

**ALASKA STATE LEGISLATURE
HOUSE STATE AFFAIRS STANDING COMMITTEE**

March 17, 2020

5:07 p.m.

MEMBERS PRESENT

Representative Zack Fields, Co-Chair
Representative Jonathan Kreiss-Tomkins, Co-Chair
Representative Grier Hopkins
Representative Andi Story
Representative Laddie Shaw

MEMBERS ABSENT

Representative Steve Thompson
Representative Sarah Vance

OTHER LEGISLATORS PRESENT

Representative Ben Carpenter
Representative Adam Wool
Representative Dan Ortiz
Representative Matt Claman
Representative Andy Josephson
Representative Chris Tuck
Representative Ivy Spohnholz
Representative Dave Talerico

COMMITTEE CALENDAR

PRESENTATION: COVID-19 OMNIBUS HEARING

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

TOMAS PUEYO, Modeler/Mathematician
San Francisco, California

POSITION STATEMENT: Co-presented and answered questions during the presentation, entitled "COVID-19 Omnibus Hearing," with the use of a PowerPoint presentation.

NIRAV SHAH, MD
Stanford University Clinical Excellence Research Center
Palo Alto, California

POSITION STATEMENT: Provided information and answered questions during the presentation, entitled "COVID-19 Omnibus Hearing."

BRYAN FISHER, Operations Manager
Division of Homeland Security and Emergency Management (DHS&EM)
Department of Military & Veterans' Affairs (DMVA)
Joint Base Elmendorf-Richardson (JBER), Alaska

POSITION STATEMENT: Co-presented and answered questions during the presentation, entitled "COVID-19 Omnibus Hearing."

HEIDI HEDBERG, Director
Division of Public Health (DPH)
Department of Health and Social Services (DHSS)
Anchorage, Alaska

POSITION STATEMENT: Co-presented and answered questions during the presentation, entitled "COVID-19 Omnibus Hearing."

JARED KOSIN, Chief Executive Officer (CEO)
Alaska State Hospital and Nursing Home Association (ASHNHA)
Anchorage, Alaska

POSITION STATEMENT: Provided information and answered questions during the presentation, entitled "COVID-19 Omnibus Hearing."

NILS ANDREASSEN, Executive Director
Alaska Municipal League (AML)
Juneau, Alaska

POSITION STATEMENT: Co-presented and answered questions during the presentation, entitled "COVID-19 Omnibus Hearing," with the use of a PowerPoint presentation.

ACTION NARRATIVE

[5:07:23 PM](#)

CO-CHAIR JONATHAN KREISS-TOMKINS called the House State Affairs Standing Committee meeting to order at 5:07 p.m. Representatives Shaw, Hopkins, Story, Fields, and Kreiss-Tomkins were present at the call to order. Also in attendance were Representatives Carpenter, Wool, Ortiz, Claman, Josephson, Tuck, Spohnholz, and Talerico. [Although the meeting was announced as joint with the House Special Committee on Military and Veterans' Affairs, and several of that committee's members were present, it was not scheduled as such.]

PRESENTATION: COVID-19 OMNIBUS HEARING

5:08:15 PM

CHAIR KREISS-TOMKINS announced that the only order of business would be a presentation, entitled "COVID-19 Omnibus Hearing."

5:09:47 PM

TOMAS PUEYO, Modeler/Mathematician, referred to his PowerPoint presentation, entitled "Coronavirus: Why You Need to Act Now," and reviewed the information on slide 2, which read:

Who Am I?

- A citizen
- Author of viral post on Coronavirus (~37M views)
- 2 MSc in Engineering
- MBA from Stanford
- Heavy stats and analytics background
- Created viral applications with 10s of millions of users
- Heavy experience modeling virals and exponential growth
- Currently VP Growth, managing a billion-dollar business at Course Hero

Endorsements

- >500 academics from > 10 countries
- Professors from MIT, NYU, Harvard, Cornell, WHO...
- Famous thinkers: Ehud Barak, Tim Berners-Lee, Steven Pinker, Andrew Yang, George Takei, Salman Khan, Margaret Atwood, Patrick Collison (CEO Stripe), Simon Baron Cohen, Edward Norton, Dick Costolo (ex-CEO Twitter), Kara Swisher, Marc Benioff (Salesforce CEO), Ev Williams (founder, Twitter, Medium)...

MR. PUEYO explained that from his educational background and experience, he has been able to compile data and analyze it to understand the viral dynamics of spread. At his current job, he can define exponential growth and make decisions under uncertainty.

MR. PUEYO turned to the graph on slide 3, entitled "Total Cases outside of China," to show the steep fast rise in virus cases from the end of February to the middle of March 2020. He

related that the slide 4 graph, entitled "Coronavirus Cases per Country," demonstrates the steep rise of the virus in South Korea, Italy, and Iran from 2/20/20 - 3/7/20; however, looking at the lower right corner of the graph, it is clear that an "explosion" of cases will occur beyond 3/7. He turned to the graph on slide 5, entitled "Official Cases per Country," which zooms in on the lower right corner of slide 4 and adds one week. It shows the exponential growth in the number of cases in Spain, Germany, France, and the U.S.

[5:12:53 PM](#)

MR. PUEYO tuned to slide 6, which read:

USA, Today

~5,000 cases

~100 deaths

+32% daily growth

2x every 2.5 days

If growth continues → 1000x in 4 weeks
(5M cases in a month)

MR. PUEYO added that these represent only the official cases. He moved on to slide 7, entitled "Chart 7: Timeline of Events in Hubei," to compare the bar graphs representing the numbers of true cases with those of official cases, and the time lag that exists between the two trend lines. When a person gets sick, he/she does not go to the hospital immediately and, therefore, is not diagnosed immediately. That creates a big lead time before a true case becomes an official case. The chart shows that between 1/21 and 1/23, the number of cases in Hubei started exploding; the city was shut down on 1/23; and immediately the number of true cases plummeted. Up until the shutdown, the number of true cases had been growing exponentially. After the shutdown, the diagnosed cases continued to increase over the month, but within two to three weeks, the number of new cases became very small.

[5:15:16 PM](#)

MR. PUEYO posed the question of how to assess the number of true cases in the U.S. Slide 8 shows the U.S. with 94 deaths; slide 9 puts those 94 deaths at week 3 and shows that on week 0, there were at least 94 cases. Slide 10 demonstrates an estimated 9,400 cases on week 0 based on information that it takes on average three weeks from onset to death and the mortality rate

is 1 percent. Since the spread of the virus doubles every week, the estimated cases for week 1 are 18,400, as shown on slide 11; slide 12 shows an estimated number of cases for week 2 at 36,800; and slide 13 indicates an estimated number of cases at present to be about 70,000. He emphasized that 70,000 is not the actual number but is based on the number of deaths; tens of thousands of people are currently sick.

[5:17:23 PM](#)

MR. PUEYO moved on to slide 14 and stated that the U.S. has many hidden cases - in the tens of thousands - and the cases are growing exponentially. He turned to slide 15, entitled "Chart 8: Coronavirus Cases," to point out that the Chinese regions outside of Hubei were able to control the epidemic, but South Korea, Italy, and Iran, which did not take the same measures as China, were not able to control it. Slide 16, entitled "Chart 9: Total Cases of Coronavirus Outside of China," reveals other countries able to control the epidemic - Singapore, Hong Kong, Japan, and Thailand.

MR. PUEYO turned to slide 17, which read, "This can be stopped." He referred to slide 18 - a chart developed by Dr. James Lawler, a University of Nebraska Medical Center professor, for the American Hospital Association, that communicates the best guesses on the impact of the coronavirus on the U.S. healthcare system in 2020. The chart shows that at the current growth rate, there will be an estimated 100 million cases; of those, about 5 percent will require hospitalization; 1-2 percent will require an intensive care unit (ICU); and a conservative estimate of fatalities based on a .5 percent mortality rate would be 500,000 people. He explained that the .5 percent mortality rate is seen in the "best place" - in China and South Korea - both very much "on top of it." The fatality rate in places that are not on top of it is 10 times higher. The fatality rate in Hubei, Iran, and Italy is about 4.8 percent. The estimate of a half a million deaths is with the assumption of a very low fatality rate.

[5:20:01 PM](#)

MR. PUEYO turned to the pictures on slides 19, 20, and 21 showing the crowd of people waiting to be treated at a hospital in Hubei, the ICU, and an exhausted health care worker. He mentioned the consequences of an overwhelmed ICU and overwhelmed hospital workers, many of whom will contract the disease themselves.

MR. PUEYO turned to slide 22 and relayed that with an overwhelmed health care system, the fatality rate would be ten times as high as the .5 percent - as seen in Hubei versus the other Chinese regions and in Italy and Iran versus South Korea. The picture in slide 23 shows unmarked graves in Iran due to the inability to manage all the deaths.

5:21:20 PM

MR. PUEYO referred to slide 24, entitled "Why it is so important to act early on COVID-19," and stated that what is needed is to "flatten the curve." Slide 24 graphically demonstrates the results of different approaches: the results of taking no action is a spike of patients - shown in purple - overwhelming the health care system; the orange line in the graph shows the capacity of the health care system; consequently the large number of patients represented by the purple spike above the orange line will not receive proper treatment, and the fatality rate will be ten times higher. The goal is to push the peak of cases back in time so that the fatality rate will be much smaller; it is called "flattening the curve."

MR. PUEYO moved on to slide 25, entitled "Chart 21: Total excess pneumonia and influenza mortality by public health response time." The chart illustrates the result of different U.S. cities reacting to the 1918 influenza ("flu") pandemic: St. Louis had a quick response and there were 350 deaths per 100,000 population; Pittsburgh's response was seven days later, and deaths were about 800 per 100,000.

MR. PUEYO turned to slide 26, entitled "Chart 22: Model of Daily New Cases of Coronavirus with Social Distancing Measures Taken One Day Apart," to illustrate the effects of social distancing on flattening the curve. "No social distancing" results in an exponential increase in cases; "social distancing" flattens that upward curve. Slide 27, entitled "Chart 23: Model of Cumulative Cases of Coronavirus with Social Distancing Measures Taken One Day Apart," demonstrates that a single day delay in social distancing results in 40 percent more cases. Taking the measure of social distancing is not only important but extremely urgent wherever there is an outbreak.

MR. PUEYO referred to slide 28, which read "What Strategy Should We Follow?" and mentioned that politicians must take everyone into consideration, not just those who are sick.

[5:25:18 PM](#)

MR. PUEYO turned to slide 29, entitled "What Strategy should We Follow?" and said that currently the number of cases is growing exponentially, and there are two options. He referred to slides 30-31 and said that the first option is to do nothing: the number of cases would explode; the health care system would be completely overrun; everyone could not be treated; and the cases and deaths would multiply. The second option is social distancing: it would slow down the number of new cases per day; and in three to six weeks the number of cases would be very small. Many view this solution as "kicking the problem down the road" and in the meantime hurting the economy greatly. He stated that the way to view this is in the context of buying time. He referred to slide 32 to emphasize what could be accomplished in the three to six weeks of social distancing, which read:

- Cut growth
 - Understand true cases
 - Get proper testing
 - Release the pressure on the healthcare system
 - Build healthcare capacity: masks, ventilators, ECMOs, ICU beds
 - Increase production
 - Recruit personnel
 - Understand cost-benefit of measures
 - Improve treatments
- Learn

MR. PUEYO offered that many of the optional measures are going to be extremely expensive; people might lose jobs, commit suicide, or die. A lockdown for months would deplete the economy. He recommended that [social distancing] would reduce the problem immediately allowing time to determine which measures matter, which measure don't matter, and which measures give the most "bang for the buck." He said that the transmission rate is 2.5 - meaning that every person who is infected will infect 2.5 people. That number must be brought down close to zero immediately; after that, easing up of the social distancing measure will bring the rate close to one. At that point all measures can be evaluated to decide which ones to continue and which to stop. He gave an example: it may make

sense not to have meetings of more than 100 people, because of the spread of the virus and the small contribution of that meeting to the economy; conversely, it may make sense to lift the prohibition on normal business operations but provide hygiene education to control the spread of disease. He maintained that this course of action does not solve the problem but offers time.

[5:29:52 PM](#)

CO-CHAIR FIELDS maintained that the presentation highlights the importance of the state government to take aggressive action to prevent the spread of the virus. He emphasized that it is imperative that the Department of Administration (DOA) issue guidance immediately regarding teleworking and staying at home without penalty; state employees are on the front lines - interacting with each other and with the public - without protective equipment. Alaska does not have an adequate number of virus tests. He asked Mr. Pueyo for an estimate of the actual number of cases in Alaska based on three confirmed cases.

MR. PUEYO responded that Alaska is fortunate in that the density of population is low and it is far from the other states. He said that it is possible that the true case rate is not orders of magnitude higher; it may be a few thousand cases or a few hundred cases, and such that it is completely controllable. It is also likely that the transmission rate in Alaska, because of the lower population density, is lower; therefore, it is very possible that some measures taken today can be released quickly, once there is a better understanding of the situation.

CO-CHAIR FIELDS commented that Mayor Ethan Berkowitz of Anchorage was criticized for taking aggressive action regarding social distancing. He maintained that it is time for the state government to take similarly aggressive steps.

[5:32:59 PM](#)

REPRESENTATIVE STORY asked whether Dr. Anne Zink, Alaska's chief medical officer, was provided with the information in the presentation.

CHAIR KREISS-TOMKINS answered that he has been in contact with the Department of Health and Social Services (DHSS) and email contact with Dr. Zink. He added that Director Heidi Hedberg, Division of Public Health (DPH), [DHSS], will present during the hearing.

[5:33:32 PM](#)

REPRESENTATIVE HOPKINS reiterated testimony that if Alaska takes strong measures now, it might see a quicker response because of the lower density of population. He asked whether with relaxing the measures, including mandatory social distancing, there exists an expectation of a second peak of cases of viruses based on research of coronaviruses.

MR. PUEYO stated that China has the most experience with the virus currently. The province of Hubei had a lockdown; it was released; and there was again growth of the virus prompting a return to increasing social distancing measures. If the transmission rate is 2.5, then getting it to below 1 will result in the virus dying out because each person with the contagion would not infect more than 1 person. Initially, the goal is to get the transmission rate as low as possible as fast as possible so that by "buying time," Alaska can understand the situation. After that, getting the transmission rate close to 1 controls the spread of the virus without heavy economic consequences. He added that the 2.5 transmission rate is what occurred in China. In Alaska, if the rate is 1.5, the measures needed to achieve a rate of 1 would be less than in many other locations. It is possible that in Anchorage the rate is higher. He maintained that in the next few weeks, once Alaska has bought itself time, there will be great understanding of the actual transmission rate and the measures with the most impact. Alaska can then implement those measures, choose to be more conservative or aggressive, and, thereby, control the outbreak.

[5:36:59 PM](#)

CO-CHAIR KREISS-TOMKINS referred to the decision point indicated on slide 31 and asked whether there is any indication that the curve is starting to flatten in Italy in response to social distancing.

MR. PUEYO referred to slide 7 to use Hubei as an example; the lockdown stopped the true cases but didn't stop the official cases. People were becoming sick over the following weeks. In Italy, the lockdown began ten days ago; official cases are increasing exponentially as demonstrated on slide 5, and that would be expected. By the end of next week, it is expected that the number of official cases will slow down and collapse, because that is what was seen in Hubei.

[5:38:38 PM](#)

NIRAV SHAH, MD, Stanford University Clinical Excellence Research Center, stated that what was learned from China was that 79 percent of all the infections was spread in the community through people who were not diagnosed early; therefore, it is not the people with symptoms who are doing most of the damage, but the people walking around not knowing they are sick or with mild symptoms spreading the virus in the community. This points to early lockdown and social distancing as having the most impact. He maintained that it is unknown at this point how many have the virus in Alaska, especially with inadequate testing.

[5:39:26 PM](#)

CO-CHAIR FIELDS recollected that South Korea has greater than ten beds per one thousand people and in Alaska there are only two per one thousand. He asked for comment on the implications that will have on mortality rates if Alaska fails to contain the virus and the number of hospital beds per capita is low.

[5:39:56 PM](#)

DR. SHAH answered that China's experience provides information on who is infected and who requires hospitalization. The Journal of the American Medical Association (JAMA) reported 0 deaths in children age 9 and under; the highest mortality rates were among older adults; among those age 80 and over, the case fatality rate was about 15 percent. It is a disease that severely effects older adults, and the chance of needing hospitalization increases exponentially the older one is. He stated that in Alaska the number of hospital beds and ventilator beds are what will make the difference. He relayed that the disease involves Severe Acute Respiratory Syndrome (SARS); one's lungs fail, and they need support while they heal. At the same time, several investigative drugs are being used to try to help the healing process. With past SARS experience, it is evident that ICU beds with ventilators are needed.

[5:41:47 PM](#)

MR. PUEYO added that Representative Kreiss-Tomkins's underlying question is: "Is our system going to collapse?" He said the variable is the number of cases; it is possible that Alaska has been extremely lucky and there are not many more cases than the official number; however, it is unlikely. He stated that implementing social distancing measures may prevent collapse of

the health care system. If Alaska is not lucky, it might collapse in the next few weeks; the key variable in that case would be the number of ventilators.

[5:42:33 PM](#)

REPRESENTATIVE CARPENTER asked for comment on testing for the virus at the onset of symptoms versus prior to onset of symptoms.

DR. SHAH replied that broad testing is limited by the number of tests on hand. When the U.S. began testing, it was severely undertesting because testing was limited to people with direct contact with those coming back from China, Iran, and Italy. The testing strategy should have been much broader earlier. Given the limited number of tests, the country is restricted to testing those at highest risk. As soon as tests become more available, testing criteria should be quickly broadened to include those at mild risk or with any suspicion of the disease.

[5:43:51 PM](#)

MR. PUEYO added that a comparison can be made between South Korea and Italy; these are the two countries outside of China with the highest rates of testing; the test results of the two countries were completely different. He explained that in Italy the testing was performed mostly on people who came to the hospital; testing revealed that the older a person was the more likely that person was infected. In South Korea everyone who wanted to be tested was tested - tens of thousands of tests per day - and it could be done at a drive-up station. With so many people, with or without symptoms, being tested, it was discovered that most people infected were not older people, but younger people - in their 30s and 40s. Consequently, most people with the virus are not showing symptoms, think they do not have the virus, and may be spreading it. The peak for true cases comes just before the peak in diagnosed cases; it spreads before symptoms are evidenced; and everyone has it, not just older people. He emphasized the importance of more tests due to people unknowingly spreading the disease.

[5:45:50 PM](#)

DR. SHAH added that New York City kept its schools open because of the hundreds of kids that would be without school meals; then it shut the schools down to contain the virus through "sheltering in place." He recommended acting early and quickly,

and then changing in response to the changing data and new information.

[5:46:52 PM](#)

DR. SHAH stated that he is a general internist by training, was the New York State health commissioner for four years, was chief operating officer (COO) for Kaiser Permanente clinical operations, and currently is a professor at Stanford University advising the state on public health issues. He mentioned that as of yesterday, there were 248 trials for new agents against COVID-19, [a novel coronavirus disease], in China and 90 trials in the U.S. He said that he is optimistic that an agent will be found with some activity against the virus. Finding drugs that are effective for treatment will also flatten the curve. Vaccine development has begun in the U.S., but vaccine development takes much longer due to the need for it to be validated and then propagated; optimistically, it would be at least 12 to 18 months before release for general use.

Dr. SHAH relayed that the other part of the equation is diagnostic testing. He expressed his optimism that two weeks from now there will be an adequate supply of COVID-19 testing kits; currently there are few restrictions on who can make the high-quality testing kits; and over 200 organizations across the country are making them. He mentioned severe shortages of personal protective equipment, which will be real and sustained over the next few weeks and months. Much work is being done to address that issue, but the U.S. was late in ordering.

[5:49:49 PM](#)

DR. SHAH concluded with three broad comments: First, stay with the science; information is published daily; an excellent source of real data is the World Health Organization (WHO); listen to Anthony Fauci, [director of the National Institute of Allergy and Infectious Diseases (NIAID)], because he is an expert. Second, communicate clearly and speak with one voice. Third, focus efforts on responding to the needs and not the hype. Some of the most vulnerable populations in America are the elderly, who are not only the most susceptible to the virus but susceptible to social isolation and other negative consequences to trying to be compliant. Another vulnerable population is the homeless; they are very much at risk, are not in the system, and are not tested quickly. The third vulnerable population is those without insurance and those "undocumented" [as legal

residents]. He challenged the legislators to consider how to address the three vulnerable populations.

[5:51:59 PM](#)

REPRESENTATIVE CARPENTER asked whether there is a correlation between the efficacy of the influenza A vaccine and what can be expected with a COVID-19 vaccine, considering there is a significant number of influenza A deaths every year regardless of there being a vaccine.

DR. SHAH answered that flu vaccines are not always effective because the predominant strain changes from one year to the next. The U.S. observes the results from Australia and Asia to make its best guess regarding the most common strain and creates the vaccine from a mix of elements. Some years the vaccine is more effective than others. He offered that in a bad year, the flu will kill 61,000 Americans; the ones dying are those with weakened immune systems, underlying medical conditions, and the elderly; but it has become the new normal. He maintained that there are too many differences between the two diseases and doesn't want to speculate. He offered his appreciation that the effort to make a vaccine has begun; there is great interest in quickly making one that works.

[5:53:53 PM](#)

REPRESENTATIVE TUCK asked whether a person who has recovered from the virus could be tested to determine if he/she is no longer infectious and whether a person can continue to harbor the virus after recovery.

DR. SHAH responded that in China, there were cases of individuals who tested positive, recovered, tested negative, and then were infected again. He stated that not enough is known about the virus - its history, its transmission, or whether it can hide out in individuals and reemerge.

[5:55:16 PM](#)

MR. PUEYO added that the answer to the question depends on the test. One test is a swab from the nose and throat; the other is a blood test for antivirals. The swab detects the virus and the blood sample detects antibodies against the virus. Depending on the test, one can determine whether a healthy person today was or was not sick in the past.

[5:56:18 PM](#)

REPRESENTATIVE TUCK referred to the experience of South Korea - which was able to flatten the curve quickly with medical attention - and asked how to know when to back off on social distancing and other precautionary measures, especially as they so greatly affect the economy.

[5:56:55 PM](#)

DR. SHAH answered that currently there is not good data to monitor the outbreak. It is believed that much virus is spreading in communities and across the U.S. On Thursday, tools will be released nationally at the county level that can monitor hidden COVID-19 in the community; companies are working on units with smart thermometers connected to smart phones to upload temperatures. There are very good predictive models on the movement of flu; therefore, after subtracting out the flu temperature signals, the elevated temperatures from the COVID-19 hotspots around the country are presumed to be COVID-19 and other flu-like illnesses. These tools will enable people to make decisions in real-time about social isolation and quarantine based on new data and the appropriate time to relax the counter measures.

[5:58:39 PM](#)

CO-CHAIR KREISS-TOMKINS asked whether there is such a thing as "too aggressive a response in this moment in time" in terms of social distancing measures and other measures with economic impacts. He asked, "Can you go too far in a reaction, if there's not documented spread?"

[5:59:26 PM](#)

MR. PUEYO acknowledged that Alaska is a special case in that the current official count is low; therefore, it is a cost-benefit question. He said that if the state imposes measures that lock everyone at home resulting in people dying, that would not be good. Alaska is in the position of making decisions based on imperfect data; the official count being low is a benefit. It depends on what Alaska's strategy will be. For lower risk, aggressive action is needed. The more social measures Alaska applies, the safer Alaskans will be, and the state buys more time; however, it will be more expensive. Each measure represents a trade-off. With low numbers, Alaska may decide to "take a gamble." He recommended that Alaska be more

conservative and choose the measures for greater safety, if they don't create undue hardship.

6:01:46 PM

DR. SHAH added that an ounce of prevention is worth a pound of cure, and public health is all about prevention. There are incredible down-stream savings, as demonstrated in the model - 40 percent more cases resulting from one day delay in social distancing. He recommended erring on the side of caution and prudence with clear communications about the assumptions and data used to make decisions. Closing public services have real implications, but clearly sharing the information on why decisions are being made and the decision points that would alter those decisions garners public support. He said that the lessons of history are clear: the earlier Alaska acts, the better off it will be; there are implications of acting too slow; the implications of acting too quickly generally pale in comparison.

6:03:20 PM

REPRESENTATIVE SPOHNHOLZ referred to the example given of New York City not closing schools due to children not getting meals. She offered that due to the aggressive social distancing policies, especially in Anchorage, some people are no longer employed or not earning income, including her sister-in-law. She asked about the right policy choices considering the costs of aggressive social distancing.

6:05:00 PM

MR. PUEYO responded that these are hard decisions, and currently Alaska is not equipped to make them properly. The benefit of the social distancing measure is a reduction in virus transmission rates; the cost is of lost wages for Alaskans. One strategy is to compensate Alaskans for lost wages so that they are not economically impacted. He reiterated the problem: currently Alaska is not equipped to make decisions but will be making them intuitively without data. Not earning wages for two weeks might not be a big expense, but if it is, then it might not be a big expense for the government. In three weeks, with more information on the cost-benefit, appropriate measures can be selected to control the illness. Not acting today may eliminate the options in three weeks due to the virus becoming a complete epidemic.

[6:07:13 PM](#)

DR. SHAH said that human costs are hard to quantify. He reiterated that Alaska should respond to the need not to the hype. He asked how Alaska can provide a safety net for those affected by the decisions that have been made. He recommended that the state respond to the needs of today and adjust its response daily based on the information.

[6:07:52 PM](#)

REPRESENTATIVE SPOHNHOLZ expressed the importance of not viewing the response as binary and abstract; there are consequences to decisions; in being aggressive in minimizing the transmission of COVID-19, the state must also aggressively advance corresponding investments to protect people from the negative consequences of the decisions.

[6:08:33 PM](#)

REPRESENTATIVE CARPENTER asked for comment on the ability of the virus to live outside the host - specifically in relationship to climate, humidity, and different surfaces.

[6:09:14 PM](#)

DR. SHAH mentioned the misinformation currently in circulation and recommended the information on the WHO website. He stated that the understanding is that COVID-19 is not very different from other viruses. On any normal surface, it is alive for a few hours. Areas of concern are places that many people touch, such as door handles; they should be avoided, a napkin used, or followed by hand washing or hand sanitizer. The virus lives longer in certain conditions according to moisture level.

[6:10:15 PM](#)

MR. PUEYO added that there are many research papers being published on the topic, and soon there will be much more understanding of the virus. He said that as of today, there are 1,500 cases of the virus in Norway, 1,200 cases in Sweden, and 1,000 cases in Denmark; therefore, he would not view Alaska being safe by virtue of its weather.

[6:11:31 PM](#)

REPRESENTATIVE CARPENTER asked whether the virus is a "winter bug" or whether it will be year-round. He asked about cases in Australia and South America.

[6:12:00 PM](#)

DR. SHAH stated that there are cases in warmer countries; India and Africa are seeing cases; however, they have fewer cases than Northern climate countries. He maintained that it is not known whether the virus will be year-round; it will depend on human behavior and other complex interactions between the virus and the host. The hope is that spread of the virus during the summer months will decline, but that is not yet known.

[6:12:48 PM](#)

MR. PUEYO added that the most relevant paper addressing the topic looked at the city by city spread in China; there was a correlation between low temperature and humidity and spread; there were decreasing transmission rates with warmer and more humid weather. He added that the paper has not been peer reviewed.

[6:13:44 PM](#)

CO-CHAIR KREISS-TOMKINS introduced the next two presenters and mentioned that areas of interest to the legislature and Alaskans are current and future testing capacity and the incident command structure in Alaska for supply chains and logistics, including in rural Alaska.

[6:14:41 PM](#)

BRYAN FISHER, Operations Manager, Division of Homeland Security and Emergency Management (DHS&EM), Department of Military & Veterans' Affairs (DMVA), stated that for the response to the COVID-19 outbreak, he is Alaska's incident commander in the State Emergency Operations Center (EOC). He reviewed the bulleted information on the 3/15/20 memorandum from DMVA Commissioner Torrence Saxe to the House Military & Veterans Affairs Committee, which read:

The department's actions are as follows:

- DMVA has been involved in the response to COVID-19 since the Wuhan Repatriation flight that occurred in late January.

- Involvement has primarily been preparing to participate in a Unified Command with the Department of Health and Social Services (DHSS) and the Department of Public Safety (DPS) in accordance with the Alaska Pandemic Influenza Plan.
- At direction of The Adjutant General, the Alaska Organized Militia stood up a Joint Task Force to prepare for any potential resource requests that may come from the State Emergency Operations Center (EOC) to the National Guard in response to this event.
- Governor Dunleavy's declaration of public health disaster emergency, issued March 11, 2020, directed the activation of the Unified Command described above.
- The State EOC is activated, and will be staffing the Unified Command to coordinate the overall response to COVID-19. This is similar to how the executive branch responds to disasters, such as the 2018 Cook Inlet Earthquake, flooding, etc.
- The mission of the State EOC and COVID-19 Unified Command is to respond to requests for assistance or resources from our local jurisdictions. We utilize the Incident Command System to organize that response.
- The Alaska Organized Militia is prepared to respond to resource requests or mission assignments that cannot be fulfilled by local, private, or other civilian methods.
- The Alaska Military Youth Academy has been in direct contact with the Department of Education and Early Development, and DHSS, and has developed contingency plans in case the Academy needs to close school.
- The entirety of DMVA has developed continuity of operations plans and orders of succession, and are planning to implement telework if directed by Department of Administration on the state side, or at the direction of the Adjutant General on the federal side.

COMMANDER FISHER added two additional objectives of the Unified Command: 1) to ensure the safety and security of responders as well as, maximize the protection of public health and welfare; and 2) to contain the spread of COVID-19 in Alaska by implementing all community mitigation actions and interventions that have been described in the past couple weeks. He relayed that DMVA continues to support DHSS; it has a role in keeping the public and media informed and in rumor control.

6:17:35 PM

COMMANDER FISHER continued by reporting that the Incident Command System (ICS) has two branches: 1) an emergency services branch that is involved with sheltering and housing quarantined residents, community mitigation strategies, a public-private partnership with industries through the Alaska Partnership for Infrastructure Protection, transportation of people around the state, and the logistics for transporting medical, pharmaceutical, and personal protective equipment throughout the state; and 2) a medical branch - DHSS - which includes the Section of Epidemiology, the Alaska State Public Health Laboratories, the Section of Public Health Nursing, and the medical countermeasures personnel.

COMMANDER FISHER added that DMVA is in constant contact with all the [State of Alaska] executive branch agencies regarding their activities. He gave as example - the Department of Commerce, Community, and Economic Development (DCCED) just today forwarded a request from [Governor Mike Dunleavy] to the U.S. Small Business Administration asking for an Economic Injury Disaster [Loan] from the U.S. Department of Agriculture (USDA). All the actions by the executive branch and local jurisdictions are managed through the Unified Command.

6:20:59 PM

HEIDI HEDBERG, Director, Division of Public Health (DPH), Department of Health and Social Services (DHSS), stated that she serves with the Unified Command. She said that the focus of DPH is building health care capacity in Alaska, and to do so it engages in multiple strategies. Building health care capacity involves leveraging telehealth and ensuring that hospitals: triage patients outside the hospital or in different locations; recommend and/or cancel elective surgeries; assess staffing capacity; have at least two weeks of supplies on hand; and are encouraged to exclude visitors to acute care patients and long-term care facilities. She maintained that all hospitals are engaging in all the tactics at various levels and DPH is supporting that effort.

MS. HEDBERG continued by saying that a key health care strategy is establishing off-site sample collections. It consists of a station located away from the emergency department where individuals who have signs and symptoms consistent with COVID-19 and/or who have travelled through countries or communities with

widespread infection can be screened and have samples collected; samples are sent to the DPH laboratory ("lab") in Anchorage or Fairbanks or one of the two reference labs - LabCorp or Quest [Diagnostics].

[6:23:47 PM](#)

MS. HEDBERG explained that "testing kit" is a lab term; the kits consist of the reagents and controls that the Centers for Disease Control and Prevention (CDC) sends to the DPH lab upon request. There are 750 test kits in Fairbanks and 900 in Anchorage. If Alaska needs more, DPH will proactively call CDC for more. The collection kits are used at the off-site collection sites to collect the samples to be tested. The collection kit includes personal protective equipment (PPE) for the health care provider who is collecting the sample. Viral transport media - or universal transport media - refers to the media at the bottom of the plastic test tube. Most importantly, the kit includes a nasopharyngeal swab; the swab is inserted up into the nose almost to the tonsils to collect cells to be tested. The sample is packaged and sent to either the Anchorage or Fairbanks labs.

[6:26:05 PM](#)

MS. HEDBERG relayed that the lab in Fairbanks is called the virology lab; it is located on the University of Alaska Fairbanks (UAF) campus and is in partnership with UAF. The Fairbanks lab has two polymerase chain reaction (PCR) thermocyclers. The lab in Anchorage has three PCR thermocyclers. Testing is done seven days per week with multiple shifts per day. To date, 295 samples have been sent to the state DPH labs and 39 samples sent to the reference labs for a total of 334 samples. Information on the number of samples sent either to the state labs or the reference labs is posted on the COVID website. The LabCorp testing facility is on the East Coast; therefore, transport time must be taken into consideration. The Quest testing facility is in California. The state is exploring the expansion of lab capacity through the University of Alaska (UA). The DPH is ordering a high-throughput extractor to expedite the testing process in Anchorage; such an extractor is currently located in the Fairbanks lab.

[6:28:42 PM](#)

REPRESENTATIVE TUCK asked for clarification of the procedure for collecting samples at the off-site station.

MS. HEDBERG responded that one can observe drive-through testing for COVID-19 on a video found on the internet. She explained that a person drives up to the initial station to answer questions by way of a screening form; at the second station the person receives a visual assessment for temperature, cough, and shortness of breath; if testing is warranted, at the third station a health care provider in PPE collects cells via the nasopharyngeal swab, which is placed into the plastic test tube with a screw top. Several communities are setting up the stations, and DHS&EM is facilitating the logistics. The goal is to prevent individuals who need testing from overwhelming the emergency departments. It is important for DPH to increase its capacity for collecting samples and testing to monitor the spread of the virus in the state.

[6:31:14 PM](#)

REPRESENTATIVE TUCK asked how tests are distributed in areas of Alaska outside of Anchorage and Fairbanks.

MS. HEDBERG answered that DPH is working with all hospitals and clinics to meet their needs: 1) it is working with federal partners to access the federal caches to supply the clinics and hospitals with testing kits; and 2) it has placed an order for swabs, which will be distributed upon receipt. There are shortages of all these items. The U.S. Department of Health and Human Services (HSS) is sending out collection kits to all the states - giving priority to those states hardest hit by the outbreak. She stated that the collection kits include PPEs, but it is unknown when the kits will arrive. The state received PPEs from the Strategic National Stockpile, which was used to fill four requests from last week. She offered, "Things are moving incredibly fast." She said that as soon as DPH receives supplies, it sends them out; DPH is actively working with its federal partners to ensure they understand Alaska's shortages and capacity and to manage expectations. She mentioned that an oral and nasal sample was previously required; now CDC only requires a nasal sample.

[6:34:21 PM](#)

REPRESENTATIVE HOPKINS referred to a sample testing machine from Roche [Diagnostics], recently approved by the U.S. Food and Drug

Administration (FDA), and asked whether Alaska has any of those machines and can utilize that new commercially approved test.

MS. HEDBERG offered to follow up to provide that information.

REPRESENTATIVE HOPKINS asked about the potential for Alaska National Guard (AKNG) medical personnel to screen and test at Alaska's airports.

[6:35:40 PM](#)

COMMANDER FISHER answered that DMVA must exhaust commercial and civilian resources before putting AKNG on active duty orders under the governor's authority. If there is a request for additional staff at airports to do health screening, DMVA would source the request through civilian contracts or local resources. If that is not possible, DMVA would rely on AKNG; AKNG is manned and ready to respond; personnel and equipment are well coordinated within the Unified Command.

REPRESENTATIVE HOPKINS asked whether DMVA has begun to look at the option of local and private contractors.

COMMANDER FISHER replied that the Unified Command and DHS&EM have standing contracts for support camps for security. There have not been requests as yet for that type of manpower; however, if there are, DMVA would contact local jurisdictions to determine local capacity, then turn to other state agencies, and if contracts are needed, work with procurement to expedite them.

[6:37:48 PM](#)

REPRESENTATIVE CARPENTER asked for clarification on samples sent out of state. He asked what the throughput was for the PCR thermocyclers and how many samples can be tested per testing kit.

[6:38:21 PM](#)

MS. HEDBERG responded that a sample collected by an Alaska health care provider may be sent to a DPH lab or one of the two reference labs - LabCorp or Quest Lab - for testing. In response to the question about throughput, she offered that it depends on staffing capacity. She said that 125 samples were tested over the weekend, and with increased staffing capacity, DPH would be able to do more. Lab personnel batch the samples to fill up the slots in the PCR thermocyclers and, thereby,

stretch the reagents and controls. She maintained that DPH has not run out of test kits and has been receiving more from CDC upon request. She added that DPH proactively contacts CDC to ensure enough supply.

REPRESENTATIVE CARPENTER referred to testimony that testing is of the utmost importance and asked the question: If manpower is a problem for maximizing the use of the PCR thermocyclers, then what staffing leveling would fully utilize the equipment for the best throughput on testing.

MS. HEDBERG answered that the test itself takes four to six hours, regardless of staffing. Staff must extract the sample and load it into the PCR thermocycler; two staff is optimal; there is a requirement to enter the information into a database that is transmitted to CDC. The totality of staffing requirement is two to three people. The Division is looking at various procedures to increase efficiency in testing and notification. It has reached out to UA for additional personnel; long-term non-permanent positions have been approved and are being filled to help with testing.

[6:43:12 PM](#)

CO-CHAIR KREISS-TOMKINS asked what the limiting factor is for testing?

MS. HEDBERG answered, "It takes a system." She maintained that DPH requires the kits, the staffed off-site collection stations, and lab testing. She expressed her concern with staff burn-out; they are working 12- to 14-hour days; the work to prepare and respond to the virus has been non-stop since the re-patriation flight on January 25 [bringing the first documented case of COVID-19 to Alaska]. More staff is being hired and more equipment expedited. She stated that the limiting factor is that "the whole system has to be stood up." She said that bending the curve through social distancing will help to slow down number of tests that need processing. She expressed appreciation for the work of the reference labs in testing the samples. Beyond that, DPH conducts further investigation with the positive cases.

[6:45:18 PM](#)

CO-CHAIR FIELDS mentioned that Fairbanks Memorial Hospital has indicated that it has an inadequate number of test kits; also,

the Anchorage Neighborhood Health Center personnel have reported a shortage of test kits.

MS. HEDBERG answered that DPH is tracking the clinics and hospitals to determine what elements are lacking - PPEs, media, and swabs. Communities must pool their resources to compile complete collections kits. She said HSS communicated their recognition that states need more collection kits; it is sending the kits to the states; Alaska is not first on the list because of its low case count.

[6:47:03 PM](#)

REPRESENTATIVE SPOHNHOLZ asked how the state will find the long-term non-permanent personnel to hire under the Alaska Mental Health Trust Authority (AMHTA) funding that was authorized, since they represent high-demand professions. She asked whether such staff can be borrowed from tribal, military, or other entities to get them on the payroll as quickly as possible in order to respond to the need.

MS. HEDBERG mentioned partnerships with the Alaska Native Tribal Health Consortium (ANTHC) and the Alaska Native Medical Center (ANMC), which provided the Section of Epidemiology with two nurses; DPH is looking to UA for microbiologists and lab technologists (techs); DPH is looking to other state agencies as well. She said that with the limited number of lab techs, microbiologists, and chemists in the state, DPH has asked retired people with current licenses to fill the positions.

REPRESENTATIVE SPOHNHOLZ referred to the four travel-related cases confirmed in Alaska, countries who are screening incoming travelers, and Alaska's reliance on air travel. She asked whether there has been discussion of screening at the airports to identify people - who are unknowingly sick with the virus - before they are integrated into their communities.

[6:49:52 PM](#)

COMMANDER FISHER answered that since the first repatriation flight, DMVA has been in discussions with partners at the airports, CDC, HHS, U.S. Customs and Border Protection (USBP), and the U.S. Coast Guard (USCG). He offered that the Ted Stevens Anchorage International Airport screens workers on their way to work on the oil fields on the North Slope. He maintained that CDC is dynamically updating its recommended guidance for travelers, workers, airports, and industry.

6:51:49 PM

MS. HEDBERG added that it is paramount that every Alaskan returning to Alaska from any country with a level 3 Travel Health Notice - as published on the CDC website - immediately return to his/her home, do not engage with anyone, and self-quarantine for 14 days. She relayed that Alaskans returning from a level 2 country - such as the U.S. - should stay home and monitor themselves if they are not feeling well. They should contact their providers, if they develop symptoms consistent with COVID-19. She mentioned the governor's focus on telework and actions of other companies. She emphasized that the state needs the help of Alaskans; they must be aware of the signs and symptoms; they must stay home if sick. She maintained that neither the state nor AKNG have the capacity to screen everyone coming into Alaska.

REPRESENTATIVE SPOHNHOLZ asked for the threshold point at which DPH might decide to screen [all] incoming travelers, considering the oil industry has identified the issue as strategically important. She expressed the importance of a functional air system in Alaska, especially now that the ferries are not functioning, and the importance of managing the spread of COVID-19.

MS. HEDBERG suggested that the question of when to institute such a measure is one of the factors that Alaska needs to put into its "triggers."

6:55:37 PM

CO-CHAIR KREISS-TOMKINS mentioned that during the hearing, two more cases of COVID-19 in Alaska have been reported - one in Fairbanks and one in Anchorage.

6:55:58 PM

REPRESENTATIVE STORY asked whether Alaska has reached out to other states in anticipation of needing more testing kits and equipment.

MS. HEDBERG replied that every state is in the same predicament as Alaska; the difference between Alaska and the other states is Alaska's aggressiveness on social distancing and community mitigation, which is enabled by Alaska's health care system being small. The State of Washington asked Alaska to do its

tuberculosis testing when it became overwhelmed, which Alaska can do currently. She maintained that since every state is grappling with the same issues, Alaska needs to look to private industry, reference labs with a higher capacity for testing, and ways to maximize its own testing capabilities.

[6:57:56 PM](#)

CO-CHAIR KREISS-TOMKINS stated that it is clear from all public health guidance that a high throughput of testing is absolutely vital to get a handle on the scope of the epidemic, so that Alaska is able to make a more data-informed decision, know how much to restrict the economy through social distancing, and know the right balance. There is not a great deal of testing capacity in Alaska or the U.S. compared with other countries, which has been a source of immense frustration for Americans. He asked Ms. Hedberg what the ideal throughput of testing in Alaska would be - in her professional perspective - if there were no resource constraints or limiting factors.

MS. HEDBERG responded that without any barriers, DPH would want to test anyone with any signs or symptoms of the virus. A test only confirms that a person has COVID-19: 80 percent of the population with COVID-19 will have mild to moderate symptoms and will recover; it is the 20 percent with a severe response to the virus and who could die that will overwhelm the health care system. She offered that with no limitations, she would want to test everyone; however, currently Alaska is testing those with signs and symptoms who have had recent travel. She maintained that DPH has not refused testing for anyone. She reiterated that "it takes a system" to increase throughput; hospitals and clinics must have the supplies they need - the collection kits and the PPEs.

[7:00:16 PM](#)

CO-CHAIR FIELDS asked whether the state is automatically relicensing recently retired nurses, doctors, and other frontline professionals who have continued to reside in Alaska and who will probably be needed in anticipation of exponential progression [of the virus] in Alaska's communities.

MS. HEDBERG answered that she has been working with the director of the Division of Corporations, Business and Professional Licensing (CBPL) [DCCED], Sara Chambers, and offered that the division has been able to fulfill the request for anyone who needs an emergency license.

CO-CHAIR FIELDS asked whether automatic relicensing of recently retired people is possible, so that there would be no lag time.

MS. HEDBERG replied that an individual would have to apply [for the license]. She maintained that to her knowledge there have been no barriers to emergency licensing when identified as a COVID-19 response.

CO-CHAIR FIELDS suggested that the state proactively reach out to these individuals or even relicense them before they even ask. He offered that waiting for them one at a time may leave the state with an inadequate capacity at the time of a surge in cases. He mentioned that frontline State of Alaska employees - such as airport workers - do not have PPEs; he asked the status of providing them with PPEs to protect them and prevent the spread of the virus.

MS. HEDBERG responded that the state is employing several tactics: 1) protective barriers, such as plexiglass, between the employee and the public; and 2) encouraging Alaskans to make online transactions to decrease the number of people in lobbies and waiting areas.

CO-CHAIR FIELDS expressed the importance of PPEs for the frontline employees.

[7:03:24 PM](#)

REPRESENTATIVE SPOHNHOLZ mentioned the testimony stating that no one has been turned away for testing. She stated that she has heard from numerous people who have been turned away due to a concern for not enough tests; the threshold for allowing someone to be tested is very high. She offered that there may be a rationing of tests which is not best for what Alaska should be doing. She mentioned a woman in Juneau with symptoms and an underlying medical condition who was turned away several times. She said that there is a perception that there is some rationing of COVID-19 tests.

MS. HEDBERG stated that she is aware of providers being afraid of not having enough collection kits and prioritizing patients. She said that providers used to call the Section of Epidemiology to ask whether to test, and the section has never said "no." She added that DPH has communicated that a healthy person with no signs and symptoms does not need to be tested. Many individuals fear that they have COVID-19 but have not traveled

recently from an area with community transmission and do not have signs and symptoms; therefore, a provider may tell them they don't need to be tested.

7:06:49 PM

CO-CHAIR KREISS-TOMKINS indicated that the committee would move on to the next two presenters.

7:07:30 PM

JARED KOSIN, Chief Executive Officer (CEO), Alaska State Hospital and Nursing Home Association (ASHNHA), relayed that emergency operation plans are in place, and the hospitals and nursing homes conduct regular drills. The ICS at all facilities has been activated. Conceptually, the plans contemplate surge events; the facilities are at a level 1; as the surge hits, they will adapt. Alaska has about 1,500 acute care beds, excluding military beds. The state, not ASHNHA, maintains count of ICU beds and ventilators. He pointed out that as the facilities fill up with patients, the distribution of patients within a facility will change. He maintained, "A lot of people are trying to do the math problem to figure out what the surge will look like and do we have enough capacity." He offered that if the surge hit all at once and the state took no action, the state would not have enough capacity. He said that ASHNHA is in wholehearted agreement with the idea that lengthening the spread of the outbreak over time offers the best chance for Alaska's health care system to cope. He acknowledged that the economic cost as well as the human cost is challenging. He asserted that if the outbreak "gets out of control," the challenge will be unprecedented. He reiterated that the hospitals can manage surges; hospital resources would be redistributed. As an example, an entire hospital hallway can be converted to a negative pressure unit through mechanical means if necessary. He concluded that the facilities would adapt to the surge, but they could be overwhelmed if the state takes no action. He maintained that the measures that the state has taken [to mitigate the spread] are appropriate.

MR. KOSIN expressed his concern with the disruption in revenue, especially for the small and mid-sized facilities. For the smaller facilities, the "cash on hand" is very small; making payroll and having staff come to work is a concern. He stated that ASHNHA is polling its members as to costs and needs, and it will be requesting funds in the future.

[7:13:17 PM](#)

CO-CHAIR KREISS-TOMKINS commented that without performing elective procedures and receiving that cashflow, small hospitals with little cash on hand may be faced with bankruptcy.

MR. KOSIN responded that one facility asked about the [U.S.] Stark Law, which prohibits hospitals and other facilities that refer patients from paying money to physicians to avoid inducements for referrals. He said that ASHHA has asked the federal government whether it would be relaxing Stark Law rules so that hospitals may supplement their surgical groups.

[7:14:53 PM](#)

REPRESENTATIVE WOOL referred to Mr. Kosin's testimony regarding the number of hospital beds in the state; he offered that the number does not address the distribution of the beds in communities. He maintained that the distribution of beds will not align with the cases.

MR. KOSIN agreed and offered that at least 20 percent of the beds are not accessible from road system. He stated, "There's no doubt that you can't just look at this from a bed count, a ventilator count, an ICU bed count" due to resources being spread out in the state. He maintained for much of the equipment, deployment requires staffing; if the [pandemic] event disproportionately affects health care workers and maintaining staff is a problem, then the ability to deploy resources will be strained, and the bed and ventilator numbers become irrelevant. He emphasized that the precautions of social distancing and hand washing provide the best opportunity for as little impact as possible.

REPRESENTATIVE WOOL offered that childcare for health care staff is an issue as well.

MR. KOSIN agreed that it is a concern. He stated that he is in constant communication with his counterparts in other states; Minnesota has converted some of the schools into safe places to watch the children of health care workers. He offered that compared to the rest of the country, arrival of the virus in Alaska is slow. He mentioned that the health care system in the state of Washington is close to being overwhelmed.

[7:19:13 PM](#)

CO-CHAIR KREISS-TOMKINS mentioned rural Alaska - communities without road access and villages in different regions of Alaska - and asked about the outlook for transporting a high-risk COVID-19 patient with a deteriorating condition from a village to the closest hospital by air.

MR. KOSIN replied that the issue is under discussion. He stated that the Seattle hospitals have declared that they will not accept any transports except for high-scale emergencies. He mentioned discussions with personnel from the Anchorage hospitals and the incident commander of the EOC. Dr. Zink has indicated that the state has been working on the issue for months and has a solution for air transport which will be in place when needed. He maintained that the Anchorage facilities are ready to receive patients through the mechanism put in place by the state and that the logistical hurdle will be addressed. He reiterated that multiple transports could very well overwhelm the system. He confirmed that he is referring to private transport - a standard medivac - not military.

[7:22:54 PM](#)

REPRESENTATIVE WOOL asked whether the emergency departments would be able to handle non-COVID-19 emergencies as well as the COVID-19 emergencies.

MR. KOSIN answered that currently hospitals are open and operating with their traditional utilization patterns; as the COVID-19 event escalates, different emergency operation plans and different levels will be executed by the ICS to triage, prioritize, and move patients. He maintained that if Alaska experiences a [COVID-19] surge event in addition to its usual patients, it will have a major problem; such is currently occurring in Seattle.

[7:25:29 PM](#)

CO-CHAIR KREISS-TOMKINS introduced the final testifier.

[7:26:05 PM](#)

NILS ANDREASSEN, Executive Director, Alaska Municipal League (AML), referred to his PowerPoint presentation, entitled "Local Governments Act," and reviewed the information on slide 2, entitled "Recognizing," which read:

- The federal government is ramping up its efforts to respond both to the public health crisis and the corresponding economic challenge facing the nation.
- The State of Alaska has taken necessary actions to flatten the curve, which will preserve the integrity of our healthcare infrastructure.
- Transportation and supply linkages remain intact, and there is no indication that food or fuel shortages will occur.
- Working together, across levels of government, we're developing solutions to what comes next in order to support residents, families and businesses.

MR. ANDREASSEN stated that the leadership teams in each of Alaska's 165 cities and boroughs are "trying to figure out what to do" to support state action. He reviewed the five priorities that AML has sent to local governments, listed on slide 3, entitled "Local Government Processes," which read:

1. Coordination of policy-making and community impact considerations
2. Continuity of Government (COG)
3. Continuity of Operations Planning (COOP)
4. Support for public health emergency measures
5. Messaging to the community

Essential deployment of first responders

- Law enforcement, EMTs and fire departments, emergency response teams

[7:32:47 PM](#)

MR. ANDREASSEN referred to slide 4, entitled "Local Governments - roles and responsibilities," which read:

- Some have health powers, especially Anchorage, which allows them to determine their own response to the pandemic, in cooperation with DHSS
- The majority do not, and depend on direction by the CDC and DHSS - this requires regular communication on the part of DHSS
- Continuity of Operations Planning - ensuring essential operations
- Implement social distancing within workforce of 20,000
- Implement social distancing by closing public facilities

- Compliance with Open Meetings Act and ensuring public participation
- In the middle of budget cycles that now must anticipate additional expenses and decreased revenues

MR. ANDREASSEN moved on to slide 5, entitled "State-Local Collaboration," which read:

- Emergency Operations Centers - communication with local emergency management officials should include municipal managers, as possible
- Tabletop planning - this should occur with cities and boroughs, prioritized as necessary
- Public health and emergency powers - some municipalities have these, and are interested in applying them as needed
- How is the State tracking and leveraging these?
- Communicating with the federal government - what is that mechanism for leveraging CDC, FEMA, and SBA resources?

[7:35:21 PM](#)

REPRESENTATIVE HOPKINS asked whether tabletop planning, shown in the second bullet on slide 5, was currently happening or will be happening.

MR. ANDREASSEN replied that it is happening but doesn't know how extensively. He maintained that there needs to be a plan for what it consists of, how it is implemented, and what should be communicated to local governments in terms of expectations.

REPRESENTATIVE HOPKINS stated that some communities, like the Fairbanks North Star Borough (FNSB), do not have health and social service powers, cannot declare a local health emergency, and, therefore, cannot access Federal Emergency Management Agency (FEMA) [U.S. Department of Homeland Security (USDHS)] funds. He asked whether the governor's state declaration of emergency covers those municipalities that do not have health and social service powers, or whether it could be expanded to cover them if needed.

MR. ANDREASSEN answered that he does not know the answer but will consult municipal attorneys.

[7:37:15 PM](#)

MR. ANDREASSEN turned to slide 6, entitled "Lessons Learned," and reviewed a list compiled through discussions with his colleagues from other states and members of the National Association of Counties (NACo) and National League of Cities (NLC). It read:

- Sufficient testing
- Protective gear for all first responders
- Containment. Containment. Containment.
- Cross-jurisdictional information sharing (horizontal)
- Inter-governmental information sharing (vertical)
- State-led management, local implementation
- Responding to social and economic considerations
- Messaging - clear, honest and concise, consistent
- Don't reinvent the wheel.
- Document expenses.

MR. ANDREASSEN moved on to slide 7, entitled "Continuity of Operations Planning," to point out the questions that local governments are having to ask, which read:

- How will day-to-day business processes be impacted in the event of reduced staffing levels?
- Are systems accessible remotely, and are personnel properly equipped to work from home if necessary?
- Do personnel policies allow teleworking, and have employees been trained on procedures to?
- What are the cyber security considerations that should be evaluated and addressed before placing an emphasis on remote work?
- Are backup systems in place to ensure critical business tasks continue to be performed in the event key staff are unavailable?
- Is there a list of functions that are essential to public safety and government business that must be performed in all cases?
- Has the city or borough identified backups for specialized vendors in order to limit?
- Does the city or borough have "devolution" procedures in place to limit, pause or discontinue performance of functions that are not essential or that may be performed at a reduced level?
- Are systems in place to allow city or borough personnel to coordinate remotely?

- Is clear guidance available to employees for expectations with regard to the time, attendance, and leave policies?
- Is there a consolidated document that outlines COOP policies and procedures, and has it been communicated?

MR. ANDREASSEN referred to the map on slide 8, entitled "Emergency or Disaster Declarations," to illustrate the cities and boroughs in Alaska with such declarations, by type of city government - home rule, first class, second class, registered - and borough classification - non-unified home rule, unified home rule, first class, second class, unorganized.

[7:39:38 PM](#)

MR. ANDREASSEN said that even though now is not the time to worry about an economic downturn, "I don't know we can lose sight of it." He continued with slide 9, entitled "Economic Downturn," which read:

- Tourism, retail, service, fishing - all industries that expect severe economic contraction
 - 10% contraction = \$25 million reduction in sales tax collection
 - Cruise-related communities depend on sales tax as 50% of their revenue
 - 50% reduction = \$20 million reduction in bed tax collection and \$3 million in rental car tax collection
 - Long term may mean property devaluation
 - Need to support small and local businesses
 - Any industry impacted by travel restrictions and social distancing will impact community revenues and expenses directly
- Expecting federal aid package - but advocate for Alaska interests.

He maintained that communities will suffer, not just in the short term, but the medium and long term. He mentioned that local governments are spending money to prepare and respond to the situation, and there will not be incoming revenue to reimburse those expenditures. He asserted that the governor's Alaska Economic Stabilization Team needs to include local economic development officials who understand what is occurring at the local level.

MR. ANDREASSEN referred to a list of tools that local governments are bringing to bear in the medium term for managing communities' social and economic risk, shown on slide 10, entitled "Local Government Tools," which read:

- Ensuring that utilities remain online, and that residents remain connected
- Economic development strategies support small and local businesses
- Implementing staff support measures, including teleworking options and adequate paid time off
- How best to utilize savings both for short term emergency management and long-term needs caused by a reduction in economic activity - liquidity
- Accessing State and Federal funds, resources meant to support community members and businesses
- Mechanisms to help with childcare, short term unemployment, food and fuel purchases
- Tax relief, where possible

MR. ANDREASSEN added that all of the tools point to the underlying question: "To what extent does the State of Alaska have the resources necessary, not only to respond to a public health crisis, but to support communities, local governments, residents to manage throughout this process?"

[7:41:39 PM](#)

MR. ANDREASSEN concluded with slide 11, entitled "AML Actions," which read:

- Dedicated newsletter sharing information and resources
- Host weekly calls with managers, attorneys and mayors
- Regular calls with White House, NACo and NLS to follow national action
- Draft documents for preparations
- Dedicated webpage for resource sharing and tracking local decisions
- Develop templates for policy and municipal actions
- Outreach to Governor's office and DHSS EOC

MR. ANDREASSEN emphasized the importance of communication and information sharing with the legislature as well as the State of Alaska.

[7:42:20 PM](#)

CO-CHAIR KREISS-TOMKINS mentioned that in coastal Alaska, where the tourism industry is an economic mainstay, there may not be a cruise ship season in 2020 - resulting in loss of sales tax revenues for municipalities, other revenues, jobs, and economic activity. He asked, "What is the outlook for some of those municipalities you're talking with in terms of their ability to stay solvent, to balance a budget? What's that worst-case scenario look like for those communities?"

[7:43:04 PM](#)

MR. ANDREASSEN answered that for some, such as Skagway, the tax collected during the summer cruise ship season can be as much as 95 percent its budget. He said that for the Denali Borough, bed tax can be as much as 80 percent of its budget. For coastal communities, tourism can account for 50 percent of the budget. He stated, "It will be devastating in every regard." The local governments will be asked to do more and provide the same level of services to residents at the same time access to resources is restricted. There are important decisions to be made this week regarding how to support local governments so that they can "weather the storm" as they support the state's actions.

CO-CHAIR KREISS-TOMKINS commented that such a call to action resonates with him and many colleagues.

[7:45:00 PM](#)

ADJOURNMENT

There being no further business before the committee, the House State Affairs Standing Committee meeting was adjourned at 7:45 p.m.