HEARTBEAT

THE BIMONTHLY NEWSLETTER OF THE ALASKA STATE MEDICAL ASSOCIATION February 2025

PRESIDENT'S COLUMN

I want to wish all of my colleagues a belated Happy New Year and hope that we will all be able to continue to serve our patients as the medical landscape weathers changes in policy and technology.

I recently had the honor of serving on the Admissions Committee for the University of Washington School of Medicine. During a full week of interviews, a diverse group of volunteer physicians from Alaska and Washington selected the next class of Alaska's medical students. I was again reminded of the rigorous preparation students undertake before entering medical school including undergraduate science curriculum, MCATs, participation in research and often post-baccalaureate science courses. I am inspired by the applicants' enthusiasm for medicine, their dedication to serving patients in Alaska, and the variety of their leadership and service experiences. Getting to know the next generation of physicians is a highlight of my professional year.

Kristin Mitchell,

The Alaska Legislature is now in session, and will consider a number of bills that will affect medical practice in our state. Many legislators are eager to hear from constituents, and physician expert testimony is often very influential as elected officials make decisions.

Senate Bill 89 - https://www.akleg.gov/PDF/34/Bills/SB0089A.PDF would codify in legislation a number of changes in Physician Assistant collaborative prac-

Mitchell Continued Page 3

Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS) changes coming March 31, 2025

REMS Program Companies will be required to provide pre-paid drug mail-back envelopes upon request to pharmacies and other dispensers that dispense opioid analgesics for outpatient use.

Encouraging health care providers to counsel patients on the options for safe disposal of unused opioid analgesics is an important component of the Opioid Analgesic REMS to avoid nonmedical use, opioid use disorder (OUD), and overdose.

More information can be obtained at:
www.opioidanalgesicrems.com or calling 1-800-503-0784.

Medical exam table, circa 1900, for sale. Contact Pam if interested.

Physician Wellness

The **Dr. Lorna Breen Health Care Provider Protection Reauthorization Act (S. 266)**, reintroduced by **Sen. Lisa Murkowski (R-AK)**, would continue to fund two education and awareness initiatives, established by the ***Lorna Breen Act*** in 2022, the first encouraging use of mental health and substance use disorder services by health care professionals, from 2025 through 2029 at $10 million per year. The second awarding grants "to establish or enhance evidence-based or informed programs to improve mental health and resiliency for health care professionals" from 2025 through 2029 at $35 million per year.

ASMA Website Info:

- For those that have not logged in yet, the site did not carry over your password. You **WILL** need to reset it in order to login.
- If you don't have an address in the "personal" field you will not receive mailings. Please login to update your profile.
- Physician images were **not** imported to the new site so please be sure you log in and upload a new photo for the OMD (Online Medical Directory).
- The system currently does not support Company Admin's uploading individual physician photos. You may email photos to Cjeanes@asmadocs.org, but please include the physician name and company so that we can be sure we're uploading to the proper profile.

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tice regulation currently being considered by the State Medical Board. ASMA has participated in discussions about regulation changes and has supported reducing administrative burden for PAs. In addition, the proposed legislation would grant Physician Assistants independent practice after completing 4000 hours of work under a collaborative agreement. ASMA and other physician organizations in Alaska believe that patients are best served by physician-led teams, and do not support this bill as introduced. If you would like to help legislators understand the importance of physician-led teams, please contact Pam Ventgen who can add you to the advocacy team. [** Pam - there may be a better way to do the link]

Bill number xxx: ASMA has worked with the Alaska Hospital and Healthcare Association on a compromise bill to reform the practice of Prior Authorization. While this bill does not solve all prior authorization issues, we believe it will significantly improve timely access to appropriate care for our patients and reduce unnecessary administrative burdens on medical practices. [**Pam please insert a bill number if you have it by press time]

Replacement of the 80th Percentile rule. Much has been written in these pages about this patient protection from balance billing and the effects of its repeal last year. ASMA is supporting replacement legislation which includes [** Pam I'm not finding Jeff's elevator pitch about this one - can you help condense here?]

Naturopath scope expansion - We anticipate that a bill may again be introduced granting Naturopaths broad prescriptive authority for FDA approved pharmaceuticals. Previous versions of this bill have also allowed for naturopaths doing office surgical procedures. ASMA maintains that Naturopaths have a role in complementary and alternative medicine for those who chose that approach, but that their education and training is not equivalent to physician training and does not prepare them to safely prescribe and monitor prescription drugs. If you feel strongly about this issue, please contact Pam Ventgen to be added to the advocacy team.

As you can see, 2025 is shaping up to be a busy year for advocacy in Alaska. Our state medical association does not usually engage with national issues, but with the unanimous recommendation of the ASMA Board of Trustees, we sent a letter to our Senate delegation to *"assert unequivocally that health decisions should be made in a scientific way with policy firmly grounded in evidence-based data."*

In this season, I find myself appreciating the longer days as I walk my rescue dogs on the beach, admiring nature's ice sculptures. I hope you too find renewal in the abundance Alaska has to offer.

Kristin Mitchell, MD, FACP

History/Explanation – *80th percentile and need to replace*

The Alaska State Medical Association (ASMA) is spearheading efforts to introduce and pass two pieces of legislation which are vital to the financial survival of medical practices in Alaska. These statutes would replace the repealed so-called 80th percentile regulation and establish provider network minimum standards for insurance companies. Although separate measures, the two bills would work in tandem to reestablish balance between insurers and providers, something that has been undermined over the last eight years but was significantly reduced by the repeal of the so-called 80th percentile regulation January 1st, 2024.

80th PERCENTILE REPLACEMENT

In 2004, the Alaska Division of insurance established the 80th percentile regulation to protect Alaskans from the large balance bills they were experiencing. (A balance bill is the difference between a provider's charge and the amount covered by an insurance policy.) At the time, most Alaskan providers were not under contract with insurers, so insurance companies applied their own interpretation of a "reasonable" or "allowable" charge to the provider's bill and paid the insured's benefits against that amount. The databases insurers were using to determine allowable charges were from lower cost markets and did not accurately reflect the cost of doing business and charges in Alaska, leaving Alaskans with large balance bills. The 80th percentile regulation required insurers to base allowable charges on the 80th percentile of charges in a specific geographic region in Alaska using a statistically valid methodology. The establishment of the 80th percentile regulation worked to protect Alaskans from large balance bills.

The unintended downside of the regulation was if a provider had 21% or more of the market for a given service in a specific geographic region their charges became the minimum allowed under the regulation. This gave providers with "monopoly power" the ability to drive up charges, substantially in some cases.

An unintended upside of the regulation was it became the standard against which providers negotiated with insurance companies. Specifically, a provider would evaluate the terms offered by an insurer with respect to what they would be paid at the 80th percentile as a non-contracted provider. If the terms were close to the 80th percentile, the provider was likely to accept them, as being in network brought other value like higher benefit payments for their patients. If the terms offered were much lower than the 80th then the provider would choose to stay out of the network.

In the period between 2014 and 2017 most Alaskan providers became contracted, or in-network providers, with the major insurers. Since the regulation only applied in the absence of a contract, the importance of the regulation to control balance billing became less important. Also, the opportunity for a provider to exert control over the minimum allowable disappeared when a contract was signed. By 2023 it is estimated only about 400 providers in the state remained out of network and almost all of those were not in what would be considered the mainstream areas of practice. What remained important was the balance the 80th percentile provided at the bargaining table. When the state repealed the 80th percentile regulation effective January 1, 2024, they did so without specifying a replacement. Instead, they left it to the insurers to determine their own standard, virtually turning the clock back to 2004 when the regulation was first established. Premera Blue Cross Blue Shield of Alaska with approximately 85% of the insured business in the state chose to use 185% of the Medicare Physician fee schedule as their standard. For reference, depending on the specialty and region, the 80th percentile was between 450% and 550% of the Medicare fee schedule on average. The effect of this change at the bargaining table has been devastating to providers. The insurers are using this shift in market power to drive significantly lower rates as the alternative for a provider, going out of network at 185% of Medicare, is not financially viable. In fact, several practices have closed as a result and anecdotally many others are planning to leave the state as they see what is coming.

The 80th percentile replacement bill being spearheaded by ASMA with strong support of Senate leadership would establish a new floor at the 75th percentile of market using the entire state as the measurement area rather than breaking into four regions and would be updated every three years instead of annually. It would also include a provision that primary care would be the greater of the 75th percentile or 450% of Medicare. With these changes, balance would be restored at the bargaining table, Alaskans would be protected from balance billing and the opportunity to exercise market power by one practice would be virtually eliminated.

INSURER PROVIDER NETWORK MINIMUMS

In the Lower 48 insurers widely employ the tactic of contracting with a subset of providers in the market to create a narrow network. Insurers do this to extract favorable terms from providers, presumably in exchange for delivering an additional volume of patients. However, the fact is, providers often agree to lower reimbursement rates only because the consequences of being left out of the network would be financially devastating. Insurers also benefit by avoiding costs because insureds have difficulty getting appointments to access care from a limited number of providers. The prospect of narrow network products

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being deployed in Alaska is especially troubling as all of Alaska is a federally designated healthcare professional shortage area. Premera Blue Cross Blue Shield of Alaska leadership has publicly expressed their desire to offer narrow network products in Alaska to deliver lower price products to consumers in exchange for "giving up a little bit of choice". In some markets in the Lower 48, insurers have used networks with as few as 21% of the available market providers. Narrow network products present serious potential health risks to consumers as it is very difficult to assess the adequacy of an insurer's network at the time of purchase. These products often have no benefit or significantly reduced benefits if an insured uses an out-of-network provider. Narrow networks present serious potential financial issues for Alaska providers who may be left out of contracts causing them to lose much needed patient volumes. And a subset of providers in a federally designated healthcare professional shortage area would undoubtedly have adverse consequences for Alaska patients!

Unlike 39 states and territories, Alaska has no defined standard for determining if an insurer's network is adequate. The National Association of Insurance Commissioners, (NAIC), the association for insurance regulators nationwide, has stated that network minimum standards are the most important thing a state can do to have well-functioning healthcare and health insurance markets.

The provider network minimum statute being spearheaded by ASMA, again with strong support from Senate leadership, would follow the NAIC model and establish standards adopted to the unique geography, population distribution and density and provider availability in Alaska. It would establish minimum percentages of providers and practices, by specialty, by geography, which must be included in an insurer's network to provide insured/regulated products in Alaska. Phase in provisions are included in the bill.

These two bills work together to restore balance at the bargaining table between providers and insurers. With balance restored, providers can successfully negotiate terms sufficient for financial viability into the future. A financially healthy provider community also provides the means to recruit enough high-quality providers to meet the needs of the community, something which is sorely needed in all medical specialties! ASMA would welcome your partnership with these critical measures!

Thank you for your interest in this work and thank you in advance for your support. If you have any questions or would like more information, please reach out to Jeff Davis at jeffrey@westongroupconsulting.com or Pam Ventgen, Executive Director, Alaska State Medical Association at pventgen@asmadocs.org.

New DEA Telehealth Prescribing Rules

In January the U.S. Drug Enforcement Administration (DEA) released three new rules impacting prescribing controlled substances via telehealth, including the long-awaited regulations regarding establishing a telehealth prescribing registration process that was first mandated by Congress back in 2008. While the registration regulation is a proposed rule, the two additional rules regarding buprenorphine and Veterans Affairs providers are final rules:

Proposed Rule – Special Registrations for Telemedicine and Limited State Telemedicine Registrations

Final Rule – Expansion of Buprenorphine Treatment via Telemedicine Encounter

Final Rule – Continuity of Care via Telemedicine for Veterans Affairs Patients

Each of the rules seek to create permanent exceptions to the existing in-person evaluation requirement related to the prescribing of controlled substances. Readers may recall that the DEA's current permanent telehealth prescribing policies have been waived since the onset on the COVID-19 public health emergency (PHE) with the current temporary waiver currently slated to expire at the end of 2025. While these final and proposed regulations by the DEA would expand permanent policies, they will not be as broad as what has been seen during the temporary waiver period.

SPECIAL REGISTRATION RULE

This proposed rule would create a special registration framework that authorizes three types of telemedicine registration, in addition to additional prescribing, recordkeeping, and reporting requirements. The special registration framework requires registrants to utilize both audio and video components of an audio-video telecommunication system for each telemedicine encounter. The three types of special registration, include:

1. The ***Telemedicine Prescribing Registration***, authorizing qualified clinician practitioners to prescribe Schedule III-V controlled substances;
2. The ***Advanced Telemedicine Prescribing Registration***, authorizing qualified specialized clinician practitioners (such as psychiatrists and hospice physicians) to prescribe Schedule II-V controlled substances; and

The ***Telemedicine Platform Registration***, authorizing qualified covered online telemedicine platforms, in their capacity as platform practitioners, to dispense Schedule II-V controlled substances (through providers possessing either of the above registrations).

The proposed rule also requires special registrants to maintain a State Telemedicine Registration issued by the DEA for every state in which a patient is treated by the special registrant, unless otherwise exempted. Using a new registration application form, known as Form 224S, the three types of Special Registrations (Telemedicine Prescribing Registration, Advanced Telemedicine Prescribing Registration, and Telemedicine Platform Registration), and the State Telemedicine Registration (one type for clinician special registrants and one type for platform special registrants) would be on a three-year cycle. Applicants are required to already hold one or more DEA registrations to prescribe or dispense controlled substances. For additional information on special registration eligibility by provider type and limited exemptions to the state telemedicine registration requirement, as well as proposed registration processes, fees and reporting requirements, please see the proposed rule in its entirety.

According to the proposed rule, special registration prescriptions must be prescribed through electronic prescribing for controlled substances (EPCS), and after the special registrant has verified the identity of the patient. Providers also must conduct a nationwide Prescription Drug Monitoring Program (PDMP) check of all 50 states and any U.S. district or territory that maintains its own PDMP. However, the nationwide PDMP check requirement would have a delayed effective date of three years. Meanwhile, for all Schedule II-V controlled substances, registrants are required to conduct a PDMP check of:

1. The state/territory where the patient is located;
2. The state/territory where the clinician special registrant is located; and

Any state/territory that has a PDMP reciprocity agreement with the states/territories where the patient and clinician special registrant are located.

Additionally, special registration prescriptions will require the inclusion of the Special Registration numbers of the clinician special registrant and the platform special registrant (if a platform special registrant facilitated the prescription), and State Telemedicine Registration numbers. The DEA believes this requirement will additionally help pharmacists verify legitimate prescriptions and limit "red flags" from being inappropriately attached to telehealth prescriptions.

The DEA specifies in the rule that the special registration process and related requirements do not apply in situations where a prior in-person evaluation has occurred, if the encounter meets one of the other current exceptions for telehealth, as well as in situations captured by the new finalized rules specific to buprenorphine and Veterans Affairs providers (which are discussed

DEA Telehealth Continued on pg 7

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more below). The DEA also clarifies that special registrants still need to comply with the laws and regulations of the state in which registered, and the laws and regulations of the state in which they are issuing special registration prescriptions via a telemedicine encounter. This includes state laws governing standards of medical practice and requirements around establishing patient-provider relationships prior to prescribing. Registrants also must be present in the United States during the time of the telehealth visit and when issuing prescriptions.

For Schedule II controlled substances, given the higher potential for abuse and dependence, the DEA proposes two additional requirements:

1. The clinician special registrant must be physically located in the same state as the patient when issuing a special registration prescription for a Schedule II controlled substance
The average number of special registration prescriptions for Schedule II controlled substances constitutes less than 50 percent of the total number of Schedule II prescriptions issued by the clinician special registrant in their telemedicine and non-telemedicine practice in a calendar month

Lastly, the DEA rule seeks to account for different telehealth models by specifically addressing online telemedicine platforms employing a direct-to-consumer (DTC) business model. The rule determines the platforms to be serving as prescribing and dispensing intermediaries, and therefore falling under broad statutory definitions for practitioners, which must be qualified and accountable to the DEA. The rule discusses concerns specific to the DTC model justifying the need to consider them as a certain subset of practitioners, including practices that may incentivize inappropriate prescribing and limit provider access to patient records (find more information in CCHP's June 2024 *Differences Between Teletherapy and Platform Therapy* newsletter). The proposed DEA rule defines "covered online telemedicine platforms" while exempting hospitals, clinics, insurers, as well as "local in-person medical practices", to differentiate between the models and ensure application of the special registration requirements appropriately. Additional criteria are attached to determining status as a covered online telemedicine platform, including meeting one or more of the following:

1. The entity explicitly promotes or advertises the prescribing of controlled substances through the platform;
2. The entity has financial interests, whether direct incentives or otherwise, tied to the volume or types of controlled substance prescriptions issued through the platform, including but not limited to, ownership interest in pharmacies used to fill patients' prescriptions, or rebates from those pharmacies;
3. The entity exerts control or influence on clinical decision-making processes or prescribing related to controlled substances, including, but not limited to: prescribing guidelines or protocols for clinician practitioners employed or contracted by the platform; consideration of clinician practitioner prescribing rates in the entity's hiring, retention, or compensation decisions; imposing explicit or de facto prescribing quotas; directing patients to preferred pharmacies; and/or
The entity has control or custody of the prescriptions or medical records of patients who are prescribed controlled substances through the platform.

This proposed rule was published in the Federal Register on January 17, 2025. Public comments must be submitted, and written comments must be postmarked, on or before 60 days after that date of publication, which would be March 18, 2025. Comments will not be accepted after 11:59 p.m. Eastern Time on the last day of the comment period. The proposed rule contains many other specific details regarding the three proposed registries, including a section on required documentation and data collection. CCHP highly encourages you to read the full proposal if the topic is of interest to you.

BUPRENORPHINE RULE

Existing law authorizes telemedicine prescribing only in specified circumstances when no in-person visit has occurred. This new buprenorphine rule additionally falls under existing exceptions and is a finalized version of the March 2023 proposed rule, Expansion of Induction of Buprenorphine via Telemedicine Encounter. The final rule has been modified, however, to address comments and concerns raised with the proposed version. The DEA also stresses that the limitations and requirements within the final rule do not apply to provider-patient relationships where a prior in-person medical evaluation has occurred. Under the rule, DEA-registered providers are authorized to prescribe buprenorphine for treatment of opioid use disorder (OUD) via audio-only or audio-video telemedicine as follows:

A DEA-registered practitioner, prior to issuing a prescription via telemedicine for a schedule III-V controlled substance approved by the Food and Drug Administration (FDA) for use in the treatment of opioid use disorder (OUD), must review the prescription drug monitoring program (PDMP) data of the state in which the patient is located when the telemedicine encounter occurs
The practitioner is authorized to prescribe up to an initial six-month supply (split amongst several prescriptions totaling six calendar months); additional prescriptions may be issued under other forms of telemedicine as authorized by the Controlled Substances Act (CSA) or after an in-person medical evaluation is conducted
The pharmacist must verify the identity of the patient prior to filling the prescription

The main changes between the new final rule and the 2023 proposed rule include expanding the initial 30-day prescription supply limitation via audio-only to a six-month supply, and removing in-person requirements for subsequent prescriptions. Since it is possible a patient will not be seen in-person by the prescribing practitioner at any point, the DEA added the pharmacist identification verification requirement. Additionally, many of

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Alaska State Medical Association

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January 22, 2025

The Honorable Senator Lisa Murkowski
The Honorable Senator Dan Sullivan

Delivered via email: services@murkowski.senate.gov and sara_berkemeier-bell@sullivan.senate.gov

Senators Murkowski and Sullivan,

I write as the president of the Alaska State Medical Association to express the concern of our Board of Trustees about qualifications of cabinet nominees subject to your advice and consent.

We honor the diversity and independence of political affiliations among Alaskans, and at the same time assert unequivocally that health decisions should be made in a scientific way with policy firmly grounded in evidence-based data. The health of the American public is too important to leave supervised by someone without impeccable credentials.

We agree with Dr Benjamin of the American Public Health Association that

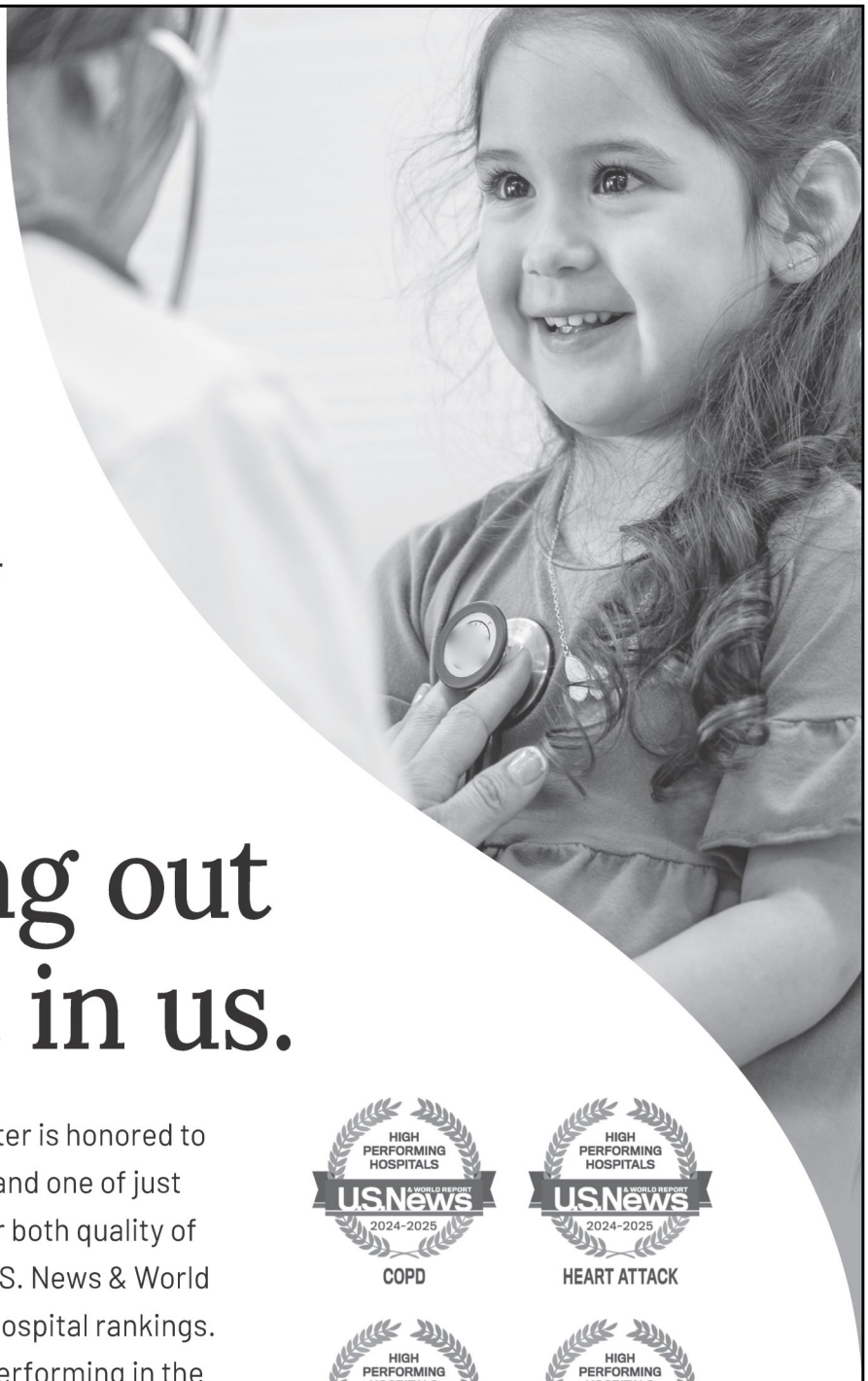
To effectively lead our nation's top health agency, a candidate should have the proper training, management skills, temperament and the trust of the public.

Here in the Great State of Alaska, we have long memories. We share in the generational trauma of the influenza pandemic of 1918 that decimated communities, particularly in rural Alaska. We honor the heroic efforts to bring lifesaving serum to residents of Nome during the 1925 diphtheria epidemic with our annual Iditarod race. We esteem our colleagues whose efforts were instrumental in bringing an effective vaccine to Alaska to stop deaths from Hepatitis B and liver cancers. We grieve with families whose children are sickened and have died from this fall's pertussis outbreak. We are holding our collective breath as I write, hoping that the serious case of measles identified recently in an unvaccinated adult does not spread to others who shared an airplane or airport visit with that person. All these illnesses, influenza, diphtheria, pertussis, measles, hepatitis B are now vaccine preventable. Vaccines are estimated by the WHO to have saved over 150 million lives over the past 50 years.

We need a leader of the nation's public health who can objectively evaluate the science- based safety and risk data related to vaccination and other essential health interventions. ASMA leaders urge you not to confirm someone who does not base their decisions on scientific evidence. Alaskans and all Americans deserve better.

Thank you all for your service to the country and to our state.

Kristin M Mitchell MD FACP
President, ASMA



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the recordkeeping requirements from the proposed rule have been removed within the final rule. In regard to the PDMP review requirement prior to prescribing, the provider will need to annotate date and times of PDMP review. If the PDMP is unavailable or inaccessible, review attempts should also be noted while the provider can continue to prescribe renewable seven-day prescriptions until the six-month limit is reached, and while continuing to attempt to review the PDMP every seven days.

This rule is effective 30 days after publication in the Federal Register, which was on January 17, 2025; therefore, the rule will be effective February 18, 2025.

VETERANS AFFAIRS RULE

This rule finalizes the VA portion of the March 2023 proposed rule, Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient have Not Had a Prior In-Person Medical Evaluation. The rule authorizes Department of Veterans Affairs (VA) practitioners acting within the scope of their VA employment to prescribe controlled substances via telemedicine to a VA patient with whom they have not conducted an in-person medical evaluation, if another VA practitioner has, at any time, previously conducted an in-person medical evaluation of the VA patient, subject to certain conditions. These conditions include reviewing both the patient's VA electronic health record (EHR), which includes the internal VA prescription database, and the prescription drug monitoring program (PDMP) data for the state in which the VA patient is located at the time of the telemedicine encounter (if the state has such a program).

If the VA EHR or state PDMP are unavailable or inaccessible, the practitioner must limit the prescription to a 7-day supply and must later review both the patient's VA EHR and the PDMP data for the state in which the patient is located at the time of the telemedicine encounter before continuing to prescribe controlled substances to the patient via telemedicine. If no PDMP program exists for the state in which the VA patient is located, the provider must review the VA EHR prior to issuing a prescription for more than a 7-day supply. The DEA notes that this rule does not apply to contracted practitioners located outside a VA facility or clinic providing care via the community care network (CCN) or conducting disability compensation evaluations.

The DEA notes that while this rule is specific to VA practitioners given the unique closed system in which they operate, the DEA is committed to periodically evaluating whether extending this authority to non-VA practitioners may be appropriate in the future. Meanwhile, the DEA references and directs the public to the proposed Special Registration rule, which addresses telehealth prescribing for non-VA practitioners. In the meantime, the DEA's temporary in-person requirement exemption implemented at the beginning of the COVID-19 PHE has been extended through December 31, 2025, while they work to establish permanent policies applicable to non-VA providers.

This final rule is effective 30 days after publication in the Federal Register, which was on January 17, 2025, making the rule effective February 18, 2025.

The DEA notes its decision in the VA rule to not adopt the broader telemedicine prescribing scheme initially proposed in the March 2023 proposed rule, Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient have Not Had a Prior In-Person Medical Evaluation. That rule received a total of 35,454 comments and was subject to considerable concern and pushback from stakeholders. Many in the telehealth community also lamented the lack of regulations addressing telehealth registration at that time, to which the DEA has also responded with its newly proposed special registration rule. Nevertheless, recent articles released in response to the new rules seem to indicate many stakeholder concerns remain related to the additional restrictions and requirements included, such as those related to limiting certain telehealth prescriptions to a specific percentage and checking PDMPs nationwide. Some have also asserted the rules may not have been quite ready but were released to ensure they were not lost amidst the forthcoming federal administration change. Again, while the more tailored regulations specific to buprenorphine and the VA are now final, the special registration regulations are still simply proposed and subject to change. Additionally, the public has 60 days to provide comments on the registration proposal.

For more information on the new DEA rules, please view the regulations in their entirety: Proposed Rule – Special Registrations for Telemedicine and Limited State Telemedicine Registrations; Final Rule – Expansion of Buprenorphine Treatment via Telemedicine Encounter; Final Rule – Continuity of Care via Telemedicine for Veterans Affairs Patients.

ALASKA PSYCHIATRIC ASSOCIATION - CME MEETING DRAFT AGENDA

COLUMBIA BALLROOM / THE HOTEL ALYESKA / GIRDWOOD, ALASKA

APRIL 4 - 6, 2025

DATE/TIME	EVENT SCHEDULE	SPEAKER
FRIDAY, APRIL 4, 2025		
7:00 - 8:30 AM	Registration and Breakfast	
8:30 - 10:00 AM	Substance Use Disorders, Evaluation and Treatment	Arwen Podesta, MD
	BREAK	
10:30 AM - 12:00 PM	Interactive Psychiatry & Lifestyle Medicine	Arwen Podesta, MD
	LUNCH	
1:30 - 3:00 PM	School Shooters: Troubled Teens or Cold Blooded Killers?	Phillip Resnick, MD
	BREAK	
3:30 - 5:00 PM	Addressing Gun Violence: Strategies for Psychiatrists	Phillip Resnick, MD
5:00 - 7:30 PM	Dinner (?)	
7:30 - 9:00 PM	Movie and Discussion	
SATURDAY, APRIL 5, 2025		
7:00 - 8:30 AM	Registration and Breakfast	
8:30 - 10:00 AM	Physician Wellbeing, Crisis and System Change	Richard Summers, MD
	BREAK	
10:30 AM - 12:00 PM	Change is the Goal of Psychodynamic Therapy	Richard Summers, MD
	LUNCH	
1:30 - 3:00 PM	Psychopharmacology of the Medically Ill	James Levenson, MD
	BREAK	
3:30 - 5:00 PM	Somatic Symptom and Related Disorders Case Presentations with Q&A	James Levenson, MD
7:30 - 9:00 PM	To Be Determined	
SUNDAY, APRIL 6, 2025		
7:00 - 8:30 AM	Registration and Breakfast	
8:30 - 10:00 AM	Prevention of Medical Errors/Quality Improvement/Patient Safety	Jacqueline Hobbs, MD, PhD
	BREAK	
10:30 AM - 12:00 PM	Perinatal/Reproductive Psychiatry	Jacqueline Hobbs, MD, PhD

Contact Tammy Thiel | 907-242-2090 | tthiel@nextwavegroup.net

ALASKA PSYCHIATRIC ASSOCIATION

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