

ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

April 2, 2016

2:02 p.m.

MEMBERS PRESENT

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

MEMBERS ABSENT

Representative Liz Vazquez, Vice Chair

COMMITTEE CALENDAR

PRESENTATION: "ACEs" by DR. MATTHEW HIRSCHFELD

- HEARD

HOUSE CONCURRENT RESOLUTION NO. 21

Urging Governor Bill Walker to join with the Alaska State Legislature to respond to the public and behavioral health epidemic of adverse childhood experiences by establishing a statewide policy and providing programs to address this epidemic.

- MOVED HCR 21 OUT OF COMMITTEE

PRESENTATION: CITIZEN REVIEW PANEL

- HEARD

PREVIOUS COMMITTEE ACTION

BILL: HCR 21

SHORT TITLE: RESPOND TO ADR. VADAPALLIERSE CHILDR. HIRSCHFELDOOD EXPERIENCES

SPONSOR(S): REPRESENTATIVE(S) TARR

02/05/16 (H) READ THE FIRST TIME - REFERRALS

02/05/16 (H) HSS, FIN

WITNESS REGISTER

MATTHEW HIRSCHFELD, M.D.
Chair, All Alaska Pediatric Partnership
Anchorage, Alaska

POSITION STATEMENT: Presented "A Systemic Approach and the Economic Benefits of Identifying and Treating Family Trauma."

TREVOR STORRS, Executive Director
Alaska Children's Trust
Anchorage, Alaska

POSITION STATEMENT: During the hearing of HCR 21, testified in support of the legislation.

DON ROBERTS
Kodiak, Alaska

POSITION STATEMENT: Testified during discussion of HCR 21.

PATRICK ANDERSON, Senior Research Fellow
Sealaska Heritage Institute
Anchorage, Alaska

POSITION STATEMENT: During the hearing of HCR 21, offered support for the legislation.

MAUREEN HALL, School Nurse
Juneau, Alaska

POSITION STATEMENT: During the hearing of HCR 21, offered her experiences regarding the legislation.

DR. DIWAKAR VADAPALLI, Chair
Citizens Review Panel
Institute of Social and Economic Research, Professor
University of Alaska Anchorage
Anchorage, Alaska

POSITION STATEMENT: Presented a PowerPoint titled, "Alaska Citizen Review Panel, and Annual Update."

CHRISTY LAWTON, Director
Central Office
Office of Children's Services
Department of Health and Social Services
Juneau, Alaska

POSITION STATEMENT: Answered questions during the presentation of the Citizens Review Panel.

ACTION NARRATIVE

[2:02:36 PM](#)

CHAIR PAUL SEATON called the House Health and Social Services Standing Committee meeting to order at 2:02 p.m. Representatives Stutes, Talerico, Tarr, Wool, and Seaton were present at the call to order. Representative Foster arrived as the meeting was in progress.

Presentation: "ACEs" by Dr. Matthew Hirschfeld

[2:04:00 PM](#)

CHAIR SEATON announced that the first order of business would be an "ACEs" presentation by Dr. Matthew Hirschfeld.

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MATTHEW HIRSCHFELD, M.D., All Alaska Pediatric Partnership, Chair, said that he is an Anchorage pediatrician and advised that All Alaska Pediatric Partnership has been working in the area of adverse childhood experiences and issues related to child abuse and neglect in Alaska, and the partnership is interested in ACEs. He turned to slide 1, and noted that in working with other organizations, the question is how to work together to decrease these adverse childhood experiences in the state.

DR. HIRSCHFELD turned to slide 2, "The Developing Brain," and said this slide clearly shows what can happen under extreme neglect. He pointed out that the brain on the right side shows a very different brain from the normal brain. The holes are called ventricles and are much larger on the brain that underwent extreme neglect, the brain is much smaller, and it is organized differently. He extended that this child will never be able to develop to their full potential having experienced extreme neglect, but this brain damage can happen anytime a child is exposed to bad things happening to them, especially with children between zero and 3-5 years of age. In the event the neglect is ongoing for a long period of time, that child exposed to those bad things happening to them will never develop to their potential. As a pediatrician and as a member of the All Alaska Pediatric Partnership, he said the intent is for children to develop to their full potential.

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DR. HIRSCHFELD turned to slide 3, "Evidence," and explained that Dr. V. Felitti lectured in Juneau in February and also gave

great talks all over town. Dr. Felitti is the chief author of "The Adverse Childhood Experience Study - ACEs Study," and things that happen to very young children can permanently affect their health, permanently affect their mental health, permanently affect whether they can hold jobs, and more. This is known through a landmark study beginning in 1998, by Dr. Felitti. He advised that it was a collaboration between CDC and Kaiser Permanente in San Diego where 17,000 adults with the average age of 57, were surveyed. He pointed out that by having adults in the Kaiser Permanente system there is access to their medical records.

DR. HIRSCHFELD turned to slide 4, "Adverse Childhood Experience Study," and related that Dr. Felitti wanted to look at 10 events that could happen in childhood and then relate those to the health of the adults he was surveying. He then read the list of 10 events surveyed, and explained that Dr. Felitti asked a series of questions around these 10 events.

DR. HIRSCHFELD turned to slide 5, "ACE: Prevalence data," and advised that Dr. Felitti found that approximately two-thirds of the adults surveyed reported having at least one of those things happening to them, which Dr. Hirschfeld described as a pretty astounding number. This was a middle-class group of people being surveyed in San Diego and most of the people had at least gone to college if not graduated from college and he found that a huge number of people had been exposed to this as a child. Interestingly, approximately one-third of the people had zero yes answers to any of the questions, and all of those people were quite a bit healthier across all measures.

DR. HIRSCHFELD turned to slide 6, "Health Measures Now Linked to Adverse Childhood Experiences Score" and said that they were looking at this huge list of things that can happen to a person as an adult. Essentially, he pointed out, if a bad thing happens to a person as a child they are at increased risk for heart disease, asthma, cancer, sexually transmitted diseases, suicide, depression,. In fact, he explained, as the number of yes answers increases, a person's risk of having one of the listed diseases as an adult goes up step-wise as well. He described it as a fascinating piece of public health because that is rarely seen. The link between a high adverse childhood experience score or answering yes to the questions, and the risk of having a suicide attempt is actually stronger than the risk between smoking and lung cancer. Basically, he related every time a person looks at a bad health outcome that can happen to an adult, it can be linked back to bad things happening as a

child. He described it as strong data that has been supported in hundreds of studies over the last 20 years, and the question today is how to decrease these yes answers in Alaska in order to decrease the risk of an unhealthy population as adults.

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DR. HIRSCHFELD turned to slide 7, "2013 Alaska BRFSS" said that through the Behavioral Risk Factor Surveillance System (BRFSS) survey, Alaska has now started to measure ACEs and the Alaska population. He advised that Patrick Sidmore, the data guru for Alaska ACEs, with one year of data discovered that for all Alaskan adults, the state has about the same percentage of people as the San Diego folks do with zero yes answers to those questions, and noted that those people are much healthier than the people who answered yes to the questions. Interestingly, he commented, Alaska has people answering yes to those questions more often, and Alaska has more people with four or five plus yes answers to the adverse childhood experiences questions. Therefore, Alaska has two-thirds of the people that say yes to those questions, but Alaska's population is skewed so that Alaskans' answer yes more often. Which means that, overall, Alaska's population will not be as healthy because there are so many bad things happening to children.

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CHAIR SEATON asked Dr. Hirschfeld to explain the header on the slide and whether the first column of percentages is the number that reported 1 yes, and so on.

DR. HIRSCHFELD replied that the top score is the ACE score - 0, 1, 2, 3, 4, 5+.

CHAIR SEATON noted there are no numbers on there, and he just wanted clarification.

DR. HIRSCHFELD explained that on the top line is Alaska's population at 10.8 percent of 5+ bad things happening to them as children. Alaska has more people in Alaska that say they've had 5+ things happening to them as children than many other states.

DR. HIRSCHFELD turned to slide 8, "Adverse Childhood Experience" offered that this is Alaska's specific data and he likes the slide because it shows Alaska's percentage relative to five other states that perform a similar survey as to Alaska. He pointed out that this is an emotional abuse, physical abuse, and

sexual abuse slide, and the red number is the highest between Alaska and these five other states. Alaska is number one with reports of sexual abuse to children, and Alaska is close to the top for emotional and physical abuse. Therefore, there are many opportunities in the state to make big changes if the state can give families and children additional support so these things do not happen to them. Due to the high sexual abuse rates for children in the state, sexual abuse is the place to start and the sexual abuse rates for women is in the 30 percent range and there are great opportunities to try to decrease sexual abuse rates, especially in women in the state.

DR. HIRSCHFELD turned to slide 9, "Household Dysfunction" and said this is where Alaska becomes much higher than the other five states it is comparing itself to. Especially, he noted, in substance abuse in the home, separation or divorce, incarcerated family member, but the state is fairly close to the top in mental illness in the home and witness to domestic violence. Alaska has many opportunities to make big changes in the health of its populations by decreasing these numbers that are happening to children.

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DR. HIRSCHFELD turned to slide 10, "Prevalence of Specific ACEs Experienced by AN People Compared with Non-AN" offered that the Alaska Native Medical Center has an epidemiology department and its epi center took Mr. Sidmore's data and looked at Alaska Native folks versus non-Alaska Native folks. The red squares show where Alaska Native folks are statistically significant from the non-Native folks. Speaking as a doctor working at the Alaska Native Medical Center and someone interested in tribal health, these are the areas he would want to focus on to try to decrease the rates in Alaskan Native people to bring them more in line with the rest of the state, together with working on the rest of the state to bring [the numbers] down. He stressed the importance that no child should be a victim of sexual abuse or substance abuse in the household, or any of those things.

DR. HIRSCHFELD turned to slide 11, "How Do We Work Together to Decrease Alaska ACEs?" section of the presentation.

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DR. HIRSCHFELD turned to slide 12, "American Academy of Pediatrics Policy Statement" said he likes to start with big organizations that are doing things on a national scale and the

American Academy of Pediatrics has decided that ACEs is interesting to them as well. They have a policy statement where providers such as family medicine doctors, nurse practitioners, pediatricians, and anyone who interacts with families should be actively assisting parents, childcare providers, teachers, policy makers, and everyone interacting with families to try to address these persistent and constant problems that are facing contemporary society, including: criminality, disparities in health, limited educational achievement, and diminished economic productivity listed on the slide.

DR. HIRSCHFELD turned to slide 13, "Why Are Providers the Front Line?" noted that he likes to think of providers as the frontline because providers have a major opportunity in this state to make an effect. The slides depict when children are seen in provider offices, and this slide mirrors immunization, and children receive lots of immunizations especially when they are under three years of age, and the immunizations bring children into provider offices. In that children are going to the doctor so often, that is a great opportunity for providers to screen families for things that could be happening at home that won't be healthy for their children. As the committee knows, he related, the biggest effect on children and making them healthier in the future is when their brain is the most plastic, when their brain is developing rapidly and that is any child under 3 years of age. When the children come in for immunizations the provider can do lots of screening for the family, and do protective corrective action to those families, and that way the families are healthier, raising healthier children, and they know how to raise healthier children. Providers can have a major effect because those families are in their offices often for children under the age of three for immunizations.

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DR. HIRSCHFELD turned to slide 14, "Parent-Screening Questionnaires" and explained that people are finally developing screening questionnaires to look at things that could be happening in families and adversely affecting children. [He described the questionnaires] and said that a provider can hand the parent a questionnaire during the office visit and then begin having a discussion about any answers that are yes, to get the families to help raise healthier children. He noted that the questions on the slide are common and used throughout the lower-48.

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DR. HIRSCHFELD turned to slide 15, "Three Questions - Gets Almost Everything" and described questionnaires as easy and many people can use them. He pointed to his Nome practice and offered that for his families those questionnaires work but they don't work as well as something else he has started to do in his practice in Nome. When he has a family that he is a little worried about, their children are not developing properly, or the children are acting out in school, or any risk factors for something that may not be going well at home, he starts having conversations with families. He also asks the questions listed on the slide that gets to the abuse questions. In the event a child has been physically abused, and the mother trusts the doctor as a provider well enough, she will start answering yes to the questions which begins a conversation to try to start getting help for that mother so it doesn't happen again to the child. Equally important he said, as to whether something has happened to the child is that the provider really wants to know whether that has affected the child's behavior. The most protective thing a child can have is a strong healthy adult relationship. For example, a child with a great mother and father is physically abused once and this stressful thing happened to the child. Although, the parents are able to walk the child through the situation, give him ways to deal with the stress, build resilience in the child so even though it was a stressful event the child was able to tolerate it well because he had great parents and adult relationship in the family. He said he is less nervous about that family if the child's behavior hasn't changed and the family is functioning well.

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DR. HIRSCHFELD related that many parents were physically abused and if their child is physically abused it can trigger strong memories in a parent. A question he asks is not only has this event affected the child's behavior, but has that event had any effect on the parent because that suggests to him that if the parents are having trouble dealing with this, they will not be able to help the child deal with it. More help is needed for that family to not only get the child through the situation but also counseling for the mother and father to make sure they are able to handle the situation and walk their child through the situation. Those two questions appear to get at the abuse questions well. Those questions do not get at neglect, he asks the parents whether they have done anything with their child that is really fun since the last time he saw them. If people

can't think of anything fun they've done with their child in three to six months since last seen in clinic, he said it makes him nervous that the child is just sitting in front of the television and they are not having great interaction in the family. He opined that those questions appear to get at most of ACEs, and noted that his families in Nome prefer to have discussions as they do not do quite as well with a written survey. Another question he might ask is for the parent to give him three words that describes their child. In the event a parent can't think of three nice words to describe their child and all three of the words have some sort of explicative in it, he becomes nervous that the family is not functioning well. This family may need outside help to raise their children in an effective environment, he said.

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DR. HIRSCHFELD turned to slide 16, "Help Me Grow" and explained that a problem he has with getting providers to use these screening tools is that there is not an easy way for providers to refer families to help, and this is a big deal. If the provider is trying to see 25-35 patients a day and there are numerous yes answers on one of the screening tools, the provider oftentimes does not have a lot of time to spend going through all of the different services available in Alaska to help these families get healthier. He explained that one of things the All Alaska Pediatric Partnership is doing in conjunction with the Maternal and Child Health Section of the state, is building a referral system called "Help Me Grow" which will allow providers an easy way to get families help. Help Me Grow was originally developed in Connecticut and it is now in approximately 26 states and basically, through a single telephone number a family can call in, talk to a case manager, and the case manager will help that family work through the paperwork, travel, find a place the family can be seen, and basically, get the family connected with services that can help the family. A problem for many families is that they are not functioning well in raising their children, and it's hard for them to function well enough to get access to services. He advised that case managers associated with the Help Me Grow Program walk families through this and actively help them access services. It's not a passive system, he described, and they actually help these families' access services through a centralized telephone number. It is a great way for providers to get these families help that is easy and Help Me Grow loops back to the provider so the provider knows that the families are accessing the services they need. He explained that, currently, this program is in the building

stage, and they are hoping to launch the program in the Anchorage, Mat-Su area sometime in the fall or early winter this year as a trial. There are many data components to this and over time they will see whether it makes a major effect on how providers interact with families to screen for bad things happening to them, he said.

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DR. HIRSCHFELD turned to slide 17, "Care Coordinators provide" and advised that the slide summarizes his comments regarding the care coordinators, who are advocates in doing assessment of needs, follow up, link families into services, and more. He said he has seen this in action in Orange County, California, and they are next going to South Carolina to see it in action. He described it as an inspiring program that families love because it makes it easy for them to access these services, and providers love it because it is easy for them to get their families in.

DR. HIRSCHFELD turned to slide 18, "What Can Policy Makers and Funders Do?" and acknowledged that these are tight budget times and there is no money asked here, but in moving forward to contemplate how to make Alaska healthier by decreasing adverse childhood experiences. He said he ponders what policy makers and funders can do, and what voters can advocate for, and one of the things currently not being is the screening he previously discussed. In the event the state can get Medicaid and private insurance companies to cover screening for those families, it would greatly increase screening performed by providers because it does take time to go through the written forms and talk to families about them. Another benefit, he suggested, would be to support the development of programs such as Help Me Grow. The program has been shown in every state, where it has been implemented, to improve family wellness and decrease system costs. It makes families healthier and they access the health system much less so it decreases Medicaid costs, he said.

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DR. HIRSCHFELD advised that another benefit is to preferentially support organizations and programs focusing on intervention in early childhood. He advised that Representative Tarr sponsored HCR 21 that basically supports any program supporting early childhood, and it is a huge program that All Alaska Pediatric Partnership supports. He described it as a great step in the process of getting early childhood on the radar for everyone in

government because, he stressed, that is where there will be the most effect to improve the health of Alaska's population in the next generation.

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DR. HIRSCHFELD turned to slides 19 and 20, "What if we Reduced Alaska's ACE Score by 1/2 Point" and "Reducing Alaska's ACE Score by 1/2" respectively, and advised that Mr. Sidmore looked what would happen if Alaska's ACE score was reduced by one-half point. He then offered a scenario that the average ACE score in Alaska is 5, and if it is decreased to 4.5 what would happen to costs in Alaska. He then referred to the next slide, and advised that Mr. Sidmore looked at six of the diseases listed on slide 6, obesity rates, number of adults on Medicaid, smoking, binge drinking, diabetes, and arthritis. In the event of decreasing the ACE score by one-half point what would happen to the above diseases, how many would not smoke, binge drink, not be on adult Medicaid because they had a healthier childhood. Essentially, Mr. Skidmore showed that Alaska will save approximately \$90 million annually, and that is only looking at the above six problems. He described \$90 million as a low number relative to all health in Alaska.

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DR. HIRSCHFELD turned to slide 21, "What Does \$90 Million Buy In Alaska?" and noted the slide depicts various items such as homes, kindergarten teachers, police officers, mechanical engineers, pediatricians, OCS operations, Medicaid costs, and more.

DR. HIRSCHFELD turned to slide 22, "If Alaska Had ACE Rates Similar to Arkansas and Vermont the Estimated Reduction in Number of Alaskan Adults for Each Category of Economic and Educational Outcome" and advised that the slide depicts specific decreases for people in Alaska if they decreased their ACE score by one-half percent.

DR. HIRSCHFELD turned to slide 23, "If Alaska had ACE Rates Similar to Arkansas and Vermont the Estimated Reduction in Number of Alaskan Adults for each Category of Behavioral Health Outcome" and noted that the number of people with depression would decrease by 9,375 Alaskans, insufficient sleep by 5,195 Alaskans, frequent mental distress by 4,478 Alaskans, and heavy drinking by 1,464 Alaskans. He described these as big numbers in a state as small as Alaska, and further described this is a

significant proportion of the population. By decreasing ACEs and getting families with young children the help they need, there can be a big change in many of the health outcomes, he said.

DR. HIRSCHFELD turned to slide 24, "If Alaska had ACE Rates Similar to Arkansas and Vermont the Estimated Reduction in Number of Alaskan Adults for each Category of Food Insecurity Outcome" and advised it refers to people who were hungry and didn't have any food. That number will be decreased by approximately 10,103 Alaskans, and the people using government food programs will decrease by 5,549 Alaskans.

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DR. HIRSCHFELD turned to slide 25, "In the brain, as in the economy, getting it right the first time is ultimately more effective and less costly than trying to fix it later." Dr. Hirschfeld explained that James Heckman is a Nobel Laureate Economist and he looked at a number of different ways to think about early childhood development and brain development. He then read Mr. Heckman's quote, as follows:

In the brain, as in the economy, getting it right the first time is ultimately more effective and less costly than trying to fix it later.

DR. HIRSCHFELD continued that this ACE data is all about the current generation and; therefore, 20 years from now the state doesn't have to build more prisons, build more of a juvenile justice system, or hire more police. The goal is for the next generation to be much healthier and save costs in Alaska, he related.

DR. HIRSCHFELD turned to slide 26, offering his services.

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CHAIR SEATON referred to slide 6, and noted that the various diseases have also been linked to low Vitamin D levels. He advised that the committee should be looking at the relationships and causal characteristics being included as well. This committee has reviewed studies from all over the world connecting some of those things, he advised.

DR. HIRSCHFELD agreed, and said if a person has 10 yes answers to those questions, it is not 100 percent that the person will

have heart disease as it is a complex disease and etiology. He explained, there is just an increased risk for developing all of these things as the ACE score goes up. He expressed that this is not a one-to-one relationship and reiterated, it is just an increased risk as the yes answers go up.

CHAIR SEATON noted that what has been interesting is that the committee has looked at ACEs over a period of time and what to do about the scores, yet there have not been many suggestions policy-wise and that he appreciates Dr. Hirschfeld's presentation.

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REPRESENTATIVE WOOL referred to this presentation and others where scores are taken and there are correlations with other illnesses or lifestyles. At the end the day, he said, the committee is told that if the score goes down a point or one-half point, all of these other things will go away. Obviously, he said, the score is just an assessment, and lowering someone's score is a complex societal lifestyle problem with not just one curative prescription because these are complex solutions.

DR. HIRSCHFELD agreed, and he said that lowering it one-half point makes it sound easy but it is incredibly complex to do that. He explained that a lot of it will be improving access for families into services that help them, such as alcohol abuse, smoking cessation, programs that teach parents how to be better parents, and the ability to access those programs and develop those programs so families can get the help they need to solve the problems they are exposing their children to. He expressed, it is an extremely complex problem and it is money upfront to save money in the future when the state is in a tough fiscal environment. Representative Wool was entirely correct, he stressed, dialing it down one-half point sounds easy but it is not even a little easy.

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CHAIR SEATON surmised that dialing it down one-half point doesn't mean that he is changing any adult, if they are adverse childhood experiences it means how many a child had during childhood. Therefore, he said, the discussion is prevention on new children to Alaska.

DR. HIRSCHFELD agreed, and he related that this effect won't be seen for 20 years until those children ... the goal of the

change is to change the zero to 3 year old ACE scores right now. By the time those children are old enough that's where there will be a decrease in healthcare costs and behavioral health costs, and others, he said.

CHAIR SEATON referred to slide 16, "Help Me Grow" and asked whether they are family functioning tools or assessments.

DR. HIRSCHFELD explained that currently, it is hard for providers, families, and other people in the state to keep track of what is available to help families. For example, a family is screened in at the pediatric practice and it is revealed they are homeless. As a provider, he does not have a great way to obtain help for this family so Help Me Grow allows the provider to give the family a centralized telephone number wherein that family can call the organization, explain their problem, and the family will be assigned a case manager who then links them to the appropriate services to help them find a place to live. He explained that it is not providing direct service, it is a link between the family and the services to make that access easier. He related that one of the hardest things for families not functioning well is that it is hard for them to access services due to the paperwork, travel, and time. The Help Me Grow case managers streamline that process for the families so they can receive the services they need. Help Me Grow does not provide services, he reiterated, it links families with the appropriate services in an active management manner so the families can get the help they need.

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CHAIR SEATON referred to slide 17, "Care Coordinators provide" assessment of needs and referral to services, care coordination, and more, and he noted the project "Protect Our Children Now" is contained within the Medicaid reform bill that was passed out of this committee. He pointed out that it provides not only nutrition but also counseling. He offered that he is hopeful that Dr. Hirschfeld will visit with Dr. Wagner while he is in South Carolina, and let the committee know of his assessment of the program Dr. Wagner is conducting, and how it is working in South Carolina.

DR. HIRSCHFELD said he would do that.

CHAIR SEATON referred to slide 18, and what policy makers and funders can do from the Medicaid standpoint. He noted that Dr. Hirschfeld has some care coordination models and he would

appreciate those coming forward together with any suggestions he may have.

The ACEs presentation was concluded.

HCR 21-RESPOND TO ADVERSE CHILDHOOD EXPERIENCES

[2:42:11 PM](#)

CHAIR SEATON announced that the next order of business would be HOUSE CONCURRENT RESOLUTION NO. 21, Urging Governor Bill Walker to join with the Alaska State Legislature to respond to the public and behavioral health epidemic of adverse childhood experiences by establishing a statewide policy and providing programs to address this epidemic.

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The committee took an at-ease from 2:42 p.m. to 2:43 p.m.

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REPRESENTATIVE TARR offered a PowerPoint presentation titled, "Adverse Childhood Experience," [referred to slides 1-9] and reminded the committee that these issues had been discussed in committee previously. She noted that Dr. Hirschfeld's presentation discussed the origins of the ACEs study and developing an ACEs score and she said she would skip over those topics. Previously, members had been asked to take their ACEs score and pointed out that in asking people to take their ACEs score it rises awareness and assists in understanding the issues better. Key findings within the Alaska work is that childhood trauma is far more common, it lasts over a lifetime, and impacts generations. Research has shown that approximately \$1.4 billion is spent every year in Alaska on substance abuse related issues from treatment to the court system to law enforcement, and she referred to Dr. Hirschfeld's presentation regarding some of the cost reductions that can be associated with reducing Alaska's ACEs scores.

REPRESENTATIVE TARR explained that HCR 21 calls on the legislature and the governor to work together to do more on policy level changes. Last year, the legislature worked hard on Erin's Law and Bree's Law, and the legislature discussed ACEs through those bills. She then stressed the importance of keeping that conversation going this year, to keep the conversation going as more awareness needs to be developed with

education and some of this can be done without funding. She pointed to slides 6-9, and advised that these are some of the opportunities for prevention, and that during the interim the committee will continue looking at policy alternative. In working through the implementation of Erin's Law and Bree's Law, she wants to make sure the legislature is part of the effort to build a statewide network of people concerned about the issues and come together.

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REPRESENTATIVE TARR advised there are 27 letters of support from organizations across the state, such as the Children's Trust, Suicide Prevention Council, Mental Health Board, Best Beginnings, and also approximately 200 hundred individuals signed petitions from different early learning conferences she attended, from the Dr. Felitti event, and from the "Go Blue Day" Child Abuse Prevention rally yesterday. In bringing all of these groups together, she noted that her hope is to bring together a network of people to determine that it isn't just about spending more money on something, but more about having a deeper understanding of these ACEs issues, and its impacts. ACEs is about connecting the dots and within the letters of support there are individuals working on mental health, early learning, substance abuse, or suicide prevention. In understanding ACEs it brings a new opportunity for connecting the dots between the negative health outcomes and looking back at the origins and determining what the origins of those problems are.

REPRESENTATIVE TARR referred to an additional slide in the committee packets from the All Alaska Pediatric Partnership regarding ACEs accumulation and read, "Young Alaskans have acquired HALF of their accumulated ACEs by the age of 3." She explained that it speaks to the importance of the early intervention programs. As Dr. Hirschfeld discussed, pediatricians and other health care providers can be frontline in that effort, and she added that early education folks such as Best Beginnings are working on early education. There was a time it was believed there was a protected wall around the fetus and that the mother smoking and drinking was okay. It was also believed that children in the pre-verbal times were unimpressed by things, and that events could be happening around them and there wasn't a big impact. To put this in context, she related, the study referenced was published in 1989, and when thinking about how recent that's been for people to learn about that data and then start doing their own research, there really hasn't

been an opportunity to implement it into the state's policies in a manner that can be implemented to have a tremendous impact. This slide shows that a lot of the bad stuff is happening at the time people previously believed children would not be impacted by the behaviors around them, or even be aware of violence or substance abuse, she said.

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REPRESENTATIVE TARR related that building awareness is part of the effort that can be accomplished without funding a new program, and through the efforts this month of child abuse prevention and organizations hosting many different activities sharing information and, hopefully, get more people involved. Working with educators and practitioners and the government in creating policy alternatives is the next step, she remarked.

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REPRESENTATIVE FOSTER expressed his support and that he appreciated Dr. Hirschfeld's presentation and learning of his efforts in his practice in Nome as it makes it more tangible for him.

REPRESENTATIVE TARR related that these are long term investments and as Dr. Hirschfeld related, within every step along the way the state has opportunities to work with children when they are in school, and that there are screening tools when meeting with families. One big opportunity is just in changing the language when there is a child with behavioral problems. The child acting out is not asked what is wrong with them, but rather the child is asked what happened to them. Things like this give her hope and that even without a lot of funding, moving toward something where most of it is simply understanding the opportunities, and the different places that can be engaged in sharing this information.

CHAIR SEATON noted his appreciation for both presentations and that he found Dr. Hirschfeld's comments interesting because he was unsure how much the medical community and quasi-medical community had been involved with those types of care coordination efforts with families. He related that it is good to hear that they are not just looking at the child, but the situation the child is in.

[2:52:20 PM](#)

REPRESENTATIVE FOSTER moved to report HCR 21, labeled 29-LS1398\A out of committee with individual recommendations with no fiscal notes.

CHAIR SEATON objected for discussion and read into the record the language on page 3, lines 14-22, as follows:

BE IT RESOLVED that the state's policy decision acknowledge and take into account the principles of early childhood brain development and, whenever possible, consider the concepts of toxic stress, early adversity, and buffering relationships, and be it

FURTHER RESOLVED that early intervention and investment in early childhood years are important strategies to achieve a lasting foundation for a more prosperous and sustainable state through investing in human capital; and be it

FURTHER RESOLVED that the Governor join with the Alaska State Legislature and address the presence of adverse childhood experiences as factors for many societal issues and to fund research for statewide solutions.

CHAIR SEATON opened public testimony

[2:52:20 PM](#)

TREVOR STORRS, Executive Director, Alaska Children's Trust, said the Alaska Children's Trust is focused on the prevention of childhood abuse and neglect. He related that the Alaska Children's Trust is also partnering with groups around the concept of reducing trauma and building resiliency in the child, the family, and the community. He noted that what has been presented today is a complex issue and what the committee does with this information is not about enacting one specific thing, but it is the framework to help promote the concept of reducing trauma adversity to not only the child, but a community and cultures within Alaska. When these issues are addressed, not only does it save money, it builds communities that can withstand trauma which is a natural part of the circle of life, but child abuse and neglect are not a natural part of the circle of life. It is resiliency that glues that circle together and the role of the community is to be certain the glue being used is the strongest and best glue so everyone benefits, he said.

REPRESENTATIVE TARR asked Mr. Storrs to send information to the committee members about the Resiliency Initiative.

MR. STORRS agreed.

[2:56:37 PM](#)

DON ROBERTS described himself as an adult survivor of these adverse childhood experiences and in listening to the presentations he noted that the system tends to forget that there are many adults dealing with this in their lives with no resources available to them. He agreed that the programs can be initiated, but they are for children and families and he is 58 years old. He took the ACEs test and had a score of 7, although it would have been higher if it asked a few other questions. Adult programs need to be integrated so when adults get into the system they are not just sidelined due to no services out there because the legislature didn't put it in, he related. Due to his adverse childhood experiences, having intimate family relationships is troublesome because he doesn't want to be the kind of parents he had where basically his childhood was filled with anger and violence. He opined that this needs to be included in the legislation. There are other services, such as peer support services that are not necessarily part of the mainstream clinical experience people should be able to use and, he opined, peer support services are often given short shrift when they tend to be far more effective in helping people deal with these issues in their lives.

CHAIR SEATON offered support for his testimony and related that there is definitely no one point in which addressing these issues can be stopped.

[3:00:28 PM](#)

PATRICK ANDERSON, Senior Research Fellow, Sealaska Heritage Institute, said he is a Senior Research Fellow in the area of childhood trauma and health restoration, and has been engaged in research and advocacy around adverse childhood experiences since 2008 when he was the CEO of an Alaska Native Rural Health System. As a consequence of his advocacy he is a member of both the American Indian and Alaska Native Task Force on suicide prevention and president of the Native American Children's Alliance (NACA), assisted in the drafting of this resolution, and that his ACEs score is 6. He described the understanding of the existence of real and identifiable childhood trauma being linked to adult health and negative behaviors as an exciting new arena of public policy. He then referred to Dr. Hirschfeld's presentation and said that if childhood trauma can be identified

early in a child's life it can be addressed before it becomes a true problem and prevention becomes a real option because parents can be taught how to avoid the behaviors that cause the development of this trauma in children. He referred to the perception that the resolution addresses early childhood prevention only, but that was not the intent. He referred to HCR 21, page 3, lines 14-16, which read:

BE IT RESOLVED that the state's policy decision acknowledge and take into account the principles of early childhood brain development and, whenever possible, consider the concepts of toxic stress, early adversity, and buffering relationships, and bit it

MR. ANDERSON pointed out that it is directed toward adult health and behaviors as well as early children's brain development, health, and behaviors. He advised he has spent the last four or five years looking for a systemic approach that addresses both the parenting generation's behaviors and children's behaviors in a family and community context. Mr. Anderson opined that the goal is to introduce a program that effectively identifies behaviors early enough to begin the healing process. Within the City of Nome, where Dr. Hirschfeld practices, there has been a discussion in the last few years around ACEs that has advanced to the point of serious consideration. During the recent convention of the National Congress of American Indians, presentations were offered on the topic including a plenary presentation by Dr. Vincent Felitti. Tribal groups in Alaska have started the process of understanding and using ACEs and are following examples from the lower-48. Dr. Ann Bullock is employed by an Indian tribal health system addressing diabetes through programs that identified and treated traumatic or toxic stress. Dr. Donald Warne is an American Indian physician who has been active through the Great Plains Tribal Chairman's Health Board in addressing ACEs and there are many other who are following their lead.

MR. ANDERSON referred to the Behavior Risk Factor Surveillance System (BRFSS) and emphasized that Alaska Natives have a 4 or more ACEs at a rate which is almost double that of the non-Native population according to BRFSS. As a result, many of the Alaska Native communities view this area as a priority to address. When Dr. Felitti was in Juneau, they took the opportunity to meet with Governor Bill Walker, Lieutenant Governor Byron Mallott, Commissioner Dean Williams of the Department of Corrections, and Jay Butler the Alaska Chief Medical Officer. They briefed Governor Walker on this issue,

made him aware of the legislation, and asked Governor Walker to support it. Mr. Anderson opined that this resolution has great potential for encouraging a wider discussion of ACEs in Alaska and if it leads to more programing to address prevention, earlier intervention, and healing that would be fantastic. He then asked that the committee pass HCR 21 out of committee and encouraged the adoption of the resolution by the legislature.

[3:05:58 PM](#)

MAUREEN HALL, School Nurse, said she is a school nurse in Juneau and she fully supports this resolution because [nurses] daily see children on the frontline in their offices. These children typically have a high ACEs score, and are seen most often which carries over into adult medicine when they leave the school setting. These individuals, she said, are the heaviest users of the health care system, are most apt to have poor educational outcomes, and end up engaging with the criminal justice system. As far as the savings being 20 years down the road, she argued that the savings will be immediate because those children will not be as sick as their peers when they have a lower ACEs score. It will prevent a lot of the adversity and they'll be healthier, and be better able to learn once they do get to school. She pointed out that this is important in raising awareness throughout our state, and she would like every school in the state become a trauma informed school, as well as Alaska's communities. By every police officer and teacher understanding how the adverse childhood experiences affect a person, she opined that it would go a long way toward preventing and increasing awareness, and helping that person be more successful down the road.

CHAIR SEATON removed his objection. There being no objection, HCR 21, Version 29-LS1398\A, with no fiscal notes, passed from the House Health, Education and Social Services Standing Committee.

Presentation: Citizen Review Panel

[3:08:38 PM](#)

CHAIR SEATON announced that the final order of business would be a presentation by the Citizen Review Panel (CRP).

DR. DIWAKAR VADAPALLI, Chair, Citizens Review Panel, Institute of Social and Economic Research, Professor, University of Alaska Anchorage, said he is an assistant professor of public policy at

the Institute of Social and Economic Research (ISER) at the University of Alaska Anchorage. He turned to slides 1-3 and explained the makeup of the panel, the presentation outline, and the panel's federal and state mandates. The Citizens Review Panel's (CRP) mandate is to evaluate the policies and practices of what translates in Alaska to be the Office of Children's Services (OCS) from a community perspective, and to perform public outreach in the process.

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DR. VADAPALLI turned to slides 4-7, and advised that the primary functions of the Citizens Review Panel (CRP) is to evaluate OCS against its own 5 year Child Abuse Prevention and Treatment Act (CAPTA), some federal and state child protection standards, and any other criteria the panel considers important. The panel is also required to conduct public outreach both to inform the public of child protection policies and procedures, and also to collect input on these policies from stakeholders. Throughout the state there are five regional OCS offices, 19 field offices, and 500 employees of which 283 are frontline workers with approximately 32 percent of these workers turning over every year, and its operating budget is approximately \$150 million. At this point, he said, it would be meaningful to consider the tasks the panel is asked to perform, the resources at its disposal to operate at a \$100 thousand annual budget, and that the panel members donate an average of approximately 300-400 hours each year. He acknowledged that these as tight budget times for the state, and that in FY2016 the panel's budget was cut by \$18 thousand yet the work remains the same. The CRP does not do the following: comment on proposed or pending legislation; get involved in individual cases, contracts, or situations; micromanage the OCS operations, conduct program evaluations, and lobby. Over the last couple of years the panel worked hard to analyze its calendar to streamline the work flow, and during the last year it conducted three public meeting site visits with numerous interviews, met every month with OCS leadership, presented its annual report to various stakeholders, and attended the CRP National Conference.

3:16:08 PM

DR. VADAPALLI turned to slide 8, "Recommendation 1: Intake Policy" and advised that each year the panel begins with a set of goals, and each goal relates to one or more components of OCS's practice model or operations. Each goal is explored on both the policy front and practice front, and it notes gaps

between stated policy and current practice. In addition, there are many things the panel follows, and a few things it comes across that are either OCS initiatives or concerns from others. The recommendations within the annual report are based upon these additional issues of interest to the panel. He advised that the next few slides include all of the recommendations from the panel from last year, and within the accompanying letter the panel submitted to the committee, it summarized OCS's response to each of the recommendations.

3:17:49 PM

CHRISTY LAWTON, Director, Central Office, Office of Children's Services, Department of Health and Social Services, said she was available for questions.

3:17:57 PM

DR. VADAPALLI returned to slide 8, and pointed out it is the first recommendation of the panel last year, and that the panel examined specific intake policies for two years in a row. The panel chose this goal because during the course of its site visits, individuals commented that children are being left in unfit conditions because a large number of cases are screened out combined with the high turnover of frontline workers, which makes the screening process burdensome and unpredictable. After examining the policy and practice of intake, the panel made several recommendations and OCS accepted all recommendations and OCS is in the process of implementing several of them. Currently, OCS intake is in transition from a regional structure to a central structure with all calls fielded by a smaller group of centrally located workers. The panel was informed that OCS is waiting on a manager being hired to direct the operations.

CHAIR SEATON referred to the change to opt-out of receiving follow up on the case, and asked him to explain the recommendation.

DR. VADAPALLI replied that the panel noticed that when someone reports a child is being maltreated, the intake worker was not required to ask the reporter whether they wanted to know what happened in response to their report. He described the recommendation more as an opt-in where the reporter is required to ask whether the reporter would like to be informed of OCS's response to the report because many individuals complained that they reported over and over again and nothing would happen. The OCS related that that is a current option, and the panel

recommended that there should be a response to the reporter unless the reporter opts-out and does not want a response.

CHAIR SEATON asked whether that policy is being implemented now and whether it appears to be more effective in obtaining community support for the program, rather than distrust that nothing happens after a report of a child's maltreatment.

[3:21:45 PM](#)

MS. LAWTON answered that OCS believes that recommendation will assist the general public and its large majority of mandated reporters to be clear about what is happening, because it may have not been clear that that option was available in prior cases. She noted that some of the changes are still pending because OCS is bringing on a manager who will oversee intake operations and some of the details are being worked out, but it is a positive change.

REPRESENTATIVE TARR referred to the [third] bullet on slide 8, "Uniformly implement the current pilot project of having a supervisor reviewing cases after 10 screened-out PSRs" and asked Ms. Lawton to explain the pilot project. She pointed out that there are people who frequently report that are potentially abusing reporting due to ongoing custody issues and would like to have a better understanding.

MS. LAWTON responded that during the last several years OCS has piloted several new practices around intake where it escalates reports to regional managers to evaluate whether it is appropriate for screen-out. This is looking at the obviously prior reports OCS has received and the likelier potential that new reports will keep coming if it doesn't intervene. Certainly, over the years OSC has heard complaints that it waits too long to intervene, so OCS started looking at that and trying to ... if they have 10 they are not automatically screened-in, it is just getting another pair of eyes to look at them in the context of the whole picture. She advised that the division has some pilot projects wherein it is paying particular attention to the zero to 12 months, whether there have been prior reports, whether there is an infant in the home, whether there is going to be a screened-out recommendation by the intake worker, and those are escalated as well. The division is still evaluating how well these various pilots have been working and their effectiveness before implementing a statewide policy, although much of it will be implemented because there have been some positive changes. She continued that with the additional sets

of eyes reviewing the report, OCS believes it is intervening with the right families and at the right time, which is key to avoiding repeat maltreatment in the future.

[3:24:18 PM](#)

REPRESENTATIVE WOOL asked her to describe what PSR and screen-out means.

MS. LAWTON answered that the PSR is Protective Services Report which is what is created when a reporter calls and lodges an allegation. Those reports are then screened-out or screened-in and each time a reporter calls regardless of whether OCS believes it is something to investigate, it is documented and a report is created. A decision is then made as to whether it meets the criteria for a screened-in which will then generate an investigation. In the event it is a screened-out, there is no further follow up, and no notification to the family, she explained.

[3:25:03 PM](#)

DR. VADAPALLI turned to slide 9, "Recommendation 2: In-Home Services" and explained that in-home services has been a challenge for OCS for a while, and the panel has noticed this consistently over several years. Most alarmingly two years ago the panel found that the in-home services workers in one region found the caseload humanly impossible, and the panel reported it last year. Therefore, the panel looked into in-home services to determine where the challenges lay, and the graph on the slide shows the percentage of in-home and out-of-home cases over the period 2011-2014 broken down by OCS region. Within the last OSC five year plan, it identified a goal to develop a model of in-home services for rural areas, and that goal continued into the current Child and Family Services Plan (CFSP). Although, he said, OCS has a clear goal in its plan the panel noticed there were no clear outcomes identified, thereby, being unable to assess whether it made its goal, or made satisfactory progress on the goal. The panel recommended that OCS constitute an internal task force to address its new in-home services model and identify specific measurable clear outcomes so it can assess periodically on the progress being made. In response, OCS indicated it wanted to persist with the existing model that its (indisc.) new increased opportunities for stakeholders to play a meaningful role in providing home services. Currently, he noted, the panel has seen new developments on the enrollment of tribal entities in providing in-home services. The panel

strongly believes that identifying additional more specific measurable outcomes is certainly important regardless of who the service provider is, whether it is through a contract, or OCS directly providing the services.

CHAIR SEATON asked for an explanation of what the new in home services model is and what services those are in relationship to OCS.

[3:28:14 PM](#)

MS. LAWTON replied that typically in-home services is viewed as an opportunity to work with a family less formally than through foster care. When OCS is working with a family and the child remains in-home the child could be in the state's legal custody but more often than not is not in the state's custody because OCS had investigated and found some concerns, wherein the parent agrees they are have a problem but is willing to work with OCS to please not take custody of their child. In the event the parent is truly motivated and genuine in their efforts and OCS believes it can keep the child safe in the home while working with the parent, OCS will try to open the case for in-home services without having to file a petition and go to court. Currently, and what OCS has done for many years, she explained, is that when a case is opened for in-home services on an ongoing basis, it is assigned to a case worker similar to any other case that is transferred from the investigative worker to an ongoing family services worker. The struggle OCS has had and the recommendation from the panel over the years, is that OCS's model hasn't been completely successful, particularly in rural Alaska. She related that the challenge has been that its case workers are trained to be more of the middle man, organizer, coordinator of services, and are not the direct service provider in those cases. The case workers do not provide the parenting classes, therapy for the parent or child, they don't go in-home and do intensive family based engagement because OCS trains them to connect families to resources. In rural Alaska, where there are not many providers, the challenge has been that OCS does not have a mechanism to train its staff to play all of those roles. It's been a challenge, and what OCS is currently trying to do and what it addressed in response to the recommendation, is put forth that perhaps OCS is not the best suited to provide in-home services due to the large portion of crisis driven work that OCS does.

[2:30:24 PM](#)

MS. LAWTON pointed out that typically in-home services takes place between the case worker and the family when there is no legal involvement, thereby, it does not bring in the court's oversight, the other legal parties, and all of the other people that ensure those cases move forward. Those families often do not receive as much attention as they need because the case worker is trying to meet the demands of all of the other cases of children in foster care. The division believes that some of its non-profit social services organizations and its tribal entities would be far better suited to serve these families in a less formal intervention. Also, she commented, those families may be more likely to engage with them than with an OCS worker to begin with. She advised she is looking at sending out a letter of interest to explore this idea, and that OCS has been talking with its tribal entities as well. Many of them have been working for a number of years to create and build the infrastructure to provide in-home services to these families that are at risk. She stressed that OCS has so many challenges to work on within its agency, it would like to find a way to get services to these families via other entities that may be better equipped than OCS.

[3:31:38 PM](#)

CHAIR SEATON referred to slide 16, and Dr. Hirschfeld's presentation regarding the Help Me Grow program, and that appears to be a family functioning tool with case management. He asked whether the department has looked into these models that would be similar to telehealth and the coordination of services, especially in rural Alaska where there is little access to services.

MS. LAWTON answered that she was unaware whether OCS has a lot of that going on and that she is not familiar with Help Me Grow, although it is on her list to speak with Dr. Hirschfeld. Many of the rural families are connected to their tribal health organizations that can provide some of those services. Most of the department's standard-type services that the families OCS sees are needs around parenting, around substance abuse, and she opined there was not much availability in terms of creative access. Although, she noted, currently there is effort through behavioral health, and with Medicaid expansion that she is hopeful there will be far more opportunities for access that doesn't look like the standard urban setting access, but there is an area for growth there.

CHAIR SEATON noted that within the telehealth presentation, it found that there was a far better compliance rate with substance abuse, counseling and such because people just could not make it to the appointments. Possibly OCS could do that through some of the telehealth data the committee received, and he offered to steer Ms. Lawton to the telehealth presentation. He pointed out that whether the issue was behavioral health or compliance with a substance abuse program, the telehealth compliance rates were approximately 80 percent higher, which included urban Alaska because people can miss the bus or whatever.

[3:34:27 PM](#)

REPRESENTATIVE WOOL noted that certain aspects of treatment had a stigma and possibly people didn't want to go in and see certain kinds of providers, but if they are in the comfort of their own home they do not have to interact with anyone publically.

CHAIR SEATON added that most of it was visual through a computer or iPad or similar. He noted his surprise at the data on the compliance rates, and that it appears the state keeps going through these cycles because it has problems with getting compliance throughout a full program.

[3:35:21 PM](#)

DR. VADAPALLI returned to slide 9, and drew the committee's attention to the last bullet point which read, "Identify additional, more specific measurable outcomes." He advised that the panel had several discussions with OCS regarding applying measurable outcomes to access programs as they move along trying to do the work it is mandated to do. He added that that has been a problem with the in-home services and a recommendation is that any new models must have an accompanying set of measurable outcomes.

CHAIR SEATON asked whether the department felt this was meaningful and doable moving forward in designing the program.

MS. LAWTON said that certainly if OCS is putting dollars out through grants or contracts, by some means it will build in measures of accountability. Certainly, she related, Dr. Vadapalli brings much expertise to this area and OCS would appreciate his crafting assistance when OCS gets to that point.

[3:36:48 PM](#)

DR. VADAPALLI turned to slide 10, "Recommendation 3: IA Backlog" and said that Initial Assessment (IA) backlog has been a challenge for several years and it is the second step of a case after the initial screen-in. The process, he explained, is that a reporter calls in and the report is screened-in or screened-out, in the event the report is screened-in there is an initial assessment conducted by an IA worker. He noted there are several different types of scenarios where an IA can quickly be concluded, or can be delayed over time. Given how busy OCS frontline workers are, and how much they have on their plates, it's not uncommon that some of these are overdue. Anything that needs to be addressed right away are addressed to the best possible extent, but there are several that just sit there and don't get closed in time. Obviously, he pointed out there is concern about what is happening with these children while a case is open but nothing is moving. However, the number of backlog IAs ran up to approximately 4,000 statewide in 2012. This happens approximately every 4 years because OCS puts all of its resources to quickly close all pending IAs once every 4 years, and 2016 is that 4 year cycle and the numbers were creeping up. The panel recommended that OCS have a structured plan to address this and dig into the nature of the IA cases that are backlogged by 30, 60, 90, or 120 days. The division came up with a system internally and it included mostly trying to keep up with the regional managers and unit supervisors to make sure that the cases are closed on time. Although, that is obviously not working as they hoped. The recommendation is to come up with a system that is a structural solution to this and to understand it better and get a solution, he said.

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CHAIR SEATON asked whether there is an explanation for the 4 year cycle.

MS. LAWTON replied that in terms of root cause, she does not think there is any mystery, and to be clear when discussing backlog, the backlog is in the completion of the final paperwork and writing up the summary of what happened and issuing the final letter that goes to the family. She expressed that this is the key issue OCS feels badly about because parents absolutely are entitled to receive notification that the case has been closed and the ultimate finding. However, when the work load is such that staff are getting too many reports than they can possibly keep up with, the paperwork always moves to the bottom of the list because the workers are going to go out

and see the people in person and assess each child's safety. She related that [there may be backlog] until OCS has more balance in terms of the work load and the number of staff available to address the issue and giving worker more tools because currently all of the staff have to basically perform duplication of documentation in almost everything they do.

[3:40:45 PM](#)

MS. LAWTON continued that the workers go out in the field and talk to the family and write on a tablet, they then come back and have to document it. She described this as a duplication of efforts that OCS simply does not have the time for them to be doing. Unfortunately, the financial aspects of getting laptops and the security issues from an IT perspective, it's just not something OCS has in the cards for probably a number of years until OCS will have the funding to do that. Until that time, the cycle is just that when OCS diverts all attention to a problem, generally, it makes headway and some improvement, but typically OCS has more problems at any given time than it does resources to focus on all of them. She opined that the cycle is more reflective that the numbers grow and OCS decides "everything is going to this until we get this settled," it then goes back to trying to address everything else, and the numbers creep again. Particularly, she noted, with IA workers and investigators because they are almost always the newest to the agency, and the greenest to working in child welfare, and typically are the employees quickly trying to move from their jobs to family services which tends to be a more predictable day schedule and work load. She remarked that they are the least skilled and the least trained employees dealing with the crisis in your face child maltreatment issues every day.

[3:42:23 PM](#)

REPRESENTATIVE SEATON surmised that OCS hasn't gotten to using Siri to type out the reports yet. He referred to 2012 when extra workers were added, and said in looking at the budget each time there is a vacancy the legislature takes the positions and doesn't refill them. He asked whether that is happening as well.

MS. LAWTON offered that the legislature has been very supportive of OCS over the years in getting it new positions, but it hasn't kept up with the pace, and OCS continues to struggle with the turnover. She noted that if OCS could solve the worker turnover issue, which is largely driven by the work load, it wouldn't

need more staff and it could do a far more effective job. This is a challenge every state in the country is facing with the backlog and that those paperwork functions tend to always be at the bottom of the list. The division has actually been asked to present in some states about how Alaska has been able to, with some frequency, get the backlog fixed. Unfortunately, OCS has not been able to devise a sustainable effort, she said.

[3:43:55 PM](#)

DR. VADAPALLI turned to slide 11, "Recommendation 4: Foster Care" and advised that previously the panel had not looked into foster care issues, and since it is a huge area of OCS's work it looked into how the recruitment and retention efforts for foster families were going. The panel noticed that recruitment efforts were not uniform across the state and there were no outcome measures; therefore, he related, there was no clear message on what the need was, how many foster families were needed, what the target of recruitment is, and when will OCS know when it gets there. The recommendation was to clearly identify outcome measures with appropriate channels for communicating a clear message with the approximate number of resource families needed. The division responded that it is working with the Center for Resource Families that provides training for foster families to make progress on identifying measures and giving a clear message. The Center for Resource Families understands the challenge OCS has in trying to identify the exact need at any point in time because children are always coming in or out. The panel believes that an approximate number can certainly be identified, he remarked.

[3:46:08 PM](#)

CHAIR SEATON referred to the outcome measures and asked whether he meant the chart [on the slide] and what the outcome measures the panel is looking for are.

DR. VADAPALLI responded that essentially OCS put a lot of plans together at a reasonable level in terms of recruiting and retaining foster families. Although, many of those sub-goals within the plan did not have any sort of outcome measures, and it was not clearly identified when OCS will know it had attained success, what is the goal here, and when it will know the goal has been achieved.

[3:47:45 PM](#)

DR. VADAPALLI turned to slide 12, "Recommendation 5: Employee Survey" and said this is an example of something that comes up during the year but is not necessarily a part of the work plan. He pointed out that there is an annual employee survey and the survey results are summarized and passed across the agency for supervisors to use to make revisions on various things. Two-three years ago when the panel started looking into the survey it noticed that the results were not summarized in a manner that supervisors could make decisions. Ms. Lawton disagreed with him, he said, and she advised that OCS is using it and that the summarized results are useful. Two years later the panel had the same challenge and asked for data and the data was (indisc.) for the last two years. Last year the survey instrument was passed on to the panel for comment and it provided feedback on how questions could be changed and the panel's list of changes did not make it into the instrument before the survey was conducted. He explained that the recommendation is about restructuring the OCS employee survey and the way the surveys are summarized which is important due to the total turnover of 32 percent over the last decade among the frontline workers. It is important to know how the workers feel about certain things and the published document on line does not separate out responses from those frontline workers. This year OCS asked the panel to assist and because he is a professor at UAA, his class is conducting the survey in collaboration with OCS this year.

[3:50:46 PM](#)

CHAIR SEATON asked whether the survey results are internal surveys.

DR. VADAPALLI replied that this is an internal staff survey but the results are summarized for the public's purposes and are on the OCS website for the entire state. He opined that by grouping all of the frontline workers into one group and examining just their responses will help OCS in identifying specific reasons for this high turnover and possibly identify solutions. This year CRP restructured the survey quite a bit, although it did not change the questions or add any new questions because this is the first time that OCS, CRP, and the graduate class from UAA are collaborating so that is a lot of change in the way the survey was administered in the past. They agreed not to add any new questions and maybe get the process right so next year additional questions may be added or different questions asked. The report will be a CRP report so it will be a public report and all members of the committee will receive a copy, he said.

3:52:31 PM

CHAIR SEATON asked whether the collaboration was working well in trying to get at the survey of the initial intake workers.

MS. LAWTON said she would wait to see the results of the survey and the overall response rate because there certainly could be value in some of the restructure, and the questions are fundamentally all the same. The division obviously sees value in gathering information from its staff population in total and it hadn't been particularly narrowing in on those frontline case workers when looking at how to deal with the turnover. She said it will be interesting to see what the results will say and what that means for future years.

3:53:24 PM

DR. VADAPALLI turned to slide 13, "Recommendation 6: Workload" and noted that a consistent message from the frontlines was the challenge of workload management. In 2006 and 2012, two workload studies recommended that OCS measure workers' workload on a regular basis and that its workload balancing tool only allowed senior managers to allocate resources and assign work between offices. The workload balancing tool did not allow workload assessment as recommended by either of the workload studies. He advised that the agency can make some progress if there is a clear tool to assess workload on an ongoing basis. In response, OCS reported that it is working with the National Child Welfare Workforce Institute to examine caseloads and workloads, and is also working with a national consultant in examining prior workload studies to determine what the next steps could be.

3:55:02 PM

REPRESENTATIVE TARR asked whether other opportunities had been looked into. For example, the Rasmuson Foundation has a program that offers sabbaticals for non-profits, executive directors, with the thinking regarding retention is to give someone a period of time to refresh. She asked whether there are other supportive things the legislature should be considering or have been done elsewhere that may help reduce the turnover.

MS. LAWTON responded that OCS is always looking to those opportunities and she is on a number of national lists serves, and probably every week a state inquires, "who's doing something

that's working" in this area. Currently, the State of Alaska together with the University of Alaska Anchorage is part of a 5 year grant it received in working with the National Child Welfare Workforce Institute, and that there is a lot of dialogue happening there. She opined there are not any magic bullets, and OCS periodically meets with human resources and personnel to go back over questions previously asked before because sometimes the questions change over time in state government. During the meetings they try to determine whether there could be flexibility with "this," or whether they could do something that the state hasn't done. For example, OCS has seen success in an office that, historically, had significant difficulties in recruiting at St. Mary's in the western region outside of Bethel. The division has employed an alternative work schedule such that the employees work one week on and one week off. It is not exactly the same as the Alaska State Troopers, but the workers at St. Mary's have stayed for approximately two years. Although, one worker recently turned over but the other worker is still there. A thought for Bethel, with the four new positions the division recently received, is basing the employees out of Anchorage and then being deployed to Bethel one week on and one week off. Although, she noted, that is not ideal from a community perspective, if the workers stay as long as what is being seen with the folks at St. Mary's they actually will become just as familiar as though they were living in those communities and there won't be the current turnover. The division is always scanning nationally to determine whether anyone has anything going on that is new or innovative, but there's not many magic bullets out there on this.

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REPRESENTATIVE TARR asked whether there was the ability to offer loan forgiveness or bonuses for individuals if they, after a five year period ... she opined that the goal is not to incentivize someone to stay just because they are looking to get extra dollars and not doing a good job. She asked whether any of those come up on those lists serves.

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MS. LAWTON opined that they have come up and nationally there was an initiative for social workers that was more focused on licensed clinical social workers working in rural areas or in Indian health organizations where there were opportunities for loan forgiveness. There hasn't been such an opportunity in Alaska with state child welfare workers, and she said she has

talked with the personnel folks and asked that in the event there was money in the budget whether OCS could offer small bonuses for staying another year. She has also looked at whether the salary rate could be increased for those workers who perform investigations and initial assessments because, she reiterated, those tend to be the greenest workers with no experience. The division actually needs the most seasoned people performing those jobs because there are less eyes, less oversight, less collaboration, and they are entirely on their own. At this point, OCS has not been able to find an avenue for that in Alaska with its current structure or budget.

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DR. VADAPALLI added that attention on recruitment and retention is important and those are considerable challenges for OCS, but this recommendation is really about the tools available for managers, supervisors, and workers to manage their workload. Also, for managers to assess the workload at an individual level on a regular continuing basis. The frontline workers have consistently said there is too much to do, no way to prioritize, and there is no way to take a break, basically, he related.

DR. VADAPALLI turned to slide 14, "Additional Work" and offered that the panel conducted three site visits and a copy of each visit report was submitted to the committee. A survey report of all select ICWA personnel from various tribal entities has been conducted annually for the last three years regarding their relationship with OCS on the frontlines. The 2015 and 2016 survey reports found that they rate their local child protection at 6 out of 10, with 10 being the best. He described it as a subjective assessment but still useful information to know. The panel attended the National Citizen Review Panel Conference and came back "pretty proud" of Alaska's CRP and the structure and support it receives, the report was submitted to the committee

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DR. VADAPALLI turned to slide 15, "National Conference 2017" and advised that the panel will be attending the 2016 National CRP Conference in Phoenix. The panel committed to hosting the National Conference 2017 in Alaska and OCS intends to support it but is skeptical about the level it can meaningfully support the CRP's efforts in hosting the conference. He opined that the conference would be useful to Alaska because it brings in national expertise and experience to weigh in on Alaska's shoes. Every time there is a national conference in any state, the

local CRPs receive a lot of focus and expertise is offered by the national experts. He further opined that this will be useful for the state in making progress on community engagement and social child protection.

DR. VADAPALLI turned to slide 16, "Goals for 2015 - 2016" and offered the ongoing goal of focusing on OCS components, and this year the panel took a critical look at its own operations to refine how things have been structured and operating. The goal being to make it easier for the public to participate and more meaningful for OCS to utilize as a tool for information to inform its policies and practices, he said.

DR. VADAPALLI turned to slide 17, "Changes in CRP operation" and explained the slide depicts changes in the panel's operation and it adopted an official set of guidelines the panel did not have in the past. Currently, when the panel meets at the beginning of the year, which is in August or September, it puts together a work plan as a set of goals and a clear annual calendar. The plan is then submitted to OCS to note on its calendars when the panel plans to produce the product during the year. Public comments are accepted at the panel's website, and documents and information are available online except for the panel's meetings with OCS leadership. The panel's intention is to create a Public Outreach Plan in the near future and offer a new recruitment and orientation packet to each new member, he explained.

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REPRESENTATIVE TARR pointed out that there is no legal requirement the legislature must provide funding or additional resources to accomplish a CRP recommendation, and asked whether Alaska is in line with other states and their experiences and challenges where they want to do more but do not have the resources.

DR. VADAPALLI responded that her question is the most challenging question all CRPs have been asking themselves, how to do what they are expected to do. He offered that a national model has not been suggested by the federal agencies or any technical consultants that they hired for technical assistance. Each panel evolved in whatever way it saw fit for its local needs. For example, Alaska has one panel and the panel appoints its own members through a formal recruitment and appointment process, but many states follow a different template and there is no national accepted template. Most challenging, he related,

is that there is no model stating the principles of the CRP or what is expected to be done at the very least, and other than the federal mandate there is nothing helping CRPs figure out what they should be doing. Over the last three years, Alaska CRP has consistently examined its own work and it now follows, what the panel calls, a participatory evaluation approach due to reading through several legislative documents and Congressional hearings documents and what the panel now understands, as a purpose of CRPs, is that it is to be a conduit for public participation in child protection. He explained that at the federal level, the legislation gave the CRPs two specific tools, to evaluate, and to collect public opinion or public outreach. He described that as a challenge; however, at the moment the Alaska CRP stands high on the rank of the other states on the efficiency and effectiveness scale because it reaches out to many stakeholders across the state. Most of the Alaska CRP funding goes to traveling across the state and meeting with people as it conducts approximately 100 interviews and approximately 10 focus groups every year through site visits.

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The Alaska CRP is the only CRP with such a supportive and clear relationship with its state legislature and many CRPs are surprised the panel actually presents to this committee, he continued that the supportive relationship with OCS is among the best across the nation. He opined that if the panel makes a recommendation that is tangible, meaningful, and measureable for OCS to do something about, then certainly it will take it on. Although, if the recommendation is vague or too broad or requires a lot of funding then it is challenging for OCS to do anything with it. He reiterated that budget cuts are not pleasant for anyone and it was a surprise that \$18,000 was taken away from the amount allocated for the CRP this year, so it is cutting back on the number of members going on site visits, and today he had to testify telephonically.

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REPRESENTATIVE WOOL asked whether there is a concern that with the caseload and workload the frontline workers have and the turnover, that the number of recommendations may increase the cause of the workload. Although, recommendations need to be made and followed, it may be that added reports and added surveys exacerbates the problem, he said.

DR. VADAPALLI opined that anything that cannot be measured, cannot be changed. Therefore, if a project is not constantly assessed, it is unknown where the project is, or the way to go, or how far it's gone in achieving the desired result. In the event the director believes a recommendation will add to the workload, the panel is open to changing its recommendations to make it more meaningful to the agency. He noted that those questions happen constantly every month with the OCS leadership and this is a process that helps both OCS derived benefit from CRP and it assists the panel in refining its methods and means in the recommendations it makes. He reiterated that this is a useful process and the recommendations are not burdensome, and if they are they should be discussed.

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CHAIR SEATON referred to Online Resources for the Children of Alaska (ORCA) and noted problems such that everything had to be double entered, or the information had to be typed in, and he asked what progress had been made with ORCA becoming a more useable tool.

MS. LAWTON opined that OSC has come a long way with ORCA and every year enhancements are made to it to make is user friendly, as well as access to the ORCA help team with any questions. Features have been changed to reduce the number of things a worker has to type in and some of those are auto populations. Currently, there is a lot of duplication because OCS does not have laptops available for a worker to access ORCA when they are working in the field and everything must be written by hand. Court orders will now be directly linked to OCS and entered into ORCA, and OCS will have the capacity in ORCA, which is a money issue, to increase space and have the capability to scan more documents, such as original evaluations reports received from second parties into ORCA. The department is also working on a shared initiative such that there would be a vault where secure information could be scanned.

CHAIR SEATON related that he was happy to hear that because not long ago it was the bane of the entire department due to so much time being spent re-entering the same data, or it would be entered and then there would be a long span of time between transmission such that the worker had to go do another job and then come back and enter a few more lines. He asked whether it was at a point that a person can complete a full report and send it.

MS. LAWTON answered yes, absolutely, and she said the reality is that ORCA is now becoming an antiquated system nationally, and the division has been working with CGI that is the provider of contract services for the division on ORCA. Soon, nationally, there will be new data management models out there that will provide opportunities for states. She explained that the division bought the whole package from another state and, consequently, had to take it as is with as license and couldn't make it their own. She further explained that there will be new off-the-shelf opportunities where the division can pick and choose components to create its own system down the road. With technology advancing at its current rate it may not be ORCA again but the next time the division starts a new system it will be light years from where the division is now, she said.

CHAIR SEATON related that it might be one of those big helps for intake workers, reports, or whatever. He expressed appreciation to panel for its work and volunteer hours, and that the panel and division is working together so well to coordinate improvement to systems.

The Citizen Review Panel presentation was concluded.

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ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:19 p.m.