ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
Bethel, Alaska
July 28, 2020
2:32 p.m.

MEMBERS PRESENT

Representative Tiffany Zulkosky, Chair
Representative Ivy Spohnholz, Vice Chair
Representative Matt Claman
Representative Harriet Drummond
Representative Sharon Jackson
Representative Geran Tarr

MEMBERS ABSENT

Representative Lance Pruitt

OTHER LEGISLATORS PRESENT

Representative Sara Hannan
Representative Bart LeBon
Representative Mike Prax

COMMITTEE CALENDAR

PRESENTATION: COVID-19 IN ALASKA: A MID-SUMMER UPDATE ON PANDEMIC RESPONSE & CONTAINMENT STRATEGIES

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

NICHOLAS PAPACOSTAS, MD, Vice President
Alaska Chapter
American College of Emergency Physicians (ACEP)
Anchorage, Alaska
POSITION STATEMENT: Testified regarding ACEP's concern with the rising number of COVID-19 cases in Alaska and urged a return to bold leadership as the way to flatten the curve.

THOMAS HENNESSY, MD, Infectious Disease Epidemiologist

Affiliate Faculty Member
College of Health
University of Alaska, Anchorage (UAA)
Anchorage, Alaska
POSITION STATEMENT: Provided testimony regarding why Alaska's COVID-19 epidemic is rapidly worsening.

JARED KOSIN, President & CEO
Alaska State Hospital and Nursing Home Association
Anchorage, Alaska
POSITION STATEMENT: Provided testimony describing when the healthcare system becomes stressed and advised that the issue before Alaska is the prevention of COVID.

ELLEN HODGES, MD, Chief of Staff
Yukon-Kuskokwim Health Corporation (YKHC)
Bethel, Alaska
POSITION STATEMENT: Provided testimony regarding the healthcare challenges in rural Alaska and suggested tools for prevention of COVID-19 in rural areas.

ROBERT ONDERS, MD, Acting Hospital Administrator
Alaska Native Medical Center (ANMC)
Alaska Native Tribal Health Consortium (ANTHC)
Anchorage, Alaska
POSITION STATEMENT: Testified that Alaska is at a critical time where decisions need to be made to change the current course.

ADAM CRUM, Commissioner
Department of Health & Social Services (DHSS)
Anchorage, Alaska
POSITION STATEMENT: Testified that DHSS has done many items to protect Alaska and is working with Alaskan communities.

ANNE ZINK, MD, FACEP, Chief Medical Officer
Office of the Commissioner
Department of Health & Social Services (DHSS)
Anchorage, Alaska
POSITION STATEMENT: Co-provided a PowerPoint presentation titled "COVID-19 in Alaska," dated 7/28/20.

JOE MCLAUGHLIN, MD, State Epidemiologist
Chief, Section of Epidemiology
Division of Public Health
Department of Health & Social Services (DHSS)
Anchorage, Alaska

POSITION STATEMENT: Co-provided a PowerPoint presentation titled "COVID-19 in Alaska," dated 7/28/20.

COLEMAN CUTCHINS, PharmD, BCPS, COVID Testing Coordinator
Office of Substance Misuse & Addiction Prevention
Department of Health & Social Services
Anchorage, Alaska
POSITION STATEMENT: Co-provided a PowerPoint presentation titled "COVID-19 in Alaska," dated 7/28/20.

TARI O'CONNOR, Deputy Director
Division of Public Health
Department of Health & Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Co-provided a PowerPoint presentation titled "COVID-19 in Alaska," dated 7/28/20.

HEIDI HEDBERG, Director
Division of Public Health
Department of Health & Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Co-provided a PowerPoint presentation titled "COVID-19 in Alaska," dated 7/28/20.

ACTION NARRATIVE

2:32:28 PM

CHAIR TIFFANY ZULKOSKY called the House Health and Social Services Standing Committee meeting to order at 2:32 p.m. Representatives Jackson (via teleconference), Claman (via teleconference), Spohnholz (via teleconference), and Zulkosky were present at the call to order. Representatives Drummond and Tarr arrived (via teleconference) as the meeting was in progress. Also present (via teleconference) were Representatives LeBon, Hannan, and Prax.

PRESENTATION: COVID-19 in Alaska: A Mid-Summer Update on Pandemic Response & Containment Strategies

2:33:43 PM

CHAIR ZULKOSKY announced that the only order of business would be a presentation regarding COVID-19 in Alaska: A Mid-Summer Update on Pandemic Response and Containment Strategies.

2:34:28 PM

NICHOLAS PAPACOSTAS, MD, Vice President, Alaska Chapter, American College of Emergency Physicians (ACEP), testified in regard to ACEP's concern with the rising number of COVID-19 cases in Alaska. He said ACEP has more than 100 members who are actively practicing emergency medicine in various settings in urban and rural locations across Alaska. He noted that he is an emergency physician actively practicing in Anchorage.

DR. PAPACOSTAS related that ACEP's members have experienced a possible uptick in patients who are presenting to emergency departments (EDs) across the state with COVID-19 symptoms and cases. He stated that Alaska's emergency physicians are very concerned about the trends they are seeing in total cases as well as the number of patients beginning to be hospitalized. Hospitalizations climbed by 60 percent during last week and the state's emergency physicians know that this is going to start climbing even more quickly.

DR. PAPACOSTAS said physicians are seeing patients in the ED who are diagnosed with COVID-19 but are not yet sick enough to stay in the hospital. Severe illness, he explained, can be delayed by as much as one to two weeks after initial diagnosis. Many patients who are going to need to be admitted in one to two weeks have already been diagnosed. It is important to take action right now, he advised, because it has been demonstrated in other locations that any public health intervention takes at least a few weeks to have demonstrable effect on the rate of increase in cases and hospitalizations. Waiting until hospitals are completely full before enacting public health measures, such as mask mandates and cutting down on large gatherings, will be too late because cases and hospitalizations will continue to increase for at least a few more weeks.

2:36:00 PM

DR. PAPACOSTAS pointed out that the American healthcare system is designed to be running at maximum capacity as much of the time as possible, a reality that makes it very difficult to expand capacity rapidly when it is needed. Even during non-pandemic times hospitals in Alaska, and particularly urban hospitals, routinely have to board patients in the emergency department. Emergency department boarding is when a patient who is deemed sick enough to require hospitalization must wait in the ED for a prolonged period of time before getting a bed in an inpatient unit. For this reason, he specified, the state and

the governor are not getting the full story if relying on the dashboards alone to make decisions about when to start taking action to contain the spread of the virus.

DR. PAPACOSTAS related that an Alaska ACEP member reported that for several days last week the member's facility had between two and ten patients boarding in the emergency department overnight, and in one case the patient waited more than forty hours for an inpatient bed. Patients being boarded in the ED, particularly for long periods of time, means that the hospital has negative bed space, he explained. This means that while the facility had physical beds, it didn't have between two and ten staffed beds with skilled nurses and technicians to care for all the patients that were admitted. This worries ACEP's physician community a great deal, he continued, as the peak of COVID-19 cases and hospitalizations has not yet begun that is going to be seen if current trends continue.

DR. PAPACOSTAS further related that while the statewide hospital dashboard shows green with seemingly plenty of beds available statewide, hospital capacity in the Anchorage region was in the red zone numerous days last week, including last night. He explained that many patients from around the state who require a high level of care for illnesses or injuries other than COVID-19 are shipped to Anchorage, and Anchorage is already approaching hospital capacity based on metrics set forth by the state.

DR. PAPACOSTAS expressed his concern with relying only on the hospital capacity dashboard to make decisions. He noted that the dashboard currently says there are 26 hospitalized patients in Anchorage and 35 intensive care unit (ICU) beds available. However, he pointed out, not reflected by the ICU number is that it likely includes pediatric and neonatal ICU beds and neither of these would be ready to take care of adult patients today. Thus, the ICU capacity is artificially inflated.

2:38:21 PM

DR. PAPACOSTAS further pointed out that people may look at the dashboard and see that there are 91 ventilators available and conclude that the state must be doing fine. But, he cautioned, that is not the full story. [At the start of the pandemic] when the press was focusing on the number of ventilators that could be produced and how quickly they could be produced, that was the wrong thing to focus on. Having ventilators without the skilled people to run them is akin to having a bunch of airplanes full of important cargo that needs to get someplace urgently but not

having pilots to get them there. The tool is only as good as the one using it and in the case of ventilated patients it's a team, he explained. A patient on a ventilator requires extremely specialized close care with an intensive care physician and skilled nursing staff who are experienced in caring for those patients. This includes respiratory therapists who are skilled at running the ventilator themselves. In most places, the usual nursing ratio for ventilated patients is one nurse for every two, or a maximum of three, patients.

DR. PAPACOSTAS advised that the question the state needs to be asking of its hospitals, if it truly wants to make informed decisions on when the system is being stressed, is how many skilled ICU nurses, skilled ICU technicians, and skilled respiratory therapists does the hospital have available. This is because unless there is enough staff to run all those ventilators the patients who are on them will have worse outcomes. Early studies in this pandemic have been on patients in hard hit areas and they demonstrated a 90 percent mortality rate, he said. Initially that made physicians pessimistic that mechanical ventilation would be of benefit, but later studies have shown that with high quality ICU care when the healthcare system is not overwhelmed, mortality can be much lower at around 30-40 percent. This drives home the point that when the healthcare system is allowed to become overwhelmed, patients that may have survived will die despite aggressive care because there is not enough human capital to take care of them. This will only be exacerbated when, inevitably, some healthcare providers are forced to quarantine because they themselves get COVID-19.

DR. PAPACOSTAS stated that bold and decisive leadership early in the pandemic led to an incredible flattening of the epidemic curve in Alaska. It provided time to build heath care capacity and learn more about the virus. While it's important not to discount economic hardships mandates would have, he continued, it would be a disservice not to take action now to contain the spread of COVID-19; otherwise, economic sacrifices endured will have been for naught and the pandemic will be paid for in economic cost as well as in lives. He urged a return to bold leadership now to stem the rising tide of cases while there is opportunity and before it is too late. Alaska's healthcare workers are working hard to care for their patients and state leadership is needed to ensure they have the capacity to do so in the best way they can.

2:41:58 PM

CHAIR ZULKOSKY recalled the statement that hospitalizations had increased 60 percent in the last week. She inquired whether Dr. Papacostas anticipates that those numbers will continue to climb and, if so, the rate of climb.

DR. PAPACOSTAS replied that he thinks hospitalizations will continue to increase. While Alaska's absolute numbers are still low, he said the concern is the week-over-week rate increase of patients being hospitalized. His physician colleagues who are seeing patients in EDs are worried that they are seeing more patients getting diagnosed with COVID-19 who have risk factors, and those patients will get sick and come back to the hospital. The epidemic curve for number of cases has started to increase, so hospitalizations are going to start following the same epidemic curve as inevitably the patients who have already been diagnosed start to develop more significant illness. Most of the time there is a lag time between being diagnosed and getting sick enough to be hospitalized. He said he is worried that Alaska's hospitalization curve will increase given the diagnosis and case count increase.

2:44:11 PM

THOMAS HENNESSY, MD, Infectious Disease Epidemiologist, Affiliate Faculty Member, College of Health, University of Alaska, Anchorage (UAA), stated that before joining UAA he served as a commissioned officer in the U.S. Public Health Service and worked for the Centers for Disease Control and Prevention (CDC) for 25 years. He served as the director of the CDC Arctic Investigations Program in Anchorage from 2006-2019. He said he currently leads a team of UAA faculty aiding Anchorage's COVID-19 response through data analysis, mathematical modeling, community surveys, and policy analysis. He noted that he also advises the university on medical and public health aspects of the university's reopening plan, and that he meets regularly with Dr. Zink and Dr. McLaughlin for information sharing and coordination.

DR. HENNESSY warned that Alaska's COVID-19 epidemic is rapidly worsening. He said this is obvious from the data, the record number of daily cases, the record number of active cases, the increase in the percentage of COVID tests that are positive, and the increased number of regions with new case rates in the high alert level established by the State of Alaska. This increase in cases was predictable and was predicted by the mathematical models after relaxation of the community mitigation measures

that had worked to flatten the curve in April. This happened because the shelter-in-place and other statewide measures were stopped. Alaska still had ongoing transmission, COVID-19 cases were still being imported with travelers and workers, and not enough Alaskans followed the advice of public health.

2:45:54 PM

DR. HENNESSY specified that the danger zones have been hit for two of the three key pandemic measures followed in the state and the third one is on track to be overwhelmed soon. These key areas include the number of new cases and the rate of growth. The second key area is the state's public health capacity to identify cases and their contacts and to enact quarantine measures to prevent further spread. His colleagues in public health are no longer able to keep up with the case load and they have asked the general public and medical providers to take up these responsibilities. This is an alarming and unprecedented step, he said, and is a sign that the Alaska public health response is overwhelmed. Medical and public health professionals in the State of Alaska and the Anchorage Health Department have been extremely conscientious and energetic in battling this pandemic. However, he advised, they do not have the personnel and technology resources needed to be successful with case investigations and contact tracing at this level. Dr. Hennessy stated that the third key area is the healthcare capacity to care for COVID-19 cases and other medical conditions. The metrics that are tracked include available hospital beds, ventilators, and intensive care unit (ICU) beds and, of these, ICU beds are the most sensitive.

2:47:19 PM

DR. HENNESSY explained that his UAA group has tracked healthcare capacity throughout the epidemic by employing mathematical models that use Alaska case data and bed availability. He said it's important to understand that the purpose of these models is to show what might happen under current conditions. These mathematical models don't show what will happen - real life is complicated - and the models are imperfect approximations. He advised that models often lead to changes in policies to prevent a predicted outcome. This was the case for the COVID-19 models [the UAA group] evaluated in March, which predicted that the healthcare capacity in Alaska could be exceeded. Fortunately, those scenarios did not come to pass, he continued, not because the models were wrong but because Alaska took action to prevent the spread of COVID-19. Dr. Hennessy further advised that the

models also predicted that COVID-19 cases would increase after the lifting of shelter-in-place and other control measures, and that is what is being seen now. In early June based on the epidemic conditions at the time, these models predicted that the ICU bed capacity in Anchorage would not be exceeded for approximately 16-20 weeks. Using data through 7/26/20, new models now predict that ICU capacity in Anchorage could be overwhelmed by 9/20/20. These are conservative estimates, he noted, because they do not include patients transferred to Anchorage from other parts of the state. So, Anchorage's safety cushion has shrunk from 20 weeks to 8 weeks for the ICU capacity. "We have never been closer to exceeding our healthcare capacity at any point in this epidemic," he stated.

2:49:02 PM

DR. HENNESSY stated that it can be seen where Alaska's COVID-19 epidemic is headed. He advised that what is being done now to control the outbreak is not working. Disasters of preventable illness and deaths exploded in places like Italy and New York City; despite extensive healthcare capacity they were surprised by the speed of the pandemic. More recently are the healthcare crises in Florida, Texas, Arizona, and California where they reopened too soon and responded too slowly even after they saw that they were in trouble. This could soon be repeated in Alaska, he warned.

DR. HENNESSY cautioned that the time for effective action to control the epidemic in Alaska is running out, but that it is not too late to prevent a healthcare crisis. The Alaska COVID-19 epidemic is now like a large ship headed for a reef - it has weight and momentum, and it will only turn slowly. Measures are followed that lag behind the current situation, he explained. Cases reported today may have been exposed two weeks ago. The persons in the ICU now may have been exposed three weeks to a month ago. If all virus transmission was stopped today, it might take two weeks before being able to measure it. Because of this lag, Alaska cannot wait until its ICUs are full to take stronger action. That will be too late, and the cost will be paid by Alaska's most vulnerable, by Alaska's healthcare workers, and by their respective families. The time to take effective statewide action is now.

2:50:46 PM

REPRESENTATIVE CLAMAN related that a mask mandate has been imposed in Anchorage. He requested Dr. Hennessy's perspective on whether a mask mandate statewide is good public policy.

DR. HENNESSY responded he would like to see the State of Alaska take a lead in enacting several mandates to help protect the public health. He said small communities need this leadership because they may lack the capacity to enact those measures on their own. A statewide mandate for the use of facial coverings and to follow social distancing and hygiene practices would send a strong signal to Alaskans that taking action is needed, so he agrees with that. Also, mandates could be established to limit the size of group gatherings. In addition, mandates could be established for capacity restrictions, social distancing, and facial coverings in bars, pubs, restaurants, and gyms, as has been done in Anchorage.

2:51:54 PM

CHAIR ZULKOSKY recalled Dr. Hennessy stating that the modeling is showing that Alaska's ability to control the pandemic has shrunk. She requested Dr. Hennessy to restate that portion of his testimony.

DR. HENNESSY explained that these mathematical models have been conducted at intervals throughout the pandemic and are based on several factors. One factor is the available healthcare capacity, which can vary day to day as stated by Dr. Papacostas. It is also based on some assumptions about the rate of growth of the pandemic, which is tracked in a number of different ways, but basically has to do with the reproductive number, which is an estimate of how many people each infected person can transmit the infection to. Right now, that reproductive number is about 1.3, he related, meaning that each COVID-19 case on average transmits the infection to one and possibly one-third other persons. Left on its own the reproductive number of this virus appears to be around 2.0-2.50, which is what was seen in China and other places when it was uncontrolled. Clearly, some control has been gained over the pandemic because the reproductive number is lower, and that is probably due to some of the good practices Alaskans have put in place and some of the public measures, also.

DR. HENNESSY specified that to actually control the epidemic the reproductive number must be below 1. To actually reduce the number of infections, each infected person must not infect yet another person, he said. To get to that point, Alaska has to

reduce transmission by about 30 percent, which is a big number and would take a lot of action. When [his UAA group] ran models in early June of reproductive numbers around 1.2, it predicted about 20 weeks before Alaska's ICUs would be overwhelmed, a sufficient cushion at that time in the epidemic. However, he explained, in re-doing those models on 7/7/20, that timeframe shrank from early to mid-October to about 9/20/20. That level of about eight weeks remains about the same today, and eight weeks is not a lot of time to make an impact on transmission dynamics. It took a month of shelter-in-place and really stringent controls on businesses, travel, and other activities to bring the epidemic under control in March, and that was when Alaska had many fewer cases and the state's public health capacity could keep up with it. Right now, with Alaska's public health capacity overwhelmed, Dr. Hennessy continued, many of those people who are infected are walking around in the community without the advice given to them by public health early in the epidemic. That means they may be transmitting unwittingly to other people in the community, which is only going to enhance the spread. This is why the window has shortened and why Alaska's healthcare capacity is threatened more so now than it ever has been at any point in the epidemic.

2:55:48 PM

JARED KOSIN, President & CEO, Alaska State Hospital and Nursing Home Association, offered his full agreement with all previous testimony and stated that today's intent is to alarm committee members because the picture is bleak. He said he would, however, recommend a path forward. He reported that hospital capacity today, and only for today, is functioning normal with no major concerns from a safety standpoint at this given moment, but the problem is that this is not a normal moment. The concept of staffed beds discussed by Dr. Papacostas, he advised, is a nuance that is going to drive all of this. If staffing falls apart, all the beds in the world will make no difference.

MR. KOSIN stated he is going to use the beds in Anchorage to provide a sense of what this looks like because Anchorage is the state's population center and is where most of the COVID-19 cases are happening. He said that without considering staffing, Anchorage has 92 ICU beds and 632 non-ICU in-patient beds, generally called med/surg beds. These are not perfect numbers, he qualified, but they give a sense of what is being looked at. He noted he won't focus on just ICU because the vast majority of COVID patients that come into the hospital will not go into the

ICU, they will spend considerable time on the med/surgical unit, and either be discharged from there or the event will play out.

MR. KOSIN explained that beds are regularly occupied, which is normal. On average in Anchorage last week, he specified, 61 percent of ICU beds were occupied on a given day. On average last week, 79 percent of med/surg beds were occupied on a given day. Many hospitals, especially in urban areas, especially in Anchorage, can run close to full. But [before getting full], limitations start to manifest and the key limitation in all of this is staffing. Sicker patients require more staff care, so the ability to manage certain staffing levels essentially erodes and becomes stretched too thin. The hospital's system is backed up when it must board patients [in the emergency department] because so many patients are coming in at the same time and staffing isn't available at that given time. When a pipeline of COVID-positive cases is waiting and those cases are going to translate to hospitalization, it gets stressful.

2:59:08 PM

MR. KOSIN addressed the question as to when stress occurs. It is completely variable, he said, and is based on patient load, patient acuity, staffing availability, and other things. Occupancy fluctuates constantly and there can be big swings, he related. One day can have several patients boarding in the emergency department waiting for a bed and then the next day can have several discharges, which means patients are recovering and going home. That clears space and hence the hospital could have a lower patient population on that given day. With fluctuations come peaks. Over last week in Anchorage, ICU occupancy peaked at 67 percent and med/surg occupancy peaked at 89 percent. In the Anchorage setting this is normal, but the unusual thing is this growing pipeline of likely hospitalizations that are coming based on the high daily COVID case counts.

MR. KOSIN continued his discussion of when does the stress begin and when can it start to be felt. Since it is variable, he posed a scenario in which stress on the healthcare system is considered to begin when there is a consistent patient load of 80 percent occupancy in the ICU and 90 percent in med/surg. To describe what that would look like, he pointed out that based on last week's averages in Anchorage, this would be an average daily increase of 18 ICU patients and 63 med/surg patients for a total of 81 COVID hospitalizations. He said 81 is a lot, especially on a sustained basis, but advised that the question needing to be asked is whether COVID can take the number of

regular admissions in Anchorage to 81. He laid out the statistics: On [7/26/20] there were 36 COVID positives in the hospital statewide, 26 of them in Anchorage. One month ago there were 4 COVID positives in the hospital, 2 weeks later it grew to 16 COVID positives in the hospital, a week ago it went to 21, and now it is averaging 35-36 a day. In one month it went from 4 COVID positive patients in the hospital to 36. So, without even considering staffing, will that hypothetical stressor of 81 new regular hospitalizations be hit? At this rate, how could it not, he stated. So, the question is, "What do we need to do?" Alaska needs to wake up, he admonished. There is no vaccine to slow this spread, so that is not an option. The next best option is pretty simple, he said. "It's doing our part as individuals. We need to wear masks, we need to wash our hands, and we need to practice social distancing. It has to happen."

3:02:39 PM

MR. KOSIN concluded by relating that the common question asked is, "Should we cease medical visits and surgeries and different operations like that to clear the way for the impending wave?" He said the answer is, "Absolutely not." Delay in medical care again creates a whole set of other issues and problems, he advised. Hospital capacity is available and fluid today, but the issue before Alaska is a prevention issue. The only chance to limit the impending harm is to prevent the rapidly growing case counts. Would building up and emptying out hundreds of beds tomorrow make a difference? "The answer is no, not without staffing and not if these cases translate to hospitalization incumbent," he said. "The only way to change this situation is to lower the daily case count. That is where all of our attention must go."

3:04:23 PM

ELLEN HODGES, MD, Chief of Staff, Yukon-Kuskokwim Health Corporation (YKHC), noted she is a family medicine doctor, and she has been privileged to serve the Yukon-Kuskokwim area for 17 years. She said the Yukon-Kuskokwim Health Corporation serves 28,000 people in 48 villages and 58 tribes in a large expanse of Southwest Alaska without roads to connect any of the villages.

DR. HODGES explained that the health resources of rural Alaska are limited. For instance, she said, YKHC has no ICU beds or physicians specially trained in caring for ICU patients. Many of YKHC's Alaska Native patients receive tertiary care at the

Alaska Native Medical Center (ANMC) [in Anchorage], and that YKHC transfers any critically ill patients to ANMC for further treatment, while patients who are not Alaska Native beneficiaries are transferred to other hospitals. She pointed out that if the ICU capacity is exceeded, YKHC does not have the resources or staffing to manage critically ill patients for extended periods of time. Last winter, she continued, this region experienced the worst outbreak of respiratory syncytial virus (RSV) seen in over a decade. This virus primarily affects young patients with respiratory symptoms that often require ventilatory support in the form of specialized high-flow oxygen or even ventilators. The region's babies filled up all of the pediatric ICU (PICU) beds in Anchorage and YKHC was very close to having to send its patients directly to Seattle for treatment. Many days saw multiple air medical evacuations to Anchorage with babies to various PICU beds at various hospitals in Anchorage to receive the support and expert care they needed to recover. Thankfully, other regions in Alaska had relatively minor outbreaks of RSV and YKHC was able to keep all of its babies in state. She said this was a sobering reminder "of how we are all connected and outbreaks in one region affect us all."

3:06:28 PM

DR. HODGES related that her region has watched increasing [COVID] cases in Anchorage with considerable alarm. Most of the cases in this region are from travel to Anchorage or somewhere on the road system. The interconnectedness of Alaska is clear, and it is known from the RSV outbreak that patients from this region can overwhelm the resources of the Anchorage hospitals. If all the ICU beds are full of Anchorage patients where will [YKHC] patients go?

DR. HODGES noted that the models used to predict the increase in cases mostly point to first an increase in community spread followed by hospital admissions, then ICU admissions and death. Alaska cannot bank on having a different trajectory than the rest of this country, she said. The evidence suggests that mitigation strategies can interrupt this seemingly inevitable sequence. The risk to Alaska's population could possibly be reduced if enough Alaskans can be convinced to wear masks, keep their social circles small, avoid indoor gatherings, limit travel, and isolate immediately if they are sick. Identifying cases, isolating sick people, and tracking down contacts are critical. To do this, testing resources and contact chasing resources are needed. Community members who have to quarantine need support. It is clear that something must be done to

interrupt the current trajectory. The choices are not simple or easy, Dr. Hodges said, and she knows the economic hardships of all Alaskans are real and painful. But, she continued, she knows too the sorrow and grief of a life cut short by a terrible virus despite all our efforts to prevent tragedy.

3:07:59 PM

DR. HODGES suggested some tools for consideration that may be especially useful for rural Alaska. She said a one-size-fits-all mask mandate might not work for the state. However, an opt-out mask mandate would allow municipalities to opt out of a statewide mandate if it weren't appropriate for that community. This would allow communities such as hers to tailor their approach to pandemic control while providing the much-needed leadership and guidance for the smallest and most vulnerable [communities] that need the support from the state. Another tool that may be useful, Dr. Hodges continued, is a testing strategy for smaller communities off the road system, similar to the interstate travel mandate. Since everyone must arrive in rural communities by air, requiring them to have a negative test in hand may reduce the number of people who arrive already infected with the virus into these communities with limited resources. It would also allow communities like Bethel to more easily enforce a testing strategy that all disembarking passengers get tested on arrival, given the only way this virus gets to her region is on an airplane. Public education strategies that are culturally appropriate and aimed at the mitigation strategies that are known to work may also be helpful. Stories are a powerful tool in her region, and the stories of the region's survivors could be told so that others can learn and maybe change critical behavior.

3:09:27 PM

CHAIR ZULKOSKY recalled that the prior three witnesses testified about the importance of staffing within health systems, not just looking at the number of beds available. She requested Dr. Hodges to talk to the capacity and morale of providers within the YKHC system who are responding to this pandemic.

DR. HODGES replied YKHC has a limited capacity for healthcare workers off the road system. She said YKHC understands from other places with large outbreaks that about one-third of medical staff that support a hospital can be out on quarantine or with active infections at any given time, which would greatly limit YKHC's response to this pandemic as YKHC already has razor

thin staffing in its hospital facility. The morale of YKHC's hospital is pretty good right now and people definitely have a community mind in the hospital, but the strain of seeing increasing cases in Anchorage and other places, as well as within this region, is starting to affect the people who live and work here. A large outbreak that forced staff to quarantine or that infected staff would drastically affect YKHC's ability to respond to the pandemic.

3:11:30 PM

REPRESENTATIVE DRUMMOND expressed her concern about the ability of communities in Dr. Hodges' region to maintain sanitation, given the lack of running water and such. She requested Dr. Hodges to speak to this.

DR. HODGES responded that several studies in the region have shown that the households with either inadequate or no running water have much higher rates of hospitalization of children and adults for pneumonia as well as skin infections. She said there is no reason to believe that COVID will affect these households any differently. She is highly concerned for the households without running water with regard to basic sanitation of the house, overcrowding, and inter-generational nature of many of the households that leads to the virus spreading rapidly in some of the rural areas.

3:13:12 PM

ROBERT ONDERS, MD, Acting Hospital Administrator, Alaska Native Medical Center (ANMC), Alaska Native Tribal Health Consortium (ANTHC), noted he is a family physician. He said the testimony heard so far makes it easy to identify the direction that Alaska is going, and the challenges before the state. He thanked the State of Alaska, Governor Dunleavy, Chief of Staff Ben Stevens, Commissioner Adam Crum, Dr. Anne Zink, Dr. Joe McLaughlin, and the unified command for working well with the tribal health system and keeping communication open. Their willingness to listen to people in the tribal health system about the challenges and concerns is appreciated. The issue at hand is about what's going on, not about necessarily individuals.

DR. ONDERS said the previous testifiers have provided very similar information to what he had prepared to speak on, so he has modified his presentation to touch on three things that he believes would be beneficial for the committee to be aware of. He stated he still believes Alaska is in a unique position in

that its geography still affords the chance to have a different outcome than the rest of the U.S. Particularly in the rural areas, he continued, that geography is an advantage. Also, Alaska has come into this pandemic a little bit later than everyone else, and being able to watch what works and doesn't work in the rest of the country puts Alaska in an advantageous position. However, he cautioned, what he isn't seeing right now is that Alaska is acting upon what isn't working in the rest of the U.S. and currently Alaska is looking to have the same trajectory as the rest of the U.S.

DR. ONDERS specified that of critical potential in Alaska is health equity. He related that COVID has exacerbated health equity differences across the U.S. African Americans and Native Americans are experiencing the highest rates of morbidity and mortality from COVID-19. This pattern is similar to what was seen in 2008 and 2009 with the H1N1 [novel influenza A virus] pandemic. He noted that Dr. Hennessy was one of the authors of an article that showed that H1N1 brought higher rates of hospitalization, intensive care unit admissions, and a mortality rate four times higher to American Indians and Alaska Natives. If Alaska continues on the current course, he anticipates the exact same outcome in Alaska with this pandemic as seen in 1918 and 2008/2009 – there will be a disproportional effect. For Alaska to have equitable outcomes, he advised, there must be disproportional protections related to resources. Dr. Hodges touched on the need for testing in rural communities, and policies. Alaska needs to have a different approach than the rest of the U.S. if it wants to have equitable outcomes. Right now Alaska's approach is similar to the rest of the U.S. and he would anticipate inequitable outcomes and Alaska Natives to bear a disproportionate burden of death and morbidity related to this pandemic. Truly it's the outcomes that matter, he stressed, and Alaska is at a critical time where decisions need to be made to change course, as emphasized by the previous testifiers.

3:17:18 PM

DR. ONDERS stated that "good intentions only go so far, and we will be measured at the end of this by the outcomes, not by our intent." Making key decisions to impact those outcomes is needed now, he emphasized. He said the staff at Alaska Native Medical Center is working incredibly hard - ANMC had bed shortages before COVID and right now it has staffing shortages. When he came to work this morning, ANMC had one bed open and seven people in the emergency room looking for seven beds post operating room procedures. Additionally, he continued, the

critical care unit (CCU) is always short of nursing. He related that ANMC is looking to open an alternate care site because all the numbers predict that many more beds are going to be needed. More room is needed so that physicians like Dr. Hodges can send their patients here. He said he is really sad to see that Alaska has lost the advantage it had, and that ANMC is having to actively build out another 30 beds for overflow because that is what ANMC anticipates is coming.

3:19:19 PM

CHAIR ZULKOSKY asked what the decisions look like to change course.

DR. ONDERS replied that high-risk activities must be mitigated, which Dr. Hennessy touched on very clearly. There are activities that are at risk for COVID spread and there are activities that aren't at risk. Alaska needs to be open for activities that aren't at risk, he said. Instead of having full-blown activities, Alaska can be smart and reflective in mitigating the risk in activities where COVID can spread, and what Dr. Hennessy spoke to would make sense. As mentioned by Dr. Hodges, he continued, there is a challenge locally to get all these implemented. It has been seen in the Lower 48 that a patchwork component of regulations does not prevent COVID spread. Since a patchwork regulatory process doesn't work well, Alaska should learn from what is being seen in other states.

CHAIR ZULKOSKY requested Dr. Onders to clarify what regulations would look like in the state of Alaska that aren't a patchwork.

DR. ONDERS responded that statewide-related policies would be beneficial with the potential to opt out of that, similar to what Dr. Hodges said, but to at least set a minimum of where it is thought that those high-risk activities are. Public health is about keeping people out of the hospital, not about watching hospital capacity. All kinds of measures are in place, the minimum that is thought needed to prevent spread, he said, and statewide those need to be in place.

3:21:45 PM

CHAIR ZULKOSKY invited the Department of Health & Social Services to begin its presentation. She thanked DHSS for providing updates to the legislature as it works hard at responding to this pandemic.

3:22:31 PM

ADAM CRUM, Commissioner, Department of Health & Social Services (DHSS), stated that DHSS has done many items to protect Alaska, such as putting forth social distancing mandates and restaurant business closures. He said the department has worked towards reopening because there are other effects, such as making sure people have the chance to move around, and DHSS is encouraging Alaskans to go outside. The department has put forward all the best information from the Centers for Disease Control and Prevention (CDC), including workplace guidance, HVAC guidance, and airport testing. He pointed out that Alaska was the first state in the U.S. to put forward a robust plan for passengers and people traveling to Alaska, including residents returning to the state, to come in and to make sure that the state is protected.

COMMISSIONER CRUM related that the department has worked with communities around the state and put forward and built robust plans for fish processing that are protecting those rural communities while thousands of individuals come in, and still have industry that brings incredibly valuable property taxes to those communities. In looking at what can be done, he said DHSS has worked with the Department of Law (DOL) and studied some of the statutory authority that communities can do. Over the last two weeks DHSS has been meeting with the Alaska Municipal League and mayors across Alaska and informing them that first- and second-class cities, and first- and second-class boroughs, have the authorities to enact quite a few public health powers themselves and restrictions. The department has informed these communities that they can enact these items to protect themselves as they see fit. The department will be working with them providing them this guidance and showing them the toolkits that are available for them to use moving forward.

3:25:03 PM

CHAIR ZULKOSKY recalled that the commissioner also testified in late June about the delegated authority that the state is providing, particularly to communities off the road system, for enacting local health mandates. She related that she has heard concern from communities and second-class cities in her district that there is confusion and extremely shaky legal grounds that did not offer clearly delegated authority from the governor or within Alaska statute. If that is the case, she asked whether the governor or the department would consider issuing a health or legal mandate that clearly states second-class cities or

communities in unorganized parts of Alaska have the legal authority to implement more stringent mandates.

COMMISSIONER CRUM replied that DHSS has been answering questions as it goes through this. He said the Department of Law has put together a group. Also, the Alaska Municipal League has been organized in specific groups; for example today there was a phone call for answering the concerns of second-class boroughs and whether they can be addressed in either statute or constitutional available powers. The department, he added, will be meeting with other cities and second-class cities. He said the chair's suggestion is an interesting option and he will make sure the governor and attorney general are aware of them.

3:26:42 PM

CHAIR ZULKOSKY recalled that the epidemiologists and providers who testified earlier today pointed out the sobering conditions and the need to act and respond now. She asked about the timeframe by which the state expects to put forward legal guidance and authority to small communities if additional statewide health mandates are not going to be issued.

COMMISSIONER CRUM responded that he understands from talking with DOL that communities have this authority right now and can move on it, and DHSS has shared this with mayors and communities. He said DHSS is working on walking them through their individual municipal codes and has had conversations with cities around the state that have actually enacted some of this. He said DHSS recognizes that the high daily COVID case count is something the department needs to make sure that municipalities understand how they can address and protect their local areas, and DHSS will continue to press this.

3:27:59 PM

CHAIR ZULKOSKY posed a scenario in which the City of Bethel enacted requirements for arriving passengers to be tested or provided a mask mandate within the community of Bethel. She further posed in the scenario that those mandates were legally challenged, and that the department had not yet come out with clear legal precedent. She asked whether, in this scenario, the State of Alaska would support municipalities and stand behind them stating that the municipalities acted with clearly delegated authority as authorized by the governor under this public health emergency.

COMMISSIONER CRUM answered that he cannot offer legal advice. He noted that that was part of the conversations and concerns that the mayors had brought up. He offered his belief that DOL came up with a solution, and [DHSS] will make sure that that is clearly articulated.

CHAIR ZULKOSKY noted that this evening the City of Bethel is considering some community mandates, but that the city had not yet received any additional legal guidance from the state in order to respond in providing more localized mandates. She said she knows that timeliness would be appreciated, especially given the magnitude of the cliff that is being approached.

3:29:46 PM

REPRESENTATIVE SPOHNHOLZ related that small business owners and communities across the state are being put in the position of making what are public health decisions for their employees. She asked what the department is doing to help small businesses understand how they can make their workplaces and businesses as safe as possible during COVID-19.

COMMISSIONER CRUM replied that throughout this DHSS has put forward all the CDC guidance and recommendations, the business toolkit that allowed employees to know, and a reopen Alaska plan. The department put forward the best guidance that it had at the time of each phase for businesses to reopen, safe practices for their employees, and the department continues to communicate. He noted that each week DHSS holds calls for different industries, calls comprised of a couple hundred people, to address specific concerns. Additionally, DHSS has created list serves for immediately posting and sharing new information when it comes out from federal partners.

3:31:04 PM

REPRESENTATIVE SPOHNHOLZ said members have heard that the business toolkit has been helpful for some small businesses. However, she continued, other businesses feel that just having guidance and suggestions from the state puts them in the position of being police and policing public health. She asked why the department would not just go ahead and issue a statewide mask mandate as a measure to take the onus off small businesses to protect public health and also to make it easier to ensure that Alaska's economy continues to stay open.

COMMISSIONER CRUM responded that many small businesses and large businesses have put forward their own mask mandates for their patients and their employees throughout this. As they put forward, there is the guidance to look at what the responsible action is for all of Alaska – covering mandates across the board or providing local powers so they can protect their own communities through the public health process. The department has put forward guidance as it sees fit, shared guidance from its federal partners, and provided consistent messaging that DHSS encourages the use of masks. The department will continue to push this information, he said.

3:32:45 PM

REPRESENTATIVE SPOHNHOLZ inquired whether there is any reason why the department wouldn't institute a statewide mask mandate.

COMMISSIONER CRUM answered that that has to do with what he just said – it has to do with what is appropriate at what point in time. Some groups are willing to do this and others are not, so the department is sharing the information for how to keep themselves and others safe.

3:33:26 PM

ANNE ZINK, MD, FACEP, Chief Medical Officer, Office of the Commissioner, co-provided the department's PowerPoint presentation titled "COVID-19 in Alaska," dated 7/28/20. She drew attention to the graph on slide 3 and pointed out that the U.S. had its initial curve, then it started to slow down, then it started to pick up, and now an easing of that second curve is starting to be seen. She moved to slide 4 and discussed show where Alaska stands compared to the rest of the U.S. She explained that the graph depicts the number of confirmed cases normalized by population. She noted that Louisiana and Florida have had an acceleration phase and that Alaska has been climbing and is above some other states when looking at cases per capita.

Dr. ZINK addressed the graph on slide 5 depicting case counts by date for communities in Alaska. She said that next week DHSS would be moving and significantly changing its dashboard to show better (indisc.) on both the current as well as residency. These are epidemic curves ("epi curves"), she explained, so the dates change as each individual case is investigated in order to find out when the patient's symptoms initially began or when the patient first tested positive.

3:35:04 PM

DR. ZINK turned to slide 6 and specified that [as of 7/27/20] overall Alaska has had 2,622 residents and 817 nonresidents test positive. The majority of those nonresidents, she noted, have been in the seafood industry and have been in quarantine during their test positive range, but not all. Total hospitalizations are at 116, total deaths at 21, and total recovered patients are at 817. She explained that recovered patients is a way for DHSS to categorize when someone is no longer thought to be infectious and to no longer require isolation. Their overall long-term health, she added, is a much more complex story that DHSS continues to watch the data and learn from.

DR. ZINK discussed the graph on slide 7 regarding the time-varying reproductive number (Rt). She said Alaska continues to see a steady Rt value of about 1.2, but that there is quite a bit of variability within the state as a whole with that number, given Alaska's large geographic area and small population. The department continues to look at both resident and nonresident cases in a reproductive number as a whole, she continued, and this information is also reported back to DHSS from the CDC and the White House in comparing to other states across the country.

3:36:20 PM

DR. ZINK displayed slide 8 depicting hospital capacity for inpatient beds, ICU beds, and ventilator capacity. She referenced the earlier testimony regarding the challenges of staffed beds, not staffed beds, and total bed capacity, and stated that DHSS gets this information from the Alaska State Hospital and Nursing Home Association. She offered appreciation to the association for its partnership in providing dashboards and information to the department on what those beds look like. From a state perspective it's hard to know what are staffed and not staffed, so the state relies on that partnership.

3:37:09 PM

DR. ZINK focused on slide 9 depicting the risk alert levels by behavioral health region in Alaska. She explained that DHSS talks with national and international partners as well as its team internally to try to help give good tools to municipalities, local authorities, and to the state as a whole to understand what really is the risk of COVID spreading in a particular community. This is challenging, she noted, because there could be people in quarantine that are not mixing or a

large outbreak, which will fluctuate the numbers. She related that the department looked at 3-day, 7-day, 20-day, and 28-day chunks to decide what made the most sense to be able to provide the most timely, accurate information for the state. The department ultimately went with the behavioral health regions shown on the map, she said, because each behavioral health region had at least 20,000 people in the region and also represented where people move for their health care, although it's definitely not perfect. From there she continued, the department broke it down into three categories: [a low alert level is] less than 5 new cases per 100,000 averaged over 14 days; [an intermediate alert level is] 5-10 new cases per 100,000 averaged over 14 days; and [a high alert level is] more than 10 new cases per 100,000 averaged over 14 days. She said it's important to note that this may lag slightly, and therefore a big outbreak in cases that happens quickly will take a while to show up in the data. She explained that the idea behind this larger chunk of time and larger population is to average out these outbreaks and give a better sense of what's happening overall in a community. While not a perfect tool, DHSS is providing additional tools to the public and local decision-makers on what the current COVID risk is in communities.

DR. ZINK concluded her portion of the presentation. She noted that there are more tools and dashboards that she would be happy to provide as the committee follows this pandemic.

3:39:04 PM

REPRESENTATIVE JACKSON inquired about the ventilator capacity in Anchorage. She further inquired about whether the homeless population is disproportionately affected.

DR. ZINK replied she would get back to the committee in writing about the ventilator capacity in Anchorage. She explained that the Alaska State Hospital and Nursing Home Association provides this information. Regarding the homeless population, she deferred to Dr. McLaughlin to answer the question.

3:40:37 PM

JOE MCLAUGHLIN, MD, State Epidemiologist, Chief, Section of Epidemiology, Division of Public Health, Department of Health & Social Services (DHSS), responding to Representative Jackson's question, stated that DHSS hasn't identified any large outbreak yet in the homeless population, but qualified that that doesn't mean it hasn't happened. Sometimes there can be a very high

rate of asymptomatic infection, he explained. It has been seen in some states, whether in homeless or prison populations, upwards of 50-70 percent of the people who become infected are asymptomatic for reasons that aren't clear. So, while no large-scale outbreaks have been detected in the [Anchorage] homeless population, it's possible that COVID is circulating in that population but has not been detected yet.

3:41:43 PM

CHAIR ZULKOSKY recalled the testimony about the ability of the COVID virus to grow exponentially. She further recalled that the medical providers testified that continuing forward with "business as usual" is likely to push Alaska to the brink of its capacity. She requested Commissioner Crum or Dr. Zink to speak to what the state's existing mitigation strategy is to revisit new or revised statewide mandates that would seek to stabilize or decrease the rates of infection, recognizing that some of these lagging indicators could suggest continued increases in critical patients and pushing hospital capacity to the limit.

COMMISSIONER CRUM answered that DHSS works closely with its partners in the hospitals to make sure the department has a good understanding on the staffing and bed capacity at the hospitals. For example, he related, 34 people are hospitalized today and there were 35 on Friday, so it's at a bit of a steady point. How this virus behaves and how it gets individuals really depends upon the populations and the clusters. The state has done a very good job in protecting its congregate settings at assisted living homes and corrections. As far as any other further mitigation strategies, he said the governor is holding a press conference tonight to discuss those items.

DR. ZINK noted that DHSS has some additional information on its dashboard that talks about projected doubling times, as well as the Rt value. The projected doubling time is currently 18.08 days, she specified, so in 18 days it is expected there will be about twice as many cases. Alaska's Rt has been holding steadily at about 1.2, meaning if one person has the virus that person gives it, on average, to 1.2 people, which can get into an exponential climb, but it just takes a bit longer. She said DHSS is also working on an internal dashboard. The department is working closely with Dr. Hennessy and his team. The CDC has a surge tool, and the DHSS team is developing an Alaska-specific surge tool to better take into account the variability within Alaska, and the hope is to have it on the dashboard shortly.

3:44:43 PM

CHAIR ZULKOSKY clarified her question by noting that at least three of the earlier testifiers said that statewide health mandates would be helpful in pushing Alaska's Rt value below 1, the value needed to contain or mitigate spread. She asked whether there is not an existing strategy at this time to revisit Alaska's reopening plans at the statewide level with additional mandates.

COMMISSIONER CRUM reiterated that members should watch the governor's press conference this evening where the governor will be discussing this.

3:45:24 PM

CHAIR ZULKOSKY requested Dr. Hennessy and Dr. Papacostas to describe what they think is the timeline by which Alaska would need to take action on the response recommendations that were made today.

DR. HENNESSY replied that it is difficult to answer how soon Alaska must act to avert a problem. He said that if the models are correct and Alaska is heading toward ICU capacity being exceeded around 9/20/20, it is known that those actions taken today even to completely curtail transmission might be delayed for two weeks in terms of producing an impact on hospitalization. So, ideally, it should be backed up as far as possible to prevent the kind of overflow in hospitals that was mentioned in the other testimony today. The longer [the state] waits the worse it will get. The sooner action is taken the more cases and hospitalizations are prevented and the more suffering that is prevented. He continued: "I think we are at a point now where we can see just over the horizon a time when we would exceed our intensive care capacity and a lot of people would suffer .... The time to act is now."

3:46:55 PM

CHAIR ZULKOSKY asked what it will look like if it gets to a point where Alaska has exceeded its capacity, and what that would mean in terms of impacts to Alaskans.

DR. HENNESSY responded that Alaska could look to other states, such as Florida, Texas, Arizona, and California, where hospital beds are full in some locations and physician providers have to make choices about who gets a ventilator and who gets to go into

an intensive care unit. He explained that there is a spillover effect into other medical conditions that should be or could be treated in the hospital system, but capacity is overwhelmed by COVID cases. So, [in Alaska] a ripple effect could be seen onto other health conditions and emergencies. He deferred to Dr. Papacostas and Mr. Kosin to speak to the anticipated impacts to the healthcare system.

3:48:18 PM

MR. KOSIN stated that the picture is awful – the story has been written before, such as the catastrophe in Italy. Alaska hospitals will step up and change operations, he said. "We will start to repurpose the way we look and the way we operate to meet the surge and the challenge," he stated, "but that doesn't take away those hard decisions that Dr. Hennessy alluded to concerning who gets the bed, who gets the ventilator, and it puts us in the situation that is awful." Action is needed now for Alaska's hospitals and nursing homes, he stressed, and for doing something in the way of how individuals are acting in terms of masking and taking responsible steps as a society. If this isn't done it's going to be a very bad picture, he warned.

3:49:39 PM

DR. ONDERS advised that the longer there is a delay, the more severe the shutdown needs to be to slow things. He related that during the month of June ANMC had the highest orthopedic volume for surgeries it had had all year because of the pent-up demand. There is plenty of health care that needs to be addressed on a routine basis. Significant life-altering procedures are being delayed, he continued, because they can be delayed or were delayed earlier, and he fears that those will have to be stopped again if action isn't taken soon enough. To keep the health of Alaska's population ongoing, the spread of COVID must be mitigated and actions taken about unsafe activities - and the earlier the better. Four weeks ago he would have said to take those actions now, he noted, but he wasn't asked then.

3:50:56 PM

REPRESENTATIVE LEBON inquired whether the presenters have any insights on how best to reopen schools. He further inquired about the percentage of positive tests for children in kindergarten through grade 12.

DR. ZINK responded that DHSS has been working closely with the Department of Education & Early Development (DEED) and has established a core team to support schools that includes a physician, a family medicine physician, a school nurse, and backup lead from the DHSS team. She noted that DHSS met with superintendents today regarding updated guidelines for reopening schools with additional details now that DHSS has more information and CDC guidelines came out [on 7/23/20]. Regarding what percent of children are testing positive, she said she doesn't have that information because DHSS has been breaking out by region more than percent of children positive. She stated she would get back to the committee with that information.

3:52:53 PM

REPRESENTATIVE LEBON related he has been hearing from parents in the Fairbanks area regarding schools reopening. He said parents are telling him that they "are caught between a rock and a hard spot" in the sense that they are trying to go back to work and employers are trying to make workplaces safe. Parents are trying to juggle a daycare facility, many of which have not reopened, plus they are juggling homeschooling their children, so the stress level is going way up. He asked whether children are carriers and likely to pass the coronavirus on. He further asked what the risk would be of sending children back to school if the schools are able to reopen.

DR. ZINK answered that DHSS continues to follow the science and data closely regarding children and their risk of transmission. She said the department also follows what that overall community risk looks like - how many cases are circulating through a community at this time. In the new DEED guidelines, DHSS talks about how to use the risk alert levels and put that into context when thinking about opening schools. She said DHSS definitely hears [the public] with how stressful this has been in so many different ways for teachers, families, kids, and working individuals in trying to balance lots of different things all at the same time. The department wants to provide a steady constant guidance and information, but also be responsive to the information. She advised that there is movement in the data that looks like children under the age of 10 may be less likely to transmit the disease. It is known that children are less likely to be significantly affected by the disease. Children of all age groups are able to potentially have COVID and some can get very sick. Generally the younger the child the better they do and the less likely they are to have significant symptoms. While the department did provide information to the House

Education Standing Committee about this, she said she is happy to provide this separately [to this committee] and to include the most recent information and DEED guidelines.

3:56:07 PM

CHAIR ZULKOSKY returned attention to the DHSS presentation.

3:56:25 PM

DR. MCLAUGHLIN resumed the department's presentation. He showed slide 10 and said Alaska's current situation begs the question, "What are the current drivers of the increased case counts here in Alaska?" He explained that there are a number of different drivers; it is multi-factorial. First, a much higher incidence is being seen in young adults than in any other age demographic. He advised that while not 100 percent clear, some potential reasons for why COVID-19 is disproportionately affecting young adults could be because they may be less compliant with interventions like social distancing, mask use, hand washing, and potentially even self-quarantining if they've been exposed. They may be more likely to congregate at parties and other social venues and they may be more likely to go in physically to work than their older counterparts. This disproportionate effect on young adults is being seen in Alaska as well as nationally.

DR. MCLAUGHLIN specified that the second issue is seafood processing facility outbreaks. He related that Alaska has had four large-scale outbreaks in seafood processing facilities this month, with three of them reported within about a five-day time period. The American Triumph outbreak was all nonresidents and the other three did involve some Alaska residents. He said these outbreaks are analogous to the meat packing outbreaks seen in the Lower 48. Any time there is a congregate setting, whether a work or living setting, the risk of COVID transmission is really increased.

3:58:46 PM

DR. MCLAUGHLIN said the third issue is widespread COVID activity; all regions of the state have now had COVID activity. The likelihood of further transmission, he advised, is increased with more cases and the more widely distributed those cases.

DR. MCLAUGHLIN stated that the fourth issue is group gatherings. He said lots of people report that they were at a wedding,

funeral, backyard barbeque, bar, nightclub, or other social gathering. The likelihood of transmission is really increased any time people get together, especially if they are not social distancing by keeping six feet apart and if they're not wearing face coverings. He related that early in the epidemic a principal author in the CDC's morbidity and mortality weekly report wrote that there are four main drivers of COVID: travel-associated importations, large-group gatherings, congregate living settings, and cryptic transmission, which is asymptomatic or mildly symptomatic transmission. Dr. McLaughlin stated that the group gatherings and the seafood processing facility outbreaks are examples of one of those modes of acceleration.

4:00:25 PM

DR. MCLAUGHLIN spoke to the fifth issue, household transmission. He specified that the people who are at highest risk for COVID infection are those who live with someone who has COVID. Household transmission is playing a big role in Alaska's increased case counts, he noted.

DR. MCLAUGHLIN identified the last issue as being breakdowns in adherence to social distancing, masking, and hand washing guidance. He said he thinks this is probably disproportionate in that some factors of society are following the guidance very closely. Anybody who is at higher risk for illness is probably more likely to be following social distancing, masking, and hand washing guidance. "The extent that we are able to really promote adherence to these three basic intervention measures is really going to help us curb this epidemic," he concluded.

4:01:39 PM

CHAIR ZULKOSKY offered her understanding that the risk alert levels are case rates per population of 100,000. She inquired whether that was normalized for different areas that are in smaller population hubs and the impact that current cases have in terms of percentages of impact.

DR. MCLAUGHLIN replied that these are rates per 100,000 population; so, they are normalized in that way. He explained that basically a rate calculation is done per day and then for the alert level those rates are averaged over a 14-day period.

CHAIR ZULKOSKY asked what the age range is for the young adults referred to in slide 10.

DR. MCLAUGHLIN responded that the highest case count by age demographic is in people in their twenties, the second highest is people in their thirties, the third highest is people in their forties, and then people in their fifties, and then it goes down from there, so a stepwise progression. He further advised that an incidence increase is being seen in teens, so DHSS is also watching that demographic.

4:03:26 PM

CHAIR ZULKOSKY asked what information is being used by DHSS to make data-informed decisions about remaining open in Alaska. Given that group gatherings are contributing to an increase in case counts, she said she would be interested in hearing what data is being evaluated every day to determine what is open in Alaska, considered, and re-evaluated.

DR. ZINK responded by reviewing the big categories of data that DHSS looks at every day and shares with the governor and communities. She noted that there is some nuance to this as there may be an outbreak and that changes the way DHSS looks at certain data. She said DHSS has been looking at the epidemiology, the overall healthcare capacity, testing, and contact tracing. Within epidemiology DHSS is looking at: community transmission level; risk alert levels; the overall Rt value; the nature of the outbreaks, such as whether they are discreet, small, isolated, easily contained, or multiple outbreaks involving multiple communities that are hard to contain or involve high risk populations; percent positivity rate as an early indicator of disease progression in any area, and whether it is less that 2 percent, between 2 and 5 percent, or greater than 5 percent, and DHSS is looking at that across regions; new case rate over seven days, which is a shorter timeframe that will help DHSS to better look at what is coming up down the pipeline, what DHSS needs to be thinking about and projecting for each community, and how DHSS needs to move resources to respond, and for that reason using cutoffs of less than 5 per 100,000, 5-10, or greater than 10 per 100,000 for each of those behavioral health regions. Dr. Zink said that also in the epidemiology, DHSS is looking at the overall (indisc.) data, which looks at COVID-like illness such as pneumonia and what is being seen in the hospitals and emergency departments. She stated that DHSS has looked at that in the past and is continuing to follow that moving forward to see if that is at average, below average, or above average and rising.

4:05:48 PM

DR. ZINK continued her response. She advised that in public health capacity and testing, DHSS is looking at whether broad testing can be done, making sure that a minimum of 2 percent of the population is tested per month. Alaska continues to be the third most tested state per capita and continues to try to get testing in every region of the state, she reported. The department looks at the testing environment as a whole to see such things as whether there are region shortages and whether the ability to do testing is being limited. Right now some shortages are being seen, as well as a community's ability to test, that alternatives are available versus at times alternatives are not available, and looking at the turnaround time at the state labs, hospital labs, and commercial labs.

DR. ZINK explained that for contact tracing DHSS is looking at two major things: how many cases per contact and what percentage of the new cases are [the department] able to contact within 24 hours as it brings on additional capacity. She stated that this information would be shared at the press conference.

CHAIR ZULKOSKY noted she hasn't seen any details or a press release. She inquired where and when Alaskans could tune in to the governor's press conference.

DR. ZINK answered that the press conference is at 5:00 p.m. tonight.

4:08:09 PM

COLEMAN CUTCHINS, PharmD, BCPS, COVID Testing Coordinator, Office of Substance Misuse & Addiction Prevention, Department of Health & Social Services, resumed the DHSS PowerPoint presentation. He turned to slide 12 and reviewed the COVID testing process. He explained that it is a medical test and therefore requires an order, the patient to register, the sample to be collected, the sample to be packaged, the sample to be transported, the sample to be processed at the lab, the results to be interpreted at the lab, the result data to go back to the provider, the result data entered into the provider's record, and the result to the patient. He pointed out that only two of those nine steps in the process actually happen at the lab and within the state lab's control. Movements have been made within the state lab and in other systems to make as many of these steps digital and adapted to an online platform as possible, he related. The process goes a lot faster when people and paper

don't have to handle certain steps and technology and digital can take over.

4:09:18 PM

DR. CUTCHINS moved to slide 13 and elaborated on testing in Alaska. He explained that the testing is a molecular test that looks for and detects the viral genetic material, which is the most sensitive and specific of all the tests to detect an active infection. Most of the testing is done at Alaska's state labs, which have massive capacity compared with most other states. While the state labs of most other states have very low capacity, they have large commercial labs in state and Alaska doesn't. He related that rapid tests are available to detect the genetic material, but their limiting factor is that they are extremely low volume. Rapid tests work very well when there is only one or two or a handful of people that need to be tested; for example, when admitting someone to the hospital and it needs to be known right away if the patient is positive. Rapid tests, he continued, have been very beneficial in small communities with only a few people, as well as in cases of outbreaks in congregate living facilities or fish processing plants.

DR. CUTCHINS continued his discussion of slide 13. He said the use of out-of-state commercial labs has recently been expanded for those communities that have good shipping logistics. More of the out-of-state commercial labs are expanding their "emergency use," he noted, which is the FDA approval process to allow for longer durations for the sample to be in transit. Early on in the epidemic, many of the labs only had a 24-hour emergency use and it was very hard to consistently get things out of Alaska in 24 hours. He said another new thing that has been beneficial in terms of looking at a multi-strategy is the "direct to consumer" COVID test where the consumer orders a test online, the test is shipped in a box with instructions on how to swab one's self, and then the swab is sent back to the lab. Alaskans have had some impressive turnaround times with of three to four days from the time of clicking on the Internet to the time the results come back. But, he cautioned, things are fluid and as demand ramps up in other parts of the country things can go up and down in terms of turnaround times.

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DR. CUTCHINS reviewed antigen testing and serology as he further discussed slide 13. He explained that molecular tests detect the viral genetic material, while antigen tests detect surface

proteins on the virus. Antigen tests are not quite as sensitive and specific, he noted, which means they have a higher false negative rate and a higher false positive rate than the molecular test. The advantage of antigen tests is that they will likely become much less expensive as they become more readily available. Some are now available on the market, he continued, but given the current limitations they are more applicable to determine if someone is positive if they are symptomatic. Antigen tests require a higher level of the virus, so even if someone tests negative it is considered a presumptive negative because the test has a much higher false negative rate. He explained that serology is about looking for antibodies in someone who has had exposure to COVID. The CDC, he noted, is very clear on its recommendations that serology only be used for epidemiologic survey because it's unknown clinically how long immunity will last. An increasing number of studies show there is significant reduction in antibodies after 90 days, even in those who have been infected.

DR. CUTCHINS continued on slide 13. He reported that the number of testing locations is being expanded throughout the state, with locations of the testing sites shown on the map of Alaska on slide 14. He said the state has distributed about 30,000 test kits for commercial fishing and about 25,000 rapid test kits to support commercial fishing in small communities. Also, the Alaska Native Tribal Health Consortium has distributed lots of rapid testing to small communities and has done lots of testing. He pointed out that testing has been done in Alaska's airports, with a little over 100,000 passengers from out of state screened in about the first seven weeks. Of those, a little over 50,000 arrived with a negative test result in hand from prior to travel and a little over 40,000 were tested in one of Alaska's airports. Testing is being done for travelers to keep Alaska's borders open.

DR. CUTCHINS noted that the time it takes to get test results varies because of Alaska's complex shipping logistics for shipments going to the state's high-throughput labs located in Anchorage and Fairbanks. He further noted that [variability is also due to] the availability of materials and reagents given there is some dependency on things happening outside of the state, although swabs and media are produced in state.

4:15:02 PM

DR. CUTCHINS addressed the topic of testing in rural Alaska. He drew attention to the map on slide 14 of testing sites in

Alaska. He said there are testing locations across the state, with the locations shown in green accepting travel vouchers and the locations shown in orange not accepting vouchers. People with travel vouchers can still be tested at the locations shown in orange, he continued, but it may be a different process than for those locations shown in green.

DR. CUTCHINS spoke to the graph on slide 15 depicting statewide cumulative tests by day. Early in the pandemic the public health lab carried the bulk of testing in Alaska, then commercial labs took over, and in mid-May hospitals and other point of care places took over, but all the while the public health lab has carried a lot of the testing. Out-of-state labs and shipping are now starting to open up so that Alaska isn't reliant on any one of the three options.

DR. CUTCHINS turned to the graph on slide 16. He pointed out that in early April Alaska's daily test positivity was at 4 percent, and that since late June it has been creeping upward. He displayed slide 17 and reported that the last time he was before the committee Alaska was the seventh most tested state in terms of population and now Alaska is third most tested. He recalled a statement by Dr. McLaughlin that Alaska will not test its way out of COVID. Testing, while extremely helpful in terms of early identifying of outbreaks and figuring out who is infected, won't be the sole reason that will negate risk of this disease.

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TARI O'CONNOR, Deputy Director, Division of Public Health, Department of Health & Social Services (DHSS), continued the DHSS PowerPoint presentation. She addressed the topic of surge capacity for contact tracing. She explained that contact tracing is an essential element of the department's efforts to test, isolate, find, and quarantine to prevent the spread of COVID-19.

MS. O'CONNOR brought attention to slide 19 and discussed the five priorities for contact tracing: coordination, quality, confidentiality and privacy, scalability, and build capacity Alaska can use for future responses. In regard to coordination, she said the priority is being able to coordinate assignments for a statewide workforce, being able to flex that workforce to provide capacity where it is needed, and being able to share information among that workforce so the work on individual cases and contacts is coordinated and people can pick up where someone

else left off. She stated that the priority of quality speaks to a high level of training in health and public health that the contact tracers have. She specified that the priority of confidentiality and privacy is related to complying with the Health Insurance Portability and Accounting Act of 1996 (HIPAA), and speaks to how DHSS structures its agreements with partners. Regarding scalability, Ms. O'Connor said DHSS is trying to build this workforce in a way to be able to respond to needs so that when the need is low DHSS is able to not have as many people engaged, but to be able to add workforce if needed. In regard to the fifth priority, she explained that while the focus is on the current response, the department is trying to build the capacity in a way that Alaska can use for future responses. This is being done, she continued, by working with Alaska institutions and Alaskans who will be here the next time there is a response.

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MS. O'CONNOR stated that slide 20 shows "where we've been, and where we are today, and where we hope to go." Prior to the start of the COVID response, she said, there were about 75 contact tracers working statewide within the DHSS Section of Public Health Nursing, the DHSS Section of Epidemiology, the Anchorage Health Department, the Maniilaq Association, and the North Slope Borough. The workforce has now been expanded to 190 contact tracers. To do this, she explained, DHSS had to build some systems that are different than the infrastructure that supported the initial group of individuals. This expanded number of contact tracers represents additional hiring within the DHSS Section of Public Health Nursing, as well as adding partnerships with the Anchorage School District, Yukon Kuskokwim Health Corporation, ANTHC Epidemiology Center, Fairbanks Memorial Hospital, CDC Arctic Investigations Program, Alaska National Guard/Air National Guard, Kenai Peninsula Borough School District, and University of Alaska Anchorage. Ms. O'Connor related that the goal is 500 contact tracers statewide, which is based on some national projections for Alaska. To do this, more tracers will be added through the University of Alaska Anchorage, as well as through the Juneau School District, Fairbanks North Star Borough School District, Matanuska Susitna Borough School District, and community health centers/federally qualified health centers/tribal health organization.

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REPRESENTATIVE SPOHNHOLZ remarked that she is pleased the number of contact tracers is up to 190, but she pointed out that 500 tracers has been the target for some time now. Given the significant surge, she asked whether anything could be done to speed up the onboarding of new contact tracers.

MS. O'CONNOR replied that to go from several dozen tracers in a few organizations to this much larger workforce, DHSS has had to do some work around building the systems and infrastructures that would allow this larger workforce. She explained that this has required the building of an entire new training system. To do this, DHSS partnered with the University of Alaska Anchorage College of Health, and now it is a statewide virtual training system. She further explained that DHSS also had to build a data management system, so the department brought the CommCare Case and Contact Management System online. This new system allows DHSS to manage all of the information on individual contacts and cases, and also allows coordination of staff assignments among the workforce shown on slide 20. She said the last piece that DHSS had to build in order to bring on this much larger workforce was a security and privacy infrastructure to ensure everything is HIPAA compliant. These three things - technology, training, and security and privacy - required DHSS to build a lot of infrastructure before it could bring anyone on. That infrastructure is now built, she said, so DHSS expects workforce additions to be much faster from hereon. For example, 50 tracers have been brought on since DHSS last spoke to the committee and the department anticipates bringing on roughly that same number in the next week or so.

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REPRESENTATIVE SPOHNHOLZ stated she is happy to hear this. She related that she recently heard that contact tracers in the Anchorage area are required to be in one place, which is concerning. She asked whether there is a way for contact tracers to be distributed throughout the state, so they don't have to congregate.

MS. O'CONNOR responded that DHSS is in the process this week of onboarding the Anchorage Health Department into the CommCare system. An advantage of the new CommCare system is that it can be accessed from either the workplace or a personal device, so people can work remotely. The partners of DHSS will make their own decisions as to where they want staff to work, but this new system will enable staff to work remotely in new ways.

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MS. O'CONNOR displayed slide 21 and summarized her portion of the presentation. She reiterated that contact tracing is part of the department's effort to test, isolate, find, and quarantine to prevent the spread of COVID-19. She stated that the department doesn't currently have enough workforce capacity to implement all of the steps of contact tracing that it would normally do. So, the department is currently prioritizing the higher risk cases and the higher risk contacts and will continue to assess this as it adds new capacity. About 50 contact tracers have been added within the last month and an additional 238 have completed training within the University of Alaska Anchorage's workforce. She added that the department's partners are now using the CommCare case and contact management system. The department is looking at streamlining the process to train and onboard staff, such that the process this week looks different than the process used last week. Further, DHSS is focusing on lessons learned, team structure, and coordinating assignments to maximize efficiency. Ms. O'Connor stated that quality assurance and quality improvement are challenges that DHSS is meeting by having the new CommCare system and being able to understand the data closer to real time. She explained that quality assurance looks back at the training, technology, and security environment that support the department's commitment to quality.

4:33:16 PM

HEIDI HEDBERG, Director, Division of Public Health, Department of Health & Social Services (DHSS), provided the final portion of the department's PowerPoint presentation. She recalled that at the beginning of the pandemic there was lots focus on not having sufficient resources at Alaska's hospitals or in the communities to respond effectively to the pandemic. She showed slide 23 and discussed the statistics of the medical supply shipments as of 7/27/20. She said DHSS has received 1,028 resource requests at the state emergency operation center, and of those requests the department is serving 62 communities and 269 individual organizations, and has shipped out numerous key resources, [gloves, surgical masks, N95 masks, gowns, TYVEK suits, face shields, and swabs]. The supply chain is continuing to open up, she related, although it is slow in some specific areas such as caps, gowns, and shoe covers. A variety of vendors are being worked with to ensure that DHSS has stock so that if a community or hospital is unable to procure then the department is able to meet that need.

MS. HEDBERG brought attention to the bar graph on slide 24 and said DHSS values the partnership of the Alaska State Hospital and Nursing Home Association. She explained that DHSS works with the association on a daily basis. The association surveys all of the hospitals and asks where the hospitals are at with their supplies. The department is then able to review, monitor, and understand what are the hot commodities, what is difficult to procure, and how can DHSS leverage at the state level some of these procurement contracts. She noted that yellow on the bar graph means a supply wasn't provided, blue means it's greater than 60 days, green denotes 30-60 days, and grey denotes less than 30 days. She indicated that overall the hospitals have sufficient stock on hand.

MS. HEDBERG moved to slide 25 depicting a graph of the total hospitalized positive COVID patients in Alaska as of 7/27/20. She credited the Alaska State Hospital and Nursing Home Association for providing these statistics. She said DHSS monitors these hospitalization numbers very closely.

MS. HEDBERG displayed slide 26 and concluded the presentation. She stated that DHSS wants to ensure it is getting information out and has therefore centralized its communications. She said committee members are welcome to share with their constituents that questions regarding COVID can be emailed to DHSS at covidquestions@alaska.gov and questions regarding data can be emailed to data.coronavirus@alaska.gov.

4:37:22 PM

CHAIR ZULKOSKY thanked the presenters, Commissioner Crum, and Dr. Zink. She further thanks all the physicians from around the state who have contacted the committee. She said the message has come through loud and clear that the time to act is now.

4:38:28 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.