service system may require a request for additional funds to make system enhancements possible. The Idaho Council on Developmental Disabilities and Consortium members are committed to working with policymakers to secure support for needed resources to make this more positive future a reality.

Depending on the work to be done, our efforts may include: facilitating workgroups to develop information, gather data, and develop recommendations; drafting and supporting legislation that, upon passage, would allow additional funds for fiscal impact of system enhancements; collaboratively drafting rules and program procedures; collaboratively developing educational materials/training for a variety of stakeholders related to the implementation of those rules and procedures; facilitating the development of interagency agreements as needed; and other strategies as identified.

We await your response to our recommendations and look forward to dialogue about how we might work together to increase the number of Idahoans with disabilities who are employed and engaged in their community.

Contact: Tracy Warren, Idaho Council on Developmental Disabilities
Email – tracy.warren@icdd.idaho.gov Phone: 208-334-2178

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, February 24, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
HCR 034	Relating to Community Water Fluoridation	**Representative Packer**
Presentation	Report of the Idaho Criminal Justice Commission	**Sara Thomas** Idaho Criminal Justice Commission

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, February 24, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:02 p.m.
HCR 034	**Relating to Community Water Fluoridation**. **Representative Kelley Packer** presented this House concurrent resolution.

Representative Packer stated that this resolution celebrates 70 years of the successful public effort to fluoridate water. She reviewed the history of fluoridation and Idaho's role in this process. Noting that some organizations argue that there are dangers associated with fluoride intake, **Representative Packer** stated that her research regarding fluoride did not identify any studies conducted in a controlled environment that proved fluoride intake relates to harmful side effects, medical issues or cancer.

TESTIMONY: **Chairman Heider** invited testimony.

Regina Bayer, Idaho citizen, read her written testimony opposing this House concurrent resolution (see attachment 1). **Ms. Bayer** indicated her belief that most of the statements in the resolution were erroneous. She discussed the water fluoridation process and stated that fluoridation is not a safe practice, particularly for those who have health conditions. She argued that fluoridated water can cause or contribute to a range of serious effects. **Ms. Bayer** stated that fluoride is considered a drug by the Food and Drug Administration (FDA). She argued that adding fluoride into the water violates a person's right to informed consent. She then reviewed several studies related to fluoride use. In conclusion, **Ms. Bayer** asked the Committee not to encourage community water fluoridation.

Senator Martin asked Ms. Bayer to indicate who her son was. **Ms. Bayer** noted that she speaks on her own behalf. **Chairman Heider** asked if she was Senator Bayer's mother. **Ms. Bayer** replied that she was. **Senator Hagedorn** commented that she is also former Representative Bayer's wife.

Dr. Steve Bruce, Dentist and Legislative Chairman of the Idaho State Dental Association, testified in support of this resolution. He commented that he has practiced dentistry for 39 years and fluoride has been a great benefit for his patients. He indicated that there are more than 125 national and international organizations that support fluoridation of water, including the American Dental Association, the American Medical Association, the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics, the National Dental Association, the Hispanic Dental Association and the World Health Organization. **Dr. Bruce** commented that scientifically sound and peer-reviewed studies support the efficacy and safety of water fluoridation, while studies that are not peer-reviewed are critical of water fluoridation. The optimal level of fluoridation in water is 0.7 parts per million. At one time there were 12 to 14 parts per million of fluoride in the water in Bruno, Idaho. Residents' teeth were brown, but they rarely experienced dental decay. **Dr. Bruce** pointed out that in order for a person to receive a toxic dose of fluoride from drinking water, that person would have to consume approximately 10,000 8-ounce glasses in a short period of time. **Dr. Bruce** indicated that topical fluoride is depleted relatively quickly, whereas systemic fluoride (fluoridated water) is particularly effective for children from ages zero to six. In conclusion, **Dr. Bruce** argued that fluoridation of water is a benefit to all Idahoans.

Senator Hagedorn asked at what level fluoride becomes toxic to an individual. **Dr. Bruce** responded that there is a number, but he cannot recall the exact amount of a toxic dose. He commented that a significant amount of fluoride is required to reach toxicity. **Senator Hagedorn** asked if it is possible for a person to reach a level of fluoride toxicity in a day or a week from the cumulative effect of using fluoride in water, toothpastes and tooth whiteners. **Dr. Bruce** replied that he doubted that a person would be able to reach toxicity within a day or a week. He noted that topical fluorides from the dentist are more concentrated with fluoride, but are only available by prescription.

Representative Packer reminded the Committee that this House concurrent resolution is not a mandate to fluoridate water. She discussed the natural occurrences of fluoride. In conclusion, **Representative Packer** stated that the purpose of the resolution is to recognize Oakley, Idaho, and the entire State, for the roles they have played in fluoride awareness.

MOTION: There being no more questions, **Senator Lodge** moved to send **HCR 034** to the floor with a **do pass** recommendation. **Senator Schmidt** seconded the motion.

Vice Chairman Nuxoll commented that there were facts presented on both sides and the question becomes which facts are correct. She indicated that she is not convinced of the merits of the resolution.

The motion carried by **voice vote**. **Vice Chairman Nuxoll** asked to be recorded as voting nay. Senator Lee will carry the bill on the floor of the Senate.

PRESENTATION: **Report of the Idaho Criminal Justice System**. **Sara Thomas**, State Appellate Public Defender and Chair of the Governor's Idaho Criminal Justice Commission (Commission), made this presentation to the Committee (see attachment 2).

Ms. Thomas reviewed the Commission's vision, mission and values. The Commission was originally created by executive order in 2005 and each Governor thereafter has continued the Commission. All three branches of government are represented on the Commission and **Ms. Thomas** reviewed the membership.

Ms. Thomas explained that the Commission has a three year strategic plan that is updated annually to achieve the goals set by the Governor. **Ms. Thomas** reviewed and discussed the three primary goals of the Commission: (i) to combat crime and protect citizens, (ii) to provide policymakers and criminal justice decision makers with accurate information and (iii) to promote efficiency and effectiveness of the criminal justice system. **Ms. Thomas** informed that Committee that the Commission has multiple subcommittees that address detailed topics, including (i) pre-trial justice, (ii) a standardized recidivism definition, (iii) mental health (see attachment 3), (iv) research alliance, (v) criminal fees and fines and (vi) sex offense statutes review.

Chairman Heider asked the Committee members if they had any questions.

Noting that Ms. Thomas' presentation referenced WITS and SUDs, **Senator Hagedorn** asked if she could clarify what those terms mean. **Ms. Thomas** replied that WITS stands for "Web Infrastructure for Treatment Services." This is a data program that includes information regarding individuals who receive mental health or substance abuse treatment. The second acronym "SUDs" stands for "Substance Use Disorders." SUDs funding was originally housed in the Department of Health and Welfare, but has since been divided up among the Department of Health and Welfare, Idaho specialty courts and juvenile corrections.

Senator Schmidt asked if the white paper on mental illness (see attachment 3) was distributed to the entire legislature. **Ms. Thomas** answered that it was only provided to the Governor, the Committee, the House Health and Welfare Committee and both Senate and House judiciary committees. **Senator Schmidt** commented that the Justice Reinvestment (JRI) Oversight Committee would benefit from the recommendations in the white paper. **Ms. Thomas** stated that she will get a copy of the white paper to the JRI Oversight Committee.

Senator Jordan asked if the Commission has been able to access and review the behavioral health treatment history of juvenile offenders. **Ms. Thomas** indicated the Commission's Capstone Project is designed to review that specific issue. There are still issues with obtaining Memorandums of Understanding (MOU) between the different groups that may share this type of information, but the Commission hopes to get the MOU issues resolved.

Chairman Heider asked how long information from body cameras is kept and if it can be stored. **Ms. Thomas** answered that it varies among law enforcement departments. There are no statewide standards. She indicated that there are many legal issues involved with body cameras that need to be addressed. She noted that storage costs for this information are huge.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:02 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Michael Jeppson
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, February 24, 2016

ATTACHMENT 1

Good afternoon Mr. Chairman, good Senators,

My name is Regina Bayer and I live in Meridian.

I'm here today representing my husband and my self.

I want to urge you not to support HCR34.

I belief that most of the statements in the resolution are erroneous, I hope you will consider the following information.

Water fluoridation is the practice of adding industrial-grade fluoride chemicals to water for the purpose of preventing tooth decay.*1a. The Oral Health Division of the CDC does hail fluoridation as one of the top ten public health achievements of the 20th century. However, comprehensive data from the World Health Organization reveals that there is no discernible difference in tooth decay between the minority of western nations that fluoridate water and the majority that do not. In fact, tooth decay rates in many non-fluoridated countries are now as low or lower than the decay rates in fluoridated ones. *1b.

The CDC in their recommendations for using fluoride to prevent and control dental caries, in their *Mortality and Morbidity Weekly Review* (2001), says "The prevalence of dental caries in a population is not inversely related to the concentration of fluoride in enamel, and a higher concentration of enamel fluoride is not necessarily more effective in preventing caries." *2.

In short, people can have perfect teeth without consuming fluoridated water or any other fluoride product. As with teeth, no other tissue or cellular process of the body requires fluoride.

It is becoming increasingly clear, fluoridating water supplies is an outdated, unnecessary, and dangerous relic from a 1950's public health culture that viewed mass distribution of chemicals much differently than scientists do today and the practice should end, NOT be encouraged. No disease has ever been linked to a fluoride deficiency.

Unlike all other water treatment processes, fluoridation does not treat the water itself but the person consuming it. The FDA accepts that fluoride is a drug.*3. Once this drug is in the water there is no control over individual dosage. Fluoridating water is a form of medication. Fluoridation of community water systems is definitely a **FREEDOM ISSUE**. It violates an individual's right to informed consent for medical treatment. The community would be doing what no doctor can do to a single patient.*4. For this reason alone I can't understand promoting this resolution.

Fluoridation is not a safe practice, particularly for those who have health conditions that render them vulnerable to fluoride's toxic effects.

It is unethical to compromise the health of some members in a population to obtain a

purported benefit for other members-particularly in the absence of the vulnerable members' knowing consent. A growing body of evidence indicates that fluoridated water, in addition to other sources of daily fluoride exposure, can cause or contribute to a range of serious effects including arthritis, damage to the developing brain, reduced thyroid function and possibly osteosarcoma in adolescent males. *5.

It is known that fluoridated water caused severe bone disease in dialysis patients. While dialysis units now filter out the fluoride, research shows that current fluoride exposures are still resulting in dangerously high bone fluoride levels in dialysis patients and patients with other forms of kidney disease.

In the 20th century, fluoride was prescribed by a number of European doctors to reduce the activity of the thyroid gland for those suffering from hyperthyroidism. *6. With water fluoridation we are forcing people to drink a thyroid-depressing medication which could serve to promote higher levels of hypothyroidism in the population and all the subsequent problems related to this disorder including depression, fatique, weight gain, muscle and joint pains, increased cholesterol levels, and heart disease. *7.

Some of the earliest opponents of water fluoridation were biochemists because of fluoride's known poisonous interactions with enzymes, the proteins which act as the catalysts that smoothly steer practically all of the 10,000 or so chemical reactions in the body. Dr. James Sumner who won a Nobel Prize for his work with enzymes, said in the 1950's "we ought to go slowly. Everybody knows fluorine & fluorides are very poisonous substances."

If there is any benefit from fluoride, it comes from topical contact with the teeth, not from ingestion. The CDC's Oral Health Division acknowledges this.*8. There is simply no need to swallow fluoride whether in the water or any other form. There are even known risks with using fluoride toothpaste. Terry Loftus, a spokesman for Procter & Gamble which makes Crest says "Toothpaste with fluoride is considered an over-the-counter drug. Parents should supervise their children under six when using it." In fact there is a warning on fluoride toothpaste that says if more than used for brushing is swallowed, get help or contact a Poison Control Center right away.

Fluoride has been tested on humans for the purpose of treating osteoporosis. The theory was that fluoride would strengthen bones. What the researchers found was that it did increase bone mass; however, the bone was much more brittle. Numerous studies have linked long term consumption of fluoridated water to increased risk of hip fracture. *9

Research has shown in numerous studies that fluoride is a mutagen and a carcinogen. *10

In July 1997 the National Federation of Federal Employees, the Union representing all of the scientists, toxicologists and statisticians at EPA headquarters stated that, "our member's review of the body of evidence over the last eleven years, including animal and epidemiological studies, indicate a causal link between fluoride/fluoridation and cancer, genetic damage,

neurological impairment and bone pathology. Of particular concern are recent studies linking fluoride exposure to lower I.Q. in chilcren." *11 UNICEF, the health arm of the United Nations, warns of fluorides negative effects. In their official position statement, they state, " more and more scientists are **NOW** seriously questioning the benefits of fluoride, even in small amounts."

Another fact is that the chemicals used for fluoridation are not high purity or pharmaceutical quality products. Rather they are by-products of aluminum and fertilizer manufacturing and contain a high concentration of toxins and heavy metals such as arsenic and lead ; proven carcinogens. So-called fluoride is really fluorosilicic acid, a toxic waste byproduct of the phosphate mining industry. If it wasn't being dumped into the water supplies of major cities, it would have to be disposed of as a hazardous waste chemical under EPA rules. *12

Seldom has an issue come before the public that affects our personal health, and our personal freedom, as much as this one. When the "smoke and mirrors" of the proponents of fluoridation are cleared away by scientific evidence, it is plain that there is no justification for putting this toxic substance in our water supply.

Fluoride is a cumulative poison. Only 50% of the fluoride we ingest daily is excreted through the kidneys. The remainder accumulates in our bones, pineal gland and other tissues. If the kidney is damaged, fluoride accumulation will increase.*13

The World Health Organization states, "Dental and public health administrators should be aware of the total fluoride exposure in the population before introducing any additional fluoride programme for caries prevention." *14

As one doctor aptly stated, "No physician in his right senses would prescribe for a person he has never met, whose medical history he does not know, a substance which is intended to create bodily change, with the advice:'Take as much as you like, but you will take it for the rest of your life because some children suffer from tooth decay.' "

Dr. Charles Heyd, Past President of the AMA said, "I am appalled at the prospect of using water as a vehicle for drugs. Fluoride is a corrosive poison that will produce serious effects on a long-range basis. Any attempt to use the water this way is deplorable."

If people really want to ingest fluoride, they can do so on their own. Those of us who don't want to add it to our bodies already have a difficult time avoiding it.

Please do not put Idaho in the position of encouraging community water fluoridation.
Respectfully, I'm asking you to oppose HCR34

*1a. Indiana State Department of Health http://www.in.gov/isdh/24524.htm

*1b.. WHO Oral Health Country/Area Profile Programme Dept. of Noncommunicable Diseases Surveillance/Oral Health WHO Collaborating Center, Malmo University, Sweden

*2. CDC (2001). Recommendations for using fluoride to prevent and control dental caries in the United States. Mortality and Morbidity Weekly Review 50 (RR14):1-42

*3. http://www.nlm.nih.gov/medicineplus/druginfo/meds/a682727.html

*4. http://www.nlm.nih.gov/medicineplus/ency/patientinstructions/000445.htm.

*5. Dr. Mercola/Mercola.com-December 13, 2014

*6. Merck Index, 1960, p. 952; Waldbott, etal., 1978, p. 163

*7. http://www.nlm.nih.gov/medicineplus/druginfo/meds/a682727.html

*8. Centers for Disease Control and Prevention (CDC, 1999)

*9. Riggs BL, Hodson SF, O'Fallon WM, et al. Effect of Fluoride treatment on the fracture rate in post menopausal women with osteoporosis. NEJM 1990:322:802-809; Hedlund and Gallagher, 1989; Riggs et al, 1990

10. Fluorides and Oral Health, Technical Report Series 846, 1994/

*11. Letter dated July 2, 1997 to Citizens for Safe Drinking Water

a.) Jacobsen SJ, Goldberg J, Miles TP, Brody JA, et al. Regional variation in the incidence of hip fractures: U.S. white women aged 65 years and older. JAMA Vol 264, pp. 500-502 (1990)

b.) Cooper C, Wickham CAC, Barker DJR, and Jacobsen SJ. Water fluoridation and hip fracture (letter). JAMA Vol. 266. pp. 513-514, 1991

c.) Danielson C, Lyon IL, Egger M, and Goodenough GK. Hip fractures and fluoridation in Utah's elderly population. JAMA Vol. 268, pp. 746-748 (1992)

d.) JAMA Vol. 273, pp. 775-776 (1995)

e. Jacobsen SJ, Holdberg J, Cooper C, and Lockwood SA. The association between water fluoridation and hip fracture among white women and men aged 65 years and older: A national ecologic study. AM J Epidermiol 1992: 2:617-626

f.) Sowers MFR, Clark MK, Jannausch ML, and Wallace RB. A prospective study of bone mineral content and fracture in communities with differential fluoride exposure. AM J Epidemiol 1991:133:649-660

g.) Keller C. Fluorides in Drinking Water. Paper presented at the Workshop on Drinking Water Fluoride influence on Hip Fractures and Bone Health. April 10, 1991, Bethesda, MD.

h.) May DS and Wilson MG. Hip fractures in relation to water fluoridation: an ecologic analysis. Presented at the Workshop on Drinking Water Fluoride influence on Hip Fractures and Bone Health. April 10, 1991, Bethesda, MD

*12. http://www.nofluoride.com/index.cfm#4reasons

*13 Dr. Mercola/Mercola.com-December 13, 2014

*14 1990 Congress ordered National Toxicological Program (NTP); Marcus Memo May 1, 1990

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, February 24, 2016

ATTACHMENT 2

IDAHO CRIMINAL JUSTICE COMMISSION

LEGISLATIVE UPDATE 2016

VISION

- Collaborating For a Safer Idaho

MISSION

- The Idaho Criminal Justice Commission is committed to collaboration to address important criminal justice issues and challenges by developing and proposing **balanced solutions**, which are **cost effective** and based on "best" practices to **achieve a safer Idaho**.

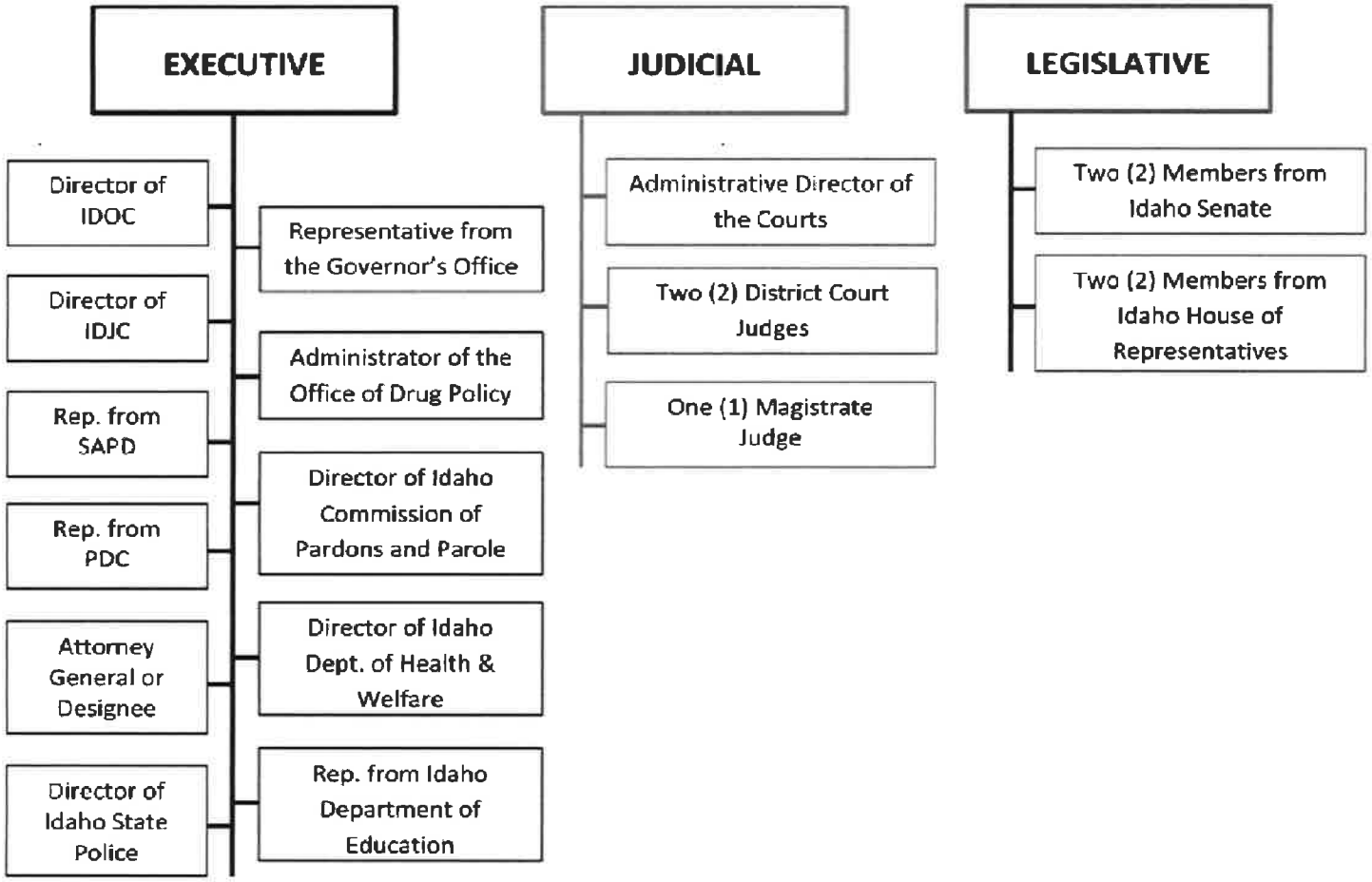
VALUES

- We are **committed** to learning and enhancing our understanding.
- We **communicate** honestly.
- We **encourage** open dialogue and feedback.
- We are **flexible** and innovative.
- We **keep** our commitments.
- We **respect** all contributions.
- We are **sensitive** to the unique perception and needs of others.

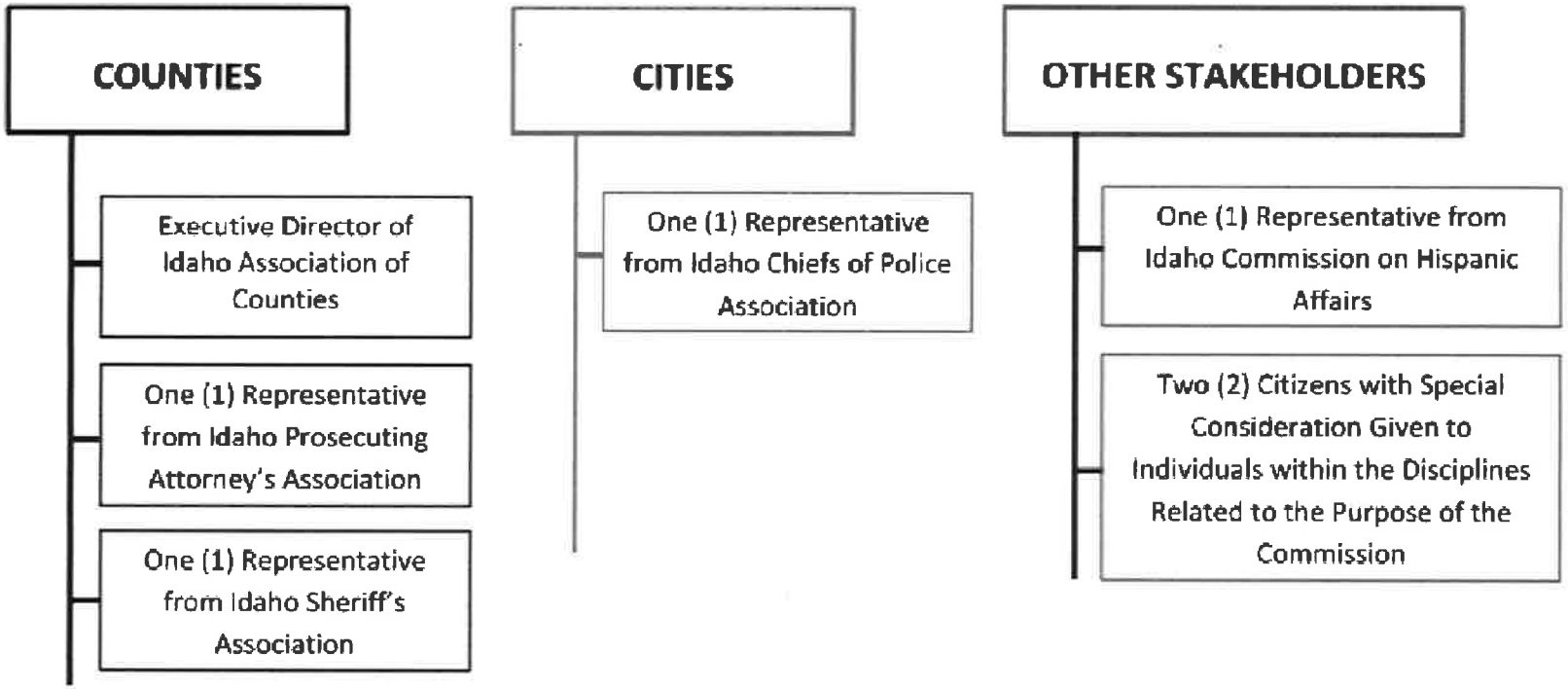
Executive Order 2015—10

C.L. "BUTCH" OTTER
GOVERNOR

WHEREAS, it is in the best interest of the citizens of the State of Idaho that government promote efficiency and effectiveness of the criminal justice system and, where possible, encourage dialogue among the respective branches of government to achieve this effectiveness and efficiency...


EXECUTIVE
Director of IDOC
Director of IDJC
Rep. from SAPD
Rep. from PDC
Attorney General or Designee
Director of Idaho State Police
Representative from the Governor's Office
Administrator of the Office of Drug Policy
Director of Idaho Commission of Pardons and Parole
Director of Idaho Dept. of Health & Welfare
Rep. from Idaho Department of Education
JUDICIAL
Administrative Director of the Courts
Two (2) District Court Judges
One (1) Magistrate Judge
LEGISLATIVE
Two (2) Members from Idaho Senate
Two (2) Members from Idaho House of Representatives

WHEREAS, communication and cooperation among the various facets of the community of criminal justice professionals is of utmost importance in promoting efficiency and effectiveness...


COUNTIES
Executive Director of Idaho Association of Counties
One (1) Representative from Idaho Prosecuting Attorney's Association
One (1) Representative from Idaho Sheriff's Association
CITIES
One (1) Representative from Idaho Chiefs of Police Association
OTHER STAKEHOLDERS
One (1) Representative from Idaho Commission on Hispanic Affairs
Two (2) Citizens with Special Consideration Given to Individuals within the Disciplines Related to the Purpose of the Commission

IDAHO CRIMINAL JUSTICE COMMISSION STRATEGIC PLAN FOR THE STATE OF IDAHO

COMBATING CRIME AND PROTECTING CITIZENS

GOAL - Reduce victimization and recidivism in the state of Idaho

Objective 1: Establish evidence-based and best practices relating to accountability, prevention, education and recidivism reduction

Objective 2: Strengthen knowledge base in Idaho by enhancing data collection abilities and sharing capabilities

PROVIDING POLICY MAKERS AND CRIMINAL JUSTICE DECISION MAKERS WITH ACCURATE INFORMATION

GOAL - Advance delivery of justice through effective interventions by proposing balanced solutions, which are cost effective and based on best practices

- Objective 1 - Determine reasonable expectation of community needs and services based on resources
- Objective 2 - Promote standards and equity
- Objective 3 - Reduce criminogenic risk factors through the expanded use of risk assessments, policies and programming
- Objective 4 - Ongoing assessment of problem solving courts and other community based sentencing alternatives
- Objective 5 - Examine emerging issues

PROMOTING EFFICIENCY AND EFFECTIVENESS OF THE CRIMINAL JUSTICE SYSTEM

GOAL - Promote well-informed policy decisions

- Objective 1 - Identify strategies to promote efficiencies and effectiveness in the criminal justice system
- Objective 2 - Continue presentations and training on trends, best practices and priority issues
- Objective 3 - Create and implement data sharing mechanisms and agreements among stakeholder agencies
- Objective 4 - Maintain awareness of substance abuse trends and priority issues

SUBCOMMITTEE WORK

PRE-TRIAL JUSTICE

STANDARDIZED RECIDIVISM DEFINITION

MENTAL HEALTH

RESEARCH ALLIANCE

CRIMINAL FEES AND FINES

SEX OFFENSE STATUTES REVIEW

Recommendations:

1. Idaho should adopt a sexual battery of an adult statute;
2. Idaho should merge the female and male rape statutes into a single statute;
3. Idaho should remove the requirement that a victim resist when a reasonable person would either see resistance as futile or believe that resistance will result in harm;
4. Idaho should add rape by threats of harm to a third party to the spousal rape statute

Idaho Criminal Justice Commission

Collaborating For A Safer Idaho

http://icjc.idaho.gov/

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, February 24, 2016

ATTACHMENT 3

AN OUTLINE TO IMPROVE THE CRIMINAL JUSTICE SYSTEM'S RESPONSE TO MENTAL ILLNESS

POTENTIAL SOLUTIONS AT EACH STEP OF THE PROCESS

"In the 1830's Dorothea Dix revolutionized the care of people with mental illness by taking them out of jails and caring for them in asylums, later known as state hospitals. In the last 50 years, we have reversed this trend, resulting in a 90 percent reduction in public hospital beds for people with serious mental illness."[1] This trend has had significant consequences. For instance when individuals with serious mental illness require hospitalization, they are left with precious few options: "[s]ome patients are housed in emergency room holding areas; some return home, where family and friends struggle to provide care; and some—at considerable risk to themselves—become homeless."[2] The only other option appears to be jail. "Jails across the country have become vast warehouses made up primarily of people too poor to post bail or too ill with mental health or drug problems to adequately care for themselves."[3] In effect and practice, "jails and prisons have become the de facto mental hospitals" of our society.[4]

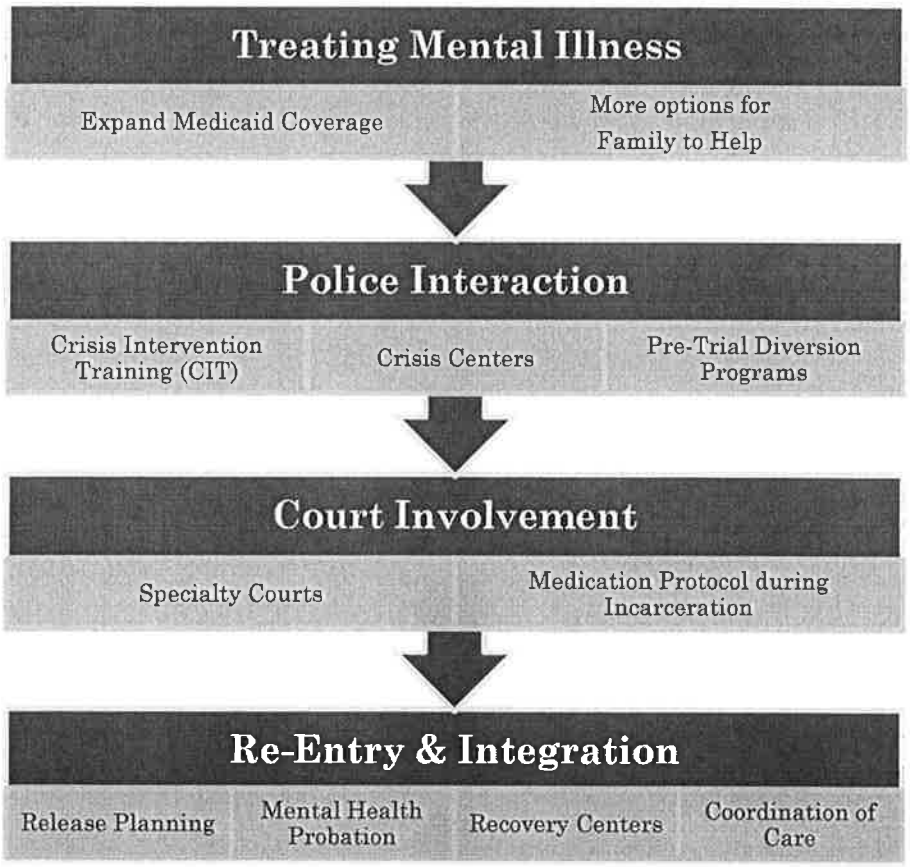
Mental health is a major issue affecting the United States and Idaho. As of 2005, "more than half of all prison and jail inmates had a mental health problem," totaling some 1,264,300 individuals.[5] More recent surveys show that "the individuals being incarcerated have more severe types of mental illness, including psychotic disorders and major mood disorders[,] than in the past."[6] To put this in perspective, "there are now 10 times more people with serious mental illness in state prisons (207,000) and county jails (149,000) than there are in state mental hospitals (35,000).[7] "In 44 of the 50 states, the largest single 'mental institution' is a prison or jail."[8]

The situation in Idaho is just as bleak. The two state psychiatric hospitals can house a total of 145 mental health patients.[9] If national trends are any indication, the "Ada County Jail in Boise (838 inmates) and the state prison in

Kuna (1,653 inmates) probably [each] hold more individuals with serious mental illness than the two hospitals combined."[10]

Still, there are solutions that can help improve the situation and do more to help the mentally ill. This is the first in a series of papers that will introduce some specific, measureable, and achievable ideas for Idaho to consider implementing. Mental health is not the concern of a few individuals or families; it is and ought to be society's concern. As Pearl S. Buck wrote: "the test of a civilization is the way that it cares for its helpless members."[11]

The graphic below illustrates the overall outline of suggestions proposed in this series. In order to understand the ideas suggested in this series, it is necessary to understand the outline itself. First, the steps of the justice system's process need some explanation and definition. Then, suggested solutions at each step are given a thumbnail sketch so that the whole outline makes some sense as a cohesive set of solutions to a significant societal problem.



I. STEPS OF THE CRIMINAL JUSTICE SYSTEM'S PROCESS

A. Treating Mental Illness

This step is everything that happens before any incident. The police are not involved. An individual may know that he or she is suffering from a mental illness. Frequently, the person's family begins to suspect a mental illness as they see their loved one behave erratically, make irrational decisions, or exhibit other symptoms of mental illness.

B. Police Interaction

Once an incident has occurred and the police have been called, the criminal justice system becomes involved. There is often reluctance to call the police because incidents with the mentally ill frequently involve close friends and family – the exact people who do not want to get their loved one "in trouble" with the law. For that same reason, cases can "disappear" as witnesses become unwilling to cooperate with the police and prosecutors. This step therefore includes the police who respond to an incident, those at the scene, and (to some extent) the prosecutors involved in the case.

C. Court Involvement

Once a Court is involved, the dynamics change substantially. Courts, trials, jails, and prisons all have various ways of providing mental health treatment. This stage involves the Court itself, the prosecution, the defense attorney, the jail, and also the Department of Correction.

D. Re-Entry & Integration

Lastly, an individual is released into the community. This may be because the sentence is served, probation is granted, or the individual is paroled. This stage involves those who take part in getting the individual back into the community and transitioning to normal life.

II. POTENTIAL SOLUTIONS AT EACH STEP OF THE PROCESS

A. Treating Mental Illness

1. Expand Medicaid Coverage

As the old adage goes: "an ounce of prevention is worth a pound of cure." Before a mentally ill individual has to become entangled with the criminal justice system, the best solution is to provide treatment. Mental illness does not require imprisonment. Nor should someone have to be involved in the criminal justice system in order to receive treatment. Unfortunately, without some means of paying for treatment, the mentally ill frequently are unable to access care. The most effective means of addressing mental illness is in the community – both in terms of efficacy in helping the individual and in terms of an efficient use of public funds.

2. More Options for Family to Help

Frequently, family and close friends know someone needs help before anyone else and perhaps even before the individual him– or herself. Before there is any involvement with police, the ability of family to get the mental health treatment that their loved one needs can save everyone involved from the trouble, heartache, and costs associated with the criminal justice system.[12] Any option for loved ones must, of course, continue to balance the individual's rights against the individual's need for treatment.[13]

B. Police Interaction

1. Crisis Intervention Team (CIT) Training

There are times when police must interact with the mentally ill. Officer safety is paramount, but the standard procedures that ensure officer safety frequently exacerbate the problems underlying the behavior of someone who needs mental health treatment. Crisis Intervention Team (CIT) Training provides officers with a different set of skills that are helpful in interacting with the mentally ill.[14] CIT Training keeps the officer safe, informs the officer of mental health issues, and helps the officer de-escalate a situation in order to keep everyone safe and

uninjured. It also results in far fewer mentally ill individuals entering the criminal justice system at the outset.

2. Crisis Centers

Crisis Centers provide a place, other than jail, for police to take individuals they suspect may need mental health treatment.[15] Jail is a difficult place to be for everyone, but it presents an especially challenging experience for the mentally ill. A Crisis Center is a place where they can receive treatment, which will be better because it will be in a therapeutic setting and more cheaply administered than in a jail. It also allows the police to get help for the mentally ill, while still allowing the police to get back to their regular duties. Having a place available that is specially designed to deal with the mentally ill is more humane, cost-effective, and efficient than incarceration. Hospitals have generalized procedures and (usually) long wait times for mental health patients. A Crisis Center is specifically tailored to address a mental health crisis – making a Crisis Center more cost-effective location for treating mental health crises. For instance, a recent report from the Idaho Department of Health and Welfare report shows $38,223 in emergency room savings in just the first two months of operating Idaho's first, and so far only, Crisis Center (located Idaho Falls).[16] It can also be the first link in a program of long-term treatment that can address mental illness, lessen demand for hospital resources, and decrease the necessity of future police interaction.

3. Pre-Trial Diversion Programs

The law has long recognized that it is unjust to punish someone without the requisite mental capacity. Providing options for the mentally ill can begin even before trial. They can be diverted away from trial and jail, and public resources could instead be used to stabilize individuals, diagnose illnesses, provide treatment, and maintain mental health. Obtaining mental health treatment is simpler, faster, and cheaper if the patient is not in jail.[17]

C. Court Involvement

1. Specialty Courts

Mental Health Courts are one of several specialty courts already gaining traction in Idaho. Though they are few in number and small in size, they are succeeding.[18] Once the Courts are involved with an individual who has a mental health issue, Mental Health Court is often the best place for him or her. Mental Health Court allows an Assertive Community Treatment (ACT) Team of mental health providers, medical professionals, and vocational rehabilitation specialists to work together with a judge, defense attorney, prosecutor and probation officer to oversee progress, manage incentives, and ensure that the individual stays on track toward a productive life. Expanding the reach and capabilities of Mental Health Courts will positively impact hundreds or thousands of lives in Idaho.

2. Medication Protocol during incarceration

If incarceration is necessary, for whatever reason, the jail officials are typically not in touch with the defendant's community mental health provider. Jails also face vastly different considerations than mental health providers. The administration of medication is a difficult task that implicates medical, legal, administrative, and custodial considerations. Imagine being treated for a severe mental illness, only to have that treatment interrupted or changed by incarceration – when one likely needs stability and medication the most. Having a single, state-wide protocol for the administration of medication (especially psychotropic medication) that is consistent in every county in Idaho will hopefully remove these interruptions and smooth whatever proceedings follow, whether that is long-term treatment, court proceedings, or even continued incarceration. Establishing clear guidelines of what medications can be used when and by whom will provide better information to jailers and a more seamless transition for the mentally ill in the criminal justice system.

D. Re-Entry & Integration

1. Release Planning

Every success is founded on a plan. The same is especially true of those with mental health issues. Having a written plan for psychiatric follow-up will increase an inmate's chances of obtaining follow-up mental health treatment after release. Having such a plan should be required of mentally ill inmates. Not only does having such a plan inform the inmate of where to go for help, it also serves to coordinate mental health resources available in the community, and ultimately to avoid future crises and incidents.

2. Mental Health Probation

Mental Health Probation is essentially the same as Assisted Outpatient Treatment (AOT). It is court-ordered outpatient treatment that provides an alternative to incarceration. While already possible in Idaho, the available options are frequently under-funded and difficult to utilize. Mental Health Probation or AOT provides a setting where an individual is required to obtain treatment (which allows a court to track and enforce its orders as necessary) while providing the skills for the individual to lead a productive life (eventually free from supervision). Mental Health Probation or AOT can include elements such as: peer support, recovery coaching, coordination with a mental health care provider (see below), and other ideas that can address each individual's needs.

3. Recovery Centers

Recovery Centers are open, more or less, during normal business hours to help individuals connect with treatment providers in the community and obtain skills necessary to become self-sufficient. Recovery Centers are a tool that can be used in tandem with Mental Health Probation or AOT to great effect. Where probation provides oversight and individual accountability, Recovery Centers supply the skills needed by individuals to succeed. Recovery Centers are part of an effort aimed at long-term recovery, where individuals can learn how to successfully function without probation or the court system monitoring.

4. *Coordination of Care*

Just like jails and community mental health providers, a similar disconnect can exist between the Department of Correction (DOC) and community mental health providers. Long-term solutions do not simply fall together by chance. They require planning and coordination. If the DOC and the defendant's community mental health provider could work together, the defendant would face a comprehensive approach without contradictory requirements and differing goals.

III. CONCLUSION

In sum, mental health is a significant issue facing the criminal justice system. These eleven suggestions hopefully provide a framework for improving the situation in Idaho. Each will be described in more detail in successive papers. The point of this series is to provide specific, measureable, and achievable ideas to improve the way Idaho, and especially the criminal justice system, treats the mentally ill that are effective and efficient.

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[1] Thomas Insel, NIMH Director's Blog: *A Misfortune Not a Crime*, NATIONAL INSTITUTE OF MENTAL HEALTH (April 11, 2014), http://www.nimh.nih.gov/about/director/2014/a-misfortune-not-a-crime.shtml.

[2] *Id.*

[3] Timothy Williams, *Jails Have Become Warehouses for the Poor, Ill and Addicted, a Report Says*, NEW YORK TIMES, p. A19 (February 11, 2015).

[4] *Id.*

[5] Doris S. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, BUREAU OF JUSTICE STATISTICS, p. 1 (Special Report, September 2006).

[6] Dean Aufderheide, *Mental Illness in America's Jails and Prisons: Toward a Public Safety/Public Health Model*, HEALTH AFFAIRS (April 1, 2014), http://healthaffairs.org/blog/2014/04/01/mental-illness-in-americas-jails-and-prisons-toward-a-public-safetypublic-health-model/.

[7] Insel, *supra* note 1.

[8] *Id.*

[9] IDAHO DEPT. OF HEALTH AND WELFARE, *About Idaho's State Hospitals*, http://www.healthandwelfare.idaho.gov/medical/mentalhealth/statehospitals/tabid/495/default.aspx (last visited November 24, 2014).

[10] THE TREATMENT ADVOCACY CENTER, *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey* (2014), http://www.tacreports.org/treatment-behind-bars (last visited November 24, 2014); *see also* Audrey Dutton, *In Crisis: Courts and jails double as mental health providers.*

IDAHO STATESMAN (October 30, 2014), http://www.idahostatesman.com/2014/10/30/3456444_courts-and-jails-double-as-mental.html?rh=1.

[11] Pearl S. Buck, MY SEVERAL WORLDS (1954)

[12] Presently, involuntary commitment can only begin if (1) the person is in the hospital already and a medical professional determines that the individual "is gravely disable due to mental illness" or "poses an imminent danger to that person or others," (2) when a law enforcement officer makes a similar determination, or (3) a loved one applies after the individual has been evaluated by a mental health examiner. I.C. §§ 66-326 & 66-329.

[13] In Idaho, a neutral judge balances those sometimes conflicting interests within some strict time limits to avoid any unnecessary delay. I.C. §§ 66-326 & 66-329.

[14] *See* Horace A. Ellis, *Effects of a Crisis Intervention Tream (CIT) Training Program Upon Police Officers Before and After Crisis Intervention Team Training*, ARCHIVES OF PSYCHIATRIC NURSING, vol. 28, pp. 10-16 (2014) (showing that police officers' knowledge, perceptions, and attitudes about mental health significantly improved after CIT Training).

[15] *See* Ali Tadayon, *Crisis center to open Dec. 4 in Idaho Falls*, IDAHO STATESMAN (November 23, 2014), http://www.idahostatesman.com/2014/11/23/3503144/crisis-center-to-open-dec-4-in.html.

[16] DIVISION OF BEHAVIORAL HEALTH OF THE IDAHO DEPT. OF HEALTH AND WELFARE, *Crisis Center Update* (February 2015).

[17] *See* Williams, *supra* note 3 (noting that "seeking mental health services sometimes meant longer stints in jail, . . . [i]n Los Angeles, those seeking help spent more than twice as much time in custody than did others — 43 days, compared with 18 days").

[18] *See* Keith Cousins, *Mental Health Court celebrates 10 years*, COEUR D'ALENE PRESS (November 7, 2014), http://www.cdapress.com/news/local_news/article_73776c53-747b-5eff-88c6-af85b40136f5.html.

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, February 25, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
S 1322	RELATING TO EPINEPHRINE AUTO-INJECTORS: Amending Idaho Code to provide that the practice of pharmacy includes prescribing epinephrine auto-injectors and other related modifications	**Starla Higdon** Treasure Valley Food Allergy Network
S 1326	RELATING TO SUICIDE PREVENTION: Amending Idaho Code to grant certain authority to the Department of Health and Welfare	**Senator Martin**
S 1341	RELATING TO RESIDENTIAL CARE OR ASSISTED LIVING FACILITIES: Amending Idaho Code to provide that residential or assisted living facilities may be cited only for violations of a requirement that is specified in an applicable law or rule	**Senator Martin**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, February 25, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	Senator Hagedorn
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:02 p.m.

S 1322 **Relating to Epinephrine Auto-Injectors**. **Chairman Heider** and **Starla Higdon**, pharmacist and Founder/Volunteer Director, Treasure Valley Food Allergy Network, presented this bill.

Chairman Heider noted that the Legislature had previously passed a bill that allows schools to provide epinephrine auto-injectors. He mentioned that distribution of epinephrine auto-injectors in schools has been a success in Idaho. He indicated that this bill will allow pharmacists to dispense epinephrine auto-injectors. **Ms. Higdon** stated that this bill increases access to epinephrine auto-injectors. **Ms. Higdon** discussed her experience of managing severe food allergies. She indicated she carries an epinephrine auto-injector with her at all times. Anaphylaxis, the medical term for severe allergic reactions, can be unpredictable. She noted that only epinephrine can treat the life threatening symptoms of anaphylaxis, not antihistamines. A delay of 20 minutes or more in the administration of epinephrine results in increased mortality risks. The earlier the administration of epinephrine in anaphylaxis, the better the outcome; this is why immediate access to epinephrine is crucial. **Ms. Higdon** indicated that various Idaho entities such as day cares, summer camps and restaurants have indicated their desire to stock epinephrine to protect their allergic patrons in case of emergency.

The purpose of this law (and others like it) is to reduce the time it takes to get epinephrine to a person in anaphylaxis. **Ms. Higdon** reported that 19 other states have passed laws similar to this bill. Thirteen additional states have similar bills being considered in their current legislative sessions. **Ms. Higdon** explained that this bill has been reviewed by (i) the Idaho State Board of Pharmacy, (ii) the Department of Health and Welfare, (iii) the Idaho Medical Association and (iv) the Trial Lawyers Association. In conclusion, **Ms. Higdon** commented that the bill will help protect the health of Idahoans with severe allergies.

Chairman Heider asked the Committee members if they had any questions.

Senator Schmidt asked if she is aware of any states that have allowed epinephrine auto-injectors to be sold over-the-counter. **Ms. Higdon** responded that she believes epinephrine auto-injectors are available only by prescription. **Senator Schmidt** asked why epinephrine auto-injectors are not being sold over-the-counter. **Ms. Higdon** answered that there still needs to be some oversight and proper training for the use of epinephrine auto-injectors. **Senator Schmidt** asked how this bill will effect the price of epinephrine auto-injectors. **Ms. Higdon** replied that this will probably not change the price. She noted that most of those who will be purchasing an epinephrine auto-injector from the pharmacist would be paying cash for this product. She acknowledged that epinephrine auto-injectors are expensive. **Senator Schmidt** commented that since the passage of legislation for epinephrine in schools, the price of epinephrine auto-injectors has increased approximately 400 percent. **Ms. Higdon** disagreed with Senator Schmidt's figure and stated that she was told the price of epinephrine auto-injectors has increased only 33 percent. **Senator Schmidt** clarified that the price of epinephrine auto-injectors has increased 400 percent since 2007 and between 2014 and 2015 the price increased 33 percent.

Senator Martin asked what adverse effects could occur if epinephrine is administered to someone who is not really in need of it. **Ms. Higdon** answered that the person would experience an increased heart rate, increased blood pressure, a feeling of anxiety and possible headaches. She noted that the half-life of epinephrine is approximately two minutes. It would take a total of approximately fifteen minutes for the body to completely eliminate a dose of epinephrine from an auto-injector.

TESTIMONY: **Chairman Heider** invited testimony.

William Llamas, pharmacist, spoke in support of this bill. He noted that he and two of his children have anaphylactic food allergies. He reiterated the need for epinephrine to treat anaphylaxis rather than regular antihistamines. He told the story about the surprise discovery of his son's anaphylactic reaction. He spoke about the life-saving capabilities of epinephrine. **Chairman Heider** asked Mr. Llamas how he initially recognized that his children suffered from anaphylactic reactions. **Mr. Llamas** replied that his daughter displayed allergy symptoms before the age of one. Once his daughter was a year old, allergy tests were performed and it was confirmed that she had specific allergies. He reiterated that he identified his son's allergies by accident. **Senator Schmidt** asked why epinephrine should not be an over-the-counter medication. **Mr. Llamas** answered that oversight is good. **Senator Schmidt** noted that the bill requires certain individuals to complete an anaphylaxis training program. He asked how this type of training will be accomplished and how completion of the required training will be documented. **Chairman Heider** suggested that Alex Adams, Executive Director, Idaho Board of Pharmacy, might be better equipped to answer this question.

Beginning with Senator Schmidt's question regarding the provision of epinephrine auto-injectors over-the-counter, **Alex Adams**, Executive Director of the Idaho Board of Pharmacy, stated that the Food and Drug Administration (FDA) is the only entity that can decide what products are available over-the-counter. He stated the State can broaden access to a prescription medicine by broadening providers' prescriptive authority, which is what this bill seeks to accomplish. Regarding the training requirement, **Mr. Adams** stated that training would be required for laypersons who would administer epinephrine, such as at a boy scout camp or restaurants. There is an exemption for health care professionals who receive this type of training during their usual course of study. He noted that the Board of Pharmacy has enforcement authority over licensees or registered members of the Board. Therefore, **Mr. Adams** commented that the bill encourages compliance by providing liability protections to laypersons who successfully complete the required training.

MOTION: There being no more questions, **Senator Martin** moved to send **S 1322** to the floor with a **do pass** recommendation. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**. Chairman Heider will carry the bill on the floor of the Senate.

S 1326 **Relating to Suicide Prevention**. **Senator Martin** presented this bill.

Senator Martin informed the Committee that he sits on the Idaho Suicide Prevention Board. He indicated that Idaho ranks high among all the states for suicide. Suicide is the second leading cause of death for individuals between the ages of 15 and 34. Three hundred twenty Idahoans died by completing suicide in 2014. He reviewed other statistics relating to suicide in Idaho.

Senator Martin stated that this bill formally adds "services for the prevention of suicide" to the mission of the Department of Health and Welfare (Department). Discussing other actions for suicide prevention, he noted that the Millennium Board recommended a one-time transfer of $120,000 from the Millennium Fund to the Suicide Prevention Hotline. **Senator Martin** also mentioned that another bill is forthcoming that will (i) set aside money for the Suicide Prevention Hotline on an ongoing basis, (ii) provide for suicide prevention education in schools and (iii) establish a suicide prevention coordination council within the Department.

TESTIMONY: **Chairman Heider** invited testimony.

Kathy Garrett, National Alliance on Mental Illness (NAMI)-Idaho, testified in support of this bill. She noted that suicide affects many members of Idaho families. She expressed NAMI-Idaho's appreciation for the Department's efforts regarding suicide awareness and prevention. **Vice Chairman Nuxoll** asked if suicide prevention was directly within the purview of NAMI. **Ms. Garrett** replied that national statistics have shown that 90 percent of those who commit suicide have mental health or substance use disorder issues. NAMI-Idaho has a policy position statement supporting suicide prevention. **Vice Chairman Nuxoll** asked if NAMI-Idaho had ever discussed coordinating all the efforts of suicide prevention. **Ms. Garrett** answered that NAMI-Idaho is composed of all volunteers. She noted that NAMI-Idaho members are trained to question, persuade and refer individuals with suicidal thoughts or expressions to the proper professionals. She indicated that NAMI-Idaho does not have the professional capabilities to manage a suicide prevention program.

CLOSING REMARKS: **Senator Martin** pointed out that the Committee members received a fact sheet regarding services for suicide prevention in Idaho (see attachment 1). He noted that this bill does not have a fiscal impact, but other related legislation may have a fiscal impact in the future.

Chairman Heider asked the Committee members if they had any questions.

Commenting that the Department is already providing suicide prevention services, **Vice Chairman Nuxoll** asked why this bill is necessary. **Senator Martin** acknowledged that the Department has a mission to provide for the health and welfare of the citizens of Idaho, but he felt that suicide prevention should be specifically enumerated in the Department's mission. **Vice Chairman Nuxoll** commented that she spoke with the Executive Director of Jannus, Inc. She asked Senator Martin if he had considered allowing Jannus, Inc., to administer a suicide prevention program, as a flow-through from the Department. **Senator Martin** replied that he was not sure how much money would be allocated to suicide prevention coordination in the other piece of pending legislation, but this bill simply adds language to the Department's mission statement. It is important for the Committee to note that other legislation regarding suicide prevention is on the way. Passage of this bill would reflect the Legislature's commitment to suicide prevention.

MOTION: There being no more questions, **Senator Harris** moved to send **S 1326** to the floor with a **do pass** recommendation. **Senator Lee** seconded the motion.

Senator Martin recognized that Senator Harris is a co-sponsor of this bill.

The motion carried by **voice vote**. Senator Martin will carry the bill on the floor of the Senate.

S 1341 **Relating to Residential Care or Assisted Living Facilities**. **Senator Martin** presented this bill.

Senator Martin commented that after the discussion on the bill by Committee, that it consider sending this bill to the 14th Order of business for amendment. The Department of Health and Welfare has recently requested changes to the last sentence in the bill and language has been drafted that is acceptable to all concerned parties (see attachment 2).

TESTIMONY: **Chairman Heider** invited testimony.

Eric Collett, Assisted Living Representative on the Board of Directors of the Idaho Health Care Association, spoke in support of this bill. He reviewed the process for creation of this bill. In meeting with Alzheimer's groups, certain access to care problems have been identified. This bill relates to one of those problems: access for individuals who suffer from Alzheimer's (or related type of dementia) coupled with violent or difficult to manage behavioral expressions. **Mr. Collett** stated that the Treasure Valley does not have facilities that routinely admit people with dementia as a primary diagnosis. He also noted that resources throughout the rest of the State are very limited. This puts providers and families in the difficult position of not being able to help people with some of the most extreme needs. **Mr. Collett** discussed the various reasons why geriatric/psychiatric hospitals do not operate in Idaho: (i) issues related to involuntary commitment and (ii) limited options (or no options) for facilities to place discharged patients. And he noted that there is a lack of discharge facilities because some Department citations against existing discharge facilities do not always correspond to the rules. To encourage the establishment of discharge facilities, **Mr. Collett** indicated that it is important to have language in statute that limits the Department to issuing citations for things that are actually in the rules. **Mr. Collett** provided the Committee with examples of when a Department citation does not correspond to the rules. He stated that this bill encourages the Department and providers to work together to create rules to address a specific concern. **Senator Schmidt** asked whether the Idaho Health Care Association recommended that the bill be recommended as written or as amended by the sponsor. **Mr. Collett** replied that the Idaho Health Care Association recommended the bill, as amended by the sponsor, be recommended to the full Senate.

Stacy Gunnerson, Vice President of Operations of Ashley Manor, testified in support of the bill, as amended. **Ms. Gunnerson** acknowledged that Department inspectors are acting in the best interest of the patients with the tools the inspectors have available to them. However, she indicated that the murkiness of the rules wastes the time of providers. Clarification of the regulations is the desired outcome of this bill. She provided the Committee with a few examples of problematic citations from the Department. **Ms. Gunnerson** reiterated that the inconsistency in inspections due to vague rules results in inconsistency in care. **Chairman Heider** asked if the regulations state a specific requirement, then why does Ashley Manor feel that these are not important rules to follow. **Ms. Gunnerson** replied that she thinks the regulations are important, but the noted that often the citations do not match the language of the rule. **Senator Schmidt** asked if attempts to clarify rules with the Department have been unhelpful. **Ms. Gunnerson** responded the Department staffers have attempted to answer her questions as best they could given that there is no clear-cut rule. **Senator Schmidt** asked whether Ms. Gunnerson has requested that the Department rewrite their rules.

Ms. Gunnerson answered she had not submitted such a request. **Senator Lee** asked Ms. Gunnerson if she was asking the Legislature to take action to ensure that providers cannot be cited for a deficiency that does not match a rule. **Ms. Gunnerson** answered yes.

Ryan Day, representing the Idaho Alzheimer's Planning Group, testified in support of this bill, as amended. He commented that this bill will break down some of the barriers to lack of access for care of Alzheimer's patients.

CLOSING REMARKS: **Senator Martin** thanked all the participants working with this bill. He reviewed the proposed changes and commented that the amendment to this bill provides that a citation must be in writing and refer to the corresponding rule.

Chairman Heider asked the Committee members if they had any questions.

Senator Schmidt commented that the proposed changes seem to simply say "follow the rules." He suggested that the issues presented in this hearing would best be resolved by the executive branch, and not the legislative branch. **Senator Martin** agreed with Senator Schmidt's statement. He commented that part of the responsibility of the Legislature is oversight. **Chairman Heider** echoed the sentiments of Senator Martin. He commented that the discussions between providers and the Department have shown that both parties desire the same thing: good rules that people can follow to provide good services.

MOTION: There being no more questions, **Vice Chairman Nuxoll** moved to send **S 1341** to the 14th Order of Business with a recommendation to amend as suggested. **Senator Lodge** seconded the motion. The motion carried by **voice vote**. Senator Martin will carry the bill on the floor of the Senate.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:10 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Michael Jeppson
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Thursday, February 25, 2016

ATTACHMENT 1

Idaho Suicide Prevention Hotline

1-800-273-TALK (8255)

by JANNUS

Suicide in Idaho

Idaho is consistently among the states with the highest suicide rates. In 2013 (the most recent year available) Idaho had the 7th highest suicide rate, 47% higher than the national average.

- In 2013, 320 people completed suicide in Idaho; a slight increase from 2012.
- Between 2009 and 2013, 79% of Idaho suicides were by men.
- In 2013, 65% of Idaho suicides involved a firearm. The national average is 51%.
- 5.8% (1 in 7) of Idaho youth attending regular public and charter high schools reported seriously considering suicide in 2013. 7.0% (1 in 14) reported making at least one attempt.
- A ten percent (10%) reduction in Idaho suicide attempts can immediately save over $4 million per year in medical costs alone. If the cost burden of suicide in Idaho was evenly distributed over the population (2008) the burden would amount to over $250 for every person living in Idaho (Piland, 2010).

Staffing Information

- This quarter volunteers contributed 3613 hours to ISPH for an in-kind value $62,400 for 2015, approximately $233,000.
- Current staff consists of one full time Project Director, a full time Volunteer Coordinator, a full time phone room supervisor, 8 part time phone room supervisors, 4 interns and an Americorp Volunteer (6.5 FTE).

2015 Program Goals

- Incremental implementation of text/ chat response in addition to existing phone response.
- Increase level of volunteer staffing and statewide launch of Hotline Ambassador Program.
- Continue to implement sustainable funding strategies.
- Continue to increase statewide awareness of Hotline.

Caller Issues

Call Statistics

Idaho Suicide Prevention Hotline

Call Statistics

October 1 to December 31, 2015

	4th Quarter	2015
Total Calls Received	1218	4866
Military Members / Families	128	617
Rescue Calls (approximate)	54	141
Follow Up Activities Completed	156	733
Percentage of Calls Receiving Follow Up Activities	13%	15%
Caller Age:		
10 - 14	35	139
15 - 19	110	462
20 - 24	111	414
25 - 34	163	633
35 - 44	98	422
45 - 54	161	487
55 - 64	96	656
65 - 74	32	122
75 - 84	3	20
85+	0	4
Didn't Report	409	1507
Total Calls Received	**1218**	**4866**

Idaho Suicide Prevention Hotline

Calls by County

October 1 to December 31, 2015

County	4th Quarter	2015
Ada	279	1203
Adams	4	19
Bannock	37	222
Bear Lake		4
Benewah	1	18
Bingham	6	46
Blaine	31	85
Boise	5	28
Bonner	21	117
Bonneville	33	194
Boundary	1	10
Butte	1	1
Camas		
Canyon	129	547
Caribou		5
Cassia	2	84
Clearwater	5	12
Clark		
Custer		6
Elmore	3	55
Franklin		5
Fremont	1	38
Gem	5	41

County	4th Quarter	2015
Gooding	3	13
Idaho	1	5
Jefferson	4	11
Jerome	4	28
Kootenai	46	394
Latah	37	70
Lemhi	2	22
Lewis	1	5
Lincoln		1
Madison	5	23
MInidoka	4	21
Nez Perce	11	112
Oneida		2
Owyhee	2	22
Payette	4	17
Power		8
Shoshone	7	32
Teton	2	3
Twin Falls	30	197
Valley	1	16
Washington	3	4
Caller Refused / Unable to Collect Data	433	848
* Other	54	272
Total Calls Received	**1218**	**4866**

* Calls received by out of state callers with 208 area code cell phone numbers

"So many lives are touched by suicide, including mine. But I have long believed that we are given adversity as a teacher, as a path toward empathy, and as a tool. So I didn't hesitate to sign up as a volunteer for the new Idaho Suicide Prevention Hotline. It was a huge relief to learn that we would be properly trained; that we would have professional supervisors to guide us as needed; that there would be support on the hotline calls and their after-effects. And none of this went undone. I feel cradled by my peers and especially by the Hotline staff." — ISPH Volunteer

1607 W. Jefferson St., Boise, ID 83702 • Office 208-258-6990 • jreusser@jannus.org
idahosuicideprevention.org • jannus.org •1-800-273-TALK (8255)

SUICIDE PREVENTION LIFELINE

CONTACT usa

Testimonials & Success Stories

"I really appreciate all the help everyone gave me. Calling the hotline saved my life. I had just suffered a brain injury, and I was having a lot of fear and anxiety. The hotline was there for me when I was cutting myself, and the responders helped me find other things to help me cope with those anxieties instead of cutting. They encouraged me to get mental health assistance and help for my brain injury. You guys don't know how much you've helped me. I really appreciate it." – *Bryan Koehler (Lemhi County, 2015)*

Mark is a Marine Corps veteran in his mid-50's who has difficulty managing his PTSD. He began calling the hotline a couple years ago while in crisis. Mark reported that when he was "ill" he had purchased bullets with the intent of taking a life, but he had chosen to give them away instead "because of this [ISPH] phone line." During a call with an ISPH volunteer, Mark explained, "Up until this past year I didn't think I could work through things and I was hiding my vet status, even from my psychiatrist, [but] your operators take me seriously and [...] this line has helped me to become a part of this world." Mark has said that because "the line is keeping me and everybody around me safe," he is able to use his skills and abilities to help others through presentations for NAMI and involvement in his community.

A 90 year old male veteran called the Idaho Suicide Prevention Hotline. He was having trouble navigating the phone tree to get through to the local Veterans Administration (VA) and was feeling upset and concerned that he was going to run out of his meds. We assessed his safety, determined he was safe, and after speaking to him for a few minutes about his situation, we offered to help advocate for him. The veteran gave us permission to contact the VA on his behalf. While we remained on the phone with the Veteran, the phone room supervisor contacted the VA pharmacy and coordinated with the pharmacist to make an outbound call to the vet so they could make sure he got his meds. We told the relieved veteran the good news and ended the call so he could be contacted by the VA pharmacy.

A male veteran with PTSD called the hotline, agitated and upset because he had been trying to get psychiatric help from the VA hospital. The veteran expressed vague thoughts of harming others but didn't want help from us and tried to end the call several times. We remained calm, made a good emotional connection with the veteran and were able to de-escalate him to the point where he agreed to stay safe for the time being. While we kept the vet on the line, the phone room supervisor contacted crisis services at the local VA, and was able to arrange for a warm transfer to the national veteran's crisis line. The transfer was successful and the call ended with the veteran speaking to the national veteran's line and agreeing to get help at a local VA. After the call, we successfully followed up with crisis staff at the local VA who coordinated with the national vet's line staff to assist the vet in getting help.

SENATE HEALTH & WELFARE COMMITTEE
Thursday, February 25, 2016

ATTACHMENT 2

(3) Residential or assisted living facilities may be cited only for a violation of a requirement that is specified in an applicable law or in a rule promulgated in compliance with an applicable law. Facilities may not be cited for an act that is not expressly proscribed by an applicable law or rule or for an omission when an applicable law or rule does not expressly require the conduct omitted. ~~In order for a citation based on violation of an applicable rule to be valid, the rule must specify the requirements for compliance with the rule.~~ If the Department requires a specific corrective action in relation to a citation, that requirement must be in writing and reference the corresponding rule.

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, March 01, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
RS24625	Requesting Unanimous Consent for Referral to Judiciary and Rules Committee for Printing: Nursing Definition Revised	**Sandra Evans** Board of Nursing
Gubernatorial Appointment Hearing	Kevin C. Boling of Coeur d'Alene, Idaho, was reappointed to the Board of Environmental Quality to serve a term commencing July 1, 2015 and expiring July 1, 2019.	**Kevin C. Boling**
Gubernatorial Appointment Hearing	J. Randy MacMillan of Buhl, Idaho, was reappointed to the Board of Environmental Quality to serve a term commencing July 1, 2015 and expiring July 1, 2019.	**J. Randy MacMillan**
Gubernatorial Appointment Hearing	Leonard "Nick" Purdy of Picabo, Idaho, was reappointed to the Board of Environmental Quality to serve a term commencing July 1, 2015 and expiring July 1, 2019.	**Leonard "Nick" Purdy**
Gubernatorial Appointment Hearing	John H. Tippets of Meridian, Idaho, was appointed Director of the Department of Environmental Quality effective July 6, 2015.	**John H. Tippets**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, March 01, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris and Jordan
ABSENT/ EXCUSED:	Senator Schmidt
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:02 p.m.
RS 24625	**Nursing Definition Revised**. **Sandra Evans**, Executive Director, Idaho Board of Nursing, presented this RS.

Sandra Evans stated that the proposed legislation amends Idaho Code to update the definition of "practice of nursing." The current definition is outdated and no longer descriptive of today's nursing practice. The updated definition clearly articulates the diversity of settings in which nurses practice and the variety of roles in which they engage. Additionally, the updated definition confirms that the practice of nursing takes place where the recipient of care is located. This proposed legislation has been reviewed and approved by the Idaho Board of Nursing and the Idaho Medical Association. There is no fiscal impact for this proposed legislation.

Chairman Heider asked the Committee members if they had any questions.

Referencing the provision that a nursing practice may be in administration, **Senator Hagedorn** asked what types of administrative positions would licensed nurses fill. **Ms. Evans** answered that traditional nursing involved bedside care. In addition to that, nurses can serve as administrators in educational institutions, patient care administrators in health care institutions, administrators of nursing regulatory board, administrators in research facilities, administrators in corporations and other related administration positions. **Senator Hagedorn** asked if the people filling those types of positions are required to have a nursing license. **Ms. Evans** replied that in some cases, such as administrators in educational institutions and health care facilities are required to be a licensed nurse.

MOTION: There being no more questions, **Senator Martin** requested unanimous consent that **RS 24625** be sent to the Senate Judiciary and Rules Committee for printing. There being no objection, the motion carried.

GUBERNATORIAL APPOINTMENT: **Consideration of Gubernatorial Appointment of Kevin C. Boling to the Board of Environmental Quality (Board)**. **Chairman Heider** introduced Mr. Boling and asked him to tell the Committee about himself and why he would like to be appointed to the Board.

Mr. Boling stated that this will be his second appointment to the Board. He has a background as a forester performing management of timberlands, saw mills and manufacturing plants. He currently owns his own business, specializing in the sale of timberlands. **Mr. Boling** commented that he appreciated the opportunity to serve.

Chairman Heider asked the Committee if they had any questions.

Senator Lee asked Mr. Boling to discuss what he has accomplished during his previous term on the Board. She also asked what issues the Board still needs to address. **Mr. Boling** answered that one accomplishment was his role in the hearings on fish consumption standards. In these hearings he questioned whether the Clean Water Act, federal regulations or other federal guidelines require States to consider fish suppression when establishing their fish consumption standards. The Environmental Protection Agency (EPA) responded no. As a result of the EPA's response to his questioning, the Board and the Idaho Legislature approved the proposed fish consumption standards. **Mr. Boling** indicated that the EPA may not approve the Idaho fish consumption rule. If not, then the Board may need to take the issue to the courts.

MOTION: There being no more questions, **Senator Harris** moved to send the Gubernatorial reappointment of Kevin C. Boling as a member of the Board to the floor with a recommendation that he be confirmed by the Senate. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**. Vice Chairman Nuxoll will carry the appointment on the floor of the Senate.

GUBERNATORIAL APPOINTMENT: **Consideration of Gubernatorial Appointment of J. Randy MacMillan to the Board**. **Chairman Heider** introduced Mr. MacMillan and asked him to tell the Committee about himself and why he would like to be appointed to the Board.

Mr. MacMillan, Vice President of Research, Technical Services and Quality Assurance for Clear Springs Foods, spoke to his reappointment to the Board. He commented that this will be his fourth term serving on the Board. He spoke about his ability to bring technical expertise to the Board. He stated that he has a PhD in fish pathology or fish diseases.

Chairman Heider asked the Committee if they had any questions.

Senator Martin asked how many individuals hold a PhD in fish pathology. **Mr. MacMillan** stated that there are very few individuals with a PhD in fish pathology. There are fish pathologists in academia, in research and also with Fish and Game Departments. **Senator Martin** asked why Mr. MacMillan desires to serve on the Board. **Mr. MacMillan** responded that it is important to ensure that the State obtains primacy over the Idaho Pollution Prevention Discharge Elimination System (IPDES). He noted that the State is currently developing guidance for implementing the IPDES permit program. **Senator Martin** acknowledged the importance of primacy.

Senator Hagedorn asked whether Mr. MacMillan feels confident that Idaho will have a good outcome if the State's primacy is challenged by the EPA. **Mr. MacMillan** indicated that the EPA is not so much concerned about primacy, but rather they are concerned about fish consumption. He said that the State is required to set human toxics criteria for the waters of the State. During this process the State went through two to three years of investigations, hearings and rulemaking. He noted that the next step after State approval of the rule is to present to the rule to the EPA for their approval. He affirmed that the Department of Environmental Quality (DEQ) has gone above and beyond to protect the public health of tribal and non-tribal individuals. **Mr. MacMillan** is confident that the State has done its due diligence on this issue. He commented that an EPA

rejection of the rule would not be because of science or because it does not protect public health, but would rather be due to politics.

MOTION: There being no more questions, **Senator Martin** moved to send the Gubernatorial reappointment of J. Randy MacMillan as a member of the Board to the floor with a recommendation that he be confirmed by the Senate. **Vice Chairman Nuxoll** seconded the motion.

Chairman Heider commented that he met Mr. MacMillan just after being elected to the Senate. He acknowledged Mr. MacMillan's accomplishments.

The motion carried by **voice vote**. Chairman Heider will carry the appointment on the floor of the Senate.

GUBERNATORIAL APPOINTMENT: **Consideration of Gubernatorial Appointment of Leonard "Nick" Purdy to the Board**. **Chairman Heider** introduced Mr. Purdy and asked him to tell the Committee about himself and why he would like to be appointed to the Board.

Mr. Purdy thanked the Governor for the appointment. He commented that this will be his fourth term serving on the Board. He stated that he is a farmer and rancher. He noted that he has experience working with the DEQ from the perspective of (i) a land owner on Silver Creek, (ii) a public drinking water system owner, (iii) a manufacturer of water pumps for municipal water systems and farms and (iv) an owner of a gas station with underground tanks. **Mr. Purdy** spoke to the need of the DEQ to supervise the placement of underground tanks in Idaho. He commented that the people who work for the DEQ are very qualified and the leadership is great on the Board.

Chairman Heider asked the Committee if they had any questions.

Other than future work related to underground storage tanks, **Senator Martin** asked what else Mr. Purdy would like the DEQ to address during his next tenure. **Mr. Purdy** replied that the IPDES primacy is an important issue.

MOTION: There being no more questions, **Senator Harris** moved to send the Gubernatorial reappointment of Leonard "Nick" Purdy as a member of the Board to the floor with a recommendation that he be confirmed by the Senate. **Senator Lodge** seconded the motion. The motion carried by **voice vote**. Senator Stennett will carry the appointment on the floor of the Senate.

GUBERNATORIAL APPOINTMENT: **Consideration of Gubernatorial Appointment of John H. Tippets as the Director of the Department of Environmental Quality**. **Chairman Heider** introduced Director Tippets and asked him to tell the Committee about himself and why he would like to be appointed as Director of the DEQ.

Director Tippets stated that he raised his family in Bear Lake County. He worked for Agrium, Inc., an owner/operator of phosphate mines and fertilizer manufacturer, for approximately 40 years before retiring. At Agrium, he served in a variety of roles, including most recently as Human Resources Manager. He reviewed his affiliations to other boards and committees during his career. He also noted his tenure with the Idaho House and Idaho Senate. **Director Tippets** has a bachelors of arts degree from Brigham Young University and a masters degree in Human Resource Management from Utah State University. He has been the Director of the DEQ since July 2015.

Director Tippets identified four priorities for the DEQ while he serves as Director: (i) safety of employees, (ii) dignity and respect among the DEQ members, (iii) a focus on continuous improvement and (iv) a service perspective. He noted that a main goal of the DEQ is to help citizens of Idaho understand and comply with the law. **Director Tippets** highlighted the main challenges the DEQ currently faces, including (i) IPDES primacy, (ii) the fish consumption and human health issues and (iii) attraction and retention of qualified employees. **Director Tippets** remarked that he enjoys working at the DEQ. He recognized that environmental regulation needs to be meaningful, effective and reasonable. He understands that his role in the Executive Branch is to administer the DEQ in accordance with the laws. He stated his appreciation for the DEQ employees and the Board.

Chairman Heider asked the Committee if they had any questions.

Senator Martin asked if primacy deals only with water or other areas as well. **Director Tippets** replied that the State has primacy for the Clean Drinking Water Act, the Clean Water Act, the Clean Air Act and other areas. Idaho is one of four states that does not have pollutant discharge primacy. The DEQ will submit an application by September 2016 and then the DEQ will phase in primacy for the State over a three-year period.

Senator Lee acknowledged her appreciation for the way the DEQ presented their rules for review to the Committee. She noted that the format assisted the Senators to better understand the intent of the rules and allows them to advocate for these rules with their constituents.

Senator Hagedorn asked if the EPA rejects the fish consumption rule, what is the next step. **Director Tippets** responded that he was still hopeful that the EPA will approve the rule, but if not then the issue will likely end up in court. He believes the State has a very strong case.

Senator Harris commented that Director Tippets is thorough, thoughtful and full of integrity.

MOTION: There being no more questions, **Senator Hagedorn** moved to send the Gubernatorial appointment of John H. Tippets as a Director of the Department of Environmental Quality to the floor with a recommendation that he be confirmed by the Senate. **Senator Lodge** seconded the motion. The motion carried by **voice vote**. Senator Harris will carry the appointment on the floor of the Senate.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:56 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Michael Jeppson
Assistant

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, March 03, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Minutes Approval	Approve Minutes of January 19, 2016	**Senator Hagedorn**
	Approve Minutes of January 20, 2016	**Senator Harris**
H 0481	RELATING TO THE RIGHT TO TRY ACT: Adds to existing law to implement the Right to Try Act regarding investigational drugs, biological products and devices for patients with terminal illnesses.	**Representative Melissa Wintrow** and **Kurt Altman** Goldwater Institute
H 0500	RELATING TO MEDICARE PROVIDER PAYMENT: Amends existing law to provide that certain services will be reimbursed at 91% of the current Medicare rate.	**Jeff Morrell** Intermountain Hospital

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, March 03, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:15 p.m.
MINUTES APPROVAL:	**Senator Hagedorn** moved to approve the Minutes of January 19, 2016. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**.
	Senator Harris moved to approve the Minutes of January 20, 2016. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**.
H 481	**Relating to the Right To Try Act**. **Representative Melissa Wintrow** presented this bill.
	Representative Wintrow stated that this bill gives a terminally ill patient the right to try investigational medication that has successfully completed Phase 1 of the Food and Drug Administration (FDA) trial process. She read a statement from her constituent, John Knudsen, who suffers from ALS, or Lou Gehrig's Disease (see attachment 1). **Representative Wintrow** indicated that she collaborated with multiple groups, including physicians groups, insurers and regulatory boards and there has been no known opposition to this bill. She yielded her time to Kurt Altman.
	Kurt Altman, Of Counsel representing the Goldwater Institute, spoke in support of this bill. He stated that he drafted the model legislation for this and similar bills all around the nation. He explained that right-to-try laws give terminally ill patients who have exhausted all other FDA approved treatments an opportunity to access investigational new drugs, biologics or devices that have passed Phase 1 of the FDA approval process. Physician approval is required. He explained that the FDA has a three-phase approval process a drug must go through before it can be marketed to the general public. This process usually takes 8 to 15 years. The bill protects patients by requiring that the drug (i) successfully complete Phase 1 of the FDA approval process and (ii) continue processing through Phases 2 and 3. **Mr. Altman** stated that the FDA does have a compassionate use program, but this program is time consuming and bureaucratic (usually 2 months to 4 months) when an individual usually does not have this kind of time. This bill makes the review and approval process much shorter. He noted that this bill is not a guarantee for a cure.

Chairman Heider asked the Committee members if they had any questions.

Senator Schmidt asked if Mr. Altman or the drug companies were aware of other consequences for patients, such as possibly ending someone's life sooner than would have otherwise occurred. **Mr. Altman** answered affirmatively. He noted that the informed consent requirements in the bill make sure that the patient is aware of the risks involved. Restating his question, **Senator Schmidt** asked if Mr. Altman was aware of premature death actually occurring under the right-to-try laws. **Mr. Altman** replied that there has been no occurrence of premature death under right-to-try laws. He noted that 95 percent of these types of laws went into effect in late fall 2015 and early 2016.

Senator Hagedorn asked how this bill would affect medical malpractice for doctors prescribing this service and the drug companies providing it. **Mr. Altman** answered that this bill releases providers and pharmaceutical companies from liability solely for the adverse effects of the investigational drug. The bill does not release providers from general malpractice liability. The informed consents mirror the informed consent forms used in clinical trials. **Senator Hagedorn** asked if malpractice insurance costs have increased in the states that have passed similar right-to-try bills. **Mr. Altman** replied that he does not have that information. He stated that he has not found evidence that malpractice insurance has increased, but he does not know for sure.

Senator Martin asked how the physician obtains experimental drugs. **Mr. Altman** responded that a physician will get the drugs directly from the pharmaceutical company.

Senator Harris asked what role the federal government plays in regulating the right-to-try activity. **Mr. Altman** answered that the FDA is solely responsible for drug approval. The FDA sets the standards and monitors the clinical trials. Noting that Senator Harris may be asking about preemption, **Mr. Altman** commented that the U.S. Constitution sets the floor for rights, and states can recognize greater rights for their citizens. Therefore, a state's enactment of a right-to-try law would be the state simply recognizing the constitutional right of self-preservation. No federal government agency regulation can preempt a state constitutional right in this situation.

Noting that the bill requires an eligible patient to consider all other FDA-approved options before attempting to use experimental drugs, **Vice Chairman Nuxoll** asked how a patient would prove that they have satisfied this requirement. **Mr. Altman** answered that this occurs in conjunction with the physician. Physicians would attest that they have considered all other FDA approved options before attempting to use experimental drugs. **Vice Chairman Nuxoll** asked if this basically meant that this requirement is fulfilled by the physician. **Mr. Altman** responded that it is a medical decision and Vice Chairman Nuxoll's assessment of the physician's role is correct.

Senator Jordan asked if there are any established best practices or benchmarks for administering this program. **Mr. Altman** answered that the American Medical Association (AMA) and related organizations do not have benchmarks for this program. The benchmarks are based on the clinical trials and other studies for the medication. **Senator Jordan** asked if the bill provides for data collection regarding use and outcomes for right try patients. **Mr. Altman** responded that one of the typical conditions for a drug company to allow use of their drug in this situation is for the data to be relayed back to the sponsoring company. He reported that this bill does not mandate data be collected by the State, but some states have referred data collection to the regulatory boards and the rulemaking process.

TESTIMONY: **Chairman Heider** invited testimony.

Penny Caldwell, concerned citizen, spoke in support of this bill. She related the story of her husband and son being diagnosed with ALS at the same time. She explained that they did not have the chance to try experimental treatments, but would have wanted the right to do so.

Dr. James Quinn, physician, spoke in support of the bill. He discussed the importance of this bill because it would give terminally ill patients hope. **Senator Schmidt** asked Dr. Quinn if he practiced in Idaho. **Dr. Quinn** responded that he is associated with Advanced Clinical Research, which conducts Phase 2 and Phase 3 clinical trials. He has been a physician for 48 years. **Senator Schmidt** asked how Dr. Quinn or other proponents would reconcile this bill with current statute that dictates that a physician is subject to medical discipline if they represent that an incurable condition can be cured. **Dr. Quinn** replied that he is not privy to that information and he assumes that this would be addressed by the Legislature.

Matt Keenan, representing the Idaho Freedom Foundation, spoke in support of this bill. He spoke about a man's story regarding a cancer diagnosis. He stated that this man was able to receive experimental treatment under Oregon's right to try law. **Mr. Keenan** stated that Idahoans with terminal illnesses to have the hope provided by the right-to-try.

CLOSING REMARKS: **Representative Wintrow** stated that she appreciates Senator Schmidt's point about reconciliation. This bill is about the philosophy of life and death. She indicated that no doctor can guarantee anything. She related the story of her mother's desire to try experimental medication. **Representative Wintrow** reminded the Committee about the extensive informed consent requirements. This bill releases physicians from liability for both trying experimental medications or deciding not to pursue experimental medications for their patients. This bill releases barriers so that terminally ill patients have the choice to seek experimental treatments.

MOTION: There being no more questions, **Vice Chairman Nuxoll** moved to send **H 481** to the floor with a **do pass** recommendation. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**. Senator Buckner-Webb will carry the bill on the floor of the Senate.

H 500 **Relating to Medicare Provider Payment**. **Jeff Morrell**, Chief Executive Officer of Intermountain Hospital, presented this bill.

Mr. Morrell stated that this bill provides a technical correction to legislation signed into law during the 2015 Legislative Session. The reimbursement methodology for services provided to an adolescent by a private, freestanding mental health facility incorrectly stated the rate for payment. The statute is being amended to reflect the original intent of the legislation. The Department of Health and Welfare (Department) supports this change.

The Committee members together with Mr. Morrell and Sheila Pugatch, Bureau Chief of Bureau of Financial Operations in the Department, discussed the rate of reimbursement for services provided to an adolescent by a private, freestanding mental health facility and the fiscal note and fiscal impact of this legislation.

MOTION: There being no more questions, **Senator Schmidt** moved to send **H 500** to the floor with a **do pass** recommendation. **Senator Harris** seconded the motion. The motion carried by **voice vote**. Senator Schmidt will carry the bill on the floor of the Senate.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:15 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Michael Jeppson
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Thursday, March 3, 2016

ATTACHMENT 1

From: Knudsen's [mailto:parretthead@me.com]
Sent: Monday, February 16, 2015 9:20 AM
To: Representative Melissa Wintrow
Subject: EXPERIMENTAL MEDICINE FOR THE TERMINALLY ILL

Hello:

My name is John Knudsen and I have Amyotrophic lateral sclerosis, or ALS, it is a disease of the nerve cells in the brain and spinal cord that control voluntary muscle movement. ALS is also known as Lou Gehrig's disease.

Amyotrophic lateral sclerosis (ALS)—also referred to as motor neurone disease (MND), Charcot disease, and, in the United States, Lou Gehrig's disease—is a neurodegenerative disease with various causes. It is characterised by rapidly progressive weakness due to muscle atrophy and muscle spasticity, difficulty in speaking (dysarthria), swallowing (dysphagia), and breathing (dyspnea). ALS is the most common of the five motor neuron diseases.

The disease is 100% fatal. I was Given the death sentence five years ago
This May, outliving the majority of people with ALS (PALS).

The disease has no known cure! Recently Lawmakers in Missouri and Louisiana have passed similar bills unanimously in recent days, while voters in Arizona will weigh that state's version of the law at the polling place this November.

This bill if have passed would allow people with terminal illness to seek experimental treatment. It would allow patients and doctors to work together to secure experimental treatments with the permission of a pharmaceutical company. Insurance companies are not required to pay for the treatment, and drug manufacturers can choose whether to charge for the medication or to provide it to the patient free of charge.

I urge you and your elected colleagues to pass a bill that would give myself
And thousands of people some hope if not a cure of literally hundreds of diseases
that rob us of our lives.

Thank you, regards,

John A. Knudsen
2403 N. 26th. St.
Boise, Idaho 83702

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, March 07, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
HCR 047	Social Work Recognition Month	**Representative John Rusche**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Monday, March 07, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	Senator Lee
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:09 p.m.
HCR 047	**Relating to Social Work Recognition Month**. **Representative John Rusche** presented this House concurrent resolution.

Representative Rusche stated this House concurrent resolution recognizes March 2016 as Social Worker Recognition Month and is similar to last year's resolution, with the date being changed. He reported that there are approximately 4,000 licensed social workers in Idaho. **Representative Rusche** said this House concurrent resolution acknowledges the contributions of social workers to the social fabric of Idaho while recognizing March as their month.

Chairman Heider asked the Committee members if they had any questions.

Chairman Heider asked if there were any activities associated with Social Worker Recognition Month. **Representative Rusche** answered that he was not aware of any local activities. He said this year's resolution was prompted when the president of the National Association of Social Workers visited Boise last week; the local social worker chapters thought it would be good to repeat the recognition.

MOTION: There being no more questions, **Senator Lodge** moved to send **HCR 047** to the floor with a **do pass** recommendation. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**. Senator Buckner-Webb will carry the House concurrent resolution on the floor of the Senate.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:15 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

Kara Machado
Assistant

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, March 09, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
Gubernatorial Appointment Hearing	Jay F. Kunze of Pocatello, Idaho, was reappointed to the Hazardous Waste Facility Siting License Application Review Panel to serve a term commencing April 13, 2015 and expiring March 6, 2018.	**Jay F. Kunze**
S 1382	RELATING TO NURSES: Amending Idaho Code to revise the definition of practice of nursing.	**Sandra Evans** Board of Nursing
H 0483	RELATING TO PHARMACY: Amending Idaho Code to provide that a pharmacist who dispenses a biological product shall communicate certain information to the prescriber.	**Ken McClure**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, March 09, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	Senator Lodge
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:01 p.m.
GUBERNATORIAL APPOINTMENT:	**Consideration of Gubernatorial Appointment of Jay F. Kunze to the Hazardous Waste Facility Siting License Application Review Panel (Panel)**. **Chairman Heider** introduced Mr. Kunze, informed the Committee that Mr. Kunze was participating via teleconference from Pocatello, Idaho. He asked Mr. Kunze to tell the Committee about himself and why he would like to be reappointed to the Panel.

Mr. Kunze stated this will be his fourth appointment to the Panel. The Panel has only been involved in the review of the hazardous burial site near Grand View, Idaho, prior to opening the site and again when the site was expanded. **Mr. Kunze** stated that he is willing to serve again. **Mr. Kunze** stated that, until ten years ago, he served as the Dean of Engineering at Idaho State University and he currently still teaches engineering classes. **Mr. Kunze** discussed his professional experience prior to working at Idaho State University, including working for the Idaho National Laboratory (INL) for more than 20 years.

Chairman Heider asked the Committee members if they had any questions.

Senator Martin asked about Mr. Kunze's background. **Mr. Kunze** replied he was born and raised in Pittsburgh, Pennsylvania, and came to Idaho when was about 26 to work on the aircraft nuclear propulsion project. In addition to the work experience mentioned above, Mr. Kunze also headed the nuclear engineering program at the University of Missouri for 12 years.

Noting that the Panel has not met for three years, **Senator Schmidt** he asked if the Panel has ever considered making recommendations regarding continued existence. **Mr. Kunze** responded he has also questioned this issue.

Chairman Heider said that most of the Committee members have toured the Grand View site and have been very impressed with the safety record and with the vigilance with which they manage that site. **Mr. Kunze** noted that he also was impressed with the safety record at the site. **Mr. Kunze** added that he thinks Idaho is doing its fair share of the work to keep the nation safe and environmentally clean.

MOTION: There being no more questions, **Senator Martin** moved to send the Gubernatorial appointment of Jay F. Kunze to the Hazardous Waste Facility Siting License Application Review Panel to the floor with recommendation that he be confirmed by the Senate. **Senator Lee** seconded the motion. The motion carried by **voice vote**. Senator Guthrie will carry the appointment on the floor of the Senate.

S 1382 **Relating to the Definition of the Practice of Nursing**. **Sandra Evans**, Executive Director for the Idaho Board of Nursing, presented this bill.

Ms. Evans stated that this bill amends Idaho Code to update the definition of "practice of nursing." The current definition is outdated and no longer descriptive of today's nursing practice. The updated definition clearly articulates the diversity of settings in which nurses practice and the variety of roles in which they engage. Additionally, the updated definition affirms that the practice of nursing takes place where the recipient of care is located. There is no fiscal impact for this bill.

MOTION: There being no questions, **Senator Harris** moved to send **S 1382** to the floor with a **do pass** recommendation. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**. Senator Martin will carry the bill on the floor of the Senate.

H 483 **Relating to Pharmacist Who Dispense Biological Products**. **Ken McClure**, Attorney representing the Idaho Medical Association and Amgen, a maker of biologic medicines, presented this bill.

Mr. McClure stated that last year the Board of Pharmacy implemented a rule that allowed for the substitution of one biologic medicine for another at the discretion of the health plan and the dispensing pharmacist. **Mr. McClure** discussed the differences between chemical medicines and biologic medicines (see attachment 1). He stated that because biologic medicines usually come from a single cell line, they are not easily replicable. The FDA allows other manufacturers to fast track the approval of biologic medicines that are similar to the originally approved biologic medicine. These medicines are called biosimilars and it is important to note that they are not identical to the original biomedicine because they come from a different cell strain. **Mr. McClure** noted that the availability of multiple biologics to treat the same condition is a good thing because it allows choice and price competition, and because one specific biosimilar may be more effective in treating a particular patient than any other biosimilar. This bill requires a pharmacist to notify the patient's physician when the pharmacist substitutes one biosimilar for another. **Mr. McClure** reviewed the exceptions to the reporting requirements. This bill informs the physician of the biologic medicine dispensed, so that if the patient experiences any problems, the physician can respond appropriately.

Chairman Heider asked the Committee members if they had any questions.

Senator Hagedorn asked for clarification regarding under what circumstances no reporting would be allowed for a biological product with no approved interchangeable products. **Mr. McClure** clarified the language by stating that said that if a pharmacist dispenses any biological product they are required to report to the physician, unless there is no substitute which could be made. In other words, the drug was dispensed as prescribed because no appropriate substitution exists. **Mr. McClure** acknowledged that the language is confusing, but it was necessary to balance the concerns of all interested parties.

Vice Chairman Nuxoll asked why this communication is necessary if pharmacists enter dispensing information into an electronic database. And she asked why patients are not responsible enough to know what specific biologic medicine they are receiving. Regarding Vice Chairman Nuxoll's first question, **Mr. McClure** responded that if a pharmacist enters the dispensing information into an appropriate electronic database, they will be considered in compliance with the reporting requirement. However, if the biologic is dispensed by a pharmacist that does not use an electronic system, they would be required to fax such information to the physician. Regarding Vice Chairman Nuxoll's second question, **Mr. McClure** stated that although a patient may be aware of the substitution, they may forget to tell their physician about the substitution. Patients may have adverse reactions several months after taking the medication. **Vice Chairman Nuxoll** asked what pharmaceutical products are required to be entered into the shared electronic systems. **Mr. McClure** stated that there are two primary public shared systems: (i) the Prescription Monitoring Program (PMP) for controlled substances and (ii) the Immunization Reminder Information System (IRIS) for immunizations. Biologics are not included in those systems, but rather in a database system that exists in the private sector.

Senator Martin asked whether this legislation primarily addresses notifications regarding refills. **Mr. McClure** explained that the reporting requirements may also be applicable to the initial prescription. **Senator Martin** asked Mr. McClure to confirm that the patient would not be telling the physician that there was a substitute; the person that fills the prescription would notify the physician of the substitution. **Mr. McClure** confirmed that the pharmacy filling the prescription would enter the dispensing information into the electronic health record, in the PMP or would fax the information to the physician.

TESTIMONY: **Chairman Heider** invited testimony.

Dr. Troy Rohn, pharmacology professor at Boise State University holding a PhD in pharmacology, testified in support of the bill. **Dr. Rohn** discussed his work and experience with biologic medications to demonstrate the difference between biologics and biosimilars. He stated that this bill is a good piece of legislation that is not too onerous for pharmacies. **Vice Chairman Nuxoll** asked why reporting of a substitution biologic is required instead of optional. **Dr. Rohn** responded that he thinks reporting is required because the physician is in the best position to make determinations about a patient's course of treatment. **Vice Chairman Nuxoll** asked if, instead of making notification a requirement, couldn't the patient tell their physician. **Dr. Rohn** said many of the diseases treated by biologics are chronic diseases in which adverse reactions could occur months after taking a particular medication. This legislation ensures that the physician is kept in the loop regarding which medications are dispensed to the patient.

Dr. Patrick Knibbe, rheumatologist, testified in support of the bill. **Dr. Knibbe** said he thinks the checks and balances provided for in this bill ensure that all parties involved in a patient's treatment are aware of what product has been dispensed to the patient. **Dr. Knibbe** discussed his rationale as physician for wanting pharmacists to report this type of information. **Senator Lee** asked whether it is more appropriate for a physician, who is concerned about biosimilars, to write the prescription to "dispense as written," instead of relying on pharmacist reporting. She also asked what actions Dr. Knibbe would take, if he was notified that a biosimilar had been dispensed. **Dr. Knibbe** said that an insurance company or pharmacies may "veto" his "dispense as written" instruction. He reiterated the importance of transparency for physicians to make decisions in the best interest of their patients.

Stephanie Benjamin testified that her daughter has been battling juvenile arthritis for eight years. She said it has been a journey to find which biologic medication will control her daughter's inflammation and reduce the pain. An effective biologic was found and has been working for about two years now, giving her an improved quality of life. **Ms. Benjamin** expressed how grateful she was to have research and development of biosimilar medications. However, although these medications are similar, they're not identical and may not bring relief to all patients. She noted her concern regarding a pharmacist's ability to substitute a patient's biologic medication without the authorization of the patient's physician. **Ms. Benjamin** asked the Committee not to allow biologic substitutions unless the patient's doctor has been notified and is allowed time to review if the substitution is in the patient's best interest. **Vice Chairman Nuxoll** asked if Ms. Benjamin had stated, in her testimony, that pharmacists can substitute biologic prescriptions without letting patients know. **Ms. Benjamin** said it was her understanding that those decisions could be made without necessarily consulting the physician and that the pharmacist may choose a different medication.

Luke Cavener, Statewide Director for the American Cancer Society (ACS) Cancer Action Network (CAN), which is a non-partisan public policy advocacy arm of the ACS, testified in support of this bill. **Mr. Cavener** stated that this bill will ease the burdens of cancer patients in Idaho.

CLOSING REMARKS: Referencing an earlier question by Senator Lee, **Mr. McClure** commented that a physician retains the right to "dispense as written." This is not an adequate solution because, if the FDA does its job properly, the biosimilar may be just as good and it is almost certain to be cheaper and as a result covered by a health plan. "Dispense as written" may result in patients being unable to afford prescribed medications. Referencing Vice Chairman Nuxoll's earlier question, **Mr. McClure** stated that the substitution is made after the physician writes the prescription; this bill seeks to ensure that the medical record is updated accordingly. **Mr. McClure** added that the bill does have a sunset clause and noted that he expects that electronic health records, at some point, will make this record-keeping process completely unnecessary.

Chairman Heider asked the Committee members if they had any questions.

Senator Martin asked if other states are enacting similar laws, or whether Idaho is one of the first to address this issue. **Mr. McClure** responded that most states either have enacted similar laws or are considering such laws at this time.

MOTION: There being no more questions, **Senator Hagedorn** moved to send **H 483** to the floor with a **do pass** recommendation. **Senator Harris** seconded the motion. The motion carried by **voice vote**. Senator Hagedorn will carry the bill on the floor of the Senate.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:55 p.m.

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Senator Heider
Chair

_____

Karen R. Westbrook
Secretary

_____

Kara Machado
Assistant

SENATE HEALTH & WELFARE COMMITTEE
Wednesday, March 9, 2016

ATTACHMENT 1

UNDERSTANDING BIOLOGIC AND BIOSIMILAR MEDICINES

Biologic medicines have ushered in a new era of medical care where we are able to not only treat the symptoms of chronic conditions like rheumatoid arthritis, multiple sclerosis and cancer, but also the source. With the development of biosimilars, treatment options for patients have the potential to expand considerably. To understand the differences between biologics, biosimilars and chemical medicines and what those differences mean for patient care, please read the below.

CHEMICAL MEDICINES	BIOLOGIC MEDICINES
MOLECULAR STRUCTURE	
Have a simple molecular structure	Have a complex molecular structure
MANUFACTURING	
Developed from a chemical "recipe" and often come in pill form.	Grown from living cells and are often developed as injections or infusions
GENERICS vs BIOSIMILARS	
Generics and their ingredients can be duplicated exactly.	No two biologics are the same, just as no two fingerprints are exactly the same.
PATIENT CARE	
Because they have the same chemical formulae, generics and brand name medications often share similar side effects.	Although they are highly similar, biosimilars can never be exactly the same as the originator biologic, and a patient's response may be different from one to the other.

WHY H483 MATTERS

- Because interchangeable biologics and biosimilars will never be exactly the same, a patient may react differently to both. In case of an adverse event, doctors should know exactly what drug is dispensed to their patients at the pharmacy.
- H483 grants patients and prescribers access to interchangeable biological drug products, opening the doors for new treatment options in Idaho.
- H483 requires that within 5 business days after dispensing, the pharmacist shall communicate to the prescriber the specific biological drug product dispensed.

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, March 10, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	**Chairman Heider**
H 0523	RELATING TO JUVENILE PROCEEDINGS: Amending Idaho Code to provide certain reporting requirements of the State Department of Health and Welfare.	**Representative Christy Perry**
H 0533	RELATING TO HOSPITAL DISTRICTS: Amending Idaho Code to provide that the board of trustees of a hospital district may appoint certain board members; and to revise provisions regarding a board quorum and vacancies.	**Jeremy Pisca** Kootenai Health Medical Center

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, March 10, 2016
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:06 p.m.
H 523	**Relating to Juvenile Proceedings**. **Representative Christy Perry** presented this bill.

Representative Perry stated that this bill requires the Department of Health and Welfare (Department) to provide the Legislature with an annual report on the status of foster care in Idaho. She reviewed potential subjects that could be addressed in the report. **Representative Perry** indicated that there is no fiscal impact to the General Fund and that the Department has been receptive to the idea.

Chairman Heider asked the Committee members if they had any questions.

Senator Schmidt asked **Representative Perry** to explain why annual reporting needs to be required in statute when there may not be an ongoing need for future reports. **Representative Perry** answered that because the responsible group within the Department has experienced significant turnover, the decision was made to put the requirement in statute. A sunset clause of approximately five years was discussed, but it was omitted because the statute could be repealed at any time.

Senator Lodge asked if this report was going to be in addition to the proposed interim committee and the Office of Performance Evaluations (OPE) report. She noted her concern that this requirement would overburden the Department and take away from the work the Department should be doing. **Representative Perry** responded that discussions about annual reporting began prior to the interim committee and OPE requests. Deputy Director Russ Barron has been supportive of all these proposed ideas. She noted that this does not have to be a long report, but will keep members of germane committees informed regarding foster care in the State. **Senator Lodge** commented that this seems to be too many requests. She asked if this is a good use of money and she commented that there should be a focus on one of these items instead of all three.

Senator Lee commented that she appreciates Senator Lodge's position, but she stated that foster care deals with some of the most vulnerable children in the State. She pointed out that this report would provide more attention to the foster care system. She stated that she appreciates the opportunity to review these types of resources and feels awareness would bring more understanding to the Legislature. She asked Representative Perry if this was the intention of this bill. **Representative Perry** answered affirmatively. She commented that the Legislature is able to make better decisions when they have been provided with more relevant information. This would help the Legislature work better with the Department to improve foster care.

Senator Harris, **Senator Hagedorn** and **Vice Chairman Nuxoll** stated their support for this bill.

MOTION: There being no more questions, **Senator Hagedorn** moved to send **H 523** to the floor with a **do pass** recommendation. **Vice Chairman Nuxoll** seconded the motion.

Senator Lodge indicated that she is not against this bill, but she thinks that the requests for multiple reports is overly burdensome and costly. These reports cost money and Senator Lodge told her constituents that she would be mindful of taxpayer dollars.

The motion carried by **voice vote**. Vice Chairman Nuxoll will carry the bill on the floor of the Senate.

H 533 **Relating to Hospital Districts**. **Jeremy Pisca**, Attorney with Risch-Pisca law firm representing Kootenai Health Medical Center (Kootenai Health), presented this bill.

Mr. Pisca stated that this bill gives hospitals, which were formed as part of a taxing district, the ability to add two additional board members. These boards are currently limited by statute to seven elected members. He discussed the growth experienced by Kootenai Health since its formation more than 60 years ago. He noted the difficulty experienced by Kootenai Health in persuading qualified individuals to run for these elected board member positions. **Mr. Pisca** stated that this bill requires a unanimous vote of the elected board members before an additional board member could be appointed. These two appointed members would serve a term that would not exceed six years and could be removed at any time. Further, these appointed members will not be authorized to vote on taxing matters. The intent of this bill is to allow the hospital to find members with specialized knowledge to serve on the board. **Mr. Pisca** indicated that there are seven hospital districts in the State. All seven districts support this legislation. Some districts are uncertain whether or not they would utilize these positions, but appointments are optional.

Chairman Heider asked the Committee members if they had any questions.

Vice Chairman Nuxoll asked for clarification regarding the support of this bill by the seven hospital districts. **Mr. Pisca** confirmed that the seven hospital districts support this legislation.

Senator Schmidt asked how often hospital board positions are in contested elections. **Mr. Pisca** answered that he did not know the answer to that question, but he did not think it occurred very often. **Senator Schmidt** commented that it was his experience that it was usually hard to fill hospital board positions, but that it was refreshing to see yard signs regarding these elections.

Instead of adding board members for expertise, **Chairman Heider** asked if hospital district boards could hire consultants for expertise. **Mr. Pisca** replied that it was more cost effective to make these people board members. Additionally, board members are bound by fiduciary duties whereas consultants are not.

MOTION: There being no more questions, **Senator Hagedorn** moved to send **H 533** to the floor with a **do pass** recommendation. **Senator Harris** seconded the motion. The motion carried by **voice vote**. Senator Hagedorn will carry the bill on the floor of the Senate.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:28 p.m.

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Senator Heider
Chair

_____

Karen R. Westbrook
Secretary

_____

Michael Jeppson
Assistant

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

2:00 P.M.
Room WW54
Thursday, March 17, 2016

NOTE TIME CHANGE

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introduction	**Chairman Heider**
Minutes Approval	Approve Minutes of January 21, 2016	**Senator Lee**
	Approve Minutes of January 25, 2016	**Senator Schmidt**
	Approve Minutes of January 26, 2016	**Senator Martin**
	Approve Minutes of January 27, 2016	**Senator Jordan**
	Approve Minutes of January 28, 2016	**Senator Nuxoll**
	Approve Minutes of February 1, 2016	**Senator Lodge**
	Approve Minutes of February 3, 2016	**Senator Lee**
	Approve Minutes of February 4, 2016	**Senator Harris**
H 0557	RELATING TO YOUTH ATHLETE CONCUSSIONS: Amending Idaho Code regarding concussion and head injury guidelines and requirements, authorization to participate in activities and monitoring students suspected of concussion.	**Matt Kaiserman** St. Luke's Sports Medicine Concussion Clinic

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, March 17, 2016
TIME:	2:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	Senator Lodge
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 2:20 p.m.
MINUTES APPROVAL:	**Senator Lee** moved to approve the Minutes of January 21, 2016. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.
	Senator Schmidt moved to approve the Minutes of January 25, 2016. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.
	Senator Martin moved to approve the Minutes of January 26, 2016. **Senator Harris** seconded the motion. The motion carried by **voice vote**.
	Senator Jordan moved to approve the Minutes of January 27, 2016. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.
	Vice Chairman Nuxoll moved to approve the Minutes of January 28, 2016. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.
	Senator Lee moved to approve the Minutes of February 1, 2016. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.
	Senator Lee moved to approve the Minutes of February 3, 2016. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.
	Senator Harris moved to approve the Minutes of February 4, 2016. **Vice Chairman Nuxoll** seconded the motion. The motion carried by **voice vote**.
H 557	**Relating to Youth Athlete Concussions**. **Matt Kaiserman**, representing St. Luke's Sports Medicine Concussion Clinic, presented this bill.
	Mr. Kaiserman discussed his athletic experience and professional career. He reviewed the services provided by St. Luke's Sports Medicine Concussion Clinic. **Mr. Kaiserman** stated that this legislation amends Idaho Code to add provisions relating to youth athletes and concussion guidelines. Specifically, this bill makes three main changes: (i) modifies coaches' requirement to review concussion guidelines from "biannually" to " biennially" to reflect the original intent to require review of the guidelines every two years, (ii) adds a requirement that youth athletes and their parents/guardians sign and return a consent form indicating that the parties have received the concussion guidelines and that they understand the inherent risks of concussions in sports and (iii) adds a new provision establishing an academic transition process, which provides that student athletes cannot return to sports after a concussion until they can resume all normal academic activities without restriction. **Mr. Kaiserman** gave examples of accommodations that may be provided to student athletes recovering from concussion to assist with their

academic transition. He noted that this transition process should be collaborative among the students, parents, teachers and medical providers.

Chairman Heider asked the Committee members if they had any questions.

Senator Hagedorn asked if there is no way to test for a concussion, then how do physicians know when an athlete has a concussion. **Mr. Kaiserman** responded that this is a clinical diagnosis that recognizes the symptoms and circumstances in which the injury was obtained. **Senator Hagedorn** stated that this bill requires schools to provide formal and informal accommodations for curriculum and monitoring by staff until a student recovers. Commenting that the fiscal note states the bill will have no fiscal impact, **Senator Hagedorn** asked whether there may actually be fiscal impact from this legislation. **Mr. Kaiserman** explained that the fiscal note is correct because the fiscal impact will be minimal at most related to the additional time contributed by the teachers.

Senator Lee stated that the language used in the new provision "modification of curriculum" implies that student athletes do not have to go to classes or keep up with curriculum. **Mr. Kaiserman** said that nothing in this legislation removes the school's ability to regulate the student's curriculum. He noted the intent of this provision is to provide for collaboration between the health care provider and the school to come to agreement of what accommodations or modifications are reasonable. Ultimate deference will be given to the educational institutions. Reviewing the language of the bill, **Senator Lee** asked why the drafters used the word "should" in the provision that "a student athlete should be able to resume all normally scheduled academic activities." **Mr. Kaiserman** stated that the word "should" was intentionally used in the provision because each athlete progresses at different rates and the word "should" provides necessary flexibility in the law.

Referring to the same provision as Senator Lee, **Vice Chairman Nuxoll** asked why the provision was necessary. **Mr. Kaiserman** stated that the purpose of this provision establishes minimal requirements for medical providers to authorize a student's return to sport after a concussion. Referencing his grandsons, **Chairman Heider** commented that students want to get back in the game. This bill requires students to resume normal activity before resuming play.

Senator Harris asks if the academic transition provision applies to all students or only student athletes. **Mr. Kaiserman** responded that the provision only applies to student athletes. He noted, however, that the schools would likely implement this program for all students.

Senator Schmidt stated that the academic transition provision essentially puts a clinical recommendation for a treatment plan into statute. He asked if this codification was discussed with any professional medical associations. **Mr. Kaiserman** responded that the bill was provided to numerous medical associations, including the Idaho Medical Association, the Idaho Board of Medicine, the Idaho Athletic Trainers Association, the Idaho Physical Therapy Association, St. Alphonsus Health System and other medical associations.

MOTION: There being no more questions, **Senator Martin** moved to send **H 557** to the floor with a **do pass** recommendation. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**. **Chairman Heider** will carry the bill on the floor of the Senate.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 2:52 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

1:00 P.M.
Room WW54
Tuesday, March 22, 2016

NOTE TIME CHANGE

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introduction	**Chairman Heider**
HCR 054	RELATING TO BEHAVIORAL HEALTH TREATMENT: Requesting a report from the Department of Health and Welfare on the strategic plan for improving behavioral health treatment.	**Representative John Rusche**
Page Farewell	Thank you to Alaire Chambers of Arco, Idaho, who served as Committee Page for the second half of this Legislative Session.	**Chairman Heider**
Minutes Approval	Approve Minutes of February 8, 2016.	**Senator Jordan**
	Approve Minutes of February 9, 2016.	**Senator Schmidt**
	Approve Minutes of February 10, 2016.	**Senator Lee**
	Approve Minutes of February 11, 2016.	**Senator Martin**
	Approve Minutes of February 15, 2016.	**Vice Chairman Nuxoll**
	Approve Minutes of February 16, 2016.	**Senator Harris**
	Approve Minutes of February 17, 2016.	**Senator Lodge**
	Approve Minutes of February 18, 2016.	**Senator Hagedorn**
	Approve Minutes of March 7, 2016.	**Senator Hagedorn**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

Sen Martin

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, March 22, 2016
TIME:	1:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Hagedorn, Martin, Lee, Harris, Schmidt and Jordan
ABSENT/ EXCUSED:	Senator Lodge
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 1:02 p.m.
PAGE FAREWELL:	**Chairman Heider** recognized and thanked Alaire Chambers for her excellent work as the Committee page for the second half of the 2016 Legislative Session. **Chairman Heider** asked Ms. Chambers to tell the Committee about her experience with the Legislature and her plans for the future. **Ms. Chambers** thanked the Senators for the opportunity to serve as a page. She said she learned a lot about the legislative process and health and welfare issues in Idaho. After graduating, Alaire will be traveling and then has plans to attend college.
HCR 054	**Relating to Behavioral Health Treatment**. **Representative John Rusche** presented this House concurrent resolution. **Representative Rusche** stated that this legislation was drafted based upon a recommendation in the Idaho Behavioral Health Plan Evaluation Report (Report) prepared by the Office of Performance Evaluations. The Report recommended improved communications. The Department of Health and Welfare (Department) and other behavioral health advocates have reviewed this legislation. The legislation provides for a strategic plan for improving behavioral health treatment in Idaho and measures progress over time. **Representative Rusche** commented that this legislation also requires the Department to present a report to the Legislature regarding this strategic plan, including policy recommendations for the Legislature.
TESTIMONY:	**Kathie Garrett**, representing the Consortium for Idahoans with Disabilities, testified in support of the House concurrent resolution. She stated that the members of the consortium include: DisAbility Rights Idaho, Idaho Council on Developmental Disabilities, Idaho Parents Unlimited, Idaho Federation for Families for Children's Mental Health, National Alliance on Mental Illness - Idaho and many others. **Ms. Garrett** discussed her experience as a behavioral health advocate. She stated that this House concurrent resolution will help to improve behavioral health services in Idaho.
CLOSING REMARKS:	**Representative Rusche** stated that it is the Legislature's responsibility to address the issues identified in evaluation reports prepared by the Office of Performance Evaluations. He encouraged the Committee's support for this House concurrent resolution. **Chairman Heider** asked the Committee members if they had any questions.

Referencing the required elements of the Department's report to the Legislature, **Senator Harris** asked if the these requirements would be too burdensome for the Department. **Representative Rusche** responded that the required elements are currently handled by the Department. This report simply provides an organized way to communicate this information to the Legislature.

Senator Martin asked Representative Rusche to confirm that the Department is addressing the issues presented in this resolution. **Representative Rusche** confirmed that they are currently being addressed by the Department, but the Department has not previously reported to the Legislature as requested by this resolution. If the Committee did not approve this resolution, **Senator Martin** asked Representative Rusche if he thought the Department would continue their work and come to the Legislature with recommendations for improvements. **Representative Rusche** stated that he was not sure the Department would provide this specific information in this specific format.

Senator Hagedorn asked how requiring the Department to create a strategic behavioral health plan will change the dynamic of educating Legislators to address behavioral health issues in this State. **Representative Rusche** suggested that previous recommendations from the Department have not provided a complete plan for the Legislature to consider. He said this report will provide a complete plan. Drawing parallels to the Governor's education task force, **Senator Hagedorn** noted that it has taken years for the Legislature to understand the reasoning behind the task force's recommendations. **Senator Hagedorn** asked how all Legislators would become educated on the intricacies of a strategic plan for behavioral health prepared by the Department. **Representative Rusche** responded that he thinks the Department does have a behavioral health plan. He believes requiring the Department to report to the Legislature regarding their plan is the best way to educate the Legislature. **Senator Hagedorn** asked why this resolution was necessary if the Department has a plan for improving behavioral health treatment and why isn't the Department articulating their needs to the Legislature. **Representative Rusche** indicated that he did not know why the Department was not reporting this information to the Legislature.

Chairman Heider asked Representative Rusche to address the concern that this resolution inappropriately micromanages the Department. **Representative Rusche** responded that this resolution does not manage the Department, it only requires reporting.

Providing examples of communication issues between (i) the Department and (ii) the Legislature and other agencies, **Senator Schmidt** stated that he was comfortable asking the Department to provide this unified strategic plan.

MOTION: There being no more questions, **Senator Martin** moved to hold **HCR 054** in Committee. **Senator Hagedorn** seconded the motion.

Senator Hagedorn commented that he believed the Department has a strategic plan for behavioral health in Idaho. He suggested that the actual issue is that the policy makers in the State are not being continuously educated. He stated that the Legislature should not be asking the executive branch set the policy for the State. Setting policy is the Legislature's job. **Senator Hagedorn** suggested that a task force made up of Legislators may be necessary. He reiterated that he cannot support the outsourcing of policy making to the executive branch.

The motion carried by **voice vote**.

MINUTES APPROVAL: **Senator Jordan** moved to approve the Minutes of February 8, 2016. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

Senator Schmidt moved to approve the Minutes of February 9, 2016. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

Senator Lee moved to approve the Minutes of February 10, 2016. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

Senator Martin moved to approve the Minutes of February 11, 2016. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

Senator Martin on written request from Vice Chairman Nuxoll moved to approve the Minutes of February 15, 2016. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

Senator Harris moved to approve the Minutes of February 16, 2016. **Senator Jordan** seconded the motion. The motion carried by **voice vote**.

Senator Hagedorn moved to approve the Minutes of February 17, 2016. **Senator Jordan** seconded the motion. The motion carried by **voice vote**.

Senator Hagedorn moved to approve the Minutes of February 18, 2016. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

Senator Hagedorn moved to approve the Minutes of March 7, 2016. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

INTRODUCTIONS: **Senator Harris** introduced his family in attendance.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 1:35 p.m.

Senator Heider
Chair

Karen R. Westbrook
Secretary

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

8:15 A.M.
Room WW54
Thursday, March 24, 2016

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introduction	**Chairman Heider**
HCR 063	RELATING TO HEALTH CARE: Stating findings of the Legislature and authorizing the Legislative Council to appoint a committee to undertake and prepare a Medicaid waiver application for a state-driven health care plan.	**Representative John Vander Woude**
H 644	RELATING TO HEALTH CARE: Adds to existing law to create the Health Grant Program for the medically underserved.	**Representative John Vander Woude**

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Nuxoll
Sen Lodge
Sen Hagedorn
Sen Martin
Sen Lee
Sen Harris
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Karen Westbrook
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, March 24, 2016

TIME: 8:15 A.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Martin, Lee, Harris, Schmidt and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 8:15 a.m.

HCR 63 **Relating to Committee to Prepare Medicaid Waiver Application**. **Representative Luker** presented this House concurrent resolution.

Representative Luker stated that the gap population in Idaho does not receive sufficient medical services to meet all of their needs. He stated that the current system of care for these individuals through community health centers, rural health clinics and the Catastrophic Health Care program (CAT Fund) is inefficient and not very cost effective. Although Medicaid expansion does provide an option for coverage, **Representative Luker** noted that expansion in other states has resulted in significant cost overruns for those states. He said Idaho is interested in a State-driven policy. This legislation (i) sets up an interim committee to undertake and prepare a Medicaid waiver application for a State-driven plan for delivering health care to the gap population, (ii) directs the interim committee to work with the Department of Health and Welfare (Department) to prepare the waiver and (iii) articulates important policy issues to be considered when drafting the waiver. Additionally, the interim committee would consider the elimination of the county indigent program and CAT Fund. **Representative Luker** stated that the interim committee would report back with a recommendation during the next legislative session.

Chairman Heider asked the Committee members if they had any questions.

Chairman Heider asked how this interim committee would differ from the interim committee two sessions earlier. **Representative Luker** indicated that this interim committee is specifically charged with preparing the waiver application.

Referencing the provision that states that traditional Medicaid is not acceptable to the Legislature due to cost, service and outcome inefficiencies, **Senator Jordan** asked when the Legislature voted to make this decision. **Representative Luker** responded that the policy statement would be made in this resolution.

TESTIMONY: **Chairman Heider** invited testimony.

Brian Whitlock, representing the Idaho Hospital Association (Association), testified in opposition to this House concurrent resolution. **Mr. Whitlock** stated that the Association does support exploration of a Medicaid waiver, but it does not feel the procedure set out in this resolution is appropriate. He noted that the executive branch should be responsible for developing the waiver.

MOTION: There being no more questions, **Senator Martin** moved to hold **HCR 63** in Committee. **Senator Jordan** seconded the motion.

Senator Hagedorn expressed his support for the motion because he doesn't think the Committee can state for the record that it has explored all options. Additionally, he noted that this legislation would limit action by the State until 2018; he would like the Legislature to take action on this issue before that time.

Senator Lodge expressed her concern that the Legislature has not done enough to identify the needs of the gap population. Additionally, she thinks it is problematic to ask the Department to prepare a waiver, only to have the Legislature possibly reject the waiver in the next session.

Senator Lee expressed her support for the motion. She indicated that she understands which people in her district are in the gap population; they are the working poor. She said they are stuck in a gap of policy that has been created in this State. Although she doesn't yet know the solution, she believes the Legislature needs to act on the compelling information that it has already received.

The motion carried by **voice vote**.

H 644 **Relating to Health Care**. **Representative Vander Woude** presented this bill.

Representative Vander Woude stated that this bill will grant $5 million to federally qualified health clinics and some rural health clinics to provide health care services to the gap population while the Legislature considers various plans for providing long-term health care to individuals in the gap population. **Representative Vander Woude** clarified that this bill sets up a grant program under which health clinics would apply for grant funds. However, he was uncertain whether clinics would apply for the grant funds if **HCR 63** was not also enacted.

Chairman Heider asked the Committee members if they had any questions.

Chairman Heider asked how the total amount of grant funds was determined. **Representative Vander Woude** responded that it was the amount he felt would be able to pass the House.

Vice Chairman Nuxoll asked Representative Vander Woude to clarify the procedures required for health clinics to obtain grant funding. **Representative Vander Woude** responded that the health clinics would request the grant, and they must report how the grant funds are used. He noted that this bill gives the health clinics flexibility to provide the services they determine are necessary. **Vice Chairman Nuxoll** asked Representative Vander Woude to confirm that this bill does not eliminate or reduce the funding for the CAT Fund. Additionally, she asked how this funding would help cut costs to Idaho's welfare programs. **Representative Vander Woude** responded that primary care and follow-up care would reduce the need for costly catastrophic care in the future. **Chairman Heider** noted that the community health centers do a great job caring for those in need.

Senator Hagedorn asked Representative Vander Woude if he felt any more funds could be allocated under this bill. **Representative Vander Woude** stated in his opinion $5 million is the maximum amount that could pass the House.

Noting that this bill requires grant recipients to report specified data to the State, **Senator Schmidt** asked whether the requested data was currently available and already being reported to the State. **Representative Vander Woude** answered that the clinics currently submit similar data to the federal government, but this report would require data specifically needed by the State to obtain future bids from service providers. **Senator Schmidt** asked Representative Vander Woude if he had reviewed the Leavitt Partners' 2013 report regarding Idaho's gap population. **Representative Vander Woude** indicated that he had not read the Leavitt report. **Senator Schmidt** noted that some health care entities, such as Heritage Health, operate multiple health clinics. Requesting clarification on funding procedures, **Senator Schmidt** asked whether the main health care entity or each individual clinic would apply for the grant funding. **Representative Vander Woude** responded that the main health care entity would apply for the grant funding and then the network would distribute funds to the individual clinics. **Senator Schmidt** asked if the federally qualified health clinics have estimated the impact of this funding. **Representative Vander Woude** stated that the clinics did not provide estimates on services that could be provided with the available funds. He noted his belief that the clinics would use the funds to the best benefit of the populations they are serving.

Senator Jordan asked what criteria have been established to determine what amount of funds must be used for the provision of care and what amount of funds may be used for administrative costs. **Representative Vander Woude** answered that the bill does not set percentages for usage. He said he believes that clinics would work as efficiently as possible. **Senator Jordan** commented that this bill does not require health clinics to report when individuals are diagnosed with uncovered illnesses and she asked how, without this information, would the State be able to determine what coverage is needed for this population. **Representative Vander Woude** responded that the bill did not contain onerous reporting requirements because he wanted most of the grant funds to be used for patient care.

MOTION: There being no more questions, **Senator Hagedorn** moved to send **H 644** to the 14th Order of Business for possible amendment. **Senator Schmidt** seconded the motion.

Senator Schmidt commented that he supported sending the bill to the 14th Order of Business because he sees opportunities to make this bill better.

The motion carried by **voice vote**. Senator Hagedorn will carry the bill on the floor of the Senate.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 8:45 a.m.

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Senator Heider
Chair

_____

Karen R. Westbrook
Secretary