REPORT OF RECOMMENDATIONS AND FINDINGS

By the Physician Assistants'
Technical Review Committee

To the Nebraska State Board of Health, the
Director of the Division of Public Health, Department of Health and
Human Services, and the Members of the Health and Human
Services Committee of the Legislature

September 30, 2019

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Part One: Preliminary Information

Introduction

The Credentialing Review Program is a review process advisory to the Legislature which is designed to assess the need for state regulation of health professionals. The credentialing review statute requires that review bodies assess the need for credentialing proposals by examining whether such proposals are in the public interest.

The law directs those health occupations and professions seeking credentialing or a change in scope of practice to submit an application for review to the Department of Health and Human Services, Division of Public Health. The Director of this Division will then appoint an appropriate technical review committee to review the application and make recommendations regarding whether or not the application in question should be approved. These recommendations are made in accordance with statutory criteria contained in Section 71-6221 of the Nebraska Revised Statutes. These criteria focus the attention of committee members on the public health, safety, and welfare.

The recommendations of technical review committees take the form of written reports that are submitted to the State Board of Health and the Director of the Division along with any other materials requested by these review bodies. These two review bodies formulate their own independent reports on credentialing proposals. All reports that are generated by the program are submitted to the Legislature to assist state senators in their review of proposed legislation pertinent to the credentialing of health care professions.

LIST OF MEMBERS OF THE PHYSICIAN ASSISTANT'S TECHNICAL REVIEW COMMITTEE, 2019

Wayne Stuberg, PhD, Chair

Jeffrey L. Howorth

Janet Rochford

Christine Chasek, LIMHP, LADC

Allison Dering-Anderson, PharmD, RP

Brandon Holt, BSRT

James Temme, RT

Part Two: Summary of Committee Recommendations

The committee members recommended approval of the revised version of the applicants' proposal.

Part Three: Summary of the Applicants' Original Proposal

Current and proposed scope of practice: 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.

Before receiving comments from testifiers the committee members were informed that a compromise had been reached between the NAPA and NMA regarding key points of contention in the original proposal. The committee members were then provided with documentation of the details of this compromise via hard copy handouts provided to them by the applicant group. The following is a brief summary of these mutually agreed-upon compromise points:

1) 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."
2) 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.
3) 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.
4) 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."
5) 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.

The full text of the most current version of the applicants' proposal can be found under the EMS subject area on the credentialing review program link at http://dhhs.ne.gov/Licensure/Pages/Credentialing-Review.aspx

Part Four: Discussion on issues by the Committee Members

What are the shortcomings of the current practice situation, if any? If there are shortcomings what needs to be done to rectify the situation?

Michelle Weber and Charles Scholtes, PA, came forward to represent the applicant proposal and answer questions from the committee members. Mr. Scholtes stated that modifications are needed in the way in which PA scope of practice is regulated in Nebraska. Modern telecommunications technology has made it much less necessary for the work of physician assistants to be closely monitored by physicians. Additionally, the disparity in numbers between physician assistants and physicians across the state makes it necessary to increase the autonomy of physician assistants in order for health care services to be provided in an efficient and timely manner. This is especially true regarding the provision of health care services in remote rural areas of our state. There is an increasing need for greater flexibility in the way we administer physician assistant services and to get away from the traditional "cookie cutter" approach to administering them. Mr. Scholtes made it clear that the proposal is not seeking to end physician oversight. Rather it seeks to streamline it so as the render physician assistant services more accessible to the public and to create a situation whereby physician assistants are the ones who make decisions about patient care and are held responsible for such decisions. Mr. Scholtes added that physician assistants carry liability insurance and can shoulder a greater amount of the burden associated with liability claims which would be of at least some assistance to overseeing physicians who currently bear the brunt of such claims.

Mr. Scholtes continued his remarks by stating that the applicants seek to make changes in their regulatory board including adding an additional physician assistant and reducing the number of physicians on their board to one member. Additionally, the applicants want to have one of their own to represent them on the Nebraska State Board of Health. Tamara Dolphins the chair of the PA regulatory Committee came forward to state that PAs see a need to increase their voice and give them a clear majority on their own regulatory body.

Tamara Dolphins commented that among the underlying reasons for the proposed changes is the fact that today's PAs are no longer exclusively the employees of their overseeing physicians as things were a half-century ago. Today's PA is part of larger health care teams that are employed by large, corporate health care organizations who in turn do much of the administration and regulation of them as well as of the other health professionals who are components of these teams of providers.

Ms. Dolphins continued by stating that the applicants do not want to end the concept of a practice agreement, rather, they want to modernize it by making it adjustable so that the practice needs of PAs and the practice needs of their overseeing physicians are reconciled in the diverse, complex team-oriented health care practice world of today.

Kurt Schmeckpeper commented that the current waiver process is too slow and that it hinders the hiring process for new physician assistants.

Mr. Schmeckpeper went on to state that the applicant group does not seek a change in scope of practice, rather the intent of the proposal is to streamline and modernize the way physician assistant regulation processes work in Nebraska for the benefit of both the public and practitioners. Dr. Dering-Anderson asked how many waiver requests there have been. Matt Gelvin responded that there have been only two over the last ten years. Brand Holt then asked how long do people have to wait during one of these waiver processes. Tamara Dolphins responded that it can take anywhere from three to six months because under current rules the Board of Medicine also reviews such requests.

Mr. Schmeckpeper then commented that the applicant group wants to make changes that can enable physician assistants to make better use of their time and better serve their patients. Rules and regulations need to be clear and consistent regarding medical procedures so that all providers can know what their role is and exactly what procedures they are to be providing at all times. According to Mr. Schmeckpeper this is not always the case under the current practice situation. He added that the applicant group does not seek independence or an end to practice agreements but rather seeks to modernize and streamline the current relationship between physicians and physician assistants.

Would the ideas proposal by the applicant group be helpful in addressing the shortcomings of the current practice situation? Would the public benefit from these proposed ideas?

Mr. Howorth questioned the value of adding another PA to the PA regulatory Committee, and asked the applicants how this action would address any of their concerns. Mr. Howorth asked the applicants why their goal of streamlining and modernizing requires legislative changes or changes in rules and regulations. He questioned how the current proposal would get done what the applicants say they want to get done.

Mr. Holt asked the applicants how their proposal—which seeks to create changes via changes in state statutes—would accomplish their goals, given that statutes are not the source of the problem, and given that the problem seems to stem from how PA services are administered in the private sector. Tamara Dolphins responded by stating that the current problems associated with PA services have their source in current statutes and rules and regulations that hinder the ability of PAs to efficiently deliver their services.

Dr. Dering-Anderson commented that proposed change number five which addresses the current provisions Section 38-2055 of the PA Statute addresses one of the most serious limitations of the current regulatory process for PAs. Dr. Dering-Anderson stated that this statutory provision defines rules and restrictions pertinent to who can prescribe what medications that are so arcane and complicated that they are almost impossible to follow or administer.

Dr. Wergen stated that the Nebraska Medical Association is opposed to some of the current wording in the proposal and some of the specific seven points that this proposal defines, but are supportive of some of these points. He went on to state that exceptions can be made to the current four to one ratio of PAs to supervising physicians, and that no statutory or rule change is necessary to make this happen. That ability is already there.

Pertinent to the second point which seeks to make current rules regarding physician-PA practice ratios more flexible an NMA representative stated that this proposed change is unnecessary due to the fact that there is already a waiver process in place for situations wherein such is necessary.

Dr. Dering-Anderson asked the applicants how a pharmacist can know if and when a given PA can or cannot prescribe a given medication, specifically focusing her question by asking, is there a negative formulary in state law that would automatically forbid PAs from prescribing a certain category of medications, for example? Mr. Schmeckpeper responded by stating that the answer to such a question is complicated and that there is no simple yes or no response possible. He went on to state that this situation is part of the larger problem associated with the need to simplify, consolidate, and standardize rules and regulations governing PA practice in Nebraska. He agreed with Dr. Dering-Anderson that no pharmacist should have to call a PAs' supervising physician to try to figure out what their PA can or cannot prescribe under the law. In a similar vein Dr. Stuberg commented that there should be a baseline formulary of medications that PAs can prescribe, period!

Tamara Dolphins responded to Dr. Stuberg by stating that there is no such baseline formulary under current Nebraska law. She went on to state that there is a need to establish some kind of guidelines in this regard based upon the scope of PA practice including any specialization that a given PA might have so that it is easier for all concerned to know what each PA should or should not be prescribing.

Would there be new harm resulting from these proposed ideas?

Dr. Dering-Anderson asked the applicants what their supervising physician does for them vis-à-vis their services to patients. Mr. Scholtes responded that after thirty-five years of practice as a physician assistant he is for all practical purposes an independent practitioner. His extensive clinical experience makes it unnecessary for any close oversight of his services. Continuing, he commented that the only PAs who need close supervision are new graduates who have yet to complete the entirety of their required 2000 clinical hours. Once they have completed these clinical hours they should be adequately prepared to provide services to their patients without the need for close monitoring of their work or clinical decisions. Mr. Scholtes continued by stating that regulatory rules for physician assistants should be formalized in such a way as to take clinical experience and training into account. Those with extensive experience and training should not be required to have their medical charts reviewed by a physician, e.g.

Pertinent to the idea of expanding the physician to PA ratio from four to eight, Dr. Stuberg asked the applicants if doing so might create greater risk to public safety. Mr. Schmeckpeper responded that there currently are no specific guidelines or definitions pertinent to exactly what "oversight" equates to in order to answer such a question.

Drs. Britt Thedinger, David Hoelting, and Robert Wergin spoke in opposition to some parts of the applicants' proposal. These testifiers expressed concern that some parts of the applicants proposal raise patient safety concerns. In their view the provision which expands physician to PA practice ratios from four to eight would spread physician oversight too thin. One physician commented that this idea might eventually lead to a situation wherein physicians simply sign-off on whatever their PA does without any actual review ever

occurring. If this occurs the idea of "adequate supervision" would be in serious jeopardy. Dr. Dering-Anderson then asked what does "adequate supervision" look like now? And, can this be defined? Dr. Hoelting responded by stating that it is defined in a very practical way such as by asking, are patient needs being met, for example?

Pertinent to the proposed updating of prescribing provisions to include non-pharmaceutical interventions NMA representatives stated their opposition to this provision to these proposed changes for reasons associated with medical liability.

Pertinent to the proposed changes in the composition of the Physician Assistant Committee to increase PA representation and decrease MD representation NMA representatives expressed their opposition to these proposed changes as not being in the public interest. .

NMA representatives expressed their opposition to the fourth point regarding updating the scope of PA practice to reflect legal medical services for which PA education and training and experience prepares them to do as not being in the public interest.

One NMA representative expressed opposition to the proposed revisions to continuous physician oversight as not being in the public interest. Concern was also expressed about the proposed removal of the requirement for continuous oversight by a physician. Here, too, these testifiers saw potential for patient safety issues. Concern was expressed that the teammate approach that is so important to patient care not be compromised by any of the proposed changes. Dr. Wergin commented that the term "delegation" would be eliminated by the proposal if it were to pass. This, he said, would be a bad idea because it would adversely impact the ebb and flow of care from the physician to the PA and back again and thereby threaten to disrupt the close team approach valued by both PAs and physicians.

Are there better ways of addressing the concerns raised by the applicant group than the ideas they proposed?

Pertinent to the following three points there was a consensus among the contending parties that there is no better way of addressing these three points than the provisions on them in the applicants' proposal:

- Pertinent to removing the sections mandating that prescribing must be included in each PA-Physician practice agreement,
- Pertinent to the point regarding making revisions to the definitions of supervision and delegation, and,
- Pertinent to the point regarding making changes in the composition of the Board of Health to include a PA member.

Brandon Holt asked the applicants whether or not their seeking to define in statute specific language defining what a PA can do or cannot do might be the reason why opponents of the proposal have concluded that the proposal is a change in scope of practice. Dr. Stuberg agreed, commenting that removing wording that allows a physician to define what his or her supervising physician can do does in fact constitute a proposed change in scope of practice for PAs. Mr. Schmeckpeper responded by stating that the applicant group would review the wording of this part of the proposal to see if they might find a better way of stating their idea regarding the definition of what physician assistants can do.

Dr. Dering-Anderson asked the applicants how the current oversight process for physician assistants works, asking specifically, is each PA assigned to someone? Or, is there a "give-and-take" in which the PA has something to say about who they end up working with? One applicant responded that there is an assignment component to this process but that there is plenty of flexibility in the process to ensure that a given PA is not assigned to someone they are unlikely to be compatible with. Mr. Schmeckpeper commented that the assignment process is a "lottery" and that this process is in need of simplification and streamlining too. Ms. Chasek commented that these kinds of changes should be handled as part of a best-practices process via negotiations between the medicine and PAs without getting the legislature involved in it.

All sources used to create Part Four of this report can be found on the credentialing review program link at
http://dhhs.ne.gov/Licensure/Pages/Credentialing-Review.aspx

Part Five: Public Hearing Testimony and Committee Comments

The following persons came forward to present testimony on behalf of the revised proposal.

After some discussion among the committee members Dr. Stuberg asked who, among the attendees, wanted to come forward to testify. During this part of the meeting the following persons came forward to present testimony: Kurt Schmeckpeper, MPAS, PA-C; Dr. Robert Wergin, MD; and Dr. Steven Williams, MD. Their testimony is presented as follows:

The testimony of Kurt Schmeckpeper, MPAs, PA-C, during the August 12 public hearing on the Physician Assistant proposal

Good morning my name is Kurt Schmeckpeper and I am speaking today on behalf of the Nebraska Academy of Physician Assistants or NAPA which is the applicant group seeking to modernize the Nebraska statutes regulating our practice. Over the last two meetings NAPA representatives have shared with this committee why our profession thinks these requested changes are needed. This committee has also heard from other groups who expressed some concern regarding some of the changes we were seeking to make. Because physicians and PAs work together to collaboratively serve patients/ we knew we could use that same model to come to agreement on the changes sought under this application. You should have in front of you two formats of the changes to the application that we are presenting for your consideration. One is a two-page document that lays out each point of the application and notes where NMA either agreed to the changes or expressed concern. For each of the areas where there had been disagreement the red print shows the new agreement that both groups would like to move forward with. The second much longer document is the red lined version of our original application/ as it was requested by the Chair of the committee.

The NMA will also be testifying today, and so my testimony is not intended to speak for them but to give you the context of how our two groups have been working together. The rest of my testimony today will walk through NAPA/s application/ calling your attention specifically to any changes we are requesting to make to our application based on the NAPA/NMA collaboration and compromise.

In general the NAPA application is seeking the modernization of the statutes regulating the PA scope of practice. These proposed changes will allow PAs to continue to provide high-quality patient care as part of a healthcare team/ while also reducing the administrative burdens or statutory confusion currently experienced by both PAs and the physicians with whom they practice. NAPA s original technical review application was divided into seven points with descriptions of the proposed changes starting on page five of the application. First NAPA is seeking to modernize the statutory mandates related to PA-physician employment relationships and the practice of PAs. Our application requests that this committee would approve removing specific employment requirements for a PA to practice in a hospital setting that are currently contained in 38-2047(5). NAPA believes that removing these hospital specific provisions will place all PAs (no matter who they are employed by) on an even playing field and will remove any unnecessary confusion about what the statutes may require for hospitals wishing to hire a PA. If this section of statute is repealed/ hospitals that are employing PAs are able to decide at their own facility how to manage this employment relationship.

The second piece of this modernization is the first area where we are requesting to change our application. Originally NAPA was requesting to remove the requirement that physician supervision be continuous. We have agreed with the NMA that rather than removing this requirement we suggest an addition of language within this supervision requirement that refers the reader back to the definition of supervision in 38-2018. We believe this change helps to clarify what is meant by "supervision" requiring the ready availability of a physician but "supervision" does not mean "in person." Our application also seeks to remove the overly prescriptive sections of statute mandating the provisions that must be included in the PA-physician practice agreement/ currently outlined in Section 38-2050(2). Again, these are decisions best left to the physician and the PA governed by the agreement. The NAPA application originally sought to increase the PA to physician ratio contained in Section 38-2050(4) from 4:1 to 8:1. However, we believe that the increased access to care we were seeking with this change could also be accomplished by leaving the current ratio in statute and instead working with DHHS to streamline the waiver process via an electronic form and allowing for electronic approval of such form by the PAC in between quarterly meetings.

The third section of our application seeks to amend statutory language to more accurately reflect the current state of physician-PA relationships. Under our application PAs are allowed to engage in practice under a collaborative agreement with the supervision of a physician and are allowed to practice as a part of a healthcare team. These changes include redefining "supervising physician" as defined in Section 38-2017 to "a licensed physician who supervises a physician assistant under a collaborative agreement" and; redefining "supervision" as defined in Section 38-2018 to mean the ready availability of the supervising physician for consultation and collaboration on the activities of a physician assistant.

An important part of the application is updating PA scope of practice provisions contained in 38-2047 that allow a PA scope of practice 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 defining the PAs scope of practice only by the scope of practice of the supervising physician. This is the fourth section of the application. Our compromise with the NMA in this area is one where we agree in principle, but the exact language for the statutory change will require some additional attention. Overall, our two organizations agree that a PA scope of practice should be based on the education, training, and experience of the PA/ as long as those skills are also supported by the PA'S current practice setting either as a component of the supervising physician's scope of practice or as a component of the scope of practice of other physicians working with the PA in the same practice.

The fifth point in our application seeks to update PA prescribing provisions under 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. While NMA had originally objected to the removal of language that specifies that PAs may prescribe drugs and devices "as delegated to do so by a supervising physicians we are proceeding with the language in our original application. Prescribing is a part of the PAs scope of practice that will remain limited by the provisions discussed in the immediately preceding section, where the PA will only be prescribing based on his or her education/ training, and experience as supported by the supervising physicians or other doctors who work with the PA in that practice setting.

The sixth point of our application seeks to modify the membership of the Board of Health listed in Section 71-260, to include one PA member. This is an important provision that will allow PAs to have better input into the regulation and oversight of our profession. And finally, our application seeks to change the governance of the PA Committee set forth in Section 38-2056.

We are proposing a compromise change to our application in this area where we would no longer aim to change the make-up of the PAC Committee but instead would change the voting provisions. The suggested change in this area would be to give the Board of Medicine and Surgery Physician representative an advisory role on the PAC that would not be a voting role. When the PAC recommendations are passed along to the Board of Medicine and Surgery that physician member will have a vote at that time as a member of that Board. The additional physician representative on the PAC will continue to have a vote on PAC matters.

Dr. Wergin's Talking Points—8/12/2019

Good morning Committee members, my name is Robert Wergin. 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 mid-level provider. I have a day-to-day understanding of working side by side with my physician assistant colleagues. I am testifying on behalf of the Nebraska Medical Association, and my testimony today will sound familiar from the last hearing. This is so our comments will be made part of the public record, and, they pertain to NAPA's original application as filed.

Over the years the NMA has enjoyed a collaborative, professional relationship with NAPA which has allowed for open communication regarding NAPA's professional goals as it relates to this application/ providing care and competing in the job market. We have appreciated this open dialogue so much so that it led to the NMA offering a non-voting seat for NAPA on NMA's Board of Directors. The NMA values the care and contributions physician assistants provide to Nebraska's patients. However, the NMA does not support NAPA's application in its entirety. There are items the NMA supports while there are others the NMA is opposed to and has concerns that making the proposed changes would compromise the quality of patient care. I will outline our position on the specific application items below.

NAPA request l(a) is to remove specific employment requirements for a PA to practice In a hospital setting. So long as a supervisory agreement between a physician and physician assistant is in place the NMA does not have a position on this item. Rather, this appears to be more appropriate to be determined by the hospitals and facilities. NAPA request l(b) is to remove the requirement that physician supervision be continuous. The NMA is opposed to l(b) and instead, 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 current practice is working and is effective in maintaining the highest quality of patient care rendered. !f you were to remove the requirement that supervision be continuous/ it may create scenarios of physicians "dropping in" every six months or so to check in with their physician assistant but this is not collaborative, and it compromises patient safety.

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. This is because physicians have extensive training to provide that expert opinion as the leader of the healthcare team.
Physician assistants are welt-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. 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 the delivery of healthcare should be by a physician-led team-based approach.

NAPA request l(c) seeks to remove any prescriptive sections mandating the provisions that must be included in the PA-physician practice agreement currently outlined in Neb. Rev. Stat. 38-2050(2). The NMA supports this request. 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. Physicians and physician assistants do collaborate/ and it makes sense to leave that decision about what is included within the practice agreement to those parties who want to truly collaborate.

In regards to NAPA request 2, the NMA is concerned that the increase in physician assistant-to-physician ratio from 4:1 to 8:1 would compromise patient care. Currently, physicians are allowed to supervise up to four physician assistants, however, physicians may exceed that limitation of four upon application to the Department of Health and Human Services (DHHS). The option to supervise more than four physician assistants currently exists, and when surveying our members, a minority of physicians supervise even four physician assistants and do not feel a need to expand that ratio. Doing so runs the risk of inadequate supervision, which could compromise quality patient care. Therefore, the NMA does not believe the need exists to change the ratio at this time.

Moving to NAPA requests 3(a) and 3(b), which redefines supervising physician and supervision. The NMA supports these requests. The NMA and NAPA have had ongoing discussions prior to this 407 application/which began in the fall of 2018. 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. NAPA request 4 is to update the PA scope of practice provisions 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. The NMA is opposed to this request and supports the current statutory requirement that physician assistants 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. Again physicians have more training education and experience, and therefore are better equipped to address questions and concerns should they arise. If PAs are practicing outside the scope of their supervising physician there is no expert available to diagnose the problem/ correct the medication/ etc. 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. 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. Nebraska's current statutory requirements of supervisory practice agreements are appropriate and have one goal in mind and that is ensuring patient safety.

The NMA has concerns that this language from application request number 4 comes from the American Academy of Physician Assistants' "Optimal Team Practice" which seeks to grant independent practice to physician assistants. These changes are dangerous and may compromise patient safety by allowing inadequately trained professionals to treat patients without the support and mentorship of a physician-led, team-based practice. It also raises another question as to whether these are changes sought by Nebraska-based physician assistants or whether the changes are in an effort to satisfy the national agenda, rather than considering what is best for Nebraska PAs and their patients.

NAPA request 5 is to update prescribing provisions to include non-pharmacological interventions and clarify provisions allowing healthcare providers to furnish medications to patients in certain cases applies to PAs. The NMA is not opposed to PAs being allowed to prescribe “non-pharmacological interventions, such as durable medical equipment and the like as listed in their proposed legislation Appendix C. However, in reviewing that same Appendix C, Neb. Rev. Stat.38-2055, the NMA 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. Again, the reason for this position is to ensure there is appropriate oversight on certain services and prescriptions to maintain a high level of quality care for patients.

NAPA request 6 is to modify membership of the Board of Health to include one physician assistant member. The NMA supports this request and believes it is appropriate and important to have physician assistant representation on the Board of Health.

And finally, NAPA request 7 to change the makeup of the PA Committee by replacing one physician representative with a physician assistant representative. While the NMA is not opposed to amending the makeup of the Committee and would support adding a physician assistant to the PA Committee so the PAs have more representation than the two physician representatives we are opposed to eliminating one of the physician representatives as requested in the application.

Currently, the PA Committee includes two physician seats: one supervising physician and another physician who is a member of the Board of Medicine and Surgery. By removing a physician seat and leaving only one physician representative on the PA Committee, we would be severely limiting the resources, knowledge, and experience brought by that physician to the committee. Not all physicians on the Board of Medicine & Surgery supervise PAs, which would further limit the resources available. By allowing for two seats on the Committee this accounts for a rural and an urban perspective, a general or a specialty perspective, etc. The current makeup of the committee has served Nebraska physicians and physician assistants well. It is a rarity when Committee decisions are not unanimous. In fact, the PA Committee members discussed this proposal, and it was their suggestion to just retain the current makeup of the Committee and not make any changes.

As Advocates for Physicians and the Health of all Nebraskans, it is the NMA's request that you do not support this application as a whole on the basis of protecting patient safety. Thank you. I would be happy to address any questions you might have as to the NMA/s position on these application requests.

Dr. Wergin's Talking Points—8/12/2019—The Modified Application

I will turn now to my comments regarding NAPA's modified application. NAPA reached out to meet with the NMA to review proposed changes to their application. We had a productive conversation on August 6 related to those modifications, and the NMA tentatively supports the modified application as we understand what was proposed at that time.

The NMA values the commitment of physician assistants to the team-oriented model of care, and we are confident we will be able to work with them to finalize the specific language to achieve both party's interests while maintaining the high level of safe and quality care delivered to patients. In summary the NMA supports the modified proposal, and we thank you for your time.

Dr. Steve Williams' Talking Points—8/12/2019

As the President, I am speaking on behalf of the Nebraska Academy of Family Physicians. The Nebraska Academy of Family Physicians represents a group of approximately 1300 Family Physicians in Nebraska. According to the National AAFP the Nebraska Chapter has the 2 highest market share in the country of Family Physicians participating in the state organization. Family Physician have close working relationships with Physician Assistants. We value our work with PA'S on healthcare teams.

The Nebraska Academy of Family Physicians participated in a second meeting with the NAPA on Tuesday August 6 . At this meeting the NAPA provided a copy of the changes being proposed. The Nebraska Academy of Family Physicians is opposed to these changes at this point until there is more time to time to thoroughly review the scope changes in the proposal with the NAFP Executive Committee and Board and have further discussions with NAPA. Scope changes are something that we believe should be diligently and thoroughly discussed. We would ask the 407 committee to do the same.

Committee Discussion Following the Presentation of Testimony

Brandon Holt asked the applicants if they want to keep the waiver process. An applicant representative responded in the affirmative. Mr. Holt asked NMA representatives if they accept the wording of the revised proposal. An NMA representative responded in the affirmative.

Allison Dering-Anderson asked for more clarification regarding how the new scope of practice would work when a PA is shared by two physicians who have very different scopes of practice. The example that she used was the utilization of Sclerotherapy. An applicant representative responded that unless there were a physician working in that office who had training in this modality a PA working there would not be allowed to provide this therapy even though he or she might have the training themselves. Mr. Schmeckpeper added that this example highlights the need for a team approach in the delivery of health care, and that the members of his group are committed to delivering care in this manner.

Dr. Stuberg then asked for input from the other committee members regarding whether or not they were amendable to accepting it as the replacement for the original proposal. After a brief discussion it was clear that there was a consensus among the committee members present that the revised proposal should be recognized as the replacement for the original proposal.

Credentialing review staff then indicated that as soon as a finalized version of this revised proposal has been received they would have it posted on the Credentialing Review Program link as the replacement for the original proposal.

Electronic copies of their testimony can be found at the following web link under EMS
http://dhhs.ne.gov/Licensure/Pages/Credentialing-Review.aspx

Part Six: Discussion and Recommendations

Discussion on the Six Statutory Criteria as They Pertain to the seven components of the revised 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.***

Dr. Dering-Anderson stated that one of the short-comings of the current physician assistant statute is that it is not cognizant enough of team practice in the delivery of health care. The applicants' proposal provides a corrective for this short-coming. Dr. Stuberg stated that the applicants' proposal also corrects short-comings vis-à-vis prescriptive authority, bringing the physician assistant statute into the twenty-first century.

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

Dr. Dering-Anderson commented that the proposal has the potential of improving access to care. Ms. Chasek stated that she was very sure that the proposal would improve access to care in rural areas of Nebraska. Mr. Temme stated that the revised waiver process also helps makes for more efficient delivery of care as well. Dr. Stuberg commented that the proposal would make collaboration between physicians and physician assistants work better than under the current situation.

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.***

Dr. Stuberg asked the committee members if they identified any potential for new harm to the public from the proposal. None of the committee members identified any such new harm.

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

Dr. Stuberg asked the committee members if they identified any short-coming with the applicants' proposal as regards this criterion. None of the committee members identified any such short-coming.

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 of service in a safe manner.***

Ms. Chasek asked what implications this criterion might have for physician assistant prescriptive authority. Dr. Dering-Anderson responded that under the current practice situation this is regulated by a laundry list. Under the proposal it would be governed in terms of "unless you can't, you can." Dr. Stuberg commented that the competency provisions of the proposal do a better job of matching up scope elements with the capabilities of respective physician assistants and their physician supervisors.

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.***

Dr. Stuberg asked the committee members if they had any comments about the implications of this criterion for the applicants' proposal. There were no comments to this question from the committee members.

Action taken on the revised proposal occurred as follows:

Voting to recommend approval of the revised physician assistant proposal were Temme, Rochford, Dering-Anderson, and Chasek. Dr. Stuberg abstained from voting. There were no nay votes. By this action the committee members recommended approval of the applicants' proposal.