Alaska HB 228 Psychedelic Medicine Task Force

Meeting 5 | April 16, 2025, 5:15-7:00 pm | via Microsoft Teams & Streamed on AKLeg.TV

Participants

Task Force Members

Name	Role	Affiliation	Attend
Sen. Forrest Dunbar	Co-chair	Alaska Senate, Attorney	*Absent*
Rep. Justin Ruffridge	Co-chair	Alaska House, Pharmacist	*Absent*
Dr. Robert Lawrence	Member, AK DOH	Designee, Chief Medical Officer, Dept. Health	Present
Angela Laflamme	Member, AK DMVA	Designee, Dept. Military & Veterans Affairs	Present
Glenn Saviers	Member, AK DCCED	Designee, Dept. Commerce, Community & Economic Development	Present
Justin Heminger	Member, NAMI	NAMI Alaska	Present
Ann Ringstad	Alternate, NAMI	NAMI Alaska, Executive Director	Present
Dr. Kristen Maves	Member, ANHB #1	Southcentral Foundation, Pharmacist	Present
Dustin Allen	Member, ANHB #2	Knik Tribe, Clinical Supervisor	Present
Lauree Morton	Member, ANDVSA	Alaska Network on Domestic Violence and Sexual Assault, Deputy Director	Present
Dr. Paula Colescott	Member, ASMA	Alaska State Medical Association	Present
Dr. Lisa Lindquist	Member, APA	Southcentral Fdn.; AK Psychiatric Assn.	Present
Dr. Michael DeMolina	Member, AAPA	Wisdom Traditions Counseling	Present
Sara Kozup-Evon	Member, APRN	Advanced Practice Registered Nurse Alliance	Present
Dr. Brittany Karns	Member, AKPhA	Alaska Pharmacy Association	*Absent*
Jennie Armstrong	Member, At Large	Former Alaska Rep., HB 228 sponsor	Present

Others Present

Name	Role	Affiliation
Sethan Tigarian	Task Force support	Office of Sen. Dunbar, staff
Anna Brawley	Facilitator	Tiny Birch Consulting, contract support

Summary Notes

NOTE: Prior to the meeting, Co-Chair Dunbar e-mailed the group to state he would not be present to chair the meeting, and that given the legislative schedule of the House, Co-Chair Ruffridge would also likely not be available. In the event both chairs were absent for this meeting, chair authority was temporarily delegated to member Dr. Lawrence.

Call to Order, Initial Meeting Business

- The meeting was called to order by Lawrence (acting co-chair) at 5:17 pm.
- Roll call established that a quorum of members was present.
- Disclosures: None from members.
- **Meeting 5 agenda approval**: Motion to approve agenda by DeMolina, second by Morton.
    - *Discussion*: No comments or additions.
    - *Vote*: No objection. Agenda approved.

- **Meeting 4 notes approval**: Motion to approve notes by Colescott, second by Heminger.
    - *Discussion*: No comments or additions.
    - *Vote*: No objection. Notes approved.

Review and Discuss Report Recommendations

- Brawley shared and walked through updated report draft. The group focused on new or modified recommendations, and what requires discussion; recommendations not flagged for revision will be included in the public comment draft.
- Members who drafted recommendations gave brief explanations, with additional changes identified by the group and noted in the document.
- Discussion on Lawrence recommendations: his changes are additional language to identify other boards who should be consulted regarding regulations, and expanding on recommended actions for the Controlled Substances Advisory Committee, also identified by Dr. Colescott as a body who should be involved in any future discussion and regulatory decision making processes.
    - Group agreed to remove word "legitimate" describing FDA-approved uses of these products, it is implied.
- Discussion on Saviers recommendations:
    - One recommendation adds a reference to consulting the Pharmacy Board, equivalent to the prior recommendation, and also noted there is a bill (SB 147) related to pharmacists being able to prescribe, if that passes this would be relevant. No objections or changes.
    - A separate recommendation suggests that if the group decides, instead or in addition to the recommendation to allow prescription authority for providers with existing authorization, to create an endorsement on a license (she is not advocating this, but posing to the group wanting this to be an endorsement). From a regulatory perspective, this would mean that providers would be required to show to the State that they have sufficient training, or if there is an existing accreditation or other requirement established for providers, they would be eligible. The details could be determined in regulation, with the appropriate board overseeing, but it would be helpful for DCCED to understand what the group's thoughts or position is.
    - Kozup: What are examples of endorsements on licenses?
        - Saviers: One example, DEA registration and being registered with the PDMP, their license would have a "DEA-registered" or "PDMP-registered" information. Dentists who administer sedation has to get an additional permit, approved by their board, and this is added to the license. These designations are connected to the license, it's optional, but there is an application & maintenance process. Advance Practice Nurse Practitioners can also get specialties added to their license, showing that they have completed training.
            - Kozup: Training would typically be before getting a license.
            - Saviers: But, they can also be added at any time, in the future.
    - Kozup: Who would regulate ANPs if they are certified, the Board of Nursing likely?
    - Lawrence: Invited providers to speak to how this might impact them.
    - Kozup: On the one hand, cost would likely be passed on to the provider, boards are supposed to be budget neutral and there are fees. On the other hand, because of the

risk of patient exploitation, having this layer of certification or endorsement would be valuable for addressing bad practices.
    - Saviers: Agree, there are pros and cons. Would like the group to consider whether to require endorsement, given the increased cost but greater level of protection.
    - Morton asked for clarification: is this alternative recommendation meant to be instead of the first recommendation?
    - Saviers: Meant to be an alternative to the idea of allowing any practitioner to be able to prescribe, without additional training or endorsement required—if the group wants to have more requirements for being able to prescribe, this is an option to consider.
    - DeMolina: His working assumption has been that the FDA will likely require an X-waiver (DEA), and knows providers around the country are seeking additional trainings. He suggested a guideline of training (such as number of hours), if the federal government does not have a standard or outline on this then Alaska should also require it. This prescription is very different than most, so training is essential.
    - Colescott: Agree, this medication should require significant training.
    - Lindquist: During medical training/residency, there are often required trainings to complete, and those are determined by the medical board. She anticipates that at some point it would be likely that psychiatrists completing residency will be required to complete this training, so in the future, this may be true for other provider types as well.
    - Saviers: Supports DeMolina's comment that it should not duplicate other existing training or certification requirements in place, but if there are not any at the federal level, that the State should consider adopting a standard. If a certification included certain required trainings, they don't need to confirm the training itself too.
    - Group agreed to modify the recommendation, reference whether an endorsement is required, depending on what the required trainings are at that time. An endorsement may not be required if there are minimum standards or trainings for certain providers.
- Discussion on DeMolina recommendations
    - This is a brief version of best practices established to date, including use of medication in context of psychotherapy, including preparation sessions and integration sessions to process the experiences during medicine sessions. He can provide more background information if people are interested. He emphasized that this is "psychedelic-assisted therapy," not "therapy assisting psychedelics use." The entire process is the treatment.
    - He noted that psychedelics are a "bottom-up" therapy, they are a form of exposure therapy because it involves re-experiencing but also engaging with new perspective or new meaning-making with the experience, to address a traumatic experience. Also recommended, for example, having specific training depending on the diagnosis being treated. For example, being a therapist who specializes in treating PTSD for combat veterans will also need specialized training, because of the nature of the topic.
    - Recommendations around necessary training components – there is a table outlining an example of credentialing and training requirements, group will discuss shortly. Group was hesitant to make specific recommendations about number of hours required, or having a detailed list of topics to include as recommendations.

- Lindquist: Recommend striking “psychological evaluation” in recommendation language, only certain physician types are authorized to conduct that. There may need to be a broader, more inclusive description.
- DeMolina: His office does a number of measures and assessments for depression, PTSD, suicidality measures, etc. before commencing treatment, those can inform how the patient is treated and monitored.
- Lindquist: Recommended instead saying “clinical evaluation” which can be inclusive of assessments and the types of measures providers may use to assess the patient.
- DeMolina: Pointed out there are medical risks, such as cardiovascular, and also exclusionary criteria for other conditions such as bipolar disorder (for some medications).
- Colescott: Would this recommendation mean Traditional Healers are acting independently, or that they would be a required part of the treatment team? Or would this include patient choice?
- DeMolina: No, the recommendation is not intended to require participating in Indigenous or traditional practices for each individual’s treatment. It means that this provider type should be considered part of the system overall, to ensure patients can access culturally relevant care, there would be options overall in provider types.
- Lindquist: The Healer position would be part of a team, and may act as a facilitator or part of the care team. They would not necessarily be in every step of the process, nor would they be required, the patient would still have a choice in who or what care they utilize. For her employer, for example, patient self-determination is very important. There is also existing training for traditional healers, and there could be additions.
- Morton: What is meant by multidisciplinary team, and would that create access challenges especially for people in rural areas?
    - Lindquist: In some situations, one provider may play multiple roles on the team during treatment. Telehealth would also be possible, especially for assessment, similar to other practices already being done within the system.
    - DeMolina: He works within one practice, but he is interested in the possibilities for telehealth use of some products such as ketamine.
    - Lindquist: Even with telehealth interventions, likely would need someone in person (such as behavioral health aide) and coordination remotely to provide oversight. In Tribal health in particular, patients utilize self-determination.
- Ethics: There is a MAPS code of ethics, which he has his staff sign in addition to their existing codes of ethics and requirements by discipline.
    - Colescott: The ethics code recommends having 2 practitioners participate in monitoring, what is the rationale?
        - DeMolina: Partly this is because of the length of time, someone may need to leave the room or stop for a snack, but still having someone present especially if there is a trauma experience or medical issue.
    - Lindquist: May want to recommend incorporating references to national ethical standards, requiring adherence to those standards as part of the regulations for licensure or certification.
- 6: Recommendation for training and certification

        - Colorado, and more recently New Mexico, have so far the strongest standards for this practice; Oregon also has a structure in place that is less strict. This is structured on Colorado, with clear guardrails for licensed and non-licensed providers in terms of training, adherence to ethics code, etc.
        - Colescott: Should there always be a licensed practitioner for use?
        - DeMolina: There is potentially a separate effort for broader legalization, which could come to pass and allow non-medical use.
        - Colescott: Skeptical that this is sufficient, especially if someone has a serious medical issue during treatment. If there is a crisis, who would be responsible?
        - DeMolina: Would the prescriber be responsible?
        - Lindquist: The facilitator would also need to be practicing within a clinical setting. One requirement would be clinical supervision, someone responsible and having a direct supervisory experience.
        - DeMolina: Colorado certifies both the individual, and the training center.
    - Credentialing matrix discussion
        - DeMolina: This is examples, based on Colorado model as well as utilizing existing providers and certification levels.
        - Morton: Explain, would this mean no one can get this credential until they have 3 years specifically with this work? If it was specific to having that experience, no one would be able to attain this.
        - DeMolina: This would mean existing practitioners.
        - Lawrence: Originally he thought about this primarily as prescribers, but clearly this is broader. There are a variety of roles and provider types within the treatment overall, both medical and behavioral health.
- Discussion on Kozup (reimbursement, billing) recommendations
    - Kozup had to leave the meeting prior, and was not available to speak to the recommendations; Brawley briefly presented the section regarding insurance coverage for psychedelic therapies.
    - Group reviewed, no recommended changes, agreed these should be included in draft.

Public Comment Process

- Brawley shared the agenda, which includes a short timeline for public comment on the draft recommendations and next steps:
    - Monday, April 21: Prepare draft recommendations and finalize public comment flyer
    - Public comment open through Monday, May 5 (2 week period)
    - Hold public hearing for testimony at Tuesday, April 29 meeting, can participate in person in Juneau, or (more practical for most) call in to the Legislative teleconference system.
    - All comments received by Monday, April 28 will be provided in April 29 meeting packet; comments received after that will shared by e-mail to the Task Force.
    - Plan for April 29 meeting: the group will (time permitting) have time for a debrief and discussion of next steps in the timeline, but will not plan to take a vote on recommendations, since there will likely be changes to consider.
    - This will require quick turnaround, and also, it is a working draft that can be modified and improved after taking in public comment, so it is a work in progress.

- Members identify organizations and networks to share the item with:
    - Alaska State Medical Association, ask them to distribute out to members.
    - APA, and a member of the Academy of Family Medicine.
    - DeMolina will share within Psychedelic "gated community" Facebook group, and emphasize the group is seeking feedback on the substance, not position statements
    - Medical Board and Nursing Boards
- Lawrence: We should give guidance how long people can testify. Group agreed on 3 minutes.
- DeMolina: Should we limit to Alaska citizens/residents only? Group agreed there is no formal restriction on this; however, the purpose is to gather meaningful feedback on the content, not gather support and opposition statements on other topics like legalization.
- Next steps: Brawley and drafting volunteers will update report for distribution; staff will finalize public notice flyer with information about public comment. Will publish report and flyer by Monday, April 21 for all Task Force members to distribute to their networks.

Meeting Wrap-Up, Adjournment

- Homework for members:
    - Read the draft recommendations, send any corrections or additions ASAP by Monday
    - Identify individuals, organizations, networks to share public comment information
    - Share the notice widely, and encourage people to participate!
- Closing comments:
    - Thanks to Dr. Lawrence for filling in as chair!
- Motion to adjourn by Lindquist, second by Lawrence. No objection, adjourned at 7:15 pm.
- Next meeting: Tuesday, April 29, 2025 at 5:15 p.m. Public comment will start at 5:30 pm.