DIRECTOR'S REPORT ON THE PROPOSAL TO MAKE CHANGES IN SOME ASPECTS OF PA SCOPE OF PRACTICE

Date: **December 6, 2019**

To: **The Speaker of the Nebraska Legislature**
The Chairperson of the Executive Board of the Legislature
The Chairperson and Members of the Legislative Health and Human Services Committee

From: **Gary J. Anthone, MD**
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Department of Health and Human Services

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Introduction

The Regulation of Health Professions Act (as defined in Neb. Rev. Stat., Section 71-6201, et. seq.) is commonly referred to as the Credentialing Review Program. The Department of Health and Human Services Division of Public Health administers this Act. As Chief Medical Officer I am presenting this report under the authority of this Act.

Description of the Proposal under Review

Summary of the Original Applicant Group Proposal

The Nebraska Academy of PAs (NAPA) requests specific revisions to existing laws governing the practice of PAs (physician assistants) in the state. NAPA believes that the proposed changes do not represent a change in PA scope of practice; rather, these changes are a modernization of the statutes regulating the practice. These changes allow PAs to continue to provide high-quality patient care as part of a healthcare team while also reducing the administrative burdens currently experienced by both PAs and the physicians with whom they practice. NAPA has prepared this document for the Division outlining the requested changes to current law, and addressing each of the Division's criteria.

All of the changes requested in this application are based on the following guiding principles:

- *Allowing flexibility in the PA-physician professional relationship increases patient access to healthcare by giving PAs greater ability to practice in separate locations, including rural and underserved areas.*
- *It frees up physicians' time, letting them focus on their patients' needs, rather than meeting strict administrative requirements.*
- *The PA practice is one in which PAs, physicians, and other practitioners work together to deliver quality patient care.*

PAs in Nebraska practice under requirements defined in Nebraska Revised Statutes, Chapter 38, Sections 2008, 2018, and 2046-2056. These statutes are attached to this application as Appendix A.

An additional provision related to the structure of the Board of Health is found in Chapter 71, Sections 2601, which is attached as Appendix B.

NAPA proposes the following changes to the current PA statutes. Several of these changes have already been implemented in other states, as noted below each of the requested changes and marked with [brackets].

(1) Modernizing the statutory mandates related to PA-physician employment relationships and the practice of PAs, including:
   (a) Removing specific employment requirements for a PA to practice in a hospital setting;
   (b) Removing the requirement that physician supervision be continuous, as contained in 382050(3); and
   (c) Removing the prescriptive sections mandating the provisions that must be included in the PA-physician practice agreement, currently outlined in Section 38-2050(2). While a practice agreement will still be required by statute, NAPA proposes the decisions as to what should be included in the practice agreement should be made at the practice or facility level.

   [Thirty-one states have adopted adaptable collaboration requirements, which allow determinations about the geographic proximity and/or on-site requirements for collaborating physicians to be determined at the practice site.

   - These states include: Arizona, Arkansas, California, Connecticut, Delaware, D.C., Georgia, Hawaii, Illinois, Indiana, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Dakota, Texas, Utah, Vermont, Washington, Wisconsin, and Wyoming.]

(2) Updating the current PA to physician ratio contained in Section 38-2050(4) from 4:1 to 8:1. NAPA believes this increased ratio will lead to better access to care for Nebraskans across our state.

   [Several states have recently increased or eliminated their ratio limits. Louisiana increased its ratio limit from four to eight in 2018, and over the last two years, Michigan, Minnesota, and Mississippi have all eliminated their ratios.
   - States with **no** ratio limit include: Alaska, Arkansas, Connecticut, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Montana, North Carolina, North Dakota, Rhode Island, Tennessee, and Vermont.]

(3) Updating language related to "supervision" and "delegation" to more accurately reflect the physician-PA relationship in which PAs are allowed to engage in practice under a collaborative agreement with the supervision of a physician and practice on a healthcare team. These changes include:
   (a) Redefining "supervising physician" as defined in Sec. 38-2017 to "a licensed physician who supervises a physician assistant under a collaborative agreement", and;
   (b) Redefining "supervision" as defined in Sec. 38-2018 to defined to mean the ready availability of the supervising physician for consultation and collaboration on the activities of a physician assistant. Consultation and collaboration may be by

telecommunication and shall not require the physical presence of the physician at the time and place services are rendered.

[As of March 15, 2019, six states (Alaska, Illinois, Michigan, Tennessee, Virginia, and West Virginia) have removed references to supervision of PAs, instead using "collaboration," or in the case of Michigan, "participation." New Mexico now allows certain experienced PAs to collaborate with physicians, as well. While NAPA is not suggestion removal of physician supervision, the experience of these states in instructive.]

(4) Updating PA scope of practice provisions contained in 38-2047 to reflect legal medical services for which a PA has been prepared by their education, training, and experience and is competent to perform, rather than relying on the supervising physician's scope.
   (a) Such services will be required to be performed under a collaborative agreement with the supervision of a physician.

[Thirty-eight states allow a PA's scope of practice to be determined at the practice site. Michigan and Maine allow PAs to practice within their own scope, based on their education, training, and experience. New Mexico allows PAs to practice within their own scope if they are regulated by the medical board and collaborate with physicians.]

(5) Updating PA prescribing provisions, Section 38-2055, to include non-pharmacological interventions and clarifying that provisions allowing healthcare providers to furnish medications to patients in certain cases applies to PAs.

(6) Modifying membership of the Board of Health, listed in Section 71-260, to include one PA member.

[Eighteen states have created at least one specific PA seat on their regulatory boards. Pennsylvania (Board of Medicine and Board of Osteopathic Medicine) has a seat which rotates among PAs, respiratory therapists, perfusionists, and licensed athletic trainers. Eight states (Arizona, California, Iowa, Massachusetts, Michigan, Rhode Island, Texas, and Utah) have established separate, autonomous or semi-autonomous PA boards to regulate PAs.

   (i) States with specific PA seats on their regulatory boards include: Alaska, Colorado, Connecticut, Maine, Maryland, Michigan, Montana (non-voting), New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oregon, Vermont, Washington, West Virginia, and Wyoming.]

(7) Updating membership of the PA Committee, set forth in Section 38-2056, to be majority-PA, with three PA members, one physician who practices with PAs and is a member of the Board of Medicine and Surgery, and one public member. NAPA believes this change in membership is appropriate where the PA Committee is tasked with making recommendations to the Board of Medicine and Surgery regarding all matters relating to PAs that come before the board.

[Twenty-nine states have a PA advisory committee or other body tasked with advising the medical board on matters related to PA licensure, practice, and discipline. Thirteen of these are majority-PA.

States with a PA advisory committee or similar body include: Alabama, Arkansas, Delaware, D.C., Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Virginia, Wisconsin, and Wyoming.

States which have majority-PA advisory committees include: Delaware, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Nevada (Medical Examiners Board), New Jersey, South Dakota, Tennessee, Virginia, and Wisconsin.

The Amended Version of the Proposal

During the review a compromise was reached between NAPA and NMA regarding key points of contention in the original proposal. The following is a brief summary of this compromise:

Pertinent to modernizing statutory mandates related to PA-MD employment relationships and PA practice vis-à-vis "continuous supervision" the compromise point is as follows: "Rather than striking the continuous supervision requirement language would be added that would refer back to the definition of supervision which states that supervision requires "ready availability" but does not mean "in person."

Pertinent to updating PA to physician ratios from 4:1 to 8:1 the compromise reached is as follows: leave the current practice ratio as is and work toward streamlining the waiver process via an electronic form and allowing for electronic approval of these forms.

Pertinent to updating PA scope of practice to reflect legal medical services for which PAs are educated and trained to provide the compromise point is as follows: PA scope of practice shall be based on the education, training, and experience of the PA as long as those skills are also supported by the PAs current practice setting either as a component of their supervising physician's scope of practice or as a component of the scope of practice of other physicians working in the same setting as the PA.

Pertinent to updating PA prescribing provisions to include non-pharmaceutical interventions the compromise point is as follows: The wording would be revised to read, "A physician assistant may prescribe drugs and devices," rather than, "A physician assistant may prescribe drugs and devices as delegated to do so by a supervising physician."

Pertinent to the membership of the PA Committee to create a PA majority the compromise point is as follows: the current make-up of this committee would be retained but the number of members who are able to vote on matters before the committee would be changed. The Board of Medicine and Surgery representative would now have only an advisory role and as such would not be a voting member. However, the other physician representative would continue to be a voting member.

Summary of Technical Committee and Board of Health Recommendations

The members of the technical review committee recommended approval of the amended, compromise version of the PA proposal.

The members of the Board of Health also recommended approval of the amended, compromise version of the PA proposal with the exception of the provision for adding a PA to the State Board of Health which the Board of Health members did not recommend, and with the exception of the idea of adding a PA to the Board of Medicine and Surgery which the Board of Health members did recommend.

The Director's Recommendations on the Proposal

Discussion on the six statutory criteria as they relate to the PA proposal:

Criterion one: The health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on the scope of practice.

I find that there is a need to streamline the management of MD / PA collaborative services in the interest of better serving the needs of Nebraska patients.

Criterion two: Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public.

I find that there is a benefit to Nebraska patients inherent in the proposed changes which promise to streamline the management of MD / PA services.

Criterion three: The proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public.

I do not find anything in the proposal that would constitute a new danger to public health and safety.

Criterion four: The current education and training for the health profession adequately prepares practitioners to perform the new skill or service.

This criterion is not germane to the proposal under review.

Criterion five: There are appropriate post-professional programs and competence assessment measures available to assure that the practitioner is competent to perform the new skill or service in a safe manner.

This criterion is not germane to the proposal under review.

Criterion six: There are adequate measures to assess whether practitioners are competently performing the new skill or service and to take appropriate action if they are not performing competently.

This criterion is not germane to the proposal under review.

Final thoughts:

I agree with the recommendations the Board of Health on the amended, compromise PA proposal including their recommendation against the idea of adding a PA to the State Board of Health. This idea, if approved, would encourage other health professions to seek a seat on the Board of Health. Currently, this Board's membership is set at seventeen members. I see no benefit to increasing the size of this Board beyond its current membership limit.

However, I do not agree with the Board's recommendation that a PA be added to the Board of Medicine and Surgery. Adding a PA to this Board would encourage other professions currently regulated by committees under the Medical Board to seek direct representation on this Board for their professions. I see no benefit to increasing the size of this Board beyond its current membership limit.