STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS, AND PROFESSIONAL LICENSING

STATE MEDICAL BOARD

MINUTES OF MEETING
Thursday May 27, 2021

By authority of AS 08.01.070(2) and in compliance with the provisions of AS 44.62, a scheduled meeting of the Alaska State Medical Board was held on Thursday, May 27, 2021

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1. Call to Order/ Roll Call
The meeting was called to order by Chair Wein at 3:15 p.m.

Roll Call
Board members present:
- Sarah Bigelow Hood, PA-C
- David Boswell, Public Member (Secretary)
- Maria Freeman, MD
- Lydia Mielke
- Richard Wein, MD (Chair)

Board Members absent:
- Steve Parker, MD
- Larry Daugherty, MD

Division staff present: Sara Chambers, Director, Natalie Norberg, Executive Administrator, Steven Alvarado, Occupational License Examiner (OLE), Jason Kaiser, OLE, Olena Ziuba, OLE,

Guests present:
Jared Kosin, President and CEO of Alaska State Hospital and Nursing Home Association
Jeannie Monk, Senior Vice President, ASHNHA
Pam Ventgen, Executive Director, Alaska Medical Association
Shane Coleman, MD, MPH - Medical Director, Behavioral Services, Southcentral Foundation
Janice Sheufelt, MD - Incoming President ASMA & Alaska licensed physician providing addiction medicine.
Ryan Wallace, MD – Psychiatrist Providence
Shannon Shea, Providence Medical Group
Valerie Edwards, MD Chief of Staff, SEARHC

2. Review Agenda
The Board reviewed and approved the agenda by affirmation.

Steve Parker, MD joined the meeting at 3:25 p.m.

3. Telehealth – Prescribing Controlled Substances

Chair Wein invited Jeannie Monk to introduce the topic and guests on behalf of Alaska hospitals and physicians. Ms. Monk identified four issues related to prescribing controlled substances by telehealth.

1) Overview of the key issues and why action is needed through legislation and regulatory changes;
2) The need for adoption of emergency regulations for continued flexibility for prescribing that were previously allowed under the governor's disaster declaration; requesting that prescribing be allowed under the declaration of an emergency situation by the Commissioner of Health and Social Services or under an urgent situation declared by the Board.
3) Overview of why having the ability to prescribe Buprenorphine by telemedicine without having a practitioner present with the patient is important during this public health emergency. They are asking that flexibilities be extended to December 31, 2021 or June 30, 2022.
4) Requested that the Board provide clarity regarding whether practitioners can provide continued treatment to established patients via telehealth after an inpatient exam has occurred.

Chair Wein invited Division staff, Sara Chambers and Natalie Norberg and Assistant Attorney General, Megyn Weigand to provide an overview of the current legal and regulatory framework for how prescribing Buprenorphine was previously allowed under a disaster declaration by the governor and proposed language for regulatory amendments to address the current void in the ability for practitioners to prescribe buprenorphine for the treatment of opioid use disorders. The Board was presented with proposed amendments to regulation 12 AAC 40.943 (b) that would allow for three ways in which a public health emergency may be declared, either by the governor, commissioner of health and social services, or in an emergency as defined by a new subsection 12 AAC 40.943. AAG Weigand explained that while federal law requires an in-person clinical evaluation to occur in order to initiate treatment or provide continued treatment with a Level III controlled (including buprenorphine) substances, this requirement has been suspended for several years by the US Secretary of Health and Human Services in recognition of the ongoing opioid epidemic. Alaska law is more restrictive and does require the in-person evaluation. The State Medical Board has the authority to address/suspend this more restrictive requirement in regulation through the proposed language. Finally, adding a new subsection to 12 AAC 40.943, to create a definition for emergency, will allow for significant flexibility for the board and practitioners to be able to be able to determine when conditions in certain areas of the state or due to geographic location create circumstances for which a public health disaster exists that prohibit an in-person evaluation.

Shane Coleman was invited to address the board. During his testimony he highlighted the confusion and frustration experienced by providers over the lack of clarity regarding whether the in-person requirement for the prescription of buprenorphine is necessary after the Governor's disaster declaration expired. The subsequent declaration made by Commissioner Crum did not specifically address the buprenorphine issue as did the previous declaration. From his clinical perspective, Dr. Coleman reiterated that Covid remains a threat for both patients and providers. Some individuals are not eligible for the vaccine because they have allergies or are immunosuppressant, making in-person visits less than optimal. Many children are on stimulants for ADHD and are currently not eligible to be vaccinated. Dr. Coleman also reiterated that more clarity regarding when the in-person visit is required is needed in the

1 state regulations. He cited the language provided in Federal regulation, “having had at least one-in
2 person medical evaluation of the patient” as being helpful and something the state should consider.

3 Janice Sheufelt was invited to address the Board. Dr Sheufelt offered provided information regarding her
4 professional background and offered the follow testimony. Dr. Sheufelt is a family physician in Juneau
5 who began practicing in 1997 for the Indian Health system and is currently working full time in addiction
6 medicine for a telehealth company, treating individuals with opioid use and alcohol addictions. Since the
7 Covid disaster began, Dr. Sheufelt has initiated telemedicine treatment to 150 patients. She assured the
8 Board that the use of buprenorphine is extremely safe. There are no contraindications for beginning
9 suboxone, except for if someone is in florid liver failure and she always screens for this prior to
10 prescribing. It is safe to initiate buprenorphine without an in-person exam. It is incredibly urgent to help
11 as many people as possible because of the opioid emergency that is ongoing in our country and in
12 Alaska. Almost every patient seen knows someone who has died from an overdose. Fentanyl is
13 becoming increasingly prevalent, either mixed in with or replacing heroin. It is extremely dangerous,
14 and people are unintentionally dying. Buprenorphine acts as a partial opioid agonist so it stabilizes the
15 receptor but does not activate it and does not create a high, so that is how it treats the disease. People
16 do not become addicted to buprenorphine. Treatment with buprenorphine is highly safe and effective.
17 Anything to eliminate barriers to treatment such as a physical exam during a public health emergency is
18 important.

19 Ryan Wallace was invited to address the Board. Dr. Wallace highlighted that the COVID pandemic has
20 exacerbated the opioid pandemic by impacting how drugs are traveling around the country and getting
21 to Alaska. Heroin supply routes have been disrupted, causing an increase use of fentanyl. Fentanyl is
22 being added to other drugs. In his experience, where fentanyl becomes more prevalent, there is an
23 increase in overdoses and deaths. Now more than ever in Alaska we are seeing a spike in overdoes
24 presentations to emergency departments since March of this year. Dr. Wallace stated that as a
25 practitioner, he values sharing space with a patient to develop a relationship. However, absent this
26 option, the alternative is that patients may die if they don’t receive treatment. He reiterated that
27 treatment with buprenorphine is extremely safe. Many patients in Alaska, due to their geographic
28 location do not have the ability to be physically in the same room with a treatment provider, so either
29 they go through a very uncomfortable withdrawal or they use again, risking overdose and death. The
30 allowances made during the pandemic for more flexible treatment through telehealth is showing us that
31 it is beneficial and safe. During the pandemic, Dr. Wallace treated a woman who was seven months
32 pregnant, addicted to heroin and meth and had not received any pre-natal care. He was able to
33 prescribe her with suboxone via telehealth. That woman now has a healthy baby and is doing well. This
34 would not have been the outcome had this option not been available.

35 Shannon Shea was invited to address the Board. Ms. Shea reiterated the ongoing need for clarity for
36 providers regarding the need for and frequency of in-person visits for other controlled substances such
37 as medications for ADHD.

38 Pam Ventgen was invited to address the Board. Ms. Ventgen advised that after we lost the emergency
39 declaration, she has received numerous phone calls from physicians, primarily psychiatrists, who were
40 seeking clarity around their ability to continue to prescribe controlled substances such as those for the
41 treatment of ADHD without an in-person visit. Buprenorphine is at the top of the list, however there are
42 other medications working effectively for patients with an established relationship with a physician. The

1 medical association would like clarity regarding whether telemedicine treatment is permissible, for
2 other controlled medications besides buprenorphine, if an in-person visit is not possible.

3 Dr. Freeman thanked the presenters and stated it was clear from their testimony that buprenorphine
4 and telemedicine are important tools for treating opioid use disorders. Dr. Freeman confirmed that the
5 priority request is for clarity regarding whether the in-person requirement is necessary for treatment
6 with buprenorphine.

7 Dr. Wein requested input from the presenters regarding whether the language in the proposed
8 regulation amendments provide the clarity needed. It was confirmed that the constructed language in
9 the proposed amendments address the issues that were presented.

10 Mr. Boswell clarified that the proposed language in the amendments address the concerns raised
11 regarding buprenorphine, but that the medical community would like additional medications to have
12 the same flexibilities for telehealth prescription without an in-person visit. Dr. Wein advised that adding
13 medications would require a separate conversation to outline the scope of additional medications.

14 The presenter panelists addressed questions from the board pertaining to why buprenorphine is a
15 controlled substance and telehealth treatment strategies that augment and enhance medication
16 assisted treatment for addiction.

17 Dr. Freeman reiterated her experience that the use buprenorphine to treat opioid use disorder is safe
18 and effective.

19 AAG Weigand advised the board that another strategy to addressing the in-person requirement to
20 treating opioid use disorder with medication assistant treatment would be to pin the flexibility to the
21 federal declaration of an emergency in state regulation.

22 It was determined that the board would vote on the proposed regulation amendments during the next
23 board meeting scheduled in one week, on June 3, 2021 in order to allow for division staff to prepare the
24 precise language needed for an emergency regulation.

25 **4. Collaborative Agreement Flexibility for itinerant Physician Assistants**

26 Dr. Wein invited Jared Kosin and Valerie Edwards to present on the issue of how physician assistant
27 collaborative agreements are managed in rural settings and a proposed regulatory amendment. Mr.
28 Kosin explained that it is common for health care clinics/facilities in Alaska to utilize locum tenens
29 physician assistants, who often rotate through various clinical setting, and it is common for these PA's to
30 have multiple collaborative agreements. If the collaborative agreement is kept open, it requires the PA
31 to continue to meet monthly with that supervising physician, regardless of if the PA and physician are
32 practicing for the same facility. Multiple short-term collaborative agreements are administratively
33 burdensome and expensive yet keeping multiple longer-term collaborative agreements open is also
34 cumbersome. The solution is a simple change to regulation that would suspend the requirement for the
35 monthly contact with the supervising physician when the PA is practicing under a different collaborative
36 plan. Dr. Edwards reported that SEARCH medical doctors experience challenges with maintaining
37 compliance with the monthly contact requirement for their PA locum tenens. SEARHC typically employs
38 10-15 locum tenens PA's for 2-6-month rotations. It is not uncommon for these PAs to rotate through
39 various clinical settings throughout the state. Monthly check-ins with these locum tenens PA's cans be

awkward because the physician and PA are not sharing patients, yet the monthly check-in is still required. The proposed amendment eliminates redundancy, administrative burden and potential HIPAA violations while still ensuring proper supervision of locum tenens PAs.

In a motion duly made by Dr. Wein, seconded by Dr. Freeman and approved by a roll call vote the board accepted the amendment to 12 AAC. 40.430 (i) to modify the requirement for monthly direct personal contact between the physician assistant and the primary or alternate collaborating physician who share a collaborative to only during the period in which the physician assistant is actively practicing under the collaborative plan.

Roll Call: Yeas, Sarah Bigelow Hood, Mr. Boswell, Dr. Freeman, Ms. Mielke, Dr. Parker, Chair Wein
Absent for Vote: Dr. Daugherty

5. Pharmacist Cooperative Agreement

Dr. Wein explained the proposed amendment will strike language from regulation to require the Board of Pharmacy to require approval of Physician-Pharmacy Cooperative Agreements. Ms. Norberg reported that there are currently 26 cooperative agreements in place. There was discussion regarding the existing process for monitoring and approving such agreements. It was acknowledged that this review process is an area for the Board to review and possibly enhance to ensure appropriate oversight of future Physician-Pharmacy Cooperative Agreements.

In a motion duly made by Dr. Wein and seconded by Dr. Freeman, the board approved by roll call vote to strike the "Board of Pharmacy" from the language in 12 AAC 40.983 (k) such that the Board of Pharmacy will no longer be required to approve Physician-Pharmacy Cooperative Agreements.

Roll Call: Yeas, Sarah Bigelow Hood, Mr. Boswell, Dr. Freeman, Ms. Mielke, Dr. Parker, Chair Wein
Absent for Vote: Dr. Daugherty

6. "Urgent Situation" Designation/Continuation of Emergency Courtesy Licenses

Chair Wein invited Ms. Norberg to introduce this topic. This matter involves the need for the board to determine whether the designation of an "urgent situation" remains to allow for the continued provision of Emergency Courtesy Licenses (ECL). Division staff provided data, a summary of trends and some problematic issues identified with the ECL program since implementation. Of primary concern is the observation that nearly 50% of the applicants are from Florida, and the discovery that the majority of these applicants are unqualified to practice medicine. Instead of having the required, full, unencumbered license from the state in which they reside, many applicants from Florida can only produce verification of a "House" License. Upon investigation, the "House" License is a limited license, under which licensees work have limited privileges and must work under the supervision of a fully licensed physician in a hospital setting. Additionally, division staff discovered that a licensing entity is actively soliciting unqualified applicants, promising full medical licensure in Alaska if they pay a fee ranging from 1000 to 1400 dollars.

It was agreed that this matter should be referred to the Investigation Unit for expedited review. It was further agreed that the Florida Board of Medicine and the Federation of State Medical Boards should be alerted to this situation. The board decided to put a hold on making any decisions regarding the

1 continuation of the ECL at this time and requested division staff to explore and present the board with
2 options for how to either improve/update the ECL application, identify alternative license types which
3 would include an expedited path for a temporary license, and/or to eliminate the ECL at a future board
4 meeting.
5
6 **7. Adjournment**
7 The Chair expressed his appreciation to the board.
8
9 There being no further business, the meeting was adjourned at 5:15 p.m.
10
11
12 Respectfully submitted: Approved:
13
14 /s/____________________ /s/____________________

15 Natalie Norberg, Executive Administrator
16 Alaska State Medical Board

Richard Wein, MD, President
Alaska State Medical Board

17
18 November 19, 2021____________ November 19, 2021____________
19 Date Date