Jody Simpson

From: Ruth Johnson
Sent: Friday, February 05, 2021 3:14 PM
To: Sen. David Wilson
Cc: Sen.Jesse.Kiehl@akleg.og
Subject: Support for SB 56

Senator Wilson,

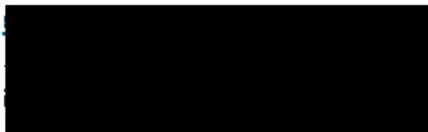
I am the administrator of a nursing home in Juneau currently experiencing a COVID outbreak. Some Alaskans may be "over COVID" but COVID is not over us! I am writing to support SB 56.

The disaster declaration allows us to take advantage of CMS 1135 waivers which give us the flexibility to operate in this unique environment. In long term care we cannot transfer a resident to a new room without two days' notice and their written permission. One provision of the 1135 waiver gives us the flexibility to move residents as needed. The only way to prevent larger outbreaks in nursing homes is to create COVID wings and cohort positive residents together until they are out of isolation.

The disaster declaration is vital to Alaska's health care system. Please protect our ability to care for your constituents effectively by supporting SB 56.

Sincerely,

Ruth Johnson
Administrator
Wildflower Court



Jody Simpson

From:	Hope McGratty [redacted]
Sent:	Friday, February 05, 2021 3:16 PM
To:	Sen. David Wilson; Sen. Shelley Hughes; Sen. Tom Begich; Sen. Mia Costello; Sen. Lora Reinbold
Subject:	Support for SB 56

Dear Senators,

I am writing in support of SB 56. I am a physician assistant working in Infectious Disease in Anchorage. I have been taking care of Covid patients since the beginning of the pandemic and it has been heartbreaking and terrifying.

There are a lot of things the state has done well and the public health measures taken early on have absolutely saved lives. Many of my patients living with HIV around the state have not had any interruption in care through our ability to see them via video. It is imperative that you extend the public health emergency declaration through September 30th, 2021.

There are very few things that our legislators do that directly impact life and death and this is one of them. Please do the right thing and vote to support SB 56.

Respectfully,

Hope McGratty PA-C, MPH

Benjamin P. Westley, MD, LLC
Infectious Disease Management Group
4120 Laurel Street Suite 204
Anchorage, AK 99508
(p) 907.561.4362
(f) 907.563.4498

Bristol Bay Area Health Corporation
6000 Kanakanak Road
P.O. Box 130
Dillingham, AK 99576
(907) 842-5201
(800) 478-5201
FAX (907) 842-9354
www.bbahc.org

Bristol Bay Area Health Corporation is a tribal organization representing 28 villages in Southwest Alaska:

Aleknagik
Chignik Bay
Chignik Lagoon
Chignik Lake
Clark's Point
Dillingham
Egegik
Ekuk
Ekwok
Goodnews Bay
Ivanof Bay
Kanatak
King Salmon
Knugank
Koliganek
Levelock
Manokotak
Naknek
New Stuyahok
Perryville
Pilot Point
Platinum
Port Heiden
Portage Creek
South Naknek
Togiak
Twin Hills
Ugashik

Our Mission: We provide quality health care with competence, compassion, and sensitivity.

February 4, 2021

The Honorable David Wilson
Chairman, Senate Health & Social Services Committee
Alaska Senate
State Capitol Room 121
Juneau, AK 99801
Via Email: Senator.David.Wilson@akleg.gov

RE: Senate Bill 56 to Extend the COVID-19 Public Health Disaster Emergency

Dear Chairman Wilson,

The extension of the public health disaster emergency (PHE) is vital for administrative, regulatory, and statutory flexibilities that have allowed Alaska to respond quickly and successfully to the COVID-19 pandemic. Alaska is leading the way in responding to the pandemic and it is vital that we continue to do so. The Bristol Bay Area Health Corporation (BBAHC) is writing in support of Senate Bill 56 and its swift passage to continue these flexibilities along with our Governor Dunleavy, Commissioner Adam Crum, Alaska Native Health Board representing all Tribes/Tribal Health Organizations in Alaska, the Alaska State Hospital and Nursing Home Association and many other groups that care about our people's health.

BBAHC is a tribal organization that serves a large rural area in southwest Alaska comprised of 27 small villages and the (hub) city of Dillingham; 21 of these villages have clinics. We do not have access to main road systems and most of the travel is done by small air carriers. This area continues to see more COVID-19 cases. In fact, there were 14 new positive cases of COVID-19 reported to the State of Alaska the week of January 29 – February 3, 2021. Also, just yesterday, the Dillingham School has closed due to possible exposure at the school. BBAHC will be hosting a mass testing event for students and staff on Sunday, February 7, 2021. Most cases reported are suspected to be travel related. We continue to ask residents to help stop the spread of COVID-19 by quarantining after travel, wear a mask, wash hands frequently with soap and water and practice social distancing and limit group activities with people outside of your household. We hope consideration is given to the anticipated many more months of this Pandemic that all our fish processors in Bristol Bay and the fishermen, etc. again prove in writing they are COVID free with the test, quarantine and the use of proper PPE's and ideally have had their shots. Note the recent issues in the news if one lets their guard down.

The State's PHE has allowed for a series of flexibilities that have allowed for Governor Dunleavy's administration, specifically the Department of Health & Social Services and the Department of Commerce, Community and Economic Development, as well as health care providers and facilities to respond effectively to COVID-19. A few of the important flexibilities made available by the PHE are:

- **Vaccine distribution** – The powers authorized under the State PHE allow the governor to control the distribution of scarce resources, including scarce COVID-19 vaccines. Without the State PHE, the Department of Health and Social Services will

not be able to distribute the COVID-19 vaccine using the State Vaccination Distribution Plan which prioritizes vulnerable populations, such as our Elders and our first responders.

- **Vaccine administration** –The State PHE does not just support the distribution of the COVID-19 vaccines, it also provides essential flexibility to allow more provider types to be able to administer vaccines. This includes the ability to deploy the Alaska National Guard for contact tracing efforts and vaccine administration.

- **Provider licensing flexibilities** – Under the PHE, providers have received expedited, limited-use licenses that have reinforced Alaska's health care workforce during a time of severe strain. Alaska has fewer health care professionals per capita than most states, and there was a chronic need for providers in Alaska even before the pandemic.

- **Telehealth provision and reimbursement** – The State's PHE also allows patients to see providers for telehealth services without first having an in-person visit. This has been important to keep patients and providers safe during the pandemic, but it has also allowed providers to bill third party payors, providing much needed funding to clinics who have seen patient visits decline dramatically during the pandemic.

- **Continued provision of medication assisted treatment for patients with substance use disorders** – 12 AAC 40.943 allows a provider to see and prescribe controlled substances used as part of medication assisted treatment for substance use disorders via telemedicine during a declared disaster emergency without conducting required in-person exams. This flexibility has been used by rural providers to ensure patients do not have to go without treatment and can remain safe during the pandemic.

- **Alternate Care Sites** – The State's PHE has been a vital component for standing up Alternate Care Sites (ACS) used for testing and treating patients for COVID-19 in non-traditional locations based on their clinical needs. For example, this flexibility allowed the State to establish a field hospital in King Salmon during the fishing season to help ensure local providers had the staffing and capacity to identify and treat COVID-19 in migrant workers. Generally, it has allowed for hospitals to establish an ACS that separates COVID-19 related care and treatment from non-COVID-19 care, keeping patients and providers safe.

- **Quarantining Sites** – The State PHE also has made it possible to quickly stand-up Quarantining Sites for COVID-19 patients during their isolation period. Without the State PHE, it would become significantly more difficult to stand these sites up, especially in our rural hub communities. This flexibility also supports local hospitality businesses which have suffered greatly due to decreased tourism during the pandemic.

- **Travel** – The State PHE also made it possible to limit travel to Alaska and to our vulnerable rural, remote communities. These limitations have continued to protect rural communities in Alaska, especially those with community-based water and sanitation facilities, which face an increased risk of community-based transmission.

Many of our rural communities cannot access the treatment options available at acute care facilities in a timely manner, making prevention from exposure to COVID-19 vital to individual and public health.

The State's PHE and flexibilities are distinct from the public health powers of local governments and the federal government, but necessary to allow the State to respond effectively to the pandemic. We urge swift passage of Senate Bill 56 by the Alaska State Legislature.

If you have any questions regarding this information, please contact Robert J. Clark, President and Chief Executive Officer at rclark@bbahc.org or call 1-907-842-5201.

Sincerely,

BRISTOL BAY AREA HEALTH CORPORATION

Robert J. Clark
President/Chief Executive Officer

cc: Senate Health & Social Services Committee Members
Alaska Senate
Alaska House of Representatives
Alaska Native Health Board
Alaska Tribal Health Consortium
Alaska State Hospital and Nursing Home Association
Evangeline "Angel" Dotomain, Alaska Indian Health Service Director
Senator Lyman Hoffman
Representative Bryce Edgmon
Bristol Bay Native Association
Bristol Bay Native Corporation
Bristol Bay Housing Authority
Bristol Bay Economic Development Corporation
United Tribes of Bristol Bay
Bristol Bay Area Health Corporation Board of Directors
Alaska Federation of Natives

CITY OF UNALASKA
43 Raven Way - P.O. Box 610
Unalaska, Alaska 99685
TEL (907) 581-1251 FAX (907) 581-4469

February 5, 2021

Senator David Wilson
State Capitol Room 121
Juneau AK, 99801

Re: Disaster Emergency Declaration

Dear Senator Wilson:

Governor Dunleavy's current emergency declaration is set to expire on February 14 at 11:59 pm. SB56 was filed to extend the declaration until September 2021, or until the Commissioner of DHSS declares, there is no longer public health threat whichever happens earlier. This will better enable a continued coordinated approach statewide and allow for the successful Health Orders to remain in place. This coordinated approach has proved to be successful thus far, and now is not the time to let our guard down. The pandemic is not over yet and we still require the State's leadership and partnership.

Unalaska is a diverse island community that includes essential workers supporting the International Port of Dutch Harbor, the number one fishing port in the nation, elders, and those living in congregate settings. Due to the unique challenges we face in our island community, our local entities have come together, uniting in our efforts to provide a coordinated response to the pandemic.

Together, we have set up an isolation site to house seafood industry workers who contract the virus. Referrals are provided through the Iliuliuk Family and Health Services (IFHS). We have used the facility regularly with fishing vessels and processing plant outbreaks. The City bears the cost of utilities, rent, insurance, and cleaning. We are thankful for industry and business partners who support the operational efforts and expenses. Our shared goal is to keep the number one fishing port in the nation running.

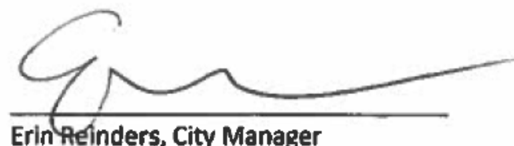
The City of Unalaska has enacted local measures focused on protecting the health of our community members, businesses, and industry; in not overwhelming the health care system. We have worked with the Unalaska City School District and local businesses in efforts to keep their services operational and safe. These efforts have been designed to complement the statewide approach to meet our specific needs.

Qawalangin Tribe of Unalaska, IFHS, Aleutian Pribilof Islands Association, and the City are working together to advocate for more vaccines for our community. The distribution of the COVID-19 vaccine remains slow. Vaccine allotments based on regional population alone do not effectively account for our remote location, limited access to health care, seasonal population influx for industry, and the significant number of individuals living in close quarters and congregant settings.

We are doing our part, and request the continued support of the State in responding to this public heal crisis. We urge you to support SB 56 and extend the State's declaration of emergency. The pandemic is not over yet and we cannot let our guard down. Thank you for your continued leadership.

Sincerely,

Mayor Vincent M. Tuitakoff, Sr



Erin Reinders, City Manager

Southcentral Foundation

February 5, 2021

The Honorable David Wilson
Chairman, Senate Health & Social Services Committee
Alaska Senate
State Capitol Room 121
Juneau, AK 99801
Via Email: Senator.David.Wilson@akleg.gov

RE: Senate Bill 56 to Extend the COVID-19 Public Health Disaster Emergency

Dear Chairman Wilson,

The extension of the public health disaster emergency (PHE) is vital for administrative, regulatory, and statutory flexibilities that have allowed Alaska to respond quickly and successfully to the COVID-19 pandemic. Alaska is leading the way in responding to the pandemic and it is vital that we continue to do so. Following the lead of the Alaska Native Health Board, the voice of Tribal health organizations in the state, I am writing in support of Senate Bill 56 and its swift passage to continue these flexibilities.

Southcentral Foundation, the Tribal health care provider for over 65,000 customer-owners in our region of Alaska, supports the continued efforts to address the pandemic, including through the utilization of provisions contained within Senate Bill 56.

Additionally, flexibilities allowed by the federal government through Centers for Medicare and Medicaid Services (CMS) 1135 waiver can only be accessed if Governor Dunleavy's disaster declaration is extended by state law. If the flexibilities allowed by CMS were to go away, Alaska would lose numerous options for the provision of health care services related to provider licensing, telehealth, and the creation of alternate care sites, among many other issues.

The State's PHE has allowed for a series of flexibilities that have allowed for Governor Dunleavy's administration, specifically the Department of Health & Social Services and the Department of Commerce, Community and Economic Development, as well as health care providers and facilities to respond effectively to COVID-19. A few of the important flexibilities made available by the PHE are:

- **Vaccine distribution** – The powers authorized under the State PHE allow the governor to control the distribution of scarce resources, including scarce COVID-19 vaccines. Without the State PHE, the Department of Health and Social Services will not be able to distribute the COVID-19 vaccine using the State Vaccination Distribution Plan which prioritizes vulnerable populations, such as Elders and first responders.

- **Vaccine administration** – The State PHE does not just support the distribution of the COVID-19 vaccines, it also provides essential flexibility to allow more provider types to be able to administer vaccines. This includes the ability to deploy the Alaska National Guard for contact tracing efforts and vaccine administration.

- **Provider licensing flexibilities** – Under the PHE, providers have received expedited, limited-use licenses that have reinforced Alaska's health care workforce during a time of severe strain. Alaska has fewer health care professionals per capita than most states, and there was a chronic need for providers in Alaska even before the pandemic.

- **Telehealth** – The State's PHE also allows patients to see providers for telehealth services without first having an in-person visit. 95% of SCF's outpatient Behavioral Health Services visits have been provided since March via tele-health for 65,000 customer owners. This has been important to keep customer owners and providers safe during care delivery it has also prevented more costly crisis and emergency care.

- **Continued provision of medication assisted treatment for patients with substance use disorders** – 12 AAC 40.943 allows a provider to see and prescribe controlled substances used as part of medication assisted treatment for substance use disorders via telemedicine during a declared disaster emergency without conducting required in-person exams. This flexibility has been used by rural providers to ensure patients do not have to go without treatment and can remain safe during the pandemic.

- **Alternate Care Sites** – The State's PHE has been a vital component for standing up Alternate Care Sites (ACS) used for testing and treating patients for COVID-19 in non-traditional locations based on their clinical needs. Generally, it has allowed for hospitals to establish an ACS that separates COVID-19 related care and treatment from non-COVID-19 care, keeping patients and providers safe.

- **Quarantining Sites** – The State PHE also has made it possible to quickly stand up Quarantining Sites for COVID-19 patients during their isolation period. Without the State PHE, it would become significantly more difficult to stand these sites up, especially in rural hub communities. This flexibility also supports local hospitality businesses which have suffered greatly due to decreased tourism during the pandemic.

- **Travel** – The State PHE also made it possible to limit travel to Alaska and to vulnerable rural, remote communities. These limitations have continued to protect rural communities in Alaska, especially those with community-based water and sanitation facilities, which face an increased risk of community-based transmission. Many rural communities cannot access the treatment options available at acute care facilities in a timely manner, making prevention from exposure to COVID-19 vital to individual and public health.

The State's PHE and flexibilities are distinct from the public health powers of local governments and the federal government, but necessary to allow the State to respond effectively to the pandemic. We urge the legislature to honor Governor Dunleavy's request and swiftly pass Senate Bill 56.

If you have any questions regarding this information, please contact me at AKyle@scf.cc or 907.729.4955.

Sincerely,
SOUTHCENTRAL FOUNDATION

April Kyle, MBA
Acting President/CEO

CC: Senate Health & Social Services Committee Members
Alaska State Senate Members
Alaska House of Representatives Members
Adam Crum, Commissioner, Department of Health and Social Services
Julie Anderson, Commissioner, Department of Commerce, Community, and Economic Development
Miles Baker, Governor Dunleavy's Legislative Director
John Moller, Office of Governor Dunleavy

BENJAMIN P. WESTLEY, M.D.

INFECTIOUS DISEASES

4120 Laurel St., Ste. 204

Anchorage, AK 99508

907-561-4362 ph

907-563-4498 fax

February 6, 2021

Dear Senators,

This letter is to voice my strong support for SB 56 and the vital extension of the existing public health disaster declaration.

It is not coincidence that Alaska has succeeded in maintaining among the lowest COVID-19 mortality rates in the nation. The declaration has made possible mandatory state entry testing and screening, use of alternative care sites for treatment with monoclonal antibody therapy and use as vaccination centers, and allows many of use to utilize telehealth services to care for our remote patients without the "red-tape" that previously precluded such services.

To be sure, disaster declarations must be ended when a disaster is no longer present. But now is no time to celebrate victory. Although leading the nation, only 13% of Alaskans have received one or more injections of COVID-19 vaccine. Until we are fully protected, Alaskans, and the world, are not safe. The South African variant in particular poses a grave threat, as it is clear that both re-infection rates and transmissibility are higher than seen with wild-type virus. Ongoing aggressive testing upon arrival to Alaska, coupled with rapid vaccine roll-out and continued compliance with distancing and masking are more critical than ever.

In summary, as an Infectious Diseases physician who has spent countless hours caring for my fellow Alaskans stricken by this disastrous virus, I strongly urge you to pass SB 56 and extend the public health disaster declaration through September 30, 2021. With ongoing aggressive work, let us hope by the fall we are finally emerging from this global public health travesty.

Sincerely,

Benjamin Westley MD FIDSA

Jody Simpson

From: Angela Koehler [redacted]
Sent: Friday, February 05, 2021 2:44 PM
To: Senate Health and Social Services
Subject: Emergency declaration allows Alaska access to important resources

Dear Senate Committee,

It is critical that you support Senate Bill 56 to extend the public health disaster emergency declaration. The public health emergency declaration has allowed Alaska to take critical steps during the pandemic to remove barriers that impede rapid responses in health care and other areas. It has allowed Alaska to access federal financial resources, utilize the National Guard, and tap into testing supplies and critical equipment.

Eliminating the emergency declaration could mean:

- vaccine availability and administration are jeopardized;
- hospitals lose access to critical supplies and flexibilities;
- No National Guard for testing, vaccine distribution, and other support

The declaration is about much more than public health orders, it is about accessing important resources that support our health care system and our businesses. Now is not the time to turn back the clock and cut off critical resources.

Sincerely,

Angela Koehler

Jody Simpson

From: Kelly Ogden [redacted]
Sent: Friday, February 05, 2021 2:43 PM
To: Senate Health and Social Services
Subject: Emergency declaration allows Alaska access to important resources

Dear Senate Committee,

It is critical that you support Senate Bill 56 to extend the public health disaster emergency declaration. The public health emergency declaration has allowed Alaska to take critical steps during the pandemic to remove barriers that impede rapid responses in health care and other areas. It has allowed Alaska to access federal financial resources, utilize the National Guard, and tap into testing supplies and critical equipment.

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- hospitals lose access to critical supplies and flexibilities;
- No National Guard for testing, vaccine distribution, and other support

The declaration is about much more than public health orders, it is about accessing important resources that support our health care system and our businesses. Now is not the time to turn back the clock and cut off critical resources.

Sincerely,

Kelly Ogden

Jody Simpson

From: Christine Palmer <[redacted]>

Sent: Friday, February 05, 2021 2:40 PM
To: Senate Health and Social Services
Subject: Emergency declaration allows Alaska access to important resources

Dear Senate Committee,

Home Health patients that are currently able to access services due to having confirmed or suspected COVID-19 (and needing to isolate) would lose access if the declaration is not extended. Home Health patients that are under the primary care of a nurse practioner or physician's assistant would also lose their current access to services.

It is critical that you support Senate Bill 56 to extend the public health disaster emergency declaration. The public health emergency declaration has allowed Alaska to take critical steps during the pandemic to remove barriers that impede rapid responses in health care and other areas. It has allowed Alaska to access federal financial resources, utilize the National Guard, and tap into testing supplies and critical equipment.

Eliminating the emergency declaration could mean:

- vaccine availability and administration are jeopardized;
- hospitals lose access to critical supplies and flexibilities;
- No National Guard for testing, vaccine distribution, and other support

The declaration is about much more than public health orders, it is about accessing important resources that support our health care system and our businesses. Now is not the time to turn back the clock and cut off critical resources.

Sincerely,

Christine Palmer

Jody Simpson

From: Angela Lewis [redacted]
Sent: Friday, February 05, 2021 2:43 PM
To: Senate Health and Social Services
Subject: The emergency declaration is critical to Alaska

Dear Senate Committee,

We need Alaska's public health disaster emergency declaration, and I urge your full and quick support for SB 56 to extend it. Please remember the health care workers who are taking care of Alaskans 24/7 during the COVID pandemic. They have made daily sacrifices to care for our community. The emergency declaration is necessary for this care to continue.

We continue to have dozens of Alaskans in hospitals and outbreaks in vulnerable populations. We face uncertainty over the impact of a new variant strain coming to Alaska. At the same time, we are mounting an intensive vaccine campaign.

Without an emergency declaration in place, we risk losing support from the national guard on testing and vaccine, flexibilities for COVID units in hospitals, and the ability to use telehealth and virtual medical visits. While we all want life to return to normal, eliminating the declaration will only slow us down. Please support SB 56.

Sincerely,

Angela Lewis

Jody Simpson

From: Kirk Elmore <kelmore@wildflowercourt.org>
Sent: Friday, February 05, 2021 2:44 PM
To: Senate Health and Social Services
Subject: Emergency declaration allows Alaska access to important resources

Dear Senate Committee,

The emergency declaration is much needed in the healthcare industry. The availability it allows for Alaskans to obtain safe, timely and much needed medical care is a direct result if this declaration. With new variants now arriving in states around us, the threat of COVID-19 is not over. We need more time, Alaskans deserve more time.

It is critical that you support Senate Bill 56 to extend the public health disaster emergency declaration. The public health emergency declaration has allowed Alaska to take critical steps during the pandemic to remove barriers that impede rapid responses in health care and other areas. It has allowed Alaska to access federal financial resources, utilize the National Guard, and tap into testing supplies and critical equipment.

Eliminating the emergency declaration could mean:

- vaccine availability and administration are jeopardized;
- hospitals lose access to critical supplies and flexibilities;
- No National Guard for testing, vaccine distribution, and other support

The declaration is about much more than public health orders, it is about accessing important resources that support our health care system and our businesses. Now is not the time to turn back the clock and cut off critical resources.

Sincerely,

Kirk Elmore
2412 Aurora Dr
Juneau, AK 99801
kelmore@wildflowercourt.org

Jody Simpson

From: Elaine Reale [redacted]
Sent: Friday, February 05, 2021 3:00 PM
To: Senate Health and Social Services
Subject: Support Alaska's emergency declaration to allow federal flexibilities to meet patient needs

Dear Senate Committee,

Please help us lead the country in covid counter measures!

I am writing today to urge your full and quick support for SB 56 to extend Alaska's public health disaster emergency declaration. Without an emergency declaration in place, we risk losing support from the national guard on testing and vaccine, flexibilities for COVID units in hospitals, and the ability to use telehealth and virtual medical visits.

The emergency declaration has nothing to do with mask mandates, hunker downs, school schedules, or restaurant closures. These are all matters of local control, and they will continue with or without the declaration.

Alaska is doing much better in the battle against COVID, but we are not past this yet. We are still busy taking care of COVID patients and caring for Alaskans' delayed health care needs while mounting an intensive vaccine campaign. Please support SB 56 and extend the emergency declaration so we can continue to work together to get through this difficult time.

Sincerely,

Elaine Reale

Jody Simpson

From: James Bunch
Sent: Friday, February 05, 2021 3:16 PM
To: Senate Health and Social Services
Subject: The emergency declaration is critical to Alaska

Dear Senate Committee,

We need Alaska's public health disaster emergency declaration, and I urge your full and quick support for SB 56 to extend it. Please remember the health care workers who are taking care of Alaskans 24/7 during the COVID pandemic. They have made daily sacrifices to care for our community. The emergency declaration is necessary for this care to continue.

We continue to have dozens of Alaskans in hospitals and outbreaks in vulnerable populations. We face uncertainty over the impact of a new variant strain coming to Alaska. At the same time, we are mounting an intensive vaccine campaign.

Without an emergency declaration in place, we risk losing support from the national guard on testing and vaccine, flexibilities for COVID units in hospitals, and the ability to use telehealth and virtual medical visits. While we all want life to return to normal, eliminating the declaration will only slow us down. Please support SB 56.

Sincerely,

James Bunch
r

Jody Simpson

From: Tammy Bailey
Sent: Friday, February 05, 2021 3:56 PM
To: Senate Health and Social Services
Subject: The emergency declaration is critical to Alaska

Dear Senate Committee,

We need Alaska's public health disaster emergency declaration, and I urge your full and quick support for SB 56 to extend it. Please remember the health care workers who are taking care of Alaskans 24/7 during the COVID pandemic. They have made daily sacrifices to care for our community. The emergency declaration is necessary for this care to continue.

We continue to have dozens of Alaskans in hospitals and outbreaks in vulnerable populations. We face uncertainty over the impact of a new variant strain coming to Alaska. At the same time, we are mounting an intensive vaccine campaign.

Without an emergency declaration in place, we risk losing support from the national guard on testing and vaccine, flexibilities for COVID units in hospitals, and the ability to use telehealth and virtual medical visits. While we all want life to return to normal, eliminating the declaration will only slow us down. Please support SB 56.

Sincerely,

Tammy Bailey

Jody Simpson

From: Michael Burke [redacted]
Sent: Monday, February 08, 2021 6:43 AM
To: Senate Health and Social Services
Subject: Support Alaska's emergency declaration to allow federal flexibilities to meet patient needs

Dear Senate Committee,

Thank you to you and to your staff for all that you do for us in the challenging position of public service in times like these.

I am writing today to urge your full and quick support for SB 56 to extend Alaska's public health disaster emergency declaration. Without an emergency declaration in place, we risk losing support from the national guard on testing and vaccine, flexibilities for COVID units in hospitals, and the ability to use telehealth and virtual medical visits.

The emergency declaration has nothing to do with mask mandates, hunker downs, school schedules, or restaurant closures. These are all matters of local control, and they will continue with or without the declaration.

Alaska is doing much better in the battle against COVID, but we are not past this yet. We are still busy taking care of COVID patients and caring for Alaskans' delayed health care needs while mounting an intensive vaccine campaign. Please support SB 56 and extend the emergency declaration so we can continue to work together to get through this difficult time.

Sincerely,

Michael Burke

Jody Simpson

From:	Justine Muench [redacted]
Sent:	Saturday, February 06, 2021 9:16 PM
To:	Senate Health and Social Services
Subject:	SB 56

I am writing in support of SB 56 extending the disaster COVID emergency order. As an Alaskan receiving oncology medical care in Seattle Washington for the last 6 years , continued telehealth appointments are imperative. Last fall Swedish Hospital amd Virginia Mason Hospital cancelled already established telehealth follow up appointments due to confusion that the Governors declaration was not sufficient and the legislature had to approve his extension. I had an oncology appointment cancelled 3 days prior. This is very frustrating, disconcerting and medically unnecessary for citizens of Alaska who need to receive advanced care in WA. After telephoning numerous individuals finally Swedish attorneys said telehealth could continue. Virginia Mason never did recognize the Governors extension and are still waiting for legislature to approve the bill back from spring 2020. Please approve SB 65 so we do not have to fly during the pandemic , submit to numerous potential COVID exposures, expense for follow up appointments that can be managed with telehealth. Thank you Justine Muench Juneau Alaska

Sent from my iPad

ALASKA PUBLIC HEALTH ASSOCIATION

Committed to Advancing Alaska's Public Health Since 1978

5 February 2021

The Honorable Laura Reinbold, Chair
Senate Judiciary Committee
Alaska State Capitol
Juneau, AK 99801

Dear Senator Reinbold and members of the committee:

The Alaska Public Health Association (ALPHA) writes to express our concerns about documents and testimony provided to you on Friday, 29 January, 2021, and to submit additional information that ought not be sidelined.

As the National Strategy for the COVID-19 Response and Pandemic Preparedness emphasizes, a science- and fact-based, comprehensive public health effort to control the virus — even with vaccination rates ramping up — will be critical to saving lives and restoring economic activity. Thus, we were dismayed by the attention paid last Friday to the pseudo-scientific Great Barrington Declaration. It was a disservice to the public for that political statement to be entered into the record of this body without clearly noting that it was immediately refuted by international experts and by the current CDC director in the John Snow Memorandum. The American Public Health Association joined a group of 20 renowned medical organizations in issuing a statement condemning the Great Barrington Declaration as "not grounded in science and…dangerous."

In an effort to correct the record and to counter the testimony provided by one of the Declaration's authors, we highlight below several of its numerous flaws.

1. The assumption that somehow public health professionals are advocates of stern lockdowns as the only mitigation strategy. This is false.

2. The assumption that it is possible to isolate the 'vulnerable' from the 'not vulnerable.' This is also false. Many Alaskans live in multigenerational households and communities with people across the risk spectrum. An estimated 60% of Americans have at least one risk factor that increases their likelihood for severe COVID-19 illness.

3. The assumption that allowing uncontrolled spread of infection would build 'herd immunity through infection acquired immunity' among low risk groups and somehow eventually protect the vulnerable. This is a dangerous falsehood that would lead to millions more American deaths from COVID-19. A publication in the Lancet called this approach a "dangerous fallacy unsupported by scientific evidence."

P.O. Box 83070, Fairbanks, AK 99708 907/450-2459 *e-mail:alpha@alaskapublichealth.org*
www.alaskapublichealth.org

Inconceivably, the invited speaker offered Sweden as a model to emulate for responding to COVID-19. The fact is that Sweden abandoned its 'natural herd immunity' approach in November 2020, when it had clearly failed. On Dec 20, 2020, COVID-19 deaths in Sweden had reached more than 787 deaths per 1 million population, which is 4.5 to ten times higher than its neighboring Nordic countries, due to its ill-advised earlier decisions. Late last year Sweden began applying tighter restrictions, with its current guidelines including many of the measures currently being followed in parts of Alaska: restrictions in size of gatherings and mandatory mask use in public and in the workplace.

We commend the responses from Commissioner Crum, Chief Medical Officer Dr. Zink, and the Division of Public Health, who continue to make data-informed and scientifically sound decisions in responding to the pandemic. We remind policy makers that the original 'lockdown' in March, 2020, was intended to buy time to gather resources and avoid overwhelming the public health and health care system. (Drastic budget cuts to the Division of Public Health, and specifically the Section of Public Health Nursing in 2016 and 2017, left Alaska in a particularly vulnerable position; the State had inadequate staff and supplies such as masks, gowns and testing materials.) Since then, however, we have learned that some form of carefully calibrated restrictions must be maintained if we hope to slow community transmission. Recall once supplies were obtained and restrictions were lifted in Spring 2020, cases rose, and Alaska has been in a push-and-pull between virus mitigation and case numbers ever since. Wide distribution of these safe and effective vaccines will move us out of this pandemic and back to a more normal way of life.

The situation remains fragile. Alaskans need up-to-date, factual information on COVID-19 from reliable, trusted sources. Misinformation and rhetoric regarding the effectiveness of current mitigation strategies and safety of vaccines undermine these public health strategies and jeopardizes the health of Alaskans. As we have observed in Anchorage and throughout the world, individual actions as well as health mandates/emergency orders are effective in controlling the spread of SARS-CoV-2 and reducing morbidity and mortality from COVID-19.

We therefore support the extension of the Public Health Disaster Emergency Declaration into September. This will allow the State of Alaska to address the COVID-19 pandemic with maximum speed and flexibility to rapidly distribute vaccine as quickly as possible thus ensuring businesses, tourism and the economy can move into the recovery phase of the pandemic. The emergency declaration allows DHSS to: deploy testing and vaccination clinics in non-traditional locations that are suited to public needs; quickly recruit national guards persons and health professionals; more rapidly develop contracts and procure needed supplies; and allocate scarce resources such as vaccines and therapeutics in a manner best suited to the public's health needs. Without a reauthorized emergency declaration, the pandemic response in Alaska will be severely hamstrung, more Alaskans will avoidably suffer and die from COVID-19, and the economic recovery will be further delayed.

The Alaska Public Health Association is affiliated with the American Public Health Association and has 150 public health professionals and other members statewide.

Sincerely,

Tim Hinterberger, PhD, ALPHA president

J.A. Meyer, PhD, MPH, RN, ALPHA past president

cc: Senate Health and Social Services Committee
Commissioner Adam Crum, Department of Health and Social Services

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ALPHA 2021 Resolution 2021-01
Alaska COVID-19 Response

Whereas, SARS-CoV-2 infection, which causes COVID-19 disease in humans, poses a significant risk to the health of Alaskans, and Alaskan Communities

Whereas, since the reopening of Alaska at the end of May, the number of daily reported cases has increased exponentially[i], and most areas of the state are at the highest alert level with cases still rising.[ii]

Whereas, the Alaska public health system has faced significant budgetary cuts in recent years and is straining to meet increased need for public health services, including the ability to rapidly test, report, contact trace, isolate cases, and quarantine contacts.[iii]

Whereas, Alaska's hospitals have limited capacity both in hospital beds[iv], as well as adequate healthcare workers[v] to provide necessary care, and case acceleration in localities with no community controls increase hospitalizations in major hubs.

Whereas, the number of hospitalizations[vi] and deaths[vii] due to COVID-19 are disproportionately higher among Native Hawaiian/Other Pacific Islanders, American Indian/Alaska Natives, and other racial/ethnic minority groups in Alaska.[viii]

Whereas, the spread of COVID-19 is driven by the number of people who are infected by an infectious person, which depends on:

1. The length of time an infectious person is out in society;
2. How frequently an infectious person interacts with others; and
3. How much virus is transmitted from an infectious person to others

Therefore, be it resolved that the Alaska Public Health Association support the implementation of evidence-based measures to prevent and mitigate the spread of the novel coronavirus including, but not limited to the following:

- **Institute Statewide Measures to Slow the Spread of COVID-19.** A statewide mask mandate, travel restrictions, and strict limits on gathering sizes can help slow the spread of COVID-19.[ix]
- **Provide Additional State Supports for Individuals, Families and Businesses.** Make public assistance options available and widely known, ensure access to affordable health care regardless of preexisting conditions, boost supplemental nutrition programs, economic relief, and unemployment benefits. Support employers to offer paid sick leave to employees who are symptomatic, close contacts of someone who has tested positive, or who receives a positive test result. Provide access to vaccinations to all Alaskans free of charge.[x]

- **Provide Additional support for Alaska's Public Health System.** Including increasing the number of people working as contact tracers/case investigators, and leverage technology and public health education to reduce the time between someone getting a positive test and getting information on what to do.

Be it further resolved that, the Alaska Public Health Association supports extending the state's Public Health Emergency Order as necessary to respond to the current crisis, as well as during the recovery phase of the epidemic.

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APHA > News & Media > News Releases > APHA News Releases > SARS CoVID-2

Public health organizations condemn herd immunity scheme for controlling spread of SARS-CoV-2

Date: Oct 14 2020
FOR IMMEDIATE RELEASE
Contact: APHA Media Relations, Rhea Farberman, TFAH

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Great Barrington Declaration is not grounded in science and is dangerous

(Washington, DC) – SARS-CoV-2, the virus that causes COVID-19, has infected at least 7.8 million people in the United States and 38 million worldwide. It has led to over 215,000 deaths domestically, and more than 1 million globally – with deaths continuing to climb.

If followed, the recommendations in the Great Barrington Declaration would haphazardly and unnecessarily sacrifices lives. The declaration is not a strategy, it is a political statement. It ignores sound public health expertise. It preys on a frustrated populace. Instead of selling false hope that will predictably backfire, we must focus on how to manage this pandemic in a safe, responsible and equitable way.

The suggestions put forth by the Great Barrington Declaration are NOT based in science.

- There is no evidence that we are even remotely close to herd immunity. To the contrary, experts believe that 85-90% of the U.S. population is still at risk of contracting SARS-CoV-2. Herd immunity is achieved when the virus stops circulating because a large segment of the population has already been infected. Letting Americans get sick, rather than focusing on proven methods to prevent infections, could lead to hundreds of thousands of preventable illnesses and deaths. It would also add greater risk in communities of color, which have already experienced disproportionate impacts of the pandemic.
- The declaration ignores what are our best tools to fight the virus, i.e. wearing masks, physical distancing, hand-washing, avoiding large crowds, strategic testing, rapid isolation of infected people and supportive quarantine for people who need to isolate.
- We have seen the failure of the herd immunity experiment in nations such as Sweden, which has the highest mortality rate among Nordic countries. COVID-19 carries a much higher risk of severe disease and death than other infections where herd immunity was attempted before a vaccine was available. It is illogical to ignore public health and scientific evidence when so many lives are at stake.

Combatting the pandemic with lockdowns or full reopening is not a binary, either/or choice. We need to embrace common sense public health practices that allow for a safe reopening of the economy and a return to in-person work and learning while also using proven strategies to reduce the spread of the virus.

The declaration suggests a so-called focused protection approach. It suggests allowing the virus to spread unchecked among young people to create herd immunity in the entire population. This notion is dangerous because it puts the entire population, particularly the most vulnerable, at risk. Young people are not all healthy, and they don't live in vacuums. They interact with family members, co-workers and neighbors. Inviting increased rates of COVID-19 in young people will lead to increased infection rates among all Americans.

Public health guidance and requirements related to masking and physical distancing are not an impediment to normalcy – they are the path to a new normal. The goal is both public health safety and economic security; the two are not in conflict with one another, they are dependent on each other. We need to focus our efforts on the development and implementation of a national, science-based and ethical pandemic disease-control strategy.

The pandemic has created serious hardships on families' economic security and on Americans' mental health and well-being. What we need is a coordinated and robust national response including mask use, hand hygiene and physical distancing, while also

ensuring social supports for those most vulnerable, including physical and mental health, and social factors. What we do not need are wrong-headed proposals masquerading as science.

This statement was authored by:

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American Public Health Association
Big Cities Health Coalition
American Academy of Social Work and Social Welfare
Association for Professionals in Infection Control and Epidemiology
Association of Public Health Laboratories
Association of Schools and Programs of Public Health
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Scientific consensus on the COVID-19 pandemic: we need to act now

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has infected more than 35 million people globally, with more than 1 million deaths recorded by WHO as of Oct 12, 2020. As a second wave of COVID-19 affects Europe, and with winter approaching, we need clear communication about the risks posed by COVID-19 and effective strategies to combat them. Here, we share our view of the current evidence-based consensus on COVID-19.

SARS-CoV-2 spreads through contact (via larger droplets and aerosols), and longer-range transmission via aerosols, especially in conditions where ventilation is poor. Its high infectivity,[1] combined with the susceptibility of unexposed populations to a new virus, creates conditions for rapid community spread. The infection fatality rate of COVID-19 is several-fold higher than that of seasonal influenza,[2] and infection can lead to persisting illness, including in young, previously healthy people (ie, long COVID).[3] It is unclear how long protective immunity lasts,[4] and, like other seasonal coronaviruses, SARS-CoV-2 is capable of re-infecting people who have already had the disease, but the frequency of re-infection is unknown.[5] Transmission of the virus can be mitigated through physical distancing, use of face coverings, hand and respiratory hygiene, and by avoiding crowds and poorly ventilated spaces. Rapid testing, contact tracing, and isolation are also critical to controlling transmission. WHO has been advocating for these measures since early in the pandemic.

In the initial phase of the pandemic, many countries instituted lockdowns (general population restrictions, including orders to stay at home and work from home) to slow the rapid spread of the virus. This was essential to reduce mortality,[6,7] prevent health-care services from being overwhelmed, and buy time to set up pandemic response systems to suppress transmission following lockdown. Although lockdowns have been disruptive, substantially affecting mental and physical health, and harming the economy, these effects have often been worse in countries that were not able to use the time during and after lockdown to establish effective pandemic control systems. In the absence of adequate provisions to manage the pandemic and its societal impacts, these countries have faced continuing restrictions.

This has understandably led to widespread demoralisation and diminishing trust. The arrival of a second wave and the realisation of the challenges ahead has led to renewed interest in a so-called herd immunity approach, which suggests allowing a large uncontrolled outbreak in the low-risk population while protecting the vulnerable. Proponents suggest this would lead to the development of infection-acquired population immunity in the low-risk population, which will eventually protect the vulnerable.

This is a dangerous fallacy unsupported by scientific evidence.

Any pandemic management strategy relying upon immunity from natural infections for COVID-19 is flawed. Uncontrolled transmission in younger people risks significant morbidity[3] and mortality across the whole population. In addition to the human cost, this would impact the workforce as a whole and overwhelm the ability of health-care systems to provide acute and routine care. Furthermore, there is no evidence for lasting protective immunity to SARS-CoV-2 following natural infection,[4] and the endemic transmission that would be the consequence of waning immunity would present a risk to vulnerable populations for the indefinite future. Such a strategy would not end the COVID-19 pandemic but result in recurrent epidemics, as was the case with numerous infectious diseases before the advent of vaccination. It would also place an unacceptable burden on the economy and health-care workers, many of whom have died from COVID-19 or experienced trauma as a result of having to practise disaster medicine. Additionally, we still do not understand who might suffer from long COVID.[3] Defining who is vulnerable is complex, but even if we consider those at risk of severe illness, the proportion of vulnerable people constitute as much as 30% of the population in some regions.[8] Prolonged isolation of large swathes of the population is practically impossible and highly unethical. Empirical evidence from many countries shows that it is not feasible to restrict uncontrolled outbreaks to particular sections of society. Such an approach also risks further exacerbating the socio-economic inequities and structural discriminations already laid bare by the pandemic. Special efforts to protect the most vulnerable are essential but must go hand-in-hand with multi-pronged population-level strategies.

Once again, we face rapidly accelerating increase in COVID-19 cases across much of Europe, the USA, and many other countries across the world. It is critical to act decisively and urgently. Effective measures that suppress and control transmission need to be implemented widely, and they must be supported by financial and social programmes that encourage community responses and address the inequities that have been amplified by the pandemic. Continuing restrictions will probably be required in the short term, to reduce transmission and fix ineffective pandemic response systems, in order to prevent future lockdowns. The purpose of these restrictions is to effectively suppress SARS-CoV-2 infections to low levels

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For the WHO COVID-19 dashboard see https://covid19.who.int/

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that allow rapid detection of localised outbreaks and rapid response through efficient and comprehensive find, test, trace, isolate, and support systems so life can return to near-normal without the need for generalised restrictions. Protecting our economies is inextricably tied to controlling COVID-19. We must protect our workforce and avoid long-term uncertainty.

Japan, Vietnam, and New Zealand, to name a few countries, have shown that robust public health responses can control transmission, allowing life to return to near-normal, and there are many such success stories. The evidence is very clear: controlling community spread of COVID-19 is the best way to protect our societies and economies until safe and effective vaccines and therapeutics arrive within the coming months. We cannot afford distractions that undermine an effective response; it is essential that we act urgently based on the evidence.

To support this call for action, sign the John Snow Memorandum.

For the John Snow Memorandum see https://www.johnsnowmemo.com/

See Online for appendix

This work was not in any way directly or indirectly supported, funded, or sponsored by any organisation or entity. NA has experienced prolonged COVID-19 symptoms. AH advises Ligandal (unpaid advisory role), outside the submitted work. FK is collaborating with Pfizer on animal models of SARS-CoV-2, and with the University of Pennsylvania on mRNA vaccines against SARS-CoV-2. FK has also filed IP regarding serological assays and for SARS-CoV-2, which name him as inventor (pending). PK reports personal fees from Kymab, outside the submitted work; PK also has a patent 'Monoclonal antibodies to treat and prevent infection by SARS-CoV-2 (Kymab)' pending and is a scientific advisor to the Serology Working Group (Public Heath England), Testing Advisory Group (Department of Health and Social Care) and the Vaccines Task force (Department for Business, Energy and Industrial Strategy). ML has received honoraria from Bristol-Meyers Squibb and Sanofi Pasteur, outside the submitted work. MM is a member of Independent SAGE and Research Director European Observatory on Health Systems and Policies, which manages the COVID Health Systems Response Monitor. DS sits on the Scottish Government COVID-19 Advisory Group, has attended SAGE meetings, and is on the Royal Society DELVE Initiative feeding into SAGE. CS reports grants from BMS, Ono-Pharmaceuticals, and Archer Dx (collaboration in minimal residual disease sequencing technologies), outside the submitted work; personal fees from Bristol Myers Squibb, Roche-Ventana, Ono Pharmaceutical, GlaxoSmithKline, Novartis, Celgene, Illumina, MSD, Sarah Canon Research Institute, Genentech, Bicycle Therapeutics, and Medicixi, outside the submitted work; personal fees and stock options from GRAIL and Achilles Therapeutics, outside the submitted work; and stock options from Epic Biosciences and Apogen Biotechnologies, outside the submitted work. GY directs the Center for Policy Impact in Global Health at Duke University, which has received grant funding from the Bill & Melinda Gates Foundation for policy research that includes policy analysis on COVID-19 control. All other authors declare no competing interests within the submitted work.

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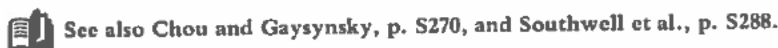
Concrete Recommendations for Cutting Through Misinformation During the COVID-19 Pandemic


See also Chou and Gaysynsky, p. S270, and Southwell et al., p. S288.

The COVID-19 pandemic presents multifaceted challenges for the US health care system. One such challenge is in delivering vital health information to the public—a task made harder by the scourge of health misinformation across the information ecosystem (Southwell et al., p. S288 in this issue of *AJPH*, and Southwell et al.[1]). I offer concrete recommendations for public health information officers and communication professionals drafting communication campaigns for health agencies and health organizations to maximize the chance that timely health advisories reach the public.

At Harvard Kennedy's Shorenstein Center, the Technology and Social Change Research Project studies how misinformation spreads and what its impact is on politics and society (bit.ly/2YcTX09bit.l). Unlike political disinformation, or fake news, health misinformation can quickly lead to changes in behaviors, which is why health communicators can't wait for tech companies to solve the problem.[2]

For example, research on antivaccination movements shows how celebrities, activists, and discredited physicians gain influence over vaccination policies, while also promoting quackery, misinformation, and conspiracies on social media.[3] Although it is difficult to know who has been affected by health misinformation, best strategies to counter it focus on addressing "silent audiences" with direct, careful, and succinct messaging.[4]

Search engines and social media platforms are struggling to control the groundswell of new attention to COVID-19 and are having difficulty matching the right information to the right person at the right time. For example, searching Google, Facebook, Twitter, or YouTube for the phrase "Where can I get tested for coronavirus?" will return different information—or worse, fake news, a predatory scam, or malware (https://politi.co/3g9uzOE).

The pandemic lays bare how the algorithmic design of search engines and social media, which prioritize fresh and relevant content, contributes to confusion by mixing different kinds of information into a single feed: the mundane, the newsworthy, and critical medical recommendations (https://bit.ly/3iQoetq). Additionally, because many platforms are designed with advertising as their backbone, authoritative content from health agencies, health professionals, and local governments is often subsumed by advertising looking to grab clicks.[5]

The situation is dire. People need timely, relevant, and local information on COVID-19. Likewise hospitals, governments, health agencies, and universities are overwhelmed with inquiries and need to use mass communication to reach everyone. Any communication strategy must use redundancy by getting the same information out across as many different channels as possible.

Here are five recommendations based on our research about medical misinformation at the Shorenstein Center:

1. Domain registrars have reported upward of 120 000 domains with keywords related to coronavirus or COVID-19. Although most of the new domains have no content, scammers are using custom domains to target people seeking information about treatment, the worried well, and those suffering financial hardships because of COVID-19 (https://nbcnews.to/3iT5QQu). Public health and health care organizations with already established and functioning Web sites should not register new domains because it is difficult to gain traction within search engines and social media. Instead, these organizations should make a page dedicated to the particular health emergency, in this case COVID-19, on their already existing Web site and update it regularly, even if there is nothing newsworthy to report. Updates provide fresh signals to algorithms, which will rank it accordingly.
2. Debunking every rumor, every conspiracy theory, and all political punditry exhausts critical resources. Furthermore, there has been a deluge of requests for interviews with medical personnel and public health advocates. Health communicators should establish a monitoring protocol to decide which misinformation is gaining traction and approaching a tipping point, such as when misinformation moves across platforms or someone newsworthy, such as a politician or celebrity, distributes it. We recommend routinely checking the

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Federal Emergency Management Agency's rumor database (https://bit.ly/3kSOKUO) and Google's fact-checking database of recently debunked news stories (https://bit.ly/2Ebnwbg). Scan comments posted to local social media groups and public messaging apps, such as Nextdoor. Keep a log of comments the organization receives via social media accounts, telephone, or e-mail. Importantly, no one should respond to misinformation unless there is good reason to do so and they have a plan for communicating it publicly (https://bit.ly/3j4PKnh). It is recommended not to respond to individuals but rather to debunk major misinformation themes.

3. Keeping up with the demand for new information during this pandemic will require a shift to mass communication strategies. In terms of risk communication, working with journalists is key to fighting misinformation. Building two-way communication bridges between health communicators and local journalists will ensure visibility and trust across professional sectors when communication emergencies happen. This is different from hosting press conferences. It's about creating real relationships, where public health is the shared goal. Helping journalists debunk misinformation and providing key recommendations will raise the credibility and visibility of public health recommendations to broad audiences.
4. If using social media to communicate, which all public health organizations should do, contact the platforms and request free public service advertising. In a crisis like this, online advertising systems can be repurposed to reach local audiences (https://bit.ly/3gcHpfc). Local television news remains a reliable way to inform many people quickly and locally.
5. Local governments and health agencies should set up text messaging systems and SMS (short message service) push notifications, where possible, to reach people outside social media. Although emergency management strongly advises that governments set up these systems before a disaster, the pandemic is an opportunity to enroll many people. Alternatively, emergency alert systems do not require a sign-up and could be adapted to reach people in a certain geographic area. For example, New York City has used emergency alerts to request health care workers.

Right now, search and social media companies are not designed to deliver authoritative, timely, relevant, and local information. Tech companies are at a crossroads, where the alliances and coalitions built now to tackle the COVID-19 pandemic will shape the future of risk communication on the Internet. It is crucial, therefore, that health communication professionals understand the limitations of social media and actively work to mitigate misinformation to lessen the harms caused by unchecked scams, hoaxes, and conspiracies; the public must be able to access timely, local, and relevant information when they need it most. AJPH

Joan Donovan, PhD

CONFLICTS OF INTEREST

The author has no conflicts of interest to disclose.

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State of Alaska Epidemiology **Bulletin** ***Recommendations and Reports***

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Evaluation of Public Health Emergency Orders and Reported COVID-19 Rates in the Municipality of Anchorage, Alaska, June – August, 2020

Contributed by: Laura Grage, RN, Tom Hennessy, MD, MPH, Lisa Bulkow, MSc, Jennifer Meyer, RN, MPH, PhD, and Gabriel Garcia, PhD, University of Alaska-Anchorage; and Eric Mooring, ScD, ScM, MPhil, Alaska Section of Epidemiology.

January 12, 2021

Executive Summary:
This report summarizes changes in the COVID-19 epidemic in Anchorage following Emergency Orders (EOs) enacted to reduce virus transmission and thus prevent excess severe illnesses and deaths. Following an EO to wear facial covering (masks) in most public locations, self-reported mask use increased, and the growth of the epidemic slowed. After another EO that restricted the number of persons allowed in public venues and the subsequent closure of those venues, daily case counts declined and maintained a declining pattern while these EOs were in effect. The data presented here indicate that the local EOs, a mask mandate, and targeted restrictions on gathering locations in Anchorage appear to have contributed to decreasing SARS-CoV-2 transmission rates.

Background

SARS-CoV-2 infections are transmitted primarily through respiratory droplets and, without vaccines or curative treatments, communities have used a variety of non-pharmaceutical interventions (NPIs) to reduce transmission and control the epidemic. These strategies have included travel restrictions, public school closures, business and public venue closures, gathering limitations, mask use requirements, and stay-at-home orders. Among NPIs that have demonstrated effectiveness, masks are the least disruptive to the economy. Studies have shown masks to be effective in filtering respiratory droplets and aerosols, thereby decreasing the risk of person-to-person viral transmission.[1-3] During the epidemic, evidence supporting mask use has advanced from modeling predictions to case studies to observational epidemiological studies.[1,4-6]

Transmission of SARS-CoV-2 is facilitated by close proximity of extended duration between an infectious individual and a susceptible contact. Environments where social mixing among persons of different households create conditions favorable for virus transmission. Crowded public venues, restaurants, and bars have been frequently implicated as locations for such transmission to occur,[7] and when restrictions are put in place, significant reductions in transmissions have been noted.[8] In an effort to control the accelerating epidemic during the summer of 2020, the Municipality of Anchorage (MOA) issued Emergency Orders (EOs) requiring mask use in public settings, followed by occupancy limitations at public venues, and closure of public venues.[9]

Models of infectious disease epidemics predict an exponential increase in cases if nothing is done to intervene. Methods to evaluate interventions during the COVID-19 epidemic have included evaluating changes in population-level incidence rates, changes in daily growth rates, and changes in the effective reproductive number (R_t).[6,8,10,11] The daily growth rate can be calculated using the natural log of cumulative daily cases minus the log of cumulative daily cases from the day before. Growth rates can be expressed as a percentage growth per day (either positive or negative). In this way, epidemic growth rates are analogous to calculating a daily compound interest rate. R_t is an estimate of the average number of persons each COVID-19 case will infect. Because R_t can change based on human behavior, it is a common measure of transmission dynamics in epidemics. R_t values >1 indicate increasing case counts and exponential growth, while R_t values <1 indicate that daily case counts are decreasing. R_t can be indirectly calculated using daily growth rates or using daily case counts and estimates of the serial interval.[12,13] The serial interval is the average duration between the time of infection from one person to the time of infection to the next person.[12]

On March 11, 2020, the State of Alaska (SOA) issued a Public Health Disaster Emergency Declaration and sought to control transmission of SARS-CoV-2 through a series of mandates (now called Health Orders) to implement NPIs. These included the suspension and limitation of visitations in congregate living settings,[14] closing public schools, public venues, restaurants, and nonessential businesses. Residents were ordered to stay at home except for outdoor exercise and essential shopping trips or critical infrastructure work.[14] Incoming interstate and international air traveler testing and quarantine procedures were enacted. The MOA issued similar actions beginning March 16, including a stay-at-home order. By April 24, the SOA began lifting restrictions; on May 22, SOA removed all mandated NPIs except for testing and quarantine for travelers arriving from out-of-state. On May 25, the MOA removed EOs that included NPIs and eased restrictions on business operations and gatherings.[9]

Later in the summer, as case counts began to rise, MOA implemented a series of EOs to limit transmission. On June 29, the MOA implemented a mask use order (EO 13). Next, EO 14 (capacity limitations in public venues, such as bars, restaurants, and gyms) and EO 15 (closure of those indoor public venues) were implemented on July 24, and August 3, respectively, and remained in effect through August 30.[9] EO 13v2, an updated version of EO 13 with minor changes, was implemented on July 31. Because of the close timing and overlap of EOs 14, 13v2, and 15, they are best evaluated together; however, EO 13 was implemented as a single order and can be evaluated on its own.

Here, we evaluate the MOA EO 13 using the change in the reproductive number, epidemic growth rate, and self-reported mask usage before and after implementation. We also evaluated EO 14 and 15 by assessing the change in the reproductive number and epidemic growth rate before and after implementation.

Methods

We compared the change in R_t at 14 and 21 days after NPIs were implemented during the summer by using case and R_t data obtained from the Alaska Coronavirus Response Hub and the SOA COVID-19 website.[15,16]

We also calculated the average exponential growth rate during three time periods: (1) the 2 weeks prior to implementation of EO 13; (2) the period when EO 13 was in effect until EO14 was implemented; and (3) the period from when EO 14 was implemented until EO 15 was no longer in effect. Growth rates as well as differences in growth rates between time periods were calculated by fitting a linear model to the log-transformed daily case counts. Wald confidence intervals were obtained for each estimate. Cases were assigned to symptom onset date. If symptom onset date was missing, the earliest of specimen collection date, hospitalization date, or report date was used instead. Time periods were lagged by 5 days from NPI intervention to account for the average incubation period for COVID-19. All calculations were performed using resident cases only.

We utilized Google mobility reports to analyze trends before and after EOs were implemented in the MOA.[17] Google mobility reports are publicly available data, which have been aggregated and anonymized from devices where the user has specifically turned "on" their phone's location history; no individual's movements in the community can be identified.[17] These reports categorize mobility from cell phones in the domains of residential, workplace, grocery and pharmacy, retail and recreation, transit stations and parks. Non-parametric tests (Spearman rho and Rank sum) were used to evaluate trends.

From May through November 2020, Alaska Survey Research conducted three population-based cell phone surveys among Anchorage residents regarding the COVID-19 epidemic. The first cell phone survey was conducted May 6–10, which was followed by four panel surveys conducted at 2-week intervals. The panels consisted of a subset of survey respondents who agreed to participate in these follow-up surveys. The second cell phone survey was conducted July 16–18 and was followed by seven panel surveys conducted at 2-week intervals. The third cell phone survey was conducted on November 5–7, followed by a panel survey conducted just after Thanksgiving on December 3–5. The surveys asked about use of masks when the person was away from their home, whether they had come within 6 feet of someone not from their household, whether they had a visitor at their home, and whether they had physical contact (e.g., hugging or shaking hands) with someone not from their household. The University of Alaska-Anchorage (UAA) research group analyzed all of the survey data.[18]

Results

Anchorage (population 291,845) constitutes approximately 40% of Alaska's residents (731,000) and both populations had rates and daily case counts of COVID-19 that remained low into June. By July 1, Anchorage daily case counts surpassed the remainder of the state and remained higher throughout the summer (Figure 1). Anchorage's 7-day average case rate and R_t both increased rapidly in late June prompting the issuance of EO 13 (Figure 2). New case rates and R_t plateaued in mid-July before rising sharply again in late July, leading to EO 14 and 15. Case rates declined thereafter and remained stable throughout August; R_t declined and remained below 1 for most of the month.

Implementation of EO 13 was followed by a reduction in SARS-CoV-2 transmission within the MOA and an increase in mask use. R_t was reduced proportionally by 18.6% after 14 days and remained lower (-4.1%) after 21 days (Table 1). The average COVID-19 epidemic growth rate in Anchorage also decreased following EO 13. In the 2 weeks preceding implementation of EO 13 (the mask order), the growth rate was 10.8% per day (95% CI: 6.2%, 15.4%). During the period after mask-wearing was mandated through EO 13, but before restrictions on capacity were placed on public venues, the growth rate decreased to 4.7% per day (95% CI: 2.7%, 6.6%; Table 2, Figure 3). Reported mask use when in public increased by 7%–14% after EO 13

(79% July 16, versus 65%–72% in surveys prior to EO 13; Table 3).

Other reported behaviors from the MOA surveys related to avoiding virus transmission (not coming within 6 feet of non-household members, not having visitors in the home, and avoiding physical contact) were similar before and after EO 13. The Google analytics mobility data for Anchorage showed changes in travel to workplaces and transit corresponding to weekends and holidays, but no sustained downward trends in community mobility that could account for the decline in R_t following EO 13 (Figure 4).

Implementation of EOs 14, 13v2, and 15 was also followed by a substantial decline in COVID-19 transmission and rates. R_t fell below 1 for most of August and we observed a corresponding decline and stabilization of daily COVID-19 case counts while these EOs were in effect. In late July, an outbreak in a local seafood plant that employs MOA residents contributed to the rise in R_t during this time, as well as the decline in R_t once the outbreak ended. However, the resolution of the outbreak cannot solely explain the sustained decline in transmission seen through August in both R_t and case rates. This was the first time Anchorage saw a R_t consistently below 1 since mid-May. The average daily growth rate further declined to -0.9% (95% CI: -1.8%, 0.1%) per day, as exponential growth not only slowed but was reversed. Reported mask use among MOA survey respondents increased through August (87%) and late September (89%). Other avoidance behaviors reported in the surveys remained similar before and after EO 14 and 15 and Google mobility data did not show trends that could account for the decline in transmission, such as large increases in residential activity and declines in workplace, transit, or retail activity.

Discussion

The MOA mask order (EO 13) in late June was followed by a decrease in the growth rate of the COVID-19 epidemic in Anchorage. The Emergency Orders that limited and then closed public venues in late July and early August were followed by an even greater drop in transmission and the epidemic in Anchorage began to decline. The conclusion that these Emergency Orders contributed to decreased SARS-CoV-2 transmission is supported by several lines of evidence. Emergency Order 13 was implemented at a time of increasing transmission and was followed within 2 weeks by a roughly 20% reduction in R_t and a roughly 60% decline in the daily growth rate over the following month. Also, surveys of Anchorage residents indicate that reported mask use in public settings increased by 7%–14% after EO 13.[18] Further, other behaviors related to viral transmission reported in the MOA surveys did not change after EO 13, and Google mobility data do not provide another plausible explanation for the decline in transmission. Following EOs 14 and 15, R_t dropped by over 30% to <1, and daily case counts and rates declined throughout August.

A growing number of observational studies suggest that mask orders are associated with decreased SARS-CoV-2 transmission.[5,6,10] This report adds further support to this body of literature. Although this study lacks a suitable comparison community that had similar COVID-19 rates and no intervention, the observations herein meet many of the criteria for a cause-and-effect relationship, including a strong association supported by several measures of effectiveness (R_t, growth rates, mask use), decreased incidence rates after the EOs were implemented, sustained lower rates while the EOs were in effect, and results that are consistent with what is known about SARS-CoV-2 transmission.[19]

The Anchorage experience indicates that even if a high proportion of people use masks, this may not be sufficient to control SARS-CoV-2 transmission if enough persons are engaged in high-risk behaviors such as close contact in crowded environments with persons outside of their household. The rise in transmission in late July may have been due to multiple factors such as transmission in congregate work settings; gatherings in private and public venues; and decreased compliance with maintaining physical distance, handwashing, and avoiding crowds. The decline in case counts after implementation of EOs 14 and 15 supports the hypothesis that bars and restaurants played an important role in SARS-CoV-2 transmission in Anchorage during the early Summer.

Mask use has been recommended by federal, state, and local public health officials since early in the epidemic. Many Alaska communities besides

Anchorage have enacted mask mandates, but a large proportion of Alaskans reside in communities without mandates. In Anchorage, following EO 13, mask use has steadily risen; in the December 3–5 panel survey, 90% of residents reported wearing masks when away from home. This is consistent with published reports which submit that mandates lead to increased compliance with public masking.[6,10,20]

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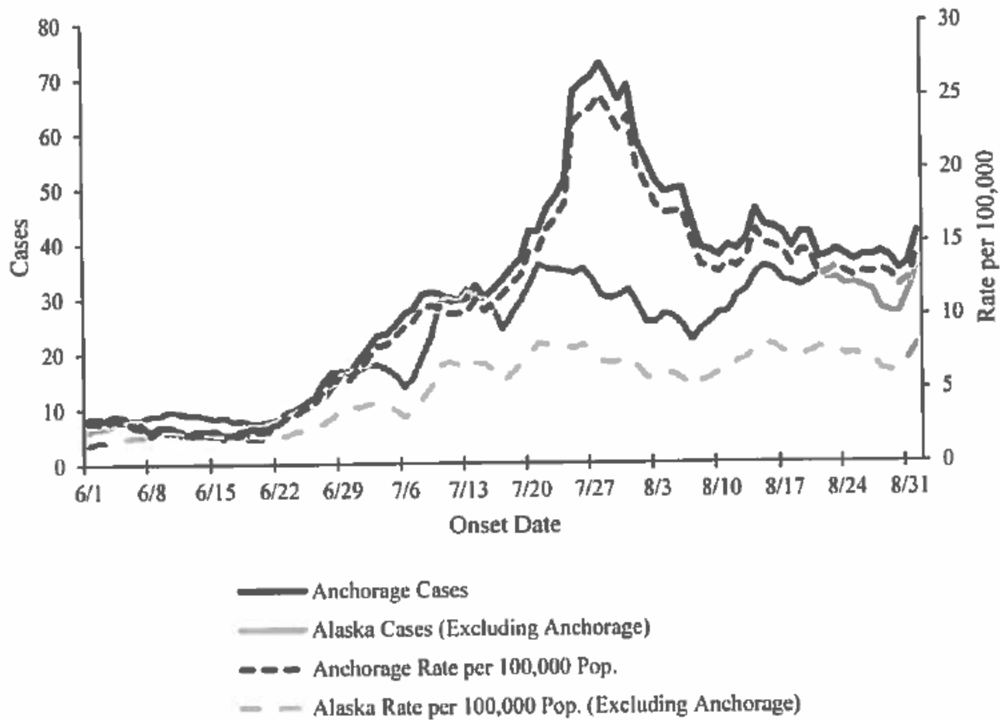
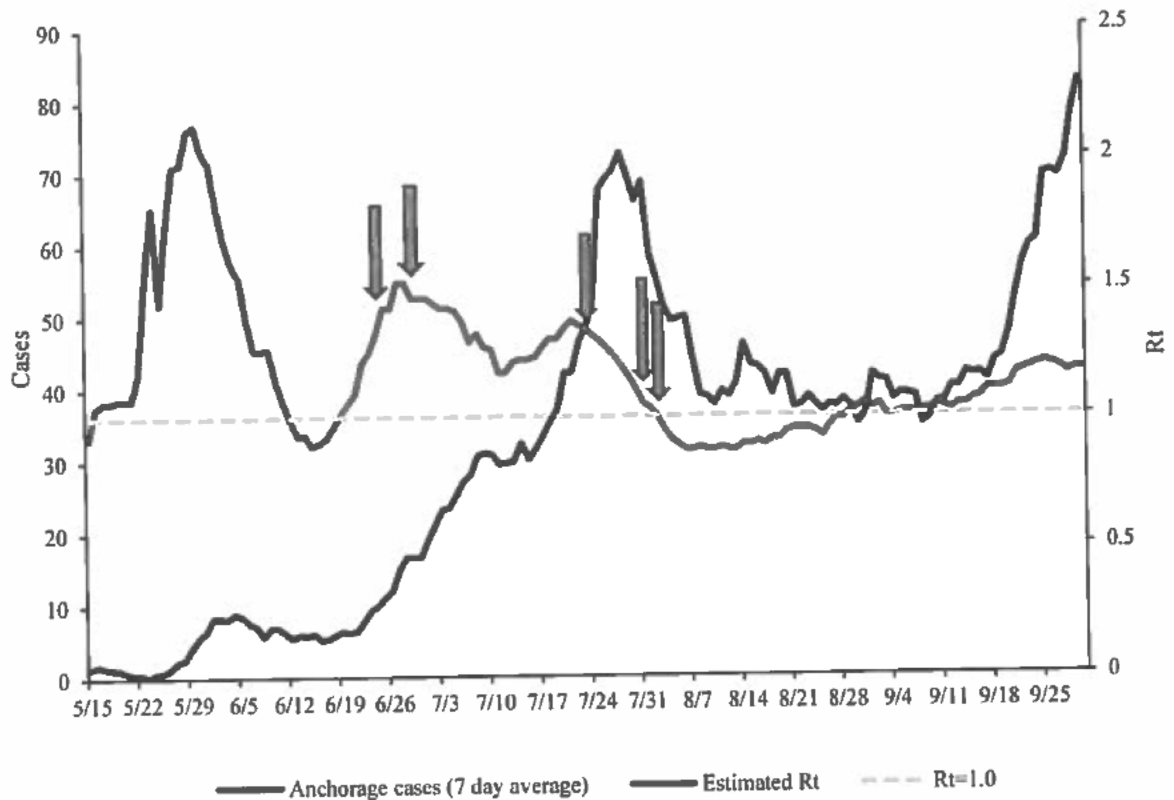
Figure 1. COVID-19 Cases by Onset Date and Rates* — Anchorage and the Rest of Alaska, June–August 2020



**The average rate of COVID-19 cases per 100,000 persons per day, averaged over the previous 7 days.*

Figure 2. Effective Reproductive Number (Rt), New COVID-19 Cases, and Timing of Emergency Orders — Anchorage 2020*



**Notes: The left vertical axis references the average of the daily COVID-19 cases over the previous 7 days. The right vertical axis shows the effective reproductive number. The red arrows indicate the date of Emergency Orders. From left to right they are: EO 13 (mask order) announced, EO 13 effective, EO 14 effective (capacity limitations in public venues), EO 13v2 effective (modified mask order), EO 15 effective (closure of indoor public venues). EO 15 remained in effect through Aug 31. EO13v2 remains in effect.*

Table 1. Change in Effective Reproductive Number following Emergency Orders — Anchorage, June–August 2020

Order #	Effective Date	Reproductive Number, R_t (95% Credible Interval)			Percent Change (%)	
		At Start	Day 14	Day 21	Day 14	Day 21
13 (Masks)	June 29	1.45 (1.26, 1.65)	1.18 (1.07, 1.31)	1.39 (1.29, 1.5)	-18.6	-4.1
14 (Venue Capacity)	July 24	1.31 (1.22, 1.4)	0.89 (0.83, 0.96)	0.90 (0.83, 0.97)	-32.1	-31.3
13v2 (Mask Update)	July 31	1.02 (0.95, 1.09)	0.90 (0.83, 0.97)	0.92 (0.85, 1.0)	-11.8	-9.8
15 (Venue Closure)	Aug. 3	0.94 (0.87, 1.0)	0.90 (0.83, 0.98)	0.97 (0.89, 1.05)	-4.3	+3.2

Table 2. COVID-19 Epidemic Growth Rates, Before and After Emergency Orders — Anchorage 2020*

Intervention	Onset Date Range	Growth Rate per Day (95% CI)	Daily Change in Growth from Prior Period, (95% CI)
Baseline	6/20–7/3	0.108 (0.062, 0.154)	--
After masking use order (EO 13)	7/4–7/28	0.047 (0.027, 0.066)	-0.061 (-0.111, -0.011)
After limits on indoor activities (EOs 14 and 15)	7/29–9/5	-0.009 (-0.018, 0.001)	-0.055 (-0.077, -0.034)

**With 5-day lag between implementation and relevant case onset dates.*

Figure 3. Fitted Epidemic Growth Rates for COVID-19 Cases in Three Phases: Before EO 13, after EO 13 but before EO 14, and after EO 14 until expiration of EO 15 — Anchorage 2020

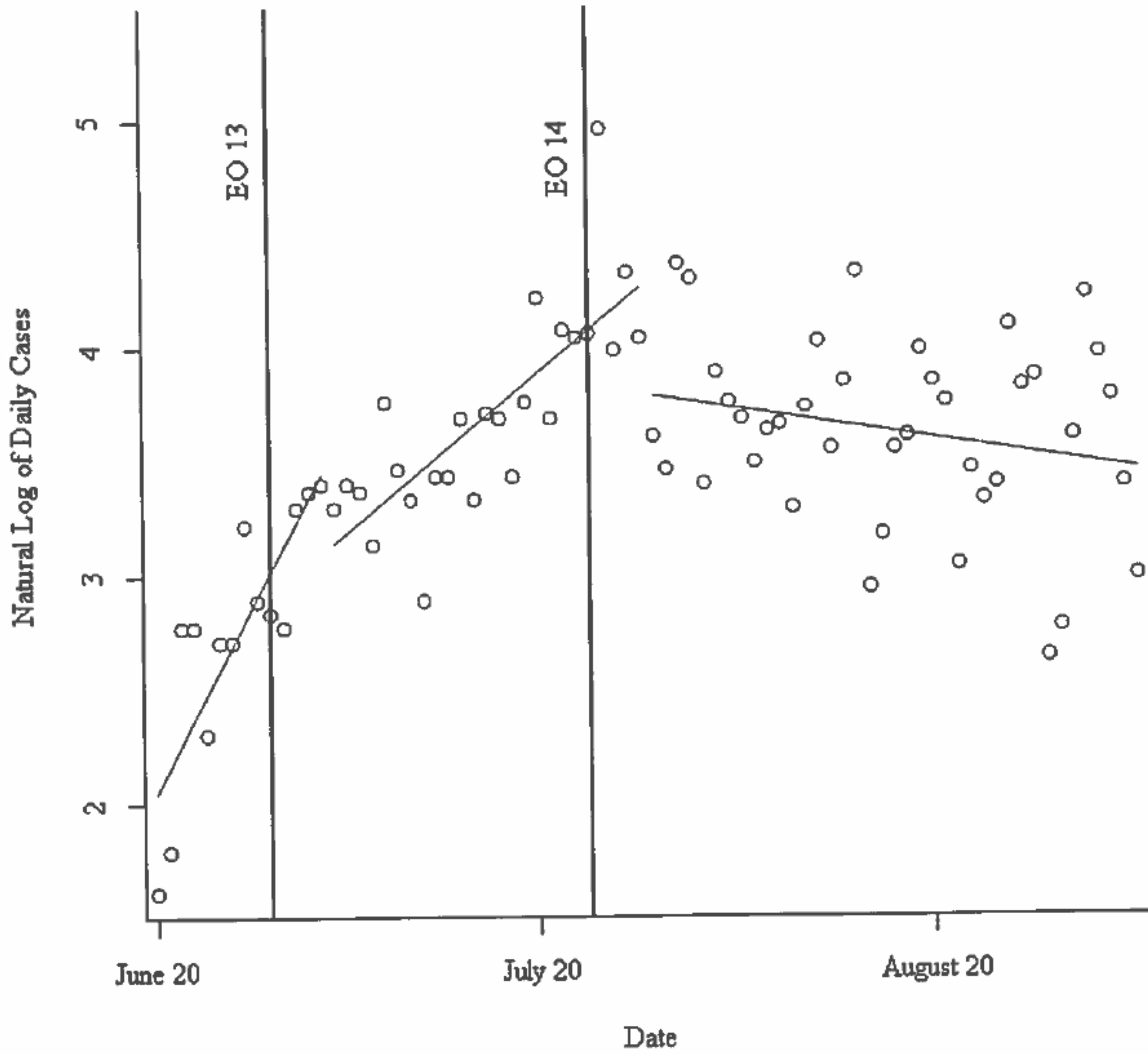


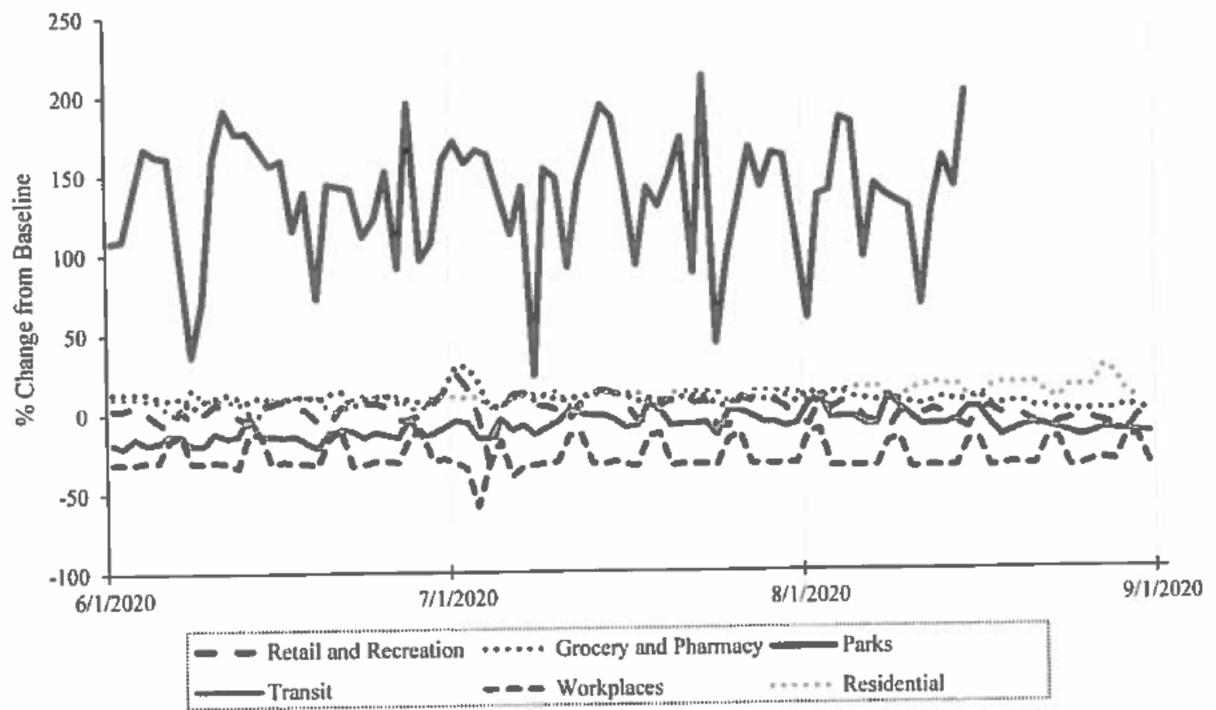
Table 3. Telephonic and Follow-up Surveys of Anchorage Residents, May–September 2020

Date Survey Started	Number of Respondents	Wore Mask All or Most of Time Outside their Home	Did Not Come within 6 ft of Someone Not in their Household	Did not Have a Visitor in their Home	Did Not Make Physical Contact with a Person Outside their Household
May 6	996*	68%[1]	38%[1]	81%[1]	83%[1]
May 22	316**	65%	26%	77%	65%
June 2	309**	69%	13%	76%	64%
June 16	295**	72%	24%	68%	53%
June 29, Mask Order					
July 16	600*	79%[1]	28%[1]	74%[1]	76%[1]
Aug. 25	859**	87%	18%	74%	67%
Sep. 22	322**	89%	13%	71%	63%
Nov. 5	600*	82%[1]	30%[1]	83%[1]	75%[1]
Dec. 3	355**	90%	19%	75%	66%

**Population-based cell phone survey. **Panel survey of a subset of prior population surveys.*

[1]Percentages reported in the population-based cell phone survey have margin of error of ± 4.0% at 95% Confidence Interval.

Figure 4. Google Mobility Trends — Anchorage, June–September 2020



Jody Simpson

From: Hazel Early [redacted]
Sent: Monday, February 08, 2021 9:43 AM
To: Senate Health and Social Services
Subject: The emergency declaration is critical to Alaska

Dear Senate Committee,

We need Alaska's public health disaster emergency declaration, and I urge your full and quick support for SB 56 to extend it. Please remember the health care workers who are taking care of Alaskans 24/7 during the COVID pandemic. They have made daily sacrifices to care for our community. The emergency declaration is necessary for this care to continue.

We continue to have dozens of Alaskans in hospitals and outbreaks in vulnerable populations. We face uncertainty over the impact of a new variant strain coming to Alaska. At the same time, we are mounting an intensive vaccine campaign.

Without an emergency declaration in place, we risk losing support from the national guard on testing and vaccine, flexibilities for COVID units in hospitals, and the ability to use telehealth and virtual medical visits. While we all want life to return to normal, eliminating the declaration will only slow us down. Please support SB 56.

Sincerely,

Hazel Early

Jody Simpson

From: Reginald Atkinson <Mayor@metlakatla.com>
Sent: Monday, February 08, 2021 9:43 AM
To: Senate Health and Social Services
Subject: Emergency declaration allows Alaska access to important resources

Dear Senate Committee,

Metlakatla Indian Community supports Senate Bill 56 to extend the Public Health Disaster Emergency Declaration.

It is critical that you support Senate Bill 56 to extend the public health disaster emergency declaration. The public health emergency declaration has allowed Alaska to take critical steps during the pandemic to remove barriers that impede rapid responses in health care and other areas. It has allowed Alaska to access federal financial resources, utilize the National Guard, and tap into testing supplies and critical equipment.

Eliminating the emergency declaration could mean:

- vaccine availability and administration are jeopardized;
- hospitals lose access to critical supplies and flexibilities;
- No National Guard for testing, vaccine distribution, and other support

The declaration is about much more than public health orders, it is about accessing important resources that support our health care system and our businesses. Now is not the time to turn back the clock and cut off critical resources.

Sincerely,

Reginald Atkinson
PO Box 8
Metlakatla, AK 99926
Mayor@metlakatla.com

Jody Simpson

From: Nicole Holliday
Sent: Monday, February 08, 2021 9:43 AM
To: Senate Health and Social Services
Subject: The emergency declaration is critical to Alaska

Dear Senate Committee,

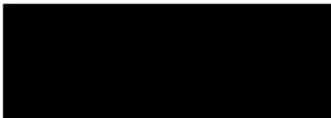
We need Alaska's public health disaster emergency declaration, and I urge your full and quick support for SB 56 to extend it. Please remember the health care workers who are taking care of Alaskans 24/7 during the COVID pandemic. They have made daily sacrifices to care for our community. The emergency declaration is necessary for this care to continue.

We continue to have dozens of Alaskans in hospitals and outbreaks in vulnerable populations. We face uncertainty over the impact of a new variant strain coming to Alaska. At the same time, we are mounting an intensive vaccine campaign.

Without an emergency declaration in place, we risk losing support from the national guard on testing and vaccine, flexibilities for COVID units in hospitals, and the ability to use telehealth and virtual medical visits. While we all want life to return to normal, eliminating the declaration will only slow us down. Please support SB 56.

Sincerely,

Nicole Holliday



Jody Simpson

From:	Ned Magen <[redacted]
Sent:	Monday, February 08, 2021 9:43 AM
To:	Senate Health and Social Services
Subject:	The emergency declaration is critical to Alaska

Dear Senate Committee,

We need Alaska's public health disaster emergency declaration, and I urge your full and quick support for SB 56 to extend it. Please remember the health care workers who are taking care of Alaskans 24/7 during the COVID pandemic. They have made daily sacrifices to care for our community. The emergency declaration is necessary for this care to continue.

We continue to have dozens of Alaskans in hospitals and outbreaks in vulnerable populations. We face uncertainty over the impact of a new variant strain coming to Alaska. At the same time, we are mounting an intensive vaccine campaign.

Without an emergency declaration in place, we risk losing support from the national guard on testing and vaccine, flexibilities for COVID units in hospitals, and the ability to use telehealth and virtual medical visits. While we all want life to return to normal, eliminating the declaration will only slow us down. Please support SB 56.

Sincerely,

Ned Magen

Jody Simpson

From: Kimberly Pettit [redacted]
Sent: Monday, February 08, 2021 10:58 AM
To: Senate Health and Social Services
Subject: Emergency declaration allows Alaska access to important resources

Dear Senate Committee,

As a Providence Alaska Medical Center employee I have seen first hand how quickly our hospital can be overcome with patients requiring care due to COVID 19. It is VITAL that we maintain flexibility with regard to our hospital units and that we have access to supplies. Please support our hospitals, healthcare workers and communities by extending the disaster declaration.

It is critical that you support Senate Bill 56 to extend the public health disaster emergency declaration. The public health emergency declaration has allowed Alaska to take critical steps during the pandemic to remove barriers that impede rapid responses in health care and other areas. It has allowed Alaska to access federal financial resources, utilize the National Guard, and tap into testing supplies and critical equipment.

Eliminating the emergency declaration could mean:

- vaccine availability and administration are jeopardized;
- hospitals lose access to critical supplies and flexibilities;
- No National Guard for testing, vaccine distribution, and other support

The declaration is about much more than public health orders, it is about accessing important resources that support our health care system and our businesses. Now is not the time to turn back the clock and cut off critical resources.

Sincerely,

Kimberly Pettit

City of Ambler
P.O. Box 9
Ambler, AK 99786
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E-mail: amblercity@gmail.com

By Email Onry :

Sen.david.wilson@akleg.gov
Jody.simpson@akleg.gov

February 8, 2021
Senator David Wilson, Chair
Senate Health and Social Services Committee
State of Alaska
State Capitol Room 121
Juneau AK, 99801

RE: City of Ambler Support for SB56

Dear Senator Wilson:

The City of Ambler, Alaska supports SB56, proposed legislation to extend the Governor's current emergency declaration. The current declaration is presently set to expire on February 14, 2021 at 11:59pm. SB56 would generally extend the declaration to September 2021. I understand that the Alaska Municipal League has provided testimony detailing many of the harmful consequences to Alaska municipalities if the declaration expires and will not repeat those here.

Alaska, and the City of Ambler, need a State of Alaska disaster declaration allowing the State to continue to respond to the current Covid-19 public health emergency. This allows the state to be responsive to the crisis in working loosely with local governments. Indeed, it also allows for close cooperation between all levels of government while action remains independent.

Further, the declaration provides the infrastructure necessary to respond. It doesn't require response, only allows for it. The declaration doesn't restrict – it removes restrictions that allow the State to act effectively.

Thank you for your consideration and support.

Sincerely,

Morgan Johnson
Mayor