

**ALASKA STATE LEGISLATURE**  
**HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE**  
Anchorage, Alaska  
June 24, 2020  
9:34 a.m.

**MEMBERS PRESENT**

Representative Tiffany Zulkosky, Chair  
Representative Ivy Spohnholz, Vice Chair (via teleconference)  
Representative Matt Claman (via teleconference)  
Representative Harriet Drummond (via teleconference)  
Representative Geran Tarr  
Representative Sharon Jackson  
Representative Lance Pruitt (via teleconference)

**MEMBERS ABSENT**

All members present

**OTHER MEMBERS PRESENT**

Representative Kelly Merrick (via teleconference)  
Representative Zach Fields (via teleconference)  
Representative Bryce Edgmon (via teleconference)  
Senator Wilson (via teleconference)

**COMMITTEE CALENDAR**

PRESENTATION(S): COVID-19 IN ALASKA: AN UPDATE ON PANDEMIC  
RESPONSE & MITIGATION STRATEGIES.

- HEARD

**PREVIOUS COMMITTEE ACTION**

No previous action to record

**WITNESS REGISTER**

ANNE ZINK, MD, FACEP, Chief Medical Officer  
Central Office  
Division of Public Health  
Department of Health and Social Services  
Anchorage, Alaska

**POSITION STATEMENT:** Co-provided a PowerPoint Presentation, entitled "House Health and Social Services Committee Update: COVID-19 in Alaska."

JOE MCLAUGHLIN, MD, MPH, Chief and State Epidemiologist  
Section of Epidemiology Division of Public Health  
Department of Health and Social Services  
Anchorage, Alaska

**POSITION STATEMENT:** Co-provided a PowerPoint presentation, entitled "House Health and Social Services Committee Update: COVID-19 in Alaska."

TARI O'CONNOR, MSW, Deputy Director  
Central Office  
Division of Public Health  
Department of Health and Social Services  
Anchorage, Alaska

**POSITION STATEMENT:** Co-provided a PowerPoint presentation, entitled "House Health and Social Services Committee Update: COVID-19 in Alaska."

COLEMAN CUTCHINS, PharmD, BCPS  
Epidemiology  
Office of Substance Misuse & Addiction Prevention  
Division of Public Health  
Department of Health and Social Services  
Anchorage, Alaska

**POSITION STATEMENT:** Co-provided a PowerPoint presentation, entitled "House Health and Social Services Committee Update: COVID-19 in Alaska."

ADAM CRUM, Commissioner  
Department of Health and Social Services  
Anchorage, Alaska

**POSITION STATEMENT:** Co-provided a PowerPoint titled "Reopening Alaska Responsibly; Data-informed Mandates and Health Alerts."

HEIDI HEDBERG, MPP, Director  
Central Office  
Division of Public Health  
Department of Health and Social Services  
Anchorage, Alaska

**POSITION STATEMENT:** Co-provided a PowerPoint presentation titled "Reopening Alaska Responsibly; Data-informed Mandates and Health Alerts."

SANA EFIRD, Assistant Commissioner

Department of Health and Social Services  
Juneau, Alaska

**POSITION STATEMENT:** Answered questions during the presentation.

MARY SWAIN, Executive Director  
Camai Community Health Center  
Naknek, Alaska

**POSITION STATEMENT:** Provided information during the presentation on COVID-19 in Alaska.

HELEN ADAMS, MD, Emergency Medicine  
Providence Alaska Medical Center  
Anchorage, Alaska

**POSITION STATEMENT:** Provided information during the presentation on COVID-19 in Alaska.

MICHAEL BERNSTEIN, MD, Chief Medical Officer  
Providence Alaska Medical Center  
Anchorage, Alaska

**POSITION STATEMENT:** Provided information during the presentation on COVID-19 in Alaska.

#### **ACTION NARRATIVE**

[9:34 a.m.]

[Due to technical difficulties, the audio was not picked during the first few minutes of the recording; however, the key points were noted by the secretary.]

**CHAIR TIFFANY ZULKOSKY** called the House Health and Social Services Standing Committee meeting to order at 9:34 a.m. Representatives Jackson, Tarr, Zulkosky, Spohnholz (via teleconference), Claman (via teleconference), Pruitt (via teleconference), and Drummond (via teleconference) were present at the call to order. Other legislators present were Representatives Merrick and Fields (via teleconference).

#### **PRESENTATION(S): COVID-19 in Alaska: An update on pandemic response & mitigation strategies.**

CHAIR ZULKOSKY announced that the only order of business would be a presentation, entitled "COVID-19 in Alaska: An update on pandemic response & mitigation strategies."

[9:37:00 AM](#)

ANNE ZINK, MD, FACEP, Chief Medical Officer, Central Office, Division of Public Health, Department of Health and Social Services, co-provided a PowerPoint Presentation, entitled "House Health and Social Services Committee Update: COVID-19 in Alaska." She began the presentation with the first two slides. Slide 1 introduced the presentation and Dr. Zink's team before the committee. Slide 2, "COVID-19 Overview," next introduced Dr. Zink's portion of the presentation. Dr. Zink continued through to slide 3, giving a brief overview of COVID-19 internationally, nationally, and in the state of Alaska. Dr. Zink stated that COVID-19 infection rates had continued to climb both nationally and internationally. The Department of Health and Social Services (DHSS) continued to watch this because how the world pandemic is managed internationally makes a big impact on Alaska. She then continued to slide 4. This slide showed comparisons between Alaska's infection rates and the rest of the United States as normalized by population. Dr. Zink noted that Alaska had not been hit as badly as other states by COVID-19. This continues to be an ongoing effort and something DHSS continues to watch closely on a day-by-day basis.

DR. ZINK then showed slide 5, "Confirmed Cases by Onset Date." She explained this as "our epidemiology curve" and then stated that DHSS announced new cases every day, but that it is important to figure out when the onset date was - when the symptoms began or when they tested positive - whichever came first. This is to help understand the epidemiology of the disease. She explained that because of this, the case numbers on slide 5's graph often changed as cases were further investigated. Dr. Zink further explained the color coding of the graph, noting that each color represents a city or region, red being Anchorage, green as Fairbanks, and orange as the Kenai Peninsula. As seen on this graph, she noted the first wave was a combination of a lot of areas, but a lot of that was Fairbanks and Anchorage. The second wave started off in the Kenai Peninsula area, as well as Anchorage. Dr. Zink stated that DHSS will continue to update the dashboard as it receives more information and feedback so as to provide the public with real-time information and transparency regarding what is happening with COVID-19 in the state of Alaska.

[9:39:36 AM](#)

DR. ZINK then showed slide 6, "Cumulative Cases." This is a summary slide showing active cases, recovered cases, and deaths of residents. Dr. Zink explained that as shown on this slide, a total of 778 Alaska residents had tested positive for COVID-19.

She related that 129 non-residents who are not shown on this graph but are shown on "the dashboard," [a tool on the DHSS website used to present the public with up to date COVID-19 statistics], had also tested positive at this point. The slide also showed 63 people in total had required hospitalization, and there was a total of 12 deaths and a total of 502 recovered patients. Dr. Zink went on to offer statistics not on the slide for the committee's awareness. She reported there were 21 additional cases on 6/24/20: 7 out of state, of which 2 are in mining, 1 in seafood, 1 visitor, and 1 unknown; and 14 Alaska Residents, of which 7 are in Anchorage, 1 from Ketchikan, 1 from Palmer, 1 from North Pole, 1 from Chugiak, 1 from Matanuska-Susitna (Mat-Su), and 1 from Fairbanks. At this time Alaska also had 14 patients who were hospitalized or were in the hospital under investigation for possible COVID-19.

DR. ZINK continued onto the next few slides starting with slide 7, entitled "Time-varying Reproductive Number ( $r_T$ )." She explained that this is going to be modified and varied based on how much Alaskans interact as individuals and how much contact tracing and isolation takes place. This really shows the ability of this disease to move from one person to another. [The  $r_T$  value] is modifiable by the way individuals interact with each other, the way they wear their masks, clean their hands, and other preventative measures that have been discussed. The  $r_T$  value is just below one, but during the spikes it has picked up above one and then was brought back down. Dr Zink noted for the committee that with a geographically diverse population, as well as low numbers of people, these modeling and statistic efforts are always limited.

DR. ZINK next presented slide 8, showing geographic variances of where there have been cases amongst the state [of Alaska]. She then explained that DHHS plans on changing some additional aspects of its dashboard to active cases as a rolling 14-day average per 100,000 people so that there is better graphic clarity showing where there are [current] cases.

[9:42:05 AM](#)

DR. ZINK then moved on to slide 9, entitled "Hospital Capacity," which showed data on available hospital beds, ICU beds, ventilators, and people who are being hospitalized. She expressed appreciation for the partnerships with healthcare providers who are helping to build up healthcare capacity. The information, she explained, was brought to DHSS by the Alaska State Hospital and Nursing Home Association (ASHNHA) as it

collects this data daily. Dr. Zink noted that many factors go into inpatient beds, ICU, and ventilator capacity outside of COVID-19. Hospitals in Alaska can be overwhelmed with influenzas or respiratory syncytial virus [RSV] on a bad year, so DHSS intends to keep watching these numbers closely. Dr. Zink further noted that the numbers shown did not represent the other work and telehealth that healthcare providers and the medical system were putting towards COVID-19.

[9:43:02 AM](#)

DR. ZINK next presented slide 10, "COVID-19 Signs and Symptoms." She noted that one of the really challenging things about this disease is that the signs can be very vague, they can be very mild, and they can look like a lot of other things, including allergies, colds, or just not feeling well. Typically, for those who are older or have significant underlying medical conditions, it can be hard to pick up on just from clinical signs and symptoms alone. Dr. Zink further explained that the medical community is still trying to understand the roll of asymptomatic and pre-symptomatic spread, but, she noted, there is clearly a roll that happens there. Another thing about this disease, Dr. Zink added, is that it is highly contagious, and people can pass the disease from one person to another before they develop any symptoms.

DR. ZINK then moved onto slide 11, "Our Goal: Widespread, Simple, Affordable Testing." She stated that because of the challenge of diagnosing COVID-19 by signs and symptoms alone, testing becomes a very important tool to identify these cases. Testing continues to be a challenge worldwide and nationwide, which will be addressed on later slides, she explained. She related that DHSS's goal was widespread, easy, and accessible testing for anyone who is symptomatic, particularly early on in the symptoms, as that is the most useful point of that testing. The department has added and will continue to add numerous layers of asymptomatic testing, particularly for high-risk individuals, as well as those who are at a higher risk to transmit the disease. This includes pre-procedural screenings, pre-dental screenings, screenings for admissions to health care and congregate settings such as long-term care facilities, testing for travel related cases, as well as use in outbreak investigations.

[9:44:41 AM](#)

DR. ZINK then introduced slide 12, "Supporting Alaskans Through COVID," and stated that a lot of work was being done to try to support Alaskans through the pandemic. She acknowledged that [COVID-19] has been very challenging and observed that the general population was "over" COVID-19 that it was "no fun," but COVID-19 sets the time table and [Alaskans must] continue to try to find ways to be resilient and healthy. Between blog posts and individual reach outs and community leadership meetings [it is important to] try to find ways to support Alaskans through COVID-19.

Dr. Zink closed her portion of the presentation with slide 13, "Supporting Businesses Through COVID," acknowledging that businesses have taken a huge toll. She admired the amazing ability for businesses to stand up in this challenging environment, be creative and inventive, and find ways to both mitigate the disease and stay open. She concluded that it is important to remember that the virus is the enemy here and not each other and seeing businesses to come together to mitigate this disease has been fantastic. Dr. Zink also mentioned that DHSS has a new website as well as many tools for businesses to help mitigate the spread of COVID-19.

[9:45:45 AM](#)

JOE MCLAUGHLIN, MD, MPH, Chief and State Epidemiologist, Section of Epidemiology Division of Public Health, Department of Health and Social Services, continued the PowerPoint presentation begun by Dr. Zink, drawing attention to slide 14, beginning his portion of the presentation: "Epidemiology." He moved to slide 15, "Contact Tracing and Case Investigation." Dr. McLaughlin stated that, until there is an effective vaccine or treatment for COVID-19, [the public] needs to continue to rely on non-pharmaceutical public health interventions to slow the spread of this virus. He then discussed one of the main interventions, "containment," which has been informally referred to as "boxing in the virus." The first step of containment, he continued, involves the rapid identification of new cases of illness which is generally aided through widespread availability of testing. This is followed by isolation of these new contacts and then interviewing them to identify their close contacts. This process is called contact tracing. Next, Dr. McLaughlin explained, close contacts are notified of their exposure and [the contact tracers] let them know they need to quarantine for 14 days. This is then followed by testing. Initially, DHSS was only testing if a patient had signs or symptoms of illness, but more recent guidance from the Center for Disease Control (CDC)

suggests that anybody [who has come in contact with the virus should] get tested, even if the individual doesn't have any symptoms. This is because many individuals who are infected never develop any symptoms at all.

[9:47:43 AM](#)

DR. MCLAUGHLIN prefaced slide 16, entitled "Types of Testing" with some background information. He underlined the importance of understanding the windows of time when [the different tests] can detect [the virus]. First, he explained, it is important to know that the incubation period for COVID-19 can range from 2 to 14 days, with an average of 5 days. This means it may take 2 to 14 days to develop symptoms after exposure for an infected person to become symptomatic. The second piece of background information he felt is relevant is that an infected person is releasing the highest concentration of the virus in his/her respiratory secretions about 2 days before symptom onset and lasting about 3 days. This is when one is most likely to transmit the virus to other people. The third piece of background information he shared is that the body begins making anti-bodies to the virus during the second week after symptom onset.

DR. MCLAUGHLIN redirected the committee's attention to slide 16. The first figure he noted was the blue line. This figure shows the time frame when a nasopharyngeal swab, the swab that goes into the back of the nose, is most likely to be positive by a polymerase chain reaction (PCR) test when a person is infected with the COVID-19 virus. He then pointed out that the curve [on the slide] is highest during the period when an infected person's body is secreting the most virus. The PCR test is used to diagnose acute infections. Dr. McLaughlin next addressed the dashed green line. This line represents when Immunoglobulin G(IgG) antibodies are detectable in an infected individual's body. He reiterated that it starts during the second week after symptom onset, peaks during the third week, but then remains elevated for weeks. He clarified that the medical community did not yet know how long it remained elevated, possibly months. Dr. McLaughlin concluded this slide by explaining that this tool is useful for detecting prior infections, but that it is not recommended for diagnosing acute illness in patients.

[9:50:49 AM](#)

DR. MCLAUGHLIN introduced slide 17, "Notification of Patients and Communities." Dr. McLaughlin began by explaining that once

an acute infection is diagnosed in a patient, this sets off a "notification cascade." First, the laboratory that performed the test is responsible for notifying the provider who ordered the test whether the test is positive or negative, as well as notifying the Division of Public Health. Then the provider is responsible for notifying the division of the positive test result, as well as notifying the patient. Once the division gets notified, Dr. McLaughlin continued, the case is assigned to a contact tracer who interviews the patient and then notifies close contacts of their exposure. The Division of Public Health also notifies the public of new cases, primarily through the DHSS website, as well as via press releases and social media. Other stakeholders [such as community officials] may be notified by DHSS staff if necessary, such as when outbreaks are detected within a facility or community.

DR. MCLAUGHLIN continued to slide 18, "Outbreaks -- Definition and Response." He began by posing the question of how an outbreak of COVID-19 is defined. Dr. McLaughlin defined an outbreak as "two or more laboratory confirmed cases in a population with onset dates within a 14-day period, and these people have to be epidemiologically linked. We need to know that they had some contact with each other, and they do not share a household, and they were not identified as close contacts with each other in another setting during standard case investigation or contact tracing." He acknowledged that this is a complex definition and went on to clarify with an example. He stated that it is like if the virus spread within a facility such as a workplace, a long-term care facility, or a fish processing plant.

DR. MCLAUGHLIN moved to slide 19, "Immunity and Repeat Infection." He posed the question, "Are we immune from the infection if we have recovered from a prior infection, and if so, how long are we immune?" He explained that [the scientific community] still doesn't know the answer. Based on what is known about other viral respiratory infections, including other human coronavirus infections, Dr. McLaughlin continued, most people do develop some level of immunity. The duration of immunity varies. For some human coronaviruses aside from COVID-19, the durability of that immunity is about one year, give or take some months. [The scientific community] doesn't know how long immunity will be conferred for COVID-19 amongst people who have had an infection.

[9:54:49 AM](#)

DR. MCLAUGHLIN then offered an aside of further background information, stating that it is unknown what proportion of the population needs to be infected to confer herd immunity. He defined herd immunity as the proportion of the community that needs to be immune to this virus in order to prevent widespread transmission in the community. He offered a possible projection that herd immunity will result when 60-70 percent of the population becomes immune to the virus. He then clarified that Alaska has a long way to go before reaching herd immunity. He cited the 778 reported cases to date and explained that even if this figure is grossly underestimated by tenfold, that is still about 1 percent of the state's population.

[9:56:02 AM](#)

CHAIR ZULKOSKY asked Dr. McLaughlin to repeat his previous statement and asked where Alaska was in terms of its current immunity.

[9:56:15 AM](#)

DR. MCLAUGHLIN repeated his explanation of herd immunity and added that most likely less than 1 percent of the population of Alaska was immune at this point. He clarified that it is unknown the actual percentage of Alaskans infected with COVID-19; all that is known is the reported case numbers, about .1 percent of the population. Because of Alaska's contact tracers and slow infection rate, he felt [DHHS] has done a good job tracking the case count, although he acknowledged that some cases have most likely gone unreported.

DR. MCLAUGHLIN then resumed his portion of the presentation on his last slide, titled "Vaccination." He explained how vaccines work by tricking the immune system to develop antibodies. Dr. McLaughlin informed the committee that there are over 135 vaccines in development, and in a best-case scenario many of these would be found safe and effective. This would give manufacturers and distributors many options to make and ship vaccine across the globe. The United States Government has focused on developing three vaccines for phase three trials under Operation Warp Speed, one by the company Moderna, one by Pfizer and BioNTech, and one by the University of Oxford and AstraZeneca. Dr. McLaughlin then discussed the CDC's plans for distribution of a vaccine once one was proven safe and effective. The CDC outlined a two-phase distribution plan. First, it planned to target "priority groups" through "mass vaccination clinics" with the initial limited vaccine supply.

Second, once more widely available, the vaccine would be distributed to the general population through traditional venues such as clinics and pharmacies.

[10:01:53 AM](#)

TARI O'CONNOR, MSW, Deputy Director, Central Office, Division of Public Health, Department of Health and Social Services, resumed the presentation on slide 22, "Contact Tracing and Surge Capacity." Ms. O'Connor discussed the increased staffing of contact tracers since the onset of the pandemic, as shown on the slide, and talked about where DHHS was in terms of contact tracers prior to the pandemic, where they were at the time of the presentation, and their future staffing and capacity goals. Prior to COVID-19, she explained, [the state had] approximately 70 contact tracers statewide, primarily state staff members in Public Health Nursing and the Section of Epidemiology, as well as partners at the Anchorage Health Department (AHD). She then stated DHSS has been working over the past month to bring in partners and hire additional staff, reaching about 140 people in the contact tracing workforce. Many of the individuals tasked with this have taken it on in addition to their primary workload, and when there is less of a need they focus on other tasks. She further stated that 87 of the contact tracers are state employees, and the rest are from the slide's listed agencies that are partnering with the state. Partners included the nurses from the Anchorage School District through the AHD, The Yukon-Kuskokwim Health Corporation (YKHC), the Alaska Native Tribal Health Consortium (ANTHC) Epidemiology Center, the Maniilaq Association, the North Slope Borough (NSB), Fairbanks Memorial Hospital, the CDC Arctic Investigations Program, and more recently the Alaska National Guard/Air National Guard and the Kenai Peninsula Borough School District.

MS. O'CONNOR stated that DHHS's goal was to have a total of 500 contact tracers with various partner organizations. Partners for the additional capacity they hoped to gain are the University of Alaska Anchorage (UAA), the Juneau School District, the Fairbanks North Star Borough School District, and the Matanuska-Susitna Borough School District. She further stated that DHSS also hoped to work with other community health centers, federally qualified health centers, and tribal health organizations. Ms. O'Connor concluded this slide by explaining that 500 was the midpoint goal of contact tracers needed for Alaska's population according to recommendations from the Association of State and Territorial Health Officials (ASTHO).

[10:05:18 AM](#)

MS. O'CONNOR continued to slide 23, "Infrastructure," and discussed training sessions to onboard the new workforce. Ms. O'Connor explained that the Department of Health and Social Services (DHSS) had been working with the UAA College of Health to adjust for onboarding a larger workforce. She next explained the work going into developing a "case and contact management tool." The goal of this program was to allow the different agencies working together on contact tracing to share data and coordinate staff assignments. Ms. O'Connor also stated that this program will allow for better "quality assurance and quality improvement." She stated, "It will allow us to more in real time look at different metrics to see how well we are doing and where there are opportunities for improvement." Ms. O'Connor finished the slide by assuring that this program was Health Insurance Portability and Accountability Act (HIPAA) compliant and there are a number of agreements in place with the program's partners to achieve this. Ms. O'Connor noted the national attention regarding proximity tracking tools and clarified that these are different from what she was working on with the state.

[10:08:46 AM](#)

MS. O'CONNOR then began slide 24, "Priorities" and summarized the goals of the contact tracing operation. The goals outlined on the slide were "coordination, quality, confidentiality and privacy, scalability, and building capacity Alaska can use in future responses." Regarding coordination, she explained that as the program began working with more partners, it was important that they were coordinated in their efforts. This was both so things wouldn't fall through the cracks and so things were approached in a consistent way. Next, she explained that it was important to maintain quality at a high level. This included ensuring the individuals involved in contact tracing have a strong background and interest in public health, the quality of the training systems, and quality of the system overall. Concerning confidentiality and privacy as well as scalability, Ms. O'Connor stated that these are both big priorities within the contact tracing project. She concluded that this system was being implemented in such a way that it could be used for future responses.

[10:11:08 AM](#)

COLEMAN CUTCHINS, PharmD, BCPS, Epidemiology, Office of Substance Misuse & Addiction Prevention, Division of Public Health, Department of Health and Social Services, continued the PowerPoint by directing attention to slide 26, "Testing in Alaska," and he discussed testing for viral ribonucleic acid (RNA). These are the molecular based rapid tests that detect live virus in the upper respiratory tract. He addressed that there has been a lot of discussion about both rapid tests and high capacity tests. Dr. Cutchins explained that there are many tests being used, but there are limiting factors to each type and it's all about using "the right tool for the right job." He explained that there are near-patient rapid testing devices like the Abbott ID NOW and (indisc.) that can quickly return a result, but their limiting factor is volume, as most can only run one test at a time. Another type of test comes from the state public health labs that are running high-throughput PCR tests that can test large numbers. He said DHHS was also working with out of state commercial labs.

DR. CUTCHINS used an analogy of a single cup coffee machine to detail how rapid tests can only be processed one at a time, so while these can offer a quick turn-around, he explained that this method is inadequate for processing large volumes of tests. Dr. Cutchins explained that this is why the state contracts with private companies to develop tests in large batches out of state.

DR. CUTCHINS then presented slide 27, which further detailed the steps involved when administering, processing, interpreting, and reporting a test. He stated that a patient has to be registered into a system and have his/her sample collected; the sample is then packaged and may likely require refrigeration; the sample is passed on to a transport in a temperature controlled insulation box with a temperature monitor; and then the lab receives the sample to process. Dr. Cutchins noted that the state public lab had significantly scaled up its capacity in the past month, achieving a 48-hour turn-around. once the samples are processed, he continued, the results aren't as simple to read as a pregnancy test with a plus or a minus. The results must be interpreted at a molecular level, and then they must be sent back to the provider where the results are entered into a data base.

[10:15:26 AM](#)

DR. CUTCHINS presented slide 28, which illustrated individual testing site locations. He mentioned that this interactive map

with individual, up-to-date testing site information is available through the DHSS website. He also pointed out the green locations on the map where traveler vouchers are accepted to get a second test 7-14 days after arrival in the state.

DR. CUTCHINS discussed slides 29 and 30, which showed cumulative test results and the percentage of daily tests that reported back as positive, respectively. He pointed out that in April the positivity rate was over 4 percent. Since then, the daily positive test rate had dropped down to about 1 percent.

DR. CUTCHINS next introduced slide 31: "National Data," which shows tests by one million population, showing that Alaska ranks seventh amongst the states. He said this is commendable, given Alaska's geographic isolation. Dr. Cutchins concluded with slide, 32, which shows a graph from the White House illustrating the national percentage for positive tests by state. This showed Alaska as having the lowest positives by state for the last seven days, and the second lowest amount of positives by state in the last 30 days.

[10:19:41 AM](#)

ADAM CRUM, Commissioner, Department of Health and Social Services, began on slide 33 of the PowerPoint presentation, entitled "Reopening Alaska Responsibly; Data-informed Mandates and Health Alerts." He directed attention to slide 34, and discussed the difference between the purpose of the mandates and the health alerts. He explained that at the beginning of the process, when "information was coming in fast and furious," the Department of Health and Social Services (DHSS) decided to release health alerts which would advise Alaskans what was deemed by health organizations including the Center for Disease Control (CDC) as the best guidance for Alaskans to protect themselves against COVID-19. He expressed that many of these alerts had remained the same, such as hand washing and social-distancing. He added that DHSS also put out health mandates, which were things that, at the time, were implemented as requirements for Alaskans to keep the spread down as they built up their healthcare capacity. He noted that DHSS pulled back mandates as the healthcare capacity increased and hospitals went back to performing elective and preventative procedures. The changing nature of the mandates is the reason for the differentiation. He briefly paraphrased slide 34, which read as follows [original punctuation provided]:

Purpose of Mandates vs. Health Alerts

There are a few things we strongly advise all Alaskans do to minimize the risk of COVID-19

- Wash your hands
- Wear a mask when around others
- Stay at least 6 feet away from others when possible
- Keep your interactions and circles small when possible.
- Even for mild symptoms get tested.

At this time, the State of Alaska does not mandate the general use of masks, limit group size, or business operations, but does encourage Alaskans to do their part to limit the spread of COVID-19.

- Mask wearing is not mandated, but encouraged. Health and science experts recommended that you wear a mask in public where social distancing is challenging to reduce the likelihood that you unknowingly spread COVID-19.

- Private companies and entities can enact their own requirements.

- Local communities can enact their own restrictions. Check with local communities as it pertains to nonessential travel off of the road system. Alaska has many small and remote communities that lack a robust healthcare system and they may restrict non-essential travel.

COMMISSIONER CRUM directed attention to slide 35, "Monitoring Metrics," and explained that the metrics listed on the slide are the items that DHSS is continuously monitoring, such as the disease activity and the current positivity rate in Alaska. He paraphrased the chart depicted on the slide, which in one column listed the various metrics and in the second column, titled "What we need to achieve to move to a slightly less restrictive phase," listed a goal for each metric. He explained that although there are increased caseloads, there have been 3,100 tests, which makes the positive rate 0.44 percent. He assured that DHSS is monitoring testing and public health so that it can monitor any spikes that may occur. He continued that, due to the "great behavior" by Alaskans, DHSS was able to put industry protocols in place for some of the high-risk areas, such as the commercial fishing and oilfield industries, which prevented the spread from location to location.

[10:24:06 AM](#)

HEIDI HEDBERG, MPP, Director, Central Office, Division of Public Health, Department of Health and Social Services, directed

attention to the portion of the PowerPoint addressing "Resources," beginning on slide 36. She covered the information on slide 37, "Supply Status," which read as follows [original punctuation provided]:

- Initial attempts to procure PPE in March and April were challenging - shortages in almost all PPE categories
- Current PPE supply lines are more open but have not returned to normal
- State inventory is stable for PPE
- Allocations required to meet ongoing requests
- Resources from commercial, in-state manufacturing and FEMA

MS. HEDBERG directed attention to slide 38, "6-22-20 Alaska State Hospital Supplies 24 Hospitals Reporting," which depicted a chart showing the supply levels of 24 hospitals in various areas around Alaska, and explained that DHSS needed to understand the needs of the public and look at some predictions by partnering with the Alaska State Hospital and Nursing Home Association (ASHNHA). She paraphrased the findings of the chart and stated that this information is valuable to the department to monitor in order to know when it is necessary to secure the scarce resources from their federal partners that are needed to keep people safe. She then directed attention to slide 39, "Resource Request Process," which she explained aims to inform on how the resource request process works during a disaster. She paraphrased the slide, which read as follows [original punctuation provided]:

Health care facility attempts to procure item through commercial supply line/multiple vendors—item is unavailable

Health care facility submits a resource request to Local Emergency Management

Local Emergency Management fills the resource request or, if no sufficient resources, submits to the State Emergency Operations Center State

Emergency Operations Center assigns the Resource Request to DHSS—DHSS fulfills dependent upon availability of item and quantity available

Note: Federal facilities, state-run facilities, and tribal health facilities may follow slightly modified request pathways.

[10:29:21 AM](#)

MS. HEDBERG proceeded to slide 40, "Medical Supply Shipments to Date," which represents the quantity of medical supplies shipped out to date. She shared that DHSS has received an unprecedented 696 resource requests and explained that this had rendered the normal supply chain unstable, but that the department is starting to see it "come back online." She explained that the slide represents the quantities of supplies that DHSS has shipped out to hospitals, clinics, and communities to support the pandemic response. Slide 40, which reads as follows [original punctuation provided]:

- DHSS has shipped the following key resources as of 6/22/2020
- 965,100 Gloves
- 80,557 Surgical Masks
- 77,187 N95 Masks
- 46,381 Gowns
- 28,339 Face Shields
- 60,368 Swabs
- 35,479 Universal Transport Media/Viral Transport Media
- 5,640 Abbott ID Tests
- 15,604 Collection Kits
- 285 gallons of Hand Sanitizer
- Additional resources deployed include Tyvek suits, goggles, thermometers, cloth facial coverings, bleach wipes, and other critical supplies

MS. HEDBERG turned attention to slide 41, which provided various methods to contact DHSS with questions surrounding the COVID-19 response and data, and proceeded to ask for any questions from the committee.

[10:32:18 AM](#)

CHAIR ZULKOSKY asked Commissioner Crum at what point the department would step in to ensure the case spikes will stabilize and decline. She also asked where out-of-state travelers would go to get tested in small Alaska communities, and if these communities would have the opportunity to restrict

travel and enforce testing mandates and their own public health measures.

[10:34:53 AM](#)

COMMISSIONER CRUM stated that he did not understand the question.

CHAIR ZULKOSKY repeated the question and offered her understanding based off of Commissioner Crum's earlier portion of the presentation that the state is not mandating various protective measures and therefore "the burden of contact tracing falls on the state," and restated her curiosity as to when the state would step-in to enforce the mandates and when something would be moved from a health alert to a mandate.

[10:35:44 AM](#)

COMMISSIONER CRUM answered with his belief that anyone who has traveled into small Southeast communities has seen the process that out-of-state travelers are "funneled through," including the declaration form and the testing set-up. He offered his understanding that the mandates are being complied with currently.

REPRESENTATIVE ZULKOSKY clarified her question and asked at what point the department will act and begin to enforce mandates such as use of masks, limiting group sizes, and out-of-state travel, and asked Commissioner Crum to speak more to the policy decision rather than the existing mandates.

COMMISSIONER CRUM confirmed that the goal of DHSS is to allow rural communities this autonomy. He used Kotzebue as an example of a rural community that has its own travel restrictions in place, and responded that if Bethel wanted to do this as well, then it could have that conversation with DHSS. He stated that the state has been having rising cases, but the aspect that DHSS is focusing on is the percent positive rate.

[10:38:51 AM](#)

REPRESENTATIVE ZULKOSKY repeated her question again, this time directing it to Dr. Zink. She restated that Alaska has been seeing consistent and frequent record-setting increases in positive COVID-19 cases and offered her understanding that this has been mostly due to travel, and with that in mind she questioned at what point Alaska is making a policy decision to

mandate protective measures. She directed an additional question to Commissioner Crum, asking if communities off the road system that do not have health powers are able to enact further restrictions in addition to the ones enacted by the state.

COMMISSIONER CRUM offered his understanding that DHSS has been clear on the fact that those communities do have that power to enact further restrictions.

10:40:16 AM

DR. ZINK responded to Chair Zulkosky's question by first addressing the autonomy of the smaller and rural independent boroughs and communities, sharing that they oftentimes work with the law on that since there are numerous legal requirements at play, and she offered to follow up individually with Chair Zulkosky to discuss the legality of that matter. Dr. Zink then responded to her second question regarding the decision to mandate protective measures, and offered her understanding that that the first restrictions during a pandemic or epidemic are the most effective and that it becomes harder to do as the pandemic or epidemic progresses. She explained that DHSS wants to make quick decisions but doesn't want to impact people's lives too drastically too quickly, and noted that balance is particularly important. She added that DHSS is looking at four metrics, which are as follows: testing, contact tracing, epidemiology, and healthcare capacity. She explained that within each one of those, there are steps that DHSS can take to mitigate the disease and the overall burden. Regarding the increasing cases, she offered her understanding that the increase is slightly different from the first wave due to increase in testing and contact tracing capability. Regarding hospital capacity, she explained that holding back on elective procedures has helped a lot in capacity, but that there are consequences now that people are starting to get those procedures again. She stated that masks continue to prove to be a vital tool in preventing a rapid spread and transmission of the disease, and that the goal is to get as many people to wear masks as possible and mitigate the disease while having the least impact on Alaskans as possible. She concluded that the department is trying to implement as strategic and geographically-responsive a plan as possible in order to try to mitigate the disease.

10:43:09 AM

REPRESENTATIVE JACKSON asked how much the state is paying for the testing. She stated her concern about the cost of vaccines and expressed her understanding that the state knows little about COVID-19 but is mass producing vaccines. She is also concerned about the reasoning behind giving the vaccine to schoolchildren first since her understanding is that they are low risk. She then addressed the workforce increase of 500 additional partners to maintain the [contact tracing] system, and wondered if these employees are Alaskans or coming from out of state, if these employees will work throughout the state including villages, if this new workforce is permanent, and how much this will cost the state.

[10:46:00 AM](#)

SANA EFIRD, Assistant Commissioner, Department of Health and Social Services, responded to Representative Jackson that DHSS is currently working on getting in place the contracts for the testing centers around the state and that she doesn't have an exact total at this time. She went on to answer that the state is looking at maximizing the funding under possible Federal Emergency Management Agency (FEMA) reimbursement, and also has received other funds through the Center for Disease Control (CDC) for epidemiology and expanding lab capacity, and that the state is working on how these costs will be covered under the various available federal programs.

CHAIR ZULKOSKY asked Ms. Efird to get that information to her office and she will ensure that it is distributed. She prompted additional discussion on Representative Jackson's questions about the vaccine and schools.

[10:47:36 AM](#)

DR. ZINK answered Representative Jackson's question and clarified that it is the intention of the department state testing will be free-of-charge to make it as accessible and affordable as possible. Regarding the question about school, she continued that DHSS is working closely with Commissioner Johnson on opening schools and what that looks like. She explained that testing is not currently part of that plan but that the CDC is working on it.

[10:48:15 AM](#)

DR. MCLAUGHLIN provided his understanding that the vaccine will be funded by the federal government and that there will be no

cost to the state. In terms of supplies, he stated his understanding that the Biomedical Advance Research and Development Authority (BARDA) will be leading the effort in getting supply kits out to states, which will be coming from the federal government.

10:49:00 AM

DR. ZINK responded to Representative Jackson regarding who will get the vaccine and offered her understanding that the state first needs to find out more about the science, the data, and understand the immunology of the vaccine before DHSS can determine that. She explained that the required science to understand that information is being conducted right now.

10:49:34 AM

MS. O'CONNOR addressed Representative Jackson's question regarding contact tracers and referenced slide 22, "Status, Targets, Partners," and explained that as is evident on the slide, contact tracers are from Alaska agencies and are by and large Alaskans. She added that depending on the agency, some contact tracers are distributed throughout the state, such as public health nurses and the University of Alaska Anchorage (UAA) workforce, and some are not. She noted that DHSS is still working on what this will look like in terms of community health centers and federally-qualified health centers and how the state will partner with these centers, but that those institutions are distributed statewide as well.

10:51:13 AM

REPRESENTATIVE TARR asked several questions: first, on capacity, she asked if the reason the dashboard [on slide 9, "Hospital Capacity"] says 927 hospitals available is due to non-critical procedures being set aside; in response to the testing, she asked if there is any plan for the state lab to allow a self-pay option for testing in order to encourage more testing; and regarding contact tracing, she expressed her curiosity if there is enough data to provide a percentage of people that have tested positive as a result of the contact tracing and if there is any information about trends. She offered her understanding that as a result of mass misinformation, particularly around masks and herd immunity, the public may not have heard about the research published positing that herd immunity may only last for a year, and she expressed her hope that that information be put out to the public. In conclusion, she expressed her support of

more stringent guidelines and making the strongest statements possible to protect the public and get the economy going.

[10:54:36 AM](#)

DR. ZINK addressed hospital capacities and responded that the number of 927 does represent the total number of hospital beds available in the state and does account for the increase in elective and preventative procedures, but that the department will continue to watch that number closely as the state can sometimes reach capacity in the winter in particular during flu season. She stated that the department will ensure that the state will be able to accommodate for that increase. She shared that there has been no restriction on elective procedures as of yet. The department confirmed with ASHNHA and that [bed capacity] is not backed up to the baseline, and the department will continue to work in partnership with the association. She agreed that the messaging is very challenging and that "you can't communicate enough" during an episode such as this, and for that reason the department is trying to find new and better ways to communicate to the public. In support of this, she shared that the department is starting to hold science forums every other Wednesday where its science team will be present and able to share information and answer questions, and this will be streamed on Facebook live and other media sources. She added that DHSS continues to do radio announcements in addition to releasing information via Facebook and in city council hall meetings around the state in order to answer local and specific questions. She continued that they also hold a series of various types of Echo meetings around the state for health care providers to continue to engage the healthcare community.

CHAIR ZULKOSKY sought clarification on the efficacy of face masks and asked if Dr. Zink would advise a temporary mandate in cases where social distancing is not possible.

[10:57:47 AM](#)

DR. ZINK said they appear to be an effective tool for source control, and there has been indication that a masks of tightly woven material can afford protection to the wearer. She said DHSS sees mask wearing as "an increasing tool" to prevent the exponential spread of COVID-19. She explained that it's part of the reason why the department have been trying to make mask information and availability as widespread as possible, and stated that her goal is to get people to wear them as much as possible.

[10:59:15 AM](#)

DR. CUTCHINS answered Representative Tarr's question on affordable testing. He said the Alaska State Public Health Laboratory isn't charging anyone for testing. He explained that it is the processing of the testing that the state isn't charging for and explained that a lot more goes into testing as previously referenced in a flow chart. He said that his agency is working all over the state to make sure that all communities have access to affordable testing, and he referenced a similar statement earlier in the hearing from Dr. Zink. He explained that the testing situation is fluid, sites are opening and closing, and DHSS is working to stabilize the situation in terms of access. He said there is a state standing order which is a blanket order that providers can use to create drive through testing locations. He explained that this means a member of the public can utilize these testing facilities without having to see his/her medical provider beforehand, if the person meets the testing criteria which includes many asymptomatic cases.

[11:00:33 AM](#)

DR. MCLAUGHLIN said that there is a lot of variability in contact tracing in terms of what is determined to be close contact when there are confirmed cases. Sometimes there are only one or two people who would be considered close contacts, and sometimes a person who is a confirmed case is very gregarious and can have close contacts numbering in the double digits. Similarly, there can be wide variability in the number of confirmed cases amongst the close contacts based on how vigilant a given contact is in following recommendations like social distancing and wearing a mask.

DR. MCLAUGHLIN addressed the question about herd immunity. He said that the duration of immunity should last close to one year, and there will likely need to be a booster dose or repeat dose taken once a year like the yearly influenza shots.

[11:02:03 AM](#)

REPRESENTATIVE CLAMAN asked Dr. Zink what she recommends for work at home versus returning to work, including how Dr. Zink is managing that at her own office. He also asked what the main conditions that predicated severe COVID-19 illness are and what the risk factors for COVID-19 are, particularly in Native groups and rural versus urban communities. He said that age and

obesity were major risk factors and said he was familiar with a Johns Hopkins study that identified obesity and heart disease as major risk factors.

[11:03:03 AM](#)

DR. ZINK answered that if work can be done via telework or other remote means, then she highly recommends it. Her own office is doing teleworking. She said that her work in the emergency department cannot be done remotely and so she recommends wearing a mask and minimizing the number of people in the space. She replied to the question about risk factors and said that preexisting conditions like heart and lung disease appear to be significant risk factors. She said that she is often asked why the small group of people with risk factors aren't protected, but she explained that the group of people with risk factors is actually a large group consisting of at least one-third of Alaskans, as mentioned by the CDC. She referenced data from the Lower 48 hospitalization rates that showed that younger people do much better but that somewhere around 30-35 percent of people are hospitalized despite not having any risk factors. In terms of urban versus rural, she said that this was something she was seeing playing out over the data nationwide. She explained that the case numbers coming out of Alaska were still a small sample size and so it is hard to make assessments based off of the Alaska data; DHSS is continuing to monitor the data but the department's goal is to have healthy and well Alaskans regardless of location, ethnicity, gender, or age, and sometimes that requires different resources being put with different groups, for example, getting resources out to rural communities earlier, getting personal protective equipment and testing in long-term care facilities, and making sure testing is available in communities that may be underserved and may not otherwise be able to access testing. She said that these appear to be the key strategies that she sees in the Lower 48, from which she is trying to learn.

REPRESENTATIVE CLAMAN asked Dr. Zink for a clarification regarding a statistic she had mentioned about Alaskans with one or more risk factors.

DR. ZINK answered that the statistic was approximately one-third of Alaskans had one or more risk factors; she said the most recent data she looked at was that 32 percent of Alaskans had one or more risk factors.

[11:05:51 AM](#)

REPRESENTATIVE SPOHNHOLZ asked about the recent outbreak that occurred at the Providence Alaska Medical Center ("Providence") in East Anchorage that was likely caused by a staff member who inadvertently contacted other caregivers. She asked what the protocol is for containing outbreaks at high-risk facilities. She also said that she has heard that testing capacity is an issue that prevents all healthcare providers at Providence and other healthcare providers from being able to identify asymptomatic carriers. She asked whether Dr. Zink could address the issue of testing capacity and whether testing all caregivers of vulnerable populations should be required.

[11:07:10 AM](#)

DR. ZINK, regarding the individual case at Providence, answered that it was a humbling experience, and DHSS is still learning about testing at long-term care facilities. She said DHSS is testing healthcare employees at these facilities, including baseline testing of all employees at the Kenai, Mat-Su, and Anchorage facilities to try to identify any further incidents. She said the disease does not care whether employees are having contact during work or while socializing at a restaurant or at home; the disease lives among any group of humans that are having contact. She said DHSS is continuing to look at ways that it can prevent outbreaks at long-term care facilities where the department knows the mortality is going to be higher. She said the department has been testing the workers associated with the outbreak at Providence on a weekly basis, and it is also evaluating how it tests long-term care workers throughout the state on a regular basis, which is a priority. She related that her team has been working with Dr. McLaughlin and his team on this issue.

[11:08:42 AM](#)

DR. MCLAUGHLIN said 57 laboratory confirmed cases are associated with this outbreak: 18 patients, 28 caregivers, and some secondary cases, as well. He added that CDC offers guidance that includes weekly testing of staff. Every facility needs to determine the proportion of staff it is able to test on a weekly basis, which varies widely from state to state. Some facilities are able to test 25 percent per week and thus are able to test 100 percent of staff every month; some are able to test 50 percent per week and thus are able to test 100 percent of staff every two weeks; and smaller facilities are able to test all of their staff every week. He said that there is also guidance

from the CDC that when an outbreak occurs, the facility should do weekly testing of its residents until two weeks have passed since cases have occurred.

CHAIR SPOHNHOLZ clarified that she wanted to know whether Alaska had the testing capacity to test all the healthcare workers in hospitals to prevent an outbreak.

DR. ZINK answered that it would be difficult to define how often DHSS would need to test healthcare workers. She said that DHSS does have the capacity to test the most vulnerable populations at long-term care facilities per the CDC guidance, but that DHSS has been moving more conservatively than the guidance because the long-term facilities in the state are small. She said DHSS is working to determine what testing modalities are best for those groups.

CHAIR ZULKOSKY expressed her appreciation for the witnesses being available to answer questions and said she would like to schedule an additional hearing sooner rather than later so that the committee is not waiting an additional four months to ask questions.

[11:12:41 AM](#)

MARY SWAIN, Executive Director, Camai Community Health Center, said that Camai Community Health Center is located in Naknek in the Bristol Bay Borough. She said that most of the sockeye salmon that is harvested in the upper Bristol Bay region is processed in Naknek. Last year, of the total 96.5 million sockeye run, total catch was 4.5 million fish, and approximately 38 million of that catch was processed in Naknek. She explained that with a fishery this large, with a community of only 800 people, the expansion that takes place is quite large; over a course of four weeks Naknek grows to over 10,000. Camai Community Health Center is a small facility with three exam rooms and an emergency care room. She said that beginning in March, the health center knew that it had to plan for a worst-case scenario for a fishing season with an outbreak of COVID-19, and it began evaluating what it had and what it would need based on the recommendations of the state, federal, and other partners who were already dealing with COVID-19. She said that the first decision the health center made was to increase staffing levels for the season; in a typical fishing season the center would have five providers and this year it has seven. She said that the center also identified the need to coordinate with as many fishing processors and industry businesses as early as possible

so that the center could build a plan together. She said that once a week the health center meets to discuss changes in the mandates and policies as well as to discuss concerns anyone in the community might have. She said the center also began providing updates on its website and Facebook page three days a week about CDC guidelines and mandates as well as plans and processes that are being put into place. She said there are times where the center reaches over 3,000 people with its updates. She said she knew early in the process that the only way forward was to provide clear and concise communications with the community.

MS. SWAIN said during a pandemic, the medical community takes the lead and, as a clinic with only 14 employees, the health center had to come together and be as prepared as possible while making decisions and working with processors for plans for isolation and treatment when a worker becomes ill. She said that most plans have medical staff to assist with care of ill persons. She said that community members are able to isolate in their homes and be monitored by the health center staff or by public health officials. This left the fishing communities as outliers who needed a place to isolate if community members became ill while on the water, and a place close to the clinic was needed as to not burden the staff with long distances to travel to monitor patients. She said that during this time she was contacted by a freight company with an offer of several modular home units if needed, and the health center decided that it had the staff to monitor 15 mildly ill patients if it had available beds. She said that with the help of the Bristol Bay borough, the health center purchased an 11-bed unit and leased an 8-bed unit for the season, which are in place and awaiting sewer and electricity and should be ready to go this week. She relayed that the state contacted her this week regarding the need for additional medical care if there were to be a bigger outbreak than the health center could manage; the state had an offer from Samaritan's Purse for a field hospital with the staff to manage it, and she said the Bristol Bay Borough seems to be the right place to have one if there is an outbreak during the fishing season. She said that plans have now been made and a field hospital can now be set up in a matter of a couple of days. She said that this has given the staff peace of mind in knowing that if the health center is overwhelmed, plans are in place, and the state has been wonderful in this endeavor.

[11:16:39 AM](#)

MS. SWAIN said the last part of the health center's response is testing and that its responsibility is to ramp up its ability to test in a short amount of time. She said that the center has processed 3,500 tests within the last few weeks, including through a walk-up clinic that is open Monday through Friday at the swimming pool across the parking lot from their building, and groups of ten or more can sign up to go to the pool outside of that timeframe. She said that the health center also coordinates with the project staff employees to send the tests to the state lab, and sometimes the center processes the tests in Naknek. Results are typically available within two to three days. She said that the health center also coordinates testing for four processors that are not in Naknek: Ekuak and Togiak Fish, which are on the Nushagak/Dillingham side of the bay, as well as Big Creek and Coffee Point Fisheries in the Egegik District. She said the health center also can do in-clinic testing with point-of-care "ID Now," which allows patients with symptoms to more quickly know whether the patients are positive.

MS. SWAIN said the health center has been sending its negative tests to the state because the viral load needed for the Avid [test] to detect a positive is much higher than the state can detect. She also relayed that all negatives sent to the state have been verified as negative. She said the health center also has a sixteen-point testing machine in its facility which can run sixteen tests at a time and have results in about one hour, and it has the supplies needed to send out tests to the state. She said the health center runs all walk-up patients and processor groups on this machine. She said she thinks the health center has a good plan in place to respond to positive cases quickly and the center has identified a few issues with processors the center is working through. The center had to get creative when sending over 700 tests to the lab, for example by using fish boxes instead of sending many smaller boxes. She said the center had also dealt with issues with a big impact like on Monday, June 22, when the center received a call regarding a positive that was detected at the state lab regarding a sample that was taken on the fifteenth.

[11:19:12 AM](#)

CHAIR ZULKOSKY asked Ms. Swain to submit her testimony in writing because of time constraints and because of additional testifiers. She further inquired whether the Camai Community Health Center was also testing people in the communities of Bristol Bay.

MS. SWAIN answered absolutely, the health center does so in addition to the other communities mentioned in her testimony.

CHAIR ZULKOSKY asked for confirmation that there were 14 employees at the facility who were able to facilitate the tests.

MS. SWAIN explained that the health center has 27 total employees because the center increased provider staff, support staff, and staff for the testing center.

CHAIR ZULKOSKY asked whether all employees are eligible to test for COVID-19 in Bristol Bay and the increased fisheries population.

MS. SWAIN responded yes.

[11:20:41 AM](#)

CHAIR ZULKOSKY asked Commissioner Crum how the state is ensuring that the processors who are doing their own testing are reporting their cases appropriately, timely, and thoroughly. She also asked if the state has a strong will to enforce the mandates and how the state plans to do so.

[11:21:20 AM](#)

COMMISSIONER CRUM answered that DHSS put processes in place so people can comply with the mandates. He said that for Health Mandate 17 for the Bristol Bay region, DHSS requested some outside help, and the state has procured a contract for health safety monitors to work in the region. He said there is public health law that requires these cases to be reported, and Dr. McLaughlin may be able to address the timing of the reporting.

[11:21:59 AM](#)

CHAIR ZULKOSKY asked Dr. McLaughlin about the state of Alaska allowing some fish processors to do their own testing and how the state is ensuring that any cases are reported timely, accurately, and thoroughly.

[11:22:19 AM](#)

DR. MCLAUGHLIN answered that any COVID-19 testing is reportable by both the ordering provider as well as the laboratory provider. He said that depending on who is doing the testing, the laboratory is required to report to the state as soon as the

laboratory gets positive test results, and the same is true for the ordering provider.

CHAIR ZULKOSKY asked what happens when entities do not comply with mandates, and she asked how concerned community members can report that an entity or organization is not complying with the mandates issued by the Office of the Commissioner or the Office of the Governor.

[11:23:15 AM](#)

COMMISSIONER CRUM replied that people can report via e-mail and can reach out with concerns.

CHAIR ZULKOSKY, given the gravity of this virus, requested the department commit to a follow-up hearing possibly in July to provide the committee with an update on new numbers.

[11:24:31 AM](#)

COMMISSIONER CRUM responded that as issues arise, some team members may not be available, nonetheless, his team can arrange for something towards the end of July.

[11:25:05 AM](#)

HELEN ADAMS, MD, Emergency Medicine, Providence Alaska Medical Center, said DHSS was incredibly effective, which has allowed [Providence] to be in the position it is in today. She said she thinks that "since we've re-opened," the increase in cases represents "a paradigm shift in our COVID-19 story." She cautioned that failure to address this shift could result in downstream mistakes in the transmission of cases and the overall burden of disease in Alaska. She explained that there are three things that must be pushed: handwashing, mask-wearing, and social distancing. She explained that she, too, was incredibly frustrated with the confusing mask regulations that were issued at the federal level, including recommendations to healthcare providers to maintain their own safety. She said that the data on mask wearing is changing where it was previously "as clear as mud." It is becoming clear that masks are effective in both clinical and non-clinical settings. She referred the committee to a large meta-analysis published on June 1 in The Lancet, which looked at 146 studies. It is becoming clear that there is power in studies showing masks are effective; the study looked at 29 studies that compared masks versus no masks and involved cumulatively over 13,000 participants, and these interventions

were shown to reduce transmission. She said that Alaska doesn't want to be another Sweden where there were twice as many infections and five times as many deaths as in its Scandinavian neighbors. She said that she doesn't want this issue to be political and she wants to tap into the Alaska spirit. She said that as a physician she doesn't want to tell legislators how to do their jobs, and whether encouraging the population to wear facemasks is done through education, outreach, or a mandate, she thinks that all of these options need to be on the table and an ongoing conversation. She proffered that the wearing of masks in public spaces is the lesser of two evils in that it allows people to go about their business and participate in the economy. The alternative is more sick people and higher costs, including Medicaid costs, or isolating again. She encouraged support of hand washing, social distancing, and dissemination of the new data that mask wearing is effective.

[11:28:53 AM](#)

MICHAEL BERNSTEIN, MD, Chief Medical Officer, Providence Alaska Medical Center, said that Providence provides acute and chronic care facilities in Anchorage, Seward, Valdez, and Kodiak. He said that he thinks that Providence does have adequate care capacity to handle surges that have been anticipated. Providence has learned from the recent outbreak in its transitional care center about the importance of doing careful monitoring. Testing has been handled by DHSS officials. He said Providence is in support of education and service announcements about masking, social distancing, and hygiene behaviors, and it is important to convey to the public that these activities help protect the more vulnerable members of the population; Providence is continuing its efforts in that regard.

DR. BERNSTEIN related that Providence is also encouraging the public to get important preventative and long-term care and is engaged in a campaign to let the public know that care should not be delayed, including stressing that it is very important to get flu vaccination this coming fall. He said while Providence is hopeful that a COVID-19 vaccination will be available, the flu vaccination will be very important to prevent influenza from confounding COVID-19 evaluations. He said that Providence doesn't know what the effects of co-infection will be. Dr. Bernstein said he continues to believe that the most vulnerable are people in long-term care and those with chronic diseases, homeless populations, and individuals of color who may have reduced access to care. He said Providence is continuing to support those populations.

[11:32:04 AM](#)

CHAIR ZULKOSKY stated that recent reporting indicates that Alaska is reaching its maximum ability to conduct contact tracing, and she said contact tracing and isolation are critical to box in and push back the spread of the virus. She asked if there are enough local tracing resources in the state and whether it was local contact tracers who were being used for non-resident cases.

[11:32:58 AM](#)

MS. O'CONNOR answered that DHSS is shooting for a capacity of 500; the capacity is at 140 right now, and she expects the current level to change significantly over the next couple of weeks. She said that DHSS is finalizing the steps to get infrastructure into place, including finalizing legal agreements and case and contact management systems.

[11:34:07 AM](#)

CHAIR ZULKOSKY suggested the way that the department has displayed hospital capacity as a dashboard that is visual and easy to understand has proven helpful.

CHAIR ZULKOSKY thanked testifiers and indicated that there would be a follow-up July hearing.

[11:35:12 AM](#)

#### **ADJOURNMENT**

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 11:35 a.m.