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

STATE MEDICAL BOARD
MINUTES OF MEETING
Friday, November 15, 2024

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

By authority of AS 08.01.070(2) and in compliance with the provisions of AS 44.62, a quarterly meeting of the Alaska State Medical Board was held Friday, November 15, 2024.

1. Call to Order/ Roll Call
The meeting was called to order by Chair Nimmo at 9:00 a.m.

Roll Call
Board members present:

David Barnes, DO
Matt Heilala, DPM
Sarah Bigelow Hood, PA-C (Vice-Chair)
Lydia Mielke, Public Member (Secretary)
Eric Nimmo, MD (Chair)
David Paulson, MD
Brent Taylor, MD
David Wilson, Public Member

Board staff present: Natalie Norberg, Executive Administrator; Jason Kaeser, Licensing Supervisor; Sonia Lipker, Senior Investigator; Shelley Irons, Investigator; Kendra Wardlaw, Investigator; Karina Medina, Probation Monitor

2. **Review / Approval of Agenda**

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote the Alaska State Medical Board approved the agenda as presented.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

3. **Review/Approval of Minutes**

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board approve the minutes for the August 9, 2024, September 19, 2024, and October 10, 2024, meetings with the edits as discussed.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

4. Ethics Disclosures

Ethics reporting by board members is done on a quarterly basis and is a standing item on the quarterly meeting agenda. The Chair requested Ms. Norberg query each board member.

There were no ethical disclosures made by board members.

5. Physician Health Committee Update

Chair Nimmo invited Dr. Mary Ann Foland to address the Board. Dr. Foland reported that she recently presented to the family practice residency program participants and reminded them about the 30-day rule to inform the Board of any unfortunate incidents (new criminal charges). During this presentation residents asked many questions about the use of marijuana, to which Dr. Foland advised it is the opinion of the PHC that use of marijuana is "not a good idea" however she is not aware of the Medical Board's policy on this issue. Dr. Foland reported that the PHC is currently monitoring 15-17 people with several more people in the process of being evaluated. Dr. Foland volunteered the PHC to take over the primary drug testing for the people the committee is monitoring, stating they can get results back faster and obtain a broader scope of testing. Ms. Norberg agreed to follow up with Ms. Ventgen for more information on this matter. Finally, Dr. Foland raised the issue of physicians with conditions of probation having their license labeled as "probationary" and this creating barriers for employment, especially for physicians getting hired in a hospital setting. This prompted a discussion regarding possible alternate labels and a request from Dr. Nimmo to Ms. Ventgen to explore with the hospital association possible options for the Board's consideration.

6. Board Interviews

Dr. Nimmo queried Dr. Paisley who requested to have his interview conducted in executive session.

> **On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions, for the purpose of discussing Case #2023-000449 with Dr. Paisley remaining for part of the session and Board and Investigative staff to remain during the entire session.**
>
> Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The Board entered executive session at 9:22 a.m. The Board returned on the record at 10:00 a.m.

> **On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board decided to table a decision on whether to modify the consent agreement (concerning Case #2023-000449) and direct the Executive Administrator and Investigations Staff to gather more information including consulting with Law and talking to institutions about what license status terms would be acceptable.**
>
> Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

Dr. Nimmo queried Dr. Dr. Taheri who requested to have his interview conducted in executive session.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow-Hood, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions, for the purpose of discussing Dr. Taheri 's application for licensure, with Board staff remaining during the session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The Board entered executive session at 10:05 a.m. The Board returned on the record at 10:16 a.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board approved Daniel Taheri, MD for a full license.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

7. Old Business

- **Telehealth Regulations**

Dr. Nimmo reminded the Board that this matter was tabled at a previous meeting. There is obsolete language in the Board's regulations concerning telehealth and this is an issue for which Ms. Norberg frequently fields questions from the public. Dr. Nimmo reviewed the options for how to proceed on this matter which include once again tabling the issue, or, simply eliminating the obsolete language and leaving everything else the same, or, appointing a committee to make recommendations for changing the entire regulation section. Board members discussed these options and voiced support for eliminating the outdated language and tabling a decision on whether to adopt the 2022 FSMB guidelines, *Appropriate Use of Telemedicine Technologies in the Practice of Medicine*, until the next meeting.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board approved the changes to *12. AAC 40.943 Standards of Practice for Telemedicine*, to eliminate the language in sections (b), (b)(1), (b)(2) and (b)(3) as presented and requested the initiation of a regulation change project.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

8. Break - the Board went off the record for a break at 10:37 a.m. and returned on the record at 10:52 a.m.

9. New Business

- **Legal Consultation**

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS

44.62.310(c)(3), for the purpose of discussing a matter related to attorney-client privilege with AAG Liz Leduc and Board staff remaining during the session.

The Board entered executive session at 9:54 a.m. The Board returned on the record at 11:38 a.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board decided to request the Dept. of Law to investigate what other states have done on the issue of medical or surgical treatment of gender dysphoria in minors for the purpose of the Board drafting a statement on this issue.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

- **PDMP Delegation**

Dr. Nimmo invited Ms. Norberg to present the topic. This matter is regarding concerns raised by board members related to the heavy workload imposed by investigative cases on board members and the possibility to have some of this workload delegated to the Executive Administrator, a strategy adopted by the Board of Pharmacy. Billy Homestead, Lead Investigator and supervisor over PDMP violations was introduced, who explained how the process of referring technical violations concerning the PDMP is currently working with the Board of Pharmacy. Board members discussed and generally voiced support for delegating these duties to the Executive Administrator.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board decided to delegate matters concerning its licensees' technical violations related to the Prescription Drug Monitoring Program to the Executive Administrator for review and recommendations.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

- **Medical Spa Guidance**

Dr. Nimmo provided an update and overview regarding the focus of and his participation in the Medical Spa Workgroup. He highlighted that this is a growing industry in Alaska and there are many individuals interested in these issues. A purpose of this work group is to put forth recommended statutes to the legislature. Services offered through this industry include IV Hydration (including the compounding of medications onsite in out-patient clinic settings), advanced aesthetic services such as chemical peels, laser treatment, Botox injections, and the use of designer drugs such as Ozempic or semaglutides. Some of the concerns raised are related to the delegation of duties to unlicensed personnel such as technicians and ethicians, and the lack of a physician or physician assistant being physically onsite; and the use of standing orders without a medical assessment of the patient.

Related to this matter are board policies which were implemented many years ago and contain duplicative and contradictory guidelines to more newly adopted regulations which were implemented by the board in 2019. The conflicts between the polices and regulations were examined and several board members voiced support for repealing the old policies.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board repealed Board-issued guidelines pertaining to: *Delegating Procedures to Non-physician personnel for Dermatological Procedures* and *Delegating to Medical Assistants*.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

10. Lunch Break - The Board recessed for lunch at 12:16 p.m. and returned on the record at 1:00 p.m.

11. Public Comments/Board Communications

There were no members of the public present who requested to address the Board. Chair Nimmo highlighted written communications received by the Board.

12. Investigations

- **Case#: 2023--000070**

  On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case# 2023--000070, with Dept. of Law, Board and Investigative staff remaining during the session and the reviewing board member excluded from the session.

  Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The Board entered executive session at 1:12 p.m. The Board returned on the record at 1:19 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board accepted the consent agreement as proposed for Vinson DiSanto in Case# 2023-000070.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Abstained: Dr. Heilala

- **Case# 2023-000401**

  On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case# 2023-000401, with Board and Investigative staff remaining during the session.

  Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The Board entered executive session at 1:21 p.m. The Board returned on the record at 1:24 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board accepted the voluntary surrender of license for La Tania Akers White in Case# # 2023-000401.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

- **Case# 2021-000336**

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case# 2021-000336, with Board and Investigative staff remaining during the session and the reviewing board member excluded from the session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The Board entered executive session at 1:27 p.m. The Board returned on the record at 1:40 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and decided by roll call vote, the Alaska State Medical Board denied the reinstatement of license application for Buck Bania, which involves Case #2021-000336.

The Board cited in its decision concerns that Dr. Bania engaged in unprofessional conduct with staff members and a patient during the period that Dr. Bania was previously licensed and employed in Alaska.

Roll Call: Nays, Ms. Bigelow-Hood, , Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Abstained: Dr. Barnes and Dr. Heilala

- **Case# 2023-000065**

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case# 2023-000065, with Board and Investigative staff remaining during the session and the reviewing board member excluded from the session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The Board entered executive session at 1:43 p.m. The Board returned on the record at 1:49 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board accepted the voluntary surrender of license for Lavern Davidhizar in Case# 2023-000065.

Roll Call: Yeas, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Abstained: Dr. Barnes

- **Case# 2023-000026**

  On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case# 2023-000026, with Board and Investigative staff remaining during the session and the reviewing board member excluded from the session.

  Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The Board entered executive session at 1:52 p.m. The Board returned on the record at 1:57 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board imposed a civil fine as presented for Derek Ellingson in Case# 2023-000026.

Roll Call: Yeas, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Abstained: Dr. Barnes

- **Case #2022-000233**

  On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case# 2022-000233, with Board and Investigative staff remaining during the session and the reviewing board members excluded from the session.

  Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The Board entered executive session at 2:00 p.m. The Board returned on the record at 2:08 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board accepted the consent agreement as proposed for Norvin Perez in Case # 2022-000233.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Ms. Mielke, Dr. Nimmo, Dr. Taylor, and Mr. Wilson.
Abstained: Dr. Heilala and Dr. Paulson

- **Case #'s 2020-000208, 2020-000491, 2023-00053**

  On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case #'s 2020-000208, 2020-000491, 2023-00053, with Board and Investigative staff remaining during the session and the reviewing board member excluded from the session.

  Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The Board entered executive session at 2:11 p.m. The Board returned on the record at 2:15 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board accepted the consent agreement as proposed for Robert Thornquist in Case #'s 2020-000208, 2020-000491, 2023-00053.

Roll Call: Yeas, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Abstained: Dr. Barnes

- **Case # 2022-000247**

  On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case # 2022-000247, with Board and Investigative staff remaining during the session.

  Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The Board entered executive session at 2:18 p.m. The Board returned on the record at 2:33 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and decided by roll call vote, the Alaska State Medical Board denied the request to modify the conditions of probation as requested in Case # 2022-000247.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Nays, Dr. Nimmo

- **Case #'s 2022-000268, 2023-000262**

  On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case #'s 2022-000268, 2023-000262 with Board and Investigative staff remaining during the session and the reviewing board members excluded from the session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The Board entered executive session at 2:36 p.m. The Board returned on the record at 2:43 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board accepted the order for a summary suspension for Robert Thompson as presented in Case #'s 2022-000268, 2023-000262.

Roll Call: Yeas, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, and Mr. Wilson.
Abstained: Dr. Barnes and Dr. Taylor

14. Applicant Review
Full Board Review

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions, for the purpose of discussing license applications for James Black, John Jones, and Scott Miller with board staff remaining during session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The board entered executive session at 2:47 p.m. The board returned on the record at 3:10 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board approved Dr. Black and Dr. Jones for full licenses.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and decided by roll call vote, the Alaska State Medical Board denied granting a physician assistant license to Scott Miller.

The Board cited in its decision, Mr. Miller currently has a revoked license in the state of WA, in accordance with AS 08.64.200 (a) (4), Mr. Miller does not meet the qualifications for licensure in Alaska.

Roll Call: Nays, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

Ratification of Full Licenses
Board members were queried about their individual applicant reviews, no concerns were identified.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board approved the following list of physician assistants for full licensure.

	Lic Type	First Name	Last Name
1.	PA	Claire	Antoszewski
2.	PA	Christopher	Robertson
3.	PA	Tyler	Tennant

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood and approved by roll call vote, the Alaska State Medical Board approved the following list of osteopathic physicians for full licensure.

	Lic Type	First Name	Last Name
1.	DO	James	Bauman
2.	DO	Daniel	Fisher
3.	DO	Sarah	Feenstra
4.	DO	Zachary	Gee
5.	DO	Roger	Kasendorf
6.	DO	Donna	Woods

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Alaska State Medical Board approved the following list of allopathic physicians for full licensure.

	Lic Type	First Name	Last Name
1.	MD	Amy	Brockmeyer
2.	MD	Joel	Brownell
3.	MD	Cheryl-Lynn	Bugailiskis
4.	MD	Mitchell	Cahn
5.	MD	Michael	Chen
6.	MD	Nancy	Cooper
7.	MD	Ruxandra	Costa
8.	MD	Andrew	Diamond
9.	MD	Alan	Donnenfeld
10.	MD	Ivana	Dzeletovic
11.	MD	Samuel	Fadare
12.	MD	Lisa	Flora

13.	MD	John	Harrison
14.	MD	Howard	Harper
15.	MD	Allison	Lam
16.	MD	Jean	Leveque
17.	MD	Nathaniel	Miller
18.	MD	Kathleen	Moen
19.	MD	Milton	Nathan
20.	MD	Nathaniel	Ord
21.	MD	Stephen	Perez
22.	MD	Scott	Puza
23.	MD	Esteban	Ramirez
24.	MD	Ivan	Rohena-Quinquilla
25.	MD	David	Steidley
26.	MD	Mark	Smethurst
27.	MD	Joanna	Tavarez
28.	MD	Matthew	Thompson
29.	MD	Priti	Vyas
30.	MD	Binod	Wagle
31.	MD	Adam	Wolfberg
32.	MD	Judith	Wolfstein
33.	MD	Christopher	Wyatt

15. Malpractice Case Reviews

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board entered executive session in accordance with AS 44.62.310 (c)(3), and Alaska Constitutional Right to Privacy Provisions, with board staff to remain in the session, for the purpose of discussing malpractice cases involving the following practitioners:

1. **Kyle Chong, MD**
2. **Donald Conklin MD**
3. **Laura Levoy, MD**
4. **Jacob Light, MD**
5. **Greg Lund, MD**
6. **Michael Mallatt, PA**
7. **Victoria Murdock, MD**
8. **Elizabeth Parker, MD**
9. **Klane While, MD**
10. **Evan Wolf, MD**

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, and Dr. Taylor.
Absent: Mr. Wilson

The Board entered executive session at 3:28 p.m. The board returned on the record at 4:00 p.m.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board decided to take no further action with respect to the malpractice cases related to the following physicians:

1. **Kyle Chong, MD**
2. **Donald Conklin MD**
3. **Laura Levoy, MD**
4. **Jacob Light, MD**
5. **Greg Lund, MD**
6. **Michael Mallatt, PA**
7. **Victoria Murdock, MD**
8. **Klane While, MD**
9. **Evan Wolf, MD**

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

On a motion duly made by Ms. Mielke, seconded by Ms. Bigelow Hood, and approved by roll call vote, the Board decided to refer the malpractice case involving Dr. Elizabeth Parker to the Investigations Unit for the purpose of gathering additional information.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

16. Wrap up/Adjourn

The next meeting is scheduled for December 19, 2024, at 4:00 p.m.

The meeting was adjourned by unanimous consent at 4:03 p.m.

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

STATE MEDICAL BOARD
MINUTES OF MEETING
Thursday December 19, 2024

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

By authority of AS 08.01.070(2) and in compliance with the provisions of AS 44.62, a special meeting of the Alaska State Medical Board was held Thursday, December 19, 2024.

1. Call to Order/ Roll Call
The meeting was called to order by Chair Nimmo at 4:00 p.m.

Roll Call
Board members present:
Eric Nimmo, MD, Chair
David Barnes, DO
Sarah Bigelow-Hood, Vice-Chair
Matt Heilala, DPM
Lydia Mielke, Public Member (Secretary)
Brent Taylor, MD
David Wilson, Public Member

Absent: David Paulson, MD and Brent Taylor, MD

State employees present:
Sylvan Robb, CBPL Director; Erika Prieksat, Chief Investigator; Sonia Lipker, Lead Investigator; Kendra Wardlaw, Lead Investigator; Jason Kaeser, Licensing Supervisor; and Natalie Norberg, Executive Administrator

2. Review / Approval of Agenda

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board approved the agenda as presented.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Taylor, and Mr. Wilson
Absent: Dr. Paulson and Dr. Taylor

3. Investigations Update

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board entered into executive session in accordance with AS 44.62.310(c)(4, for the purpose of discussing Case#2023-000549 with Division staff remaining during the session.

The Board entered executive session at 4:03 p.m. The Board returned on the record at 4:36 p.m.

Dr. Paulson joined the meeting at 4:24 p.m.

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board decided against modifying the conditions of probation in Case#2023-000549 as presented.

Roll Call: Nays, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson and Mr. Wilson
Absent: Dr. Taylor

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board entered into executive session in accordance with AS 44.62.310(c)(4, for the purpose of discussing Case#2023-001091 with Division staff remaining during the session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson and Mr. Wilson
Absent: Dr. Taylor

The Board entered executive session at 4:38 p.m. The Board returned on the record at 4:44 p.m.

On a motion duly made by Ms. Mielke and seconded by Mr. Wilson, the Alaska State Medical Board accepted the consent agreement as proposed for Thomas Barale in Case#2023-001091. It was noted that the Reviewing Board Member abstained from the executive session.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson and Mr. Wilson
Abstained: Ms. Bigelow-Hood
Absent: Dr. Taylor

4. Applicant Full Board Review

It was reported that Mr. Ohlrich submitted all requested documents and was recommended for licensure.

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board approved Greg Ohlrich for a full license to practice as a physician assistant in the State of Alaska.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, and Dr. Paulson
Note: Internet connectivity issues prevented Mr. Wilson from casting a vote
Absent: Dr. Taylor

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions, for the purpose of discussing the license application for Sean Chang.

The Board entered executive session at 4:49 p.m. The Board returned on the record at 4:54 p.m.

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood the Alaska State Medical Board approved Dr. Sean Chang a full license to practice in the State of Alaska.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson and Mr. Wilson
Absent: Dr. Taylor

5. Old Business - Telemedicine

Chair Nimmo initiated a discussion regarding the 2022 FSMB guidelines Telemedicine. There was a lack of consensus from board members regarding adopting the guidelines by reference into regulation. Board members generally agreed that they would like to better understand the differences between the 2014 FSMB guidelines (which were adopted by reference into regulation and the 2022 guidelines. The executive administrator agreed to prepare and provide this information to the Board at a future meeting.

Dr. Brent Taylor joined the meeting at 5:07 p.m.

6. New Business – Physician Pharmacy Agreement

Chair Nimmo facilitated a discussion regarding a Cooperative Practice Agreement proposed by a group of physicians and pharmacists affiliated with the Alaska Native Medical Center and Southcentral Foundation. Board members voiced concerns regarding the broad scope of clinical activities outlined in the plan to be delegated to pharmacists, which in essence appears to endorse pharmacists in the ability to practice medicine. Board members questioned the legal basis for pharmacists to be granted such abilities. It was also noted that the agreement appears to specifically lack language to prohibit the pharmacists from administering or dispensing schedule I, II, II, or IV controlled substances, which violates section 12 AAC 40.983 [c](11).

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood the Alaska State Medical Board decided to table a decision regarding the approval of the proposed Cooperative Practice Agreement and request the Executive Administrator to ask South Central Foundation to bring their proposed agreement in compliance with existing regulation.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson, Dr. Taylor and Mr. Wilson

6. Wrap up / Adjourn

The next meeting will be on January 16, 2024, at 4:00 PM.

The meeting was adjourned by unanimous consent at 6:05 p.m.

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

STATE MEDICAL BOARD
MINUTES OF MEETING
Thursday January 16, 2025

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

By authority of AS 08.01.070(2) and in compliance with the provisions of AS 44.62, a special meeting of the Alaska State Medical Board was held Thursday, December 16, 2025.

1. Call to Order/ Roll Call
The meeting was called to order by Chair Nimmo at 4:00 p.m.

Roll Call
Board members present:
Eric Nimmo, MD, Chair
David Barnes, DO
Sarah Bigelow-Hood, Vice-Chair
Matt Heilala, DPM
Lydia Mielke, Public Member (Secretary)
David Paulson, MD
David Wilson, Public Member

Absent: Brent Taylor, MD

State employees present:
Cheryl Mandala, Administrative Law Judge; Robert Bacaj, Assistant Attorney General; Sonia Lipker, Lead Investigator; Kendra Wardlaw, Lead Investigator; Jason Kaeser, Licensing Supervisor; and Natalie Norberg, Executive Administrator

2. Review / Approval of Agenda

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board approved the agenda as presented.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson and Mr. Wilson
Absent: Dr. Taylor

3. Investigations Update

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board entered into executive session in accordance with AS 44.62.310(c)(4, for the purpose of discussing Case#2024-000633 with Division staff remaining during the session and the reviewing board member abstaining from the session.

The Board entered executive session at 4:05 p.m. The Board returned on the record at 4:11 p.m.

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board voted against issuing a full license to Dr. Asad Niazi.

The Board cited in its decision concerns related to the applicant's failure to disclose pertinent information on his application and a failure to cooperate in the investigative process.

Roll Call: Nays, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson and Mr. Wilson
Abstained: Dr. Barnes
Absent Dr. Taylor

4. Deliberative Session

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board entered into a deliberative session in accordance with AS 44.62.310(d) solely to make a decision concerning the Office of Administrative Hearing's decision related to sanctions,

In the Matter of Timothy Carey,
Office of Administrative Hearings Case Number 24-0001-MED
Board Case Numbers: 2022-000262/276/436 & 20223-000119

with all others excluded during the deliberative session.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson and Mr. Wilson
Absent: Dr. Taylor

The Board entered the deliberative session at 4:15 p.m. The Board returned on the record at 5:59 p.m.

It was noted that during the deliberative session, Administrative Law Judge Mandala and Robert Bacaj, Assistant Attorney General, as special counsel appointed to the Board, were invited to join and entered the deliberative session.

On a motion duly made by Ms. Mielke and seconded by Ms. Bigelow-Hood, the Alaska State Medical Board in Board Case Numbers: 2022-000262/276/436 & 20223-000119, Office of Administrative Hearings Case Number 24-0001-MED, Pursuant to AS 44.64.060(e)(3), adopted the proposed decision with the revised following sanctions:

- **Reprimand as set out in VIII (a),**
- **A civil fine of $15,000, with $3,000 suspended,**
- **A period of probation until respondent pays the fine and satisfactorily completes at least 20 hours of additional CME as described in paragraph VIII(3)(b).**

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Nimmo, Dr. Paulson and Mr. Wilson
Absent: Dr. Taylor

5. Elections

Chair Nimmo opened the floor for nominations for a Board Chairperson.

Upon a nomination by Mr. Wilson, seconded by Dr. Barnes and approved by a roll call vote, Dr. Taylor was elected to be Board Chair.

Roll Call: Yeas, Dr. Barnes, Ms. Bigelow-Hood, Dr. Heilala, Ms. Mielke, Dr. Paulson and Mr. Wilson
Abstained: Dr. Nimmo
Absent: Dr. Taylor

Dr. Paulson volunteered to be the representative for the Board to the Medical Spa Services Work Group. Members of the board voiced their support and appreciation for Dr. Paulson assuming this role.

6. Wrap up / Adjourn

Members of the board acknowledged and thanked Dr. Nimmo for his service.

Members of the board discussed and agreed to change the previously scheduled February 14 quarterly board meeting to February 21, 2025.

The meeting was adjourned by unanimous consent at 6:17 p.m.

Embracing Pharmacists' Practice Ability: Addressing Collaborative Practice Agreements

BRANDY SEIGNEMARTIN, PHARMD| ALASKA PHARMACY ASSOCIATION

Pharmacist Education and Training: Doctorate Level Clinicians

4 years of PharmD education, including 1,740 - 1,990 hours of clinical patient care training.

- Patient care process
- Patient assessment
- Therapeutics and pharmacology
- Required experiential clinical training in primary care, institutional medicine, general medicine, community pharmacy

Comprehensive skills: Diagnosis, prescribing, patient management within the standard of care.

Comparison: Pharmacists vs. APRNs with 750 hours clinical training.

Required Elements of the Didactic Doctor of Pharmacy Curriculum

Clinical Laboratory Data
Application of clinical laboratory data to disease state management, including screening, diagnosis, progression, and treatment evaluation.

Medication Prescribing, Preparation, Distribution, Dispensing, and Administration
Prescribing, preparing, distributing, dispensing, and administering medications including, but not limited to: injectable medications, identification and prevention of medication errors and interactions, maintaining and using patient profile systems, prescription processing technology and/or equipment including oversight of support personnel, and ensuring patient safety. Educating about appropriate medication use and administration for various disease states including substance use disorder. All students must receive training in immunizations.

Patient Assessment
Evaluation of patient function and dysfunction through the performance of tests and assessments leading to objective (e.g., physical assessment, health screening, and lab data interpretation) and subjective (patient interview) data important to the diagnosis and provision of care.

Pharmacotherapy
Evidence-based clinical decision making, therapeutic treatment planning (including diagnosing and prescribing), and medication therapy management strategy development for patients with specific diseases and conditions that complicate care and/or put patients at high risk for adverse events. Emphasis on patient safety, clinical efficacy, pharmacogenomic and pharmacoeconomic considerations, and treatment of patients across the lifespan.

Self-Care Pharmacotherapy
Therapeutic needs assessment, including the need for triage to other health professionals, drug product recommendation/selection, diagnosis, prescribing, and counseling of patients on non-prescription drug products, non-pharmacologic treatments, and health and wellness strategies, including nutraceuticals.

Pharmacists Roles

- Dispensing of Medications
  - Traditional Role
  - Doctrine of Shared Responsibility

- Provider
  - Team-based care
  - Chronic Disease State Management
  - Medication Assisted Treatment for Opioid Use Disorder
  - Public Health Applications in the community setting (test and treat, smoking cessation, minor ailments and conditions, etc.)

Scope of Practice

The activities that a health professional is permitted to engage in as defined by state laws and regulations

Determined by the political process = geographical differences

One-size-fits all: applies to all professionals in class

Static (aside from law changes)

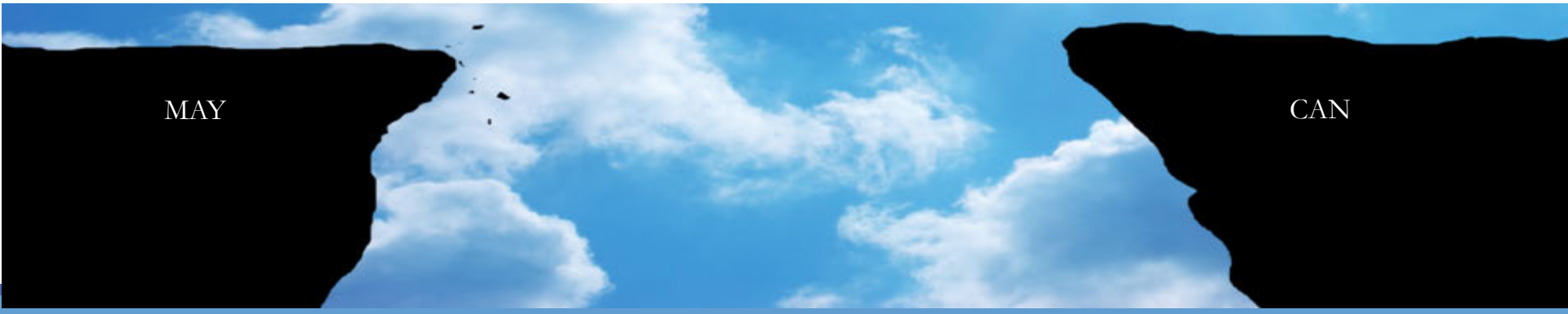
Clinical Ability

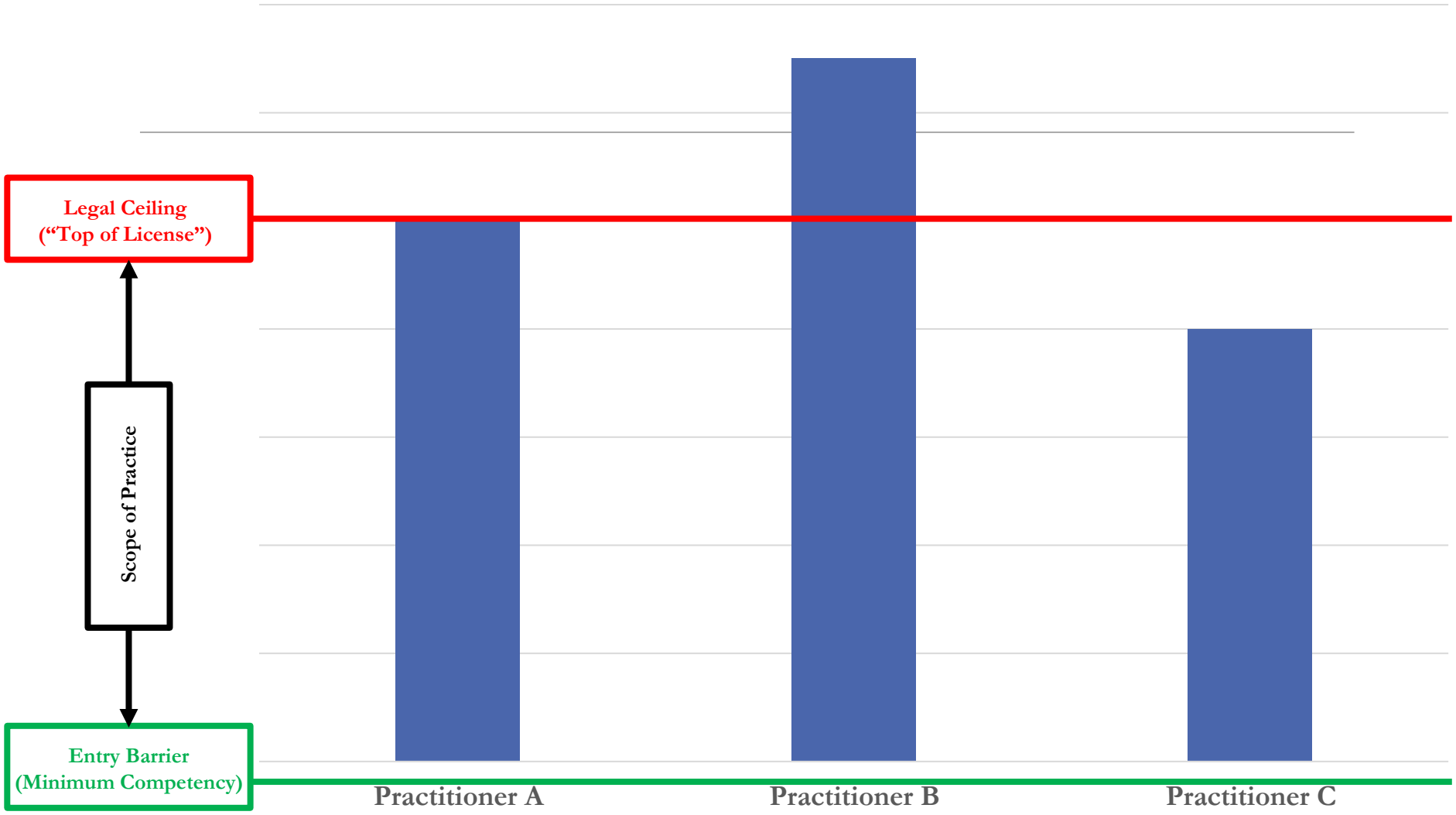
The true competence and ability of the health professional

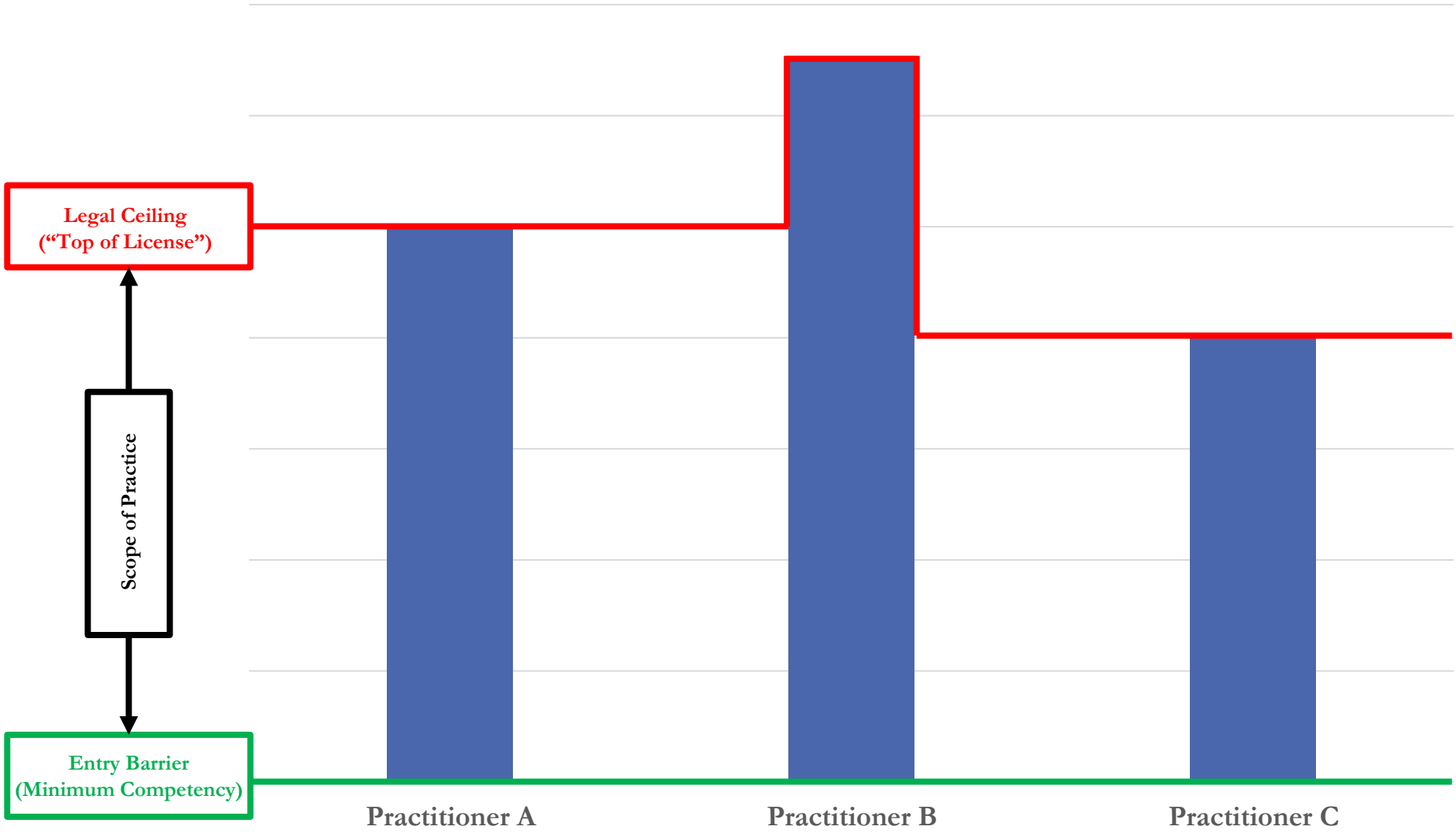
Determined by education, training, career experience, and practice environment

Individualistic: recognizes professional heterogeneity

Dynamic; advances with new education, technology, etc.




Legal Ceiling
("Top of License")
Scope of Practice
Entry Barrier
(Minimum Competency)
Practitioner A
Practitioner B
Practitioner C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Practitioner A
Practitioner B
Practitioner C

Alaska's standard of care regulatory model is already in place: what does this mean for practice authority & accountability?

Depending on a pharmacists education, training, and experience level – under SOC, pharmacist may independently:

- Obtaining patient histories and review health records to document and identify medication use patterns, contraindications, detect adverse events, etc.
- Performing appropriate physical examination for "other patient care services"
- Providing comprehensive medication therapy management (MTM)
- Order and interpret laboratory tests to monitor drug therapy for efficacy or toxicity
- Provide follow-up visits, specifically to manage chronic diseases
- Prescribe limited drugs and devices: immunizations, epi pens, opioid antagonists and emergency medications, OTC agents
- *Why would this authorities also be in a CPA?*

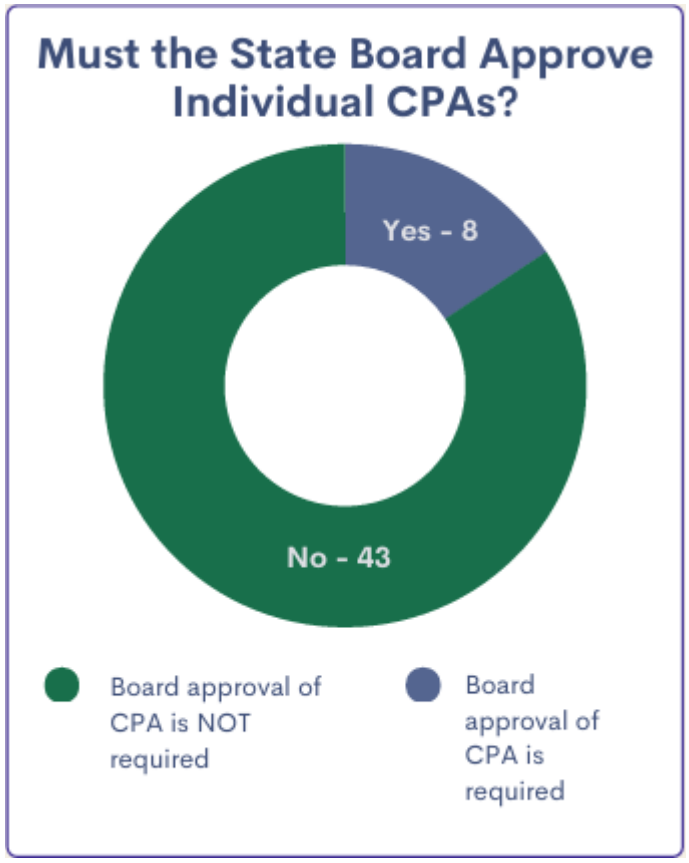
Pharmacist Collaborative Practice: The Current Landscape

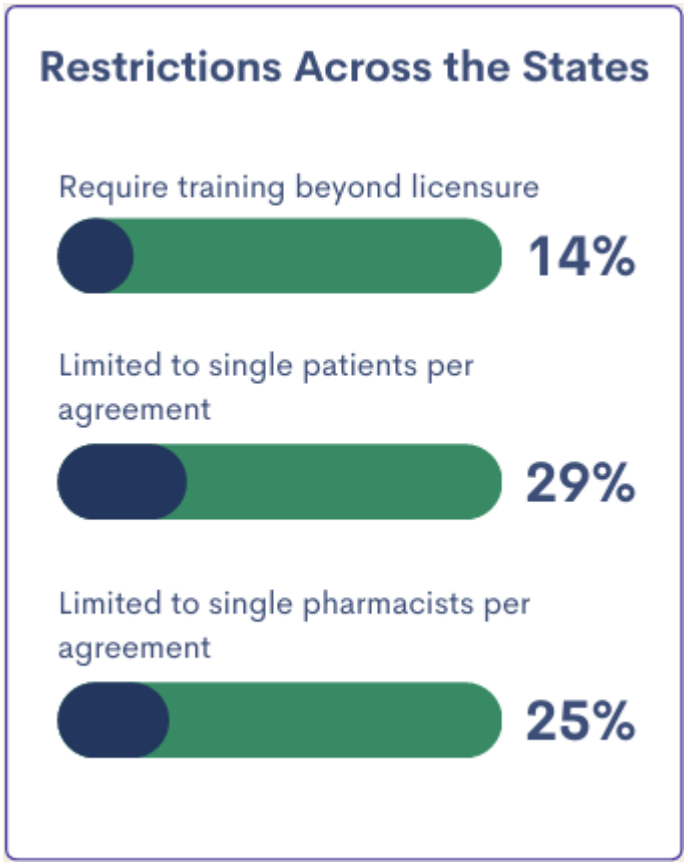
- To go beyond limitations currently in place, CPA is needed for all pharmacists regardless of setting
- Health systems or facilities may have policies or medical bylaws in place requiring a formal collaborative agreement for specific authorities, even if they are within the licensed authority / SOC

CPAs 101

Collaborative Practice Agreements (CPAs) create formal practice relationships between pharmacists and prescribers. CPAs can benefit collaborative care delivery by identifying what functions – in addition to the pharmacist's typical scope of practice – are delegated to the pharmacist by the collaborating prescriber, under negotiated conditions outlined in the agreement.

Collaborative Practice with Pharmacists Exists in All 50 States





Broad Authority Enables Local Innovation

Washington State was the first to authorize collaborative practice authority over **45 years ago**. The authority continues to be broad and at any given time, there are over 30,000 active CPAs in the state. This collaborative care delivery occurs without educational requirements beyond licensure and without board approval of the agreements, allowing for local innovation.

What does the literature say?

"Several studies have demonstrated the benefit of a pharmacist/physician collaborative practice model in improving the management of chronic diseases such as hypertension, dyslipidemia, arrhythmias, heart failure, diabetes, asthma, osteoporosis, and psychiatric disorders. The benefits of collaboration include increased medication appropriateness, decreased occurrence of medication-related problems, medication errors and adverse drug reactions, increased communication with patients, improved patients' medication knowledge and adherence, decreased morbidity and mortality, improved patient health outcomes, reduced physician workload, and decreased healthcare costs [11–19]. As a result of this mounting evidence, there is a growing call for increased pharmacist-physician collaboration [20]."

Albassam A, Almohammed H, Alhujaili M, Koshy S, Awad A. Perspectives of primary care physicians and pharmacists on interprofessional collaboration in Kuwait: A quantitative study. PLoS One. 2020 Jul 20;15(7):e0236114. doi: 10.1371/journal.pone.0236114. PMID: 32687539; PMCID: PMC7371165.

Call to Action

Request support from the Alaska Board of Medicine to:

- Approve collaborative practice agreements: trust collaborating physicians and pharmacists in their patient care abilities according to the standard of care.
- Embrace pharmacists' role in alleviating healthcare challenges.
- Align efforts to improve patient care and healthcare efficiency.

Alaska Board of Pharmacy: Background on Cooperative Practice Agreements

Alaska State Medical Board Meeting

February 21, 2025

Ashley Schaber, PharmD, MBA, BCPS

Chair, Board of Pharmacy

Cooperative Practice Agreements:

Historical Partnership between the AK State Medical Board and the Board of Pharmacy

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

1Department of Commerce, Community, & Economic Development

Corporations, Business, & Professional Licensing
Board of Pharmacy

P.O. Box 110806
Juneau, Alaska 99811-0806
Main: 907.465.2550

March 20, 2023

The Honorable Senator Wielechowski
Alaska State Senate
State Capitol Room 103
Juneau, Alaska 99801
Senator.Bill.Wielechowski@akleg.gov

Re: SB 55 – Extend State Medical Board – Letter of Support

Dear Senator Wielechowski,

The Board of Pharmacy ("board") is submitting its position on SB 55, an act extending the termination date of the State Medical Board; and providing for an effective date. During its March 20, 2023, meeting, the board discussed SB55 and voted to support it because of the importance of the State Medical Board in ensuring Alaskans have access to safe care. Additionally, it allows physicians to continue to enter into cooperative practice agreements with pharmacists. These agreements are important for healthcare access in Alaska as they allow pharmacists to partner in the healthcare team using their training and experience in medication therapy. These agreements have been in place for many years through partnership with the Board of Pharmacy and the State Medical Board.

The board supports this legislation and will continue to be a collaborative resource with the State Medical Board to optimize and expand access to safe care for Alaskans.

Thank you,

Ashley Schaber

Ashley Schaber, PharmD, MBA, BCPS (Chair)
Alaska Board of Pharmacy

Facts on Cooperative Practice Agreements in Alaska

- **Concept has been in Alaska statute and regulation for many years, since early 2000s.**
- **Currently 26 Cooperative Practice Agreements actively in place throughout Alaska.**
  - **These create increased access to care.**
- **No known safety or quality issues have been identified in the time these agreements have been in place.**
- **House Bill 145 (2021-2022 Legislature) added AS 08.80.337**
  - **Clarifies that pharmacists may provide patient care services under a collaborative practice agreement or independently in listed scenarios.**
  - **Allows for pharmacists to be reimbursed for services provided under collaborative practice agreements.**

Incorporation of Standard of Care Concept: Board of Pharmacy Regulation Updates 2024

Standard of Care

- **12 AAC 52.205. General standards of pharmacy practice,** brings the regulations into alignment with standards of clinical practice. Licensees are expected to practice consistent their education, training, and experience and within the accepted standard of care that would be provided in a similar setting by a reasonable and prudent licensee with similar education, training, and experience.
- **12 AAC 52.920. Disciplinary guidelines,** clarifies regulatory language and brings the language into alignment with addition of 12 AAC 52.205. Acts or omissions within the practice of pharmacy (including under cooperative practice agreements) that fail to meet the standard of care are considered unprofessional conduct and a basis for the imposition of disciplinary sanctions.

Thank you for your continued partnership

- Contact information
  - Board of Pharmacy
    - BoardofPharmacy@Alaska.Gov
    - PO Box 110806
      Juneau, AK 99811-0806

From:	Norberg, Natalie M (CED)
To:	Eric Nimmo
Subject:	FW: Physician-Pharmacist (Lin-Thompson) Cooperative Practice Agreement Application
Date:	Friday, December 6, 2024 4:13:56 PM
Attachments:	Physician-Pharmacist Cooperative Practice Agreement Application-Lin, Thompson signed.pdf

Hello,

We received another new Physician-Pharmacy agreement. Would you like me to add this to the December 19 Board meeting agenda?

Natalie Norberg
Executive Administrator
Alaska State Medical Board

From: Board, Medical (CED sponsored) <medicalboard@alaska.gov>
Sent: Friday, December 6, 2024 4:06 PM
To: Norberg, Natalie M (CED) <natalie.norberg@alaska.gov>
Subject: FW: Physician-Pharmacist (Lin-Thompson) Cooperative Practice Agreement Application

Natalie,

Please see attached

~Jake

From: Thompson, Judy B <JBThompson@anthc.org>
Sent: Thursday, December 5, 2024 1:58 PM
To: Board, Medical (CED sponsored) <medicalboard@alaska.gov>
Cc: Board of Pharmacy (CED sponsored) <boardofpharmacy@alaska.gov>; Schaber, Ashley R <arschaber@anthc.org>; Lin, Ai-Ling <alin@anthc.org>
Subject: Physician-Pharmacist (Lin-Thompson) Cooperative Practice Agreement Application

Hello,

Please find attached the Physician-Pharmacist (Lin-Thompson) Cooperative Practice Agreement Application for review at the board's December 19th meeting, if possible.

Don't hesitate to reach out if you have any questions or need additional information.

Best,

judy

Judy Thompson, PharmD, BCPS, CDCES
Captain, United States Public Health Service
Director, ANTHC Diabetes Program

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Physician-Pharmacist Cooperative Practice Agreement Application

Under 12 AAC 40.983, a physician may participate in a cooperative agreement with a pharmacist by submitting this application and copy of the protocol to the State Medical Board for approval. A "cooperative practice agreement" is an agreement by which a physician authorizes a pharmacist to manage a patient's medication therapy.

The Board of Pharmacy must also endorse the approval before a physician and pharmacist can engage in the agreement. This is a joint application; there is no need to submit separate applications to each board.

PART I Application Type

Application Type:	☒ New Agreement ☐ Renewal ☐ Modification of Existing Agreement ☐ Termination of Agreement

PART II Cooperative Practice History

1. Agreement number for renewal, modification, and termination application types only:				
2. **If a modification,** describe what protocols have changed since the cooperative practice was initially issued or last renewed (e.g., new designation types added or removed):				
3. **If a renewal,** please confirm the protocols and services provided under the existing cooperative practice agreement have not changed since initially issued or last renewed, whichever is most recent. (If there have been changes, apply by modification.)				
Original Agreement Date:	12/05/2024			
Requested Effective Dates for Agreement:*	**Start Date:**	01/01/2025	**End Date:**	12/31/2026

**May not exceed two years.*

PART III Designation Types

Protocol Type:	☐ Travel Medication ☐ Immunizations ☐ Hypertension ☐ Emergency Contraception ☐ Anticoagulation ☒ Other, Please Specify: See CPA protocol

PART IV Physician Information

Physician Name:	Ai-Ling Lin	**License Number:**	115304
Email Address:	alin@anthc.org	**Phone Number:**	907-729-1125
Employer Name:	Alaska Native Tribal Health Consortium	**Physician Type:**	

PART V Additional Physicians

Please list additional participating physicians involved in the cooperative practice agreement, if known. *Attach additional pages, if needed.*

Physician Name	Alaska License Number	Expiration Date

PART VI Pharmacy Information (If Applicable)

Pharmacy Name:	Alaska Native Tribal Health Consortium		
Pharmacy Email Address:		**Alaska Pharmacy License Number:**	NA
Pharmacy Physical Address:	Street: 3900 Ambassador Dr City: Anchorage State: AK Zip: 99508		

PART VII Pharmacist Information

Cooperating Pharmacist Name:	Judith Thompson	**License Number:**	219705
Practice Address: (If Not Pharmacy Listed Above)	Street City State Zip		
Email Address:	jbthompson@anthc.org	**Phone Number:**	907-729-2164

PART VIII Additional Pharmacists

Please list additional participating pharmacists involved in the cooperative practice agreement, if known. *Attach additional pages, if needed.*

Pharmacist Name	Alaska License Number	Expiration Date

PART IX Cooperative Practice Protocol Details (12 AAC 40.983)

1.	Does the protocol contain an agreement in which physicians authorized to prescribe legend drugs in this state authorize pharmacists licensed in this state to administer or dispense in accordance with that written protocol?	☑ Yes ☐ No
2.	Does the protocol contain a statement identifying the physicians authorized to prescribe and the pharmacists who are party to the agreement?	☑ Yes ☐ No
3.	Is a time period for the protocol specified? (May not exceed two years.)	☑ Yes ☐ No
4.	Does the protocol include the types of collaborative authority decisions that the pharmacists are authorized to make, including: **A.** Types of diseases, drugs, or drug categories involved and the type of collaborative authority authorized in each case? **B.** Procedures, decision criteria, or plans the pharmacists are to follow when making therapeutic decisions, particularly when modification or initiation of drug therapy is involved?	☑ Yes ☐ No
5.	Does the protocol include activities the pharmacists are to follow in the course of exercising collaborative authority, including documentation of decisions made, and a plan for communication and feedback to the authorizing practitioners concerning the specific decisions made?	☑ Yes ☐ No
6.	Does the protocol contain a list of the specific types of patients eligible to receive services under the written protocol?	☑ Yes ☐ No
7.	Does the protocol include a plan for the authorizing practitioners to review the decisions made by the pharmacist at least once every three months?	☑ Yes ☐ No
8.	Does the protocol include a plan for providing the authorizing physicians with each patient record created under the written protocol?	☑ Yes ☐ No
9.	Does the protocol specify and require completion of additional training, if required for the procedures authorized under the protocol?	☑ Yes ☐ No
10.	Does the protocol include a provision that allows the physician to override the agreement if the physician considers it medically necessary or appropriate?	☑ Yes ☐ No
11.	Does the plan acknowledge that the physician will not receive any compensation from a pharmacist or pharmacy as a result of the care or treatment of any patient under the agreement?	☑ Yes ☐ No

PART X Agreement

For Physicians: By providing my signature below, I acknowledge that I will also comply with all provisions required by the State Medical Board's Cooperative Practice Agreement regulations.

For Pharmacists: By providing my signature below, I acknowledge that a signed copy of the approved collaborative practice application and protocols must remain at the pharmacy location at all times as required by 12 AAC 52.240(i).

☒ Attach a copy of your written protocol.

Cooperating Physician Signature:		**Date Signed:**	12/05/2024
Cooperating Pharmacist Signature:		**Date Signed:**	12/05/2024

Alaska Native Medical Center
Clinical Pharmacist Practitioner Collaborative Practice Agreement- Diabetes Specialty Clinic

Description of agreement:
This Collaborative Practice Agreement (CPA) is established on this 5 day of December in the year 2024 pursuant to the Alaska State Board of Pharmacy Administrative Code Regulation (12 AAC 52.240), between the Alaska Native Tribal Health Consortium (ANTHC) and Southcentral Foundation (SCF) for Clinical Pharmacist Practitioner (CPP) to exercise collaborative practice authority by an ANMC provider for the pharmacist to initiate or modify drug therapy in accordance with approved guidelines at ANMC.

Authority is limited to patients under the care of ANMC providers or their designees within the provider's scope of practice. Providers acknowledge that they will not receive direct compensation from a pharmacist or the pharmacy because of the care or treatment of any patient under the agreement. ANMC providers are determined by the medical staff at ANMC and include those with community staff privileges.

The CPA will be granted for two years following ANMCs procedure, unless rescinded earlier in writing by the authorizing provider or CPP. The CPP shall notify the Alaska State Board of Pharmacy in writing within 30 days after the written agreement is terminated.

Referring provider must physically examine and evaluate a patient before that patient may be included under a collaborative practice agreement to which that physician is a party.

Changes to the CPA shall be reported to the Alaska State Board of Pharmacy via resubmission signed by the ANMC Director of Pharmacy (or designee), the ANMC Chief Medical Officer (or designee), and the SCF Senior Quality Assurance Medical Director (or designee).

I. RATIONALE, PURPOSE, and GOALS

ANMC is jointly owned and operated by ANTHC and SCF. CPPs are integrated throughout the campus healthcare system in various clinics and medical floors. By working alongside multidisciplinary healthcare teams, CPPs seek to build relationships between patients and provider care teams through disease medication management, monitoring, and education with the following goals:

- Expand care access and continuity of care
- Expand pharmacy clinical services and roles
- Provide further education regarding medical conditions and respective therapies (e.g., monitoring and safety)
- Improve patient care outcomes and quality of life
- Meet and exceed quality indicators and metrics
- Expand collaboration between pharmacists and providers
- Expand team-based approach to care

II. CREDENTIALING, PRIVILEGING, TRAINING, and COMPETENCY

A. The CPP shall have successfully completed the following:
   a. Professional PharmD degree from an ACPE-accredited school or college of pharmacy
   b. Board certification through Board of Pharmacy Specialties, to be achieved within 3 years of joining the Medical Staff or obtaining eligibility to apply for board certification.
   c. Completed ANMC Credentialing and Privileging process once board eligible or certified.
   d. Alaska Pharmacist licensure
   e. All requirements listed in the ANMC Medical Staff Bylaws
   f. **Required previous experience**: Applicants for initial appointment must be able to demonstrate the performance of at least 15 patient encounters, reflective of the scope of privileges requested in the appropriate area of specialization in the past 12 months or successful completion of an accredited training program in the past 12 months.

B. The CPP will complete all competency assessments set by the ANMC Director of Pharmacy or designee and continue to obtain continuing education credits for board recertification and pharmacist licensure.
   a. The CPP will review and be familiar with the local clinical prescribing guidelines and other nationally recognized treatment guidelines and associated protocols.
   b. Advanced training/experience or certifications should be documented in CPP's credentialing file and competency folder.

III. ELIGIBILITY, REFERRAL PROCESS, and PROVIDER COMMUNICATIONS

A. Eligibility
   a. Any person eligible for services through ANMC may be referred to pharmacy services for components of disease state management. Maintaining a level of competency, the CPP may provide care for the conditions listed in but not limited to Table 1.
   b. If pregnancy occurs in an existing CPP managed patient, the CPP will discuss case with referring provider and next steps in care as applicable.

B. Referral Process
   a. Referrals may be submitted by any ANMC credentialed provider. The provider will continue to manage the overall care of the patient referred to the CPP.
      i. The patient must have a documented diagnosis before the CPP may initiate, modify or discontinue a medication per this CPA.
   b. Referrals for eligible patients will be documented through the electronic health record (EHR).
   c. All provider referrals are considered active unless rescinded in writing within the EHR.
      i. The patient must maintain care with their referring provider at least annually. Referrals will become inactive if the aforementioned is not met and will reactivate upon visit with the referring provider.
   d. CPPs may place a consultation to other healthcare team members or departments as needed (e.g., Integrated care team members, specialty departments, behavioral health consultants, dietitians, optometry, audiology, cardiology).

e. Providers may override the agreement if they consider the decision medically necessary or appropriate.

C. Communication
   a. The CPP will provide written documentation of each encounter with a patient in the electronic medical record which will be available for the provider to review.
   b. The CPP will communicate with the provider anytime an issue or question in care arises for further evaluation by the provider.
   c. The CPP will refer patients back to their referring provider if extended beyond the CPAs scope of practice or if patient reach their disease state goals.
      i. Referrals to specialty clinics will be consulted with the patient's provider first.
   d. The CPP will refer patients to their provider for follow-up of chronic disease, annual physicals, and evaluation or treatment of acute or abnormal findings.
   e. If a patient does not keep their appointment (DNKA) for more than 3 consecutive appointments, the CPP may refer the patient back to their provider and document in the EHR.

IV. CLINICAL ACTIVITIES

This CPA, in accordance with the standards of care and clinical practice guidelines, allows the CPP to perform the following but not limited to:

- Obtain patient histories and review health records to document medication use patterns, detect adverse drug effects, uncover potential drug interactions, contraindications to therapy, and identify evidence of drug efficacy.
- Prescribe (initiate, modify, renew, or discontinue) medications
- Perform appropriate, limited physical examination
- Provide comprehensive medications therapeutic management (MTMs)
- Provide and document patient education and health promotion
- Order and interpret pertinent laboratory tests to monitor drug therapy for efficacy and toxicity
- Provide follow-up visits with patients

The CPP may see patients through clinic/floor, telephonic, telehealth, or shared interdisciplinary team visits.

The CPP will follow the emergency response procedure for their area.

In managing and/or treating patients, the CPP may select, initiate, continue, modify, discontinue, administer, and monitor drug therapy for patients as delegated by the provider or site-approved policies and procedures. To determine care that may be delegated, the provider must confirm the care delegated is consistent with the licensee's education, training, and experience; and within the accepted standard of care and guidelines that would be provided in a similar setting by a reasonable and prudent licensee with similar education, training, and experience.

Standards of Care and national practice guidelines will be utilized to determine pharmacotherapy and therapeutic monitoring including but not limited to the following:

Table 1

Disease State	Medication Therapies	Clinical Practice Guideline(s)*
Provider referral required for prescribing and ordering authority		
Hypertension	All blood pressure modifying agents and blood pressure monitoring medical equipment	The Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC)
Diabetes / Gestational Diabetes	All oral, injectable, and inhaled antidiabetic agents; as well as medical equipment related to diabetes care and treatments for hypoglycemia	American Diabetes Association
Hyperlipidemia	All cholesterol modifying agents	ACC/AHA Blood Cholesterol Guideline
Immunizations	All immunizations	Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control and Prevention (CDC)

V. OUTCOMES

CPP outcomes may be assessed annually and reported to pharmacy leadership as needed. Additional information such as disease state outcomes, evaluation of access, no-show rates, adverse medication outcomes, interventions, or other pertinent measures may also be collected.

VI. QUALITY ASSURANCE and PERFORMANCE IMPROVEMENT

A. The ongoing monitoring of quality assurance, performance improvement, and continuous competency will encompass Ongoing Professional Practice Evaluation (OPPE), Focused Professional Practice Evaluation (FPPE), and Quality Assurance reviews.

B. Each CPP will be briefed on professional practice evaluation processes and forms upon initial credentialing and privileging approval by the medical staff and whenever there are adjustments to the evaluation elements. The assignment, collection, and assessment of FPPE and OPPE will be managed by ANMC Director of Pharmacy or designee.

C. The ANMC Director of Pharmacy or designee (e.g., collaborating physician, medical director) will review the results of the professional practice evaluations and report them to the medical staff office at the appropriate reporting time. Feedback will be regularly provided to the CPPs.

D. The collaborating provider or designee will perform CPP chart reviews periodically (at least every 3 months) and provide regular feedback regarding findings. Documentation will be placed in the CPP's credential file.

VII. PHYSICIANS AUTHORIZED TO PRESCRIBE AND PHARMACISTS PARTY TO THE AGREEMENT

Physician: Ai-Ling Lin, License # 115304

Pharmacist: Judith Thompson, License # 219705d

ALASKA STATE MEDICAL BOARD CHECKLIST - PHYSICIAN-PHARMACIST COOPERATIVE PLAN

Cooperative Plan (License Record) Number: _____

Physician Name(s): Claire Stoltz, MD — License No. 101687
Foundation Health Partners — License No. _____
_____ — License No. _____

Pharmacist Name (s): Tammy Beaudreault (PHAP1645) Karen Miller (PHAP1109) — License No. _____
Megan Wiegand (PHAP1464) — License No. _____
Rose LaMesjerant (PHAP2185) — License No. _____

Date Received: 1/10/2025

Written Proposed Agreement addresses the following elements:

1. Includes types of cooperative practice decisions the physician is granting to the pharmacist ☐ No ☐ Yes
   Check all that apply:
   ☐ Types of diseases or conditions: List See list on Table 1
   ☐ Types of medications or medication categories: List See list on Table 1
2. Includes procedures, decision criteria or plans the pharmacist must follow when making therapeutic decisions, particularly when initiating or modifying medications. ☐ No ☐ Yes
3. Includes expectations and requirements for the pharmacist to follow with respect to documentation of decisions made, and a plan for communication and feedback to the physician regarding decisions made ☐ No ☐ Yes
4. Includes a plan for the physician to review decisions made by the pharmacist at least once every three months. ☐ No ☐ Yes
5. Includes a plan for the pharmacist to provide the physician any patient records created under the agreement. ☐ No ☐ Yes
6. Includes a provision that allows the physician to override the agreement if the physician considers it medically necessary or appropriate. ☐ No ☐ Yes
7. Includes an acknowledgement that the physician will not receive any compensation from the pharmacist or pharmacy as a result of the care or treatment of any patient under the agreement. ☐ No ☐ Yes
8. Includes a prohibition against the administration or dispensing of any schedule I, II. III or IV controlled substances. ■ No ☐ Yes
   Although Table I references "non-controlled" pain management agents for pain management

Comments: _____

Date Application Complete/forwarded to Board Member for Review: _____ Examiner: NN

ALASKA STATE MEDICAL BOARD CHECKLIST - PHYSICIAN-PHARMACIST COOPERATIVE PLAN

BOARD MEMBER REVIEW FOR APPROVAL

☐ APPROVED ☐ HOLD FOR BOARD ☐ INTERVIEW REQUIRED

Comments: _____

_____

Date Issued: _____

VALID FOR 6 MONTHS

Signed: _____ Date _____

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Physician-Pharmacist Cooperative Practice Agreement Application

Under 12 AAC 40.983, a physician may participate in a cooperative agreement with a pharmacist by submitting this application and copy of the protocol to the State Medical Board for approval. A "cooperative practice agreement" is an agreement by which a physician authorizes a pharmacist to manage a patient's medication therapy.

The Board of Pharmacy must also endorse the approval before a physician and pharmacist can engage in the agreement. This is a joint application; there is no need to submit separate applications to each board.

PART I Application Type

Application Type:	☒	New Agreement	☐	Renewal	☐	Modification of Existing Agreement	☐	Termination of Agreement

PART II Cooperative Practice History

1. Agreement number for renewal, modification, and termination application types only:				
2. **If a modification,** describe what protocols have changed since the cooperative practice was initially issued or last renewed (e.g., new designation types added or removed):				
3. **If a renewal,** please confirm the protocols and services provided under the existing cooperative practice agreement have not changed since initially issued or last renewed, whichever is most recent. (If there have been changes, apply by modification.)				
Original Agreement Date:				
Requested Effective Dates for Agreement:*	**Start Date:**	1/1/2025	**End Date:**	

**May not exceed two years.*

PART III Designation Types

Protocol Type:	☐	Travel Medication	☒	Immunizations	☒	Hypertension	☐	Emergency Contraception
	☒	Anticoagulation	☒	Other, Please Specify:	See attached		

PART IV Physician Information

Physician Name:	Dr. Claire Stoltz	**License Number:**	101687
Email Address:	claire.stoltz@foundationhealth.org	**Phone Number:**	907 459 3500
Employer Name:	FHP	**Physician Type:**	MD / FM

PART V Additional Physicians

Please list additional participating physicians involved in the cooperative practice agreement, if known. *Attach additional pages, if needed.*

Physician Name	Alaska License Number	Expiration Date
See attached FM | IM | PHVC | 1stCare SeniorCare		

PART VI Pharmacy Information (If Applicable)

Pharmacy Name:	N/A		
Pharmacy Email Address:		**Alaska Pharmacy License Number:**	
Pharmacy Physical Address:			

PART VII Pharmacist Information

Cooperating Pharmacist Name:	Tammy Beaudreault	**License Number:**	PHAP1645
Practice Address: (If Not Pharmacy Listed Above)	1001 Noble St Fairbanks AK 99701		
Email Address:	tammy.beaudreault@foundationhealth.org	**Phone Number:**	907-459-3500

PART VIII Additional Pharmacists

Please list additional participating pharmacists involved in the cooperative practice agreement, if known. *Attach additional pages, if needed.*

Pharmacist Name	Alaska License Number	Expiration Date

PART IX Cooperative Practice Protocol Details (12 AAC 40.983)

1.	Does the protocol contain an agreement in which physicians authorized to prescribe legend drugs in this state authorize pharmacists licensed in this state to administer or dispense in accordance with that written protocol?	☒ Yes ☐ No
2.	Does the protocol contain a statement identifying the physicians authorized to prescribe and the pharmacists who are party to the agreement?	☒ Yes ☐ No
3.	Is a time period for the protocol specified? (May not exceed two years.)	☒ Yes ☐ No
4.	Does the protocol include the types of collaborative authority decisions that the pharmacists are authorized to make, including: **A.** Types of diseases, drugs, or drug categories involved and the type of collaborative authority authorized in each case? **B.** Procedures, decision criteria, or plans the pharmacists are to follow when making therapeutic decisions, particularly when modification or initiation of drug therapy is involved?	☒ Yes ☐ No
5.	Does the protocol include activities the pharmacists are to follow in the course of exercising collaborative authority, including documentation of decisions made, and a plan for communication and feedback to the authorizing practitioners concerning the specific decisions made?	☒ Yes ☐ No
6.	Does the protocol contain a list of the specific types of patients eligible to receive services under the written protocol?	☒ Yes ☐ No
7.	Does the protocol include a plan for the authorizing practitioners to review the decisions made by the pharmacist at least once every three months?	☒ Yes ☐ No
8.	Does the protocol include a plan for providing the authorizing physicians with each patient record created under the written protocol?	☒ Yes ☐ No
9.	Does the protocol specify and require completion of additional training, if required for the procedures authorized under the protocol?	☒ Yes ☐ No
10.	Does the protocol include a provision that allows the physician to override the agreement if the physician considers it medically necessary or appropriate?	☒ Yes ☐ No
11.	Does the plan acknowledge that the physician will not receive any compensation from a pharmacist or pharmacy as a result of the care or treatment of any patient under the agreement?	☒ Yes ☐ No

PART X Agreement

For Physicians: By providing my signature below, I acknowledge that I will also comply with all provisions required by the State Medical Board's Cooperative Practice Agreement regulations.

For Pharmacists: By providing my signature below, I acknowledge that a signed copy of the approved collaborative practice application and protocols must remain at the pharmacy location at all times as required by 12 AAC 52.240(i).

☒ Attach a copy of your written protocol.

Cooperating Physician Signature:		**Date Signed:**	12/13/24
Cooperating Pharmacist Signature:	Tammy Beaudreault	**Date Signed:**	12/5/24

Provider Last Name	Provider First Name	Provider Type	Alaska Medical License Number	Provider NPI
Accola	Brian	MD	MEDS6391	1447236823
Dahle	Aaron	PA-C	169558	1831486299
Figueroa	Amber	DO	145345	1689768905
Franklin	Julia	MD	149491	1225486228
Kaufmann	Cristiane	MD	117118	1215375340
Leistikow	Corrine	MD	MEDS2487	1417922774
Stoltz	Claire	MD	101687	1780948026
Ellis	Sarah	FNP-C	203079	1720385412
Gowtham	Sriharsha	MD	191517	1043747587
Mangum	Sally	DO	142391	1912351917
Moore	Cindy	AGNP-BC	216212	1164299178
Smith	Ariana	FNP	202989	1992410237
Swenson	Michael	MD	MEDS2746	1891761201
Trivette	Jodee	PA-C	231548	1063764504
Dunlevy	April	ACNP-BC	117527	1861745283
Gondeck	Kari	DNP	214807	1750571188
Jinich	David	MD	187971	1861447500
Knuths	Lydia	PA-C	213929	1457933426
Ombrellaro	Mark	MD	103591	1699793968
Wolf	Emily	PA-C	211212	1104415322
Wrenn	Romel	MD	7040	1255302717

Foundation Health Partners
Collaborative Practice Agreement for Clinical Pharmacy Services

Description of agreement:
This Collaborative Practice Agreement (CPA) is established on this 6 day of Dec in the year 2024, pursuant to Alaska State Board of Pharmacy Administrative Code Regulation (12 AAC 52.240), between Foundation Health Partners (FHP) Ambulatory Clinic practitioners and FHP Clinical Pharmacists. FHP Ambulatory Clinic practitioners consists of physicians, nurse practitioners, and physician assistants authorized to prescribe legend drugs in the State of Alaska. The signature of the FHP Medical Director authorizes this CPA on behalf of each individual provider and will substitute for individual signatures. The signature of the Principal Clinical Pharmacist authorizes this CPA on behalf of each individual pharmacist and will substitute for individual signatures. No FHP practitioner will receive any form of compensation or renumeration from a pharmacist or pharmacy in association with this agreement.

Authority is limited to patients under the care of FHP Ambulatory Clinic providers or their designees, and only under the scope of their current practice.

This CPA will be granted for one year from this date, unless rescinded earlier in writing by the authorizing practitioners or clinical pharmacists. The clinical pharmacists shall notify the Alaska State Board of Pharmacy in writing within 30 days after the written protocol is terminated. Changes to this CPA shall be reported to the Alaska State Board of Pharmacy via resubmission signed by the principal clinical pharmacist and FHP Medical Director.

Under this CPA, the clinical pharmacist is given authority to order labs and initiate or modify (including refilling or discontinuing) medication therapy for administration or dispensation of the drug categories listed and in related to the treatment of disease states outlined herein.

Claire Stoltz, MD
Printed Name: FHP Medical Director

1016087
Alaska State License Number

Signature: FHP Medical Director

12/6/24
Date

Tammy Beaudreault
Printed Name: Principal Clinical Pharmacist

PHAP1645
Alaska State License Number

Tammy Beaudreault
Signature: Principal Clinical Pharmacist

12/4/24
Date

Individual Pharmacist Training, Competency, and Application

I. Submission of a signed copy of the FHP Ambulatory Clinic CPA by an FHP pharmacist along with an application to be approved by the Board to practice under the CPA will indicate the following:
   a. FHP verification of the pharmacist's license to practice pharmacy in the state of Alaska
   b. FHP's completion of a credentialing and privileging review of the clinical pharmacist with a determination of appropriate education and practice experience to engage in clinical pharmacy practice at FHP
   c. FHP's granting of privileging to engage in collaborative practice under the FHP CPA
   d. The pharmacists' personal review and understanding of all components of the FHP Ambulatory Clinic CPA and associated policies, procedures, and guidelines
   e. The pharmacist's attestation that they are competently trained and experienced to engage in collaborative practice under the CPA for the privileged disease states

Clinic Information

I. This policy will apply to all FHP Ambulatory Care Clinics providing primary care services.

Patient Identification

I. Provider Referral
   a. FHP Ambulatory Clinic providers may refer patients for whom they feel pharmacy services would be beneficial, including drug therapy initiation, modification, or discontinuation, provided:
      i. The patient has a diagnosis from the FHP Ambulatory Clinic provider before the clinical pharmacist initiates, modifies, or discontinues a medication per this CPA.
      ii. Patients evaluated and monitored by the pharmacist are followed at least annually by the Ambulatory Clinic provider.
   b. Referrals will be made via the electronic medical record (EMR) and shall include diagnosis or reason for referral.
   c. The pharmacist will only manage the specific disease state(s) for which the patient was referred.
   d. All provider referrals are considered active unless rescinded in writing within the electronic medical record.

II. Population Health Management
   a. Reports from medical records may be utilized to initiate standing order referrals for pharmacy services as approved by FHP policy.

Procedures and Decision Criteria:

I. Patient Management
   a. Following a referral, the pharmacist will evaluate a patient in a face to face or electronic/telephonic manner appropriate to collect sufficient subjective and objective data to establish or revise a care plan for the disease state(s) and/or clinical scenario(s) for which the patient is referred to the treating pharmacist.
   b. Care plans may include continuation, modification, discontinuation or addition of pharmacotherapy, education, self-management activities, and/or laboratory monitoring.

i. Pharmacotherapy decisions and authorities are as listed in prescribing activities and Table 1.

c. The pharmacist will provide instructions to the patient to schedule follow up encounters with the pharmacist or Ambulatory Clinic provider to review care plan changes and assess current status.

II. Decision Criteria

a. The pharmacist will exercise professional judgement in utilizing the professional guidelines described in Table 1, current evidenced based literature, patient insurance formularies, and the principles of shared decision making in selecting specific pharmacotherapies and establishing an/or updating care plans.

b. The pharmacist will exercise professional judgement in determining the frequency and in a manner of follow up to recommend that facilitate timely collection of necessary subjective and objective data and minimize the risk of complications of treatment or disease progression.

Prescribing Activities

I. The pharmacist will serve as an agent of the referring provider. The referring provider has the final responsibility for the medical appropriateness of all prescriptions written within the scope of this Agreement.

II. Prescribing activities may include:

a. Initiation of drug therapy for the management of the disease states delineated within this Agreement and the management of side effects of those medications.

b. Continuation of drug therapy for the management of the disease states delineated within this Agreement and management of side effects of those medications.

c. Modification of drug therapy including alteration of dose or dosing interval, or conversion to a more suitable drug regimen to improve efficacy or decrease potential toxicity for the management of the disease states delineated with in this Agreement and the management of side effects of those medications.

d. Discontinuation of drug therapy.

III. The names of the FHP Ambulatory Clinic provider and pharmacist will be indicated on the prescription drug order, with language indicating the pharmacist is practicing under this CPA.

IV. This CPA does not include the prescriptive authority for any controlled substances. Recommendations for controlled substances, if deemed warranted, will be forwarded to the referring provider.

Documentation

I. Documentation

a. Written documentation of each office visit and/or electronic or telephonic encounter with the patient will be provided in the EMR, making them immediately available to the referring provider for signature.

b. The pharmacist will use clinical judgment and refer the patient to their Ambulatory Clinic provider when necessary.

c. The pharmacist will immediately report any emergency situations (after stabilizing the patient) or any occurrences that fall outside of the CPA or any associated guidelines to the Ambulatory Clinic provider.

Communication and Quality Improvement

II. Communication

a. In addition to the written documentation of each encounter, the pharmacist will:
   i. Use clinical judgment and refer the patient to the Ambulatory Clinic provider when necessary.
   ii. Immediately report any emergency situations (after stabilizing the patient) or any occurrences that fall outside of the CPA and warrant immediate evaluation and/or management to the Ambulatory Clinic provider or, when the provider is not immediately available, a covering FHP provider
   iii. Notify the Ambulatory Clinic provider and arrange for transfer of care back to the provider when a patient elects to discontinue care with a pharmacist.

III. Quality Improvement

a. FHP referring providers will audit a sample of pharmacist CPA activities at least quarterly and retain documentation of the review.
b. This CPA will be reviewed annually by FHP Ambulatory Clinic providers and pharmacists, and the agreement shall be revised as needed.

Table 1: Scope of pharmacist Collaborative Practice Agreement

Disease State/Clinical Condition	Medication Therapies	Clinical Practice Guideline(s)*
Anticoagulation	All anticoagulants and anticoagulation-related medical supplies	American College of Chest Physicians Conference on Antithrombotic and Thrombolytic Therapy (CHEST) and Michigan Anticoagulation Quality Improvement Initiative (MAQI[2])
Drug Level Dose Adjustment	Any medication for which drug level dose adjustments are recommended	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Hepatic Dose Adjustment	Any medication for which hepatic dose adjustments are recommended	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Immunizations	All immunizations	Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control and Prevention (CDC)
Orders for Drug Monitoring	Any medication for which laboratory or non-laboratory orders are a routine part of drug monitoring	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Overdose prevention	Any medication used for the prevention or treatment of drug overdose, including naloxone	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Renal Dose Adjustment	Any medication for which renal dose adjustments are recommended	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Smoking Cessation	Nicotine replacement, bupropion, varenicline	US Department of Health and Human Services, Treating Tobacco Use and Dependence
Transitional Care	Any medication management related items connected with patient transition from inpatient to outpatient care	Pertinent guidelines as determined by patient's diagnoses and medical history
Travel Medications & Vaccinations	Any medications and immunizations recommended for preventative treatment related to foreign travel	US Department of Health and Human Services, Centers for Disease Control and Prevention
Asthma	Inhaled and oral agents for asthma and asthma-related medical supplies	National Asthma Education and Prevention Program (NAEPP)
Blood Pressure	All blood pressure modifying agents and blood pressure monitoring medical equipment	The Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC)
Chronic Heart Failure	ACE Inhibitors, Angiotensin II Receptor Blockers, Angiotensin II Receptor Blockers/neprilysin inhibitor (ARNI), Aldosterone Antagonists, Beta Blockers, Digoxin, Diuretics, Nitrates	American College of Cardiology/American Heart Association (ACC/AHA)
Chronic Obstructive Pulmonary Disease	Inhaled and oral agents for chronic obstructive pulmonary disease and exacerbations, oral antibiotics for COPD-related infections, and COPD-related medical supplies	Global Initiative for Chronic Obstructive Lung Disease (GOLD)
Depression	All antidepressants	Diagnostic and Statistical Manual of Mental Disorders (DSM)
Diabetes Mellitus	All oral, injectable, and inhaled antidiabetic agents; as well as medical equipment related to diabetes care and treatments for hypoglycemia	American Diabetes Association
Dyslipidemia	All cholesterol modifying agents	ACC/AHA Blood Cholesterol Guideline
Gastroesophageal Reflux Disease	Antacids, histamine antagonists, proton-pump inhibitors, metoclopramide, sucralfate	American College of Gastroenterology (ACG)

Hormone Therapy	All hormone replacement agents	American College of Obstetricians and Gynecologists; Endocrine Society Clinical Practice Guidelines
Hypothyroidism	All thyroid replacement agents	American Association of Clinical Endocrinologists (AACE)
Osteoporosis	Bisphosphonates, calcium, vitamin D, denosumab, teriparatide	Clinicians Guide to Prevention and Treatment of Osteoporosis
Pain Management	All non-controlled pain management agents	Centers for Disease Control and Prevention; American Pain Society
Weight Management	All weight management and nutrition related agents	Endocrine Society Clinical Practice Guidelines; US Department of Health and Human Services Dietary Guidelines for Americans; ACC/AHA

*Pharmacist will follow the most current published version of the guidelines and use clinical judgment

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Physician-Pharmacist Cooperative Practice Agreement Application

Under 12 AAC 40.983, a physician may participate in a cooperative agreement with a pharmacist by submitting this application and copy of the protocol to the State Medical Board for approval. A "cooperative practice agreement" is an agreement by which a physician authorizes a pharmacist to manage a patient's medication therapy.

The Board of Pharmacy must also endorse the approval before a physician and pharmacist can engage in the agreement. This is a joint application; there is no need to submit separate applications to each board.

PART I Application Type

Application Type:	☒	New Agreement	☐	Renewal	☐	Modification of Existing Agreement	☐ Termination of Agreement

PART II Cooperative Practice History

1. Agreement number for renewal, modification, and termination application types only:				
2. **If a modification,** describe what protocols have changed since the cooperative practice was initially issued or last renewed (e.g., new designation types added or removed):				
3. **If a renewal,** please confirm the protocols and services provided under the existing cooperative practice agreement have not changed since initially issued or last renewed, whichever is most recent. (If there have been changes, apply by modification.)				
Original Agreement Date:				
Requested Effective Dates for Agreement:*	**Start Date:**	1-1-2025	**End Date:**	

**May not exceed two years.*

PART III Designation Types

Protocol Type:	☐	Travel Medication	☒	Immunizations	☒	Hypertension	☐ Emergency Contraception
	☒	Anticoagulation	☒	Other, Please Specify:	See attached		

PART IV Physician Information

Physician Name:	Dr Claire Stoltz	**License Number:**	101687
Email Address:	Claire.Stoltz@foundationhealth.org	**Phone Number:**	907-459-3500
Employer Name:	Foundation Health	**Physician Type:**	FP

PART V Additional Physicians

Please list additional participating physicians involved in the cooperative practice agreement, if known. *Attach additional pages, if needed.*

Physician Name	Alaska License Number	Expiration Date
See attached		

PART VI Pharmacy Information (If Applicable)

Pharmacy Name:	N/A		
Pharmacy Email Address:		**Alaska Pharmacy License Number:**	
Pharmacy Physical Address:	Street City State Zip		

PART VII Pharmacist Information

Cooperating Pharmacist Name:	Karen D. Miller	**License Number:**	PHAP1109
Practice Address: (If Not Pharmacy Listed Above)	Street 1001 Noble St City State Zip		
Email Address:	Karen.miller@foundationhealth.org	**Phone Number:**	907-322-6314

PART VIII Additional Pharmacists

Please list additional participating pharmacists involved in the cooperative practice agreement, if known. *Attach additional pages, if needed.*

Pharmacist Name	Alaska License Number	Expiration Date

PART IX Cooperative Practice Protocol Details (12 AAC 40.983)

1.	Does the protocol contain an agreement in which physicians authorized to prescribe legend drugs in this state authorize pharmacists licensed in this state to administer or dispense in accordance with that written protocol?	☒ Yes ☐ No
2.	Does the protocol contain a statement identifying the physicians authorized to prescribe and the pharmacists who are party to the agreement?	☒ Yes ☐ No
3.	Is a time period for the protocol specified? (May not exceed two years.)	☒ Yes ☐ No
4.	Does the protocol include the types of collaborative authority decisions that the pharmacists are authorized to make, including: **A.** Types of diseases, drugs, or drug categories involved and the type of collaborative authority authorized in each case? **B.** Procedures, decision criteria, or plans the pharmacists are to follow when making therapeutic decisions, particularly when modification or initiation of drug therapy is involved?	☒ Yes ☐ No
5.	Does the protocol include activities the pharmacists are to follow in the course of exercising collaborative authority, including documentation of decisions made, and a plan for communication and feedback to the authorizing practitioners concerning the specific decisions made?	☒ Yes ☐ No
6.	Does the protocol contain a list of the specific types of patients eligible to receive services under the written protocol?	☒ Yes ☐ No
7.	Does the protocol include a plan for the authorizing practitioners to review the decisions made by the pharmacist at least once every three months?	☒ Yes ☐ No
8.	Does the protocol include a plan for providing the authorizing physicians with each patient record created under the written protocol?	☒ Yes ☐ No
9.	Does the protocol specify and require completion of additional training, if required for the procedures authorized under the protocol?	☒ Yes ☐ No
10.	Does the protocol include a provision that allows the physician to override the agreement if the physician considers it medically necessary or appropriate?	☒ Yes ☐ No
11.	Does the plan acknowledge that the physician will not receive any compensation from a pharmacist or pharmacy as a result of the care or treatment of any patient under the agreement?	☒ Yes ☐ No

PART X Agreement

For Physicians: By providing my signature below, I acknowledge that I will also comply with all provisions required by the State Medical Board's Cooperative Practice Agreement regulations.

For Pharmacists: By providing my signature below, I acknowledge that a signed copy of the approved collaborative practice application and protocols must remain at the pharmacy location at all times as required by 12 AAC 52.240(i).

☒ Attach a copy of your written protocol.

Cooperating Physician Signature:		**Date Signed:**	12/13/24
Cooperating Pharmacist Signature:		**Date Signed:**	11-27-24

Provider Last Name	Provider First Name	Provider Type	Alaska Medical License Number	Provider NPI
Accola	Brian	MD	MEDS6391	1447236823
Dahle	Aaron	PA-C	169558	1831486299
Figueroa	Amber	DO	145345	1689768905
Franklin	Julia	MD	149491	1225486228
Kaufmann	Cristiane	MD	117118	1215375340
Leistikow	Corrine	MD	MEDS2487	1417922774
Stoltz	Claire	MD	101687	1780948026
Ellis	Sarah	FNP-C	203079	1720385412
Gowtham	Sriharsha	MD	191517	1043747587
Mangum	Sally	DO	142391	1912351917
Moore	Cindy	AGNP-BC	216212	1164299178
Smith	Ariana	FNP	202989	1992410237
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Jinich	David	MD	187971	1861447500
Knuths	Lydia	PA-C	213929	1457933426
Ombrellaro	Mark	MD	103591	1699793968
Wolf	Emily	PA-C	211212	1104415322
Wrenn	Romel	MD	7040	1255302717

Foundation Health Partners
Collaborative Practice Agreement for Clinical Pharmacy Services

Description of agreement:
This Collaborative Practice Agreement (CPA) is established on this 6 day of Dec in the year 2024, pursuant to Alaska State Board of Pharmacy Administrative Code Regulation (12 AAC 52.240), between Foundation Health Partners (FHP) Ambulatory Clinic practitioners and FHP Clinical Pharmacists. FHP Ambulatory Clinic practitioners consists of physicians, nurse practitioners, and physician assistants authorized to prescribe legend drugs in the State of Alaska. The signature of the FHP Medical Director authorizes this CPA on behalf of each individual provider and will substitute for individual signatures. The signature of the Principal Clinical Pharmacist authorizes this CPA on behalf of each individual pharmacist and will substitute for individual signatures. No FHP practitioner will receive any form of compensation or renumeration from a pharmacist or pharmacy in association with this agreement.

Authority is limited to patients under the care of FHP Ambulatory Clinic providers or their designees, and only under the scope of their current practice.

This CPA will be granted for one year from this date, unless rescinded earlier in writing by the authorizing practitioners or clinical pharmacists. The clinical pharmacists shall notify the Alaska State Board of Pharmacy in writing within 30 days after the written protocol is terminated. Changes to this CPA shall be reported to the Alaska State Board of Pharmacy via resubmission signed by the principal clinical pharmacist and FHP Medical Director.

Under this CPA, the clinical pharmacist is given authority to order labs and initiate or modify (including refilling or discontinuing) medication therapy for administration or dispensation of the drug categories listed and in related to the treatment of disease states outlined herein.

Claire Stoltz, MD	101087
Printed Name: FHP Medical Director	Alaska State License Number
	12/6/24
Signature: FHP Medical Director	Date
Karen Miller	PhaP1109
Printed Name: Principal Clinical Pharmacist	Alaska State License Number
	11-27-2024
Signature: Principal Clinical Pharmacist	Date

Individual Pharmacist Training, Competency, and Application

I. Submission of a signed copy of the FHP Ambulatory Clinic CPA by an FHP pharmacist along with an application to be approved by the Board to practice under the CPA will indicate the following:
   a. FHP verification of the pharmacist's license to practice pharmacy in the state of Alaska
   b. FHP's completion of a credentialing and privileging review of the clinical pharmacist with a determination of appropriate education and practice experience to engage in clinical pharmacy practice at FHP
   c. FHP's granting of privileging to engage in collaborative practice under the FHP CPA
   d. The pharmacists' personal review and understanding of all components of the FHP Ambulatory Clinic CPA and associated policies, procedures, and guidelines
   e. The pharmacist's attestation that they are competently trained and experienced to engage in collaborative practice under the CPA for the privileged disease states

Clinic Information

I. This policy will apply to all FHP Ambulatory Care Clinics providing primary care services.

Patient Identification

I. Provider Referral
   a. FHP Ambulatory Clinic providers may refer patients for whom they feel pharmacy services would be beneficial, including drug therapy initiation, modification, or discontinuation, provided:
      i. The patient has a diagnosis from the FHP Ambulatory Clinic provider before the clinical pharmacist initiates, modifies, or discontinues a medication per this CPA.
      ii. Patients evaluated and monitored by the pharmacist are followed at least annually by the Ambulatory Clinic provider.
   b. Referrals will be made via the electronic medical record (EMR) and shall include diagnosis or reason for referral.
   c. The pharmacist will only manage the specific disease state(s) for which the patient was referred.
   d. All provider referrals are considered active unless rescinded in writing within the electronic medical record.

II. Population Health Management
   a. Reports from medical records may be utilized to initiate standing order referrals for pharmacy services as approved by FHP policy.

Procedures and Decision Criteria:

I. Patient Management
   a. Following a referral, the pharmacist will evaluate a patient in a face to face or electronic/telephonic manner appropriate to collect sufficient subjective and objective data to establish or revise a care plan for the disease state(s) and/or clinical scenario(s) for which the patient is referred to the treating pharmacist.
   b. Care plans may include continuation, modification, discontinuation or addition of pharmacotherapy, education, self-management activities, and/or laboratory monitoring.

i. Pharmacotherapy decisions and authorities are as listed in prescribing activities and Table 1.

c. The pharmacist will provide instructions to the patient to schedule follow up encounters with the pharmacist or Ambulatory Clinic provider to review care plan changes and assess current status.

II. Decision Criteria

a. The pharmacist will exercise professional judgement in utilizing the professional guidelines described in Table 1, current evidenced based literature, patient insurance formularies, and the principles of shared decision making in selecting specific pharmacotherapies and establishing an/or updating care plans.

b. The pharmacist will exercise professional judgement in determining the frequency and in a manner of follow up to recommend that facilitate timely collection of necessary subjective and objective data and minimize the risk of complications of treatment or disease progression.

Prescribing Activities

I. The pharmacist will serve as an agent of the referring provider. The referring provider has the final responsibility for the medical appropriateness of all prescriptions written within the scope of this Agreement.

II. Prescribing activities may include:

a. Initiation of drug therapy for the management of the disease states delineated within this Agreement and the management of side effects of those medications.

b. Continuation of drug therapy for the management of the disease states delineated within this Agreement and management of side effects of those medications.

c. Modification of drug therapy including alteration of dose or dosing interval, or conversion to a more suitable drug regimen to improve efficacy or decrease potential toxicity for the management of the disease states delineated with in this Agreement and the management of side effects of those medications.

d. Discontinuation of drug therapy.

III. The names of the FHP Ambulatory Clinic provider and pharmacist will be indicated on the prescription drug order, with language indicating the pharmacist is practicing under this CPA.

IV. This CPA does not include the prescriptive authority for any controlled substances. Recommendations for controlled substances, if deemed warranted, will be forwarded to the referring provider.

Documentation

I. Documentation

a. Written documentation of each office visit and/or electronic or telephonic encounter with the patient will be provided in the EMR, making them immediately available to the referring provider for signature.

b. The pharmacist will use clinical judgment and refer the patient to their Ambulatory Clinic provider when necessary.

c. The pharmacist will immediately report any emergency situations (after stabilizing the patient) or any occurrences that fall outside of the CPA or any associated guidelines to the Ambulatory Clinic provider.

Communication and Quality Improvement

II. Communication

a. In addition to the written documentation of each encounter, the pharmacist will:

i. Use clinical judgment and refer the patient to the Ambulatory Clinic provider when necessary.

ii. Immediately report any emergency situations (after stabilizing the patient) or any occurrences that fall outside of the CPA and warrant immediate evaluation and/or management to the Ambulatory Clinic provider or, when the provider is not immediately available, a covering FHP provider

iii. Notify the Ambulatory Clinic provider and arrange for transfer of care back to the provider when a patient elects to discontinue care with a pharmacist.

III. Quality Improvement

a. FHP referring providers will audit a sample of pharmacist CPA activities at least quarterly and retain documentation of the review.

b. This CPA will be reviewed annually by FHP Ambulatory Clinic providers and pharmacists, and the agreement shall be revised as needed.

Table 1: Scope of pharmacist Collaborative Practice Agreement

Disease State/Clinical Condition	Medication Therapies	Clinical Practice Guideline(s)*
Anticoagulation	All anticoagulants and anticoagulation-related medical supplies	American College of Chest Physicians Conference on Antithrombotic and Thrombolytic Therapy (CHEST) and Michigan Anticoagulation Quality Improvement Initiative (MAQI^2)
Drug Level Dose Adjustment	Any medication for which drug level dose adjustments are recommended	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Hepatic Dose Adjustment	Any medication for which hepatic dose adjustments are recommended	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Immunizations	All immunizations	Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control and Prevention (CDC)
Orders for Drug Monitoring	Any medication for which laboratory or non-laboratory orders are a routine part of drug monitoring	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Overdose prevention	Any medication used for the prevention or treatment of drug overdose, including naloxone	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Renal Dose Adjustment	Any medication for which renal dose adjustments are recommended	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Smoking Cessation	Nicotine replacement, bupropion, varenicline	US Department of Health and Human Services, Treating Tobacco Use and Dependence
Transitional Care	Any medication management related items connected with patient transition from inpatient to outpatient care	Pertinent guidelines as determined by patient's diagnoses and medical history
Travel Medications & Vaccinations	Any medications and immunizations recommended for preventative treatment related to foreign travel	US Department of Health and Human Services, Centers for Disease Control and Prevention
Asthma	Inhaled and oral agents for asthma and asthma-related medical supplies	National Asthma Education and Prevention Program (NAEPP)
Blood Pressure	All blood pressure modifying agents and blood pressure monitoring medical equipment	The Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC)
Chronic Heart Failure	ACE Inhibitors, Angiotensin II Receptor Blockers, Angiotensin II Receptor Blockers/neprilysin inhibitor (ARNI), Aldosterone Antagonists, Beta Blockers, Digoxin, Diuretics, Nitrates	American College of Cardiology/American Heart Association (ACC/AHA)
Chronic Obstructive Pulmonary Disease	Inhaled and oral agents for chronic obstructive pulmonary disease and exacerbations, oral antibiotics for COPD-related infections, and COPD-related medical supplies	Global Initiative for Chronic Obstructive Lung Disease (GOLD)
Depression	All antidepressants	Diagnostic and Statistical Manual of Mental Disorders (DSM)
Diabetes Mellitus	All oral, injectable, and inhaled antidiabetic agents; as well as medical equipment related to diabetes care and treatments for hypoglycemia	American Diabetes Association
Dyslipidemia	All cholesterol modifying agents	ACC/AHA Blood Cholesterol Guideline
Gastroesophageal Reflux Disease	Antacids, histamine antagonists, proton-pump inhibitors, metoclopramide, sucralfate	American College of Gastroenterology (ACG)

Hormone Therapy	All hormone replacement agents	American College of Obstetricians and Gynecologists; Endocrine Society Clinical Practice Guidelines
Hypothyroidism	All thyroid replacement agents	American Association of Clinical Endocrinologists (AACE)
Osteoporosis	Bisphosphonates, calcium, vitamin D, denosumab, teriparatide	Clinicians Guide to Prevention and Treatment of Osteoporosis
Pain Management	All non-controlled pain management agents	Centers for Disease Control and Prevention; American Pain Society
Weight Management	All weight management and nutrition related agents	Endocrine Society Clinical Practice Guidelines; US Department of Health and Human Services Dietary Guidelines for Americans; ACC/AHA

*Pharmacist will follow the most current published version of the guidelines and use clinical judgment

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Physician-Pharmacist Cooperative Practice Agreement Application

Under 12 AAC 40.983, a physician may participate in a cooperative agreement with a pharmacist by submitting this application and copy of the protocol to the State Medical Board for approval. A "cooperative practice agreement" is an agreement by which a physician authorizes a pharmacist to manage a patient's medication therapy.

The Board of Pharmacy must also endorse the approval before a physician and pharmacist can engage in the agreement. This is a joint application; there is no need to submit separate applications to each board.

PART I Application Type

Application Type:	☒	New Agreement	☐	Renewal	☐	Modification of Existing Agreement	☐ Termination of Agreement

PART II Cooperative Practice History

1. Agreement number for renewal, modification, and termination application types only:				
2. **If a modification,** describe what protocols have changed since the cooperative practice was initially issued or last renewed (e.g., new designation types added or removed):				
3. **If a renewal,** please confirm the protocols and services provided under the existing cooperative practice agreement have not changed since initially issued or last renewed, whichever is most recent. (If there have been changes, apply by modification.)				
Original Agreement Date:				
Requested Effective Dates for Agreement:*	**Start Date:**	1/1/25	**End Date:**	

**May not exceed two years.*

PART III Designation Types

Protocol Type:	☐	Travel Medication	☐	Immunizations	☐	Hypertension	☐ Emergency Contraception
	☐	Anticoagulation	☒	Other, Please Specify:	See attached		

PART IX Cooperative Practice Protocol Details (12 AAC 40.983)

1.	Does the protocol contain an agreement in which physicians authorized to prescribe legend drugs in this state authorize pharmacists licensed in this state to administer or dispense in accordance with that written protocol?	☒ Yes ☐ No
2.	Does the protocol contain a statement identifying the physicians authorized to prescribe and the pharmacists who are party to the agreement?	☒ Yes ☐ No
3.	Is a time period for the protocol specified? (May not exceed two years.)	☒ Yes ☐ No
4.	Does the protocol include the types of collaborative authority decisions that the pharmacists are authorized to make, including: **A.** Types of diseases, drugs, or drug categories involved and the type of collaborative authority authorized in each case? **B.** Procedures, decision criteria, or plans the pharmacists are to follow when making therapeutic decisions, particularly when modification or initiation of drug therapy is involved?	☒ Yes ☐ No
5.	Does the protocol include activities the pharmacists are to follow in the course of exercising collaborative authority, including documentation of decisions made, and a plan for communication and feedback to the authorizing practitioners concerning the specific decisions made?	☒ Yes ☐ No
6.	Does the protocol contain a list of the specific types of patients eligible to receive services under the written protocol?	☒ Yes ☐ No
7.	Does the protocol include a plan for the authorizing practitioners to review the decisions made by the pharmacist at least once every three months?	☒ Yes ☐ No
8.	Does the protocol include a plan for providing the authorizing physicians with each patient record created under the written protocol?	☒ Yes ☐ No
9.	Does the protocol specify and require completion of additional training, if required for the procedures authorized under the protocol?	☒ Yes ☐ No
10.	Does the protocol include a provision that allows the physician to override the agreement if the physician considers it medically necessary or appropriate?	☒ Yes ☐ No
11.	Does the plan acknowledge that the physician will not receive any compensation from a pharmacist or pharmacy as a result of the care or treatment of any patient under the agreement?	☒ Yes ☐ No

Provider Last Name	Provider First Name	Provider Type	Alaska Medical License Number	Provider NPI
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Under this CPA, the clinical pharmacist is given authority to order labs and initiate or modify (including refilling or discontinuing) medication therapy for administration or dispensation of the drug categories listed and in related to the treatment of disease states outlined herein.

Claire Stoltz, MD
Printed Name: FHP Medical Director

1016087
Alaska State License Number

Signature: FHP Medical Director

12/6/24
Date

Megan Wiegand
Printed Name: Principal Clinical Pharmacist

PHAP1464
Alaska State License Number

Megan Wiegand
Signature: Principal Clinical Pharmacist

11/21/24
Date

i. Pharmacotherapy decisions and authorities are as listed in prescribing activities and Table 1.

c. The pharmacist will provide instructions to the patient to schedule follow up encounters with the pharmacist or Ambulatory Clinic provider to review care plan changes and assess current status.

II. Decision Criteria

a. The pharmacist will exercise professional judgement in utilizing the professional guidelines described in Table 1, current evidenced based literature, patient insurance formularies, and the principles of shared decision making in selecting specific pharmacotherapies and establishing an/or updating care plans.

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b. The pharmacist will use clinical judgment and refer the patient to their Ambulatory Clinic provider when necessary.

Table 1: Scope of pharmacist Collaborative Practice Agreement

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Renal Dose Adjustment	Any medication for which renal dose adjustments are recommended	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
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Transitional Care	Any medication management related items connected with patient transition from inpatient to outpatient care	Pertinent guidelines as determined by patient's diagnoses and medical history
Travel Medications & Vaccinations	Any medications and immunizations recommended for preventative treatment related to foreign travel	US Department of Health and Human Services, Centers for Disease Control and Prevention
Asthma	Inhaled and oral agents for asthma and asthma-related medical supplies	National Asthma Education and Prevention Program (NAEPP)
Blood Pressure	All blood pressure modifying agents and blood pressure monitoring medical equipment	The Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC)
Chronic Heart Failure	ACE Inhibitors, Angiotensin II Receptor Blockers, Angiotensin II Receptor Blockers/neprilysin inhibitor (ARNI), Aldosterone Antagonists, Beta Blockers, Digoxin, Diuretics, Nitrates	American College of Cardiology/American Heart Association (ACC/AHA)
Chronic Obstructive Pulmonary Disease	Inhaled and oral agents for chronic obstructive pulmonary disease and exacerbations, oral antibiotics for COPD-related infections, and COPD-related medical supplies	Global Initiative for Chronic Obstructive Lung Disease (GOLD)
Depression	All antidepressants	Diagnostic and Statistical Manual of Mental Disorders (DSM)
Diabetes Mellitus	All oral, injectable, and inhaled antidiabetic agents; as well as medical equipment related to diabetes care and treatments for hypoglycemia	American Diabetes Association
Dyslipidemia	All cholesterol modifying agents	ACC/AHA Blood Cholesterol Guideline
Gastroesophageal Reflux Disease	Antacids, histamine antagonists, proton-pump inhibitors, metoclopramide, sucralfate	American College of Gastroenterology (ACG)

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Alaska State Medical Board
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *MedicalBoard@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

Physician-Pharmacist Cooperative Practice Agreement Application

Under 12 AAC 40.983, a physician may participate in a cooperative agreement with a pharmacist by submitting this application and copy of the protocol to the State Medical Board for approval. A "cooperative practice agreement" is an agreement by which a physician authorizes a pharmacist to manage a patient's medication therapy.

The Board of Pharmacy must also endorse the approval before a physician and pharmacist can engage in the agreement. This is a joint application; there is no need to submit separate applications to each board.

PART I Application Type

Application Type:	☒	New Agreement	☐	Renewal	☐	Modification of Existing Agreement	☐ Termination of Agreement

PART II Cooperative Practice History

1. Agreement number for renewal, modification, and termination application types only:				
2. **If a modification,** describe what protocols have changed since the cooperative practice was initially issued or last renewed (e.g., new designation types added or removed):				
3. **If a renewal,** please confirm the protocols and services provided under the existing cooperative practice agreement have not changed since initially issued or last renewed, whichever is most recent. (If there have been changes, apply by modification.)				
Original Agreement Date:				
Requested Effective Dates for Agreement:*	**Start Date:**	01/01/2025	**End Date:**	

**May not exceed two years.*

PART III Designation Types

Protocol Type:	☐	Travel Medication	☐	Immunizations	☒	Hypertension	☐ Emergency Contraception
	☒	Anticoagulation	☒	Other, Please Specify:	See attached		

PART IV Physician Information

Physician Name:	Claire Stoltz	**License Number:**	101687
Email Address:	claire.stoltz@foundationhealth.org	**Phone Number:**	907-459-3500
Employer Name:	Foundation Health Partners	**Physician Type:**	Family Medicine

PART V Additional Physicians

Please list additional participating physicians involved in the cooperative practice agreement, if known. *Attach additional pages, if needed.*

Physician Name	Alaska License Number	Expiration Date
See Attached		

PART VI Pharmacy Information (If Applicable)

Pharmacy Name:	Not applicable		
Pharmacy Email Address:	n/a	**Alaska Pharmacy License Number:**	n/a
Pharmacy Physical Address:	n/a Street City State Zip		

PART VII Pharmacist Information

Cooperating Pharmacist Name:	Rose LaMesjerant	**License Number:**	PHAP2185
Practice Address: (If Not Pharmacy Listed Above)	Street: 1001 Noble St City: Fairbanks State: AK Zip: 99701		
Email Address:	rose.lamesjerant@foundationhealth.org	**Phone Number:**	907-458-5610

PART VIII Additional Pharmacists

Please list additional participating pharmacists involved in the cooperative practice agreement, if known. *Attach additional pages, if needed.*

Pharmacist Name	Alaska License Number	Expiration Date
Not applicable		

PART IX Cooperative Practice Protocol Details (12 AAC 40.983)

1.	Does the protocol contain an agreement in which physicians authorized to prescribe legend drugs in this state authorize pharmacists licensed in this state to administer or dispense in accordance with that written protocol?	☑ Yes ☐ No
2.	Does the protocol contain a statement identifying the physicians authorized to prescribe and the pharmacists who are party to the agreement?	☑ Yes ☐ No
3.	Is a time period for the protocol specified? (May not exceed two years.)	☑ Yes ☐ No
4.	Does the protocol include the types of collaborative authority decisions that the pharmacists are authorized to make, including: **A.** Types of diseases, drugs, or drug categories involved and the type of collaborative authority authorized in each case? **B.** Procedures, decision criteria, or plans the pharmacists are to follow when making therapeutic decisions, particularly when modification or initiation of drug therapy is involved?	☑ Yes ☐ No
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6.	Does the protocol contain a list of the specific types of patients eligible to receive services under the written protocol?	☑ Yes ☐ No
7.	Does the protocol include a plan for the authorizing practitioners to review the decisions made by the pharmacist at least once every three months?	☑ Yes ☐ No
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9.	Does the protocol specify and require completion of additional training, if required for the procedures authorized under the protocol?	☑ Yes ☐ No
10.	Does the protocol include a provision that allows the physician to override the agreement if the physician considers it medically necessary or appropriate?	☑ Yes ☐ No
11.	Does the plan acknowledge that the physician will not receive any compensation from a pharmacist or pharmacy as a result of the care or treatment of any patient under the agreement?	☑ Yes ☐ No

PART X Agreement

For Physicians: By providing my signature below, I acknowledge that I will also comply with all provisions required by the State Medical Board's Cooperative Practice Agreement regulations.

For Pharmacists: By providing my signature below, I acknowledge that a signed copy of the approved collaborative practice application and protocols must remain at the pharmacy location at all times as required by 12 AAC 52.240(i).

☒ Attach a copy of your written protocol.

Cooperating Physician Signature:		**Date Signed:**	12/13/24
Cooperating Pharmacist Signature:		**Date Signed:**	11/27/2024

Provider Last Name	Provider First Name	Provider Type	Alaska Medical License Number	Provider NPI
Accola	Brian	MD	MEDS6391	1447236823
Dahle	Aaron	PA-C	169558	1831486299
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Stoltz	Claire	MD	101687	1780948026
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Wrenn	Romel	MD	7040	1255302717

Foundation Health Partners
Collaborative Practice Agreement for Clinical Pharmacy Services

Description of agreement:
This Collaborative Practice Agreement (CPA) is established on this 6 day of Dec in the year 2024, pursuant to Alaska State Board of Pharmacy Administrative Code Regulation (12 AAC 52.240), between Foundation Health Partners (FHP) Ambulatory Clinic practitioners and FHP Clinical Pharmacists. FHP Ambulatory Clinic practitioners consists of physicians, nurse practitioners, and physician assistants authorized to prescribe legend drugs in the State of Alaska. The signature of the FHP Medical Director authorizes this CPA on behalf of each individual provider and will substitute for individual signatures. The signature of the Principal Clinical Pharmacist authorizes this CPA on behalf of each individual pharmacist and will substitute for individual signatures. No FHP practitioner will receive any form of compensation or renumeration from a pharmacist or pharmacy in association with this agreement.

Authority is limited to patients under the care of FHP Ambulatory Clinic providers or their designees, and only under the scope of their current practice.

This CPA will be granted for one year from this date, unless rescinded earlier in writing by the authorizing practitioners or clinical pharmacists. The clinical pharmacists shall notify the Alaska State Board of Pharmacy in writing within 30 days after the written protocol is terminated. Changes to this CPA shall be reported to the Alaska State Board of Pharmacy via resubmission signed by the principal clinical pharmacist and FHP Medical Director.

Under this CPA, the clinical pharmacist is given authority to order labs and initiate or modify (including refilling or discontinuing) medication therapy for administration or dispensation of the drug categories listed and in related to the treatment of disease states outlined herein.

Claire Stoltz, MD	101687
Printed Name: FHP Medical Director	Alaska State License Number
	12/6/24
Signature: FHP Medical Director	Date
Rose LaMesjeunt	PHAP2185
Printed Name: Principal Clinical Pharmacist	Alaska State License Number
	11/27/2024
Signature: Principal Clinical Pharmacist	Date

Individual Pharmacist Training, Competency, and Application

I. Submission of a signed copy of the FHP Ambulatory Clinic CPA by an FHP pharmacist along with an application to be approved by the Board to practice under the CPA will indicate the following:
   a. FHP verification of the pharmacist's license to practice pharmacy in the state of Alaska
   b. FHP's completion of a credentialing and privileging review of the clinical pharmacist with a determination of appropriate education and practice experience to engage in clinical pharmacy practice at FHP
   c. FHP's granting of privileging to engage in collaborative practice under the FHP CPA
   d. The pharmacists' personal review and understanding of all components of the FHP Ambulatory Clinic CPA and associated policies, procedures, and guidelines
   e. The pharmacist's attestation that they are competently trained and experienced to engage in collaborative practice under the CPA for the privileged disease states

Clinic Information

I. This policy will apply to all FHP Ambulatory Care Clinics providing primary care services.

Patient Identification

I. Provider Referral
   a. FHP Ambulatory Clinic providers may refer patients for whom they feel pharmacy services would be beneficial, including drug therapy initiation, modification, or discontinuation, provided:
      i. The patient has a diagnosis from the FHP Ambulatory Clinic provider before the clinical pharmacist initiates, modifies, or discontinues a medication per this CPA.
      ii. Patients evaluated and monitored by the pharmacist are followed at least annually by the Ambulatory Clinic provider.
   b. Referrals will be made via the electronic medical record (EMR) and shall include diagnosis or reason for referral.
   c. The pharmacist will only manage the specific disease state(s) for which the patient was referred.
   d. All provider referrals are considered active unless rescinded in writing within the electronic medical record.

II. Population Health Management
   a. Reports from medical records may be utilized to initiate standing order referrals for pharmacy services as approved by FHP policy.

Procedures and Decision Criteria:

I. Patient Management
   a. Following a referral, the pharmacist will evaluate a patient in a face to face or electronic/telephonic manner appropriate to collect sufficient subjective and objective data to establish or revise a care plan for the disease state(s) and/or clinical scenario(s) for which the patient is referred to the treating pharmacist.
   b. Care plans may include continuation, modification, discontinuation or addition of pharmacotherapy, education, self-management activities, and/or laboratory monitoring.

i. Pharmacotherapy decisions and authorities are as listed in prescribing activities and Table 1.

c. The pharmacist will provide instructions to the patient to schedule follow up encounters with the pharmacist or Ambulatory Clinic provider to review care plan changes and assess current status.

II. Decision Criteria

a. The pharmacist will exercise professional judgement in utilizing the professional guidelines described in Table 1, current evidenced based literature, patient insurance formularies, and the principles of shared decision making in selecting specific pharmacotherapies and establishing an/or updating care plans.

b. The pharmacist will exercise professional judgement in determining the frequency and in a manner of follow up to recommend that facilitate timely collection of necessary subjective and objective data and minimize the risk of complications of treatment or disease progression.

Prescribing Activities

I. The pharmacist will serve as an agent of the referring provider. The referring provider has the final responsibility for the medical appropriateness of all prescriptions written within the scope of this Agreement.

II. Prescribing activities may include:

a. Initiation of drug therapy for the management of the disease states delineated within this Agreement and the management of side effects of those medications.

b. Continuation of drug therapy for the management of the disease states delineated within this Agreement and management of side effects of those medications.

c. Modification of drug therapy including alteration of dose or dosing interval, or conversion to a more suitable drug regimen to improve efficacy or decrease potential toxicity for the management of the disease states delineated with in this Agreement and the management of side effects of those medications.

d. Discontinuation of drug therapy.

III. The names of the FHP Ambulatory Clinic provider and pharmacist will be indicated on the prescription drug order, with language indicating the pharmacist is practicing under this CPA.

IV. This CPA does not include the prescriptive authority for any controlled substances. Recommendations for controlled substances, if deemed warranted, will be forwarded to the referring provider.

Documentation

I. Documentation

a. Written documentation of each office visit and/or electronic or telephonic encounter with the patient will be provided in the EMR, making them immediately available to the referring provider for signature.

b. The pharmacist will use clinical judgment and refer the patient to their Ambulatory Clinic provider when necessary.

c. The pharmacist will immediately report any emergency situations (after stabilizing the patient) or any occurrences that fall outside of the CPA or any associated guidelines to the Ambulatory Clinic provider.

Communication and Quality Improvement

II. Communication

a. In addition to the written documentation of each encounter, the pharmacist will:

i. Use clinical judgment and refer the patient to the Ambulatory Clinic provider when necessary.

ii. Immediately report any emergency situations (after stabilizing the patient) or any occurrences that fall outside of the CPA and warrant immediate evaluation and/or management to the Ambulatory Clinic provider or, when the provider is not immediately available, a covering FHP provider

iii. Notify the Ambulatory Clinic provider and arrange for transfer of care back to the provider when a patient elects to discontinue care with a pharmacist.

III. Quality Improvement

a. FHP referring providers will audit a sample of pharmacist CPA activities at least quarterly and retain documentation of the review.

b. This CPA will be reviewed annually by FHP Ambulatory Clinic providers and pharmacists, and the agreement shall be revised as needed.

Table 1: Scope of pharmacist Collaborative Practice Agreement

Disease State/Clinical Condition	Medication Therapies	Clinical Practice Guideline(s)*
Anticoagulation	All anticoagulants and anticoagulation-related medical supplies	American College of Chest Physicians Conference on Antithrombotic and Thrombolytic Therapy (CHEST) and Michigan Anticoagulation Quality Improvement Initiative (MAQI^2)
Drug Level Dose Adjustment	Any medication for which drug level dose adjustments are recommended	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Hepatic Dose Adjustment	Any medication for which hepatic dose adjustments are recommended	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Immunizations	All immunizations	Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control and Prevention (CDC)
Orders for Drug Monitoring	Any medication for which laboratory or non-laboratory orders are a routine part of drug monitoring	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Overdose prevention	Any medication used for the prevention or treatment of drug overdose, including naloxone	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Renal Dose Adjustment	Any medication for which renal dose adjustments are recommended	Medication-specific Prescribing Information (PI) as approved by the Federal Drug Administration (FDA)
Smoking Cessation	Nicotine replacement, bupropion, varenicline	US Department of Health and Human Services, Treating Tobacco Use and Dependence
Transitional Care	Any medication management related items connected with patient transition from inpatient to outpatient care	Pertinent guidelines as determined by patient's diagnoses and medical history
Travel Medications & Vaccinations	Any medications and immunizations recommended for preventative treatment related to foreign travel	US Department of Health and Human Services, Centers for Disease Control and Prevention
Asthma	Inhaled and oral agents for asthma and asthma-related medical supplies	National Asthma Education and Prevention Program (NAEPP)
Blood Pressure	All blood pressure modifying agents and blood pressure monitoring medical equipment	The Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC)
Chronic Heart Failure	ACE Inhibitors, Angiotensin II Receptor Blockers, Angiotensin II Receptor Blockers/neprilysin inhibitor (ARNI), Aldosterone Antagonists, Beta Blockers, Digoxin, Diuretics, Nitrates	American College of Cardiology/American Heart Association (ACC/AHA)
Chronic Obstructive Pulmonary Disease	Inhaled and oral agents for chronic obstructive pulmonary disease and exacerbations, oral antibiotics for COPD-related infections, and COPD-related medical supplies	Global Initiative for Chronic Obstructive Lung Disease (GOLD)
Depression	All antidepressants	Diagnostic and Statistical Manual of Mental Disorders (DSM)
Diabetes Mellitus	All oral, injectable, and inhaled antidiabetic agents; as well as medical equipment related to diabetes care and treatments for hypoglycemia	American Diabetes Association
Dyslipidemia	All cholesterol modifying agents	ACC/AHA Blood Cholesterol Guideline
Gastroesophageal Reflux Disease	Antacids, histamine antagonists, proton-pump inhibitors, metoclopramide, sucralfate	American College of Gastroenterology (ACG)

Hormone Therapy	All hormone replacement agents	American College of Obstetricians and Gynecologists; Endocrine Society Clinical Practice Guidelines
Hypothyroidism	All thyroid replacement agents	American Association of Clinical Endocrinologists (AACE)
Osteoporosis	Bisphosphonates, calcium, vitamin D, denosumab, teriparatide	Clinicians Guide to Prevention and Treatment of Osteoporosis
Pain Management	All non-controlled pain management agents	Centers for Disease Control and Prevention; American Pain Society
Weight Management	All weight management and nutrition related agents	Endocrine Society Clinical Practice Guidelines; US Department of Health and Human Services Dietary Guidelines for Americans; ACC/AHA

*Pharmacist will follow the most current published version of the guidelines and use clinical judgment

ALASKA STATE MEDICAL BOARD CHECKLIST - PHYSICIAN-PHARMACIST COOPERATIVE PLAN

Cooperative Plan (License Record) Number: 232252

Physician Name(s): _____ License No. _____
AK Native Medical Center and South Central Foundation License No. _____
_____ License No. _____

Pharmacist Name (s): _____ License No. _____
_____ License No. _____
_____ License No. _____

Date Received: 11-15-2024; revised version received 2/12/2025

Written Proposed Agreement addresses the following elements:

1. Includes types of cooperative practice decisions the physician is granting to the pharmacist ☐ No ■ Yes
   Check all that apply:
   ☐ Types of diseases or conditions: List see attached list
   ☐ Types of medications or medication categories: List See attached list
2. Includes procedures, decision criteria or plans the pharmacist must follow when making therapeutic decisions, particularly when initiating or modifying medications. ☐ No ■ Yes
3. Includes expectations and requirements for the pharmacist to follow with respect to documentation of decisions made, and a plan for communication and feedback to the physician regarding decisions made ☐ No ■ Yes
4. Includes a plan for the physician to review decisions made by the pharmacist at least once every three months. ☐ No ■ Yes
5. Includes a plan for the pharmacist to provide the physician any patient records created under the agreement. ☐ No ■ Yes
6. Includes a provision that allows the physician to override the agreement if the physician considers it medically necessary or appropriate. ☐ No ■ Yes
7. Includes an acknowledgement that the physician will not receive any compensation from the pharmacist or pharmacy as a result of the care or treatment of any patient under the agreement. ☐ No ■ Yes
8. Includes a prohibition against the administration or dispensing of any schedule I, II. III or IV controlled substances. ☐ No ■ Yes
   Only the prescription of legend drugs are authorized.

Comments: _____

Date Application Complete/forwarded to Board Member for Review: _____ Examiner: N Norberg

ALASKA STATE MEDICAL BOARD CHECKLIST - PHYSICIAN-PHARMACIST COOPERATIVE PLAN

BOARD MEMBER REVIEW FOR APPROVAL

☐ APPROVED ☐ HOLD FOR BOARD ☐ INTERVIEW REQUIRED

Comments: _____

_____

Date Issued: _____

VALID FOR 6 MONTHS

Signed: _____ Date _____

From: Carlton, Callista
To: Norberg, Natalie M (CED)
Subject: ANMC CPA
Date: Wednesday, February 12, 2025 8:55:37 AM
Attachments: 2025.2.12 ANMC CPA submitted to Medical Board.docx

Good morning,

Please see attached updated Cooperative Practice Agreement (CPA) for ANMC. We would appreciate a review to confirm the board finds this version acceptable, prior to collecting signatures again from our providers and formally submitting to the board. Based on feedback provided from the Medical Board, we made the following edits:

- 12 AAC 40.983 (c)(11) - a prohibition on the administration or dispensing of any schedule I, II, III, or IV controlled substances. → added statement that explicitly states in Section IV. Clinical Activities.
- 12 AAC 40.983 (d) - The physician, or a physician assistant under the supervision of the physician, must physically examine and evaluate a patient before that patient may be included under a cooperative practice agreement to which that physician is a party. The physician must issue a prescription or medication order for each patient valid for up to one year. The physician, or a physician assistant under the supervision of the physician, must conduct a physical examination of a patient at least once a year while that patient is included under a cooperative practice agreement to which that physician is a party. The requirements of this subsection do not apply to a cooperative practice agreement allowing the administration of emergency contraception, immunizations of persons 18 years of age or older, and those immunizations recommended to be given on a yearly basis by the United States Department of Health and Human Services Centers for Disease Control and Prevention.
    - We addressed the statement regarding "medication order for each patient valid up to one year" to: "The referring provider must have an established relationship with the patient as evidenced by a prescription, medication order, or referral to the pharmacist within the last year." @natalie.norberg@alaska.gov, this statement is based on an interpretation of the intent. We can adjust if needed.
- 12 AAC 40.920 (f), clarified that the Clinical Activities in our CPA does not allow pharmacists "to independently assess, diagnose and treat certain disease states" but the delegation of medication management per standard of care. Edits made to this section to emphasize that the delegation of duties is not to diagnose but medication management once a diagnosis (listed in Table 1) is finalized.
- Removed the statement regarding "limited physical exam."

We appreciate your time and look forward to feedback.

Kind Regards,

Callista Carlton PharmD, HSA
Clinical Director of Pharmacy
Southcentral Foundation
4320 Diplomacy Drive
Anchorage, AK 99508
(907) 729-5111 or (907) 729-8874
ccarlton@scf.cc

 Book time to meet with me

Alaska Native Medical Center and Southcentral Foundation
Clinical Pharmacist Practitioner Cooperative Practice Agreement

Description of agreement:
This Cooperative Practice Agreement (CPA) is established on this XX day of Month in the year 2025 pursuant to the Alaska State Board of Pharmacy Administrative Code Regulation (12 AAC 52.240), between the Alaska Native Tribal Health Consortium (ANTHC) and Southcentral Foundation (SCF) for Clinical Pharmacist Practitioner (CPP) to exercise cooperative practice authority by an Alaska Native Medical Center (ANMC) or Southcentral Foundation (SCF) provider for the pharmacist to initiate or modify drug therapy in accordance with approved guidelines at ANMC.

Authority is limited to patients under the care of ANMC and SCF providers or their designees within the provider's scope of practice. Providers acknowledge that they will not receive direct compensation from a pharmacist or the pharmacy because of the care or treatment of any patient under the agreement. providers consist of physicians, nurse practitioners, and physician assistants authorized to prescribe legend drugs in the State of Alaska.

The CPA will be granted for two years following the organizations' procedures, unless rescinded earlier in writing by the authorizing provider or CPP. The CPP shall notify the Alaska State Board of Pharmacy in writing within 30 days after the written agreement is terminated.

Referring provider must physically examine and evaluate a patient before that patient may be included under a cooperative practice agreement and must also conduct a physical examination of a patient at least once a year while that patient is included under a cooperative practice agreement to which that physician is a party. The referring provider must have an established relationship with the patient as evidenced by a prescription, medication order, or referral to the pharmacist within the last year.

Changes to the CPA shall be reported to the Alaska State Board of Pharmacy via resubmission signed by the ANMC Director of Pharmacy (or designee), the ANMC Chief Medical Officer (or designee), and the SCF Senior Quality Assurance Medical Director (or designee).

I. RATIONALE, PURPOSE, and GOALS

ANMC is jointly owned and operated by ANTHC and SCF. CPPs are integrated throughout the campus healthcare system in various clinics and medical floors. SCF owns and operates the *Benteh Nuutah* Valley Native Primary Care Center and operates several tribal clinics. SCF also utilizes the Nuka System of Care, a relationship-based and integrated health care system, that goes beyond the patient centered medical home model. By working alongside multidisciplinary healthcare teams, CPPs seek to build relationships between patients and provider care teams through patient-centered disease medication management, monitoring, and education with the following goals:

- Expand care access and continuity of care
- Expand pharmacy clinical services and roles
- Provide further education regarding medical conditions and respective therapies (e.g., monitoring and safety)

- Improve patient care outcomes and quality of life
- Meet and exceed quality indicators and metrics
- Expand collaboration between pharmacists and providers
- Expand team-based approach to care

II. CREDENTIALING, PRIVILEGING, TRAINING, and COMPETENCY

A. The CPP shall have successfully completed the following:
    a. Professional PharmD degree from an ACPE-accredited school or college of pharmacy
    b. Board certification through Board of Pharmacy Specialties, to be achieved within 3 years of joining the Medical Staff or obtaining eligibility to apply for board certification.
    c. Completed ANMC Credentialing and Privileging process once board eligible or certified.
    d. Alaska Pharmacist licensure
    e. All requirements listed in the ANMC Medical Staff Bylaws
    f. **Required previous experience**: Applicants for initial appointment must be able to demonstrate the performance of at least 15 patient encounters, reflective of the scope of privileges requested in the appropriate area of specialization in the past 12 months or successful completion of an accredited training program in the past 12 months.

B. The CPP will complete all competency assessments set by the ANMC Director of Pharmacy or designee and continue to obtain continuing education credits for board recertification and pharmacist licensure.
    a. The CPP will review and be familiar with the local clinical prescribing guidelines and other nationally recognized treatment guidelines and associated protocols.
    b. Advanced training/experience or certifications should be documented in CPP's credentialing file and competency folder.

III. ELIGIBILITY, REFERRAL PROCESS, and PROVIDER COMMUNICATIONS

A. Eligibility
    a. Any person eligible for services through ANMC may be referred to pharmacy services for components of disease state management. Maintaining a level of competency, the CPP may provide care for the conditions listed in but not limited to Table 1.
    b. If pregnancy occurs in an existing CPP managed patient, the CPP will discuss case with referring provider and next steps in care as applicable.

B. Referral Process
    a. Referrals may be submitted by any ANMC credentialed provider. The provider will continue to manage the overall care of the patient referred to the CPP.
        i. The patient must have a documented diagnosis before the CPP may initiate, modify or discontinue a medication per this CPA.
    b. Referrals for eligible patients will be documented through the electronic health record (EHR).
    c. All provider referrals are considered active unless rescinded in writing within the EHR.

i. The patient must maintain care with their referring provider at least annually. Referrals will become inactive if the aforementioned is not met and will reactivate upon visit with the referring provider.

d. CPPs may place a consultation to other healthcare team members or departments as needed (e.g., Integrated care team members, specialty departments, behavioral health consultants, dietitians, optometry, audiology, cardiology).
e. Providers may override the agreement if they consider the decision medically necessary or appropriate.

C. Communication
   a. The CPP will provide written documentation of each encounter with a patient in the electronic medical record which will be available for the provider to review.
   b. The CPP will communicate with the provider anytime an issue or question in care arises for further evaluation by the provider.
   c. The CPP will refer patients back to their referring provider if extended beyond the CPAs scope of practice or if patient reach their disease state goals.
      i. Referrals to specialty clinics will be consulted with the patient's provider first.
   d. The CPP will refer patients to their provider for follow-up of chronic disease, annual physicals, and evaluation or treatment of acute or abnormal findings.
   e. If a patient does not keep their appointment (DNKA) for more than 3 consecutive appointments, the CPP may refer the patient back to their provider and document in the EHR.

IV. CLINICAL ACTIVITIES

This CPA, in accordance with the standards of care and clinical practice guidelines, allows the CPP to perform the following for patients with documented diagnosis outlined in Table 1 or site-approved policies and procedures:

- Obtain patient histories and review health records to document medication use patterns, detect adverse drug effects, uncover potential drug interactions, contraindications to therapy, and identify evidence of drug efficacy.
- Prescribe (initiate, modify, renew, or discontinue) medications for management of the disease states delineated within Table 1 or agreed upon by both referring provider and CPP.
  - This CPA does not include the prescriptive or administering authority for any controlled substances. Recommendations for controlled substances, if deemed warranted, will be provided to referring provider.
- Provide comprehensive medication therapeutic management (MTMs)
- Provide and document patient education and health promotion
- Order and interpret pertinent laboratory tests to monitor drug therapy for efficacy and toxicity
- Provide follow-up visits with patients

The CPP may see patients through clinic/floor, telephonic, telehealth, or shared interdisciplinary team visits.

The CPP will follow the emergency response procedure for their area.

The CPP may select, initiate, continue, modify, discontinue, administer, and monitor drug therapy for patients as delegated by the provider or site-approved policies and procedures. To determine the medication management care that may be delegated, the provider must confirm the care delegated is consistent with the CPP's education, training, and experience; and within the accepted standard of care and guidelines that would be provided in a similar setting by a reasonable and prudent CPP with similar education, training, and experience.

Standards of Care and national practice guidelines will be utilized to determine pharmacotherapy and therapeutic monitoring including but not limited to the following:

Table 1

Disease State	Medication Therapies	Clinical Practice Guideline(s)
Provider referral required for prescribing and ordering authority		
Anticoagulation	All anticoagulants and anticoagulation-related medical supplies	American College of Chest Physicians Conference on Antithrombotic and Thrombolytic Therapy (CHEST)
Asthma	Inhaled and oral agents for asthma and asthma-related medical supplies	National Asthma Education and Prevention Program (NAEPP) Global Initiative for Asthma (GINA)
Hypertension	All blood pressure modifying agents and blood pressure monitoring medical equipment	The Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC)
Chronic Obstructive Pulmonary Disease	Inhaled and oral agents for chronic obstructive pulmonary disease and exacerbations, oral antibiotics for COPD-related infections, and COPD-related medical supplies	Global Initiative for Chronic Obstructive Lung Disease (GOLD)
Diabetes / Gestational Diabetes	All oral, injectable, and inhaled antidiabetic agents; as well as medical equipment related to diabetes care and treatments for hypoglycemia	American Diabetes Association
Hyperlipidemia	All cholesterol modifying agents	ACC/AHA Blood Cholesterol Guideline
Hepatitis C	Oral medications for the treatment of hepatitis C without compensated cirrhosis	American Association for the Study of Liver Disease/Infectious Disease Society of America
HIV Pre-exposure Prophylaxis	Medications for the prevention of HIV transmission to at-risk individuals	Centers for Disease Control/Infectious Disease Society of America
Immunizations	All immunizations	Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control and Prevention (CDC)
Osteoporosis	All osteoporosis medications on formulary	USPSTF Screening for Osteoporosis in Postmenopausal Women American College of Physicians
Weight Management	All weight management and nutrition related agents	Endocrine Society Clinical Practice Guidelines; US Department of Health and Human Services Dietary Guidelines for Americans; ACC/AHA

V. OUTCOMES

CPP outcomes may be assessed annually and reported to pharmacy leadership as needed. Additional information such as disease state outcomes, evaluation of access, no-show rates, adverse medication outcomes, interventions, or other pertinent measures may also be collected.

VI. QUALITY ASSURANCE and PERFORMANCE IMPROVEMENT

A. The ongoing monitoring of quality assurance, performance improvement, and continuous competency will encompass Ongoing Professional Practice Evaluation (OPPE), Focused Professional Practice Evaluation (FPPE), and Quality Assurance reviews.
B. Each CPP will be briefed on professional practice evaluation processes and forms upon initial credentialing and privileging approval by the medical staff and whenever there are adjustments to the evaluation elements. The assignment, collection, and assessment of FPPE and OPPE will be managed by ANMC Director of Pharmacy or designee.
C. The ANMC Director of Pharmacy or designee (e.g., collaborating physician, medical director) will review the results of the professional practice evaluations and report them to the medical staff office or when appropriate to the Vice President of VNPCC at the appropriate reporting time. Feedback will be regularly provided to the CPPs.
D. The collaborating provider or designee will perform CPP chart reviews periodically (at least every 3 months) and provide regular feedback regarding findings. Documentation will be placed in the CPP's credential file.

2014 FSMB Model Policy for Telemedicine compared to 2022 FSMB Model Guidelines for Telemedicine

2014 Guidelines	2022 Guidelines	Comments
Section 1. Preamble. Defines telemedicine as the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider. The regulation of telemedicine should: 1) determine when a physician-patient relationship is established; 2) assure privacy of patient data; 3) guarantee proper evaluation and treatment of the patient consistent with the same standard of care; 4) limit the inappropriate prescribing and dispensing of certain medications Pg. 2	2022 Preamble language remains essentially the same. Added language relates to upholding consistent ethical and professional standards applied to all aspects of a physician's practice. Pages 3-4	
Section 2. Licensure. Licensure is required in state where patient is located. Pg. 4	2022 Guidelines maintains the same language around licensure: but with these 5 exceptions (licensure is not required): **1) Physician-to-Physician consultations** **2) Prospective patient screening for complex referrals (AKA "life threatening condition")** 3) Episodic follow-up care **4) Follow-up after travel for surgical/medical treatment** 5) Clinical trial Pg. 4	This represents one of the biggest changes (2022 Alaska law legalized non-licensure in highlighted scenarios AS 08.02.130)
Section 3. Standard of Care. Establishment of Physician-Patient Relationship: occurs when the physician agrees to undertake diagnosis and treatment of patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician and patient …. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient." Pg. 4	2022 – Adds language related to "Scope of Practice": *A practitioner who uses telemedicine should ensure that the services provided are consistent with the practitioner's scope of practice including their education, training, experience and ability.* Pg. 6 2022 - Establishment of Physician-Patient Relationship remains essentially the same, but with this additional language: "A physician-patient relationship may be established via either synchronous or asynchronous telemedicine technologies without any requirement of a prior in-person meeting, so long as the standard of care is met." Pg. 6	

2014 FSMB Model Policy for Telemedicine compared to 2022 FSMB Model Guidelines for Telemedicine

2014 Guidelines	2022 Guidelines	Comments
Evaluation and Treatment of the Patient Urges telemedicine providers to implement measures to uphold patient safety in the absence of traditional physical exams. "Treatment, including a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care." Pg. 7	2022 - Evaluation and Treatment of the Patient language remains essentially the same, but with some slight changes: "Diagnosis, prescribing, or other treatment based solely on static online questionnaires, or those that do not obtain all the information necessary to meet applicable stands of care, are no acceptable. Physicians practicing telemedicine utilizing adaptive questionnaires must have the ability to ask follow-up questions or obtain further history, especially when doing so is required to collect adequate information to appropriately diagnose or treat. " Pg. 7	
Informed Consent includes terms and concepts such as but not limited to: • Identification of the patient, the physician and the physician's credentials • Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, scheduling, etc.) • Details on security measures taken with the use of telemedicine technologies Pg. 4 Disclosure and Functionality of Online Services includes concepts such as but not limited to: • Fees for services and how payment is made • Use and response times for emails, electronic messages and other communications • Patient rights and the complaint process • Appropriate uses and limitations of the site, including emergency health situations Pg. 6	2022 Guidelines combine these two sections: Informed Consent with Disclosure and Functionality of Online Services Making Available Telemedicine Technologies; the language covered under these topics remain the same. Pg. 7	

2014 FSMB Model Policy for Telemedicine compared to 2022 FSMB Model Guidelines for Telemedicine

2014 Guidelines	2022 Guidelines	Comments
Continuity of Care - patients should be able to seek follow up care from their telemedicine provider. Referrals for Emergency Services – an emergency plan is required and must be provided to the patient. Pg. 5	Continuity of Care and Referral for Emergent Situations 2022 - These sections are combined and expanded. "Patients should be able to seek, with relative ease, follow-up care or information from the physician who conducts an encounter using telemedicine technologies…Physicians have the responsibility to refer patients for in-person follow up care when a patient's medical issue requires an additional in-person physical exam, diagnostic procedure, ancillary lab, or radiologic test…Physicians have an obligation to support continuity of care for their patients. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient may be considered patient abandonment and may result in disciplinary action. Pg. 9	The represents one of the biggest changes
Medical Records should include copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies… Pg. 5	2022 – Medical Records section remains essentially the same but with this added language: "Records should be in a format that is easily transferable to the patient. If requested by the patient, physicians must share the medical record with the patient's primary care physician and other relevant members of the patient's existing care team." Pg. 9	
Privacy and Security of Patient Records & Exchange of Information References compliance with HIPAA, and other guidance documents issued by the Dept of Health. Written policies and procedures should be maintained at the same standard as traditional in-person encounters. Pg. 5	2022 - Privacy and Security of Patient Records & Exchange of Information section remains the same. Pg. 10	
Section 4. Definitions "Telemedicine" "Telemedicine Technologies" Page 3	2022 – Additional terms added under definitions: "Consulting Physician" "Patient Abandonment" Remote Patient Monitoring" "Static Online Questionnaire" Pages 9-10	

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup

Adopted as policy by the Federation of State Medical Boards in April 2014

INTRODUCTION

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the "Model Guidelines for the Appropriate Use of the Internet in Medical Practice" (HOD 2002)[1] and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards") based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients[2] via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

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[1] *The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Model Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).*

[2] *The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.*

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Model Guidelines for State Medical Boards' Appropriate Regulation of Telemedicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider.[3] However, state medical boards, in fulfilling their duty to protect the public, face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the prescribing and dispensing of certain medications.

The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these technologies can enhance medical care by facilitating communication with physicians and their patients or other health care providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice.[4]

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.[5]

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;

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[3] *See Center for Telehealth and eHealth Law (Ctel), http://ctel.org/ (last visited Dec. 17, 2013).*

[4] *Id.*

[5] *See Cal. Bus. & Prof. Code § 2290.5(d).*

- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

Section Two. Establishing the Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.[6] The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

Section Three. Definitions

For the purpose of these guidelines, the following definitions apply:

"Telemedicine" means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.[7]

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.

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[6] *American Medical Association, Council on Ethical and Judicial Affairs, Fundamental Elements of the Patient-Physician Relationship (1990), available at http://www.ama-assn.org/resources/doc/code-medical-ethics/1001a.pdf.*

[7] *See Ctel.*

Section Four. Guidelines for the Appropriate Use of Telemedicine Technologies in Medical Practice

The [Name of Board] has adopted the following guidelines for physicians utilizing telemedicine technologies in the delivery of patient care, regardless of an existing physician-patient relationship prior to an encounter:

Licensure:
A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.[8]

Establishment of a Physician-Patient Relationship:
Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship consistent with the guidelines identified in Section Two, and, while each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.

Evaluation and Treatment of the Patient:
A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:
Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician's credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

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[8] *Federation of State Medical Boards, A Model Act to Regulate the Practice of Medicine Across State Lines (April 1996), available at http://www.fsmb.org/pdf/1996_grpol_telemedicine.pdf.*

Continuity of Care:
Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient, and subject to the patient's consent, any identified care provider of the patient immediately after the encounter.

Referrals for Emergency Services:
An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

Medical Records:
The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records & Exchange of Information:
Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information," issued by the Department of Health and Human Services (HHS).[9] Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional face-to-face encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory

[9] *45 C.F.R. § 160, 164 (2000).*

results must be secure within existing technology (i.e. password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:
Online services used by physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated physicians;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Online services used by physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the site and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Advertising or promotion of goods or products from which the physician receives direct remuneration, benefits, or incentives (other than the fees for the medical care services) is prohibited. Notwithstanding, online services may provide links to general health information sites to enhance patient education; however, the physician should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, physicians should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of preferred relationships with any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit form that pharmacy.

Prescribing:
Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by [Name of Board].

Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

Section Five. Parity of Professional and Ethical Standards
Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC). There should be parity of ethical and professional standards applied to all aspects of a physician's practice.
A physician's professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies.

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THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Report of the FSMB Workgroup on Telemedicine
Adopted by the FSMB House of Delegates, April 2022

INTRODUCTION

In April 2014, the Federation of State Medical Boards (FSMB) adopted the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practices of Medicine,* superseding the *Model Guidelines for the Appropriate Use of the Internet in Medical Practice (2002).* At the time of its adoption, the *Model Policy (2014)* addressed current regulatory challenges associated with the provisions of telemedicine. Since then, the utilization of telemedicine has dramatically increased, resulting in not only advancements in telemedicine technologies, but also identification of newer or more pressing challenges to effective telemedicine utilization.

There are numerous factors contributing to the continual increase of telemedicine being used as a component of the practice of medicine. The greatest of these catalysts by far has been the global COVID-19 pandemic and resulting national public health emergency (PHE). Prior to the declaration of a PHE by the United States, telemedicine visits accounted for a small percentage of total care visits, but within the first six months of the PHE, total telemedicine visits increased by more than 2,000 percent. Certain specialties, such as psychiatry, endocrinology and neurology, saw greater increases in telemedicine utilization than others. The PHE increased familiarity with telemedicine for patients and providers alike and signals greater use in the future.[1][2] Telemedicine allows continued relationships between patients and providers after both office-based and telemedicine visits. Patients and physicians alike also now expect telemedicine to continue to be a component of healthcare delivery.

The rapid expansion of telemedicine has at the same time led to concerns regarding fraud and abuse, patient safety and access inequity. While the PHE led to rapid expansion of telemedicine, counties in the United States with lower median income, less broadband availability, and less pre-

[1] Cortex C, Mansour O, Qato DM, Stafford R, Alexander C. Changes in Short-term, Long-term, and Preventative Care Delivery in US Office-Based and Telemedicine Visits During the COVID-19 Pandemic. *Jama Health Forum.* 2021;2(7):e211529. Doi:10.1001/jamahealthforum.2021.1529
[2] Mehrotra A, Chernew M, Linetsky D, Hatch H, Cutler D, Schneider E. The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases. The Commonwealth Fund. 22 Feb 2021.

PHE telemedicine use continue to utilize telemedicine at a far lesser rate than other counties.[3] Additional patient groups have also experienced inequity of telemedicine access, including older adults, those with limited English proficiency, and people from certain racial and ethnic minority groups. In 2019, despite the ubiquitous appearance of smartphone and related devices availability, 25 million Americans lacked internet access, while 14 million people did not have equipment capable of sharing or playing video images, such as a laptop, pc computer, smartphone, tablet or other device. Specifically, 18 percent of adults aged 65 or older did not have internet access at home, 13 percent of people living in non-metropolitan areas lacked internet access, and seven percent living in metropolitan areas lacked internet access.[4] These marginalized and minoritized communities may be left behind despite advancements in telemedicine and improved access to care, unless such inequities are addressed.

Telemedicine is one component of the delivery of healthcare, and it can vary in quality, appropriateness and usefulness. It is important that as telemedicine continues to be utilized, regulatory agencies balance expanding regulatory opportunities for the adoption of telemedicine technologies with ensuring public health and safety. To address the challenges and evolving use of telemedicine, as well as apply lessons learned from the COVID-19 pandemic, Kenneth B. Simons, MD, the Chair of the Federation of State Medical Boards (FSMB), appointed the Workgroup on Telemedicine in May of 2021 to revise and expand the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (2014)* to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards"), health care providers and patients. The Workgroup was charged with evaluating the impact of license waivers and modifications on the practice of medicine across state lines; evaluating the easing of geographic, site-specific and modality restrictions on the practice of telemedicine and the impact on patient access and care; reviewing current state and federal legislative, policy and regulatory trends; and evaluating the appropriate use of telemedicine during a public health emergency versus nonemergent/nonurgent times.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine, while raising awareness for licensees and patients alike as to the appropriate standards of care in the delivery of medical services via telemedicine technologies. The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation. It is the intent of the workgroup to offer a model policy for use by state medical boards and lawmakers to expand regulatory opportunities and enable wider, appropriate adoption of telemedicine technologies for delivering care while ensuring the public's health and safety.

In developing the guidelines that follow, the workgroup took into account lessons learned from the PHE and conducted a comprehensive review of extant state and federal statutes and regulations,

[3] Patel S, Rose S, Barnett M, Huskamp H, Uscher-Pines L, Mehrotra A. Community Factors Associated with Telemedicine Use During the COVID-19 Pandemic. *Jama Netw Open.* 2021;4(5):e2110330. Doi:10.1001/jamanetopen.2021.10330.

[4] Amin K, Rae M, Ramirez G, Cox C. How Might Internet Connectivity Affect Health Care Access? Peterson-KFF Health System Tracker. December 14, 2020. https://www.healthsystemtracker.org/chart-collection/how-might-internet-connectivity-affect-health-care-access/#item-start

telemedicine technologies currently in use and proposed/recommended standards of care, and identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

SECTION 1. Model Guidelines for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine in the United States and offer opportunities for improving the delivery and accessibility of health care, particularly through telemedicine. Telemedicine continues to be best defined as the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location, with or without an intervening healthcare provider. State medical boards, in fulfilling their statutory duty to protect the public, often face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient consistent with the same standard of care; and 4) limiting the inappropriate prescribing and dispensing of certain medications.

The [Name of Board] recognizes the potential benefits of the use of telemedicine technologies to deliver medical care. When utilized appropriately, telemedicine technologies can enhance connection between patients and physicians, and reduce inequities in the delivery of care. Telemedicine technology can facilitate patient examinations and permit diagnosis, if acceptable under the standard of care. Telemedicine technologies also enable remote patient monitoring and permit physicians to obtain medical histories, give medical advice and counseling, and prescribe medication and other treatments.

These guidelines do not alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method of enabling physician-to-patient communications. Telemedicine is one component of the practice of medicine. A physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history taking of the patient consistent with established, evidence-based standards of care for the particular patient presentation. When the standard of care that is ordinarily applied to an in-person encounter cannot be met by virtual means, the use of telemedicine technologies is not appropriate.

The Board has developed these guidelines to educate licensees and the public as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies,

while promoting the responsible and safe practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

Physicians are encouraged to comply with nationally recognized health standards and codes of ethics. There should be consistent ethical and professional standards applied to all aspects of a physician's practice. A physician's professional discretion as to the diagnoses, scope of care, or treatments should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e., a prescription or referral) or the utilization of telemedicine technologies.

Section Two. Licensure

A physician must be licensed, or appropriately authorized, by the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time that telemedicine technologies are used. Physicians who diagnose, treat, or prescribe using online service sites are engaging in the practice medicine and must possess appropriate licensure in all jurisdictions where their patients receive care.[5]

There are a few instances, however, where certain exceptions may permit the practice of medicine across state lines without the need for licensure in the jurisdictions where the patient is located. These exceptions to licensure are only permissible for established medical problems or ongoing workups and care plans, or in cases of prospective patient screening for complex referrals. Should medical care be sought by the patient for a different medical diagnosis or condition, the physician must refer the patient to a physician licensed in the state where the patient is located or obtain a license to practice medicine in the state where the patient is located. Specifically, these exceptions are:

Consultations and Screenings

Physician-to-Physician Consultations
The physician-to-physician consultation exception permits a consulting physician licensed in another state in which they are located to use telemedicine or other means to consult with a licensed

[5] To avoid confusion about when a physician does or does not require a license to practice across state lines, states are encouraged to consider various means of license portability. States may promote license portability by joining national compacts, such as the Interstate Medical Licensure Compact, as one mechanism to help physicians achieve necessary multi-state licensure to legally provide care to patients in other states.

practitioner who remains responsible for diagnosing and treating the patient in the state where the patient is located.

Prospective Patient Screening for Complex Referrals
Physicians providing specialty assessments or consultations, such as at Centers for Excellence, are not required to obtain a license in the state where the patient is located in order to screen a patient for acceptance of a referral. The out-of-state physician may then provide care via telemedicine utilizing the physician-to-physician consultation exception above. If the out-of-state physician agrees to diagnosis, counsel, or treat the patient directly, the patient must travel to the state where the physician is licensed, or the physician must obtain a license to practice medicine in the state where the patient is located.

Episodic and Follow-Up Care for Established Patients

Episodic Follow-Up Care
A patient that is temporarily located outside the jurisdiction of a physician with which the patient has an established relationship may receive care via telemedicine technologies provided it is possible for the physician to gather sufficient clinical information during the evaluation to provide care that meets the accepted standard of care. If the patient is presenting with new medical conditions, the physician may consider directing the patient to obtain local care.

If the physician becomes aware that the patient's out of state location is no longer temporary, the physician should similarly develop a plan to transition care to a physician licensed in the state where the patient is located. Physicians providing care under this exception should also be prepared to make referrals to a hospital or to a local specialist who can step in and assist, especially in cases of devolving medical or mental status.

Follow-up After Travel for Surgical/Medical Treatment
Due to the unavailability, rarity or severity of a diagnosis or necessary treatment, a patient may choose to travel specifically to obtain specialty care at a medical center located in another state. In this situation, a significant portion of the diagnosis and treatment of the patient should occur in the physician's state of licensure, to include but not limited to, a surgical or procedural intervention. After the workup, procedure, or treatment is performed, the patient may return to their own state of residence and require additional follow-up care. When this follow-up can be effectively provided virtually, physicians should be allowed to utilize telemedicine without obtaining a license to practice in the state where the patient resides. Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical condition make that necessary.

Clinical Trials

Physicians who work on clinical trials recruit patients based off certain criteria in hopes of increasing the likelihood of a successful and diverse clinical trial. When working on clinical trials that are enabled by telemedicine technologies, physicians should be not be precluded from including patients that reside in a state where the physician does not have a license to practice medicine. Physicians providing out-of-state care under this exception should ensure that their

patients have backup plans to receive care locally if changes in their medical condition make that necessary.

Section Three. Standard of Care

A practitioner who uses telemedicine must meet the same standard of care and professional ethics as a practitioner using a traditional in-person encounter with a patient. The failure to follow the appropriate standard of care or professional ethics while using telemedicine may subject the practitioner to discipline by the medical board.

Scope of Practice

A practitioner who uses telemedicine should ensure that the services provided are consistent with the practitioner's scope of practice, including the practitioner's education, training, experience and ability. Physicians may supervise and delegate tasks via telemedicine technologies so long as doing so is consistent with applicable laws.

Establishment of a Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.[6] The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks care from a physician. The relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an in-person encounter between the physician (or other appropriately supervised health care practitioner) and patient. A physician-patient relationship may be established via either synchronous or asynchronous telemedicine technologies without any requirement of a prior in-person meeting, so long as the standard of care is met.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity, location, and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. If available, a patient should be able to select an identified physician for telemedicine services, not be assigned to a physician at random, and have access to follow-up care.

[6] American Medical Association, Council on Ethical and Judicial Affairs, *Fundamental Elements of the Patient-Physician Relationship (1990),* available at http://www.ama- assn.org/resources/doc/code-medical-ethics/1001a.pdf.

Evaluation and Treatment of the Patient

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Gathering clinical history to make a diagnosis is often an iterative process and physicians need to have the opportunity and ability to ask iterative follow-up questions. If an evaluation requires additional ancillary diagnostic testing under the standard of care, the physician must complete such diagnostics, arrange for the patient to obtain the needed testing, or refer the patient to another provider. Additionally, as part of meeting the standard of care, physicians must use digital images, live video, or other modalities as needed to make a diagnosis if the standard of care in-person would have required physical examination. Treatment and consultation recommendations made in a virtual setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in in-person settings. Diagnosis, prescribing, or other treatment based solely on static online questionnaires, or those that do not obtain all of the information necessary to meet applicable standards of care, are not acceptable. Physicians practicing telemedicine utilizing adaptive questionnaires must have the ability to ask follow-up questions or obtain further history, especially when doing so is required to collect adequate information to appropriately diagnosis or treat.

Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of a traditional physical examination. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are recommended. To further assure patient safety in the absence of a physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe.

Prescribing medications via telemedicine, as is the case during in-person care, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each prescription issued during a telemedicine encounter must be evaluated by the physician in accordance with state and federal laws, as well as current standards of practice, and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

Informed Consent, Disclosure, and Functionality of Online Services Making Available Telemedicine Technologies

Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient and the patient's location
- Identification of the physician, the physician's credentials, and the physician's state or territory of practice;
- Identification of the patient's primary care physician, if available;

- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, patient education, etc.);
- The patient agrees that the physician determines, in conjunction with applicable laws, whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, enabling password protection of data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party, if consistent with state and federal law.

Physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated healthcare providers;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the online platform and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the online platform owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Physicians may choose to make health-related and non-health-related goods or products available to patients to meet a legitimate patient need in instances where the goods are medically necessary for patients and not immediately or reliably available to patients by other means. Physicians who choose to make goods available to patients should be cautioned that they must be mindful of the

inherent power differential that characterizes the physician-patient relationship and therefore the significant potential for exploitation of patients. The principle of non-exploitation of patients also applies to scenarios involving physician-owned pharmacies located in practice offices. In such instances, physicians should offer patients freedom of choice in filling any prescriptions and must therefore allow prescriptions to be filled elsewhere.[7]

Continuity of Care and Referral for Emergent Situations

Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient and, subject to the patient's consent, any identified care provider of the patient immediately after the encounter. Physicians have the responsibility to refer patients for in-person follow-up care when a patient's medical issue requires an additional in-person physical exam, diagnostic procedure, ancillary lab, or radiologic test.

If a patient is inappropriate for care via telemedicine technologies or experiences an emergent situation, complication, or side effects after an encounter using telemedicine technologies, physicians should have a standing plan in place and have the responsibility to refer the patient to appropriate care (e.g. acute care, emergency room, or another provider) to ensure patient safety. It is insufficient for physicians to simply refer all patients to the emergency department; each situation should be evaluated on an individual basis and referred based on its severity and urgency.

Physicians have an obligation to support continuity of care for their patients. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient may be considered patient abandonment or result in discipline from the Board. A physician may not delegate responsibility for a patient's care to another person if the physician knows, or has reason to know, that the person is not qualified to undertake responsibility for the patient's care.

Medical Records

The medical record should include, if not required by law, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records. Records should be in a format that is easily transferable to the patient. If requested by the patient, physicians must share the medical record with the patient's primary care physician and other relevant members of the patient's existing care team.

[7] FSMB. *Position Statement on Sale of Goods by Physicians and Physician Advertising*. April 2016, available at: https://www.fsmb.org/siteassets/advocacy/policies/position-statement-on-sale-of-goods-by-physicians-and-physician-advertising.pdf

Privacy and Security of Patient Records & Exchange of Information

Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information" and "Confidentiality of Substance Use Disorder Patient Records," issued by the Department of Health and Human Services (HHS).[89] Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional in-person encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) healthcare personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory results must be secure within existing technology (i.e., password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

Section 4. Definitions

For the purposes of these guidelines, the following definitions apply:

"Consulting Physician" means a physician who evaluates a patient and relevant medical data or images, or other information, through telemedicine technologies upon recommendation of a referring physician.

"Patient Abandonment" means the termination of a health care physician-patient relationship without the assurance that an equal or higher level of care meeting the assessed needs of the patient's condition is present and available.

"Remote Patient Monitoring" means the use of synchronous or asynchronous electronic information and communication technology to collect personal health information and medical data from a patient in one location that is transmitted to a licensee in another location for use in the treatment and management of medical conditions that require frequent monitoring.

[8] *45 C.F.R. § 160, 164 (2000).*
[9] *42 C.F.R. Part 2 (2017).*

"Static Online Questionnaire" means an internet questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast with an adaptive, interactive, and responsive online interview.

"Telemedicine" means the practice of medicine using electronic communications, information technology or other means between a licensee in one location and a patient in another location, with or without an intervening healthcare provider. Telemedicine is not an e-mail/instant messaging conversation or fax-based interaction. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, in-person encounter between a provider and a patient. Telemedicine may include audio-only communications, but audio-only communications should only be used as a substitute when a patient is unable or unwilling to access live-interactive modalities or when audio-only interactions are considered the standard of care for the corresponding healthcare service being delivered.

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location, with or without an intervening healthcare provider.

SECTION 2. Equity of Healthcare Access

When utilized and deployed effectively as a seamlessly integrated part of healthcare delivery, telemedicine can improve access and reduce inequities in the delivery of healthcare. To be effective, certain barriers must be eliminated or reduced, such as literacy gaps, access to broadband internet, and coverage and payment of telemedicine services.

Education

Physicians, health systems, and other telemedicine providers should develop educational and training information for patient groups with known limited digital literacy and access.

Broadband Internet

State governments should pursue policies to expand broadband access to all geographic regions, including low-cost options to those communities that are unable to afford it.

Coverage and Payment

Limiting coverage may lead to additional inequities in the delivery of healthcare via telemedicine. Health plans should provide coverage for the cost of healthcare services provided through telemedicine on the same basis and to the same extent that the carrier is responsible for coverage through in-person treatment or consultation. Health plans should not have separate networks for telehealth or select telehealth providers.

ADDITIONAL REFERENCES

12 Va. Admin. Code § 5-31-10

45 C.F.R. § 160, 164 (2000)

Alaska Admin. Code tit. 7, § 110.639

AMA. Council on Ethical and Judicial Affairs. *Code of Medical Ethics*.

AMA. *Report of the Council on Medical Service.* Addressing Equity in Telehealth. 7-CMS-21. (June 2021).

AMA. *Report of the Council on Medical Service*. Licensure and Telehealth. 8-CMS-21. (June 2021).

AOA. Policy Statement – Telemedicine. H601-A/17. (July 2017)

Ark. Code Ann. § 17-80-402(5)

Cal. Bus. & Prof. Code § 2290.5(d).

Center for Connected Health Policy. Impact of Audio-only Telephone in Delivering Health Services During COVID-19 and Prospects for Future Payment Policies & Medical Board Regulations. August 25, 2021.

Center for Connected Health Policy. *State Telehealth Laws and Reimbursement Polices Report, Fall 2021*. October 2021.

The Department of Health and Human Services, HIPAA Standards for Privacy of Individually Identifiable Health Information. August 14, 2002.

FSMB. *Model Guidelines for the Appropriate Use of the Internet in Medical Practice.* April 2002.

FSMB. *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*. April 2014.

Iowa Admin. Code r. 653-13.11(8)

Miss. Code R. § 30-2635-5

North Carolina Medical Board. Position Statement. Telemedicine. May 2021.

Nev. Rev. Stat. § 630.304 – 630.305

Medicare Program: CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-payment Medical Review Requirements., 86 FR 64996 (Nov. 19, 2021)(revising 42 C.F.R. § 403, 405, 410, 411, 414, 415, 423, and 425).

Wash. Admin. Code § 246-919-668

Washington Medical Commission. Policy Statement. Telemedicine. November 2021.

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[10] State Medical Board or organizational affiliations are presented for purposes of identification and do not imply endorsement of any draft or final version of this report.

THE STATE of ALASKA
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Department of Commerce, Community, and Economic Development

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2025 Legislative Guidance for CBPL Board & Commission Members

The primary guidance for board and commission members during legislative session is in the CBPL Guide to Excellence in Regulation – Section IX: Legislation and Legislative Audit (pages 63-70), available on the CBPL Board Resources webpage: www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/BoardMemberResources.

Section IX of the guide includes information on the following:

- Initiating legislation
- The Open Meetings Act (it always applies)
- Legislative session
- The need to be informed about legislation (and how to do that)
- Guidelines for board member testimony
- Legislative testimony call-in dos and don'ts
- Legislative audit

It's important to remember that division staff cannot represent a board or it's positions in meetings with legislators or in legislative hearings, except by pointing to a letter of support or opposition if the board has submitted one for a specific bill. Otherwise, the division only speaks to the Administration's position on legislative items. This means it's essential for board and commission members to carefully review Section IX of the CBPL Guide to Excellence in Regulation to be aware of how the process works and what their responsibilities include.

If a board or commission member has questions on how the legislative process works, please refer to the helpful information linked below. Boards and commissions are encouraged to schedule a walkthrough or training with the DCCED Boards and Regulations Advisor on the process as soon as they begin contemplating seeking legislation; and are always welcome to ask the Advisor or division management to attend a meeting where they are discussing potential statute change to seek sponsorship of. Division management and the department's Boards and Regulations Advisor are also happy to answer any specific questions from board and commission members, but please be aware that we tend to be very busy during legislative session so, at times, it may take a couple days to receive a response or call back.

HELPFUL INFORMATION

Additional resources on BASIS that will be helpful in understanding how to navigate BASIS, understand what you're seeing, and become more familiar with the legislative process:

- Tips for Using Basis: https://akleg.gov/docs/pdf/basis.pdf
- Frequently Asked Questions: https://akleg.gov/faq.php
- Legislative Abbreviations & Acronyms: https://akleg.gov/docs/pdf/abbracro.pdf
- Glossary of Legislative Terms: https://akleg.gov/docs/pdf/glossary.pdf

- Current Senators: https://akleg.gov/senate.php
- Current Representatives: https://akleg.gov/house.php
- Current Committees: https://www.akleg.gov/basis/Committee/List/34
- Steps in Passage of a Bill: https://akleg.gov/docs/pdf/passbill.pdf
- Legislative Process: https://akleg.gov/docs/pdf/legprocess.pdf
- How to Read a Bill History: https://akleg.gov/docs/pdf/readbill.pdf
- Layman's Guide to the Budget Process: https://akleg.gov/docs/pdf/budgproc.pdf

How to Watch or Listen in on a Bill Hearing:

- If the bill is currently being heard in a committee:
  - Identify what committee it's being heard in.
  - Go to akleg.gov, select the "Live Now" tab, and select the appropriate committee; **OR**
  - Go to Gavel Alaska (ktoo.org/gavel) and select the appropriate committee.
- If the bill was already heard and the hearing has since concluded:
  - Go to akleg.gov and search for the bill. Once on the bill's page, go to the "Meetings" tab and click on the link for the hearing you want; **OR**
  - Go to Gavel Alaska and look for the hearing in the "Archives".

DEPARTMENT CONTACTS:

- DCCED Boards and Regulations Advisor – Sara Chambers: sara.chambers@alaska.gov, W: (907) 465-2144
- CBPL Director – Sylvan Robb: sylvan.robb@alaska.gov, W: (907) 465-2524, C: (907) 419-7678
- CBPL Deputy Director – Glenn Saviers: glenn.saviers@alaska.gov, W: (907) 465-2691, C: (907) 321-1423

Division management is often in meetings or hearings throughout the day during legislative session, so email may sometimes be the quickest way to get a response. If you opt to call, make sure to leave a voicemail and consider following up with an email. Please do understand that while management will get back to you as quickly as possible, they may not always be able to get back to you the same day.

Additionally, even when you opt to reach out to one of the contacts above, please be sure to also loop in your board staff before or latest, immediately after, the conversation so they can remain in the loop.

Background:

This statute applies to all board members representing the various professional licensing boards within the Department of Commerce & Economic Development. Board members are busy volunteers who need to be able to perform their duties as efficiently as possible. This antiquated language in statute requires board members to receive/respond to summary suspension requests only by telephone (or fax). Board members, especially members of the Medical Board, would appreciate greater flexibility in the modes of communication (such as email) they are authorized to use with investigators on urgent matters. The elimination of the words "by telephone or facsimile" will allow greater flexibility and efficiency.

Sec. 08.01.087. Investigative and enforcement powers of department.

(a) The department may, upon its own motion, conduct investigations to

(1) determine whether a person has violated a provision of this chapter or a regulation adopted under it, or a provision of AS 43.70, or a provision of this title or regulation adopted under this title dealing with an occupation or board listed in AS 08.01.010; or

(2) secure information useful in the administration of this chapter.

(b) If it appears to the commissioner that a person has engaged in or is about to engage in an act or practice in violation of a provision of this chapter or a regulation adopted under it, or a provision of AS 43.70, or a provision of this title or regulation adopted under this title dealing with an occupation or board listed in AS 08.01.010, the commissioner may, if the commissioner considers it in the public interest, and after notification of a proposed order or action ~~by telephone or facsimile~~ to all board members, if a board regulates the act or practice involved, unless a majority of the members of the board object within 10 days,

SENATE BILL NO. 89

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH LEGISLATURE - FIRST SESSION

BY SENATORS TOBIN, Gray-Jackson, Giessel

Introduced: 2/7/25
Referred: Health and Social Services. Labor and Commerce

A BILL

FOR AN ACT ENTITLED

"An Act relating to physician assistants; relating to collaborative agreements between physicians and physician assistants; relating to the practice of medicine; relating to health care providers; and relating to provisions regarding physician assistants in contracts between certain health care providers and health care insurers."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 08.64.010 is amended to read:

Sec. 08.64.010. Creation and membership of State Medical Board. The governor shall appoint a board of medical examiners, to be known as the State Medical Board, consisting of five physicians licensed in the state and residing in as many separate geographical areas of the state as possible, one physician assistant licensed **in the state** [UNDER AS 08.64.107], and two persons with no direct financial interest in the health care industry.

*** Sec. 2.** AS 08.64.107 is repealed and reenacted to read:

Sec. 08.64.107. Scope of practice of physician assistants; collaborative

agreements. (a) The board shall adopt regulations establishing

(1) acts within the practice of medicine, osteopathy, and podiatry that physician assistants may perform; the regulations must, at a minimum, allow physician assistants to perform acts that physician assistants are generally educated and trained to perform by accredited physician assistant programs described in AS 08.64.206(1); the regulations may not allow a physician assistant to perform surgery or operate on a human without assistance;

(2) requirements for a physician assistant to practice a new specialty; and

(3) methods of periodic assessment that a collaborating physician may use to evaluate a physician assistant.

(b) Except as provided in (d) of this section, a physician assistant with less than 4,000 hours of postgraduate clinical experience may practice only under a collaborative agreement maintained with the employer of the physician assistant. The collaborative agreement must

(1) be in writing;

(2) require a collaborating physician to oversee the performance, practice, and activities of the physician assistant;

(3) describe the methods of periodic assessment the collaborating physician will use to evaluate the physician assistant's competency, knowledge, and skills; and

(4) describe each specialty in which the physician assistant is obtaining clinical experience under the collaborative agreement.

(c) If a physician assistant is practicing in a remote area, a collaborating physician may oversee the physician assistant under (b)(2) of this section by providing the physician assistant with direct telephonic, electronic, or video access to the collaborating physician or another senior health care provider.

(d) A physician assistant shall notify the board if the physician assistant begins practicing in a new specialty. If the board determines that the new specialty requires the physician assistant to obtain additional hours of postgraduate clinical experience, the physician assistant may practice only under a collaborative agreement maintained

with the employer of the physician assistant until the hours of postgraduate clinical experience required under this subsection and (b) of this section are obtained.

(e) A physician assistant shall provide a copy of the collaborative agreement to the board. Upon obtaining the hours of postgraduate clinical experience required under (b) and (d) of this section, the physician assistant shall notify the board and attest to the number of hours of postgraduate clinical experience obtained by the physician assistant on a form provided by the board.

(f) The board may not require a physician assistant to obtain hours of postgraduate clinical experience in excess of the 4,000 hours required under (b) of this section and the additional hours required when practicing a new specialty under (d) of this section.

*** Sec. 3.** AS 08.64 is amended by adding a new section to read:

Sec. 08.64.206. Qualifications for physician assistant applicants. Each physician assistant applicant shall meet the qualifications prescribed in AS 08.64.200(a)(3) - (5) and shall submit

(1) a certificate of graduation obtained from a physician assistant program accredited, at the time of graduation, by

(A) the American Medical Association's Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs if the applicant graduated before January 1, 2001; or

(B) the Accreditation Review Commission on Education for the Physician Assistant if the applicant graduated on or after January 1, 2001;

(2) proof of current certification issued by the National Commission on Certification of Physician Assistants;

(3) proof of receiving a passing score on the physician assistant national certifying examination offered by the National Commission on Certification of Physician Assistants;

(4) proof of any hours of postgraduate clinical experience obtained by the applicant, including the specialties in which those hours were obtained.

*** Sec. 4.** AS 08.64.230 is amended by adding a new subsection to read:

(d) If a physician assistant applicant passes the examination and meets the requirements of AS 08.64.206 and 08.64.255, the board or its executive secretary shall grant a license to the applicant to practice the acts within the practice of medicine, osteopathy, and podiatry, as determined by the board under AS 08.64.107(a).

*** Sec. 5.** AS 08.64.250(a) is amended to read:

(a) The board may waive the examination requirement and license by credentials if the physician, osteopath, **physician assistant,** or podiatry applicant meets the requirements of AS 08.64.200, 08.64.205, **08.64.206,** or 08.64.209, submits proof of continued competence as required by regulation, pays the required fee, and has

(1) an active license from a board of medical examiners established under the laws of a state or territory of the United States or a province or territory of Canada issued after thorough examination; or

(2) passed an examination as specified by the board in regulations.

*** Sec. 6.** AS 08.64.270(a) is amended to read:

(a) The board, a member of the board, the executive secretary, or a person designated by the board to issue temporary permits may issue a temporary permit to **an** [A PHYSICIAN APPLICANT, OSTEOPATH APPLICANT, OR PODIATRY] applicant who meets the requirements of AS 08.64.200, 08.64.205, **08.64.206,** 08.64.209, or 08.64.225 and pays the required fee.

*** Sec. 7.** AS 08.64.275(a) is amended to read:

(a) A member of the board, its executive secretary, or a person designated by the board to issue temporary permits may grant a temporary permit to a physician**,** [OR] osteopath**, or physician assistant** for the purpose of

(1) substituting for another physician**,** [OR] osteopath**, or physician assistant** licensed in this state;

(2) being temporarily employed by a physician**,** [OR] osteopath**, or physician assistant** licensed in this state while that physician**,** [OR] osteopath**, or physician assistant** evaluates the permittee for permanent employment; or

(3) being temporarily employed by a hospital or community mental health center while the facility attempts to fill a vacant permanent physician**,** [OR]

osteopath**, or physician assistant** staff position with a physician**,** [OR] osteopath**, or physician assistant** licensed in this state.

*** Sec. 8.** AS 08.64.275 is amended by adding a new subsection to read:

(g) A physician assistant applying under (a) of this section shall pay the required fee and shall meet the requirements of AS 08.64.206 and 08.64.279. In addition, the physician assistant shall submit evidence of holding a license to practice in a state or territory of the United States or in a province or territory of Canada.

*** Sec. 9.** AS 08.64.312(c) is amended to read:

(c) The board or its designee may exempt a physician, osteopath, [OR] podiatrist**, or physician assistant** from the requirements of (b) of this section upon an application by the physician, osteopath, [OR] podiatrist**, or physician assistant** giving evidence satisfactory to the board or its designee that the physician, osteopath, [OR] podiatrist**, or physician assistant** is unable to comply with the requirements because of extenuating circumstances. However, a person may not be exempted from more than 15 hours of continuing education in a five-year period; a person may not be exempted from the requirement to receive at least two hours of education in pain management and opioid use and addiction unless the person has demonstrated to the satisfaction of the board that the person does not currently hold a valid federal Drug Enforcement Administration registration number.

*** Sec. 10.** AS 08.64.326(a) is amended to read:

(a) The board may impose a sanction if the board finds after a hearing that a licensee

(1) secured a license through deceit, fraud, or intentional misrepresentation;

(2) engaged in deceit, fraud, or intentional misrepresentation while providing professional services or engaging in professional activities;

(3) advertised professional services in a false or misleading manner;

(4) has been convicted, including conviction based on a guilty plea or plea of nolo contendere, of

(A) a class A or unclassified felony or a crime in another jurisdiction with elements similar to a class A or unclassified felony in this

jurisdiction;

(B) a class B or class C felony or a crime in another jurisdiction with elements similar to a class B or class C felony in this jurisdiction if the felony or other crime is substantially related to the qualifications, functions, or duties of the licensee; or

(C) a crime involving the unlawful procurement, sale, prescription, or dispensing of drugs;

(5) has procured, sold, prescribed, or dispensed drugs in violation of a law regardless of whether there has been a criminal action or harm to the patient;

(6) intentionally or negligently permitted the performance of patient care by persons under the licensee's supervision that does not conform to minimum professional standards even if the patient was not injured;

(7) failed to comply with this chapter, a regulation adopted under this chapter, or an order of the board;

(8) has demonstrated

(A) professional incompetence, gross negligence, or repeated negligent conduct; the board may not base a finding of professional incompetence solely on the basis that a licensee's practice is unconventional or experimental in the absence of demonstrable physical harm to a patient;

(B) addiction to, severe dependency on, or habitual overuse of alcohol or other drugs that impairs the licensee's ability to practice safely;

(C) unfitness because of physical or mental disability;

(9) engaged in unprofessional conduct, in sexual misconduct, or in lewd or immoral conduct in connection with the delivery of professional services to patients; in this paragraph, "sexual misconduct" includes sexual contact, as defined by the board in regulations adopted under this chapter, or attempted sexual contact with a patient outside the scope of generally accepted methods of examination or treatment of the patient, regardless of the patient's consent or lack of consent, during the term of the physician-patient relationship, as defined by the board in regulations adopted under this chapter, unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the physician-patient relationship, was in a dating, courtship,

or engagement relationship with the licensee;

(10) has violated AS 18.16.010;

(11) has violated any code of ethics adopted by regulation by the board;

(12) has denied care or treatment to a patient or person seeking assistance from the **licensee** [PHYSICIAN] if the only reason for the denial is the failure or refusal of the patient to agree to arbitrate as provided in AS 09.55.535(a);

(13) has had a license or certificate to practice medicine in another state or territory of the United States, or a province or territory of Canada, denied, suspended, revoked, surrendered while under investigation for an alleged violation, restricted, limited, conditioned, or placed on probation unless the denial, suspension, revocation, or other action was caused by the failure of the licensee to pay fees to that state, territory, or province; or

(14) prescribed or dispensed an opioid in excess of the maximum dosage authorized under AS 08.64.363.

*** Sec. 11.** AS 08.64.334 is amended to read:

Sec. 08.64.334. Voluntary surrender. The board, at its discretion, may accept the voluntary surrender of a license. A license may not be returned unless the board determines, under regulations adopted by it, that the licensee is competent to resume practice. However, a license may not be returned to the licensee if the voluntary surrender resulted in the dropping or suspension of civil or criminal charges against the physician **or physician assistant**.

*** Sec. 12.** AS 08.64.336(a) is amended to read:

(a) A physician **or physician assistant** who professionally treats a person licensed to practice medicine or osteopathy in this state for alcoholism or drug addiction, or for mental, emotional, or personality disorders, shall report [IT] to the board if there is probable cause that the person may constitute a danger to the health and welfare of that person's patients or the public if that person continues in practice. The report must state the name and address of the person and the condition found.

*** Sec. 13.** AS 08.64.336(e) is amended to read:

(e) A physician, **physician assistant,** hospital, hospital committee, or private

professional organization contracted with under AS 08.64.101(a)(5) to identify, confront, evaluate, and treat individuals licensed under this chapter who abuse addictive substances that in good faith submits a report under this section or participates in an investigation or judicial proceeding related to a report submitted under this section is immune from civil liability for the submission or participation.

*** Sec. 14.** AS 08.64.336(f) is amended to read:

(f) A physician**, physician assistant,** or hospital may not refuse to submit a report under this section or withhold from the board or its investigators evidence related to an investigation under this section on the grounds that the report or evidence

(1) concerns a matter that was disclosed in the course of a confidential physician-patient or psychotherapist-patient relationship or during a meeting of a hospital medical staff, governing body, or committee that was exempt from the public meeting requirements of AS 44.62.310; or

(2) is required to be kept confidential under AS 18.23.030.

*** Sec. 15.** AS 08.64.360 is amended to read:

Sec. 08.64.360. Penalty for practicing without a license or in violation of law. Except for [A PHYSICIAN ASSISTANT OR] a person licensed or authorized under another law of the state who engages in practices for which that person is licensed or authorized under that law, a person practicing medicine or osteopathy in the state without a valid license or permit is guilty of a class A misdemeanor. Each day of illegal practice is a separate offense.

*** Sec. 16.** AS 08.64.370 is amended to read:

Sec. 08.64.370. Exceptions to application of chapter. This chapter does not apply to

(1) officers in the regular medical service of the armed services of the United States or the United States Public Health Service while in the discharge of their official duties;

(2) a physician**,** [OR] osteopath**, or physician assistant** licensed in another state who is asked by a physician**,** [OR] osteopath**, or physician assistant** licensed in this state to help in the diagnosis or treatment of a case, unless the physician**, osteopath, or physician assistant** is practicing under AS 08.02.130(b);

(3) the practice of the religious tenets of a church;

(4) a physician **or physician assistant** in the regular medical service of the United States Public Health Service or the armed services of the United States volunteering services without pay or other remuneration to a hospital, clinic, medical office, or other medical facility in the state;

(5) a person who is certified as a direct-entry midwife by the department under AS 08.65 while engaged in the practice of midwifery whether or not the person accepts compensation for those services;

(6) a physician **or physician assistant** licensed in another state who, under a written agreement with an athletic team located in the state in which the physician **or physician assistant** is licensed, provides medical services to members of the athletic team while the athletic team is traveling to or from or participating in a sporting event in this state.

*** Sec. 17.** AS 08.64.380(6) is amended to read:

(6) "practice of medicine" or "practice of osteopathy" means [:]

(A) for a fee, donation, or other consideration, to diagnose, treat, operate on, prescribe for, or administer to [,] any human ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition; or to attempt to perform or represent that a person is authorized to perform any of the acts set out in this subparagraph;

(B) to use or publicly display a title in connection with a person's name, including "doctor of medicine," "physician," "M.D.," [OR] "doctor of osteopathic medicine," [OR] "D.O.," **"physician assistant," or "P.A."** or a specialist designation including "surgeon," "dermatologist," or a similar title in such a manner as to show that the person is willing or qualified to diagnose or treat the sick or injured;

*** Sec. 18.** AS 08.64.380(7) is amended to read:

(7) "practice of podiatry" means the medical, mechanical, and surgical treatment of ailments of the foot, the muscles and tendons of the leg governing the functions of the foot, and superficial lesions of the hand other than those associated with trauma; the use of preparations, medicines, and drugs as are necessary for the

treatment of these ailments; the treatment of the local manifestations of systemic diseases as they appear in the hand and foot, except that

(A) a patient shall be concurrently referred to a physician**,** [OR] osteopath**, or physician assistant** for the treatment of the systemic disease itself;

(B) general anaesthetics may be used only in colleges of podiatry approved by the board and in hospitals approved by the joint commission on the accreditation of hospitals, or the American Osteopathic Association; and

(C) the use of X-ray or radium for therapeutic purposes is not permitted.

*** Sec. 19.** AS 11.71.900(20) is amended to read:

(20) "practitioner" means

(A) a physician, **physician assistant,** dentist, advanced practice registered nurse, optometrist, veterinarian, scientific investigator, or other person licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or to administer or use in teaching or chemical analysis a controlled substance in the course of professional practice or research in the state;

(B) a pharmacy, hospital, or other institution licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or to administer a controlled substance in the course of professional practice or research in the state;

*** Sec. 20.** AS 13.52.390(31) is amended to read:

(31) "physician assistant" means an individual licensed **as a physician assistant** under **AS 08.64** [AS 08.64.107].

*** Sec. 21.** AS 18.08.089(a) is amended to read:

(a) A mobile intensive care paramedic licensed under this chapter, a physician assistant registered or licensed under **AS 08.64** [AS 08.64.107], or an emergency medical technician certified under this chapter may make a determination and pronouncement of death of a person under the following circumstances:

(1) the mobile intensive care paramedic or emergency medical technician is an active member of an emergency medical service certified under this chapter;

(2) neither a physician licensed under AS 08.64 nor a physician exempt from licensure under AS 08.64 is immediately available for consultation by radio or telephone communications;

(3) the mobile intensive care paramedic, physician assistant, or emergency medical technician has determined, based on acceptable medical standards, that the person has sustained irreversible cessation of circulatory and respiratory functions.

*** Sec. 22.** AS 21.07.010(b) is amended to read:

(b) A contract between a participating health care provider and a health care insurer that offers a health care insurance policy may not contain a provision that

(1) has as its predominant purpose the creation of direct financial incentives to the health care provider for withholding covered medical care services that are medically necessary; nothing in this paragraph shall be construed to prohibit a contract between a participating health care provider and a health care insurer from containing incentives for efficient management of the utilization and cost of covered medical care services;

(2) requires the provider to contract for all products that are currently offered or that may be offered in the future by the health care insurer; [OR]

(3) requires the health care provider to be compensated for medical care services performed at the same rate as the health care provider has contracted with another health care insurer**; or**

(4) imposes a practice, education, or collaboration requirement on physician assistants that is inconsistent with or more restrictive than the requirements imposed under AS 08.64 or a regulation adopted by the State Medical Board.

*** Sec. 23.** AS 23.30.395(3) is amended to read:

(3) "attending physician" means one of the following designated by the employee under AS 23.30.095(a) or (b):

(A) a licensed medical doctor;

(B) a licensed doctor of osteopathy;

(C) a licensed dentist or dental surgeon;

(D) a licensed physician assistant [ACTING UNDER SUPERVISION OF A LICENSED MEDICAL DOCTOR OR DOCTOR OF OSTEOPATHY];

(E) a licensed advanced practice registered nurse; or

(F) a licensed chiropractor;

*** Sec. 24.** AS 33.30.901(10) is amended to read:

(10) "health care provider" means

(A) a physician assistant licensed to practice in the state [AND WORKING UNDER THE DIRECT SUPERVISION OF A LICENSED PHYSICIAN OR PSYCHIATRIST];

(B) a mental health professional as defined in AS 47.30.915; or

(C) an advanced practice registered nurse as defined in AS 08.68.850;

*** Sec. 25.** AS 08.64.170(a)(1) is repealed.

HOUSE BILL NO. 95

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE ALLARD

Introduced: 2/12/25
Referred: Health and Social Services, Labor and Commerce

A BILL

FOR AN ACT ENTITLED

"An Act relating to midwives and the practice of midwifery; relating to apprentice midwives; renaming the Board of Certified Direct-Entry Midwives as the Board of Licensed Midwives; relating to the Board of Licensed Midwives; extending the termination date of the Board of Certified Direct-Entry Midwives; relating to insurance; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE INTENT. It is the intent of the legislature to preserve the right of women to deliver children at home with licensed midwives, to remove obstacles for safe deliveries outside of hospitals, to ensure quality care of pregnant women and the children they deliver, and to guarantee that the practice of midwifery by a licensed midwife is covered by insurance regardless of the location where the care is received.

*** Sec. 2.** AS 08.01.010(17) is amended to read:

(17) Board of **Licensed** [CERTIFIED DIRECT-ENTRY] Midwives (AS 08.65.010);

*** Sec. 3.** AS 08.02.110(a), as amended by sec. 1, ch. 44, SLA 2024, is amended to read:

(a) An acupuncturist licensed under AS 08.06, an audiologist or speech-language pathologist licensed under AS 08.11, a behavior analyst licensed under AS 08.15, a person licensed in the state as a chiropractor under AS 08.20, a professional or associate counselor licensed under AS 08.29, a dentist under AS 08.36, a dietitian or nutritionist licensed under AS 08.38, a massage therapist licensed under AS 08.61, a marital and family therapist licensed under AS 08.63, a medical practitioner or osteopath under AS 08.64, a **licensed** [DIRECT-ENTRY] midwife [CERTIFIED] under AS 08.65, a registered or advanced practice registered nurse under AS 08.68, an optometrist under AS 08.72, a licensed pharmacist under AS 08.80, a physical therapist or occupational therapist licensed under AS 08.84, a psychologist under AS 08.86, or a clinical social worker licensed under AS 08.95, shall use as professional identification appropriate letters or a title after that person's name that represents the person's specific field of practice. The letters or title shall appear on all signs, stationery, or other advertising in which the person offers or displays personal professional services to the public. In addition, a person engaged in the practice of medicine or osteopathy as defined in AS 08.64.380, or a person engaged in any manner in the healing arts who diagnoses, treats, tests, or counsels other persons in relation to human health or disease and uses the letters "M.D." or the title "doctor" or "physician" or another title that tends to show that the person is willing or qualified to diagnose, treat, test, or counsel another person, shall clarify the letters or title by adding the appropriate specialist designation, if any, such as "dermatologist," "radiologist," "audiologist," "naturopath," or the like.

*** Sec. 4.** AS 08.02.130(j)(1), as amended by sec. 2, ch. 44, SLA 2024, is amended to read:

(1) "health care provider" means

(A) an audiologist or speech-language pathologist licensed under AS 08.11; a behavior analyst licensed under AS 08.15; a chiropractor licensed under AS 08.20; a professional or associate counselor licensed under

AS 08.29; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a dietitian or nutritionist licensed under AS 08.38; a naturopath licensed under AS 08.45; a marital and family therapist licensed under AS 08.63; a physician licensed under AS 08.64; a podiatrist, osteopath, or physician assistant licensed under AS 08.64; a **licensed** [DIRECT-ENTRY] midwife [CERTIFIED] under AS 08.65; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist or occupational therapist licensed under AS 08.84; a psychologist or psychological associate licensed under AS 08.86; or a social worker licensed under AS 08.95;

(B) a physician licensed in another state; or

(C) a member of a multidisciplinary care team who is licensed in another state;

*** Sec. 5.** AS 08.03.010(c)(8) is amended to read:

(8) Board of Certified Direct-Entry Midwives (AS 08.65.010) - June 30, **2031** [2025];

*** Sec. 6.** AS 08.03.010(c)(8), as amended by sec. 5 of this Act, is amended to read:

(8) Board of **Licensed** [CERTIFIED DIRECT-ENTRY] Midwives (AS 08.65.010) - June 30, 2031;

*** Sec. 7.** AS 08.64.370 is amended to read:

Sec. 08.64.370. Exceptions to application of chapter. This chapter does not apply to

(1) officers in the regular medical service of the armed services of the United States or the United States Public Health Service while in the discharge of their official duties;

(2) a physician or osteopath licensed in another state who is asked by a physician or osteopath licensed in this state to help in the diagnosis or treatment of a case, unless the physician is practicing under AS 08.02.130(b);

(3) the practice of the religious tenets of a church;

(4) a physician in the regular medical service of the United States

Public Health Service or the armed services of the United States volunteering services without pay or other remuneration to a hospital, clinic, medical office, or other medical facility in the state;

(5) a person who is **a licensed** [CERTIFIED AS A DIRECT-ENTRY] midwife [BY THE DEPARTMENT] under AS 08.65 while engaged in the practice of midwifery whether or not the person accepts compensation for those services;

(6) a physician licensed in another state who, under a written agreement with an athletic team located in the state in which the physician is licensed, provides medical services to members of the athletic team while the athletic team is traveling to or from or participating in a sporting event in this state.

*** Sec. 8.** AS 08.65.010(a) is amended to read:

(a) There is established the Board of **Licensed** [CERTIFIED DIRECT-ENTRY] Midwives.

*** Sec. 9.** AS 08.65.010(b) is amended to read:

(b) The board consists of five members appointed by the governor subject to confirmation by the legislature in joint session. Members serve for staggered terms of four years**,** and, except as provided in AS 39.05.080(4), each member serves until a successor is appointed and qualified. The board consists of

(1) three [TWO] members who are **licensed** [CERTIFIED IN THIS STATE AS DIRECT-ENTRY] midwives**;**

(2) [,] one **member who is either a**

(A) physician licensed by the State Medical Board in this state who has an obstetrical practice or has specialized training in obstetrics**; or**

(B) [, ONE] certified nurse midwife licensed by the Board of Nursing in this state**;** [,] and

(3) one public member.

*** Sec. 10.** AS 08.65.030 is amended to read:

Sec. 08.65.030. Duties and powers of board. (a) The board shall

(1) **review applications for a license to engage in the practice of midwifery to determine whether the applicant satisfies the requirements of AS 08.65.050** [EXAMINE APPLICANTS AND ISSUE CERTIFICATES TO THOSE

APPLICANTS IT FINDS QUALIFIED];

(2) [ADOPT REGULATIONS ESTABLISHING CERTIFICATION AND CERTIFICATE RENEWAL REQUIREMENTS;

(3)] issue permits to apprentice [DIRECT-ENTRY] midwives;

(3) [(4)] hold hearings and order the disciplinary sanction of a person who violates this chapter or a regulation of the board;

(4) [(5)] supply forms for applications, licenses, permits, [CERTIFICATES,] and other papers and records;

(5) [(6)] enforce the provisions of this chapter and adopt regulations necessary to make the provisions of this chapter effective;

(6) [(7) APPROVE CURRICULA AND ADOPT STANDARDS FOR BASIC EDUCATION, TRAINING, AND APPRENTICE PROGRAMS;

(8) PROVIDE FOR SURVEYS OF THE BASIC DIRECT-ENTRY MIDWIFE EDUCATION PROGRAMS IN THE STATE AT THE TIMES IT CONSIDERS NECESSARY;

(9) APPROVE EDUCATION, TRAINING, AND APPRENTICE PROGRAMS THAT MEET THE REQUIREMENTS OF THIS CHAPTER AND OF THE BOARD, AND DENY, REVOKE, OR SUSPEND APPROVAL OF THOSE PROGRAMS FOR FAILURE TO MEET THE REQUIREMENTS;

(10)] adopt regulations establishing

(A) licensing requirements that are in accordance with national licensing standards;

(B) license renewal requirements; and

(C) practice requirements for **licensed** [CERTIFIED DIRECT-ENTRY] midwives under **AS 08.65.140(a)** [AS 08.65.140].

(b) The board may

(1) adopt regulations requiring [BY REGULATION REQUIRE THAT] a **licensed** [CERTIFIED DIRECT-ENTRY] midwife **to** undergo a uniform or random period of peer review to ensure the quality of care provided by the **licensed** [CERTIFIED DIRECT-ENTRY] midwife**;**

(2) approve curricula and adopt standards for basic education,

training, and apprentice programs; and

(3) approve education, training, and apprentice programs that meet the requirements of this chapter and of the board, and deny, revoke, or suspend approval of those programs for failure to meet the requirements.

*** Sec. 11.** AS 08.65.030 is amended by adding a new subsection to read:

(c) The board may not adopt a regulation that

(1) requires a person to have a nursing degree to be licensed under this chapter;

(2) requires a licensed midwife to practice midwifery under the supervision of, or in collaboration with, another health care provider or a health care facility;

(3) requires a licensed midwife to enter into an agreement, whether written, oral, or in another form, with another health care provider or a health care facility; or

(4) limits the location where a licensed midwife may practice midwifery.

*** Sec. 12.** AS 08.65.050 is amended to read:

Sec. 08.65.050. Qualifications for license. The board shall issue a **license** [CERTIFICATE] to practice [DIRECT-ENTRY] midwifery to a person who

(1) **holds a valid certified professional midwife certificate issued by a nationally recognized midwife organization that is recognized by the board;**

(2) applies on a form provided by the board;

(3) [(2)] pays the fees required under AS 08.65.100;

(4) [(3)] furnishes evidence satisfactory to the board that the person has not engaged in conduct that is a ground for imposing disciplinary sanctions under AS 08.65.110;

(5) [(4)] furnishes evidence [SATISFACTORY] to the board that the person has completed a course of **midwifery** study and supervised clinical experience; the study and experience must be of at least **two years'** [ONE YEAR'S] duration; **and**

(6) [(5)] successfully completes the **national midwifery** examination required by the board.

*** Sec. 13.** AS 08.65.080 is amended to read:

Sec. 08.65.080. Renewal. A **license** [CERTIFICATE] issued under AS 08.65.050 [OR 08.65.070] expires on a date determined by the board and may be renewed every two years upon payment of the required fee and the submission of evidence satisfactory to the board that the **licensed** [CERTIFIED DIRECT-ENTRY] midwife **holds a valid certified professional midwife certificate issued by a nationally recognized midwife organization that is recognized by the board,** has met the continuing education requirements of the board, has demonstrated continued practical professional competence under regulations adopted by the board, and has not committed an act that is a ground for discipline under AS 08.65.110.

*** Sec. 14.** AS 08.65.080 is amended by adding a new subsection to read:

(b) A person who was issued a license to practice midwifery by the board because the person held a valid certificate to practice direct-entry midwifery under AS 08.65.050 or former AS 08.65.070 on the day before the effective date of this section may renew that license in accordance with (a) of this section as (a) of this section read on the day before the effective date of sec. 13 of this Act, but is otherwise subject to this chapter.

*** Sec. 15.** AS 08.65.090 is amended to read:

Sec. 08.65.090. Apprentice [DIRECT-ENTRY] midwives. (a) The board shall issue a permit to practice as an apprentice [DIRECT-ENTRY] midwife to a person who satisfies the requirements of **AS 08.65.050(2) - (4)** [AS 08.65.050(1) - (3)] and who has been accepted into a program of education, training, and apprenticeship approved by the board under AS 08.65.030 **and that prepares the apprentice for the national midwifery examination**. A permit application under this section must include information the board may require. The permit is valid for a term of two years and may be renewed in accordance with regulations adopted by the board.

(b) An apprentice [DIRECT-ENTRY] midwife may perform all the activities of a **licensed** [CERTIFIED DIRECT-ENTRY] midwife if supervised in a manner prescribed by the board **in regulation** [BY

(1) A CERTIFIED DIRECT-ENTRY MIDWIFE WHO HAS BEEN LICENSED AND PRACTICING IN THIS STATE FOR AT LEAST TWO YEARS

AND HAS ACTED AS A PRIMARY OR ASSISTANT MIDWIFE AT 50 OR MORE BIRTHS SINCE THE DATE THE CERTIFIED DIRECT-ENTRY MIDWIFE WAS FIRST LICENSED;

(2) A CERTIFIED DIRECT-ENTRY MIDWIFE WHO HAS BEEN LICENSED FOR AT LEAST TWO YEARS IN A STATE WITH LICENSING REQUIREMENTS AT LEAST EQUIVALENT IN SCOPE, QUALITY, AND DIFFICULTY TO THOSE OF THIS STATE AT THE TIME OF LICENSING, HAS PRACTICED MIDWIFERY FOR THE LAST TWO YEARS, AND HAS ACTED AS A PRIMARY OR ASSISTANT MIDWIFE AT 50 OR MORE BIRTHS SINCE THE DATE THE CERTIFIED DIRECT-ENTRY MIDWIFE WAS FIRST LICENSED;

(3) A PHYSICIAN LICENSED IN THIS STATE WITH AN OBSTETRICAL PRACTICE AT THE TIME OF UNDERTAKING THE APPRENTICESHIP; OR

(4) A CERTIFIED NURSE MIDWIFE LICENSED BY THE BOARD OF NURSING IN THIS STATE WITH AN OBSTETRICAL PRACTICE AT THE TIME OF UNDERTAKING THE APPRENTICESHIP].

*** Sec. 16.** AS 08.65.110 is amended to read:

Sec. 08.65.110. Grounds for discipline, suspension, or revocation of <u>license</u> [CERTIFICATION]. The board may impose a disciplinary sanction on a person holding a **<u>license</u>** [CERTIFICATE] or permit under this chapter if the board finds that the person

(1) secured a **<u>license</u>** [CERTIFICATE] or permit through deceit, fraud, or intentional misrepresentation;

(2) engaged in deceit, fraud, or intentional misrepresentation in the course of providing professional services or engaging in professional activities;

(3) advertised professional services in a false or misleading manner;

(4) has been convicted of a felony or other crime that affects the licensee's ability to continue to practice competently and safely;

(5) intentionally or negligently engaged in or permitted the performance of client care by persons under the **<u>licensed</u>** [CERTIFIED DIRECT-

ENTRY] midwife's supervision that does not conform to minimum professional standards regardless of whether actual injury to the client occurred;

(6) failed to comply with this chapter, with a regulation adopted under this chapter, or with an order of the board;

(7) continued to practice after becoming unfit due to

(A) professional incompetence;

(B) failure to keep informed of current professional practices;

(C) addiction or severe dependency on alcohol or other drugs that impairs the ability to practice safely; **or**

(D) physical or mental disability; **or**

(8) engaged in lewd or immoral conduct in connection with the delivery of professional service to clients.

*** Sec. 17.** AS 08.65.120(a) is amended to read:

(a) When **the board** [IT] finds that a person holding a **license** [CERTIFICATE] or permit **under this chapter** is guilty of an offense under AS 08.65.110, the board, in addition to the powers provided in AS 08.01.075, may impose the following sanctions singly or in combination:

(1) permanently revoke **the license** [A CERTIFICATE] or permit [TO PRACTICE];

(2) suspend **the license** [A CERTIFICATE] or permit for a determinate period of time;

(3) censure **the** [A] person [HOLDING A CERTIFICATE OR PERMIT];

(4) issue a letter of reprimand;

(5) place **the** [A] person [HOLDING A CERTIFICATE OR PERMIT] on probationary status and require the person to

(A) report regularly to the board **on** [UPON] matters involving the basis of probation;

(B) limit practice to those areas prescribed;

(C) continue professional education until a satisfactory degree of skill has been attained in those areas determined by the board to need

improvement;

(6) impose limitations or conditions on the practice of **the** [A] person holding **the license** [A CERTIFICATE] or permit.

*** Sec. 18.** AS 08.65.120(d) is amended to read:

(d) The board may reinstate a **license** [CERTIFICATE] or permit that has been suspended or revoked if the board finds after a hearing that the applicant **for the reinstatement** is able to practice with reasonable skill and safety.

*** Sec. 19.** AS 08.65.140 is amended to read:

Sec. 08.65.140. Required practices. The board shall adopt regulations regarding the practice of [DIRECT-ENTRY] midwifery. At a minimum, the regulations must require that a **licensed** [CERTIFIED DIRECT-ENTRY] midwife

(1) [RECOMMEND, BEFORE CARE OR DELIVERY OF A CLIENT, THAT THE CLIENT UNDERGO A PHYSICAL EXAMINATION PERFORMED BY A PHYSICIAN, PHYSICIAN ASSISTANT, OR ADVANCED PRACTICE REGISTERED NURSE WHO IS LICENSED IN THIS STATE;

(2)] obtain informed consent from a client before onset of labor;

(2) [(3)] comply with AS 18.15.150 regarding taking of blood samples, AS 18.15.200 regarding screening of phenylketonuria (PKU), AS 18.50.160 regarding birth registration, AS 18.50.230 regarding registration of deaths, AS 18.50.240 regarding fetal death registration, and regulations adopted by the Department of Health concerning prophylactic treatment of the eyes of newborn infants [;

(4) NOT KNOWINGLY DELIVER A WOMAN WITH CERTAIN TYPES OF HEALTH CONDITIONS, PRIOR HISTORY, OR COMPLICATIONS AS SPECIFIED BY THE BOARD].

*** Sec. 20.** AS 08.65.140 is amended by adding a new subsection to read:

(b) A licensed midwife may practice midwifery without

(1) being under the supervision of, or collaborating with, another health care provider or a health care facility; or

(2) entering into a written or other form of agreement with another health care provider or a health care facility.

*** Sec. 21.** AS 08.65.150 is amended to read:

Sec. 08.65.150. Prohibited practices. Except as provided in AS 08.65.170, a person who is not **licensed** [CERTIFIED] under this chapter as a **licensed** [DIRECT-ENTRY] midwife may not practice midwifery for compensation.

*** Sec. 22.** AS 08.65.160 is amended to read:

Sec. 08.65.160. License [CERTIFICATION] required if designation used. A person who is not **licensed** [CERTIFIED] under this chapter**,** [OR] whose **license** [CERTIFICATION] is suspended or revoked, or whose **license** [CERTIFICATION] has lapsed [,] who knowingly uses in connection with the person's name the [WORDS OR] letters **"L.M.," the words "Licensed Midwife,"** ["C.D.M.," "CERTIFIED DIRECT-ENTRY MIDWIFE,"] or other letters, words, or insignia indicating or implying that the person is **licensed** [CERTIFIED] as a **licensed** [DIRECT-ENTRY] midwife by this state or who in any way, orally or in writing, directly or by implication, knowingly holds out as being **licensed** [CERTIFIED BY THE STATE] as a **licensed** [DIRECT-ENTRY] midwife in this state is guilty of a class B misdemeanor. **In this section, "knowingly" has the meaning given in AS 11.81.900.**

*** Sec. 23.** AS 08.65.170 is amended to read:

Sec. 08.65.170. Exclusions. This chapter does not apply to a person **who is licensed as**

(1) [WHO IS LICENSED AS] a physician in this state;

(2) **an advanced practice registered** [WHO IS LICENSED AS A CERTIFIED] nurse [MIDWIFE] by the Board of Nursing in this state.

[(3) REPEALED

(4) REPEALED]

*** Sec. 24.** AS 08.65.180 is amended to read:

Sec. 08.65.180. Responsibility for care. If a **licensed** [CERTIFIED DIRECT-ENTRY] midwife seeks to consult with or refer a patient to a licensed physician, the responsibility of the physician for the patient does not begin until the patient is physically within the physician's care.

*** Sec. 25.** AS 08.65.190(1) is amended to read:

(1) "board" means the Board of **Licensed** [CERTIFIED DIRECT-ENTRY] Midwives;

*** Sec. 26.** AS 08.65.190(3) is amended to read:

(3) "practice of midwifery" means providing necessary supervision, health care, preventative measures, and education to women during pregnancy, labor, and the **first** postpartum **year** [PERIOD]; **providing preconception care;** conducting deliveries on the midwife's own responsibility; providing immediate postpartum care of the newborn infant, well-baby care for the infant through the age of **six** [FOUR] weeks, and preventative measures for the infant; identifying physical, social, and emotional needs of the newborn and the woman; arranging for consultation, referral, and continued involvement of the midwife on a collaborative basis when the care required extends beyond the scope of practice of the midwife; providing direct supervision of student and apprentice midwives; and executing emergency measures in the absence of medical assistance, as specified in regulations adopted by the board.

*** Sec. 27.** AS 08.65.190 is amended by adding new paragraphs to read:

(4) "health care facility" has the meaning given in AS 18.35.399;

(5) "health care provider" has the meaning given in AS 09.65.300(c);

(6) "licensed midwife" means a midwife who is licensed under this chapter to practice midwifery;

(7) "midwife" means a person who practices midwifery;

(8) "preconception care" means health care that identifies and treats a person's biomedical, behavioral, and social risk factors to maximize the person's conception health and pregnancy outcomes during the person's reproductive years.

*** Sec. 28.** AS 09.65.300(c)(1), as amended by sec. 15, ch. 44, SLA 2024, is amended to read:

(1) "health care provider" means a physician, physician assistant, dentist, dental hygienist, osteopath, optometrist, chiropractor, registered nurse, practical nurse, advanced practice registered nurse, naturopath, physical therapist, occupational therapist, marital and family therapist, psychologist, psychological associate, behavior analyst, assistant behavior analyst, licensed clinical social worker, athletic trainer, **licensed** [CERTIFIED DIRECT-ENTRY] midwife, licensed professional counselor, or licensed associate counselor;

*** Sec. 29.** AS 11.41.470(1) is amended to read:

(1) "health care worker" includes a person who is or purports to be an acupuncturist, advanced practice registered nurse, anesthesiologist, **licensed** [CERTIFIED DIRECT-ENTRY] midwife, chiropractor, dentist, health aide, hypnotist, massage therapist, mental health counselor, [MIDWIFE,] nurse, occupational therapist, occupational therapy assistant, osteopath, naturopath, physical therapist, physical therapist assistant, physician, physician assistant, psychiatrist, psychological associate, psychologist, radiologist, religious healing practitioner, surgeon, x-ray technician, or a substantially similar position;

*** Sec. 30.** AS 18.20.095(e)(2) is amended to read:

(2) "licensed staff member" means a person who is employed by the hospital to provide direct patient care and who is licensed or certified in the state as a physician or physician assistant under AS 08.64, **licensed** [DIRECT-ENTRY] midwife under AS 08.65, nurse or nurse aide under AS 08.68, or physical therapist or occupational therapist under AS 08.84;

*** Sec. 31.** AS 18.50.165(b) is amended to read:

(b) The registrar shall distribute copies of the form prepared under (a) of this section to each hospital in the state, to each physician in the state whose practice includes attendance at births, to each certified nurse midwife and **licensed** [CERTIFIED DIRECT-ENTRY] midwife in the state, and to each other interested person in the state who requests copies of the form.

*** Sec. 32.** AS 21.36.090(d), as amended by sec. 21, ch. 44, SLA 2024, is amended to read:

(d) Except to the extent necessary to comply with AS 21.42.365 and AS 21.56, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group health insurance policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a health maintenance organization or a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, physician assistant, dentist, osteopath, optometrist, chiropractor, advanced practice registered nurse, pharmacist, naturopath, physical therapist, occupational therapist, marital and family therapist, psychologist, psychological associate, licensed clinical social worker, licensed professional

counselor, licensed associate counselor, **licensed** [CERTIFIED DIRECT-ENTRY] midwife, or dental hygienist holding an advanced practice permit.

*** Sec. 33.** AS 21.42.347(d) is amended by adding a new paragraph to read:

(3) "home birth" means the delivery of a child in the home setting.

*** Sec. 34.** AS 21.42.347 is amended by adding a new subsection to read:

(e) A health care insurer who provides coverage for the costs of childbirth shall provide coverage for the costs of home birth services, including prenatal care, delivery, and postpartum care of both mother and infant, provided by a licensed midwife who is acting within the scope of the practice of midwifery under AS 08.65.

*** Sec. 35.** AS 21.42.355 is amended by adding new subsections to read:

(c) If a health care insurance plan or an excepted benefits policy or contract provides indemnity for the cost of preconception care or services of a physician provided to women during pregnancy, childbirth, and the period after childbirth up to one year, indemnity in a reasonable amount shall also be provided for the cost of a midwife licensed under AS 08.65 who provides the same services. Indemnity may be provided under this subsection only if the licensed midwife is practicing as a licensed midwife within the scope of the license.

(d) If a health care insurance plan or an excepted benefits policy or contract provides for furnishing preconception care or those services required of a physician in the care of women during pregnancy, childbirth, and the period after childbirth up to one year, the contract shall also provide that a midwife licensed under AS 08.65 may furnish those same services instead of a physician. Services may be provided under this subsection only if the licensed midwife is practicing as a licensed midwife in accordance with the regulations adopted under AS 08.65.030(b)(2), and the services provided are within the scope of practice of the license.

(e) In this section, "preconception care" has the meaning given in AS 08.65.190.

*** Sec. 36.** AS 21.84.335(b)(15) is amended to read:

(15) **AS 21.42.355(a) and (b)** [AS 21.42.355];

*** Sec. 37.** AS 25.20.055(a) is amended to read:

(a) When a birth occurs to an unmarried woman in a hospital or en route to a

hospital to which the woman is later admitted, the hospital shall ensure that a staff member

(1) meets with the woman before release from the hospital;

(2) attempts to meet with the father of the unmarried woman's child, if possible;

(3) presents to the mother and, if possible, the father, a pamphlet or statement regarding the rights and responsibilities of a natural parent; the Department of Health shall prepare this pamphlet and distribute copies of it to each hospital in the state, to each physician in the state whose practice includes attendance at births, to each certified nurse midwife and **licensed** [CERTIFIED DIRECT-ENTRY] midwife in the state, and to other interested persons in the state who request copies;

(4) provides to the mother and, if possible, the father, all forms, statements, or agreements necessary to voluntarily establish a parent and child relationship, including an acknowledgment of paternity form prepared under AS 18.50.165;

(5) on request of the mother and father, assists the father in completing specific forms, statements, or agreements necessary to establish a parent and child relationship between the father and the child; and

(6) on request of the mother and father, mails a completed voluntary acknowledgment of paternity form to the state registrar for filing under AS 18.50.165.

*** Sec. 38.** AS 25.20.055(b) is amended to read:

(b) When a birth occurs to an unmarried woman who is not in a hospital for the birth nor admitted to a hospital immediately after the birth, and the birth is attended by a physician, certified nurse midwife, or **licensed** [CERTIFIED DIRECT-ENTRY] midwife, the physician, certified nurse midwife, or **licensed** [CERTIFIED DIRECT-ENTRY] midwife shall perform the duties described in (a)(2) - (6) of this section or ensure that an agent performs those duties.

*** Sec. 39.** AS 44.62.330(a)(36) is amended to read:

(36) Board of **Licensed** [CERTIFIED DIRECT-ENTRY] Midwives;

*** Sec. 40.** AS 47.07.900(13) is amended to read:

(13) "midwife services" means services within the practice of

midwifery, as defined in AS 08.65.190, that are performed by a **licensed** [CERTIFIED DIRECT-ENTRY] midwife, and miscellaneous fees, other than facility fees, for birth kits, oxygen, and other ancillary expenses necessary for a birth attended by a **licensed** [CERTIFIED DIRECT-ENTRY] midwife;

*** Sec. 41.** AS 47.20.320(d) is amended to read:

(d) A hospital or other health facility, clinical laboratory, audiologist, physician, registered or advanced practice registered nurse, **licensed** [CERTIFIED DIRECT-ENTRY] midwife, officer or employee of a health facility or clinical laboratory, or an employee of an audiologist, physician, or registered or advanced practice registered nurse is not criminally or civilly liable for furnishing information in good faith to the department or its designee under this section. The furnishing of information in accordance with this section is not a violation of AS 08 or AS 18 or regulations adopted under AS 08 or AS 18 for licensees under those statutes.

*** Sec. 42.** AS 08.65.060 and 08.65.070 are repealed.

*** Sec. 43.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: CONTINUATION OF BOARD. Each member of the Board of Certified Direct-Entry Midwives, as that board is constituted under AS 08.65.010, as that section read on the day before the effective date of sec. 9 of this Act, shall serve on the Board of Licensed Midwives, established by AS 08.65.010, as amended by secs. 8 and 9 of this Act, for the remainder of the member's term under AS 08.65.010, as that section read on the day before the effective date of sec. 9 of this Act, and until the member's successor is appointed by the governor and confirmed by the legislature under AS 08.65.010(b), as amended by sec. 9 of this Act.

*** Sec. 44.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: CURRENT DIRECT-ENTRY MIDWIVES, MIDWIVES LICENSED BY CREDENTIALS, AND APPRENTICE MIDWIVES. (a) Notwithstanding AS 08.65.050, as amended by sec. 12 of this Act, the Board of Licensed Midwives shall issue a license to practice midwifery to a person who held a valid certificate to practice direct-entry midwifery issued under AS 08.65.050 on the day before the effective date of sec. 12 of this Act. The

license to practice midwifery expires on the expiration date of the certificate to practice direct-entry midwifery.

(b) Notwithstanding the repeal of AS 08.65.070 by sec. 42 of this Act, the Board of Licensed Midwives shall issue a license to practice midwifery to a person who held a valid certificate to practice direct-entry midwifery issued under AS 08.65.070 on the day before the effective date of sec. 42 of this Act. The license to practice midwifery expires on the expiration date of the certificate to practice direct-entry midwifery.

(c) Notwithstanding AS 08.65.090, as amended by sec. 15 of this Act, the Board of Licensed Midwives shall issue a permit to practice as an apprentice midwife to a person who held a valid permit to practice as an apprentice direct-entry midwife issued under AS 08.65.090 on the day before the effective date of sec. 15 of this Act.

*** Sec. 45.** The uncodified law of the State of Alaska is amended by adding a new section to read:

RETROACTIVITY. Section 5 of this Act is retroactive to June 30, 2025.

*** Sec. 46.** Section 45 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 47.** Section 5 of this Act takes effect June 30, 2025.

*** Sec. 48.** Except as provided in secs. 46 and 47 of this Act, this Act takes effect September 1, 2025.

From:	Norberg, Natalie M (CED)
To:	davebarnes@mtaonline.net; Sarah Hood; mheilala@gmail.com; Lydia Mielke; Dr Paulson; akbt64@gmail.com; Wilson, David (DOT sponsored)
Subject:	New Midwive Bill - HB95
Date:	Thursday, February 13, 2025 9:00:34 AM
Attachments:	image001.png image002.png image003.png HB0095A - Midwive Bill.pdf

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Dear Board Members,

A new bill was introduced yesterday which broadens the scope and authority of midwives. I am flagging this bill for the Board in case there is an interest from board members to issue a statement in support or opposition of this bill during the next board meeting. I have attached a copy of the bill and highlighted certain sections which may be of interest:

- Sec. 6, page 6: adds a new subsection that prohibits requiring midwives to practice under the supervision of or in collaboration with another health care provider or health care facility or limits the location of where they can practice
- Sec. 19, page 10: repeals (deletes the language pertaining to) and probits the requirement to:

  1) recommend before care or delivery of a client that the client undergo a physical exam by a physician, PA or ANP;

  2) the prohibition of midwives knowingly delivering a woman with certain types of health conditions, prior history or complications as specified by the board.
- Sec. 26, page 12: adds to the scope of midwifery the practice of "providing preconception care"
- Sec. 27. Page 12: defines "preconception care" as meaning care that identifies and treat s person's biomedical, behavioral and social risk factors to maximize the person's conception health and pregnancy outcomes during the person's reproductive years.

Please respond to me directly to let me know your thoughts regarding this bill and whether you would like it discussed at the next board meeting.

Thank you.

Natalie Norberg, LMSW
Executive Administrator, State Medical Board
Corporations, Business & Professional Licensing

natalie.norberg@alaska.gov
Office: 907-465-6243 | Fax: 907-465-2974
www.commerce.alaska.gov

Department of Commerce Community, and Economic Development
Corporations, Business and Professional Licensing

Summary of All Professional Licensing
Schedule of Revenues and Expenditures

Medical Board	FY 18	FY 19	Biennium	FY 20	FY 21	Biennium	FY 22	FY 23	Biennium	FY 24	FY 25 1st & 2nd QTR
Revenue											
Revenue from License Fees	$ 347,304	$ 2,380,618	$ 2,727,922	$ 578,308	$ 2,597,830	$ 3,176,138	$ 945,106	$ 2,876,309	$ 3,821,415	$ 852,030	$ 2,110,476
General Fund Received					$ -	-	$ 272,744	$ 173,090	445,834	$ 40,368	$ -
Allowable Third Party Reimbursements	3,517	184	3,701	$ -	$ -	-	$ -	$ -	-	$ 1,071	$ -
TOTAL REVENUE	$ 350,821	$ 2,380,802	$ 2,731,623	$ 578,308	$ 2,597,830	$ 3,176,138	$ 1,217,850	$ 3,049,399	$ 4,267,249	$ 893,469	$ 2,110,476
Expenditures											
Non Investigation Expenditures											
1000 - Personal Services	488,823	473,122	961,945	420,810	521,976	942,786	446,216	454,584	900,800	507,288	280,971
2000 - Travel	17,577	15,801	33,378	13,357	-	13,357	8,875	1,471	10,346	3,442	-
3000 - Services	44,741	31,730	76,471	23,009	46,044	69,053	69,997	97,210	167,207	93,406	7,079
4000 - Commodities	2,016	1,525	3,541	1,252	1,290	2,542	3,278	3,045	6,323	2,972	1,310
5000 - Capital Outlay	-		-	-	-	-	-	-	-	-	-
Total Non-Investigation Expenditures	553,157	522,178	1,075,335	458,428	569,310	1,027,738	528,366	556,310	1,084,676	607,108	289,360
Investigation Expenditures											
1000-Personal Services	210,010	226,965	436,975	264,001	272,106	536,107	289,348	336,511	625,859	411,332	140,289
2000 - Travel		2,104	2,104	2,032	-	2,032	2,655	-	2,655	-	-
3023 - Expert Witness	1,700	7,577	9,277	16,050	22,775	38,825	31,350	14,000	45,350	39,107	3,300
3088 - Inter-Agency Legal	60,885	34,329	95,214	56,267	33,435	89,702	42,629	208,613	251,242	484,830	77,023
3094 - Inter-Agency Hearing/Mediation	9,299	28,803	38,102	18,640	911	19,551	11,870	61,195	73,065	164,138	34,862
3000 - Services other		3,348	3,348	1,919	625	2,544	1,257	2,126	3,383	1,112	308
4000 - Commodities		-	-	-	-	-	-	-	-	126	-
Total Investigation Expenditures	281,894	303,126	585,020	358,909	329,852	688,761	379,109	622,445	1,001,554	1,100,645	255,783
Total Direct Expenditures	835,051	825,304	1,660,355	817,337	899,162	1,716,499	907,475	1,178,755	2,086,230	1,707,753	545,143
Indirect Expenditures											
Internal Administrative Costs	225,669	263,046	488,715	285,614	316,771	602,385	250,301	286,502	536,803	250,148	125,074
Departmental Costs	150,736	168,176	318,912	123,361	143,500	266,861	122,427	120,114	242,541	143,482	71,741
Statewide Costs	78,101	72,595	150,696	90,219	108,989	199,208	92,456	86,033	178,489	88,909	44,455
Total Indirect Expenditures	454,506	503,817	958,323	499,194	569,260	1,068,454	465,184	492,649	957,833	482,539	241,270
			-			-					
TOTAL EXPENDITURES	**$ 1,289,557**	**$ 1,329,121**	**$ 2,618,678**	**$ 1,316,531**	**$ 1,468,422**	**$ 2,784,953**	**$ 1,372,659**	**$ 1,671,404**	**$ 3,044,063**	**$ 2,190,292**	**$ 786,413**
Cumulative Surplus (Deficit)											
Beginning Cumulative Surplus (Deficit)	$ 137,265	$ (801,471)		$ 250,210	$ (488,013)		$ 641,395	$ 486,586		$ 1,864,582	$ 567,759
Annual Increase/(Decrease)	(938,736)	1,051,681		(738,223)	1,129,408		(154,809)	1,377,996		(1,296,823)	1,324,063
Ending Cumulative Surplus (Deficit)	$ (801,471)	250,210		$ (488,013)	$ 641,395		$ 486,586	$ 1,864,582		$ 567,759	$ 1,891,822
Statistical Information											
Number of Licenses for Indirect calculation	7,138	8,421		9,801	12,808		8,259	9,221		7,676	

Additional information:

- *General fund dollars were received in FY21-FY24 to offset increases in personal services and help prevent programs from going into deficit or increase fees.*
- *Most recent fee change: Fee reduction FY25*
- *Annual license fee analysis will include consideration of other factors such as board and licensee input, potential investigation load, court cases, multiple license and fee types under one program, and program changes per AS 08.01.065.*

Department of Commerce Community, and Economic Development
Corporations, Business and Professional Licensing

Summary of All Professional Licensing
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Appropriation Name (Ex)	(Multiple Items)
Sub Unit	(All)
PL Task Code	MED1

Sum of Budgetary Expenditures	Object Type Name (Ex)			
Object Name (Ex)	1000 - Personal Services	3000 - Services	4000 - Commodities	Grand Total
1011 - Regular Compensation	211,351.11			211,351.11
1014 - Overtime	2.30			2.30
1021 - Allowances to Employees	180.00			180.00
1023 - Leave Taken	44,533.57			44,533.57
1028 - Alaska Supplemental Benefit	15,705.58			15,705.58
1029 - Public Employee's Retirement System Defined Benefits	13,397.43			13,397.43
1030 - Public Employee's Retirement System Defined Contribution	10,884.53			10,884.53
1034 - Public Employee's Retirement System Defined Cont Health Reim	7,002.25			7,002.25
1035 - Public Employee's Retiremnt Sys Defined Cont Retiree Medical	1,708.08			1,708.08
1037 - Public Employee's Retiremnt Sys Defined Benefit Unfnd Liab	35,484.77			35,484.77
1040 - Group Health Insurance	65,648.12			65,648.12
1041 - Basic Life and Travel	4.16			4.16
1042 - Worker's Compensation Insurance	1,402.56			1,402.56
1047 - Leave Cash In Employer Charge	5,910.86			5,910.86
1048 - Terminal Leave Employer Charge	4,094.39			4,094.39
1053 - Medicare Tax	3,594.80			3,594.80
1077 - ASEA Legal Trust	219.52			219.52
1079 - ASEA Injury Leave Usage	40.39			40.39
1080 - SU Legal Trst	95.76			95.76
3002 - Memberships		3,881.00		3,881.00
3023 - Expert Witness		3,300.00		3,300.00
3026 - Transcription/Record		93.77		93.77
3035 - Long Distance		46.39		46.39
3036 - Local/Equipment Charges		5.96		5.96
3045 - Postage		216.86		216.86
3057 - Structure, Infrastructure and Land - Rentals/Leases		89.76		89.76
3085 - Inter-Agency Mail		71.94		71.94
3088 - Inter-Agency Legal		79,268.21		79,268.21
3094 - Inter-Agency Hearing/Mediation		35,599.20		35,599.20
4005 - Subscriptions			1,310.00	1,310.00
Grand Total	**421,260.18**	**122,573.09**	**1,310.00**	**545,143.27**

From: Ariane Lewis
To: Norberg, Natalie M (CED); Board, Medical (CED sponsored)
Subject: Re: Alaska State Medical Board Guidance on Brain Death Determination
Date: Friday, December 6, 2024 9:35:31 AM

I'm writing to follow up on my below email regarding acknowledging the 2023 American Academy of Neurology (AAN)/American Academy of Pediatrics (AAP)/Child Neurology Society (CNS)/Society of Critical Care Medicine (SCCM) Pediatric and Adult Brain Death/Death by Neurologic (BD/DNC) Criteria Consensus Practice Guideline as the accepted medical standard for determination of BD/DNC.

Please let me know your organization's views on this matter.

Thank you.

Ariane Lewis, MD

Professor of Neurology and Neurosurgery, NYU Langone Medical Center

On Fri, Nov 8, 2024 at 8:50 AM Ariane Lewis <ariane.kansas.lewis@gmail.com> wrote:

> Dear Executive Administrator Norber and Chair Wein,
>
> As a Professor of Neurology and Neurosurgery at NYU Langone Medical Center with expertise in brain death/death by neurologic criteria, I am writing to respectfully request the Alaska State Medical Board acknowledge the 2023 American Academy of Neurology (AAN)/American Academy of Pediatrics (AAP)/Child Neurology Society (CNS)/Society of Critical Care Medicine (SCCM) Pediatric and Adult Brain Death/Death by Neurologic (BD/DNC) Criteria Consensus Practice Guideline as the accepted medical standard for determination of BD/DNC.
>
> The Alaska statute on determination of death indicates that, "An individual is considered dead if, in the opinion of a physician licensed or exempt from licensing under AS 08.64 or a registered nurse authorized to pronounce death under AS 08.68.700, based on acceptable medical standards, or in the opinion of a mobile intensive care paramedic, physician assistant, or emergency medical technician authorized to pronounce death based on the medical standards in AS 18.08.089 (the paramedic, physician assistant, or emergency medical technician has determined, based on acceptable medical standards, that the person has sustained irreversible cessation of circulatory and respiratory functions), the individual has sustained irreversible cessation of circulatory and respiratory functions, or irreversible cessation of all functions of the entire brain, including the brain stem. Death may be pronounced in this circumstance before artificial means of maintaining respiratory and cardiac function are terminated." However, the statute defers to physicians regarding the identity of the "accepted medical standards." The AAN published a practice guideline for BD/DNC determination in adults in 1995, then updated it in 2010. A guideline for BD/DNC determination in pediatric patients was published by the AAP in 1987, then updated in 2011 by the AAP, CNS and SCCM. Last year the AAN, AAP, CNS and SCCM published a guideline for BD/DNC for persons of all ages. No other medical societies have published a BD/DNC guideline, so this is the accepted medical standard in the United States for BD/DNC determination.
>
> Unfortunately, in the absence of stipulated accepted medical standards, reviews of hospital BD/DNC policies demonstrated inconsistencies compared with the standards published by the 2010 AAN and 2011 AAP/CNS/SCCM guidelines. This is problematic because it could lead to inaccurate BD/DNC determination, which would have major negative medical, legal, and ethical implications and erode public trust in the ability of clinicians to accurately determine BD/DNC.
>
> For example, Nevada had to modify their determination of death statute in 2017 after the Supreme Court of Nevada ruled that it was not clear which standards represented the accepted medical standards. Their statute now notes the accepted medical standards are those written by the AAN and the SCCM, or their successor organizations. In New York, the Department of Health indicated the accepted medical standards for BD/DNC determination are the 2023 AAN/AAP/CNS/SCCM Pediatric and Adult BD/DNC Consensus Practice Guideline: https://www.health.ny.gov/professionals/hospital_administrator/determining_brain_death/.
>
> For the past few years, the Uniform Law Commission considered revising the Uniform Determination of Death Act to address a number of concerns, and one revision that was discussed was specification of the accepted medical standards. However, for a variety of reasons, the revision process was

abandoned. As such, it is left to individual states to address this issue because a person should not be considered dead at one hospital, but alive at another.

I previously contacted the Alaska Department of Health about this issue and their CMO discussed it with the Alaska Hospital and Healthcare Association, and both felt this was outside their purview, but recommended contacting your organization.

As such, I respectfully request the Alaska State Medical Board acknowledge the 2023 AAN/AAP/CNS/SCCM Pediatric and Adult BD/DNC Consensus Practice Guideline as the accepted medical standard for determination of BD/DNC.

Thank you for your consideration.

Sincerely,

Ariane Lewis, MD
Professor of Neurology and Neurosurgery, NYU Langone Medical Center

--

Ariane Lewis, MD, FAAN, FNCS

Professor, Departments of Neurology and Neurosurgery, Director of Neurocritical Care

Co-Editor-in-Chief, Journal of Clinical Neuroscience

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O: 646-501-0243

From: Board, Medical (CED sponsored)
To: Norberg, Natalie M (CED)
Subject: FW: Pharmacist Support
Date: Thursday, January 2, 2025 12:10:43 PM

From: Carrie Urena <carrieurena22@gmail.com>
Sent: Tuesday, December 31, 2024 8:08 AM
To: Board, Medical (CED sponsored) <medicalboard@alaska.gov>
Subject: Pharmacist Support

To the Medical Board of Alaska,
Hello my name is Carrie Urena. I recently wrote in a letter of support for a change in wording to the pharmacists cooperative practice agreements. I realize that was sent from my work email when it should have been sent from my personal email. The letter was speaking to my personal opinions and experiences and were not opinions made by or approved by SEARHC, my employer. Please feel free to reach out with any questions. I have pasted a copy of the original email below for clarification purposes. Apologies for any confusion this may have caused.

Respectfully,
Carrie Urena

To the Medical Board of Alaska,

My name is Carrie Urena. I am a pharmacist currently working at an opioid treatment program in southeast Alaska. I received my Doctor of Pharmacy degree in 2022 through the UAA/ISU Doctor of Pharmacy partnership program. Since graduating I have also completed a PGY1 residency at the Alaska Native Tribal Health Consortium and become board certified in pharmacotherapy.

Many people that know me know I am passionate about opioid use disorder (OUD). I have driven my education and experiences towards learning more about how to help improve outcomes for this population, with a specific focus on our Alaskan Native population. It is

for this reason that I am writing you today.

Although most of the nation saw a drop in opioid related deaths during the second half of 2023, here in Alaska we not only didn't see a drop in these numbers, but we saw an increase. Access to care is a huge issue throughout our state and this is where pharmacists can help play a crucial and needed role. We are formally trained, with a doctorate level education in medication management. This is our specialty. I am writing to ask for your support in allowing us to work at the top of our clinical ability and training. In order to accomplish this, we would need an update to the wording presented in the statues and regulations listed below. The current wording does not allow pharmacists to administer or dispense controlled medications. The two main medications for opioid use disorder (MOUD), with evidence for decreasing mortality rates, are buprenorphine and methadone, both of which are controlled substances. I would ask that the restrictions on controlled substances be removed, allowing pharmacists to enter into Cooperative Practice Agreements for MOUD as they would with any other disease state covered by these agreements.

I understand that change is not always comfortable for everyone, but I honestly believe that by removing these restrictions on controlled substances we can help provide a much-needed service when it comes to access and availability of MOUD to our Alaskan communities. I feel that it is also important to mention that we never forget when we are addressing things like overdoses and mortality rates, that these numbers we are quoting represent someone's loved one. Each one holds unimaginable pain and heartache, and this doesn't even address the day-to-day suffering experienced by those currently in the middle of it all, or the struggles that their loved ones are going through while watching it all happen yet unable to stop it. Pharmacists are a great resource that can help overcome some of these barriers to care so our communities can finally start to heal. So, I am here, writing to you, and asking for your support in making this a reality.

I appreciate you taking the time to hear what I have to say and look forward to many positive changes within our futures and the futures of our communities.

- 12 AAC 40.983. COOPERATIVE PRACTICE AGREEMENTS WITH PHARMACISTS: (c) A cooperative practice agreement between a physician and a pharmacist must include - (11) a prohibition on the administration or dispensing of any schedule I, II, III, or IV controlled substances.

Carrie Urena
PharmD, BCPS

From: Board, Medical (CED sponsored)
To: Norberg, Natalie M (CED)
Subject: FW: Premera reduction in reimbursement
Date: Thursday, January 2, 2025 11:19:27 AM

From: Alaska Premier Health <akpremierhealth@yahoo.com>
Sent: Tuesday, December 31, 2024 11:03 AM
To: Board, Medical (CED sponsored) <medicalboard@alaska.gov>
Subject: Premera reduction in reimbursement

Hello -

We are alarmed and distressed by the decision by Premera to cut mid-level (and other) providers reimbursement by 15% effective April 1. There already is a significant shortage of providers and this sizable cut will drive more providers out of the state. Our practice alone employs 7 Physician Assistants who were hired and contracted at a rate we could afford. This 15% reduction is going to crush our bottom line to negative and result in reduction in staffing. Is the medical board taking any action to reverse this effort by Premera to take more out of Alaskan employers/employees pockets? What can we do to endure such a negatively impactful, unilateral move by Premera? Any help is appreciated.

Laurie Mapes, CEO

Alaska Premier Health
907-561-3488 phone
907-562-3488 fax

From: Board, Medical (CED sponsored)
To: Norberg, Natalie M (CED)
Subject: FW: Recognition
Date: Wednesday, January 15, 2025 11:20:18 AM

From: tlcaylor@mac.com <tlcaylor@mac.com>
Sent: Tuesday, January 14, 2025 1:40 PM
To: Board, Medical (CED sponsored) <medicalboard@alaska.gov>
Cc: Lisa Lindquist <lisaklindquist@gmail.com>
Subject: Recognition

Hello to the Alaska State Board of Medical License,

Thank you for your service.

A few years back, Dr. Lindquist, I and others testified about the application/reapplication for a medical license in our state. You made significant changes in response to the licensing questions to remove barriers to mental health for medical professionals.

I was just on a virtual meeting - national presentation of Lorna Breen Foundation and was surprised to see Alaska not recognized for it's changes.

Here are the states that receive recognition for what they're doing to support medical professional's mental health from a licensing standpoint: https://drlornabreen.org/removebarriers/

I encourage you to reach to out them, so in our efforts to continue to recruit and retain physicians for the state, your hard work and thoughtful changes are acknowledged.

Thank you!

Tonya Caylor, MD

Tonya L Caylor, MD, FAAFP, PCC
Alaska GME Council Working Group Lead
Clinical Associate Professor | University of Washington Network of Family Medicine Residencies
On-Call Faculty | Alaska Family Medicine Residency
Physician Coach | Joy in Family Medicine Coaching Services®
(907) 947-3501

From:	Bowles, Michael P (CED)
To:	Norberg, Natalie M (CED); Wolf, Patty J (CED); Saviers, Glenn A (CED)
Cc:	Robb, Sylvan S (CED)
Subject:	Fwd: DEA Announces Three New Telemedicine Rules that Continue to Open Access to Telehealth Treatment while Protecting Patients
Date:	Thursday, January 16, 2025 4:48:03 PM

Hello,

Sharing in case you do not get these updates. This is petty big news which will likely add to the pharmacist collaborative practice discussions.

Respectfully,
Michael Bowles
Executive Administrator
Alaska Board of Pharmacy
Division of Corporations, Business, and Professional Licensing
Office: (907) 465-1073
Fax: (907) 465-2974

Begin forwarded message:

From: "U.S. Drug Enforcement Administration" <dea@public.govdelivery.com>
Date: January 16, 2025 at 8:03:40 AM GMT-7
To: "Bowles, Michael P (CED)" <michael.bowles@alaska.gov>
Subject: DEA Announces Three New Telemedicine Rules that Continue to Open Access to Telehealth Treatment while Protecting Patients

FOR IMMEDIATE RELEASE
Contact: DEA Media Affairs
(571) 776-2508

Press Release

DEA Announces Three New Telemedicine Rules that Continue to Open Access to Telehealth Treatment while Protecting Patients

WASHINGTON – The U.S. Drug Enforcement Administration is announcing three new rules to make permanent some temporary telemedicine flexibilities established during the COVID-19 public health emergency while also establishing new patient protections.

In developing these rules, DEA has focused on the patient to ensure telemedicine is accessible for medical care. Importantly, these rules do not apply to telemedicine visits in which a patient has already been seen in-person by a medical provider. Once a patient has had an in-person visit with a medical provider, the medical provider may prescribe any medications through telemedicine indefinitely. Also, if a telemedicine visit does not involve a patient being prescribed medications, then the telemedicine rules do not apply. Patients can always have telemedicine visits with medical providers. These rules only apply if a patient has never been seen in-person by the medical provider and the patient is being prescribed controlled medication.

“DEA’s goal is to provide telehealth access for needed medications while ensuring patient safety and preventing the diversion of medications into the illicit drug market,” said DEA Administrator Anne Milgram. “We

understand the difficulties some patients have accessing medical providers in-person, and we want to ease this burden while also providing safeguards to keep patients safe. These rules also mark a significant step forward for patient safety by requiring online telemedicine platforms to register with DEA and taking steps to establish a nationwide Prescription Drug Monitoring Program (PDMP)."

Expansion of Buprenorphine Treatment via Telemedicine Encounter

This rule provides patients with remote access to buprenorphine, the medicine used to treat opioid use disorder. This change allows a patient to receive a 6-month supply of buprenorphine through a telephone consultation with a provider. Further prescriptions of buprenorphine will require an in-person visit to a medical provider.

For more information: Federal Register :: Public Inspection: Expansion of Buprenorphine Treatment via Telemedicine Encounter

Special Registrations for Telemedicine and Limited State Telemedicine Registrations

This proposed rule would establish special registrations that will permit a patient to receive prescribed medications through telemedicine visits without ever having an in-person medical evaluation from a medical provider. The special registration is available to medical providers who treat patients for whom they will prescribe Schedule III-V controlled substances. An Advanced Telemedicine Prescribing Registration is available for Schedule II medications when the medical practitioner is board certified in one of the following specialties: psychiatrists; hospice care physicians; physicians rendering treatment at long term care facilities, and pediatricians for the prescribing of medications identified as the most addictive and prone to diversion to the illegal drug market. This regulation allows specialized medical providers to issue telemedicine prescriptions for Schedule II-V medications.

DEA is seeking public comment on additional medical specialists that should be authorized to issue Schedule II medications. Public comments will also be requested on additional patient protections for the prescribing of Schedule II medications by telemedicine, including whether the special registrant should be physically located in the same state as the patient being prescribed schedule II medications; whether to limit schedule II medications by telemedicine to medical practitioners whose practice is limited to less than 50% of prescriptions by telemedicine; and the appropriate duration needed for the rules' provisions to be enacted.

For the first time online platforms that facilitate connections between patients and medical providers that result in the prescription of medications will be required to register with DEA. This is critical as DEA has found some unscrupulous medical providers on online platforms have used flexible telemedicine rules to put profit ahead of the well-being of patients.

The special registration rule will also require the establishment of a national PDMP to help the health industry protect against abuse and the diversion of controlled substances into the illegal drug market. A national PDMP will provide pharmacists and medical practitioners with visibility of a patient's prescribed medication history.

For more information: Federal Register :: Public Inspection: Special Registrations for Telemedicine and Limited State Telemedicine Registrations

Continuity of Care via Telemedicine for Veterans Affairs Patients

An additional rule was done in consultation with the U.S. Department of Veterans Affairs (VA). It exempts VA practitioners from Special Registrations requirements. Once a patient has received an in-person medical examination from a VA medical practitioner, the provider-patient relationship is extended to all VA practitioners engaging in telemedicine with the patient.

For more information: Federal Register :: Public Inspection: Continuity of Care via Telemedicine for Veterans Affairs Patients

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The new rules were developed in consultation with the U.S. Department of Health and Human Services and after significant input from the public. DEA received input during public listening sessions that were hosted by DEA in September 2023. Healthcare practitioners, experts, advocates, and patients shared their experiences and recommendations. DEA also carefully reviewed and considered the more than 38,000 comments from the

public in response to the original draft rule that was proposed on March 1, 2023. As a result of the comments and listening session, DEA has now made significant revisions to the draft rules.

These rules are a result of the temporary rules to prescribe medications via telemedicine that were adopted during the COVID-19 public health emergency. A third temporary extension of COVID-19 Telemedicine Flexibilities last year extended the temporary rule until December 2025.

###

From: Bowles, Michael P (CED)
To: Bannarbie, Shane R (CED); Billiet, Rachel K (CED); Bowman, Reid T (CED); Bowman, Tami J (CED); Carabajal, Ashley L (CED); Kaeser, Jason R (CED); Maroney, Lisa K (CED); Norberg, Natalie M (CED); Pace, Jeanne M (CED); Saviers, Glenn A (CED); Sherrell, Lisa D (CED); Wilson, La Creatia I (CED); Wolf, Patty J (CED)
Cc: Saviers, Glenn A (CED); Robb, Sylvan S (CED)
Subject: FW: DEA Diversion Control Division News (December 2024)
Date: Monday, December 2, 2024 9:09:32 AM
Attachments: image001.png
image002.png
image003.png

Good morning,

Forwarding as a FYI on the extension and to let you all know that we had a provider reach out and let us know they were one of those who's credentials were used in electronic prescription fraud, so it has made it to Alaska as well. The DEA was informed.

Michael Bowles
Executive Administrator, Board of Pharmacy
Corporations, Business and Professional Licensing

michael.bowles@alaska.gov
Office: 907-465-1073
www.commerce.alaska.gov

From: Diversion Control Division <DEA_DCD@public.govdelivery.com>
Sent: Monday, December 2, 2024 8:58 AM
To: Bowles, Michael P (CED) <michael.bowles@alaska.gov>
Subject: DEA Diversion Control Division News (December 2024)

Gove Delivery Header

DEA Diversion Control Division News (December 2024)

DEA and HHS Extend Telemedicine Flexibilities through 2025

In 2023, in response to a set of proposed telemedicine rules, DEA received more than 38,000 comments and held two days of public listening sessions. In light of that feedback and discussion, and to give DEA time to consider a new path forward for telemedicine, DEA and the Department of Health and Human Services (HHS) extended current telemedicine flexibilities through the end of 2025.

The full text of the extension, entitled "Third Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications," was submitted to the Federal Register jointly with HHS on Nov. 15, 2024. Read more about the extension.

DEA Warns of Electronic Prescription Fraud

The Drug Enforcement Administration has identified illegal schemes to generate fake electronic prescriptions, or e-scripts, for controlled substances by exploiting vulnerabilities in e-script software.

Tens of thousands of fake prescriptions have been filled by pharmacies throughout the United States. The clinicians' names on these fake e-scripts did not know that their identities and credentials were being used to generate the e-scripts.

A new public safety alert video describes what DEA is seeing and what can be done to address the issue.

If you suspect you have been the victim of a scheme, immediately notify the DEA.

For more information on preventing prescription fraud, read the Pharmacist's Guide to Prescription Fraud and other resources.

Enhanced Controlled Substance Ordering System to Launch December 9, 2024

The updated Controlled Substance Ordering System (CSOS) will provide increased security without impacting customer service or patients' access to medications.

The system – used by DEA-registered pharmaceutical drug manufacturers and distributors, pharmacies, hospitals, and others – allows for the electronic ordering of Schedule I through V controlled substances.

An estimated 190,000 of DEA's more than 2.1 million registrants utilize CSOS. Learn more about the new, enhanced CSOS program and upcoming training opportunities.

In the News...

DEA's Diversion Control Division strives to prevent, detect, and investigate the diversion of controlled pharmaceuticals and listed chemicals from legitimate sources. When the safety and health of the American people is in jeopardy, DEA takes action against those who violate the law.

Madera Pharmacist Sentenced to over 7 Years in Prison for Illegally Trafficking Hundreds of Thousands of Opiate Pills - **Nov. 25, 2024**

Hospital in Washington Agrees to Pay $15,000 Penalty and Implement Corrective Actions to Address Theft of Controlled Substances - **Nov. 18, 2024**

China-Based Chemical Company, Its Director and Senior Employees Indicted for Alleged Fentanyl Manufacturing and Distribution - **Nov. 8, 2024**

Covetrus Agrees to Pay $1,125,000 for Failing to Adequately Address Suspicious Opioid Orders and for Inadequate Recordkeeping Practices - **Oct. 30, 2024**

Want to keep up with the latest drug diversion news? **Sign up** for Twitter/X alerts and look for us on LinkedIn, Facebook, and Instagram.

News Updates
Get the latest news updates. **Sign up** for email updates.

You have received this e-mail because you have asked to receive updates from the DEA Diversion Control Division. Update your subscription to this service, modify your password or e-mail address, or stop subscriptions at any time on your Subscriber Preferences Page. You will need to use your e-mail address to log in. If you have questions or problems with the subscription service, please contact subscriberhelp.govdelivery.com. If you have questions about DEA Diversion Control, please contact deadiversionwebmaster@dea.gov.

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From: Prieksat, Erika L (CED)
To: Norberg, Natalie M (CED)
Cc: Wardlaw, Kendra A (CED)
Subject: State-Wide Drug Diversion Training Opportunity - NADDI
Date: Thursday, February 6, 2025 10:51:23 AM
Attachments: image001.png
image002.png
image003.png

Hi Natalie,

I am planning a state-wide National Association of Drug Diversion Investigators (NADDI) training tentatively scheduled for May 8, 2025, in Anchorage at the Crime Lab. The plan is to have multiple presenters from Alaska present to different agencies information on current drug trends in AK, drug overdose data, diversion/drug trafficking case studies, healthcare fraud, the prescription drug monitoring program, and/or addiction/treatment. I am working to start a NADDI Chapter in Alaska and this training is a part of that process.

What is NADDI?
NADDI is the leading drug training organization in the nation, with the largest networking platform for professionals involved in the field of illicit drug diversion and the ongoing drug crisis. The NADDI networking platform provides the opportunity to bring diverse viewpoints, education, support, and resources to the individuals facing the challenges in the fight against illicit drugs in the areas of adulteration, counterfeiting, drug trafficking, healthcare fraud, and so much more. It is the perfect platform to make connections and build strong professional relationships.
https://www.naddi.org/home NADDI's objective is simple: to improve its members' ability to investigate, prosecute, and prevent pharmaceutical drug diversion.

I recently attended one of NADDI's national trainings and walked away with a lot of valuable information, including known and unknown substances on the market, trafficking, healthcare drug diversion, FBI case studies, new case law relating to over prescribing, and new technology for investigators. I realized that Alaska can greatly benefit from starting a NADDI chapter to increase public safety, develop partnership among different agencies and prevent harm.

This is still in the planning stage, so there is no registration information yet, but the registration fee is generally about $100 and lunch should be provided. I have been reaching out to multiple agencies around Alaska to gauge interest in attending as well as working to get presenters for the topics listed above. I am sending to you in case you and members of the Medical Board would be interested in attending. I am happy to talk further and answer any questions and can keep you posted on developments as they come up.

Thanks,

Erika

Erika Prieksat
Chief Investigator
Corporations, Business and Professional Licensing
erika.prieksat@alaska.gov
Office: 907-269-4964
www.commerce.alaska.gov

From: Kelly Alfred
To: Kelly Alfred
Subject: Announcement: FSMB Foundation"s 2025 Grant Cycle
Date: Thursday, January 9, 2025 12:25:38 PM
Attachments: image001.png

Dear Medical Board Chairs/Presidents and Executive Directors,
This email is being sent on behalf of Dr. Janelle Rhyne, President of the FSMB Foundation, and Dr. Patricia King, Vice President of the FSMB Foundation.
The FSMB Foundation, the philanthropic arm of the Federation of State Medical Boards, is pleased to announce the launch of its 2025 grant cycle, which is designed to assist state medical boards with technology innovations and upgrades in the area of board operations, emergency preparedness and license portability.

For this call for applications, the Foundation is especially interested in supporting state medical boards in projects related to the following categories:

- Category 1 - Projects designed specifically for improving state medical board technology and processes in licensing, discipline, and public communication and outreach.
- Category 2 - Funding to support state medical and osteopathic boards, state departments of health, or other emergency management entities with the integration of Provider Bridge into their state emergency preparedness and response programs.
- Category 3 - Funding to support state and territory medical boards' activities to meet the need for license portability related to the Interstate Medical Licensing Compact and the Interstate Physician Assistant (PA) Compact.

State medical and osteopathic boards, state departments of health and other emergency management entities are invited to submit applications for projects related to the above stated focus areas. For this grant cycle, a total of $300,000 is available. Applicants for Categories 1 and 2 may apply for up to $50,000 in funding support, and applicants for Category 3 may apply for up to $15,000.

The application process is now open and prospective applicants are encouraged to apply no later than **March 28, 2025, at 11:59p.m. (EDT).** To learn more about the 2025 grant cycle and/or to apply for a grant, please visit https://www.fsmb.org/fsmb-foundation/grant-opportunities/

Funding decisions regarding the 2025 grant applications will be made by the FSMB Foundation Grants Committee on or around April 18, 2025, and applicants will be notified at that time.

To submit your application by the stated deadline, please email it to fsmbfoundation@fsmb.org. We also invite questions concerning your application. Please submit them to the above email address with "FSMB Foundation 2025 Grant Application" in the subject line.

We are committed to providing grant and funding opportunities that support state medical board efforts to advance best practices in medical regulation and strengthen the safety and quality of health care, and we sincerely hope these grants will be helpful to your board.

Sincerely,

Janelle Rhyne, MD, MACP
President

Patricia A. King, MD, PhD
Vice President
Chair, FSMB Foundation Grants

Committee

Sincerely,

Kelly C. Alfred, M.S.
Director, Education Services

Federation of State Medical Boards
400 Fuller Wiser Road | Suite 300 | Euless, TX 76039
o. 817-868-5160 | kalfred@fsmb.org | www.fsmb.org

fsmb Integrity in Medical Regulation. Trust in Care.

From:	Frances Cain (FSMB)
To:	Frances Cain (FSMB)
Cc:	Andrea Ciccone
Subject:	For your information: 2024 Annual Report on USMLE and December 2024 Quarterly FSMB Update on USMLE
Date:	Friday, December 13, 2024 7:51:45 AM
Attachments:	Outlook-x3i5tiw4.png 2024 Annual Report on the USMLE - FINAL.pdf Quarterly FSMB Update on USMLE - December 2024.pdf 2024 USMLE Primer for State Boards.pdf

Dear State Board Executive Directors,

On behalf of the FSMB and NBME, I am pleased to share the *2024 Annual Report on the United States Medical Licensing Examination® (USMLE)*. This report is intended to provide state medical and osteopathic boards with an overview of the USMLE program and recent updates that may be of interest to board staff and members.

Also attached is the December 2024 edition of the Quarterly FSMB Update on USMLE.

We encourage you to share both of these documents with your board. I have also included a PDF copy of a presentation entitled, "2024 USMLE Primer for State Boards" to assist you with presenting about USMLE to your board, should you wish to do so. If you would like a PPT copy of the presentation, please do not hesitate to contact me.

I hope you find these helpful to you, your board members and your staff. Please feel free to contact me if you have any questions or if I can be of assistance at any time.

Take care,
Frances

Frances Cain, MPA
Director, Assessment Services

Federation of State Medical Boards
400 Fuller Wiser Road | Euless, TX 76039
o. 817-868-4022 | fcain@fsmb.org | www.fsmb.org

From: David Johnson (FSMB)
To: David Johnson (FSMB)
Subject: predictive validity research supporting USMLE
Date: Wednesday, January 22, 2025 7:50:34 AM
Attachments: Relevant USMLE research supporting the validity of licensing decisions v final.docx
article 1 USMLE and patient outcomes 2024.pdf
article 2 USMLE and patient outcomes 2014.pdf
article 3 USMLE and SMB disc actions 2017.pdf
article 4 USMLE and SMB disc actions 2022.pdf
article 5 USMLE attempts and SMB disc actions 2021.pdf
article 6 USMLE and ACGME milestones 2021.pdf

Executive Directors
State Medical and Osteopathic Boards

Since its introduction in 1992, the United States Medical Licensing Examination® (USMLE®) has provided the medical licensing community with a high-quality assessment tool ensuring that licensed physicians are held to a rigorous and reliable standard. Passing USMLE Step 1, 2 Clinical Knowledge (CK), and 3 ensures that physicians have demonstrated they understand and can apply medical knowledge and clinical reasoning to provide safe and effective patient care.

USMLE has administered more than three million Step administrations since 1992—providing much of the groundwork for an extensive research program that continues to produce numerous peer-reviewed contributions to the professional literature of medical licensing, education and training.

Staff at NBME and FSMB working on the USMLE program have assembled a collection of key recent articles evaluating the predictive validity of USMLE. Predictive validity involves studying how the exam scores are associated with relevant future outcomes and thus can provide strong evidence that the exam truly measures competencies related to safe and effective practice. Extensive research has focused on USMLE performance and its correlation with other key measures, such as performance on other professional assessments, residency outcomes, disciplinary actions by state medical boards, and, most importantly, patient outcomes.

These studies augment the validity evidence from the rigorous exam development, scoring, and standard setting practices that collectively support the validity of licensing decisions informed, in part, by requiring successful completion of USMLE Steps 1, 2 and 3. These key articles are shared in their entirety or with citation and brief summary. Note: The appendix in the attached Word document provides links to the online versions of these articles.

Our intent is to share relevant literature supporting medical boards' continued utilization of the USMLE as the primary assessment tool in the decision to issue a full, unrestricted medical license. Please feel free to share any or all of these materials as you deem appropriate to staff and/or your board members. Questions about these studies or interpretations of this data may be directed to Daniel Jurich, PhD, NBME Associate Vice President for USMLE.

Sincerely,

David Johnson, MA — FSMB Chief Assessment Officer

Alex J. Mechaber, MD, MBA — NBME Vice President for USMLE

USMLE
United States Medical Licensing Exam

From:	Kelly Alfred
To:	Kelly Alfred
Subject:	Upcoming FSMB Events: Tri-Regulatory Symposium & Opioid Regulatory Summit, New Executive Directors Orientation and More!
Date:	Tuesday, January 21, 2025 7:09:34 PM
Attachments:	image001.png

Dear State Medical Board Presidents/Chairs and Leadership Staff,

We're excited about several upcoming FSMB events that you won't want to miss! These gatherings provide unique opportunities to connect with colleagues, share insights, and address critical issues in medical regulation.

Tri-Regulatory Symposium and Opioid Regulatory Summit

Location: Tysons Corner Marriott Hotel, 8028 Leesburg Pike, Tysons Corner, VA 22182

Dates: March 6 & 7, 2025

Registration Deadline: February 5, 2025

*If you would like to attend, please contact **edu@fsmb.org** for the registration link.

Join us in Tysons Corner, Virginia, for these two important meetings:

- **March 6, 2025 - Tri-Regulatory Symposium**: Explore the intersection of medical, nursing, and pharmacy regulation in addressing current challenges and fostering collaboration.
- **March 7, 2025 - Opioid Regulatory Summit**: Delve into strategies and solutions for mitigating the opioid crisis through effective regulatory approaches.

Both events will feature distinguished speakers, interactive panels, and opportunities to engage with leaders across healthcare regulation.

New Executive Director Orientation

Location: FSMB's Texas Office

Date: June 25 - 26, 2025

Registration Deadline: February 14, 2025

* Please RSVP to **edu@fsmb.org** by the registration deadline if you are interested in attending.

FSMB is pleased to announce that we will reintroduce the New Executive Director Orientation meeting at FSMB's Texas office on June 26, 2025. A networking dinner will be planned for the evening before the Orientation on Wednesday, June 25. All travel-related expenses to attend the meeting will be covered by FSMB. This orientation is intended for newer Executive Directors and their deputies to become familiar with FSMB's activities and operations, thereby enhancing their understanding of how the FSMB can fulfill their

needs. It will also include time for information sharing as well as additional content on how they can be effective leaders in their respective roles. Additional details will be shared soon.

FSMB AM25 – Seattle, Washington

Make plans to join us in Seattle for FSMB's Annual Meeting on April 24-26, 2025, where we'll discuss the innovations transforming healthcare and their impact on medical regulation. For more information about this year's meeting or to register, please visit the **event site**.

Information about Annual Meeting scholarships was distributed to the state medical board community in December 2024. The deadline to claim your board's scholarships is **March 1, 2025.**

We look forward to seeing you at one or more of these exciting events, and please do not hesitate to reach out with any questions.

Warm regards,

Kelly C. Alfred, M.S.
Director, Education Services

Federation of State Medical Boards
400 Fuller Wiser Road | Suite 300 | Euless, TX 76039
o. 817-868-5160 | kalfred@fsmb.org | www.fsmb.org

fsmb Integrity in Medical Regulation. Trust in Care.

From: Kelly Alfred
To: Kelly Alfred
Subject: Reminder: FSMB Annual Meeting Scholarship Deadline - March 1
Date: Thursday, January 30, 2025 11:38:45 AM
Attachments: image001.png
2025 Role of the Voting Delegate.pdf
Importance: High

Dear Presidents/Chairs and Staff Fellows,

This is a friendly reminder that the deadline to accept FSMB scholarships to attend the AM25 is **March 1, 2025.**

The FSMB's 2025 Annual Meeting will be held in **Seattle, Washington on April 24-26**. To assist in offsetting the costs for board members and staff to participate in the meeting, all state medical boards are eligible to receive up to 3 scholarships. The available scholarships are as follows:

- One (1) scholarship for the **Voting Delegate**: Usually this is the SMB President/Chair or alternate board member, but a state may also select a Staff Fellow or other senior staff member to serve as voting delegate.
- One (1) scholarship for **Senior Staff**: If a Staff Fellow is designated as the Voting Delegate, this would be available for another member of the Member Medical Board staff.
- One (1) scholarship at the **Member Medical Board's discretion**: Member Medical Boards may use this scholarship for either a board member or staff member to attend the meeting.

In addition to these three (3) scholarships, the FSMB will award twelve (12) scholarships for Member Medical Board Public Members to attend the 2025 Annual Meeting. To be eligible for a scholarship, the recipient must be a Public Member of a Member Medical Board who has *never attended* an FSMB Annual Meeting and is not a recipient of any other scholarship. Only one (1) Public Member per state board may receive the award, and scholarships will be awarded on a first come, first served basis.

Attached is a letter from FSMB Chair Katie Templeton, JD, and President and CEO Dr. Humayun Chaudhry regarding the selection of your voting delegate.

To receive the scholarships, please identify your board's 2025 scholarship recipients by completing the scholarship application, which can be found using the links below. Detailed information about these scholarships, including eligibility and meeting attendance requirements, as well as application instructions, is provided.

- **Voting Delegate, Senior Staff, and Member Medical Board**
- **Public Member Scholarship**

All 2025 scholarships will be in the amount of $3,600.00 each for travel, lodging and meals. The Annual Meeting registration fee is also waived for scholarship recipients, and it does not count towards the $3,600.00 amount.

Once we've received your scholarship application, an acknowledgement of receipt and additional instructions will be sent to each recipient within three business days.

We look forward to seeing you in Seattle, and please do not hesitate to reach out with any questions.

Sincerely,

Kelly C. Alfred, M.S.
Director, Education Service

Federation of State Medical Boards
400 Fuller Wiser Road | Suite 300 | Euless, TX 76039
o. 817-868-5160 | kalfred@fsmb.org | www.fsmb.org

fsmb Integrity in Medical Regulation. Trust in Care.

FEDERATION OF STATE MEDICAL BOARDS

TO: Presidents/Chairs and Staff
FellowsMember Medical Boards

RE: Role of the Voting Delegate

Dear Colleagues:

Preparations are underway for the Federation's 2025 Annual Meeting, scheduled for April 24-26 in Seattle, WA. The FSMB's House of Delegates (HOD) business meeting will be held on April 26, the last day of the annual meeting. FSMB member board participation at the HOD meeting is **extremely important** because it is the member boards' opportunity to guide the organization and participate in the policymaking process. The role of the voting delegate in that process is especially important as the delegate represents their state medical board, both on policy decisions and during elections, casting their vote for the future leaders of the Federation.

In anticipation of the HOD business meeting, we ask that you consider which of your board members will be best suited to serve as your board's voting delegate. For the voting delegate to serve in a truly representative capacity, the delegate is asked to fulfill a number of responsibilities.

Before the HOD meeting, the voting delegate is asked to:

- Become familiar with the structure and purpose of the FSMB HOD and the policymaking and election processes (information will be provided);
- Attend meetings of the state medical or osteopathic board the delegate represents (to gain information about statewide and national issues that will be addressed at the HOD meeting);
- Review all pre-meeting materials;
- Attend the FSMB's *Candidates Forum* at the Annual Meeting as well as the reception honoring the candidates; also attend the Reference Committee meeting and provide Reference Committee testimony, as necessary; and
- Network with colleagues at the Annual Meeting for additional information and perspectives on issues.

During the HOD meeting, the voting delegate is asked to:

- Follow the meeting rules as outlined by the Rules Committee;
- Represent the position of the delegate's board during discussions, as necessary; and
- Vote at the time requested.

Following the meeting, the voting delegate is asked to:

- Discuss the results of the HOD meeting with the delegate's board

As the role of the voting delegate is an important one, we encourage you to give careful consideration in the selection of the individual who will be your representative at our 2025 meeting.

Sincerely,

Katie L. Templeton, JD
Chair

Humayun J. Chaudhry, DO, MACP, FRCP
President and Chief Executive Officer

FEDERATION OF STATE MEDICAL BOARDS
70 Boards. One Mission.

FEDERATION OF STATE MEDICAL BOARDS

Board of Directors Meeting
October 24-25, 2024

HIGHLIGHTS

The FSMB Board of Directors met in Dallas, TX on October 24-25, 2024. The following is a summary of that meeting.

2025 Annual Meeting Scholarships

In an effort to assist the state medical boards in sending representatives to the FSMB's 2025 Annual Meeting in Seattle, Washington on April 24-26, the Board of Directors approved an Annual Meeting scholarship of $2,500 for the three eligible recipients (Voting Delegate, Staff Fellow, and an additional Staff or Board Member) from each of the 48 contiguous states plus the District of Columbia. A $3,600 scholarship will be available to the eligible recipients of the non-contiguous state medical boards.

Analysis of FSMB Strategic Partnerships

FSMB Staff provided a comprehensive overview of existing organizational partnerships and their corresponding operational costs as well as the various administration services and support functions provided to partner organizations. The presentation demonstrated how these relationships contribute to overall organizational sustainability and function.

FY 2024 Independent Auditors' Report

The Board of Directors accepted the FY 2024 Independent Auditors' Report. The Report will be presented for action at the FSMB's House of Delegates meeting on April 26, 2025.

Public Awareness Campaign

Erik Hansen and Stuart Perkins of MeKanic presented a comprehensive campaign summary about the ongoing development of a national campaign to raise public awareness of medical regulation. The presentation detailed plans for a potential multi-year campaign. The team provided an in-depth analysis of target audience segments and their behavioral patterns. Social media was identified as the primary distribution channel, selected for its ability to maximize digital engagement and enable real-time campaign

optimization. The presentation also covered various campaign concepts, with emphasis on creative approaches and thematic elements designed to align with organizational objectives while resonating with target audiences. The Board approved budgeting for allocation to the marketing campaign.

HOD Draft Policy on Reference Committees

The Board approved a draft HOD policy to be presented for approval at the April 2025 House of Delegates meeting that would formalize polices and procedures for Reference Committees.

Guest Speakers

Guest speakers for the meeting included Dr. Robert Cain, President and CEO of the American Association of Colleges of Osteopathic Medicine, and Dr. David Skorton, Chair and CEO of the Association of American Medical Colleges, and from the International Association of Medical Regulatory Authorities (IAMRA) Ms. Joan Simeon, Chair and Ms. Nicole Krishnaswami, Chair-elect.

Informational Reports

Informational reports were provided on the activities/work of the FSMB Chief Advocacy Officer, Chief Assessment Officer, Chief Learning Officer, Chief Legal Officer, Chief Operating Officer, and the Ethics & Professionalism Committee, Oversight of Clinical Decision-Making Workgroup, Reentry to Practice Workgroup, and Journal Oversight Committee. Also included were reports on the American Board of Medical Specialties (ABMS), Accreditation Council for Continuing Medical Education (ACCME), Accreditation Council for Graduate Medical Education (ACGME), and the National Commission on Certification of Physician Assistants (NCCPA), National Academy of Medicine (NAM) Action Collaboratives on (1) Clinician Well-Being and Resilience and (2) Combatting Substance Use and Opioid Crises. Board member reports from the American Association of Physicians of Indian Origin (AAPI), American Osteopathic Association (AOA) HOD, International Medical Education Leaders Forum's (IMELF), International Medical Graduate Event, National Council of State Boards of Nursing (NCSBN), National Conference of State Legislatures (NCSL), and National Medical Association (NMA) Annual Meeting.

From: Lauren Mitchell (FSMB)
Subject: FSMB Board Meeting Highlights (October 24-25, 2024)
Date: Thursday, January 30, 2025 1:05:29 PM
Attachments: image001.png
image003.png
image004.png
Highlights October 2024.pdf

Dear FSMB Member Board Presidents/Chairs and Staff Fellows,

Attached for your information are the highlights from the October 24-25, 2025 meeting of the FSMB Board of Directors.

Kind regards,
Lauren

Lauren Mitchell
Manager, Board of Directors Liaison and Governance Support

Federation of State Medical Boards
400 Fuller Wiser Rd | Euless, TX 76039
o. 817-868-4060 | lmitchell@fsmb.org | www.fsmb.org

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From: Galbreath, Donna <dgalbreath@SouthcentralFoundation.com>
Sent: Wednesday, February 12, 2025 8:53 AM
To: Board, Medical (CED sponsored) <medicalboard@alaska.gov>
Subject: Pharmacy Collaborative Practice Agreements

To the Alaska Medical Board

The Pharmacy Collaborative Practice Agreement (CPA) is a formal relationship between pharmacists and providers that allows pharmacists to perform certain patient care functions as authorized by an agreed upon protocol. These agreements improve care, increase access, improve chronic condition management, and increase health care team productivity. Most importantly CPA agreements help improve health outcomes.

Pharmacists at Alaska Native Medical Center have desks within the primary care clinics alongside clinic teams and work with providers and patients every day as an integrated model. Already having a strong relationship with providers and patients the addition of CPAs is an expansion of work by pharmacists following approved protocols. Since pharmacists are already sitting with the clinical teams, they will be able to quickly have conversations with providers when questions arise.

Fifty states allow CPAs, and these agreements have been successful. Studies have shown that CPAs have improved the management of chronic disease. CPAs will allow pharmacists to use their training and clinical skills to work at the top of their license and further support the work of the health care team to improve health outcomes.

The Alaska Workforce Development analysis 2024 showed the ongoing need for health care workers in Alaska. CPAs will help mitigate part of this problem. The overall result will be improved access to health care for all Alaskans.

I fully support the Pharmacy Collaborative Practice Agreement.

Thank you,

Donna R Galbreath MD
Medical Director Quality Assurance
Southcentral Foundation
Dgalbreath@scf.cc
907-947-1227

From: Griffis, Danny <dgriffis@SouthcentralFoundation.com>
Sent: Wednesday, February 12, 2025 8:44 AM
To: Board, Medical (CED sponsored) <medicalboard@alaska.gov>
Subject: ANMC Pharmacist CPA

To whom it may concern,

I am writing this email as testimony towards the February 22, 2025 Alaska State Medical Board meeting in regards to the ANMC Pharmacist collaborative agreement. I am the medical director for rural services for Southcentral Foundation. We have 13 and are adding a 14th rural Community Health Centers/look a likes for which we directly provide primary care, 11 of which are off of the road system. Additionally, we support another 50+ clinics located across the Rural Anchorage Service Unit. Prior to this role I spent 15 years in Family Medicine in rural Critical Access Hospitals where I practiced in the emergency department, inpatient, outpatient, hospice, SNF, and mountain/swiftwater search and rescue environments.

I am writing in support of the ANMC collaborative agreement. ANMC has a long standing history of integrated pharmacists working in close collaboration with providers and has demonstrated excellence in the field as noted by Anticoagulation Center of Excellence certification. I have personally collaborated with multiple ANMC pharmacists in the delivery of complex care in the outpatient setting in both our urban and highly remote clinics as well. I have significant regard for the skill sets of these individuals and wish to relay my support of the CPA submitted to the board.

Thank you for your consideration,

Danny Griffis, MD
Medical Director | Valley Villages Group
Southcentral Foundation
Cell: 208-494-4813

From: Hartman, Daniel <DaHartman@SouthcentralFoundation.com>
Sent: Tuesday, February 11, 2025 5:46 PM
To: Board, Medical (CED sponsored) <medicalboard@alaska.gov>
Subject: ANMC Pharmacist Collaborative Practice Agreement

Alaska State Medical Board

550 W. 7th Ave, STE 1500

Anchorage, AK 99501

To the Board,

Thank you for the opportunity to comment, please enter this letter as physician testimony at the February 22, 2025, Alaska State Medical Board meeting (re: ANMC Pharmacist CPA).

I would like to express my thanks to the Alaska State Medical Board for their support for previously approved pharmacist collaborative practice agreements at Providence Alaska Medical Center, and at Anchorage Neighborhood Health Center. These steps by the Board have furthered excellent care of patients at those facilities, and for patients cared for statewide in referral.

My experience in collaborative practice with doctoral level pharmacists reaches back to 1999, where I worked with pharmacists daily at the National Clinicians Consultation Center (UCSF) in providing expert clinical advice to providers nationally in providing optimal care for HIV-positive persons. Pharmacist direct input to the providers calling that consult service led to support for initiating antiretroviral regimens and for management of co-morbidities, and I am certain this saved lives.

My work in as inpatient director and medical staff president at Yukon Kuskokwim Health Corporation deepened my appreciation of the value of pharmacist direct input in care, from 2002 to 2013, whether it involved correction to a renally dosed antibiotic on a busy pediatric ward or the safety of a particular regimen in an elder. I am certain direct pharmacist input in care saved lives there, as well.

More recently at ANMC, from 2013 to present, I have been involved in decisions in complex outpatient care involving our integrated pharmacist model where direct and timely proposed orders submitted by pharmacists changed the arc of people's health. I've also seen care decisions modified with speed and fidelity by pharmacists on the inpatient side where the pharmacist presence and input simply are what made the difference.

ANMC pharmacists' direct input in care resulted in our campus Anticoagulation Center of Excellence certification in 2018 and 2020; among over 3000 anticoagulation centers in the United States, only 125 have received this certificate. We anticipate a similar level of quality assurance will be brought to management of collaborative practice agreements in pharmacy driven care on our campus.

Thank you for your time, and for the opportunity to comment to the Board. Please accept my recommendation for adoption of the ANMC Pharmacist CPA as drafted.

Best regards,

Daniel Hartman, MD MPH
Daniel Hartman, MD MPH
Service Line Medical Director
Specialty Division
Southcentral Foundation
Alaska Native Medical Center
(907) 787-9428 (mobile)
(907) 729-9099
dahartman@scf.cc

ALASKA NATIVE MEDICAL CENTER

February 12, 2025

Alaska Medical Board
550 W 7th AVE, STE 1500
Anchorage, AK 99501-3567

To Whom it May Concern

The Pharmacy Collaborative Practice Agreement (CPA) is a formal relationship between pharmacists and providers that allows pharmacists to perform certain patient care functions as authorized by an agreed upon protocol. I believe that these agreements significantly improve care, increase access, improve chronic condition management, and increase health care team productivity. Most importantly CPA agreements help improve health outcomes.

Pharmacists at Alaska Native Medical Center have desks within the primary care clinics alongside clinic teams and work with providers and patients every day as an integrated model. Because they already have this strong relationship with providers and patients, the addition of CPA is a logical expansion of work by ANMC pharmacists following approved protocols. Since pharmacists are already sitting with the clinical teams, they will be able to quickly have conversations with providers when questions arise. Fifty states allow CPAs, including Alaska, and these agreements have been successful. CPAs will allow pharmacists to use their training and clinical skills to work at the top of their license and further support the work of the health care team to improve health outcomes.

In short, the overall result of approving these CPAs in Alaska will be improved access to health care for all Alaskans. I fully support the ANMC Pharmacy Collaborative Practice Agreement. Please don't hesitate to contact me with any questions.

Sincerely,

Matthew Hirschfeld, MD/PhD
Vice President—Specialty Division
Southcentral Foundation
Alaska Native Medical Center
Anchorage, Alaska
mhirschfeld@scf.cc
(907) 360-5620

American Board of Medical Specialties
353 North Clark Street, Suite 1400
Chicago, IL 60654
T: (312) 436-2600
F: (312) 436-2700 www.abms.org

February 10, 2025

Natalie Norberg
Executive Administrator
Alaska State Medical Board
333 Willoughby Ave., 9th Fl
State Office Building
Juneau, AK 99801-1770

Re: New Federal Law Sets Standards for Physician Certifying Organizations

Dear Ms. Norberg:

On behalf of the American Board of Medical Specialties (ABMS), I am pleased to provide this critical update and some helpful resources related to efforts to better recognize organizations that provide specialty certifications to physicians.

The question of what constitutes a legitimate board certification program is one that many state medical boards and other policy makers have been asked to answer in recent years. While more than 80 percent of medical specialists nationwide are certified by a specialty organization, the details of what constitutes a certifying program are not well understood.

Specialty certification remains one of the most important factors for patients selecting a physician. However, as specialty certification programs continue to emerge and diverge, patients are being increasingly exposed to programs that are vastly different in training and assessment requirements.

To ensure the integrity of physician credentialing organizations, policy makers are turning to the adoption of consistent professional standards and definitions of legitimate certification bodies. Adopting a common baseline definition of specialty certification ensures patients can trust in the integrity of the credential; avoids public confusion about differing credentials; and provides policy makers and health care organizations better guidance when assessing certification programs.

Adopting common language has already been embraced by state and federal governments. In 2024, Colorado included a definition of national board certification in its medical practice act for the first time. More significantly, the United States Congress adopted standards for recognizing certifying bodies to be applied to the 130,000+ person workforce of the Defense Health Agency (DHA), ensuring all active military personnel will have access to the highest qualified specialty physicians. In both cases, the legislative changes adopted were based on language previously developed by the medical profession and adopted by the American Medical Association as well as the definition established by credentialling experts at the Institute for Credentialling Excellence.

Your medical board and other policy makers may also want to consider adopting the standards and definitions already implemented at the DHA requiring that organizations seeking recognition for providing physician certification should, at a minimum:

- Maintain a process to define, periodically review, enforce, and update specific standards regarding knowledge and skills of the specialty or subspecialty;
- Administer a psychometrically valid assessment to determine whether a physician/medical specialist meets standards for initial certification, and recertification or continuing certification;
- Establish and enforce a code of professional conduct; and
- Require that a physician/medical specialist satisfy the certifying body's requirements for both initial certification and recertification or continuing certification requirements of the certifying body that granted the initial certification.

Trust in specialty medical care relies on patients knowing that board certification, regardless of the organization, includes a commitment to certain professional standards. ABMS' certification standards—as implemented by its 24 Member Boards—have long satisfied these baseline standards for purposes of credentialing, privileging, and advertising. Other medical specialty certifying bodies have achieved this same recognition for these same purposes. Some organizations may attempt, however, to become recognized even though they fail to meet these standards. For example, some organizations do not develop specialty-specific standards and psychometrically valid assessments as a part of their programs. Instead, their organizations' programs rely primarily on continuing medical education, and these types of programs significantly deviate from the high-quality certification programs offered by ABMS Member Boards and other recognized certifying bodies. Allowing organizations that cannot meet these basic standards of specialty certification to claim they are offering a certificate with similar rigor and oversight risks patient safety and threatens public trust in specialty medicine.

You can find more information on common approaches to recognizing board certification, as well as resources on the value of ABMS board certification, on our website. We welcome the opportunity to discuss these issues in more detail with your board members and staff and thank you in advance for your attention to this matter of significant importance to public trust in medicine.

Sincerely,

Richard E. Hawkins, MD
President and Chief Executive Officer

From: AKAPA Advocacy Fayette <alaskaadvocacypa@gmail.com>
Sent: Tuesday, February 18, 2025 6:31 AM
To: Norberg, Natalie M (CED) <natalie.norberg@alaska.gov>
Cc: Jen Fayette <jennyfayette@yahoo.com>; Meghan Hall <megcph@gmail.com>
Subject: PA Modernization Senate Bill 89

Honorable Members of the Medical Board,

The Alaska Academy of Physician Assistants (AKAPA) and sponsor Senator Loki Tobin have introduced legislation this session to modernize our licensing and practice in Alaska.

Senate Bill 89 (SB89) is the culmination of many months spent working with physicians and other stakeholders on a solution to the undue administrative burden placed on PAs in this state. The pillars of this bill are similar to the pillars of SB115 from last session with some notable changes:

- Maintain commitment to collaborative practice with all members of the healthcare team.
- PAs with less than 4000 post graduate practice hours must
- have a collaborative agreement.
- Medical Board to determine what specialty changes require additional hours under a collaborative agreement.
- Remote PAs under a collaborative agreement must be able to reach their collaborating physician or a more senior provider while working in clinic.
- Scope of practice determined by the board with the stipulation that PAs are allowed to practice to the full extent of their education, training, and experience.
    - PA regulations created by the Medical Board will not allow a PA to perform surgery independently
- Prevents insurance companies from imposing practice, education or collaboration requirements on PAs that are inconsistent with or more restrictive than imposed in statutes or regulations.
- Updates current medical statutes to ensure that PAs are governed by these state statutes already in place.

As you can see, this bill is more than just about the collaborative plan. PAs are not asking to change how they practice medicine or their scope of practice, they are simply asking for a level playing field when it comes to licensing requirements. If changes are not made to the current structure, the state could lose many experienced PAs leading to reduced access to care, especially in remote and rural areas.

The AKAPA has a Legislative Committee ready and willing to discuss this bill and any concerns you may have. Please reach out to us for any questions. We would appreciate the opportunity to give a short presentation on SB89 to help familiarize the board with this bill.

The future of healthcare in Alaska is shifting. All providers are going to need to work together to ensure that everyone has the access to care they need.

We look forward to hearing from you.

Respectfully,

Meghan Hall, PA-C
Jenny Fayette, PA-C
President AKAPA
Legislative Co-chair
megcph@gmail.com
jennyfayette@yahoo.com
907-227-4132
907-891-1697

AK PA SB89

Support SB 89 to expand access Patient Access to Care

To expand access to all levels of medical care, Alaska must start with ensuring our healthcare workforce is fully supported and empowered. For physician assistants (PAs), that means updating our practice laws.

40% of Alaskans live in regions without adequate access to primary care.

The Alaska Academy of Physician Assistants (AKAPA) asks for your support of SB89.

What would SB89 Do?

SB89 would modernize PA practice statutes to align legislative language with how PAs currently practice—not how they practiced in 1974 when the law was written.

Proposals in SB89 Include:

- Maintain PA commitment to practice medicine in collaboration with physicians and other members of the healthcare team; while enabling PAs to practice to the top of their education, training, and experience.

- Provide a structure for new PAs (<4000 hours) to practice under a collaborative agreement with a collaborating physician that can be addressed and maintained at the practice level

- Allow PAs to provide safe, responsible, and effective quality care to patients.

- PAs will continue to be regulated by the Alaska State Medical Board and subject to all regulations that apply to all medical providers. Additionally, PAs will continue to meet all certification, credentialing, and privilege requirements that may be required by a practice or system.

- Prevents insurance companies from imposing practice, education or collaboration requirements on Pas that are inconsistent with or more restrictive than imposed in statutes or regulations.

How Would SB89 Help Patients?

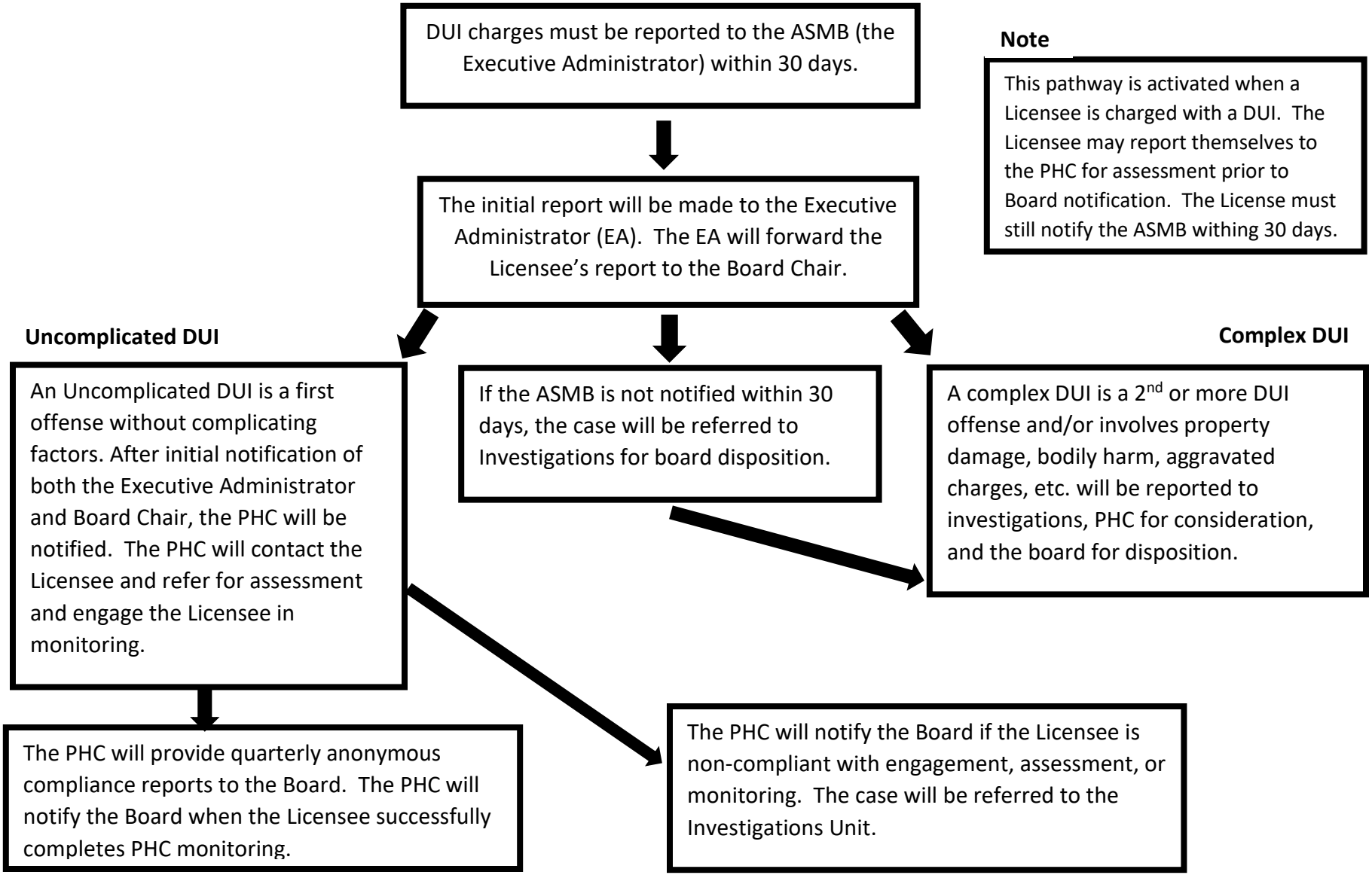
A 2023 survey from The Harris Poll found that more than two-thirds of U.S. adults have seen a PA, and 91% say the PA provided safe and effective healthcare.

PAs are master educated clinicians who practice in every medical setting and specialty.

Updating these practice laws will give medical teams and healthcare employers flexibility to deploy the PA workforce where it may be needed the most without administrative constraints. It will also create a practice environment that is modernized, helping Alaska to recruit and retain more qualified healthcare providers for the state.

Alaska State Medical Board (ASMB) Process for Screening and Referring a Licensee with a DUI

DUI Pathway



Process adopted by the State Medical Board on May 19, 2023

Process for Referring Licensees with DUI Offense to the Physician Health Committee

Licensees who fall under the jurisdiction of the Alaska Medical Board (MD, DO, DPMs and PA's) are required to report to the Medical Board within 30 days of being charged with a DUI.

1. A Licensee reports a DUI charge to the Medical Board. The report is received and reviewed by the Executive Administrator (EA). At a minimum, the Licensee's report should include a copy of the charging document and police report.
2. The (EA) forwards the Licensee's report to the Board Chair. Based on the information provided by the Licensee, a determination is made by the Board Chair regarding whether the incident is considered an "Uncomplicated" offense or a "Complex" offense.

   An Uncomplicated offense is defined as a first offense without complicating factors. Examples of complicating factors are provided under the definition of a complicated offense.

   A Complicated Offense is defined as a 2nd DUI offense and/or includes but is not limited to an incident that involves property damage, bodily harm, or aggravated charges.
3. If the Board Chair determines the offense is Uncomplicated, the Licensee will be referred to the PHC.
   - The PHC will contact the Licensee and refer the Licensee for assessment and engage the Licensee in monitoring.
     - If the Licensee is determined to be compliant with engagement, assessment, and monitoring by the PHC; the PHC will provide quarterly anonymous compliance reports to the Board. The PHC will notify the Board when the Licensee successfully completes PHC monitoring.
   - If the Licensee is determined to be non-compliant by the PHC, the PHC will refer the Licensee to the Board (the EA and Board Chair) and the EA/Board Chair will refer the Licensee to the Investigations Unit.
4. If the Board Chair determines the offense is Complicated, the Licensee will be referred to the Investigations Unit.

15. Applicant Review / License Approvals – DO, MD, PA

	Lic Type	First Name	Last Name
1.	DO	Lance	Robbins
2.	MD	Iram	Ahmad
3.	MD	Paul	Beck
4.	MD	Mark	Byard
5.	MD	John	Diveris
6.	MD	Steven	Foley
7.	MD	Timo	Hakkarainen
8.	MD	Patrick	Healey
9.	MD	Angela	Jackson-Lopez
10.	MD	Gregory	Myrick
11.	MD	William	Seeds
12.	MD	James	Sibbet
13.	MD	George	Wu
14.	PA	John	Milstead
15.	PA	Cheryl	McGovern