ALASKA STATE LEGISLATURE
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
March 22, 2022
1:33 p.m.

MEMBERS PRESENT

Senator David Wilson, Chair
Senator Shelley Hughes, Vice Chair
Senator Mia Costello
Senator Lora Reinbold
Senator Tom Begich

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

SENATE BILL NO. 124
"An Act relating to admission to and detention at a subacute mental health facility; establishing a definition for 'subacute mental health facility'; establishing a definition for 'crisis residential center'; relating to the definitions for 'crisis stabilization center'; relating to the administration of psychotropic medication in a crisis situation; relating to licensed facilities; and providing for an effective date."

- HEARD & HELD

PRESENTATION(S): THE STATE OF ALASKA'S HEALTH

- HEARD

PREVIOUS COMMITTEE ACTION

BILL: SB 124
SHORT TITLE: MENTAL HEALTH FACILITIES & MEDS
SPONSOR(s): RULES BY REQUEST OF THE GOVERNOR

04/12/21	(S)	READ THE FIRST TIME - REFERRALS
04/12/21	(S)	HSS, FIN
04/27/21	(S)	HSS AT 1:30 PM BUTROVICH 205
04/27/21	(S)	Heard & Held
04/27/21	(S)	MINUTE(HSS)
04/29/21	(S)	HSS AT 1:30 PM BUTROVICH 205

04/29/21	(S)	-- MEETING CANCELED --
05/04/21	(S)	HSS AT 1:30 PM BUTROVICH 205
05/04/21	(S)	Heard & Held
05/04/21	(S)	MINUTE(HSS)
05/05/21	(S)	JUD REFERRAL ADDED AFTER HSS
05/06/21	(S)	HSS AT 1:30 PM BUTROVICH 205
05/06/21	(S)	<Bill Hearing Canceled>
03/08/22	(S)	HSS AT 1:30 PM BUTROVICH 205
03/08/22	(S)	Heard & Held
03/08/22	(S)	MINUTE(HSS)
03/15/22	(S)	HSS AT 1:30 PM BUTROVICH 205
03/15/22	(S)	Heard & Held
03/15/22	(S)	MINUTE(HSS)
03/17/22	(S)	HSS AT 1:30 PM BUTROVICH 205
03/17/22	(S)	Heard & Held
03/17/22	(S)	MINUTE(HSS)
03/22/22	(S)	HSS AT 1:30 PM BUTROVICH 205

WITNESS REGISTER

NANCY MEADE, General Counsel
Office of the Administrative Director
Alaska Court System
Anchorage, Alaska
POSITION STATEMENT: Answered questions on SB 124.

STEVEN BOOKMAN, Senior Assistant Attorney General
Human Services Section
Civil Division
Department of Law
Anchorage, Alaska
POSITION STATEMENT: Answered questions on SB 124.

DR. ANNE ZINK, Chief Medical Officer
Department of Health and Social Services (DHSS)
Anchorage, Alaska.
POSITION STATEMENT: Presented a PowerPoint on the State of Alaska's Health and answered questions on the Crisis Now model.

ACTION NARRATIVE

1:33:29 PM
CHAIR DAVID WILSON called the Senate Health and Social Services Standing Committee meeting to order at 1:33 p.m. Present at the call to order were Senators Reinbold, Costello, Hughes, and Chair Wilson. Senator Begich arrived shortly thereafter.

SB 124-MENTAL HEALTH FACILITIES & MEDS

1:34:17 PM
CHAIR WILSON announced the consideration of SENATE BILL NO. 124 "An Act relating to admission to and detention at a subacute mental health facility; establishing a definition for 'subacute mental health facility'; establishing a definition for 'crisis residential center'; relating to the definitions for 'crisis stabilization center'; relating to the administration of psychotropic medication in a crisis situation; relating to licensed facilities; and providing for an effective date."

He noted that the committee started the amendment process last Thursday and stopped on Amendment 13.

1:35:16 PM
At ease

1:35:32 PM
CHAIR WILSON reconvened the meeting.

CHAIR WILSON acknowledged that Senator Begich had joined the meeting.

1:35:40 PM
SENATOR HUGHES moved that the committee rescind its action [to adopt] Amendment 10.1 to SB 124.

1:35:46 PM
CHAIR WILSON objected for discussion purposes.

1:35:50 PM
At ease

1:36:25 PM
CHAIR WILSON reconvened the meeting.

1:36:27 PM
SENATOR HUGHES explained that she held discussions with the department. The amendment applied to voluntary commitments but must also apply to involuntary ones. She said she serves on the next committee of referral, the Senate Judiciary Committee, and would address her concerns in that committee as the amendment does not meet the intended objective.

1:36:55 PM

CHAIR WILSON withdrew his objection; he found no further objection, and the action [to adopt] Amendment 10.1 was rescinded.

1:37:14 PM
SENATOR REINBOLD moved to adopt Amendment 13, work order 32-GS1730\B.2.

32-GS1730\B.2
Dunmire
3/14/22

AMENDMENT 13

OFFERED IN THE SENATE BY SENATOR REINBOLD
TO: CSSB 124(HSS), Draft Version "B"

Page 3, following line 24:
Insert a new bill section to read:
"*** Sec. 11.** AS 47.30.700 is amended by adding a new subsection to read:
(c) When a crisis stabilization center, crisis residential center, evaluation facility, or treatment facility admits a respondent under this section, the crisis stabilization center, crisis residential center, evaluation facility, or treatment facility shall, unless the petition was filed by an immediate family member of the respondent, immediately notify the respondent's immediate family, or, if the respondent is a minor, a parent or guardian of the minor, that the respondent has been admitted."

Renumber the following bill sections accordingly.

Page 4, line 17:
Delete "a new subsection"
Insert "new subsections"

Page 4, following line 21:
Insert a new subsection to read:
"(d) When a crisis stabilization center, crisis residential center, evaluation facility, or treatment facility admits a person under this section, the crisis stabilization center, crisis residential center, evaluation facility, or treatment facility shall immediately notify the person's immediate

family, or, if the person is a minor, a parent or guardian of the person, that the person has been admitted."

Page 13, lines 1 - 2:
Delete "secs. 1 - 27"
Insert "secs. 1 - 28"

Page 13, lines 27 - 28:
Delete "sec. 23"
Insert "sec. 24"

Page 13, line 29:
Delete "sec. 23"
Insert "sec. 24"

Page 14, line 7:
Delete "Section 28"
Insert "Section 29"

1:37:17 PM
CHAIR WILSON objected for purposes of discussion.

1:37:25 PM
At ease

1:39:38 PM
CHAIR WILSON reconvened the meeting.

1:39:39 PM
SENATOR REINBOLD stated that Amendment 13 would require immediate notification of a family member when an individual is admitted to a crisis stabilization center, crisis residential center, evaluation facility, or treatment facility.

1:40:05 PM
SENATOR BEGICH said he understood the intent, but his concern was to ensure that the contact with family was safe, and that might not happen if Amendment 13 were to pass,. He suggested that the amendment could be considered in the Senate Judiciary Committee. He maintained his objection.

1:41:15 PM
SENATOR COSTELLO wondered if adding the language "or guardian" on lines 8 and 22, after "family" would address his concern.

1:41:54 PM

SENATOR HUGHES stated that she would work on the language in the Senate Judiciary Committee to ensure that parents and guardians were notified and that Senator Begich's safety concern was also addressed.

SENATOR REINBOLD said her concern was for immediate family members who did not know where the person was being admitted. She suggested the committee conceptually amend Amendment 13 today and the next committee of referral could address how to avoid notifying family members in abusive situations.

1:44:39 PM
SENATOR BEGICH said he had contemplated Senator Costello's suggestion, which he understood would add "respondent's immediate family or guardian." He offered to withdraw his objection if she agreed to offer the amendment.

SENATOR COSTELLO offered to make a conceptual amendment.

1:45:00 PM
CHAIR WILSON asked Ms. Meade to comment on Amendment 13.

1:45:36 PM
NANCY MEADE, General Counsel, Office of the Administrative Director, Alaska Court System, Anchorage, Alaska, stated that she reviewed Amendment 13 and did not find any technical issues.

1:45:54 PM
SENATOR COSTELLO moved Conceptual Amendment 1 to Amendment 13.

Page 1, line 8:
Insert "or guardian" following "family"

Page 1 line 22:
Insert "or guardian" following "family"

SENATOR COSTELLO stated that it would read "immediate family or guardian" in both instances.

1:46:31 PM
CHAIR WILSON objected for purposes of discussion.

1:46:36 PM
CHAIR WILSON offered his view that Conceptual Amendment 1 to Amendment 13 would not address the issue of notifying an immediate family member that the admitted person would not want

notified. He related the notification could be a brother, sister, grandmother, mother, or another family member.

SENATOR BEGICH agreed. He felt comfortable that Senator Hughes would work on language in the next committee of referral.

CHAIR WILSON remarked that generally, he did not prefer to have another committee address an unfinished amendment. He asked the will of the committee.

1:47:43 PM
SENATOR REINBOLD asked if this relates to the full amendment.

CHAIR WILSON answered that Conceptual Amendment 1 to Amendment 13 was before the committee.

1:48:02 PM
CHAIR WILSON stated the committee would take a roll call vote on Conceptual Amendment 1 to Amendment 13.

1:48:04 PM
SENATOR HUGHES stated she understood that Chair Wilson was uncomfortable that the issue was unfinished. She committed to work on the issue in the next committee of referral. She offered support for Conceptual Amendment 1 to ensure that notification to the immediate family occurs.

1:48:30 PM
At ease

1:49:01 PM
CHAIR WILSON reconvened the meeting and asked for a roll call vote.

1:49:13 PM
A roll call vote was taken. Senators Begich, Hughes, Costello, and Reinbold voted in favor of adopting Conceptual Amendment 1 to Amendment 13, and Senator Wilson voted against it. Therefore, Conceptual Amendment 1 to Amendment 13 was adopted on a 4:1 vote.

CHAIR WILSON announced that Conceptual Amendment 1 to Amendment 13 was adopted on a vote of 4 yeas and 1 nay.

1:49:43 PM
SENATOR REINBOLD opined that parental consent should be required for admission to the crisis care facilities, not just

notification. She said it was easier to modify and adjust the notification language once it is in the bill. She urged members to vote yes.

1:50:24 PM
CHAIR WILSON stated that some patients do not always want family members informed of their medical conditions, especially when they are not minors. He offered his belief that this was a significant concern.

1:50:48 PM
SENATOR HUGHES offered to address this issue and Senator Begich's concern that a family member could be abusing the person. She offered to review both of those issues in the Senate Judiciary Committee.

1:51:10 PM
SENATOR BEGICH commented that he would have opposed Amendment 13 if Senator Hughes hadn't indicated she would work on these issues in the Senate Judiciary Committee.

1:51:28 PM
CHAIR WILSON removed his objection; he found no further objection, and Amendment 13, as amended, was adopted.

1:51:43 PM
SENATOR REINBOLD moved to adopt Amendment 14, work order 32-GS1730\B.4.

32-GS1730\B.4
Dunmire/Foote
3/14/22

AMENDMENT 14

OFFERED IN THE SENATE BY SENATOR REINBOLD
TO: CSSB 124(HSS), Draft Version "B"

Page 7, line 30, following "if":
Insert "the respondent is"

Page 8, line 1:
Delete all material and insert:
"(2) if the respondent is a minor,

(A) the minor has the rights identified in AS 47.30.700 - 47.30.815;

(B) psychotropic medication may not be administered to the minor unless a parent or legal guardian has given permission to the crisis stabilization center or crisis residential center to administer the psychotropic medication; and

(C) a parent or legal guardian has the right to be fully informed of possible side effects of a proposed psychotropic medication."

1:51:46 PM
CHAIR WILSON objected for discussion purposes.

1:51:48 PM
SENATOR REINBOLD explained that Amendment 14 would ensure that parental or guardian permission is required before administering psychotropic drugs to a minor in a crisis care facility. She stated her belief that informed consent is a critical right.

1:53:04 PM
SENATOR HUGHES said she was unsure whether Senator Reinbold was present during a prior discussion about the need for medical personnel to give medication during life-threatening situations, such as a person experiencing a heart attack. In those instances, medical personnel might not have time to get a parent, guardian, or other family member's permission before administering drugs or providing procedures. She noted that minor athletes could have heart attacks. She related a scenario where a minor was endangering their life or others when admitted to crisis stabilization centers. She asked Senator Reinbold if she was suggesting that the center would have to get permission from a parent or legal guardian before saving the child's life.

SENATOR REINBOLD recalled a discussion about the language in Amendment 3. She recognized that the court system stated that "serious" did not need to be added, but a psychiatrist she spoke to disagreed because it required a higher standard. She offered his view that the committee should revisit the amendment. She offered her belief that a parent or guardian should be involved when psychotropic drugs are administered because of the risk of side effects. She said she would want a parent or guardian involved when administering psychotropic drugs during a life-threatening situation.

1:55:39 PM

SENATOR HUGHES agreed that some psychotropic drugs were not administered in life-threatening situations. For instance, she understood that lithium was used for routine behavioral health, which a crisis stabilization center would prescribe. She offered her view that consent could be required unless the minor's life was endangered. She asked whether the sponsor would be willing to consider an exception for emergency situations in which the minor's life was at risk.

1:57:04 PM
SENATOR REINBOLD said she was open to having an exception for life endangerment.

1:57:32 PM
At ease

1:58:10 PM
CHAIR WILSON reconvened the meeting.

1:58:11 PM
SENATOR BEGICH asked whether these rights were already covered in law.

1:58:49 PM
STEVEN BOOKMAN, Senior Assistant Attorney General, Human Services Section, Civil Division, Department of Law, Anchorage, Alaska, agreed that law addresses this in AS 25.20.025, Examination and treatment of minors. It essentially says that parents make decisions about minors. It lists instances in which a parent cannot be contacted or, if contacted, is unwilling to grant or withhold consent that a minor can consent to treatment. He stated that the concerns voiced earlier about crisis medication, where the alternative was to tie someone down, and non-crisis medication intended to improve a general condition, was an important distinction. He offered his view that this was addressed in the existing statute.

1:59:49 PM
SENATOR BEGICH stated his belief that it was covered.

1:59:58 PM
CHAIR WILSON agreed.

2:00:11 PM
SENATOR REINBOLD commented that was what she had thought. She stated that the bill amends AS 47, not AS 25 and that these are new residential centers. She said she was told that AS 25 would

not apply to them. She stated that Amendment 14 would make it clear that the rights in Article 10 apply to the minors in these new facilities.

2:00:55 PM
SENATOR HUGHES asked whether Legislative Legal Services said AS 25 would not apply.

SENATOR REINBOLD answered that her information came from a patient advocacy group concerned about the new subacute facilities. She stated that Amendment 14 would ensure that Article 10 rights also apply to minors.

CHAIR WILSON stated that Mr. Bookman clarified that AS 25 does apply. He noted that the court administrator nodded her agreement that Title 25 would apply to SB 124.

2:02:06 PM
SENATOR HUGHES asked for assurance that AS 25 would separate the life-threatening situations from medication given to soothe the patient, such that consent from a parent or guardian would not be necessary.

2:02:40 PM
MR. BOOKMAN answered that he believed it would do so. He stated that AS 25.20.025 covers medical treatment generally. He indicated that regarding crisis medication, the intent of SB 124 is to incorporate the standard currently used in evaluation centers. Under AS 47.30.838, a crisis medication may be used only if there's a crisis or an impending crisis requiring immediate use of the medication to preserve life or prevent significant physical harm. He offered his belief that a mood stabilizer or something that is soothing would not be permitted because that medication would not be necessary to prevent an impending or actual crisis. The crisis medication would need to have an immediate effect. It would not be permissible under AS 47.30.838.

2:04:08 PM
SENATOR HUGHES stated that it made sense that AS 25 would apply to situations where a child is rushed to an emergency room for treatment. Although she supports the concept of Amendment 14, she does not support the amendment. She offered to follow up with Legislative Legal Services for assurances that AS 25 does apply and that parental consent would be required in non-emergency situations. If not, she offered to raise the issue in the Senate Judiciary Committee.

2:05:03 PM
SENATOR REINBOLD asked whether parental and minor rights in AS 47.37.815 apply to the new facilities.

MR. BOOKMAN answered yes. He explained that the minor would have rights as any patient would. He clarified that the new crisis stabilization centers, and crisis residential centers would not have the ability to involuntarily prescribe non-crisis medication. It is not an issue for minors because the only way a minor at one of these centers could receive long-term medication would be with the parent or guardian's permission. He explained that the existing statute would allow for a limited exception if the parents were unavailable and the minor was mature enough to consent.

2:06:38 PM
SENATOR REINBOLD offered her view that Amendment 14 was critical because psychotropic medication can cause nightmares, increased saliva, swelling of the face, lips, tongue, or throat, thoughts of suicide, or other harmful side effects. She offered her support for informed consent, parental involvement, and an advocate or legal guardian.

2:07:42 PM
CHAIR WILSON maintained his objection.

2:07:45 PM
A roll call vote was taken. Senator Reinbold voted in favor of Amendment 14, and Senators Hughes, Costello, Begich, and Wilson voted against it. Therefore, Amendment 14 failed on a 1:4 vote.

2:08:05 PM
CHAIR WILSON announced that Amendment 14 failed on a vote of 1 yea and 4 nays.

2:08:18 PM
CHAIR WILSON held SB 124 in committee.

2:08:24 PM
At ease

PRESENTATION(S): THE STATE OF ALASKA'S HEALTH

2:11:16 PM
CHAIR WILSON reconvened the meeting and announced the presentation on the State of Alaska's Health.

2:11:58 PM
At ease

2:12:16 PM
CHAIR WILSON reconvened the meeting.

2:12:20 PM
ANNE ZINK, MD; Chief Medical Officer, Department of Health and Social Services (DHSS), Anchorage, Alaska, stated that she would present a high-level overview of the State of Alaska's health. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

> The goal of this presentation is to provide you with data and foundational knowledge so that the legislative branch, the executive branch, and the public can work together to improve the health and well-being of Alaskans.
>
> As the Chief Medical Officer for the State of Alaska, I oversee the Division of Public Health, I serve as the clinical liaison across state departments, and I work with clinicians throughout the State and directly care for patients in the Emergency Department.

2:13:07 PM

> The health of Alaskans is greater than DHSS, or any one Department or organization. It involves many state and federal agencies – as well as thousands of health care providers, community and tribal leaders – who work tirelessly day in and day out.
>
> The cost of health care and what the State pays goes beyond Medicaid – it includes the State Retiree Plan, the Department of Corrections, the State employee health plan, not to mention the myriad of grants and contracts.
>
> This presentation today is for you – and for everyone working to improve the lives of Alaskans.
>
> The goal of the presentation was to provide the committee with data and foundational knowledge so the legislative branch, executive branch, and the public could work together to improve Alaskans' health and well-being.

2:13:52 PM
DR. ZINK reviewed slide 2, consisting of puzzle pieces listing health factors. The slide stated that behind every decision, every policy, every report, there is a person. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

> Early in my career, one of my mentors told me – always do what is right for the patient, and remember the rest is noise.
>
> That advice has guided me, as a physician and now in my service to the State.
>
> The scope of health care is broad and complex, but we must always remain focused on the people we serve – the individuals behind the puzzle pieces.
>
> And health care is more than seeing a doctor. Studies show that up to 80% of a person's health is determined by factors outside of traditional health care, including behavioral factors such as tobacco use or physical activity, as well as social, economic and community factors such as having a job, housing, access to food, transportation, or even community connectiveness can contribute heavily to outcomes such as the length and quality of life.
>
> This is why everything from access to local trails, to integrating behavioral health services, matter in a person's overall health.

2:14:37 PM
DR. ZINK reviewed slide 3, Life Expectancy Trends, which consisted of two graphs depicting national trends. She said the figure on the left-hand side showed the life expectancy from 1880 to 2019, which increased over time except for disruptions, such as the 1918 pandemic, WWI and WWII. She highlighted that in recent years the life expectancy had flattened and was beginning to decrease. She noted that this was due primarily attributed to overdose and suicide. The COVID-19 pandemic is not shown on the slide, but if it were, it would show a continued decline in life expectancy. Historically the most significant transformation in life expectancy came from a better understanding of infectious diseases by providing clean water and sewer to protect health. This continues to be a struggle throughout the world and in

Alaska. She noted that 32 communities lack functioning water and sewer.

DR. ZINK stated that the next health care transformation came in the 21st Century based on advancements in diagnostic and therapeutic medicine, including antibiotics, vaccines, and lab work. She indicated that despite advances, infectious diseases have persisted, and health care costs have continued to rise. She noted that not everyone has the same access to care or has improved outcomes.

DR. ZINK directed attention to the graph on the right-hand side of slide 3, which showed a comparison of life expectancy versus health expenditures for other countries compared to the US. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

2:16:14 PM

> Looking at the graph on the right comparing what the US spends on health care per capita and life expectancy over time to other developed countries**, the big outlier in the group is the US, which has the highest health expenditures per capita but lags behind other developed countries in life expectancy, and this difference has accelerated over time**. The reasons for this are multifactorial, hotly debated and complex to change, but important to think about in terms of how we spend our dollars towards health.
>
> The health of the population and the amount of money we spend on health care directly impacts everything from military readiness to the ability to educate our children and we know **healthy economies are built with healthy people.**
>
> For example, when employers spend more money on healthcare, less money is available for innovation or other investments. Or for schools - when a large portion of the budget must pay for health benefits for employees and retirees, that translates into less overall funding, and larger class sizes for students.
>
> The goal is to use each dollar as wisely as possible to improve health outcomes of Alaskans. The least expensive patients are those who are physically and mentally healthy. What has become increasingly clear

is that the next major impact on the life expectancy and the cost of care will come less from novel medical discoveries, but more from **the way health care delivery is structured**.

It will take **providers, patients, the public, and policy makers** working together to make this meaningful change.

2:17:59 PM
DR. ZINK turned to slide 4, Your New Health Care System, which depicted a flowchart of services. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

So how do we move forward? How do we work together to promote and protect the health and well-being of Alaskans?

First, we must look at **how our systems align**.

This map is not a meme. It was made during the creation of the Affordable Care Act to outlines out how different parts of the federal government are involved in providing health care to Americans. It is overwhelming, but powerful to spend time looking at all the connections which speaks to the complexity of health care delivery.

It's also worth noting that this map only applies to federal complexity, and does not address connections between state government, local municipalities, Tribal health care, and other federal health care like Veterans Affairs and the Department of Defense, or the other health factors we spoke of earlier like housing, transportation, employment, education and more.
Soon it can feel like this 2D graph is insufficient. We need a 3D matrix.

2:18:46 PM
DR. ZINK reviewed slide 5, which consisted of an aerial photograph of Unalaska. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

And adding to this complexity is the uniqueness of Alaska – including our large size, vast geography, diverse cultures, and transportation constraints, with most of our state off road system.

Our geography and our uniqueness can be our advantage. The distances and cost in Alaska force us to think about health care delivery differently. For example, take a patient with head trauma. In other states, patients like this are often admitted to the ICU for monitoring. But here, because of our distance constraints, we have taken a closer look at this practice. Alaska's trauma committee created guidelines that have enabled many patients to stay in their communities safely. This approach reduces costs and supports patients, without compromising care.

Our geography and historical background have also led to unique partnerships. In Alaska public health and health care are Tribal health, school health, industrial health, and military health. Our limited resources and distances foster relationships not seen at all at all, or to the same degree, in other states.

2:19:46 PM

And Health Care is delivered differently. In many rural communities the only health care is the tribal health care system, providing robust and comprehensive care to both native and non-native beneficiaries in some of the hardest to reach regions in our state. Hospital have had to design their hele-pads for military Blackhawk helicopters because they may be bringing in the next trauma victim, or vaccination efforts aboard deep-sea fish processing vessels to keep the crew active, working and healthy.

Alaska has a chance to be a leader in health care reform that is focused on the improved outcomes for the whole person at reduce cost if we use our geography and our partnerships to our collective advantage.

2:20:34 PM

DR. ZINK reviewed slide 6, a collage highlighting services and slogans the department provides to Alaskans. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

> And that is the goal within the Department of Health and Social Services.
>
> As you know well, the work done by the current department of DHSS is broad, diverse, and serves Alaskans at all stages of life. By simplifying health care delivery, braiding funding, and aligning care, we can provide better care for less cost, and that was a big driver behind the split of the Department of Health and Social Services, which goes into effect July 1st.
>
> With the Department of Family and Community Services, the focus will be on providing direct care services in 24/7 facilities, as well as communities.
>
> With the Department of Health, the focus will be on data-driven strategies to connect prevention to health care payment, delivery, and long-term services, in the most effective way possible.

2:21:18 PM

DR. ZINK reviewed slide 7, Health Care and Public Health, which depicted a three-bucket model. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

> At this point you may be asking yourself: how do we accelerate to this transition?
>
> I find this "three buckets" model helpful to look at how **public health and health care complement each other and overlap to create whole person and whole community care, which is key to moving forward**.
>
> Let's take diabetes for example. In the traditional health care setting, a provider may test for diabetes, provide medication for their disease, and offer education and training on how to live as healthy a life as possible.
>
> Meanwhile, the public health system helps support additional education, as well as community-based lifestyle programs to improve access to healthy foods

and increase physical activity. Public Health also sets up tools to help patients and providers track and manage diabetes and works with policy makers to ensure treatments such as insulin are accessible and affordable.

2:22:11 PM

The shadowed area shows where the two systems overlap. Together, these systems support the patient, but more importantly they work to prevent other individuals from developing the disease. When systems are integrated, the patient does not notice that these buckets are separate, AND there are fewer patients overall.

That is the beauty and the challenge - when a system works well, the user doesn't even recognize there is a system. I flew here this morning and spent my time reflecting on the beauty and wonder of Alaska, not worrying if they hundreds of systems involved to make my flight safe, enjoyable and on time would work and the same should be true for patients needing care.

And when we are able to invest in public heath, we reduce the overall burden of disease. We now expect our children to grow to adults. Our TB wards have been converted to universities, our orphanages from infectious disease into hospitals, our expectation is for health, not bracing for premature death.

2:23:05 PM

As a state and a nation, we are familiar with bucket #1 – the delivery of health care - and do a great job with it. The health care in Alaska and the U.S. is generally incredible high quality, but it comes a high cost without always the expected benefit.

But it is bucket #2 – health care services outside the traditional clinical setting – and bucket #3 – interventions that reach a whole population – where our collective focus can help provide savings and improve outcomes. The braiding is these buckets was a big driver of the 1115 waiver.

What is clear, we must not go back on efforts made over the last center to improve the public's health,

as it will cost us dearly, both financially and with the lives of our neighbors, friends and loved ones.

2:23:58 PM
DR. ZINK reviewed slide 8, The Role of Public Health. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

Now let's look a bit closer at what public health is and what it does.

Public health has transformed substantially over time, and each development has built on what came before. In the field of public health, we commonly talk about this evolution as Public Health versions 1.0, 2.0 and 3.0.

In Alaska, Public Health 1.0 included public health nurses who diagnosed and treated diseases like tuberculosis alongside the creation of Community Health Aides, providing clinical care to those who didn't have it, and trying to fill in gaps in health care. Other parts of this stage included improving sanitation, food and water safety, ensuring vaccines and treatments were available to the general population.

2:24:39 PM
In 1965, Medicaid and Medicare were created, essentially to provide a way to pay for health care for the elderly and the poor – in other words, to provide payment for Public Health 1.0. Today, over 200,000 Alaskans are covered by Medicaid and Medicare.

However, there were still gaps apparent even with greater access to health care, and public health transformed to 2.0 with a systematic approach to address risk factors, prevent and address chronic diseases, and address emerging threats such as HIV/AIDS.

Then, Public Health 3.0 expanded beyond traditional programs and services to work collectively with partners to address health concerns and empower individuals to be their most healthy and well selves.

The pandemic has further challenged the role of public health, highlighting unresolved gaps in care and the need for improved informatics and information sharing.

Our next steps will be to improve the way we gather and share data to better coordinate health care delivery, collectively move towards prevention, and to ensure systems are in place to support every Alaskan with diverse needs.

2:25:50 PM
DR. ZINK reviewed slide 9, Cost and Life Expectancy, which consisted of a line graph. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

But how about the cost?

This is a fascinating look at health care expenditures per state compared to life expectancy. It is a bit old, made by the Alaska Department of Administration with data through 2014, but you can see Alaska and North Dakota standing out as some of the states with **highest health care cost** in the country, but also **above average life expectancy.** West Virginia and the District of Columbia stand out as high cost, yet lower than average life expectancy. States that are achieving *higher* life expectancy at *lower* costs include Hawaii, California, Colorado, and Arizona.

2:26:28 PM
What I also find interesting is that **more money in health care does not translate to higher life expectancy** when we look across states; in fact, the inverse appears to be true.

Rural states also tend to spend more on health care than more urban states, but there are numerous exceptions.

2:26:46 PM
DR. ZINK reviewed slide 10, Health Care Reform Quadruple Aim. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

In addition to the three buckets and the various versions of Public Health, another framework that is helpful for this discussion is the quadruple aim of health care reform. Often used by hospital systems, this framework provides four goals that combined together improve care and reduce costs.

Starting with the patient's experience the goal is to improve public access to health data and services, empowering Alaskans to make healthy life choices.

Then, building into population health, focusing on measuring health factors and health outcomes for entire communities, providing tools and connections to health systems, and connecting public health and health care.

Next is cost. We reduce costs by aligning how health care is paid for, and by investing more money in prevention. Examples include chronic disease prevention programs, the use of telehealth or digital platforms, and programs that expand care within community settings. In addition, tools like an all-payer claims database will help bring transparency to healthcare costs.

2:27:50 PM

Critical to all this work is the health care team, both direct and indirect. We can support the health care team through reducing administrative burden, loan repayment, workforce recruitment and retention, and clinical support tools.

When all four of these aims are working smoothly together, we achieve better results.

2:28:17 PM

DR. ZINK reviewed slide 11, Causes of Death in Alaska, which consisted of two bar charts. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

So now let’s look at some data on where Alaska stands and how we compare to the rest of the United States on specific health issues.

On the left you see leading causes of premature death in 2020 for Alaska compared to the US. This is different than overall causes of death.
In 2020, the biggest causes of premature death in Alaska *and* the U.S. were due to unintentional injury, cancer and heart disease.

Here's where we are different: Alaska stands out in having about **twice the amount of premature death** caused by **suicide and liver disease** compared to the U.S., as noted in red.

Differences can be due to multiple factors, but a big one is our **health behaviors.** To look at how these behaviors contribute to premature death in Alaska, we did an analysis of the reasons behind these deaths. This is shown on the right.

2:29:06 PM

Looking at leading causes of over **20,000** deaths, **59% were potentially preventable at a younger age**.

We then looked upstream and identified deaths attributable to specific risk factors. **The leading risk factors contributing to premature death were obesity, being overweight, or physically inactive, as well as smoking tobacco.**

2:29:32 PM

DR. ZINK reviewed slide 12, Suicide Prevention, which consisted of two bar charts and a line graph showing the number of annual suicide attempts and mortality rates.

As we talked about in the past slide, looking at Alaska compared to the US, Alaska had about **2 times the amount of premature death** caused by **suicide and liver disease**, so let's dive into one of those topics a bit and talk about suicide.

Our state has struggled with having some of the highest rates of suicide in the nation, often ranking as the most suicides per capita, and currently ranking second in the nation behind Wyoming.

In general, suicides have had an outsized impact on youth. **In 2019, suicide was *the leading cause* of death for youth and young adults, ages 15-24**. This

was the only age group in our state where suicide was the leading cause of death.

Nationally, if you look at the graph at the bottom left, suicides between 1975-2015 for 15-19 year-olds, the highest for boys was in the early 1990s. It came down, but is now steadily increasing for both boys and girls in the more recent years.

It was great to see in 2020 in Alaska, we had a **decrease** in the number of adolescents who died by suicide, and a slight decrease in suicides in the State overall. However, we have seen an **increase in suicide attempts**. In 2021, there was a significant increase in suicide attempts for 11-14 year-olds, with rates higher than any other prior year. We have also seen increases in suicide attempts for people ages 60 and older.

Fortunately, although we have seen increases in the overall number and rates of suicide attempts, this did not translate into higher suicide rates. An important thing to remember when we look at data around suicide **attempts** is that **9 out of 10 people who survive a suicide attempt DO NOT go on to die by suicide later.**

2:31:20 PM

Alaska's data demonstrates a similar pattern to what we are seeing nationally. In December 2021, the U.S. Surgeon General issued an advisory to highlight the urgent need to address the national youth mental health crisis.

DHSS has allocated additional resources and funding to support mental health and suicide prevention. This includes specific training such as the **Zero Suicide framework** for both behavioral health and primary care providers, **youth and young adult suicide prevention media campaigns**, expanding the **Alaska Careline**, and partnering with entities such as the Department of Education and the Office of Children's Services.

2:32:05 PM

DR. ZINK reviewed slide 13, Drug Overdose Deaths Continue to Rise, consisting of a bar chart showing the overdose death rate for all drugs and opioids in Alaska compared to the US. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

Now let's dive into another top leading cause of premature death: Unintentional injuries. This category includes drug overdoses that are considered unintentional poisonings, motor vehicle crashes, and unintentional falls.

In 2020, both Alaska and the US as a whole saw our worst drug overdose death rates yet. Based on **preliminary data from 2021, in Alaska, the drug overdose death rate increased by over half from 2020**.

The drug overdose death rate is driven fentanyl, a synthetic opioid that is 50 times more potent than heroin. **74% of opioid overdose deaths in Alaska involved fentanyl in 2021.**

In 2018 you see a dip in Alaska compared to the U.S. This was attributed to increased screening for those at risk, referral for treatment, linkage to care, and treatment availability, prescription drug monitoring programs and regulations, and widespread messaging and distribution of naloxone through DHSS's Project Hope.

2:32:53 PM

It's important to note that other drugs play a role as well. Methamphetamine- and other psychostimulant-involved overdose deaths continue to rise due to their increasing purity and potency. **Approximately two-thirds of overdose deaths involve more than two substances -- excluding alcohol**.

Many of the overdose deaths in Alaska are unintentional, due to people not realizing that fentanyl may be in other drugs or counterfeit prescription medications.

Just this week, we saw 6 deaths in the Mat-Su and at least 17 overdose emergencies thought to be due to a lethal batch of heroin, resulting in a Narcotics Alert to be issued by Mat-Su law enforcement.

2:33:38 PM

DR. ZINK reviewed slide 14, Charting a path forward, which depicted a sea filled with icebergs. She asked how Alaska could

move forward and how to take the myriad of data points and chart a path through this complex world of health care delivery to improve outcomes for Alaskans.

2:33:50 PM
DR. ZINK reviewed slide 15, The River and the Bridge. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

> To answer that question, I am going to begin with a story that you may have heard before.
>
> Imagine a large river where you see someone downing, so you race in and pull them out, only to see another person struggling in the river. You look up and see hundreds of people trying frantically to save all the drowning people who have fallen into the river. As everyone along the shore tries to rescue as many people as possible, you look up and see a seemingly never-ending stream of people downing, so you begin to run upstream. One of other rescuers hollers, "Where are you going? There are so many people that need help here." To which you reply, "I'm going upstream to find out why so many people are falling into the river."

2:34:30 PM
DR. ZINK noted that this rings particularly true for her as an emergency physician who found herself more and more involved in public health to try to figure out how to move upstream. She continued:

> Upstream you find a broken bridge that people keep falling off of, into the water. By fixing the bridge, more people cross the river without falling in, which requires much less effort than pulling people out of the river later.
>
> For every dollar we spend on health care, we spend about 3 cents on prevention, 6-10 cents on primary care and 87-91 cents on acute and specialty care. When we look at other countries with longer life expectancies at a lower cost per capita, they all get there in slightly different ways, but constantly they have methods for paying or incentivizing upstream prevention.

The other advantage to moving ups stream and investing in systems of care is makes us more resilient when new challenges are presented: earthquakes, ice storms, pandemics. **Preparedness is prevention**.

2:35:32 PM
DR. ZINK reviewed slide 16, Moving Upstream, consisting of a diagram of health factors and a photograph of two rural Alaskans. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

There are a multitude of factors that cause poor health, which is not only costly to individuals, but is a shared burden to our communities. **In 2020, our Alaska hospitals billed $1.0 billion for emergency department visits and $4.4 billion for hospital stays**. As an emergency room doctor, I can tell you that care can be life saving, and not all illness can be prevented. But by focusing on the health outcomes and moving upstream to find fix the proverbial broken bridges, we can save lives and save money.

Today, I want to highlight **three key efforts** that I think we can all get behind to move upstream.

The first is **Healthy Alaskans, the State's Health Improvement Plan.** It is co-led by DHSS and the Alaska Native Tribal Health Consortium. The mission of Healthy Alaskans is to provide a framework and foster partnerships to optimize health for all Alaskans and their communities. This is our roadmap for upstream improvements, with communities, health care entities, Tribes, and other stakeholders working together.

Healthy Alaskans sets goals every 10 years.

2:36:46 PM
DR. ZINK reviewed slide 17, Healthy Alaskan 2020 successes, which listed eight successes.

1. Reduced cancer mortality rate
2. Reduced percentage of adolescents who recently used tobacco products
3. Reduced percentage of adults who are overweight
4. Increased percentage of adolescents who have 3 or

more adults from whom they could seek help
5. Reduced percentage of adults who recently engaged in binge drinking
6. Reduced percentage of adolescents who recently engaged in binge drinking
7. Decreased percentage of adults who report not affording a doctor in last year
8. Increased percentage of population ages 18-24 with a high school diploma

2:36:45 PM
DR. ZINK paraphrased her prepared testimony, which read:

[Original punctuation provided.]

Often I get asked, does this really work? Can the goals established in our state's health improvement plan be achieved? **Yes, but by working together, we can do even more.**

Looking back on the 2020 goals, **8 of them were accomplished** including: reducing **cancer mortality** rate, the percentage of adolescents who recently used **tobacco products** and the percentage of adults who are **overweight.**

We saw:

- More youth reporting that they had 3 or more adults they could seek **help** from, which reduces the impact of adverse childhood experiences
- A decrease in the percentage of adults and adolescents who recently engaged in **binge drinking**
- An increase in the percentage of adults who could **afford a doctor**
- An increase in the number of young adults with a **high school diploma.**

2:37:30 PM
All of those are great success stories.

Let's take a closer look at three examples:

Reduction in Cancer Mortality (#1):

This was achieved through various efforts including:

- The Alaska Comprehensive Cancer Control Plan (2021-2025)
- The Alaska Cancer Partnership
- Ladies First: Alaska Breast and Cervical Cancer Early Detection
- Promoting primary prevention. In other words, making the healthy choice the easy choice to stop cancer before it starts by being active, eating well and avoiding tobacco, to name a few examples.

Binge Drinking Reduction (#5, #6):
Efforts aimed at improving these goals include these programs and campaigns:

- Healthy Voices, Healthy Choices Alaska
- Be [You] Campaign (*teens*)
- ANTHC Substance Misuse Prevention Program
-

Tobacco Use Reduction (#2):
These inventions have helped with this goal:

- Tobacco Quit Line
- Smokefree Alaska Bill (2018)
- DHSS Tobacco Prevention and Control Program, Strategic Plan

2:38:03 PM
DR. ZINK highlighted two items on the list related to efforts to reduce adult and adolescent binge drinking from the Healthy Voices, Healthy Choices Coalition campaign, and the Alaska Native Tribal Health Consortium's Substance Misuse and Prevention Program.

DR. ZINK noted that the reduced percentage of adolescents who recently used tobacco products involved help with the Tobacco Quit Line, a legislative partnership with Smoke Free Alaska in 2018, and the department's Tobacco Prevention and Control Strategic Plan.

2:38:35 PM
DR. ZINK reviewed slide 18, Healthy Alaskans 2030 goals. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

What does 2030 look like? You can see from those three examples of success, one of the common ingredients is collaboration with diverse partners.

Healthy Alaskan's Goals are chosen, as they are finite, measurable, and actionable so that we have a common framework and common objectives. We can get lost on the mired of system, diseases and interventions - this slide deck was once over 100 sides on what was important to share with you all for the State of Alaska's health - but paring it down, and collective working on a few key challenges we can do more together.

2:39:12 PM

I have provided copies of Healthy Alaskans 2030 for you all, including the goals and metrics used by the plan.
Healthy Alaskans regularly monitors each goal and shares progress via annual scorecards. It also maintains a list of evidence-based strategies and actions to help reach the targets for each objective.

And we invite you as policy makers, as well as the public, health providers, patients and the press to take a look these objectives and join us in making a Healthier Alaska.

2:39:56 PM

DR. ZINK reviewed slide 19, Healthy You in 2022. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

A side effort has been taken on by DHSS to bring extra attention to Healthy Alaskans 2030 - the Healthy You in 2022 campaign.

The past few of years with the pandemic has been very long, hard, and for many devastating- both physical and mental and was the reason for this renewed effort on focusing on the basics of health.

The campaign draws from the work of various departments and programs to help Alaskans to focus on being physically and mentally well. The first quarter

is focused on movement and play, the second quarter is on mental health and well-being, the third quarter is healthy eating and sleep, and the last quarter is healthy habits.

We invite you all – and every Alaskan – to help build a Healthy You in 2022. You can find more on the microsite HealthyYou.Alaska.gov

2:40:47 PM
DR. ZINK reviewed slide 20, Data Modernization. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

A second area I want to highlight is Data Modernization. Often, we think of IT as Information Technology, but more and more it is really Innovation Technology. **It is hard to change that which can not be seen or measured.**

Early in the pandemic, we enlisted the help of national guard members to enter one lab result into three different systems. It was clear, the lack of IT infrastructure capabilities hampered not only our response here in Alaska, but across the country.

2:41:18 PM
Improved data can help community leaders know what health challenges affect their community and target their efforts; health care providers see the more complete picture of the health of their patient; and patients have better access to their own records empowering their health.

There are many large efforts happening at a state and national level on data modernization. Within the Department of Health, we have brought on a new Chief Health Data Officer to help lead all of these efforts.

Key to this transformation is creating a governance structure, and road map for the numerous data systems, and technologies both within the State and community, to improve the health of Alaskans.

This, however, will be an area that will need collective time and attention to achieve the desired outcomes.

Through improved data modernization that provides reliable, understandable, and relevant data to the public at their fingertips, Alaskans can and will achieve more. Improved data modernization is more cost-efficient, more secure, and allows for real-time decision-making to better support health care providers and individuals.

2:42:24 PM
DR. ZINK reviewed slide 21, Health Care Workforce Support. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

The third, or last thing, I wanted to highlight today are the people who serve Alaskans in health care, both directly and indirectly such as much of public health.

Alaska's health care workforce has always been limited and the pandemic has made it even worse. For the first time in 2020, we saw a decrease in Alaska Health Care employment, leaving more work, during the pandemic, to fewer people. We will not be able to improve the continuum of care, without a robust workforce.

2:42:56 PM
Administrative burdens, malpractice risk, limited training and recruitment, limited clinical supports, physical violence, and the emotional exhaustion of the work, leave providers burnt out, leaving the profession and sadly committing suicide at twice the national rate.

It is important to remember that **burn out is not the failure of the person, but a failure of the system**. In 2020 in the US, 82% of healthcare workers reported emotional exhaustion, 55% reported questioning their career path, and 45% of nurses said they did not have adequate emotional support. We see similar result of the public health workforce with people leaving this critical profession at unprecedented rates.

Though collaboration with key partners, and by addressing the bottle necks and barriers across the health care ecosystem, we can grow and support Alaska's health care workers, the backbone and heart of care in Alaska.

2:43:55 PM
DR. ZINK reviewed slide 22, Moving Forward. She paraphrased her prepared testimony, which read:

[Original punctuation provided.]

The focus on moving upstream is not new to us in the State of Alaska. We are constantly focused on finding the root of improved health – and this critical work continues in many forms.

Whether we are using layered prevention identify and end a GI outbreak related to contaminated food, or changes to Medicaid delivery, by **working together upstream, we can collectively keep Alaskans healthier and we can use our resources more effectively.**

2:44:23 PM
The Department of Health and Social Services continues to move forward with our partners to ensure that systems are working for Alaskans, instead of Alaskans just working within systems. We are more prepared and more resilient to the myriad of challenges we may face from tsunamis to budget cuts, infectious disease to forging aggression when we are healthy and well and have systems, that like our democracy is by the people, and truly for the people of this great state.

This slide shows some of the milestones along this journey.

The 1115 Medicaid Demonstration Waiver is a great example of upstream prevention. This waiver serves as the vehicle to redesign, build, and expand the Medicaid payment for behavioral health system to support at-risk children and families, and use data-driven, integrated systems of care to improve the outcomes for Alaskans suffering from mental illness, substance use disorder, and more.

This work then fits with in the work of the "Crisis Now model" which builds on three key systems:

1. "Someone to Talk to" (a crisis call center that coordinates in real time) which is being built with the ongoing efforts of 988. Beginning July 16, this new three-digit dialing will connect people in crisis, or loved ones worried about their family, to support and resources.

2. "Someone to Respond" (24/7 mobile crisis teams to respond to a crisis in-person), and

3. "Place to go" (23-hour and short-term stabilization, offering a safe and supportive behavioral health crisis placement for those who cannot be stabilized by call center staff or mobile crisis team response). Juneau is going to open the first 23-hour stabilization center in Alaska.

2:46:14 PM

This Crisis Now model helps to support people in need, reduces the burden on law enforcement who often responds to mental health crises, and gets patients care more quickly and in the least restrictive way possible, reducing ED visits and inpatient psychiatric admissions.

2:46:28 PM

Those are just a few examples of the upstream work that will help us achieve the goal of healthier Alaskans and reduced health care costs. This is a journey we're all on together and I look forward to working with the Legislature and all of our partners to achieve these goals. Your support and work has been critical to these successes so far and will continue to be critical in the months and years to come.

2:46:50 PM

DR. ZINK thanked members. She stated that together the department and the legislature could provide better care at a lower cost to Alaskans by building on the efforts of Healthy Alaskans 2030, improving data modernization, supporting the health care workforce, and finding ways to pay for prevention.

DR. ZINK stated that she was grateful for the legislature's efforts and the Chair's willingness to host this first-ever

State of Alaska's Health presentation. She said she looks forward to collectively improving care for all Alaskans.

2:47:21 PM
SENATOR BEGICH directed attention to slide 13 to the drug overdose deaths. He noted that a slow increase followed a significant decline in 2017-2018. He indicated he was studying the efficacy of treatment programs. He said he recognized the impact of NARCAN, although the drug is dispensed anonymously, so it cannot be tracked. He wondered if the increase was a reflection of reductions or the effectiveness of treatment grants. He asked what tool would decrease the death rate and whether it would be increased grant programs.

DR. ZINK offered her view that it was going up for many reasons, so it would take time to understand it better. She stated that many people in the field were concerned by the dramatic increase in overdose deaths related to fentanyl. She explained that fentanyl is 50 times more powerful than heroin and that many people may think they are taking a prescription drug like Norco, hydrocodone, or oxycontin, which they have previously taken. However, the drug is a counterfeit pill laced with fentanyl. She said one medication is lethal. She said the two to four milligram (mg) dose of NARCAN, naloxone, is not enough to overcome the level of fentanyl in the victim. Thus, the department is working on an 8 mg dose, plus distributing fentanyl patches so people can test their drug for the presence of fentanyl. She acknowledged that more could be done to help prevent people from using opioid drugs and reduce reliance on the drugs.

2:50:18 PM
SENATOR BEGICH wondered what specific funding the legislature could provide to support the work being done to address the fentanyl issue. He indicated that he lost a nephew to fentanyl use.

DR. ZINK said the work in the field involves the Department of Public Safety and the Department of Health and Social Service's Divisions of Behavioral Health and Public Health. She offered to research and report to the committee on specific funding needs.

2:51:39 PM
SENATOR REINBOLD referred to the Crisis Now model. She noted she had constituents who expressed concern about the perceived mistreatment of disabled psychiatric patients, including Access Alaska and Faith Myers. One constituent was a Russian who

alleged he was held in a psychiatric facility for political reasons. She asked what the Crisis Now model was and what assurances the legislature had that these abuses would not occur.

2:53:34 PM
DR. ZINK acknowledged that as an emergency medicine physician, she had observed daily the ways the current system is failing patients. She said she understood that members would receive letters expressing concern or frustration. She recalled that people literally wore through their paper scrubs awaiting a psychiatric evaluation and treatment.

2:53:55 PM
DR. ZINK explained that the Crisis Now model was a collective effort to improve care. The Crisis Now model would provide the person seeking mental health assistance with 1) someone to call, 2) someone to respond, and 3) a place to go. She elaborated on the planned mental health care improvements. First, people can currently call Alaska Care, but the federal government has been working to create a 988 number specifically for mental health assistance and additional resources, rather than just calling 911. Second, law enforcement spends significant time trying to stabilize someone in crisis. Crisis Now would provide Mobile Crisis teams trained in mental health to respond to a person in crisis, helping them get needed support and resources, so they don't end up in an emergency room (ER). Currently, law enforcement picks up the person in crisis and takes them to the ER, waiting for a behavioral health clinician to assess them. The ER is bright and loud and not a therapeutic environment for patients. Third, Crisis Now would provide short-term 23-hour crisis stabilization centers. Someone's wife may have left them, or the person may have experienced another acute event that made them suicidal or violent. However, being able to go to a place to talk, cool off, or get access to medication can help. Sometimes people need to sober up, and they are more able to make decisions or connect to family and loved ones.

2:56:14 PM
DR. ZINK stated that ensuring the system works requires everyone to be involved, trying to understand the system and the process, reviewing data, and getting feedback from constituents to ensure that Crisis Now serves the people.

2:56:41 PM
SENATOR REINBOLD wondered how to ensure that people won't be abused. She asked whether the department supports an All-Payer

Claims database. She further asked for an update on the hospital's Federal Emergency Management Agency (FEMA) workers.

DR. ZINK responded that ensuring abuse doesn't occur would require constant monitoring. She offered her view that it makes sense in Alaska to have an All-Payer Claims Database for improved transparency in overall healthcare costs. Providers see patients with numerous payer sources, so reducing the administrative burden makes sense, but it is challenging. She offered her view that FEMA workers were finished, that the contracts ended. She noted that many took full-time jobs in Alaska.

2:57:45 PM
SENATOR HUGHES recalled that Senator Begich had questions about drug overdoses. She stated that she received an update on the Set Free Alaska pilot project, designed to help people with addiction problems become productive citizens. She reported that it was going well, and once data was collected, it was possible to replicate it throughout the state. She referred to slide 9. She noted that Alaska was on the high end for health care expenditures based on 2014 data. She anticipated that Alaska's expenditures would be even higher now. She encouraged the department to consider preventive and primary care costs to move Alaska forward. She recalled that Alaska spends 80-90 percent on specialty acute care, which needs to be addressed. She noted that Director Wing-Heier reported to the Senate Labor and Commerce Committee that some people pay a deductible as high as $15,000. She surmised that many people are not receiving the care they need. She emphasized the need to reduce health care costs.

3:00:09 PM
DR. ZINK responded that cost of care was a huge limiting factor, and people won't seek care for serious injuries or health issues because of the deductible costs.

3:00:33 PM
CHAIR WILSON suggested members send their questions to his office and he would forward them to the department.

SENATOR REINBOLD said she had a list of 13 questions to submit.

3:02:40 PM
There being no further business to come before the committee, Chair Wilson adjourned the Senate Health and Social Services Standing Committee meeting at 3:02 p.m.