ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
March 12, 2015
3:08 p.m.

MEMBERS PRESENT

Representative Paul Seaton, Chair
Representative Liz Vazquez, Vice Chair
Representative Neal Foster
Representative Louise Stutes
Representative David Talerico
Representative Geran Tarr
Representative Adam Wool

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

PRESENTATION: DIVISION OF PUBLIC HEALTH

- HEARD

PRESENTATION: FACING FOSTER CARE IN ALASKA

- HEARD

HOUSE BILL NO. 40
"An Act relating to the use of electronic cigarettes; and providing for an effective date."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: HB 40
SHORT TITLE: USE OF ELECTRONIC CIGARETTES AS SMOKING
SPONSOR(s): REPRESENTATIVE(s) HERRON

01/21/15	(H)	PREFILE RELEASED 1/9/15
01/21/15	(H)	READ THE FIRST TIME - REFERRALS
01/21/15	(H)	HSS, JUD
03/10/15	(H)	HSS AT 3:00 PM CAPITOL 106
03/10/15	(H)	Heard & Held
03/10/15	(H)	MINUTE(HSS)

03/12/15 (H) HSS AT 3:00 PM CAPITOL 106

WITNESS REGISTER

JAY BUTLER, MD, Chief Medical Officer/Director
Division of Public Health
Central Office
Department of Health and Social Services
Anchorage, Alaska
POSITION STATEMENT: Presented a PowerPoint overview on the Division of Public Health.

JILL LEWIS, Deputy Director - Juneau
Division of Public Health
Central Office
Department of Health and Social Services
Juneau, Alaska
POSITION STATEMENT: Answered questions during the overview of Department of Health and Social Services.

REBEKAH MORISSE, Unit Manager
Perinatal & Early Childhood Health
Women, Children & Family Health
Division of Public Health
Department of Health and Social Services
Anchorage, Alaska
POSITION STATEMENT: Presented a PowerPoint titled "Home Visiting in Alaska."

STEPHANIE WRIGHTSMAN-BIRCH, Chief
Women, Children & Family Health
Division of Public Health
Department of Health and Social Services
Anchorage, Alaska
POSITION STATEMENT: Presented a PowerPoint "The Evidence Supporting Folic Acid Supplementation" during the overview on the Division of Public Health.

ROSALYN SINGLETON, Staff Physician
Section of Epidemiology
Division of Public Health
Department of Health and Social Services
Anchorage, Alaska
POSITION STATEMENT: Presented a PowerPoint titled "Rickets and Vitamin D Deficiency in Alaska Native Children."

AMANDA METIVIER, Statewide Coordinator/Executive Director

Facing Foster Care in Alaska
Anchorage, Alaska
POSITION STATEMENT: Presented an overview on facing foster care in Alaska.

REPRESENTATIVE BOB HERRON
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: As the sponsor of HB 40, testified and answered questions about the proposed bill.

MISTY MICHELLE JENSEN
Wasilla, Alaska
POSITION STATEMENT: Testified in support of HB 40.

EMILY NENON, Alaska Government Relations Director
American Cancer Society Cancer Action Network
Anchorage, Alaska
POSITION STATEMENT: Testified in support of HB 40.

JAY BUTLER, MD, Chief Medical Officer/Director
Division of Public Health
Central Office
Department of Health and Social Services
Anchorage, Alaska
POSITION STATEMENT: Testified and answered questions during the discussion of HB 40.

ASHLEY PELTIER
Wasilla, Alaska
POSITION STATEMENT: Testified in support of HB 40.

CLAY BEZENEK
Ketchikan, Alaska
POSITION STATEMENT: Testified in opposition to HB 40.

ACTION NARRATIVE

3:08:36 PM

CHAIR PAUL SEATON called the House Health and Social Services Standing Committee meeting to order at 3:08 p.m. Representatives Seaton, Wool, Talerico, Stutes, Vazquez, and Tarr were present at the call to order. Representative Foster arrived as the meeting was in progress.

PRESENTATION: Division of Public Health

3:09:07 PM

CHAIR SEATON announced that the first order of business would be a presentation by the Division of Public Health.

3:11:35 PM

JAY BUTLER, MD, Chief Medical Officer/Director, Division of Public Health, Central Office, Department of Health and Social Services, began with an overview PowerPoint presentation titled "Healthy Alaskans 2020." He stated that, as nutrition was a very big topic, quite a bit of the division's work was focused on obesity. He shared that he would discuss two micro-nutrients, folic acid and Vitamin D, during this presentation. He distinguished between the Healthy Alaskans plan and this program, noting that, although both were moving in the same direction for healthier people and a healthier state, they differed in a number of measures. He moved on to slide 2, "State/Tribal Partnership," and said that the program had been co-organized and co-lead by the Division of Public Health and the Alaska Native Tribal Health Consortium (ANTHC). He noted that both organizations had statewide public health responsibilities and worked with local health care providers throughout the state. The mission of the Division of Public Health was to protect and promote the health of Alaskans and the mission of ANTHC was for Alaska Natives to be the healthiest people in the world, which created a synergy for achieving the vision of Healthy Alaskans in Healthy Communities, slide 3. He said that this work was driven by a statewide voluntary advisory team composed of 35 Alaskans from a variety of disciplines, including behavioral health, education, early childhood development, criminal justice, environmental health, public health, and health insurance and health policy. These partners had defined the mission for the program to "provide a framework and foster partnerships to optimize health for all Alaskans and their communities." He reported that the advisory team also defined "Guiding Principles," slide 4, for how the effort would move forward. These included the use of the best scientific research and data available, as well as tapping into local knowledge from the diverse cultures. He stated that the building of strong partnerships with mutual accountability to funders and each other was also a guiding principle. He noted that the program would address health equity, an ongoing struggle in the state, as well as strengthen communities and empower individuals to take personal responsibility for health.

He declared that the final guiding principle was to improve the quality of life across each individual's lifespan.

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DR. BUTLER moved on to slide 5, "Process of Engagement," and stated the process had started in the communities through on line surveys and town hall meetings, which provided the opportunity for input to the important health issues for Alaskans. He declared that the group had ultimately worked through more than 70 issues, and focused on the areas with good data and where they could make a difference. He explained that the advisory team made recommendations to the Healthy Alaskans 2020 steering committee. He added that an unofficial guiding principle was the recognition that the team could not do everything. He pointed to a national federal effort that had more than 2,000 goals.

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DR. BUTLER directed attention to slide 6, "25 Health Priorities," which listed 25 health priorities with specific data indicators, action plans, and targets to meet by 2020. He directed attention to the Healthy Alaskans 2020 scorecard which detailed the base line in 2010 and the goal for 2020, with the most recent data, and offered an idea of the direction and the current achievements. [Included in members' packets] He reported that, although six of the goals had already been attained, health had a lot of moving parts and vigilance needed to be maintained. He offered an example of youth smoking, although tremendous progress had been gained, there was constant concern for losing ground. He pointed out that these indicators did not cover everything done by the division, but were a statewide process with partners outside government. He declared that the group were "bureaucratic silo busters." He added that this did not address new and emerging issues, either, pointing to the legalization of marijuana.

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DR. BUTLER addressed slide 7, "The Full Spectrum of Health," which demonstrated the ways the advisory team had grouped the indicators to better address broad topics and health factors, including healthy behaviors, access to clinical care, social determinants of health, and the physical environment. He spoke about slide 8, "Web-based Tools," explaining that the program did not have a book, but, instead had a website which allowed

tracking, a list of actions undertaken, and updates on performance.

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DR. BUTLER identified slide 9, "Stories from Partners," and stated that the partners were using these efforts to guide their strategic planning and to develop performance improvement plans that could guide them for what they do best. He declared that the ongoing process would generate accessible data to quantify the problems and progress. He stated that the Healthy Alaskans 2020 had provided a focal point for understanding community priorities, for selecting strategies to improve health, and for leading efforts among the partners, including the Alaska Wellness Coalition, University of Alaska Anchorage Behavioral Health Alliance, Recover Alaska, DHSS, ANTHC, and the Juneau Suicide Prevention Coalition. He summarized slide 10, "Progress and Next Steps," stating that it had identified health priorities, set targets, and selected strategies to achieve those targets. He said that the current focus was to identify lead partners to ensure that the efforts were aligned to work together.

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CHAIR SEATON, referencing slide 4, asked about the guiding principle for health equity and how it drives the process.

DR. BUTLER replied that during the process the inequities between Alaska Natives and other Alaskans was examined, pointing to suicide as a problem with which tribal leaders were struggling.

CHAIR SEATON asked if this inequity was for better health status or access to health care and health facilities. He offered his belief that equity could be a somewhat amorphous term.

DR. BUTLER offered an example of the measure for life expectancy, noting that the life expectancy for Alaska Natives was five years shorter than for other Alaskans, and stating that this was a health inequity. He said that there were areas where some groups enjoyed better health than others.

CHAIR SEATON asked if there were sub-populations, such as Pacific Islanders in Anchorage, if they exhibited less healthy outcomes, so that concentration could be directed toward addressing it.

DR. BUTLER emphasized that this would be done in partnership with the communities.

CHAIR SEATON surmised that data identification was a means to demonstrate the equities.

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CHAIR SEATON asked for more information on slide 7 and how the chart worked.

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JILL LEWIS, Deputy Director - Juneau, Division of Public Health, Central Office, Department of Health and Social Services, said that the numbers correlated to the 25 leading health indicators, and that, in some cases, those indicators were directly related to a specific health behavior or social and economic factor. She offered tobacco use as an example, as this was specific for the increase in percentage of high school students who have not smoked and in percentage of adults who currently did not smoke. She declared that showing this alignment could often be very specific. She noted that the listings at the top were more general across categories of health factors and focused on overall health outcomes. She offered an example for priority number one [slide 6], cancer deaths, which reflected the rate of cancer deaths in the state, and was directly related to the Length of Life category [on slide 7] rather than a specific Health Factor or Policies & Programs.

CHAIR SEATON asked for an explanation as to how this would be used, and a more detailed description for how the flow chart on slide 7 worked.

MS. LEWIS explained that the portion on the left of the chart, with the upward pointing arrows, indicated the means to address the full spectrum for health outcomes. This began with Policies & Programs which influenced the Health Factors, which, in turn, influenced the Health Outcomes. She noted that the Health Factors were the categories grouped in the middle of the chart, Physical Environment, Social & Economic Factors, Clinical Care, and Health Behaviors. She declared that it was necessary to address each of these in order to reach the Health Outcomes. She offered an example that there would be a definite gap if there were not any leading health indicators that dealt with Social & Economic Factors. She stated that the grid illustrated

the full array and spectrum of the indicators, instead of a singular issue such as tobacco use.

3:32:00 PM

CHAIR SEATON asked if this was an identifier or a mechanism to drive the necessary action, or just an explanation for a way to understand the 25 health priorities.

MS. LEWIS replied that it was more of a way to look at the 25 health indicators across the spectrum as opposed to a way to approach or organize an alignment for the efforts.

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REPRESENTATIVE TARR asked if there was any integration between these 25 health priorities and those policy recommendations from the health care commission.

DR. BUTLER directed attention to slide 5, which he had only quickly addressed. He declared that there was representation from the Alaska Health Care Commission in the process, as the commission often referenced Healthy Alaskans 2020 and their common goals for prevention in its annual reports.

3:34:59 PM

REBEKAH MORISSE, Unit Manager, Perinatal & Early Childhood Health, Women, Children & Family Health, Division of Public Health, Department of Health and Social Services, directed attention to slide 2, "Why Home Visiting?" and explained that this was important for families as there was established evidence that home visits by nurse, social worker or other early childhood educators could improve child and family outcomes. She shared that the early childhood time period was critical for brain development, and that the home was a critical part of the learning environment. She pointed out that parents also needed support, as "kids don't come with instruction manuals." She said that while home visiting only described the "where" the real support was for families and parent education, slide 3, "Evidence-Based Home Visiting Models." She reported that there were 17 models for home visiting designated as evidence based through demonstration and randomized control trials. She listed Nurse-Family Partnership (AK), Parents as Teachers (AK), and Early Head Start - Home Visiting (AK) as the evidenced based programs in Alaska. She noted that there were difference to these programs, and could vary from the type of professional

providing services, the intensity and frequency of visits, the types of services delivered during a visit, the eligibility for the participants, and the goals and objectives of the programs.

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MS. MORISSE moved on to slide 4, "Home Visiting within the Division of Public Health," and highlighted three programs: Maternal, Infant, & Early Childhood Home Visiting; Healthy Start; and Public Health Nursing. She mentioned that there were also other home visiting programs in Alaska that were not administered through the Division of Public Health, including the military, Office of Children's Services, and the Infant Learning Program. She addressed slide 5, "Maternal, Infant & Early Childhood Home Visiting (MIECHV) Program" and explained that it was administered by her section of Women, Children & Family Health. She reported that there was only one local implementing agency, Providence In-home Services, in Anchorage. She stated that home visiting had been ongoing in Alaska in varying capacities for a long time, and that nationally it had increased in recent years to implement evidence based home visiting services for at-risk families and communities. She reported that the division had received federal funding in 2010 to implement an evidence based model in an at-risk community. She pointed out that emphasis on programs to be evidence based had been an important change. She reported that, after completion of a statewide needs assessment, the Nurse - Family Partnership was selected as the model for the Alaska program. She directed attention to slide 6, "Goals of the MIECHV program," which listed improved health outcomes, improved socio-economic status, school readiness, decreased incidence of partner violence and child maltreatment, and improved parenting skills. The state was required to report on a benchmark plan that had performance measures related to these goals, which included educational attainment, tobacco use, prenatal care, employment, and breast feeding.

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MS. MORISSE shared slides 7 - 10, "Nurse-Family Partnership," and stated that the Nurse - Family Partnership was the best as it targeted the outcomes which public health wanted improved in Alaska. She reported that it was an evidence based model, grounded in over 37 years of randomized, controlled trials, which compared maternal, child health, and child development outcomes with groups of similar mothers who did not participate in this program. She identified some of the outcomes, which

included: improvements to pre-term delivery, child abuse and neglect, school readiness, maternal employment status, and a decrease in criminal activity. She reported that there were certain criteria and guidelines for an evidence based program, and these included administration by registered nurses in the home, as nurses were perceived as trusting and competent professionals. The nurses have a set of visit to visit guidelines although the model did allow the client to offer visit content and for the nurse to use judgement to pick visit priorities or topics. She shared that pregnant women had to be enrolled by the 28th week of pregnancy and be a first time mom, which allowed for early education on having a healthy pregnancy. She stated that the clients in the Providence program had to be low income. The visits began prenatally and ended when the child was two years of age. She reported that the Nurse - Family Partnership model included all the health promotions listed, and with regard to nutrition, the nurses covered what foods to avoid during pregnancy, portion sizes, types of healthy food needed in pregnancy, eating healthy on a tight budget, and taking multi vitamins with folic acid daily. She shared that the nurse served as a model for healthy behaviors, and the nurses took a positive approach in order to build on the client's strength. Along with health education and screening, there were discussions on life planning, including plans for work and further education.

3:42:10 PM

MS. MORISSE explained slide 11, "What makes this evidence-based?" She declared that it was necessary to implement the model in the way it was designed for replication, as model fidelity was important for achieving the desired program outcomes as designated in the original trials. In the Alaska program, this allowed for continuous quality improvement and running data reports on a monthly basis allowed public health and the nurse home visitors to better understand what things were going well, and what needed improvement. She declared that consistent content was based on prevention science.

3:43:04 PM

MS. MORISSE read from slide 12, "Return on Investment:" "The Rand Corporation reports that for every dollar a community invests in NFP, they can see up to $5.70 in return." The trials noted increases in family education and employment status, along with savings related to governmental costs such as Medicaid and food stamps.

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MS. MORISSE spoke about slide 13, "Alaska MIECHV Preliminary Outcomes," and declared that the Alaska benchmark for the program showed preliminary outcomes that demonstrated improvement in breast feeding, prenatal care, and tobacco use, among others. By September 30, 2014, there were 100 women enrolled in the program, which was its capacity. Of the seven mothers with children one year of age, five had improved their employment status, and all seven had improved their educational obtainment level since enrollment. She allowed that the numbers and the results were still small and in a rather short time frame, even though the NFP program had been following families for many years. She highlighted Healthy Start, describing it as a case management program operated out of the Norton Sound Health Corporation, slide 14, "Healthy Start - Nome." It was an acute management program with home visits as a component, and it served families from pregnancy until the child was two years of age. Its main goal was to decrease infant mortality, and the program had a strong community focus and an emphasis with linking clients to behavioral health services.

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MS. MORISSE spoke about slides 15 and 16, "Public Health Nursing." She reported that, although there was not a formal home visiting program, public nursing did provide home visiting services using evidence based practice guidelines, and these visits were done on a case by case episodic basis, depending on the community and the available resources. She pointed out that the target for this program were the high risk families. She said that public health nurses monitored body mass index, offered counseling on a healthy life style, and provided important screenings related to immunizations, domestic violence, and alcohol. She stated that the goal was not to provide long term case management services in public health nursing, but rather for the nurse to link the at-risk family with needed referrals and facilitate that initiation of case management. These services were not intended to duplicate any other home visiting services or models, but were a safety net for at-risk families.

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MS. MORISSE, in response to Chair Seaton, said that there was only one program, and that 105 families were enrolled in the program.

CHAIR SEATON asked if there was a plan for the 11,000 births, of which almost half would be first term births. He asked if this was a pilot project to determine if there was useful success at the cost. He asked for clarification that these were non-public health nurses in a private setting, and he asked about the funding.

MS. MORISSE replied that this federal funding was through the Health Resources and Services Administration, and that, as Alaska received a minimum amount of formula funding, there was only one program in one community. She reported that they had applied for competitive expansion funding which would allow for expansion of the current program, adding four more nurse home visitors. She acknowledged that there was a need for access by more than 100 families.

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CHAIR SEATON directed attention to slide 8, and asked if there was a sufficient sample for the pre-term delivery rate, as it had increased in the last year from 9.6 to 10.3, which was the wrong direction.

MS. MORISSE said that the outcomes listed were identified in the NFP's three randomized control trials, so that it was not Alaska data. She said that pre-term delivery was not one of the indicators that they reported on, although it was monitored in the program. She reported that she did not have a specific percentage, but she would follow up with the information.

CHAIR SEATON asked for the outcomes of the randomized control trials so that it was possible to compare with Alaska. He referenced proposed trials with 500 mothers taking Vitamin D, which was now being funded in South Carolina by an insurance company, as there were savings from the decrease of pre-term births from 10.5 percent to 7 percent. He asked about more information regarding pre-natal vitamins having a specific amount of folic acid.

3:52:41 PM

STEPHANIE WRIGHTSMAN-BIRCH, Chief, Women, Children & Family Health, Division of Public Health, Department of Health and

Social Services, said that she would discuss the scientific evidence that supported the national recommendations for folic acid supplementation and the steps which lead to this national recommendation for all women ages 15 - 44. She directed attention to slide 2, "What is Folic Acid?" and reported that folic acid was Vitamin B and was commonly found in foods. It was also known as folate, which was its synthetic form used in vitamin supplements and added to fortified foods. In its natural form, it was found in small amounts in spinach, broccoli, asparagus, and citrus fruits. She stated that it was an important dietary component which research had indicated would prevent neural tube defects. She moved on to slide 3, "Neural Tube Defects (NTD)," and explained that these were the incomplete development of the brain, the spinal cord, or its coverings, which occurred early in pregnancy. She stated that research had shown that it was difficult to get an adequate amount of folic acid from diet alone, so it was suggested that pregnant women take a supplement of folic acid. She relayed that the two most common NTDs were spina bifida and anencephaly. She said that spina bifida occurred when an unborn baby's spinal column did not close to protect the spinal cord, and the nerves that controlled leg movements and other functions did not work properly, often resulting in life long disabilities. She explained that anencephaly occurred when most or all of the brain did not develop and babies most often died shortly after birth. She reported that about 3,000 pregnancies were effected annually by spina bifida or anencephaly. She relayed that it was estimated that 50 - 70 percent of neural tube defects could be prevented with a minimum of 0.4 mg of folic acid daily. As many pregnancies were not planned, it was recommended that all women between 15 - 44 years of age take a daily multivitamin with a minimum of 0.4 mg of folic acid.

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MS. WRIGHTSMAN-BIRCH addressed slide 4, "Early Recommendations," and shared that in 1992, recommendations were made based on some of the first research done on folic acid by the U.S. Public Health Service. In 1996, the U.S. Preventative Service Task Force (USPSTF) also recommended that 0.4 mg of folic acid should be taken daily by women of childbearing age, based on randomized control trials that demonstrated statistically significant reductions in neural tube defects by women taking 0.8 mg of folic acid. The Food and Drug Administration (FDA) also mandated that folic acid be added to enrich grain products in 1998. She explained slide 5, "2009 USPSTF Evidence Review," noting that this systematic review of the benefits and harm had

an important role in guiding clinical and public health practice, as well as public education. One randomized controlled study in Hungary demonstrated significant differences between women who received the supplements and those who did not. There were also two large case control studies reviewed for the association of supplementation and the outcome for NTDs. She emphasized that all of the data was non-conflicting, with the same consistent results.

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MS. WRIGHTSMAN-BIRCH moved on to slide 6, "2009 USPSTF Evidence Review," reporting that, as this task force was known for its comprehensive review, it had led to an updated recommendation that all women planning or capable of pregnancy take a supplement containing a minimum of 0.4 mg to 0.8 mg of folic acid. She declared that this recommendation had a high level of certainty that the net benefit was substantial, as the evidence was consistent and came from multiple, well designed studies where the data did not conflict and it was unlikely that the conclusions would be any different in future studies. She pointed out that there would be an additional update in 2016, and she opined there could be a suggestion to increase the minimum level of folic acid. She reported that, in 1999, when the early recommendations and evidence on folic acid were published, the campaign was established between the Centers for Disease Control (CDC), the March of Dimes, and the National Council on Folic Acid, slide 7, "National Folic Acid Campaign." She reported that surveys were conducted to demonstrate the baseline data, and this indicated that many women were not aware of folic acid, or the possibility of NTDs. This was a public health opportunity to educate women. She offered an example of the March of Dimes first survey in 1995 to establish a benchmark of knowledge and behaviors of women in child bearing age, relative to daily consumption of folic acid. She shared that surveys had been done for the next six years to measure progress, and that although the resulting changes included an increased awareness of folic acid and the knowledge of recommendations, it did not translate into a significant change in behavior in the proportion of women surveyed. She said there was even an initial decrease for those taking folic acid; however, with the added efforts by the State of Alaska, there was an increase to those taking folic acid or multi vitamins. She allowed that recommendations did not always fully lead to action and a change in behaviors. She declared the importance to add folic acid to foods.

MS. WRIGHTSMAN-BIRCH addressed slides 8 - 9, "Alaska Folic Acid Coalition," and stated that the coalition had maximized its use of funding with educational materials, speakers, and surveys.

4:04:55 PM

MS. WRIGHTSMAN-BIRCH referenced slide 10, "Since Supplementation Recommendations," and reported that the prevalence of spina bifada had declined 31 percent between 1995 and 1996, and again nationally between 1998 - 2006. This was a decrease from 5.04 to 3.49 babies with NTDs per 10,000 live births in the U.S. She explained that the prevalence of NTDs had also decreased in Alaska, slide 11, "Alaska Data on NTDs." She reported that an Alaska statute required hospitals and physician offices to report birth defects. She declared that this reporting was important to help guide and focus the educational efforts. She pointed to the decrease in infants born with NTDs in Alaska, an average of about seven children born with NTDs in each of the last eleven years, with slightly more than 50 percent of these children born with spina bifada specifically. She stated that the NTD birth numbers had decreased each year since 2008, and were now averaging less than four children each year.

4:07:09 PM

MS. WRIGHTSMAN-BIRCH shared that this was now a standard practice in prenatal care, and that the recommendation was for multivitamins to contain a minimum of 0.4 mg of folic acid, slide 12, "Current Status." She stated that Public Health continuously monitored the reports of NTDs, and there was verification as necessary. She noted that there was now data from a survey after pregnancy, "Pregnancy Risk Associated Monitoring Systems," offering extensive knowledge which helped new and novel ways to disseminate the information. She stated that monitoring the data allowed Public Health to determine program priorities and monitor for new evidence based intervention, and assure that rates continued to decrease over time. She mentioned that there were ongoing studies for the relationship between folic acid intake and congenital heart defects.

4:08:43 PM

CHAIR SEATON asked about the national recommendations which had been increased to 0.8 mg.

MS. WRIGHTSMAN-BIRCH replied that the preventative task force recommendation was for 0.4 - 0.8 mg.

CHAIR SEATON asked if there was any follow up information for whether the 0.4 mg was ineffective or was it a compliance issue with regard to the current births with NTDs.

MS. WRIGHTSMAN-BIRCH replied that there was not any follow up information, and she reflected on the data from the CDC on slide 3, which stated that probably only 50 - 70 percent of NTDs could be prevented by taking 0.4 mg of folic acid daily. She concluded that the current decrease to the rate of NTDs in Alaska could be a result of compliance, availability of nutritional supplements, or random genetic issues. She noted that Medicaid provided for the cost of prenatal vitamins. She reported that her review of over the counter vitamins indicated that most multi vitamins contained the minimum amounts of folic acid.

CHAIR SEATON suggested that it was worthwhile to follow up on the passive reports for whether there had been compliance.

4:12:06 PM

DR. BUTLER stated that there was indisputable data on Vitamin D which supported public health practice, and the following presentation would focus on skeletal health.

4:13:14 PM

ROSALYN SINGLETON, Staff Physician, Section of Epidemiology, Division of Public Health, Department of Health and Social Services, presented slide 2, "Objectives," and said that the objective of the first study discussed was to understand the causes of rickets and preventive measures in Alaska Native children. The second study was an exploration of the relationship between traditional marine diet and maternal Vitamin D levels. She shared that she would also discuss current educational and outreach efforts.

4:14:38 PM

DR. SINGLETON referenced slide 3, "Vitamin D deficiency," stating that this nutritional deficiency had increased in prevalence since the 1990s. She reported that the risk factors included insufficient sun exposure, an obvious issue in Alaska. She described rickets as a state of extreme vitamin D deficiency

in growing bone, and had a peak incidence between 3 and 18 months of age. She detailed that the wrists and ribs swelled, and the legs bowed, with occasional seizures from low calcium levels. She moved on to slide 4, "Definition of Vitamin D Deficiency," which she defined as a level of 25OHD below 20 ng/ml, and was associated with a higher risk for skeletal effects. She shared that Vitamin D insufficiency was described as below 21 - 29 ng/ml, with increased risks for exo-skeletal effects which were not as clearly understood.

DR. SINGLETON addressed slide 5, "Screening for Vitamin D Deficiency," and said that the evidence was insufficient to recommend universal screening for Vitamin D deficiency, with advised screening only in children and adolescents having conditions associated with reduced bone mass and/or recurrent fractures. She noted that screening was recommended for at-risk individuals which included children with obesity, and black and Hispanic children, although this was somewhat controversial as it would involve screening and retesting large numbers of children without any evidence of cost benefit to reducing fractures. She said that salmon and other oily fish had some of the highest Vitamin D contents of any foods, slide 6, noting that canned sockeye salmon had more than 700 IU of Vitamin D. She pointed out that Alaska Natives with a high marine subsistence diet had high intake of Vitamin D, while maintaining high levels of Vitamin D. She moved on to slide 7, "Vitamin D supplementation," and noted that any breastfed or partially breastfed infant be supplemented with 400 IU of Vitamin D, whereas non breastfed infants with less than on liter per day of a Vitamin D fortified formula should be supplemented with 400 IU, as well. She reported that the Vitamin D in one liter of infant formula was about 400 IU. She recommended 600 IU of Vitamin D for older children and adolescents if the dietary intake was inadequate.

4:19:01 PM

DR. SINGLETON said that she had not seen any cases of rickets until 1996, which caught her attention. She shared that she was approached in 2010 by a physician at the Alaska Native Medical Center concerned about the increased number of rickets in northern communities, slide 8, "Study: Rickets and Vitamin D Deficiency in Alaska Native Children." She reported that a group of tribal and CDC physicians and epidemiologists had donated their time to study the issue, and the incidence of rickets was evaluated. A case control study for children with Vitamin D deficiency and confirmed rickets was compared with age

and region match children, in order to study factors associated with rickets. She reported that one of the first findings was that the incidence increased by latitude, slide 9. She stated that the overall study results showed that rickets were higher in Alaska Native children than the general U.S. population or other Indian Health Service sites, based on large data base studies. She reported that rickets diagnosis also increased when there was a diagnosis of malnutrition, and that rickets and Vitamin D deficiency occurred in both breastfed and formula fed infants, although more common in infants who did not receive Vitamin D supplementation, slide 10, which confirmed the recommendations for vitamin D supplementation. She explained that there was interest in the potential connection between apparent increases in rickets and the known decline in marine subsistence diet among Alaska Natives. Prior to the 1960s, a significant proportion of energy was derived from the marine subsistence diet, although more recent food intake surveys showed that only about 6 percent of energy in younger people came from marine subsistence foods. She referenced an interim study in the late 1990s, that showed that 21 percent of energy came from native foods, and that 82 percent of the Vitamin D came from those same subsistence foods. She spoke about a study, slide 11, "Serologic Survey of Biomarkers for Traditional Marine Diet and Vitamin D Levels in YK Delta Childbearing-aged Women," that explored how the intake of traditional marine foods and serum Vitamin D levels had changed in child bearing women. She said that the biomarkers of a traditional marine diet and Vitamin D levels would be studied from serum samples of 20 - 29 year old women in the Yukon-Kuskokwim Delta from the 1960s to the 1990s.

4:22:58 PM

DR. SINGLETON moved on to describe slide 12, "A Biomarker of Traditional Marine Food Intake," and stated that fish and marine mammals were naturally enriched in the heavy stable isotope of nitrogen. As fish and marine mammal intake increased, so did the isotope ratio in blood and hair. She reported that a person with no marine diet intake would have a delta 15 N of about 8 per mil. Each increase of one per mil, a unit of relative enrichment, corresponded with an increase in traditional food intake of about 7 percent of total energy. She moved on to slide 13, "Serum Vitamin D and N values, YK Women 1960s to 1990s," which found a significant decline in both Vitamin D levels from sufficient levels with a mean over 40 ng/ml in the 1960s to the mid-20s ng/ml in the 1990s. She relayed that 100 percent of the women tested in the 1960s had Vitamin D levels

greater than 20 ng/ml with more than half having levels greater than 50 ng/ml. In contrast, by the 1990s, only 72 percent had levels greater than 20 ng/ml, and zero percent had levels greater than 50 ng/ml. She pointed out that the delta 15 N had decreased from a mean of 13, which was similar to levels found in elders, to just over 10, which was a low marine diet intake.

4:24:49 PM

DR. SINGLETON directed attention to slide 14, "Serum Vitamin D and N values," which showed that the vitamin D levels and the delta 15 N levels were very highly correlated. Concluding with slide 15, "Summary: Vitamin D and delta 15 N," she stated that Vitamin D levels correlated very highly with intake of traditional marine foods, and had declined significantly between the 1960s and the 1990s. She stated that marine dietary intake by women of child bearing age was very high in the 1960s, similar to that in current Yupik elders, but that it had now dropped to low levels. This decreased marine intake was associated with low Vitamin D levels in child bearing age women. In pregnant women, this could put the infants at risk for rickets early in life. This could explain the apparent increase to rickets in the current population beginning in the 1990s. She stated that the Division of Public Health had put out a state Epi bulletin on rickets and Vitamin D deficiency in children, with highlights of the infant vitamin D guidelines, slide 16, "Study Outcomes and Next Steps." She reported that this was followed up with presentations in both Anchorage and Bethel. She mentioned the very recent publication of a peer review journal showing the results of the first study, and a presentation at the Alaska Native Research Conference in 2014. She said that public relations officials had been contacted and they were helping design a message for the nutritional benefit of salmon and other traditional foods, as well as for Vitamin D supplementation. She reported that ANTHC was engaging communities to increase subsistence diet.

4:27:47 PM

CHAIR SEATON asked for the link and the articles for both the initial study and the pediatric and endocrine articles. He questioned the modern traditional technique for drying salmon hung under plywood or tarps, and he pointed out that, as this food preservation technique no longer included exposure to sun while drying, there was a tremendous difference in the amount of Vitamin D created as a supplement. He pointed out that the

traditional preservation technique was for foods to be sun dried, which increased the vitamin D level in foods.

Presentation: Facing Foster Care in Alaska

4:30:05 PM

CHAIR SEATON announced that the next order of business would be a presentation on Facing Foster Care in Alaska.

[Chair Seaton passed the gavel to Vice Chair Vazquez]

4:31:13 PM

AMANDA METIVIER, Statewide Coordinator/Executive Director, Facing Foster Care in Alaska, explained that Facing Foster Care was a statewide non-profit organization of young people in and from the foster care system. She reported that she had spent three years in the foster care system, and after she had aged out of the program, she had gone on to become a foster parent. She shared that she had two degrees in social work from University of Alaska Anchorage (UAA). She referenced proposed HB 27, and explained that there were 22 statewide foster youth currently in the capital meeting with various legislator offices and discussing issues and concerns that were important to them. She offered her belief that, as they were the ones who "live and breathe this system every single day," they were the experts in this field. She introduced the group of foster youth in the room, and asked them to remain standing in response to a variety of questions which reflected their experiences in foster care: how many had been in foster care for more than 2 years, 4 years, 6 years, 8 years, 10 years, 12 years, 15 years, 16 years, 17 years, 18 years, 19 years; how many had more than 1 foster care placement, more than 2, more than 5, more than 10, more than 15, more than 20, more than 22, more than 24, more than 26, more than 30, more than 32, more than 35, more than 40, more than 45, more than 50, more than 55, more than 60; how many had changed schools more than 2 times, 4 times, 6 times, 8 times, 10 times, 15 times; how many had been placed separately from their siblings; how many had experienced homelessness; how many felt they had been judged for their status in foster care. She expressed her appreciation for the opportunity to meet with the committee. She directed attention to proposed HB 27, and asked that it be ensured that youth were ready to be released from care before being asked to leave the system. She referenced the federal standard of 12 - 24 months for finding permanency for youth in placement, and asked that youth be moved quickly out of

the system in Alaska. She stated that, as a lot of money was spent by leaving youth in care for many years, which also caused a lot of damage to them, it was important to find a permanent family. She stated that the proposed bill required foster parent recruitment, noting that there were now a record high 2400 kids in the foster care system. She stated that the proposed bill supported early information sharing with tribes, so there could be support and intervention, if necessary, to avoid more young people entering the system. She offered her belief that the state was the parent of young people in the system.

HB 40-USE OF ELECTRONIC CIGARETTES AS SMOKING

4:37:01 PM

VICE CHAIR VAZQUEZ announced that the final order of business would be HOUSE BILL NO. 40, "An Act relating to the use of electronic cigarettes; and providing for an effective date."

4:37:36 PM

REPRESENTATIVE BOB HERRON, Alaska State Legislature, expressed his appreciation for products available to help curtail tobacco use. He declared that his concern was with safe disposal of the exhaled aerosol. He expressed his desire for e-cigarette use to only be in an area where smoking was allowed.

4:38:45 PM

VICE CHAIR VAZQUEZ opened public testimony.

4:38:57 PM

MISTY MICHELLE JENSEN said that she was speaking for herself, and she stated her support of HB 40 to treat electronic cigarettes the same as traditional cigarettes, with regard to the second hand smoke. She cited the Centers for Disease Control (CDC) and stated that the vapor from an e-cigarette was an aerosol which contained nicotine and toxic chemicals and was not safe to smoke or inhale. She declared that she was horrified by the messages in advertisements and stores which promoted e-cigarettes as safe. She emphasized that "this simply is not true." She stated that there was a danger for the re-normalization of smoking with the emergence of these new products and that it was necessary for the leaders in health

care to send a clear message that smoking included the use of electronic cigarettes.

4:40:31 PM

EMILY NENON, Alaska Government Relations Director, American Cancer Society Cancer Action Network, directed attention to a letter dated March 4, 2015 [Included in members' packets] declaring support of HB 40. She reported that there were hundreds of different products being marketed as electronic (e) cigarettes, and that, as they were unregulated, the ingredients were unknown. She pointed out that the proposed bill would strictly address exposure to the second hand aerosol from these e-cigarettes. She explained that the difference between a vapor and an aerosol was that an aerosol contained fine particles of liquid and/or solids. She cited a "growing number of studies that have looked at the contents of e-cigarette aerosol" and listed propylene glycol, nicotine, and flavorings, as well as heavy metals, volatile organic compounds, tobacco-specific nitrosamines, and other potentially harmful chemicals as the most common ingredients. She declared concern for second hand exposure to these ingredients.

REPRESENTATIVE STUTES asked for the studies that supported her statements. She shared that her research indicated "maybe, possibly, could be, and it appears that there's just not enough information to classify these as a tobacco type cigarette." She directed attention to a March 12, 2015 study which did not find any health concerns in e-cigarette vapors. She stated that this was "clearly a pretty controversial issue." She acknowledged the position taken by Ms. Nenon, as she was employed by the American Cancer Society. She declared that there was not enough evidence to convince her [that the vapors were dangerous.]

MS. NENON offered to supply the necessary studies and continue the discussion.

4:44:53 PM

JAY BUTLER, MD, Chief Medical Officer/Director, Division of Public Health, Central Office, Department of Health and Social Services, said that:

> it may well be that aerosol's from e-cigarettes pose less of a threat from second hand exposure than traditional cigarettes, but I would caution against assuming that they are safe, given that studies have

shown that metabolites of nicotine are recoverable from people who are exposed to aerosol's from e-cigarettes secondhand.

DR. BUTLER allowed that the Division of Public Health had struggled with the question of where e-cigarettes fell on the spectrum of risk. He shared that the division had recently completed a literature review, and he offered to supply copies of this to the committee for reference. He stated that, although there was the potential for use of e-cigarettes as a harm reduction technique or a smoking cessation tool, some of the data suggested that they were being used as a way to deliver supplemental nicotine. He directed attention to the ways this product was marketed, as a way to smoke when smoking was not allowed. He expressed concern that, although a lot of progress had been made in smoking reduction in youth, the marketing of the flavoring in e-cigarettes was focused on a young demographic.

DR. BUTLER highlighted the threat for e-cigarettes to re-normalize smoking behavior. He pointed out that, as e-cigarettes were not regulated, the aerosol ingredients were considered proprietary information, which posed a threat to indoor air quality. He emphasized that the goals of HB 40 to only allow e-cigarette use in places where cigarette smoking is not prohibited "makes good public health sense."

4:48:03 PM

ASHLEY PELTIER stated her support of HB 40, to treat electronic cigarettes the same as traditional cigarettes with regard to secondhand smoke exposure. She reported that the vapor emitted had been shown to contain ultra-fine particles which exacerbated respiratory issues when inhaled, and had been shown to contain chemicals such as benzene, cadmium, and formaldehyde. She noted that there were particularly enticing flavors added to appeal to youth. She reminded the committee that the tobacco industry had previously stated that second hand smoke was harmless and that smoking was good for us. She expressed her reluctance to trust the tobacco industry statements that e-cigarettes and second hand aerosol were safe, and that no one should unknowingly be exposed to a substance that can harm them. She declared that everyone had the right to breathe clean air.

4:49:45 PM

CLAY BEZENEK stated that he was against HB 40, although he understood the reasoning behind the proposed bill. He suggested that there should be federal legislation to regulate the industry. He shared that he knew many people who had quit smoking because of e-cigarettes. He declared that he was anti-smoking, and that he was often annoyed to continually smell cigarette smoke. He opined that this was a positive step for the tobacco industry to market e-cigarettes, although this proposed regulation was "a little pre-mature" as it vilified people or forced them to move. He noted that he needed to see conclusive evidence that the vapor was harmful.

4:52:32 PM

VICE CHAIR VAZQUEZ stated that public testimony would be kept open and that HB 40 would be held over.

4:53:02 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:53 p.m.