ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
January 21, 2016
3:03 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

OTHER LEGISLATORS PRESENT

Senator Berta Gardner

COMMITTEE CALENDAR

PRESENTATION: STATEWIDE SUICIDE PREVENTION COUNCIL

- HEARD

PRESENTATION: STATE HEALTH INFORMATION TECHNOLOGY

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

WILLIAM MARTIN, Chair
Statewide Suicide Prevention Council
Juneau, Alaska
POSITION STATEMENT: Spoke during a PowerPoint presentation from the Statewide Suicide Prevention Council.

KATE BURKHART, Executive Director
Statewide Suicide Prevention Council

Department of Health and Social Services
Juneau, Alaska
POSITION STATEMENT: Spoke during a PowerPoint presentation from the Statewide Suicide Prevention Council.

BETH DAVIDSON, Acting Coordinator
State Health Information Technology
Office of the Commissioner
Department of Health and Social Services
Anchorage, Alaska
POSITION STATEMENT: Presented a PowerPoint on State Health Information Technology.

ACTION NARRATIVE

3:03:12 PM

CHAIR PAUL SEATON called the House Health and Social Services Standing Committee meeting to order at 3:03 p.m. Representatives Seaton, Wool, Vazquez, and Tarr were present at the call to order. Representatives Talerico, Stutes, and Foster arrived as the meeting was in progress. Also in attendance was Senator Gardner.

PRESENTATION: Statewide Suicide Prevention Council

3:03:30 PM

CHAIR SEATON announced that the first order of business would be a PowerPoint presentation by the Statewide Suicide Prevention Council.

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WILLIAM MARTIN, Chair, Statewide Suicide Prevention Council, reported that he represented the Alaska Federation of Natives on the council and, after noting that the council had been established by the Alaska State Legislature fifteen years prior, he directed attention to slide 2, which listed the 13 voting volunteer members, and the 4 legislative members appointed by the house and senate leadership.

KATE BURKHART, Executive Director, Statewide Suicide Prevention Council, Department of Health and Social Services, offered further support to the benefits of institutional memory by the leadership of the council's senior volunteer members.

MR. MARTIN moved on to discuss slide 3, which listed the responsibilities of the Council for its advice and guidance for suicide prevention to the Governor, legislature, and Alaska communities. He stated that the council worked to improve health and wellness throughout the state, by reducing suicide and its effects on individuals, families, and communities. He declared a desire to broaden Alaskan's awareness of suicide, with emphasis on recognition for the signs of suicide. He reported that classes were available to enhance instruction on suicide prevention services and programs, especially to corporations and agencies. He stated that the council desired to develop healthy communities through a comprehensive collaboration of community and faith based approaches to health, implemented at the community level with support by regional, state, and federal resources. He shared that the statewide suicide prevention plan was being updated, and that the council was working to strengthen existing partnerships while building new partnerships between public and private entities for the enhancement of suicide prevention.

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MS. BURKHART pointed out that, as these were very broad mandates for a small council with limited resources, the council had decided to coordinate its efforts through a collaboration with partners both within and outside state government, insuring effective communication.

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MR. MARTIN addressed slide 4, "coordinate," which depicted the report, "Casting the Net Upstream: Promoting Wellness to Prevent Suicide," which was available on-line. Moving on to slide 5, "collaborate," he pointed to a variety of agencies which collaborated with the council, including the Alaska Training Cooperative and teams from the Iron Dog race.

MS. BURKHART elaborated on the collaborative opportunities created for communities to apply for small project grants to fund smaller events. She noted that the council helped to coordinate these resources and ensure that the funded projects were aligned with the state plan, per the agreements with Department of Health and Social Services and Department of Education and Early Development.

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MR. MARTIN moved on to slide 6, "communicate," declaring the council's support for the CARELINE, which handled many suicide prevention phone calls. He referenced the statewide youth program for discussions about suicide, "You Are Not Alone."

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MS. BURKHART noted that the Anchorage Rotary had funded a campaign, "You Can Save a Life," as an example of the Alaskan response to a call for action from campaigns working in the communities.

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MR. MARTIN discussed slide 7, "warning signs," which listed warning signs for people at risk of suicide: threats for ways to hurt or kill oneself, out of the ordinary writing about death and dying, acting recklessly and engaging in risky activities without thinking or paying attention, experiencing dramatic mood changes, expressing feelings of purposeless, or giving away their personal goods accompanied by statements that these were no longer necessary. He stated that these were the times when it was so important to listen, as often this was what individuals were seeking.

MS. BURKHART shared that these situations whereby the warning signs were recognized and additional guidance and support was necessary, were the times for a call to CARELINE.

MR. MARTIN directed attention to slide 8, "casting the net upstream," and he described this plan of action. He read: "every life matters. Your life matters. And you are not alone. Together, we can prevent suicide and save lives."

MS. BURKHART explained further that this Alaska suicide plan was unique among the other plans of states, as it provided strategies and resources at three levels: the individual level; the community level; and, the state level. It was not a plan which placed all the direction and obligation on the state, which, she opined, had led to its successful implementation.

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MR. MARTIN referred to slide 9, "web of causality," stating that suicide was a result of many causal factors, which included mental health disorders, depression, alcohol and drug use,

trauma, sudden loss, grief, economics, and lack of connection to culture, heritage, and spiritual tradition.

MS. BURKHART added that nutrition and social isolation were also issues, noting that the council attempted to educate and operate in a multi-dimensional way.

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MR. MARTIN read each of the six goals on slide 10, "goals," which included that Alaskans accept responsibility for preventing suicide, Alaskans effectively and appropriately respond to people at risk of suicide, and Alaskans support survivors in healing. He added that quality data and research was available and used for planning, implementation, and evaluation of suicide prevention.

MS. BURKHART expanded on the specific aspects for each of the goals, which included a multitude of more than 40 strategies.

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MR. MARTIN directed attention to slide 11, "regional teams," stating that the different regional groups had their own priorities for the goals. Moving on to slide 12, "suicide data," he shared the consistency of the overall statistics for the annual rate and number of suicides in Alaska since 2003. He pointed out that both the statewide and national rates of suicide were increasing.

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MS. BURKHART moved on to slide 13, "crisis intervention." She explained that CARELINE was a nationally accredited crisis line, based in Fairbanks and staffed by trained Alaskans. She pointed to its increased role as a resource for both people in crisis, and those struggling but not yet experiencing a suicide crisis. She shared that CARELINE was funded by the State of Alaska and, as it was a critical component to the suicide prevention system, it was widely advertised and included in most Department of Health and Social Services materials. She added that there was also a text option for CARELINE to enhance its appeal to younger people.

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MR. MARTIN said that the State of Alaska made training in evidence based suicide prevention and intervention models accessible to all interested Alaskans, slide 14, "training." Directing attention to the QPR/Gatekeeper training program, he applauded the Juneau Suicide Coalition for its goal of training at least 25 percent of the people over 18 years of age in the Juneau area within the next two years.

MS. BURKHART reported that the numbers for the training would fluctuate due to the funding or subsidizing of the training. She declared that a stable and consistent source of access to training was through the e-Learning program offered by Department of Education and Early Development, although other organizations were more dependent on grants.

CHAIR SEATON asked if e-Learning was individualized or group training.

MS. BURKHART replied that this was a distance delivered training most often used by educators and staff, although the public did also have access to training on a host of topics, including suicide prevention, most often on an individual basis.

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MR. MARTIN directed attention to slide 15, "childhood trauma," and explained Adverse Childhood Experiences (ACEs) as the traumatic events which occur during childhood and adolescence, which included abuse, neglect, domestic violence, and household mental illness or substance abuse. He shared that a lowering of the Behavioral Risk Factor Surveillance Survey (BRFSS) data, a reflection of ACEs score, resulted in a lower rate of suicide and better physical and mental health. Moving on to slide 16, he stated that "getting rid of the Adverse Childhood Experiences, then our suicide problem will be drastically reduced." He pointed out that an ACEs score of 7 or greater increased the risk of suicide by 51-fold among children and adolescents, and 30-fold among adults. Nearly 64 percent of suicide attempts among adults and 80 percent of these attempts among children and adolescents were attributed to increased ACEs. He declared that it was necessary to stop these childhood adverse experiences.

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MR. MARTIN shared slide 17, "what's working," reporting that Department of Education and Early Development and the Council

partnered to offer suicide prevention and awareness programs in 10 school districts, as a part of a broader health and wellness program. He reported that the Sources of Strength program, slide 18, "what's working," was offered as a peer level program by the Juneau School District.

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MS. BURKHART expanded on these school based suicide prevention programs, pointing out that the Lower Kuskokwim School District was the only school district in Alaska with a social work department offering licensed clinical social workers in the schools as permanent employees. She reported that this allowed for mental health services to be available in the schools for students. She stated that three things working so well in the schools were trained adult nurses and counselors, access to mental health services, and peer to peer student models when talking about school based suicide prevention.

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MR. MARTIN read from slides 19 and 20, "what's working," stating that "access to effective services for behavioral health disorders is a key protective factor against suicide." He lauded culturally relevant prevention and wellness promotion programs, including the Qungasvik Project and the Elluam Tungiinum Projects in Southwest Alaska. He offered, as examples of Project AWARE, that mental health counselors and youth trained in mental health first aid had increased the number of students accessing community behavioral health services by 25 percent. He moved on to slide 21, "what's next," which listed continued implementation of the Casting the Net Upstream program, with a review and update of this program. This program would include increased access to evidence-based suicide prevention training for all Alaskans, would support services and resources for parents and families, and would publish an updated state plan in January, 2017.

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REPRESENTATIVE TARR offered strategies for getting information to individual Alaskans, including that CARELINE, training opportunities, and other resources could be shared by legislative members through their newsletters. She pointed out that, as the number of CARELINE calls was increasing, it was important to maintain the in-state regional cultural support.

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REPRESENTATIVE STUTES asked if the Alaska Mental Health Trust Authority was able to fund support.

MS. BURKHART replied that the Alaska Mental Health Trust Authority was already funding outreach by the council and some innovative screening projects to integrate behavioral health and primary care, as research data had shown that many suicides had occurred within a few months after office visits to primary care providers. She shared that the funding of small project grants issued by the trust were often community based suicide prevention projects.

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REPRESENTATIVE FOSTER noted that he was a big supporter of the aforementioned Qungasvik Project, as it focused on the culturally relevant aspects of suicide prevention. He asked if the council collaborated with this project, in order to take what was working and use it in other rural parts of the state.

MS. BURKHART replied that this model had been developed with a National Institute of Health grant as a specifically Yupik model, and included a participatory process that allowed the community to utilize and build on traditional ways of knowing to solve each problem. She acknowledged that the council had learned from this model, and now used the Casting the Net Upstream program as a means for Alaskans to tell the council what they wanted to do to solve the problem. She pointed out, however, that the Qungasvik Project model did not translate well outside this region and culture.

REPRESENTATIVE FOSTER expressed his agreement that although this Qungasvik Project model may not work well outside the region, the overall concept for integrating culturally relevant aspects of suicide prevention could be used successfully in other regions of Alaska.

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REPRESENTATIVE VAZQUEZ asked to know the amount of contributions over the past five years by the Alaska Mental Health Trust Authority to the council and the percentage of this contribution to the overall council budget.

MS. BURKHART explained that the council did not receive any direct funding from Alaska Mental Health Trust Authority. She acknowledged that the communication strategy which the trust funded was $25,000, held by the trust while the council suggested ways to spend this. She reported that although the annual council budget appeared to be more than $600,000, on July 1 of each year, $475,000 of this was given to Department of Education and Early Development for its school based suicide prevention program.

REPRESENTATIVE VAZQUEZ directed attention to the data from the Bureau of Vital Statistics, slide 12 of the PowerPoint presentation, and asked if there were best practices currently used by other states that could improve this rate. She lauded CARELINE as being effective. She offered her belief that the rate was not moving very much, and asked what could be done.

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MR. MARTIN offered his belief that the council and other suicide enterprises had contributed a great effort toward a reduction in the rate of suicide. He declared that the issue was complicated, and any known solution would have already been implemented. He mentioned that the reporting methodology had only recently improved, as in earlier years not all these deaths were reported as suicides, noting that, in his youth, "there were no youth suicides." Consequently, with this change of culture and the change in the growing-up process, the elders had no suggestions for resolution.

REPRESENTATIVE VAZQUEZ noted that with some cultures there may have been under reporting in past years, due to a feeling of shame for suicide.

REPRESENTATIVE TARR offered her belief that only recently, as more information had come to light, there was a better understanding of the inter-connectedness of childhood trauma and suicide.

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MS. BURKHART shared that the council and its partners in Department of Health and Social Services and Department of Education and Early Development had committed to evidence-based practices, and she directed attention to goal 6, slide 10, declaring it was necessary to evaluate the suicide prevention system in order to make thoughtful decisions for moving forward.

CHAIR SEATON mused that, as it was projected that the suicide rate could move even higher although the data reflected "some very extensive efforts," the success of these efforts had to be questioned. He asked if the suicide rate had been lowered with the specific program in the Lower Kuskokwim School District.

MS. BURKHART pointed out that there was a reduced incidence of suicide among enrolled students, but noted that these low numbers did not always reflect the entire region. As many of these regions were very small, a small change in the numbers often showed a greater impact; therefore, it was necessary for evaluation to determine the success of each program.

CHAIR SEATON expressed agreement that it was necessary to evaluate the efficiency, especially when suicide rates were increasing.

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REPRESENTATIVE WOOL acknowledged that it was easier said than done to reduce the ACEs scores. He asked if that message was also getting out to the communities, so that families would be more sensitive to the social situation. He opined that the results may not be recognized for a decade or longer.

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MS. BURKHART noted that, in addition to her role as Executive Director for the Statewide Suicide Prevention Council, she was also Executive Director of the Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse. She stated that the Alaska Mental Health Board had worked diligently to make Alaska specific ACEs data available to help guide policy. She declared that "the desire all over the state to understand how this affects Alaskans in particular is huge." She stated that there were multiple groups working on this, including the Alaska Pediatric Partnership and the Alaska Children's Trust. She offered to present an overview of all the combined work.

CHAIR SEATON offered his belief that the Statewide Suicide Prevention Council could not be held accountable to solve abuse, neglect, domestic violence, household mental illness, household substance abuse, divorce of parents, and incarceration of parents, all of which were aspects of ACEs.

CHAIR SEATON referenced the research article titled "The association of vitamin D deficiency with psychiatric distress and violence behaviors in Iranian adolescents: the CASPIAN-III study." [Included in members' packets] In describing this youth behavioral study, he reported that Vitamin D levels were tested and then compared in 1100 students. He stated that there was 50 to 80 percent more self-reported anger, anxiety, poor quality sleep, sadness, depression, and worry in those students with low levels of Vitamin D. He expressed his concern that, although these evidence based clinical studies and random control studies showed that depression, worry, anxiety, anger, and poor sleep quality issues in adolescents was associated with low Vitamin D levels, the Statewide Suicide Prevention Council has no mention of low Vitamin D or nutrition in its wellness plan to address suicide prevention. He pointed out that this information, as well as other studies, had previously been shared with both the committee and the council. He reported that there were many studies that showed the benefits from adequate levels of Vitamin D. He expressed his disappointment in this lack of utilization for evidence based medicine and research, suggesting that this research for the association of low Vitamin D levels with the aforementioned anger and depression issues needed to be distributed to the communities, while noting that Vitamin D could be distributed for less than $10 per year.

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REPRESENTATIVE TARR shared that nutrition had been "a big topic of our last [council] meeting." She noted that research showed that Omega fatty acids were also a health indicator for suicide prevention. Directing attention to chronic health conditions on the web of causality, she declared that this spoke broadly to the issue of nutrition. She noted, as the statewide plan was being re-written, there could be more specific discussion about the role of nutritional opportunities in suicide prevention.

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CHAIR SEATON pointed out that the research on the balance of Omega 3 and Omega 6 fatty acid had been presented to the Department of Defense for use as nutritional armor specifically for depression. He opined that there were much simpler ways for change than to change the life style or interactions of families. He noted that the state was moving that way for state employees, as it had lauded Vitamin D in the recent Alaska Care wellness brochure. He questioned why this had not been shared

with other state residents, as it was reflected in the cost benefit basis. He declared that continuous research reflected these advances.

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REPRESENTATIVE WOOL pointed out that the rate of suicide per 100,000 was "fairly constant" and asked if this reflected the changes in population distribution throughout the state. He then asked how this compared to other rural communities throughout the world.

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MS. BURKHART explained that both statewide numbers and statewide per capita rates were reported by the council in order to clarify that this was not a rural problem. She offered that this information could also be provided by region. She reported that rural regions typically had a higher rate and a lower number than urban areas. Although Alaska had consistently been the state with the highest suicide rate in the nation, over the past few years this had not been the case. She noted that other rural western states had now gotten worse, and that the national rate had also increased. She offered to research the question of the increased incidence of suicide among indigenous people, noting that reporting had only gotten more rigorous in the past 10 years.

PRESENTATION: State Health Information Technology

4:15:39 PM

CHAIR SEATON announced that the next order of business would be a presentation on the State Health Information Technology.

4:16:47 PM

BETH DAVIDSON, Acting Coordinator, State Health Information Technology, Office of the Commissioner, Department of Health and Social Services, referenced slide 2, "Overview," and stated that this project utilized an electronic connection to the statewide Health Information Exchange allowing health care providers to submit required public health data to the state in a simple, cost effective, and secure method. This addressed a requirement under the Centers for Medicare and Medicaid Services meaningful use program, and provided a benefit to both the providers and public health. She moved on to slide 3, "What is the Health

Information Exchange?" She stated that in recent years, nationally, the health information exchange had been headed toward an electronic exchange utilizing electronic technology. She relayed that Senate Bill 133, passed in May, 2009, had created a statewide health information exchange that was interoperable and compliant with state and federal specifications and protocols for exchanging health records and data. In March, 2010, the Department of Health and Social Services awarded a contract to Alaska eHealth Network to be the non-profit board and organization to procure and manage the statewide health information exchange. She clarified that this was a web based software solution. In February, 2011, a pilot program in Fairbanks began to use the exchange. In February, 2012, the federal rules under the Office of the National Coordinator Health Information Exchange Cooperative Agreement grant changed, and the Alaska health information exchange was now required to implement and demonstrate push-based exchange, a secure encrypted e-mail for more than 300 participants, before being allowed to move on to a more robust, query based health information exchange. She explained this query based system to be when provider's electronic health records solutions were interfaced and connected to the statewide health information exchange. This was system to system versus utilizing a person. She offered an example that allowed the health care provider to send a referral for a patient to a specialist. It could also be used for provider consults and discussions about a mutual patient, for sharing transition of care documentation, and to transmit electronic protected health information to the State of Alaska from health care organizations outside the state. In February, 2013, Department of Health and Social Services received permission to move the exchange into "full production mode." The Alaska health information exchange utilizes secure encrypted data exchange, using standards developed specifically for health care. The patient's health care provider can access the records without the patient leaving their home. The exchange allows for faster and more effective emergency treatment, support from tele-health activities, improved public health disease reporting, and avoidance of duplicate testing and negative drug and allergy reactions. She offered an anecdote for the utility of the exchange.

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MS. DAVIDSON moved on to slide 4, "Project Details," and explained that this allowed a healthcare provider to submit public health data for immunizations, electronic laboratory results, and syndromic surveillance through the health

information exchange to the Department of Health and Social Services (DHSS) through its Enterprise Service Bus, a piece of information technology that securely and discretely connected different information systems within the department using a combination of open technology standards to access, move, or transform data. This data was accessible by related systems. She pointed that it was more cost effective to move data, as it reduced the cost to create, maintain, and monitor the connections and avoided the duplication of effort. Moving on to slide 5, "Project Tasks," she shared that funding from the Centers for Medicare and Medicaid Services had allowed that the two systems, Immunization and Electronic Laboratory Reporting, be upgraded to allow for effective communication with the Alaska health information exchange. At the same time, there was design and implementation for the necessary electronic connection between the health information exchange and the Enterprise Service Bus. They also worked with Centers for Disease Control and Prevention (CDC) to design and implement a connection between the health information exchange and CDCs BioSense for syndromic surveillance. The testing of the system was done in parallel with the previous data transmission systems to ensure that the data was flowing correctly and being received timely and in the correct structure. After the test period, the new system connections were finalized.

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MS. DAVIDSON spoke about slide 6, "Benefits to Providers." She declared that it was more cost effective for providers when the health information exchange was connected to the DHSS Enterprise Service Bus, a single connection between disparate systems. Electronic connections allowed for real time data, fewer errors, and secure data transmission. Moving on to slide 7, "Benefits to DHSS," she explained that the project allowed for improved data and was timely and cost effective. She offered examples for the incorporation of BioSense data into weekly flu snapshots to allow a sense of statewide activity. She pointed out that the transfer of electronic lab results allowed savings of time for data entry and allowed for detection of cluster outbreaks with more immediate response to the communities.

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MS. DAVIDSON directed attention to slide 8, "Future Plans," and listed some of the future plans for the health information exchange which included: transmitting sensitive disease reporting to the Division of Public Health, behavioral health

data reporting to both the state and primary care providers, availability to patients for their personal health records, and utilizing the health information exchange as all payer claims data base. They were also reviewing clinical quality measure reporting by health care providers to meet state and federal program requirements.

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REPRESENTATIVE STUTES asked for clarification that this was "an avenue to report to the public health the required information." She opined that this would be a program for physicians to report "everything that goes on with every patient they see, so you can keep track of 'em." She declared that this interpretation alarmed her.

MS. DAVIDSON declared that this was not the intention of DHSS. She stated that the health information exchange was designed to support community health care providers to work together to share patient data, as necessary, to support referrals to specialists, for transition of care, and for cooperation among health care providers, especially primary care and behavioral health care providers. She noted that the intention was to allow the emergency room to no longer be a primary care provider. She further explained that syndromic surveillance data was the identified aggregate data that produced data for the state and the Division of Public Health to support communities in the identification of trends and outbreaks across the state, which included flu, salmonella poisoning and other infectious diseases. She declared that there was not any intention for health care providers to submit "every ounce of data that they ever possibly capture within their electronic health records."

REPRESENTATIVE STUTES reiterated that this was still a concern for her.

CHAIR SEATON asked if this data was for the already required reportable diseases, or would it include a full panoply of other non-reportable diseases. He questioned whether this e-network would be an expansion beyond the required incidence reporting.

MS. DAVIDSON replied that it was only what was already required under state and federal law for reportable diseases.

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REPRESENTATIVE STUTES asked for clarification that this did not include prescriptions which were not reportable to the Division of Public Health. In response to Ms. Davidson, she questioned whether the program would be expanded to include such things as asthma, as this alarmed her for its invasiveness and the subsequent Health Insurance Portability and Accountability Act (HIPAA) consequences.

MS. DAVIDSON replied that this was not the intention.

CHAIR SEATON reviewed the aspects of the program, which included that these required reports and data were the same as would have been submitted as paperwork, although now they would be submitted more quickly and would be electronic.

MS. DAVIDSON noted that DHSS was now being provided reports, which were required, that had not been submitted previously, as a secure electronic method was now available.

REPRESENTATIVE VAZQUEZ asked which immunizations were required to be reported.

MS. DAVIDSON said that the requirement was only that an immunization had been given, and there was not any administrative aspect.

REPRESENTATIVE VAZQUEZ asked if this covered all the Medicaid patients receiving a flu shot.

MS. DAVIDSON explained that this only included patients who had opted into the health information exchange through a participating health care provider. She pointed out that a patient had the option to opt out of the exchange. She stated that there was not a requirement under either state or federal law for a Medicaid patient to participate in the health information exchange.

REPRESENTATIVE VAZQUEZ asked if there was a written form which explained the patient rights, and required a patient signature.

MS. DAVIDSON explained that the Alaska eHealth Network was a non-profit organization which managed the health information exchange and worked directly with each of the provider organizations. She stated that although the provider was responsible for these forms, the network would work with the provider organization to develop the form, if necessary.

REPRESENTATIVE TALERICO asked if the in-depth notes to her presentation were available to be shared.

MS. DAVIDSON agreed to share the notes.

4:47:28 PM

CHAIR SEATON, referencing the controlled substances data base and its required use, asked about an estimate for the time and cost to convert this controlled substances data base into the health information exchange to better help prevent opioid addiction.

MS. DAVIDSON offered to research and provide an estimate of the time and cost, noting that this was already being researched as an option.

4:50:36 PM

REPRESENTATIVE TARR asked about the security backup measures for the electronic information in the exchange in the event of a crisis situation with the need for critical health information.

MS. DAVIDSON noted that, as this health information exchange was web based, in an emergency, access to the internet and this data would be one of the highest priorities. In further response to Representative Tarr, she stated that there had not been any security breaches.

CHAIR SEATON asked if all providers of controlled substances would have to join the exchange, or could they be members only for the reporting of controlled substance, and not the rest of the required reporting.

4:54:44 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:54 p.m.