Dr. Thedinger Talking Points

Good morning Committee members, my name is Britt Thedinger, and I am an ear, nose and throat surgeon in Omaha. I am the President of the Nebraska Medical Association, and I wanted to provide a bit of background on the NMA and NAPA’s working relationship, and then also read a letter provided to you by Dr. Rob Rhodes, who is a family practice physician here in Lincoln.

The NMA and NAPA share a common mission for our professions: to advocate for and deliver the highest quality of care to our patients. To that end, the NMA and NAPA often work together on legislation to advance that goal. For instance, this past session, the NMA and NAPA worked together to expand the educational efforts, public outreach, and training efforts of the Nebraska Coalition for Patient Safety. Our professions stepped forward, together, to advocate for patient safety in this state.

I will now turn to the letter from Dr. Rhodes, who prioritized fostering the relationship between the NMA and NAPA and has been engaged in these discussion, but unfortunately, is unable to be here today.

Letter from Dr. Rhodes

A few other items worth noting related to specific points outlined in the Physician Assistant’s 407 application, beginning with NAPA’s application request:

1(a) to remove specific employment requirements for a physician assistant to practice in a hospital setting.
   • And so long as a supervisory agreement between a physician and physician assistant is in place, the NMA does not have a position on that item.
   • Rather, this appears to be more appropriate to be determined by the hospitals in the state.

Moving to NAPA’s application Requests 3(a) and 3(b), which redefines supervising physician and supervision. The NMA supports these requests. When the NMA and NAPA met in November, this was an area we identified the NMA could support. In fact, this language was proposed by the NMA and approved by our Board of Directors, then communicated to NAPA upon Board approval.

Thank you. My colleagues Dr. Hoelting and Dr. Wergin will be speaking to the remaining items on the application. I will turn it over to David.
Dr. Hoeltmg Talking Points

Good morning. My name is David Hoeltmg. I have lived and practiced in Pender, Ne since 1978. I am board certified in Family Medicine, and have taught, worked with, and supervised PA's since the mid 80's. I have been a past board member and president of the NAFP. I have been a delegate to the AAFP Congress of Delegates, where frequently issues concerning PA's and supervising physician came up. Finally, I am finishing up my 10th and final year as the supervising physician on the PA Committee which advises the Ne Board of Medicine.

I will be speaking to specific points outlined in the Physician Assistant's 407 application, beginning with NAPA's application request:

1(b) to remove the requirement that physician supervision be continuous, as contained in 38-2050(3).
• The NMA is opposed to 1(b) and supports the current statutory framework that requires supervision be continuous, but does not require the physical presence of the supervising physician at the time and place that services are rendered.
• The present system has worked well. It does not require that supervisors be on the premises all the time with the PA, such as when they are at satellite clinics. They don't have to staff all patients, but it is important that they be available to provide information and assistance when needed by the PA that they have a collaborative agreement with. This is particularly important with new PA's and PA's not as familiar with the practice. Issues concerning this have come before the PA Committee. There is also the risk with the new wording that the "supervisor" simply drops by periodically to sign charts without actually providing any real supervision. We believe this would endanger patients and patient care.
• The current practice is working and is effective in maintaining the highest quality of patient care rendered. Physician assistants play a unique role in the delivery of care to patients. However, by removing the requirement that supervision be continuous, this could compromise patient safety and care. Physicians supervise physician assistants to ensure there is a backstop for when issues or problems may arise.
• Physician assistants are well-equipped to handle a myriad of patient concerns, however, their education and training is in a model that is general in nature, and trains them to work under the supervision of a practicing physician.
  o Physician assistants' education encompasses two years in length with 2,000 hours of clinical care. In stark comparison, physicians undergo medical school and residency, treating patients under expert medical faculty. Physicians complete more than 10,000 hours of clinical education and training during their four years of medical school plus 3-7 years of residency training totaling between 16,000-21,000
hours of clinical training. Physicians are uniquely trained and should appropriately be the leader of the healthcare team.

(if asked about the definition of “continuous”) You’re right, there is not a definition of continuous included, but it’s working. We are readily available. If a question arises, there is a physician available that is accessible to answer questions and clarify issues. And quite truthfully, the NMA supports NAPA’s application request 3(b), which appears to contain a definition of continuous supervision.

I will move to application Request 1(c) next, which seeks to remove any prescriptive sections mandating the provisions that must be included in the PA-physician practice agreement currently outlined in 38-2050(2)

• The NMA supports 1(c).
• When the NMA and NAPA representatives met in November, this was an area we identified the NMA could support.
• This request works and makes sense because there is an actual collaborative agreement to practice with the physician and physician assistant.
  o Physicians and physician assistants do collaborate, and it makes sense to leave that decision about what is included within that practice agreement to those parties who want to truly collaborate.

My next comments pertain to application Request 2, which moves the physician assistant to physician ratio from 4:1 to 8:1.

• The NMA is opposed to this request.
• We believe that this is unnecessary, as there is already a mechanism to increase the number of PA’s under the supervision of a physician. A clinic or physician may request a waiver from the PA Committee. During the 10 years I have been on the committee, there have been less than 5 requests, and all have been granted. These have all been prompted when a supervising physician left the practice, leaving 1 or more PA’s without supervisors.
• The NMA has polled physicians in the state about increasing the # of PA’s that could be supervised by a single provider. Almost all expressed reservations about supervising greater than 4 PA’s, and most felt the ideal # would be 1 or 2.
• Increasing the ratio to 8:1 could lead to a lack of supervision and compromised care I discussed earlier relating to supervision needing to remain continuous.

And finally, I am going to jump to NAPA’s application Request Number 7, which changes the makeup of the PA Committee to have a majority of PAs on the Committee. My colleagues will speak to the remaining points in the application momentarily.

• As I’ve stated, I have been on the PA committee for 10 years. During that time, I have witnessed nothing but the highest levels of professionalism by all the members of the committee, physicians and PAs. At present, there are 2 physicians—one is a member of the Board of Medicine, and the other is a practicing physician who supervises 1 or more PA’s.
During this time, the 2 physicians were from different aspects of practice—urban and rural, academic and private practice, specialty and primary care. This gives a much broader perspective to the committee, which is valuable. Also, most members on the Board of Medicine don't work with PA's, making it difficult to fill this possession.

- I have not really seen an "us vs them" attitude displayed at all on the committee in the 10 years. Consistently, decisions are made on the basis of 1. What is the law? And 2. What would be in the best interests of the patients and the providers. I can count on one hand the number of times the decision made was NOT unanimous.

- The members of the committee discussed this at the last meeting we had. I stated that the NMA was not opposed to increasing the number of PA's on the committee to achieve a PA majority. The feeling of the PA's was that this would make the committee "unbalance". The final statement was "why don't we just leave it like it is."

Thank you, and I would be happy to address any questions you might have as to the NMA's position on these application requests.
Dr. Wergin Talking Points

Good morning Committee members, my name is Robert Wergin, and I am a family medicine physician in Seward, Nebraska...

- I have been in practice as a family physician for 37 years. During much of that time I have worked closely with Physician Assistants in a team-based delivery care model. I have been a rural family physician in a rural health clinic since 1995 in both Milford and Seward Nebraska. Rural health clinics require at least 50% of your open hours to be offered with a Physician Assistant or midlevel provider. I have a day to day understanding of working side by side with my physician assistant colleagues.

I will address the remaining points contained in the application, beginning with NAPA’s application request:

Request #4 to “update physician assistants scope to reflect legal medical services for which they have been prepared by their education, training, and experience, rather than relying on the supervising physician’s scope.”

- The NMA is opposed to 4 and supports the current statutory framework that ensures PAs practice within the scope of their supervising physician.
- The NMA’s concern with this point is based on patient safety and ensuring physician assistants are supervised by the appropriate physician with expertise in that area should a concern arise.
- For example, parents who take their children to a board certified pediatrician’s office and are seen by a physician assistant, would not want that physician assistant to be trained under the supervision of a dermatologist.
  - In a rural practice it is important to provide comprehensive care to our communities and patients. I understand that our team-based care with our skill set is important to provide the health care our community needs. I often work with my PA to insure and even expand his skill set to provide those needed services. However, from a medical legal aspect I do not provide services myself and would not allow my PA to provide a service I not qualified to do myself. It is important that I understand the potential complications and outcomes related to the care we provide as a team. As an example, I wouldn’t have a PA do Botox injections even if they had a past experience of providing that service since I myself don’t do that service.
  - As Dave already point out, PAs are trained in an entry-level, general nature, in comparison to the 16,000-21,000 hours of clinical education and training physicians receive.
  - The purpose of a supervising physician is to ensure there is a physician available to answer questions or address complications should they arise because of their extensive training and education.
- With that said, there is flexibility that could be achieved at the practice level agreement that allows for a physician assistant to provide services to patients that, say, perhaps may
fall more appropriately under an alternative supervising physician within that same
hospital or clinic.
  o For example:
    - In a rural setting there may be a service that is essential to provide in a
timely manner. Working with their collaborative physician a PA could place
a chest tube or perform a thoracentesis to remove fluid from around the
lung. This could be an important procedure for a patient’s outcome.
Handling a complex medical issue jointly could free up the physician’s time
as well and provide the needed services of a complex medical patient.

Next I will move to application request number 5, which they state, “Amends physician assistant’s
prescribing provisions to include non-pharmacological interventions and allows them to furnish
medications to patients.”

  • The NMA is not opposed to PAs being allowed to prescribe non-pharmacological
  interventions, such as DMEs and the like, as listed in their proposed legislation Appendix C
  o Statute 38-2055
  o However, in looking at Appendix C 38-2055, we would be opposed to the striking
of “delegation.”
    - The NMA believes that such prescribing would be appropriate so long as it
is under the supervising physician’s delegation
  o The NMA would support striking the following statutory language, “Any limitation
placed by the supervising physician on the prescribing authority of the physician
assistant shall be recorded on the physician assistant’s scope of practice agreement
established pursuant to rules and regulations adopted and promulgated under the
Medicine and Surgery Practice Act.”
    - Striking this language makes sense given our support of NAPA’s proposal to
allow flexibility between the physician and the PA as to what is in their
practice agreement. This current statutory language clouds the matter as
to prescribing, and so long as the preceding sentence remains as written in
current statute, the NMA would support eliminating that prescriptive
statutory language.

  • Again, the reasoning for our position is simply based on patient safety and allowing
physicians and PAs to work collaboratively.
  o Physicians and physician assistants work well together, and provide different
perspectives, roles and responsibilities in the delivery of care
  o As physicians have received extensive amounts of training and clinical experience,
it would be appropriate to retain the delegation requirement, so the physician be
provide that oversight when necessary.

And finally, application request number 6 is to modify the Board of Health membership to include
one physician assistant member. The NMA supports this request and feels it is appropriate anc
important to have PA representation on the Board of Health.

Thank you, and I would be happy to address any questions you might have as to the NMA’s position
on these application requests.
The most powerful prescription is a well-trained physician.

- **Physician**
  - Graduate-level education: 4 years
  - Residency/fellowship training: 3-7 years
  - Total: 7-11 years

- **Physician Assistant**
  - 2-2.5 years

Source: AMA