

**ALASKA STATE LEGISLATURE**  
**HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE**

March 7, 2017

3:07 p.m.

**MEMBERS PRESENT**

Representative Ivy Spohnholz, Chair  
Representative Bryce Edgmon, Vice Chair  
Representative Sam Kito  
Representative Geran Tarr  
Representative David Eastman  
Representative Jennifer Johnston  
Representative Colleen Sullivan-Leonard  
Representative Dan Saddler (alternate)

**MEMBERS ABSENT**

Representative Matt Claman (alternate)

**COMMITTEE CALENDAR**

PRESENTATION: SUBSTANCE ABUSE TREATMENT SYSTEM IN AK

- HEARD

HOUSE BILL NO. 138

"An Act establishing the month of March as Sobriety Awareness Month."

- HEARD & HELD

HOUSE BILL NO. 43

"An Act relating to prescribing, dispensing, and administering an investigational drug, biological product, or device by physicians for patients who are terminally ill; providing immunity related to manufacturing, distributing, or providing investigational drugs, biological products, or devices; and relating to licensed health care facility requirements."

- MOVED HB 43 OUT OF COMMITTEE

**PREVIOUS COMMITTEE ACTION**

BILL: HB 138

SHORT TITLE: MARCH: SOBRIETY AWARENESS MONTH

SPONSOR(S): REPRESENTATIVE(S) WESTLAKE

02/22/17 (H) READ THE FIRST TIME - REFERRALS  
02/22/17 (H) HSS, CRA  
03/07/17 (H) HSS AT 3:00 PM CAPITOL 106

BILL: HB 43

SHORT TITLE: NEW DRUGS FOR THE TERMINALLY ILL  
SPONSOR(S): REPRESENTATIVE(S) GRENN

01/18/17 (H) PREFILE RELEASED 1/13/17  
01/18/17 (H) READ THE FIRST TIME - REFERRALS  
01/18/17 (H) HSS, JUD  
02/28/17 (H) HSS AT 3:00 PM CAPITOL 106  
02/28/17 (H) Heard & Held  
02/28/17 (H) MINUTE(HSS)  
03/02/17 (H) HSS AT 3:00 PM CAPITOL 106  
03/02/17 (H) Heard & Held  
03/02/17 (H) MINUTE(HSS)  
03/07/17 (H) HSS AT 3:00 PM CAPITOL 106

**WITNESS REGISTER**

TOM CHARD, Executive Director  
Alaska Behavioral Health Association  
Juneau, Alaska

**POSITION STATEMENT:** Presented a PowerPoint about the substance abuse treatment system in Alaska.

KATE BURKHART, Executive Director  
Advisory Board on Alcoholism & Drug Abuse  
Division of Behavioral Health  
Department of Health and Social Services  
Juneau, Alaska

**POSITION STATEMENT:** Presented a PowerPoint about the substance abuse treatment system in Alaska.

REPRESENTATIVE DEAN WESTLAKE  
Alaska State Legislature  
Juneau, Alaska

**POSITION STATEMENT:** Presented HB 138, as the sponsor of the bill.

FORREST WOLFE, Staff  
Representative Dean Westlake  
Alaska State Legislature  
Juneau, Alaska

**POSITION STATEMENT:** Explained HB 38 on behalf of the bill sponsor, Representative Westlake.

GREGORY NOTHSTINE, President  
Sobermute Reviving Our Spirit  
Anchorage, Alaska

**POSITION STATEMENT:** Testified in support of HB 138.

BROOKE IVY, Staff  
Representative Jason Grenn  
Alaska State Legislature  
Juneau, Alaska

**POSITION STATEMENT:** Recapped HB 43 on behalf of the bill sponsor, Representative Grenn.

#### **ACTION NARRATIVE**

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**CHAIR IVY SPOHNHOLZ** called the House Health and Social Services Standing Committee meeting to order at 3:07 p.m. Representatives Spohnholz, Sullivan-Leonard, Johnston, Eastman, Edgmon, Kito, and Saddler (alternate) were present at the call to order. Representative Tarr arrived as the meeting was in progress.

#### **Presentation: Substance Abuse Treatment System in AK**

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CHAIR SPOHNHOLZ announced that the first order of business would be a presentation on the substance abuse treatment system in Alaska. She noted that the committee had recently focused on the opioid epidemic in Alaska, which deserved a lot of attention. She reminded the committee that the number one drug of choice in Alaska remained alcohol, and this was a huge drain on the state. She referenced a 2012 study by the McDowell Group which found that, in 2009, 9.5 percent of the Alaska population, ages 12 and older, were dependent on or abusing alcohol and drugs. She reported that, in 2010, this cost the economy \$1.2 billion. She pointed out that this was a legal, over the counter drug.

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TOM CHARD, Executive Director, Alaska Behavioral Health Association, explained that the Alaska Behavioral Health

Association was "a trade association of sorts, made up of mental health and drug and alcohol [treatment] providers across the state." He reported that there were about 60 members, both for-profit, non-profit, tribal, and non-tribal providers, and the association served all ages.

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KATE BURKHART, Executive Director, Advisory Board on Alcoholism & Drug Abuse, Division of Behavioral Health, Department of Health and Social Services, stated that they would provide an overview of the substance use disorder treatment system. She said they would tell a story based on information from people who had made the journey toward recovery, and provided an overview for how the system worked, its strengths and weaknesses. She added that they would also share the provider perspective. She estimated that about 11.5 percent of Alaskan adults needed substance use disorder treatment, and of those people, more than one third had a co-occurring mental illness, which made treatment that much more complicated. She reported that mental health disorders and substance use disorders "travel together more often than they travel apart."

REPRESENTATIVE JOHNSTON asked about the methodology for this estimate.

MR. CHARD replied that the National Survey on Drug Use and Health contacted individuals and asked them questions and, based on a clinical approach, determined who might be substance abuse dependent and might have a disorder. He explained that this statistical study used research to determine a trend basis and a state by state comparison for Alaska.

REPRESENTATIVE JOHNSTON asked if these were random telephone surveys.

MR. CHARD explained that the surveys were statistically randomized and were oversampled to ensure that they were statistically valid.

REPRESENTATIVE EASTMAN asked how old the survey results were and what the Alaska ranking was among states.

MS. BURKHART replied that these were the most current survey results and that she would follow up with the state ranking.

MR. CHARD offered his belief that these were the survey results from 2014 and 2015. He addressed slides 3 - 4, "Setting the Stage," and pointed out that the state funded programs only provided treatment to 7,808 people. He noted that, although there were private practitioners that did not receive state funds, the current discussion would focus on public source funds.

REPRESENTATIVE JOHNSTON asked if this included tribal funding.

MR. CHARD expressed his agreement.

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MS. BURKHART continued with slide 4, and stated that, based on the Behavioral Risk Factor Surveillance System and questions based on Adverse Childhood Experiences, 66 percent of Alaskans reported one or more adverse childhood experience. She reported that these experiences could range from the death of a parent, to child abuse and neglect, or incarceration of a parent. She reported that 21.4 percent of Alaskan adults reported growing up in a household with one or more adults experiencing mental illness; that 29.7 percent of Alaskan adults reported growing up in a household with one or more adults abusing alcohol or other drugs; and, that 19.5 percent of all Alaskan adults reported four or more adverse childhood experiences while growing up. She called this the dose response, as the more you had in your life, there was a compounding effect.

MS. BURKHART turned to slide 5, "Martha's Story," and introduced Martha, a fictional composite Alaskan, who is 30 years old, lives in a small rural community in Western Alaska, and experiences the consequences of significant childhood trauma and untreated depression, a moderate mental health disorder. She lives with her mother, who is also dependent on alcohol. Martha was convicted of DUI five years ago. She is a frequent user of the health clinic, seeking relief for a host of physical ailments and pain. She meets periodically with the itinerant mental health provider.

MR. CHARD addressed slide 6, "Missed Opportunities," and listed the mother's dependence on alcohol, the adverse childhood experiences, and the DUI as examples of missed opportunities for early intervention and a much more cost effective treatment outcome to mitigate the impact of the problems.

MS. BURKHART stated it was important to understand that the current substance abuse disorder treatment was funded and designed to serve the most acutely addicted, and that there was not a system designed for early opportunities for intervention. She explained that this was not a linear process, but was more "herky-jerky." She stated that Martha was at the pre-readiness stage, slide 7, as she knows that she has a problem and she was scared of the pain of opioid withdrawal and the fact that she was desperate enough to consider using street drugs. She was also scared that, when she tried to stop using opioids, she had thoughts of suicide, and she had no one to talk to. Martha has an appointment at the health clinic and the provider, who knows Martha well, administered a substance abuse screening as part of the appointment. Their conversation, supported by motivational interviewing techniques, allowed Martha to disclose that she was dependent on alcohol and other drugs, and she was scared of what might happen if she doesn't get help.

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MR. CHARD moved on to slide 8, and Martha divulges to her health care provider that she might have a substance abuse problem, the moment of clarity. Mr. Chard reiterated that this was not a linear path. This moment of clarity was an opportunity for the treatment system to intervene and to turn the tide. The problem was that a lot of people don't recognize their problem. Some of them do recognize, but don't seek treatment. Those who do seek treatment often face waitlists, or other challenges for treatment, which can include childcare, housing, or employment challenges. Only about 33 percent recognize they need treatment and try to get treatment, which he acknowledged as a big issue, nationally and regionally. He reported that the treatment provider had to meet the individual at the moment of clarity, as that moment could "pass in a blink of an eye."

MS. BURKHART turned attention to slide 9, reporting that Martha was ahead of the game as she already had a health care provider and she was receiving health care service in an integrated health system. Her clinic provider calls the behavioral health department at the larger health organization, gets Martha an appointment for her initial intake assessment, and then, Martha doesn't go, which Ms. Burkhart labeled as a standard eventuality, as the moment of clarity was fleeting. Martha makes another appointment, but she arrives late. The counselor realized that, based on Martha's history, she needs more than a basic substance abuse assessment, and, as she needs an integrated mental health and substance abuse assessment, another

appointment was made with a mental health professional through telehealth.

MR. CHARD shared slide 10, and referenced the integrated behavioral health assessment [Included in members' packets], which was based on the work of trained counselors and clinicians. He referenced the ASAM (American Society of Addiction Medicine) criteria as the instrument to determine the level of treatment and care, and then it was determined what the available resources were for the best treatment outcome. When the trained counselor does the exam, they find a level of care corresponding to the individual's needs. He directed attention to slide 11, the level of care. He reported that, unfortunately, the substance abuse treatment system was mostly geared for the later end of the treatment system. He noted that there were outpatient treatment service providers, as well as residential providers, and a few withdrawal management service providers.

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MR. CHARD addressed slide 12, "Levels of Care in Alaska," which included a sobering center (Bethel) with another due to open in Fairbanks in 2017; 3 withdrawal management centers, with another due to open in Soldotna in 2017; 21 residential treatment centers, with another due to open in Mat-Su in 2017; 2 non-profit Medication Assisted Treatment (MAT) with state grantee methadone programs (Anchorage, Fairbanks); 2 private for profit MAT programs offering methadone and buprenorphine, (Anchorage, Mat-Su); and 2 OCS-engaged parents treatment programs (Anchorage, Mat-Su). There were 45 outpatient substance use disorder treatment providers, noting that it was rare for multiple providers in one community to provide the same service.

MS. BURKHART shared that there was a sobering center in Anchorage which was funded by the municipality. She moved on to slide 13, and based on her assessment, the clinicians determined that Martha needed intensive treatment to help her withdraw from alcohol and opioids, a treatment not available in her village. Martha was nervous about going to a big city for treatment, fearing she would not go to the treatment facility and instead take advantage of the increased access to alcohol and opioids and go find people to use with. This was an important point in Martha's journey toward recovery, as she can seek the recommended level of treatment in an urban center or seek a less clinically appropriate alternative closer to home. Ms. Burkhart

noted the importance of the treatment process, the crux in the road, and either go to the level of care suggested by the clinical assessment treatment center, or stay and receive services at a lower level of care. Ms. Burkhart stressed that this was a crossroads that many people faced.

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MS. BURKHART directed attention to slide 14. There were currently 34 withdrawal management beds in Alaska, in Juneau, Anchorage, and Fairbanks, and, with last year's funding, there will be additional withdrawal management beds in Soldotna later in the year. She declared that some hospitals were able to do medically monitored detoxification if absolutely necessary, based on the medical needs.

MR. CHARD emphasized that the 34 withdrawal management beds served the entire population of the state, and he acknowledged that there were not enough of these beds. He pointed out that travel had to be arranged to get to the treatment and that there was a lot of coordination behind the scenes.

REPRESENTATIVE JOHNSTON asked for clarification between a management center and a detox center.

MR. CHARD relayed that the older term was detox, which was now being relabeled nationally as withdrawal management, partially in recognition that this was a much longer process.

REPRESENTATIVE JOHNSTON asked if this was for some drugs and alcohol, not necessarily just for opioids.

Mr. CHARD reiterated that there were acute problems from alcohol in Alaska, and that many of the withdrawal management beds were set up for alcohol, as people could die from detoxification of alcohol, whereas detox from many drugs was not as dangerous. He reported that, because of the emergence of complicated clients, there were a lot of new detox beds opening, particularly for opioid detoxification. He stated that these were all medically monitored services to maintain safety for the patient.

MS. BURKHART, in response to Representative Sullivan-Leonard, said that Nugens Ranch was a residential program, not a withdrawal management program. She returned attention to slide 14, and stated that the system was prioritized by these federal guidelines: 1) pregnant injecting drug users; 2) other pregnant drug users; and 3) other injecting drug users. She added that

there was additional state guidance, which prioritized families engaged with the Office of Children's Services. She relayed that it was a common occurrence for these priorities to supersede others on the wait list. As a bed was expected to become available in three weeks in Anchorage, Martha and her clinician worked together to develop a plan to help her maintain her treatment readiness while she waited for the withdrawal management bed. Ms. Burkhart declared that three weeks was a very long time to "remember that you want to get treatment."

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MS. BURKHART moved on to slide 15, and shared that, as Martha had identified a risk that she would divert from treatment on the way, the treatment team arranged to have family members take and wait with her at the village and hub airports. It was also arranged for the provider to pick her up at the Anchorage airport. Despite all the precautions and preparation, Martha showed up at the airport severely intoxicated, and was not allowed to board the flight to Anchorage. Martha's family member called the local treatment provider, who worked with the withdrawal management treatment team in Anchorage to hold the bed. Martha stayed with a family member overnight, and was taken to the airport the next day. Martha arrived in Anchorage and was met at the airport by someone from the withdrawal management center.

MR. CHARD directed attention to slide 16. Martha spends the next seven days in Anchorage in a medically monitored high intensity inpatient setting, a withdrawal management setting. The treatment team explored whether placement at a residential treatment setting closer to home following discharge from withdrawal management was available and was the best treatment option. This was another important point in Martha's journey toward recovery, as the discharge and placement process can either support or divert Martha's progress. He stated that this was one challenge of the treatment providers, getting ready for the next service setting, finding a new availability, and finding travel.

MS. BURKHART stated that it was important to recognize that for Martha to stay all seven days was a huge victory, as many people just walked out. She emphasized that maintaining the treatment readiness was very difficult, especially in the most acute time frame.

MR. CHARD added that, as these were all voluntary treatment programs, the individual would go through the necessary level of treatment, feel better, and then leave the program with the idea of doing it by themselves.

MS. BURKHART shared slide 17, and said that Martha was ready for an intensive residential program. There were about 315 residential treatment beds in Alaska today, which included the aforementioned Nugens Ranch. She pointed out that the residential treatment programs were not one size fits all, as some were for males only, some were for women only, and some were co-ed. Some were for women with children. Some programs were 30-90 days long, some were 6-12 months long, and each one had unique features for specific client populations. She pointed out that there would be additional capacity for women with children in the Matanuska-Susitna Valley thanks to three years of funding appropriated by the Legislature last year.

MR. CHARD pointed out that the Institutions for Mental Diseases (IMD) exclusion, slide 18, dated back to the 60s, early in Medicaid, to prevent tearing down state psychiatric hospitals just to build community psychiatric hospitals. One of the challenges faced by residential substance use disorder treatment providers was for this IMD Exclusion, which prohibited the use of Medicaid for care provided to people in mental health and substance use disorder residential treatment facilities larger than 16 beds. Flat funding and funding cuts in both grants and Medicaid have resulted in staffing shortages that make it difficult to fully utilize the residential beds that are available. As funding has been cut, facilities cannot adequately staff all the beds, and this has created an opportunity, as not all the beds are being fully utilized.

MS. BURKHART addressed slide 19, and asked "What if there is no residential treatment bed available or what if there's not one available on a realistic time horizon." She stated that one option was for Medication Assisted Treatment (MAT), which was an evidence-based treatment for opioid and/or alcohol dependence. It combined medication with behavioral health treatment to help the person achieve and maintain recovery. Opioid dependence MAT and alcohol dependence MAT had been shown to increase retention in treatment, decrease illicit opiate use and criminal activity, increase employability, improve birth outcomes among pregnant addicted women, and lower risk of contracting HIV or Hepatitis C by reducing the potential for relapse. Medication Assisted Treatment was available through some community health centers, community behavioral health centers, and private physicians'

offices, slide 20. Methadone treatment was available in Fairbanks, Anchorage, and Wasilla, and MAT capacity had been actively expanded thanks to a federal grant from the Department of Health and Social Services, focusing on building capacity in Anchorage and Juneau.

REPRESENTATIVE TARR asked about federal restrictions to expanding MAT.

MS. BURKHART replied that not anyone can provide MAT treatment. If a physician or a nurse practitioner wanted to provide treatment, licensing was required by the state and federal governments, and there was a limit to the number of clients served. She stated that the methadone programs were the most rigorously regulated. Many other medications were also effective for pain management, and there were no limits on the pain management practices. She declared: "same medications, different regulatory structures."

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MS. BURKHART moved on to slide 21, and said that Martha wanted to find a residential program closer to her home community. There was a culturally relevant, appropriate clinical level program in her region, which would have an opening in about two weeks. Martha can't stay at the withdrawal management treatment center for the two weeks while she has to wait for the opening in residential treatment, which creates a warning for the opportunity to divert off the recovery journey. She works with the treatment team at the withdrawal management center, her behavioral health provider at home, and a case manager to come up with a plan for those two weeks. Martha can go back to the hub community and stay with a family friend who is sober and willing to help her stay sober during those two weeks. Martha can also attend the nightly AA meetings hosted at the residential treatment center where she was planning to go. This would also help her to establish a relationship with the treatment provider.

MR. CHARD directed attention to slide 22. Martha spends six weeks in the residential treatment program, and then, after residential treatment, Martha needs to move to a lower level of outpatient treatment to build on the progress she has made. At each of these steps there is risk for diversion from the road to recovery. Martha was able to transition to outpatient treatment in the hub community, staying with family. Transitioning from the structure of residential treatment to outpatient treatment

was another critical point in Martha's recovery journey. Martha's social and familial networks contributed to and supported her alcohol and drug use.

MS. BURKHART discussed the opportunity for relapse and the need for a relapse prevention plan, slide 23. Martha was invited to a family birthday party, and although she really wanted to go, she knows that it's a risk to her sobriety. She has a safety/relapse prevention plan that she and her clinician developed as part of her outpatient treatment plan. There was alcohol at the party, and everyone was drinking. Martha makes it through most of the evening, but then decides "one beer won't hurt," and she drinks until she passes out. The next day, she is very hung over and someone offers her prescription opioid pain pills to "take the edge off." Martha takes her usual dose of pills, but because she's been sober for almost 60 days, she doesn't have the same tolerance, and she overdoses. Ms. Burkhart stated that this happens with great frequency for people who don't realize how their tolerance has waned with prolonged sobriety.

MR. CHARD shared slide 24, and relays that the first responders had Narcan onboard, so they were able to save Martha when they responded to her overdose. Martha's outpatient treatment provider talks to Martha about going back into a residential program to help her avoid a long-term relapse. Martha was worried that she won't be able to stay sober in her home community. She works with her clinicians to find a residential treatment program that includes aftercare, transitional living and recovery support services. He added that, although Narcan can save a life, it was not treatment.

MS. BURKHART addressed slide 25, and shares that Martha decides to go to another residential program because she was struggling to stay on her chosen road. Martha moves successfully through the levels of treatment offered by the substance use disorder treatment provider. During that time, she connects with other people in recovery and starts to build a support network for healthy and stable social networks to maintain recovery. She was homesick, but she was also afraid of relapse. Martha worked with a case manager to address barriers to her recovery: find stable housing; connect with vocational rehabilitation for employment; work with the primary care provider regarding actual health conditions; and find healthy alternatives in the community which did not include drinking. She points to slide 26, and declares that Martha celebrated 12 months of sobriety. She was working full-time and sharing an apartment with a

friend. She went to the 12-step meetings 3-4 times each week for support. Martha was seeing a mental health professional to address the underlying mental health issues that had been masked by drug and alcohol use. The coping skills she was learning in therapy helped her navigate the triggers that might lead her to drink or want to use again. Martha felt strong enough in her recovery to go home to visit her mother. They had a good visit. She reported that for those working to achieve recovery in a new environment, going home was a big deal, as it could be an opportunity to address many triggers.

MR. CHARD shared slide 27, and noted that several points along the journey to recovery hinted at problems the substance use disorder treatment providers had that were hampering their ability to provide the support she needs. Providers and policymakers were working together to address the larger challenge that was affecting healthcare delivery systems across the country: Access; Quality; and Cost.

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MS. BURKHART turned to slide 29, "Patient & Provider Stigma." She spoke about an earlier presentation regarding the science of addiction, and noted that individuals with a substance use disorder were not treated the same as individuals with other disorders and diseases. Substance use disorder treatment providers were not treated the same as other healthcare practitioners, as there was a stigma attached, in how we pay them, the documentation that we require of them for oversight, and how we credential them. The stigma was beyond the person needing help, and affected everyone involved in helping that person.

MR. CHARD spoke about slide 30, reporting that the Behavioral Health providers in Alaska were required by regulation (7 AAC 70.150) to be accredited by a national accrediting body (Joint Commission, CARF, COA, or other). Accrediting bodies maintained strict standards that ensured adequate oversight of clinical and business practices, treatment effectiveness, and continuous quality improvement. There was duplicative reporting, documentation, and oversight requirements that diverted resources from treatment. The 2014 Streamlining Initiative was a successful public/ private partnership to help address these issues.

MR. CHARD reported that Alaska was constantly recruiting for more qualified people in the substance use disorder workforce,

as it was an area of job growth in the economy, with good pay and benefits in communities across the state, slide 31.

MS. BURKHART moved on to slide 32, and spoke about The Peer Support workforce, a relatively untapped opportunity that had a lot of potential to fill vacancies with individuals who have lived experience that could help inform treatment and improve outcomes. The way a person's criminal background check was conducted was still a major hurdle, as people in recovery could have a felony, which was a disqualifier for many health care professions. Peer Support providers were not currently credentialed, and it would be necessary to expand the ability for reimbursement. She relayed that telehealth was a critical component to the behavioral health system, and was often used by substance use disorder treatment providers to tap into outside expertise.

MR. CHARD said that substance abuse treatment providers were predominantly funded by unrestricted grant funding, although there was some designated grant funding from the current alcohol tax. He said that Medicaid Expansion would allow more individuals to qualify. He noted that this was also changing the treatment system with a transition toward a Medicaid reimbursement, even though Medicaid rates did not actually cover the cost of care. He said that rates had not been changed since 2006, slide 34. He stressed that there were still some services which Medicaid would not pay for.

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MS. BURKHART stated that, as it was not possible to provide every service in every community, it was necessary to ensure that publicly funded substance use disorder treatment providers operated in concert across the State of Alaska, each as a critical component in a larger system of care. That system of care strives to meet every individual where they are on their journey and help them achieve recovery. It was a customized approach, operating in a system that seeks uniformity for policy and funding purposes. It was challenging for trained clinicians to find the best resources available to assist people in their journey to recovery. It was extremely difficult for someone, especially in crisis, to navigate the system themselves. She relayed that enrollment in Alaska 211 had been encouraged to all the service providers, slide 35.

MS. BURKHART reported that substance use disorders were incredibly complex, and the people who experienced them have

many behavioral, physical, and social needs. The substance use disorder treatment system was difficult to navigate, and there were multiple transition points where a recovery process could be derailed. Just as teams of health care professionals work together to serve clients, Department of Health and Social Services, the Alaska Behavioral Health Association, and other stakeholders were working together to maintain and strengthen the system. She stated that this was "a pretty strong relationship," slide 36.

REPRESENTATIVE JOHNSTON asked about the possibility for an 1115 waiver.

MS. BURKHART said that she had participated on the writing team and the policy team for the concept paper. She had positive conversations with the Centers for Medicare and Medicaid Services, regarding the concept paper [Included in members' packets]. She stated that federal healthcare policy was currently up in the air. She emphasized that they were moving forward with the process, and that the application would be submitted this summer.

REPRESENTATIVE JOHNSTON stated that while she was reading the grant book, she had found duplication and intertwining of grants, and she opined that it was not a very clear system, even as she could see legislative intent in some of the grants. She said that a lot of these were not federal pass through, and that there was a need to readdress some of these grants. She declared that she was in total support of non-profit organizations. She lamented that lack of benchmarks. She offered her belief that speaking of the stigma was not fair, as no one had the answers.

MS. BURKHART replied that she had looked at all the FY16 grants. She explained that you had to be a grantee in order to bill Medicaid, hence the very small grants.

REPRESENTATIVE EDGMON said that the narrative helped illustrate that Martha could have had kids, she could have been an FASD baby, and there could have been domestic violence involved. He declared that it was an inherently complicated issue.

REPRESENTATIVE TARR offered her belief that the need far exceeded the amount of service available, hence the appearance of overlap for the grants. She opined that an organization could not get too big without losing the personal touch and the

intensive management support toward recovery, and that this could be the reason for the appearance of similar services.

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MR. CHARD acknowledged that the capacity for services could not meet the demand. He pointed out that there were 34 withdrawal management beds for 740,000 people. He said that each of the treatment providers worked to employ evidence based practices, and some of these models were in smaller settings. He stated that it depended on the client's needs, and what treatment program would work best. He asked that the committee mention any programs that appeared duplicative, as he may be able to explain any differences. He pointed out that some serve the kid population, and some serve the adult population.

REPRESENTATIVE SULLIVAN-LEONARD stated that Martha was a clear description of anyone in Alaska. She mentioned that she had not noticed any treatment component for faith based groups in the state. She said that the Department of Corrections had declared that the faith based treatments within the correctional facility were successful.

MS. BURKHART replied that some state programs were faith based, and they were often part of the system. She relayed that the clinical and accreditation requirements to be part of the system were the same for everyone. She allowed that having the choice to pursue was good, but there were not always many options.

CHAIR SPOHNHOLZ stated that addiction treatment was a very personal experience and that it was necessary to find a treatment experience that aligned with your values. She reflected on the pauses necessary for treatment, and that the challenge was when someone would show up ready for treatment, but without immediate availability, and the person would often relapse. She asked if there had been any research for solutions to this problem.

MR. CHARD expressed his agreement that, although elasticity for the system was important, there were not enough treatment programs and providers for the need. He emphasized that services cost money, and resources were necessary. He declared that innovations in peer support and telemedicine, among others, were helping to address this question.

MS. BURKHART added that one area which had not been explored enough were the natural helpers in the community, and the

resources available from tribal or extended families. As a system, she asked how the community would keep someone safe until there were openings.

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The committee took a brief at ease.

**HB 138-MARCH: SOBRIETY AWARENESS MONTH**

[4:28:32 PM](#)

CHAIR SPOHNHOLZ announced that the next order of business would be HOUSE BILL NO. 138, "An Act establishing the month of March as Sobriety Awareness Month."

[4:28:42 PM](#)

REPRESENTATIVE DEAN WESTLAKE, Alaska State Legislature, stated that proposed HB 138 designated the month of March, each year, as Sobriety Awareness Month. He relayed that this was to help and support all those people who have struggled. The proposed bill would provide the opportunity for schools, community groups, and other entities to recognize, appreciate and celebrate those Alaskans that choose to live a life of sobriety. Individuals that lead sober lives are an asset to Alaska in that they can help reduce the incidence of alcohol or drug related social ills such as crime, recidivism, domestic violence, child abuse and neglect. He relayed an experience with a group of empowering stories of sobriety at a gathering.

[4:30:22 PM](#)

FORREST WOLFE, Staff, Representative Dean Westlake, Alaska State Legislature, read from the Uniform Alcoholism and Intoxication Treatment Act [Included in members' packets]:

It is the policy of the state to recognize, appreciate, and reinforce the example set by its citizens who lead, believe in, and support a life of sobriety.

MR. WOLFE offered his belief that a permanent designation of March as Sobriety Awareness Month would help the State of Alaska meet this declaration of policy.

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GREGORY NOTHSTINE, President, Sobermute Reviving Our Spirit, said that he was aware the Alaska State Legislature was the first in the nation to pass a statute recognizing appreciation and reinforcement of citizens for living a life of sobriety. He said that there were elders and senior citizens who were not recognized for contributions and efforts for building a safer community. He offered his belief that millions of dollars were spent on treatment centers, whereas, this proposed bill was reinforcing appreciation of its citizens. He expressed his support of the proposed bill.

REPRESENTATIVE JOHNSTON stated that she was glad this was March, as, she opined, spring could be a very stressful time, when alcohol "rears its ugly head and suicide." She suggested that celebrations and festivals in March were great. She stated her support for the proposed bill.

REPRESENTATIVE EDGMON offered his belief that "tribes" could be added to the wording in the proposed bill.

[4:34:48 PM](#)

REPRESENTATIVE SPOHNHOLZ shared that she had been sober for 14 years, and that celebrating sobriety as a healthy lifestyle choice for Alaskans was a step in the right direction for our community to come together in March every year. She stated that making it dedicated forever showed commitment from the state. She stated her support for the proposed bill.

[HB 138 was held over.]

**HB 43-NEW DRUGS FOR THE TERMINALLY ILL**

[4:35:48 PM](#)

CHAIR SPOHNHOLZ announced that the final order of business would be HOUSE BILL NO. 43, "An Act relating to prescribing, dispensing, and administering an investigational drug, biological product, or device by physicians for patients who are terminally ill; providing immunity related to manufacturing, distributing, or providing investigational drugs, biological products, or devices; and relating to licensed health care facility requirements."

[4:36:12 PM](#)

BROOKE IVY, Staff, Representative Jason Grenn, Alaska State Legislature, recapped the proposed bill, and stated that it would streamline an existing process through the U.S. Food and Drug Administration, the Compassionate Use Program, which allowed for those diagnosed as terminally ill to access investigational medications outside the clinical trial process in an effort to save their own lives. The proposed bill would allow terminally ill patients to work directly with their doctor and the drug manufacturer, given informed consent, to access those treatments.

[4:37:13 PM](#)

CHAIR SPOHNHOLZ opened public testimony on HB 43. There being no one to testify, she closed public testimony.

[4:37:59 PM](#)

REPRESENTATIVE EDGMON moved to report HB 43 out of committee with individual recommendations and the accompanying fiscal notes.

[4:38:09 PM](#)

REPRESENTATIVE EASTMAN objected. He stated there was "a very wide gap between the purposes for which a drug is tested and the actual uses that we are now giving physicians immunity for, and that's concerning to me."

[4:38:45 PM](#)

A roll call vote was taken. Representatives Spohnholz, Tarr, Sullivan-Leonard, Johnston, Eastman, Edgmon, and Kito voted in favor of HB 43. Therefore, HB 43 was reported out of the House Health and Social Services Standing Committee by a vote of 7 yeas - 0 nays.

[4:39:49 PM](#)

#### **ADJOURNMENT**

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:39 p.m.