

1 STATE OF ALASKA
2 DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
3 DIVISION OF CORPORATIONS, BUSINESS, AND PROFESSIONAL LICENSING
4

5 STATE MEDICAL BOARD
6

7 MINUTES OF MEETING
8 Thursday May 27, 2021
9

10 *These are DRAFT minutes prepared by staff of the Division of Corporations, Business and Professional*
11 *Licensing. They have not been reviewed or approved by the Board.*
12

13 By authority of AS 08.01.070(2) and in compliance with the provisions of AS 44.62, a scheduled meeting
14 of the Alaska State Medical Board was held on Thursday, May 27, 2021
15

16 **Thursday May 27, 2021**
17

18 **1. Call to Order/ Roll Call**

19 The meeting was called to order by Chair Wein at 3:15 p.m.
20

21 **Roll Call**

22 Board members present:

23 Sarah Bigelow Hood, PA-C
24 David Boswell, Public Member (Secretary)
25 Maria Freeman, MD
26 Lydia Mielke
27 Richard Wein, MD (Chair)
28

29 Board Members absent:

30 Steve Parker, MD
31 Larry Daugherty, MD
32

33 Division staff present: Sara Chambers, Director, Natalie Norberg, Executive Administrator, Steven
34 Alvarado, Occupational License Examiner (OLE), Jason Kaiser, OLE, Olena Ziuba, OLE,
35

36 Guests present:

37 Jared Kosin, President and CEO of Alaska State Hospital and Nursing Home Association
38 Jeannie Monk, Senior Vice President, ASHNHA
39 Pam Ventgen, Executive Director, Alaska Medical Association
40 Shane Coleman, MD, MPH - Medical Director, Behavioral Services, Southcentral Foundation
41 Janice Sheufelt, MD - Incoming President ASMA & Alaska licensed physician providing addiction
42 medicine.
43 Ryan Wallace, MD – Psychiatrist Providence
44 Shannon Shea, Providence Medical Group
45

1 Valerie Edwards, MD Chief of Staff, SEARHC

2
3 **2. Review Agenda**

4 The Board reviewed and approved the agenda by affirmation.

5
6 Steve Parker, MD joined the meeting at 3:25 p.m.

7
8 **3. Telehealth – Prescribing Controlled Substances**

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

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

21
22 Chair Wein invited Division staff, Sara Chambers and Natalie Norberg and Assistant Attorney General,
23 Megyn Weigand to provide an overview of the current legal and regulatory framework for how
24 prescribing Buprenorphine was previously allowed under a disaster declaration by the governor and
25 proposed language for regulatory amendments to address the current void in the ability for
26 practitioners to prescribe buprenorphine for the treatment of opioid use disorders. The Board was
27 presented with proposed amendments to regulation 12 AAC 40.943 (b) that would allow for three ways
28 in which a public health emergency may be declared, either by the governor, commissioner of health
29 and social services, or in an emergency as defined by a new subsection 12 AAC 40.943. AAG Weigand
30 explained that while federal law requires an in-person clinical evaluation to occur in order to initiate
31 treatment or provide continued treatment with a Level III controlled (including buprenorphine)
32 substances, this requirement has been suspended for several years by the US Secretary of Health and
33 Human Services in recognition of the ongoing opioid epidemic. Alaska law is more restrictive and does
34 require the in-person evaluation. The State Medical Board has the authority to address/suspend this
35 more restrictive requirement in regulation through the proposed language. Finally, adding a new
36 subsection to 12 AAC 40.943, to create a definition for emergency, will allow for significant flexibility for
37 the board and practitioners to be able to be able to determine when conditions in certain areas of the
38 state or due to geographic location create circumstances for which a public health disaster exists that
39 prohibit an in-person evaluation.

40 Shane Coleman was invited to address the board. During his testimony he highlighted the confusion and
41 frustration experienced by providers over the lack of clarity regarding whether the in-person
42 requirement for the prescription of buprenorphine is necessary after the Governor’s disaster declaration
43 expired. The subsequent declaration made by Commissioner Crum did not specifically address the
44 buprenorphine issue as did the previous declaration. From his clinical perspective, Dr. Coleman
45 reiterated that Covid remains a threat for both patients and providers. Some individuals are not eligible

1 for the vaccine because they have allergies or are immunosuppressant, making in-person visits less than
2 optimal. Many children are on stimulants for ADHD and are currently not eligible to be vaccinated. Dr.
3 Coleman also reiterated that more clarity regarding when the in-person visit is required is needed in the
4 state regulations. He cited the language provided in Federal regulation, “having had at least one-in
5 person medical evaluation of the patient” as being helpful and something the state should consider.

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

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

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

41 Pam Ventgen was invited to address the Board. Ms. Ventgen advised that after we lost the emergency
42 declaration, she has received numerous phone calls from physicians, primarily psychiatrists, who were

1 seeking clarity around their ability to continue to prescribe controlled substances such as those for the
2 treatment of ADHD without an in-person visit. Buprenorphine is at the top of the list, however there are
3 other medications working effectively for patients with an established relationship with a physician. The
4 medical association would like clarity regarding whether telemedicine treatment is permissible, for
5 other controlled medications besides buprenorphine, if an in-person visit is not possible.

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

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

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

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

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

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

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

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

29 Dr. Wein invited Jared Kosin and Valerie Edwards to present on the issue of how physician assistant
30 collaborative agreements are managed in rural settings and a proposed regulatory amendment. Mr.
31 Kosin explained that it is common for health care clinics/facilities in Alaska to utilize locum tenens
32 physician assistants, who often rotate through various clinical setting, and it is common for these PA's to
33 have multiple collaborative agreements. If the collaborative agreement is kept open, it requires the PA
34 to continue to meet monthly with that supervising physician, regardless of if the PA and physician are
35 practicing for the same facility. Multiple short-term collaborative agreements are administratively
36 burdensome and expensive yet keeping multiple longer-term collaborative agreements open is also
37 cumbersome. The solution is a simple change to regulation that would suspend the requirement for the
38 monthly contact with the supervising physician when the PA is practicing under a different collaborative
39 plan. Dr. Edwards reported that SEARCH medical doctors experience challenges with maintaining

1 compliance with the monthly contact requirement for their PA locum tenens. SEARHC typically employs
2 10-15 locum tenens PA's for 2-6-month rotations. It is not uncommon for these PAs to rotate through
3 various clinical settings throughout the state. Monthly check-ins with these locum tenens PA's can be
4 awkward because the physician and PA are not sharing patients, yet the monthly check-in is still
5 required. The proposed amendment eliminates redundancy, administrative burden and potential HIPAA
6 violations while still ensuring proper supervision of locum tenens PAs.

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

12
13 Roll Call: Yeas, Sarah Bigelow Hood, Mr. Boswell, Dr. Freeman, Ms. Mielke, Dr. Parker, Chair Wein
14 Absent for Vote: Dr. Daugherty

15 16 **5. Pharmacist Cooperative Agreement**

17
18 Dr. Wein explained the proposed amendment will strike language from regulation to require the Board
19 of Pharmacy to require approval of Physician-Pharmacy Cooperative Agreements. Ms. Norberg reported
20 that there are currently 26 cooperative agreements in place. There was discussion regarding the
21 existing process for monitoring and approving such agreements. It was acknowledged that this review
22 process is an area for the Board to review and possibly enhance to ensure appropriate oversight of
23 future Physician-Pharmacy Cooperative Agreements.

24
25 **In a motion duly made by Dr. Wein and seconded by Dr. Freeman, the board approved**
26 **by roll call vote to strike the "Board of Pharmacy" from the language in 12 AAC 40.983 (k) such**
27 **that the Board of Pharmacy will no longer be required to approve Physician-Pharmacy**
28 **Cooperative Agreements.**

29
30 Roll Call: Yeas, Sarah Bigelow Hood, Mr. Boswell, Dr. Freeman, Ms. Mielke, Dr. Parker, Chair Wein
31 Absent for Vote: Dr. Daugherty

32 33 **6. "Urgent Situation" Designation/Continuation of Emergency Courtesy Licenses**

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

1 It was agreed that this matter should be referred to the Investigation Unit for expedited review. It was
2 further agreed that the Florida Board of Medicine and the Federation of State Medical Boards should be
3 alerted to this situation. The board decided to put a hold on making any decisions regarding the
4 continuation of the ECL at this time and requested division staff to explore and present the board with
5 options for how to either improve/update the ECL application, identify alternative license types which
6 would include an expedited path for a temporary license, and/or to eliminate the ECL at a future board
7 meeting.

8

9 **7. Adjournment**

10 The Chair expressed his appreciation to the board.

11

12 There being no further business, the meeting was adjourned at 5:15 p.m.

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15 Respectfully submitted:

16

Approved:

17 /s/ _____

18 Natalie Norberg, Executive Administrator
19 Alaska State Medical Board

20

/s/ _____

Richard Wein, MD, President
Alaska State Medical Board

21 _____

22 Date

Date