ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
April 14, 2015
3:08 p.m.

MEMBERS PRESENT

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

MEMBERS ABSENT

Representative Neal Foster

COMMITTEE CALENDAR

PRESENTATION: ALASKA SECTION OF EPIDEMIOLOGY

- HEARD

HOUSE BILL NO. 99
"An Act relating to the voluntary termination of life by terminally ill individuals; and providing for an effective date."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: HB 99
SHORT TITLE: VOLUNTARY TERMINATION OF LIFE
SPONSOR(s): REPRESENTATIVE(s) DRUMMOND

02/09/15	(H)	READ THE FIRST TIME - REFERRALS
02/09/15	(H)	HSS, JUD
04/09/15	(H)	HSS AT 3:00 PM CAPITOL 106
04/09/15	(H)	Heard & Held
04/09/15	(H)	MINUTE(HSS)
04/14/15	(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 (DHSS)
Anchorage, Alaska
POSITION STATEMENT: Answered questions during the presentation by the Section of Epidemiology.

JOE McLAUGHLIN, M.D., MPH
Chief and State Epidemiologist
Section of Epidemiology
Division of Public Health
Department of Health and Social Services (DHSS)
Anchorage, Alaska
POSITION STATEMENT: Presented a PowerPoint during the presentation by the Section of Epidemiology.

REPRESENTATIVE HARRIET DRUMMOND
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Answered questions about HB 99 as the sponsor of the bill.

ACTION NARRATIVE

3:08:39 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, Vazquez, and Stutes were present at the call to order. Representative Tarr arrived as the meeting was in progress.

Presentation: Alaska Section of Epidemiology

3:09:05 PM

CHAIR SEATON announced that the first order of business would be a presentation by the Alaska Section of Epidemiology in the Division of Public Health, Department of Health and Social Services (DHSS). He emphasized the importance of understanding the Section of Epidemiology, as it had influence on health in Alaska.

3:10:02 PM

JAY BUTLER, MD, Chief Medical Officer/Director, Division of Public Health, Central Office, Department of Health and Social Services (DHSS), explained that he would be in a supporting role in the presentation, noting that Dr. McLaughlin had been the section chief since 2007, and was the president-elect of the Council of State and Territorial Epidemiologists.

3:12:10 PM

JOE McLAUGHLIN, M.D., MPH, Chief and State Epidemiologist, Section of Epidemiology, Division of Public Health, Department of Health and Social Services (DHSS), introduced a PowerPoint titled "Epidemiologists-The Disease Detectives." He directed attention to slide 2, "Definitions," which he declared was the study of how and why diseases occur in populations. He shared that epi meant upon, demos meant people, and ology was the study of, hence the definition being the study of people. He defined an epidemic as the occurrence of cases of an illness in a community that are in excess of normal expectancy. He shared that epidemics that were limited to a more localized increase of a disease were called outbreaks; whereas larger scale epidemics that affected many people on multiple continents were referred to as pandemics. He moved on to slide 3, "Fundamental Assumptions and Goal," and stated that the primary assumption of epidemiology was that diseases did not occur at random, and could, therefore, be studied and described. Once a disease was understood, it could be mitigated and prevented. He stated that the main goal of the epidemiologist was to learn about the distribution and determinance of diseases in populations, by finding the characteristics of the disease, who it affected in the population, where and when it specifically occurred, and what was the problem that actually occurred.

3:15:06 PM

DR. McLAUGHLIN directed attention to slide 4, "Alaska Section of Epidemiology," and reported that epidemiology was one of the eleven sections in the Alaska Division of Public Health. He noted that this was not the only section which did epidemiologic work, as the Sections of Chronic Disease and Women's, Children's & Family Health, as well as Public Health Nursing, all routinely engaged in epidemiologic work. He addressed slide 5, "What specifically does the Section of Epidemiology do?" He explained that the Section of Epidemiology consists of six major program areas, with about 65 staff, fellows, and interns working in the section. He listed the six program areas, which included infectious diseases, HIV/STD, and immunization. He stated that

the day-to-day work addressed most of the essential functions of public health pictured on the slide. He offered to focus in on the work as a subset of the functions.

DR. McLAUGHLIN directed attention to slide 6, "Essential Service #1: Monitor," and indicated that monitoring health outcomes was the first piece of the public health essential functions pie, which is essentially the role of epidemiologists and public health in general. The epidemiologic term used for monitoring was surveillance, which represents the ongoing collection, analysis, and interpretation of population health data that forms the backbone of public health practice. This is closely integrated with timely dissemination of data to key stakeholders such as health care providers, the public, and many others. He directed attention to slide 7, "Why Do Surveillance?" Surveillance allows epidemiologists to directly measure what is going on in the population with respect to diseases and other key health outcomes, he stated. The surveillance data enables us to get answers to the fundamental epidemiologic questions of who, what, where, why, and when. It further allows assessment of trends over time to determine the need for public health intervention, prioritize resources, evaluate effectiveness, and provide critical feedback to stakeholders.

DR. McLAUGHLIN directed attention to slide 8, "Conditions Reportable to Public Health in Alaska," stating a number of conditions that were legally reportable by health care providers and laboratories in Alaska, including approximately 50 infectious diseases, cancer, and birth defects. These reportable conditions are summarized in the reportable conditions manual, which is available online at the Section of Epidemiology's website at www.epi.alaska.gov.

REPRESENTATIVE TALERICO asked about legally reportable conditions and whether the Section of Epidemiology was required to report them.

DR. McLAUGHLIN answered yes.

DR. McLAUGHLIN directed attention to slide 9, "Surveillance Conditions Reportable," noting the amount of time that health care providers and labs are given to report depends on the condition and ranges from an immediate reporting requirement for public health emergencies as shown on the slide, including anthrax, botulism, diphtheria, and polio to as long as six months for other diagnosis, such as cancer.

DR. McLAUGHLIN directed attention to slide 10, "Report Out to Stakeholders," and noted that all of the Division of Public Health's sections that collect reportable conditions data report out their findings to stakeholders in a variety of formats. For example the Infectious Disease Program provides an annual summary of reportable infectious disease case counts over the past two years in an epidemiology bulletin. In addition, some of the infectious diseases warrant their own specific epidemiology bulletins that provide more detailed epidemiologic information, for example, tuberculosis, HIV, and gonorrhea. Turning to the next slide 11, entitled "Monitor Trends," he noted that the Section of Epidemiology can track trends over time, for example, reviewing influenza surveillance data to determine when the seasonal influenza epidemic is peaking and when the epidemic will end. In addition, epidemiology can follow yearly trends to determine variations in diseases from year to year. He turned to slide 12, "Provide Reassurance," stating that sometimes surveillance data provides critical reassurance to the public. For example, the statewide Hair Mercury Bio-monitoring Program allows women of child-bearing ages to submit hair samples to the state public health lab to be analyzed for mercury content since elevated mercury content in the blood can affect brain development in their fetuses and breast-feeding infants. Parents are naturally concerned about this contaminant in their foods, which is of in particular importance to people consuming lots of fish and other subsistence foods. Fortunately the feedback the Section of Epidemiology can provide mothers and communities indicates that the vast majority of people whose hair was tested came back far below the threshold level of concern. This information provides evidence based reassurance to the public, he said.

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DR. McLAUGHLIN directed attention to slide 13, "Detect Outbreaks," noting that surveillance allows epidemiologists to detect, respond to, and stop epidemics. This slide depicts an outbreak of campylobacter bacterial infection associated with consumption of raw, unpasteurized milk that occurred in 2013. Since the state public health lab performs molecular characterization of campylobacter strains, the Section of Epidemiology was able to quickly determine that the first several cases in this outbreak were the same strain of campylobacter. This prompted a quick public health investigation that uncovered the outbreak and enabled epidemiologists to encourage people not to drink the infected milk. Thus shortly thereafter the outbreak stopped. He

directed attention next to slide 14, "Essential Service #2: Investigate," which means epidemiologists diagnose and investigate health problems and hazards in the community. These investigation are often prompted by an unusual clustering of cases. However, for very serious diseases, only one constitutes an outbreak and requires prompt investigation, for example, food borne botulism. He advised that botulism is a life-threatening illness caused by consumption of food contaminated with botulinum toxin, which is one of the most potent, naturally-occurring neurotoxins on the planet. Alaska has the unfortunate distinction of having one of the highest rates of food-borne botulism in the world, he said. This bacteria thrives in oxygen-poor conditions, which are the conditions required for fermenting and putrefying foods. Many cultures ferment food, such as some cheeses and sauerkraut. All of Alaska's cases of botulism have been caused by the consumption of traditional Alaskan Native foods that were aged or putrefied, for example, aged fish heads, fish eggs, and seal flipper, as well as putrefied seal oil.

DR. McLAUGHLIN directed attention to slide 15, "Recent Outbreak Example, 12/19/14," depicting a botulism case that began on 12/19/14 at 3:30 p.m. when an epidemiology nurse received a call from the Yukon-Kuskokwim Delta Regional Hospital (YKDRH) and was informed that botulinum anti-toxin was administered to two adults who manifested classic signs and symptoms of botulism, including neuro-paralysis. The two adults shared a meal that included rendered seal oil consumed in a village at 6 p.m. on 12/18/14. Their symptoms emerged 12-16 hours after consumption. Both adults with respiratory muscle involvement were medivaced to Alaska Native Medical Center's intensive care unit. Another adult and two children, ages 8 and 12, also ate the meal but were asymptomatic. The seal oil was obtained from a distributor in another village, he said.

DR. McLAUGHLIN said he was contacted on the same day and he and the nurse epidemiologist developed an immediate action plan, including sending additional antitoxin kits to the YKDRH since at least three other people had been exposed [slide 16]. Public health nurses were called in to do initial field work and pull contaminated seal oil from refrigerators and monitor those who were exposed for any symptoms. The plan included flying an epidemiology nurse to the village for an onsite investigation and flying the two exposed children to Bethel.

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DR. BUTLER added that the first rule of outbreak public health was that all outbreaks are identified after 3 p.m. on Friday.

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DR. McLAUGHLIN directed attention to slide 17, "12/21/14," which fell on a Sunday. One of the medical doctors at YKDRH reported that the foregoing 8-year-old child who consumed contaminated seal oil had fixed and dilated pupils and excessive thirst, signs of botulism. The Section of Epidemiology determined the child probably had botulism and the doctor was advised to administer antitoxins and continue monitoring both children.

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REPRESENTATIVE WOOL asked whether any harm can occur with the administration of the antitoxin to someone who had not contracted botulism.

DR. McLAUGHLIN replied that it was not medically indicated to administer antitoxins in the absence of clinical botulism due to potential side effects, although the newer anti-toxin has fewer side effect risks.

3:32:06 PM

DR. McLAUGHLIN directed attention to slide 18, entitled "12/22/14," noting that specimens of seal oil were sent to the state lab for testing, the distributor was contacted, and up to eight other people were identified as potentially being exposed. Public health nurses had daily contact with everyone who had consumed seal oil to monitor them for symptoms. By that point up to 18 exposed individuals had been identified. An itinerant nurse manager flew to Dillingham to assist follow up on all of them.

DR. McLAUGHLIN directed attention to slide 19, entitled "12/23/14," noting that public health nurses were unable to fly to village B, where the supplier lived due to weather. Lab results were provided to public health nurses, the YKDRH, and health care providers in Dillingham. The lab indicated that the seal oil had the highest percentage of botulinum toxin ever encountered by the lab. He referred to slide 20, entitled "12/24/14," stated that another epidemiology nurse who brought three additional antitoxin kits to assist with surveillance and monitoring of exposed persons was flown to Dillingham. The Section of Epidemiology held a meeting with the Bristol Bay Area

Health Corporation and hospital, medical, and clinical staff to develop a collaborative plan since botulism can incubate in the system for weeks. The plan included media interviews to inform people of the outbreak.

DR. McLAUGHLIN directed attention to slide 21, "Summary of Botulism Surveillance," noting this case involved three cases of botulism, that all survived, but over 20 additional people consumed some of the highly toxic seal oil. He expressed concern over the number of cases and the outcome if more seal oil was distributed to people and they had consumed the contaminated seal oil.

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REPRESENTATIVE WOOL, in reference to slide 21, asked how two people in Wasilla had been possibly exposed.

DR. McLAUGHLIN explained that some of the contaminated seal oil had been shipped to Wasilla.

3:37:17 PM

DR. McLAUGHLIN directed attention to slide 22, "Essential Service #3: Educate," which provides a nice segue to education, mentioning a number of ways the division provides information on botulism to communities, including on the department's website and in educational talks to medical staff.

DR. McLAUGHLIN directed attention to slide 23, "Working with the Media," noting the Section of Epidemiology works with media to keep the public informed. He referred to slide 24, "Epidemiology," describing the epidemiology website that highlights current events in Alaska as well as links to programmatic webpages.

DR. McLAUGHLIN directed attention to slide 25, "Alaska Public Health Advisory," explaining that the Section of Epidemiology releases public health advisories when necessary, with the primary audience being health care providers in order to keep them informed of any emerging issues of public health importance. He next directed attention to slide 26, "Epi Bulletins," which he said he previously mentioned; however, this slide highlights the bulletins, which are generally widely read.

DR. McLAUGHLIN directed attention to slide 27, "Bulletin Recommendations and Reports," noting multi-page reports have

been issued and are available. One recent report provided fish consumption advice for Alaskans, noting that Alaska's fish is considered very safe, that salmon are low in mercury and high in nutrients.

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DR. McLAUGHLIN directed attention to slide 28, "Phone Calls from the Public," noting that the Section of Epidemiology fields numerous calls about public concerns 24 hours a day, 7 days a week, (24/7) including all holidays, responding to a wide range of topics such as bedbugs and sexually-transmitted infections. Referring to slide 29, "Essential Service #4: Mobilize Community Partnerships," stating that this plays into all of the other essential services that the Section of Epidemiology does. It involves collaboration on projects, conducting investigations and community outreach with key partners out-of-state and in Alaska, including physicians, hospitals, other state agencies, and tribal or governmental organizations. The majority of what the Section of Epidemiology does involves partner collaboration, recalling one recent far-reaching effort was the Healthy Alaskans 20-20 Project, which involved leaders from the Alaska Native Tribal Health Consortium and the Department of Health and Social Services (DHSS), as well as an advisory team consisting of stakeholders from across Alaska. The team has considered hundreds of health priorities and has narrowed them down to 25-leading health priorities. The purpose was to set up a health framework that will serve as the foundation for collective accountability.

DR. McLAUGHLIN directed attention to slide 30, "Essential Service #5: Develop Policies and Plans that Support Individual/Community Health," including emergency response planning. Turning to slide 31, "The 2014 Ebola Epidemic," he highlighted one recent example of an infectious disease response planning during the Ebola outbreak - the largest outbreak in history - primarily affecting three West African countries and resulting in over 25,000 cases and 10,000 deaths. He reported that the US had 2 imported cases and one death. This resulted in a massive burden for state and local health departments to monitor travelers returning from affected countries. He directed attention to slide 32, "Case Counts and Deaths," that list total cases in Guinea, Liberia, and Sierra Leone.

DR. McLAUGHLIN directed attention to slide 33, "Ebola Preparedness in Alaska," stating a multi-agency Ebola Taskforce was promptly created in the fall 2014, with representatives and

participation from the House Health and Social Services Standing Committee, Municipality of Anchorage, law enforcement, the military, and other governmental agencies. The Section of Epidemiology informed hospitals about Ebola and provided education and guidance for preparedness, including developing a website. In addition, they had ongoing monitoring of travelers. He noted a total of 20 returning travelers arrived in Alaska from Ebola-affected countries. The Alaska State Public Health Laboratory brought Ebola testing on line and successfully processed specimens. He directed attention to slide 34, "DHSS Ebola Response Plan," noting that the Department of Health and Social Services Ebola Response plan contained ten sections that address the major health concern regarding Ebola preparedness and response.

3:48:47 PM

DR. McLAUGHLIN directed attention to slide 35, "All Hazards Example," noting one example was the Fukushima nuclear reactor accident in northeast Japan on March 11, 2011. When the Fukushima power plant disaster occurred the Section of Epidemiology worked with its partners to provide subject matter expertise to the public by creating a website, publishing a bulletin, and testifying before the legislature on risk, as well as providing guidance on food and drinking water safety. He turned to slide 36, "Where were samples collected?," declaring to date the FDA has tested 20 composite fish samples from multiple areas in Alaska, with all samples as "non-detect" for radiation. He directed attention to slide 37, "Water Samples Tested for Radiation," which highlighted the sampling sites depicted on the slide, from the western coast of the US to Canada and Alaska. All of these samples have come back as "non-detect" for radiation, he said.

DR. McLAUGHLIN directed attention to slide 38, "Essential Service #7: Linking People to Needed Services and Assure Access to Care," highlighting another essential service, linking people to infectious disease, HIV/STD, and immunization care. Turning to slide 39, "Tuberculosis Control Program," stating that the program performs case management for all suspect and active tuberculosis cases to ensure appropriate follow-up to reduce the risk of transmission. The epidemiologists also perform contact investigations for those in close contact with persons with active tuberculosis, including offering consultations, and interpreting X-rays. Unfortunately, Alaska has typically been number one or two in terms of incidence of tuberculosis in the US, he said.

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CHAIR SEATON asked what efforts the epidemiologist makes when advised of an active tuberculosis case within a community.

DR. McLAUGHLIN explained that after identifying a person with active tuberculosis, it's important that the patient receives adequate care. The epidemiologist team performs contact investigations to identify anyone who has been in contact with the patient and subsequently screens them, typically with a TB skin test. If multiple people are identified, the epidemiology screens everyone in the village or community, he said.

3:53:59 PM

DR. McLAUGHLIN directed attention to slide 40, "Tuberculosis incidence rates, 1952-70," and spoke about the dramatic tuberculosis rates in Alaska Native population, which are the highest in the world. The historical rates still affect today's rates, he said, noting that Alaska has ongoing challenges due to a number of factors, including access to care. He referred to slide 41, "Active TB Rate by year, Alaska," which illustrates the active cases since 1991. Although the cases have continued to drop, Alaska's rates are higher than in the Lower 48. About 50 percent of the infectious disease program deals with tuberculosis, he said. He referred to slide 42, "AK TB Cases by Race," which shows the highest rates, about 70 percent fall within the Alaska Native population.

CHAIR SEATON asked whether the proportion of tuberculosis in rural Alaska is the same or if more tuberculosis has been found in villages in the Alaska native population.

DR. McLAUGHLIN replied that what seems to contribute to the problem is the lack of infrastructure and limited access to care; for example, many homes are small dwellings, housing lots of multi-generational people. Some villages do not have running water, which tends to hamper general cleanliness and sanitation. He wondered if the question was more about whether white cases occur in Alaska Native villages. In fact, a lot of the white cases are found in urban settings in the homeless population.

DR. BUTLER stated that there was substantial variability in incidence year to year so when clusters occur they tend to bias the figures. He stated in the past 10 years, there have been more urban cases, as stated earlier. He suggested that perhaps

the Alaska Native population was overrepresented in the homeless population and he was not certain if he could answer whether it was urban/rural or a non-Native/Alaska Native issue, but it tends to be domestic and the disease can reactivate years later. He suggested that tuberculosis in other states has been driven more by immigrants.

CHAIR SEATON noticed the relationship between Asian/Pacific Islanders was higher. He asked for further clarification on the location of the incidence of tuberculosis in the foregoing population.

DR. McLAUGHLIN said that vast majority of the Asian/Pacific Islander population are foreign-born and have immigrated to Alaska.

4:00:11 PM

REPRESENTATIVE TALERICO asked if tuberculosis was a bacterial infection.

DR. McLAUGHLIN said that was correct.

REPRESENTATIVE VAZQUEZ asked whether tuberculosis was contagious.

DR. McLAUGHLIN answered that tuberculosis was contagious, but not as much as measles, noting tuberculosis typically requires closer contact.

REPRESENTATIVE VAZQUEZ reflected on a serious case in southern Florida.

DR. BUTLER replied that certain viral illnesses including measles and tuberculosis are airborne and the infection can become airborne and spread through the ventilation systems. Thus patients are placed in airborne infection isolation rooms for precaution and the ventilation system does not circulate to other parts of the hospital. Tuberculosis can be transmitted via the ventilation systems, he said.

4:02:49 PM

REPRESENTATIVE VAZQUEZ asked how many cases in Alaska required that type of care.

DR. McLAUGHLIN said the figures varied from 50-70 cases per year.

4:03:14 PM

DR. McLAUGHLIN directed attention to slide 43, "HIV/STD Program - Direct Patient Services and Linkage to Care," stating that the staff performs disease investigative follow-up on HIV, syphilis, gonorrhea, and chlamydia cases. The epidemiologists also perform partner notification services to inform people they potentially have been exposed to the disease. He turned to slide 44, "Chlamydia Infection Rates - Alaska and the United States," showing high rates in Alaska, stating that the chlamydia infection rates in the US continues to climb, with Alaska having one of the highest rates in the country. The epidemiologists do follow-up on most of the chlamydia cases, which means Alaska probably identifies more disease through active surveillance. He directed attention to slide 45, "Gonococcal Infection Rates - Alaska and the United States," noting that Alaska has been in the middle of the pack in terms of national rates; however, during 2009, gonorrhea cases has spiked several times.

4:06:45 PM

DR. McLAUGHLIN directed attention to slide 46, "Primary, Secondary, Early Latent and Congenital Syphilis Cases, Alaska," stating that syphilis cases have increased since 2008, primarily with men who have sexual contact with other men (MSM). Many of these cases are anonymous MSM, with Internet and mobile applications that promote anonymous sexual activity. The Section of Epidemiology actively works with any new incidence. Most of these syphilis cases are concentrated in Anchorage and Fairbanks. He turned to slide 47, "Percentage of HIV Cases by Region of Diagnosis," slide 48, noting that Alaska has a low incidence state for HIV, with the highest rates in the Anchorage and Mat-Su area. He emphasized that HIV was the Section of Epidemiology's number one priority to help ensure it does not spread. Referring to slide 49, "2014 Cases of HIV First Diagnosed in Alaska by Age at Diagnosis," he pointed out the highest incidence of HIV was in Whites (49 percent, followed by Alaska Native (26 percent), and the Black population (19 percent). He turned to slide 50, "Linkage to Care (L2C) Program," which showed the 2014 cases with the highest rate in the 25-34 years of age and the second highest rate in the 15-24 years of age group. The Linkage to Care (L2C) Program uses HIV surveillance data to identify individuals newly diagnosed with

HIV and previously diagnosed with HIV who are living in Alaska and not accessing medical care. The Section of Epidemiology's goal is to link them to medical care. In 2015, 56 people were identified as eligible and were offered linkage to care. Of those, 98 percent subsequently re-engaged or engaged in HIV medical care. He said that 71 percent of the HIV patients achieved "viral suppression," meaning that the virus has been suppressed in their system and making it much less likely for the disease to progress and for HIV transmission to occur.

4:11:19 PM

DR. McLAUGHLIN directed attention to slide 51, "Immunization Program Activities that Improve Access to Care," He highlighted the program as the Section of Epidemiology's largest program. He reported that this program works to procure and distribute vaccines to health care providers statewide. He pointed out several features of the program, VacTrAK, which is Alaska's immunization registry. All immunizations issued in Alaska must be entered into the database, which he characterized as a great tool to help epidemiologists understand the immunization coverage rates in Alaska. It helps improve portability of care since all providers can access the history. In addition, the Section of Epidemiology has an Alaska Vaccine Assessment Program, which creates a vaccine assessment account, funded by insurance companies and other payers. It enables the program to purchase and distribute state-supplied vaccines to improve access and affordability to life-saving vaccines statewide.

4:13:35 PM

REPRESENTATIVE VAZQUEZ asked if there was any disaster preparedness done in his office.

DR. McLAUGHLIN answered yes; again referencing the Ebola and Fukishima efforts, in fact, disaster preparation was one of the key things the department does. The Emergency Program Section, an entire section within the Division of Public Health, works 24/7 on preparedness and is responsible for orchestrating preparedness efforts for the department.

DR. BUTLER offered to do a presentation on disaster preparedness and emergency programs. He explained that recently the program held a mock disaster in Homer, working with the Alaska National Guard, as well as local responders on disasters. The Section of Epidemiology has been focused on pandemic preparedness control of infectious diseases.

4:16:01 PM

REPRESENTATIVE VAZQUEZ said she has been impressed with the Division of Public Health.

REPRESENTATIVE TALERICO commented on the Section of Epidemiology Bulletin. He said it was impressive amount of information and is very well done.

DR. BUTLER offered to send the Bulletins by e-mail.

CHAIR SEATON asked to put members on the e-mail alerts.

REPRESENTATIVE VAZQUEZ asked whether he had any Vitamin D alerts.

CHAIR SEATON pointed to Vitamin D and rickets in Native Alaskans. He said he shared an article with Dr. Butler on core symptoms of autism improvements with Vitamin D supplements. It seemed as if all the data was observational, but the focus of the committee was on prevention instead of response. He asked how to implement observational data when looking at prevention or if that data is solely used when responding to life threatening situations or outbreaks. He remarked that costs to treat autism per individual was very high in Alaska.

4:20:03 PM

DR. BUTLER replied that substantial epidemiology is hypothesis generating looking for association and then causation. He acknowledged that sometimes the answers are straightforward, but other times they are more nuanced. In terms of when it was appropriate to move beyond medical practice toward public health intervention, cautioned it is necessary to ensure no harm is done when making a direct jump to intervention. Ultimately the goal is to determine the right intervention at the right time with a minimum of cost. He acknowledged the Vitamin D story was intriguing. He suggested that the health care community has been struggling through the details. He raised the issue some have about the efficacy of monthly injections. He acknowledged there was a pragmatic side to consider, noting it can be frustratingly slow, but the importance of balancing cost, risk, and benefit and that decisions are made on the best information available.

CHAIR SEATON stated that prevention is a key for the committee.

4:23:39 PM

HB 99-VOLUNTARY TERMINATION OF LIFE

DRAFT

4:23:53 PM

CHAIR SEATON announced that the final order of business would be HOUSE BILL NO. 99, "An Act relating to the voluntary termination of life by terminally ill individuals; and providing for an effective date."

4:24:04 PM

CHAIR SEATON explained that there were three amendments to be introduced, although the committee did not plan to move the proposed bill at this time.

REPRESENTATIVE WOOL moved to adopt Amendment 1, labeled 29-LS0112\W.1, Bannister, 4/11/15, which read:

Page 2, line 3:
Delete "an adult"
Insert "21 years of age or older"

Page 4, line 2:
Delete "an adult"
Insert "21 years of age or older and"

Page 12, line 30:
Delete all material.

Renumber the following paragraphs accordingly.

CHAIR SEATON objected for discussion.

REPRESENTATIVE WOOL explained that he was concerned with the appropriate age for access to the prescription, and offered that 21 years of age was more appropriate for an age to terminate your life without parental consent.

4:26:21 PM

REPRESENTATIVE HARRIET DRUMMOND, Alaska State Legislature, stated that she was amenable with the proposed amendment for the

time being. She noted that, should the proposed bill be forwarded, its next committee of referral was the House Judiciary Standing Committee and they could also consider the legal issues. She opined that 18 was the age of legal consent for medical procedures, which was the reason the bill sponsor had maintained the age similar to the Oregon law. She offered her belief that only one person under 30 years of age had taken the prescription in Oregon. She declared that she would accept this proposed amendment for the benefit of the committee.

CHAIR SEATON offered his belief that the proposed amendment would resolve some of the issues that people had.

CHAIR SEATON removed his objection. There being no further objection, Amendment 1 was adopted.

4:27:43 PM

CHAIR SEATON explained that Amendment 2 had been suggested by the court system, and that it deleted "a court" on page 2, line 4. He said that this would no longer supersede an individual's attending physician, as the court did not believe this was within its purview.

4:28:56 PM

CHAIR SEATON moved to adopt Amendment 2, labeled 29-LS0112\W.2, Bannister, 4/11/15, which read:

Page 2, line 4:
Delete "a court,"

REPRESENTATIVE TALERICO objected for discussion.

REPRESENTATIVE TALERICO removed his objection. There being no objection, Amendment 2 was adopted.

4:29:32 PM

CHAIR SEATON moved to adopt Amendment 3, labeled 29-LS0112\W.3, Bannister, 4/13/15, which read:

Page 13, lines 19 - 20:
Delete "correctional facility owned or administered by the state;"

Page 13, line 25, following "includes":

Insert "a state correctional facility as defined in AS 33.30.901 and"

REPRESENTATIVE TALERICO objected for discussion.

CHAIR SEATON explained that this amendment had been proposed by the correctional system, and changed the way the proposed bill specified the correctional facilities.

REPRESENTATIVE TALERICO removed his objection. There being no further objection, Amendment 3 was adopted.

CHAIR SEATON asked if Representative Drummond was supportive of Amendment 2 and Amendment 3.

[HB 99 was held over]

4:31:14 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:31 p.m.