



State of West Virginia *Board of Medicine*

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On April 30, 2014, the West Virginia Board of Medicine filed a Notice of Comment Period on a Proposed Rule, 11 CSR 1B. The Board simultaneously filed the proposed rule as a proposed emergency rule to implement the newly enacted Physician Assistants Practice Act, W. Va. Code §30-3E-1 *et seq.*

The Board's Notice established a thirty day comment period on the proposed rule. During the comment period, the Board received six written comments from the following entities and/or individuals:

1. West Virginia Primary Care Association;
2. American Academy of Physician Assistants;
3. Lincoln Primary Care Center, Inc.;
4. Michael Grome, PA-C;
5. University of Charleston Physician Assistant Program; and
6. Belington Community Medical Services Association, Inc.

The Board has carefully considered these comments, and based upon deliberations spurred by the many thoughtful comments received, determined that certain modifications proposed by the commenters would enhance the implementation of the Physician Assistants Practice Act and the appropriate utilization of physician assistants within their current scope of practice in this state. Copies of the comments are attached hereto, and a summary of the comments and the Board's response thereto is provided herein below.

Comments and Responses Related to Definitions Set Forth in §11-1B-2

The Board received several comments related to the definitions section of the proposed rule.

The American Academy of Physician Assistants proposed modifications with respect to the definitions included in the proposed rule. See Letter from AAPA, pp. 1-2. The AAPA's comments with respect to the definition of "license," "licensure" and "supervising physician" appear to be based upon a misunderstanding of how the Physician Assistants Practice Act will be dually implemented by the West Virginia Board of Medicine and the West Virginia Board of Osteopathic Medicine. This Board is responsible for implementing the Physician Assistants

Practice Act with respect to physician assistants who are licensed by this Board, and the definitions are appropriately tailored to that purpose.

The AAPA also proposed that definitions for direct supervision and personal supervision be stricken from the rule, along with reference to these concepts within the rule, permitting physician/physician assistant teams to develop the appropriate level of supervision on the practice level. The Physician Assistants Practice Act does much to streamline the regulatory process with respect to physician assistants; however, upon review of this comment, it was the determination of the Board that it is important to maintain these definitions for different levels of supervision so that, when appropriate, the Board has the discretion to authorize practice under clear and unambiguous supervision standards that can be easily understood by all when necessary to ensure patient safety. Therefore, the Board did not adopt or incorporate any amendments to the proposed rule based upon these comments.

Michael Grome, P.A.-C and Belington Community Medical Services Association, Inc. provided commentary on the definition of “protocol.” Each commenter proposed a modification to the definition which would not require the supervising physician to personally “prepare” the written treatment protocols utilized by his or her physician assistant. Rather, the commenters suggested that the supervising physician be permitted to “approve” protocols. The Board considered this comment and elected to modify this definition to address the concern raised by the commenters.

The Board has amended §11-1B-2.1.bb to revise the definition of protocol in response to comments received by the Board. This subdivision now permits wider collaboration regarding the creation and adoption of protocols.

Comments and Responses Related to Responsibilities of the Supervising Physician, Set Forth in §11-1B-10

The Board received comments from Michael Grome, P.A.-C. and Bellington Community Medical Services Association, Inc. with respect to subdivision 10.5.b. Section 10 of the rule sets forth the responsibilities of the supervising physician and the guidelines for appropriate supervision. Subdivision 10.5.b requires a supervising physician to be immediately available to the physician assistant, either in-person or by electronic communication, for all necessary consultations. The commenters suggest that this provision be modified to list the alternate supervising physician in addition to the supervising physician. The Board concluded that the proposed modification was unnecessary. The subdivision in question relates to the specific obligations of the supervising physician. Subsection 10.8 sets forth a supervising physician’s ability to designate an alternate to supervise the physician assistant in the supervising physician’s absence. The Board made no changes to the proposed rule based upon this comment.

The Board received four comments with respect to subdivision 10.5.d. This subdivision incorporates a requirement for physician assistants in the first six months of an authorized practice agreement to meet with his or her supervising physician on a monthly basis for review sessions discussing specific conditions, protocols and procedures and specific patients. The Commenters pointed out the rigidity of this provision and that it would require very experienced

physician assistants to engage in meetings which were intended for new practitioners. Some commenters opined that the nature of the physician/physician assistant team was such that regular supervision occurs on a daily basis, and that the established monthly meetings were both unnecessary and appeared crafted to micromanage the physician/physician assistant team. These comments were well taken by the Board, and as a result of reviewing the same, the Board elected to modify this provision so that the required monthly meetings would be limited to new practitioners, who would most benefit from additional monthly instruction, training and in-person contact with the supervising physician.

The Board has amended §11-1B-10.5.d to clarify the meeting requirements for supervising physicians and physician assistants. Substantial and persuasive commentary was received on this provision of the Emergency Rule. The amendment requires that an authorized practice agreement shall establish manner and frequency with which periodic, in person, education and review sessions shall occur for experienced physician assistants. For physician assistants in their first year of practice, the rule requires that face to face meetings occur for the first six months of a practice agreement. This modification more accurately reflects the intention of the Board that practice agreements establish customized supervision standards that are specific to the type practice, the practice location and the education, training and experience of the physician assistant. The amended provision continues to set forth a minimum standard for new practitioners.

All six commenters raised concerns regarding subsection 10.7. The way this subsection was initially drafted, it established specific periodic intervals at which a patient must see the supervising physician rather than the physician assistant and required patients being treated for certain conditions to always be seen initially by a physician. The commenters unanimously voice concerns that rigid limits included in this subsection would inhibit the full utilization of physician assistants. At least one commenter pointed out that no other state places such limitations on initial patient visits. This language was seen as a barrier to care, as patients are not always initially seen by a physician in the current primary care practice landscape. The comments were persuasive, and the Board determined that the best way to ensure that patients receive appropriate physician contact in a variety of practice settings would be to require the supervising physician to contemplate the issue and incorporate standards related thereto within the practice agreement.

The Board has therefore amended §11-1B-10.7 to require supervising physicians to establish protocols within the practice agreement for when a patient being treated regularly for a life-threatening, chronic, degenerative, or disabling condition shall be seen by the supervising physician. By incorporating these protocols into a Board-approved practice agreement, flexibility exists to customize protocols that are specific to the type practice, the practice location and the education, training and experience of the physician assistant.

While the Board did not receive a specific written comment regarding subsection 9.5, in light of its amendments to subsections 10.5 and 10.7, and in an effort to be consistent with requiring certain delegated acts to be delineated in practice agreements, the Board elected to amend §11-1B-9.5 to clarify that if a supervising physician intends to delegate the signing of orders (where permitted by the place of practice) to his or her physician assistant, this delegation

and protocols related thereto must be incorporated into the terms of an authorized practice agreement.

The Board received one comment regarding subsection 10.8. This subsection sets forth the ability of a supervising physician to designate alternate supervisors. The subsection provides that when an alternate supervising physician is supervising a physician assistant, the alternate supervisor and the primary supervisor are jointly responsible for the acts of the physician assistant. The commenter suggested the alternate supervisor should not be held responsible for the acts of the physician assistant, and proposed a revision of the rule to eliminate joint responsibility. The commenter suggested that joint responsibility may make it more difficult for a small practice to obtain alternate coverage. The Board carefully considered this argument, but ultimately determined that it was both important and appropriate for both the supervising physician on record and the physician actually providing supervision to the physician assistant to be responsible for the acts of the physician assistant. Accordingly, no changes were made to this subsection.

The Board received one comment on subsection 10.11, which establishes the number of physician assistants a physician may supervise, either as a supervising physician or as an alternate. The commenter requested that this subsection be modified to exclude a limitation on the number of physician assistants for whom a physician may serve as an alternate. In support of this proposal, the commenter asserts that by limiting the number of physician assistants to five, inclusive of alternates, the rule decreases the number of physician assistants a physician may simultaneously supervise.

It is important to note that under the previous law, physicians were restricted to supervising no more than three physician assistants at a time. The new Physician Assistants Practice Act has expanded physician supervision from three physician assistants to five:

A supervising physician may enter into practice agreements with up to five full-time physician assistants at any one time. **A physician is prohibited from being a supervising or alternate supervising physician to more than five physician assistants at any one time.** However, a physician practicing medicine in an emergency department of a hospital or a physician who supervises a physician assistant who is employed by or on behalf of a hospital may provide supervision for up to five physician assistants per shift if the physician has an authorized practice agreement in place with the supervised physician assistant or the physician has been properly authorized as an alternate supervising physician for each physician assistant.

W. Va. Code §30-3E-9(d) (emphasis supplied). Other than in hospital settings, where physicians are limited to supervising five physician assistants per shift, the new law expands physician supervision of physician assistants to a total of five.

The Board's reading of the statute is that this total is inclusive of physician assistants for whom a physician is either a supervisor or an alternate supervisor. Because the law has already expanded the number of physician assistants that may be supervised by a physician at one time,

and because subsection 10.11 is in accord with the language of W. Va. Code §30-3E-9(d), the Board elected to make no amendment to this subsection.

Comments and Responses Related to Practice Agreements, Set Forth in §11-1B-11

Two commenters requested that the Board consider amending the proposed rule to exempt practice agreements for physician assistants in a hospital setting from requiring Board approval. The American Academy of Physician Assistants proposed amending subsections 11.3 and 11.5 to achieve this exemption. In support of this proposal, the commenters assert that the trend is to move away from Boards approving all procedures a physician assistant performs, and that procedures performed in licensed facilities are already scrutinized through credentialing and privileging, obviating the need for the Board to also approve advanced procedures in these settings.

Prior to the enactment of the Physician Assistant Practice Act, every physician assistant filed a job description with the Board. The job description was presented to the Physician Assistant Committee of the Board for review and approval. Only after the Committee reviewed the job description and recommended approval to the full Board, and the Board acted upon such a recommendation, could the physician assistant receive authorization to practice. The Board acknowledges that this was an unwieldy process which often would require a physician assistant to wait weeks before receiving approval from the Board. §11-1B-11 establishes a process which permits a more efficient review and approval process for practice agreements. Pursuant to the proposed rule, if a practice agreement contemplates the delegation of core duties only, authorization to practice may be issued by Board staff. Certain advanced duties, when accompanied by the appropriate documentation may also be approved by staff. The delegation of other advanced duties must be determined by the Board. Because of the rigorous credentialing process at hospitals and ambulatory surgical centers, if a practice agreement is accompanied by certain documentation establishing that the facility has credentialed the physician assistant to perform the advanced duties, Board staff is authorized to authorize practice pursuant to the practice agreement without the need to await the next Board meeting. In crafting this portion of the proposed rule, the Board elected to utilize the credentialing process at hospital and ambulatory surgical centers to streamline the practice agreement approval process. However, the Board did not want to create a class of practice agreements which do not require Board approval. In the Board's opinion, doing so could potentially invite confusion into the process and result in ambiguity regarding whether Board approval is required or not. The proposed rule strikes a balance between a streamlined process and requiring physician assistants to receive authorization prior to commencing practice under a practice agreement. Accordingly, the Board elected not to make any amendments to alter the requirement that all practice agreement receive Board authorization.

During the course of discussions regarding the practice agreement approval process, it became apparent that subdivision 11.5.d. may not have been as clear as the Board would have liked. The Board therefore elected to amend §11-1B-11.5.d.1 for clarity. Practice agreements, in any practice setting, which seek to delegate core duties only, may be approved by the staff on behalf of the Board if all other conditions of §11-1B-11.5 are met. The previous wording of this

subdivision, which focused on the absence of advanced duties in a practice agreement created unintended confusion. No substantive change was made regarding this section.

The Board received one comment on subsection 11.12. This subsection permits an alternate supervisor to assume the role of supervising physician in the event of the original supervising physician's sudden departure, incapacity or death. The comment received with respect to this subsection requested that a physician assistant be permitted to have more than one supervising physician. The Board considered this comment and reflected that the rule permits a physician assistant to have more than one supervising physician if the physician assistant has more than one employer, or needs separate supervising physicians because they are utilized in two different scopes of practice. For other circumstances, a supervising physician may designate alternate supervisors, who may supervise the physician assistant in the supervising physician's absence. By designating the other supervisors as alternates, additional practice agreements do not have to be submitted, and additional fees are not incurred in association therewith. The Board determined that no amendment was needed, and made no changes to this subsection.

Comments and Responses Related to Delegation Of Prescriptive Authority, Set Forth in §11-1B-12

The Board received two comments regarding the eligibility criteria for the delegation of prescriptive authority to physician assistants. Both commenters advised that the current pedagogical model for physician assistant programs incorporates pharmacology throughout the course curriculum, rather than in a designated four hour credit class. The University of Charleston Physician Assistant Program explained that, in accordance with its accreditation standards, UC requires a first semester two hour course on clinical pharmacology and thereafter incorporates pharmacology across the course curriculum.

Prior to 1990, when programs for physician assistant education were accredited under less rigorous standards, the Board developed the four semester hours of clinical pharmacology requirement for eligibility for prescriptive privileges. Baccalaureate and master's degree programs for physician assistant education, consistent with current accreditation requirements, incorporate pharmacologic instruction throughout the curriculum in a manner that far exceeds the equivalence of four semester hours.

Because the current pedagogical model incorporates pharmacology throughout the curriculum, receipt of the necessary pharmacology instruction is demonstrated by graduation. Therefore, the Board elected to amend §11-1B-12.1.a to reflect the modern pedagogical practices at accredited programs for physician assistant education. The Board has retained the four semester hours of clinical pharmacology requirement as an alternative eligibility criteria for physician assistants who otherwise meet the requirements for licensure, but have not graduated with a baccalaureate or master's degree from an approved program of instruction for physician assistants.

Amendments Approved by the Board

On July 14, 2014, the West Virginia Board of Medicine authorized the Agency Approved version of the proposed legislative rule §11-1B-1 *et. seq.* The agency approved rule includes the following amendments as discussed more fully hereinabove. As appropriate, surrounding provisions are provided for context. Amended provisions appear in bold text.

All of the amendments which are enumerated herein below, with the exception of the amendment to §11-1B-17.1.a, were previously incorporated into the Board's Emergency Amendment to an Emergency Rule, which became effective on or about June 17, 2014. The amendment to §11-1B-17.1.a is incorporated into the agency approved rule to correct a typographical error.

| Modified Provision | Amendments Incorporated into Agency Approved Rule |
|---------------------------|--|
| §11-1B-2.bb | “Protocol” means written treatment instructions established by a supervising physician for use by a physician assistant. The instructions should be flexible, in accordance with the setting where the physician assistant is employed. |
| §11-1B-9.5 | Unless prohibited by the place of practice, a physician assistant may sign orders to be countersigned later by his or her supervising physician as set forth in an authorized practice agreement. |
| §11-1B-10.5.d | Periodic, in person, education and review sessions discussing specific conditions, protocols, procedures and specific patients shall be held by the supervising physician for the physician assistant under his or her supervision in accordance with the terms of an authorized practice agreement. For physician assistants in the first six (6) months of an authorized practice agreement and who have practiced as a physician assistant for less than one year, such periodic in person meetings must occur monthly. The supervising physician and physician assistant must retain written documentation of these meetings. |
| §11-1B-10.7 | A patient being treated regularly for a life-threatening, chronic, degenerative, or disabling condition shall be seen by the supervising physician as frequently as the patient's condition requires, and in accordance with the terms established in an authorized practice agreement. |
| §11-1B-11.5.d.1 | 11.5. Upon receipt of a proposed practice agreement and the appropriate fee the Board, through its staff, shall issue a letter of authorization to practice pursuant to |

the proposed practice agreement if:

11.5.a. The proposed practice agreement is adequate;

11.5.b. The physician assistant holds an unrestricted license;

11.5.c. Based upon the submitted information, it appears that the physician assistant is able to perform the proposed delegated duties safely; and

11.5.d. The practice agreement:

11.5.d.1. Proposes the delegation of core duties in any practice setting;

11.5.d.2. Proposes the delegation of advanced duties at a hospital or ambulatory surgical center;

11.5.d.3. Proposes the delegation of advanced duties that the physician assistant has previously been authorized by the Board to perform; or

11.5.d.4. Proposes only those advanced duties for which general approval protocol has been established by the Board and the physician assistant has met such protocol.

§11-1B-12.1.a

12.1. A supervising physician may delegate limited prescriptive authority to a physician assistant in a practice agreement if:

12.1.a. The physician assistant has obtained a baccalaureate or master's degree from an approved program of instruction for physician assistants or has successfully completed an accredited course of instruction in clinical pharmacology approved by the Board of not less than four (4) semester hours. The Board may, at its discretion, grant up to one credit hour equivalent for two (2) or more years of prescribing experience in other jurisdictions;

11-1B-17.1.a

17.1. The Board may deny an application for license, or other authorization to practice as a physician assistant and may discipline a physician assistant licensed by the Board who, after a hearing, has been adjudged by the Board as unqualified due to any of the following reasons:

17.1.a. Conduct by a physician assistant which is equivalent to any of the grounds cited for the discipline of physicians or podiatrists in W. Va. Code §30-3-14(c) or section 12 of the Board's rule 11CSR1A, Licensing and Disciplinary Procedures: Physicians; Podiatrists;



May 27, 2014

Robert C. Knittle, Executive Director
West Virginia Board of Medicine
101 Dee Drive
Charleston, WV 25311

Dear Mr. Knittle,

The West Virginia Primary Care Association ("WVPCA") appreciates the opportunity to comment on the proposed rule changes to the Physician Assistants Practice Act, 30-3E- 1, et seq.

The WVPCA represents 31 community health centers ("CHCs") in West Virginia with more than 250 clinical sites. CHCs range in size from multi-site practices to single office settings in remote locations, and provide primary care services for at least one in five West Virginians. Physician assistants ("PAs") are close to 50% of the non-physician provider staffing at CHCs. The three PA education programs in West Virginia have provided our practices with excellent quality graduates, as they are able to enter the workforce, with appropriate supervision, and help maintain access for patients during decades of dwindling physician recruits in the state. The WVPCA is pleased with the passage of Senate Bill 425 during this year's regular legislative session, which made significant improvements in the regulations for PAs and will likely enhance the likelihood that CHCs will employ PAs in the future.

Due to recent concern and feedback we have received from several practicing PAs, we write to express several concerns about the proposed rule changes.

With respect to 11-1B-10.7:

10.7. A patient being treated regularly for a life-threatening, chronic, degenerative, or disabling condition shall be seen initially by the supervising physician and as frequently as the patient's condition requires, but no less than within every five appointments or within 180 days, whichever occurs first.

We respectfully request that this language be removed completely, as this language will act as a barrier to care, as patients are not always initially seen by the supervising physician, nor are some patients seen by the supervising physician within every five appointments or within 180 days.

PA education and rigorous national continuing medical education requirements insure that PAs are trained and are capable of caring for initial patients, including those with the conditions listed above. The physician shortage in our state means that PAs play a vital role in providing access for patients with chronic conditions. In fact, the core duties, as defined in section 11-1B-9.1.a-l, include "screening patients to establish the need for medical attention," "decisions for data gathering and appropriate

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management and treatment of patients being seen for the initial evaluation of a problem," as well as other core duties that apply to treatment of an initial patient.

In addition, this requirement will decrease access for patients currently being followed by physicians. Physicians and PAs who have been practicing in West Virginia likely have an established panel of patients. If stable, these patients may be seen two to four times a year. As written, this rule will require that these patients see a physician for half or even all of their appointments. A physician would have to decrease access for his or her own established patients in order to see those of the PA. In team based care applied by many, if not all CHCs, the PA provides care for the stable, chronic patients, with access to physician consultation and transfer to the physician of complex or unstable patients. Since the patients seen by the physician are often the unstable, more critical patients, requiring the physician to see all of the patients regularly cared for by the PA creates the potential for harm to the most vulnerable population and undermines the concept of team based care.

While we agree that strong physician oversight and co-management of complex patients is critical to PA practice, this provision will place an undue burden on practices and will result in decreased patient access and decreased patient safety. Ultimately, it may make practices reluctant to employ PAs given the restrictive nature of the rule. The other provisions of the proposed rules and the practice agreements can serve to delineate the parameters of patient co-management within practices and take into account the patient population, PA level of experience, and supervisory mechanisms such as electronic medical record. Therefore, we suggest that the above language be removed.

With respect to 11-1B-10.11:

10.11. A physician is prohibited from serving as a supervising physician or alternate supervising

11CSR1B

physician for greater than five physician assistants at any one time. However, a physician practicing medicine in an emergency department of a hospital or a physician who supervises a physician assistant who is employed by or on behalf of a hospital may provide supervision for up to five physician assistants per shift if the physician has an authorized practice agreement in place with the supervised physician assistant or the physician has been properly authorized as an alternate supervising physician for each physician assistant.

We respectfully request that the language not include alternate physicians in the total number supervised by each physician. Also, in practices where PAs and physicians are employees of a facility, we request that each physician may serve as each PA's alternate when the scope of practice is the same. This will avoid the need for complex coverage arrangements, and helps insure access for patients, as well as appropriate supervision for PAs.

If supervision of alternates is included in the total of five PAs per physician, this will effectively limit the number a physician can supervise in any practice with two or more physicians, where physicians serve as alternates for each other's PAs. A practice with two physicians could not employ more than five PAs total in order to comply with the rule if each physician serves as an alternate.

While the rule says that a supervising physician may be in phone or electronic communication with the PA, there will nevertheless be times when a supervising physician may not be accessible and the PA must rely on an alternate exclusively. Emergency medical leave, maternity leave, and travel to areas without phone or electronic access are all examples of times when a supervisor may not be available and an alternate must be delegated.

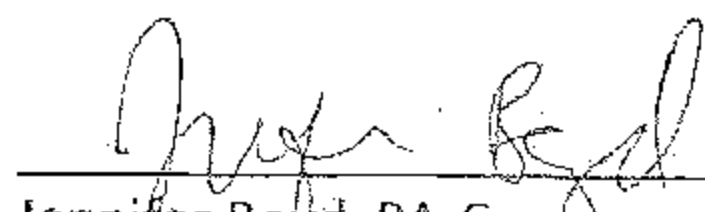
By including primary supervision and alternate supervision in the total of five, the number of PAs per physician will be decreased. Limiting the number of PAs supervised by each physician in this way will have an adverse effect on access for patients in the state by hindering a practice's ability to easily employ PAs. As mentioned earlier, with the current shortage of primary care physicians, it is important to avoid restrictions that will decrease the pool of non-physician provider options, particularly for remote rural practices.

Thank you for your time and consideration of these comments. We are pleased to see the current regulations being updated to bolster and support the role that PAs have in health care delivery in West Virginia.

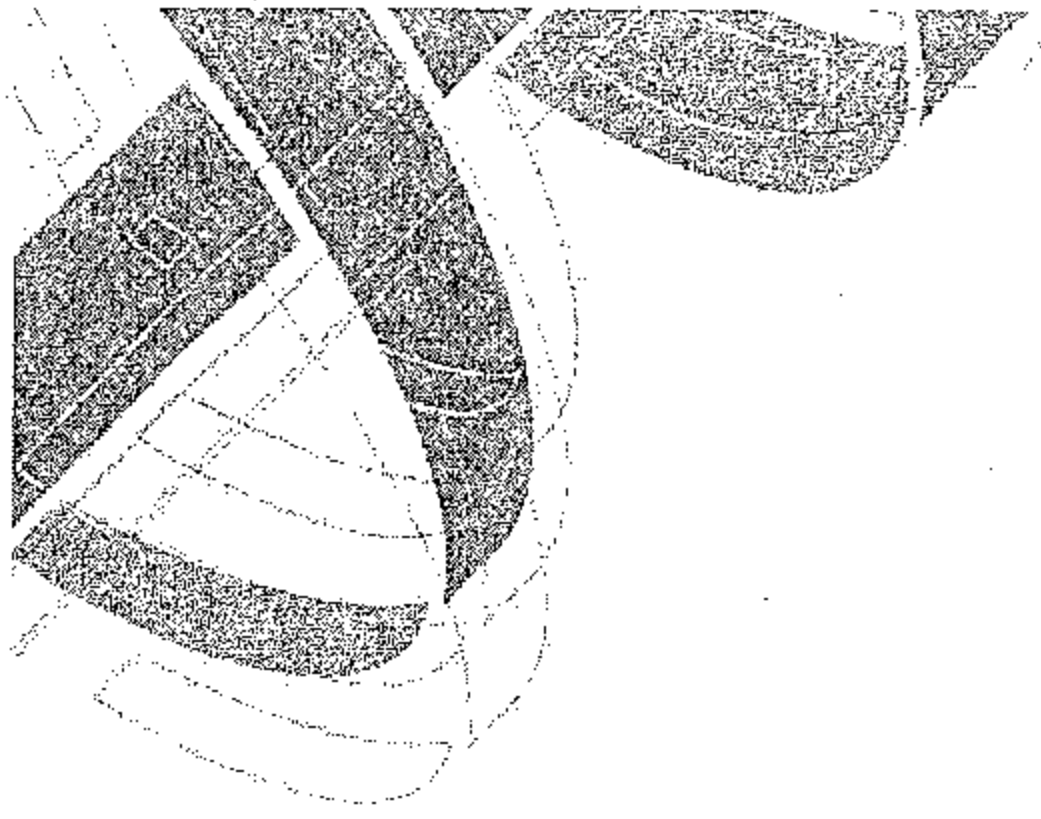
Sincerely,



Louise Reese, CEO



Jennifer Boyd, PA-C
Director of Clinical Quality



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WV BOARD OF MEDICINE



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May 16, 2014

Mr. Robert C. Knittle, Executive Director
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, WV 25300

RE: Title-Series 11-01B, Licensure, Disciplinary and Complaint Procedures, Continuing Education, Physician Assistants

On behalf of the more than 95,000 physician assistants (PAs) represented by the American Academy of Physician Assistants (AAPA) across all medical and surgical specialties, AAPA appreciates the opportunity to comment on the West Virginia Board of Medicine's (Board's) proposed changes to 11CSR 1B, Licensure, Disciplinary and Complaint Procedures, Continuing Education, Physician Assistants.

AAPA readily acknowledges and commends the dynamic partnership of the Board, West Virginia Board of Osteopathic Medicine (WVBOO) and the West Virginia Association of Physician Assistants (WVAPA) which ultimately resulted in the enactment Senate Bill 425, legislation which modernizes the licensing and regulation of PAs for the first time in three decades in the Mountain State. Upon our review of the proposed changes to the regulations however, we found several discrepancies and less than optimal provisions that the Academy would like to bring to the attention of the Board.

In order to keep the language that appears in Chapter 142, Acts, Regular Session, 2014 (Senate Bill 425) consistent with the text of the proposed rule, we have several suggestions for the Board's consideration. They are as follows:

§11-1B-2. Definitions.

While AAPA understands that the time has not yet come for the statutory and regulatory provisions governing PAs who are licensed by either or both of the allopathic and osteopathic boards to mirror one another, this unfortunately results in complex board processes, inconsistencies and confusion for physician-PA teams who earnestly make every effort to comply with the applicable laws and rules. Inherent problematic provisions are outlined below in the following portions of the proposal.

Currently, 2.1.o. defines the term "License" to mean, 'a license issued by the Board to a physician assistant applicant pursuant to the provisions of the W.Va. Code § 30-3E-1 et. seq.' Subsection 2.1.f. defines the term "Board" to mean the West Virginia Board of Medicine. This is inconsistent with the law that was enacted via the successful passage of Senate Bill 425. Under § 30-3E-1(9) of the new law, the term "License" means 'a license issued by *either of the boards* pursuant to this article.' In addition the law defines the term "Boards" under § 30-3E-1(4) to mean, 'the *West Virginia Board of Medicine and the West Virginia Board of Osteopathic Medicine*.' The definitions in the proposed regulations therefore need to be amended in order to be consistent with state law.

Under 2.1.q. "Licensure" is defined to mean 'the approval of individuals by the Board to practice as a physician assistant to a medical doctor and/or podiatrist, and the process of application and consideration for this



authorization.' The definition is void of references to doctors of osteopathy. While it is readily acknowledged that the Board of Medicine has no authority to grant an osteopathic license, this definition is inconsistent with what is subsumed in the new law which provides in relevant part that under § 30-3E-1(4),(9) and (14):

- The term "Boards" means, 'the *West Virginia Board of Medicine and the West Virginia Board of Osteopathic Medicine*.'
- The term "License" means 'a license issued by *either of the boards* pursuant to this article.'
- The term "Supervising physician" means a *doctor of medicine, osteopathy or podiatry* fully licensed by the appropriate board in this state, without restriction or limitation, who supervise physician assistants.'

Subsection 2.1.dd defines the term "Supervising Physician" to mean 'a doctor of medicine or podiatry fully licensed, without restriction or limitation, who supervises physician assistants.' However, the law defines the term "Supervising physician" under § 30-3E-1(14) to mean a *doctor of medicine, osteopathy or podiatry fully licensed by the appropriate board* in this state, without restriction or limitation, who supervise physician assistants.' The definitions in the proposed regulations therefore need to be amended in order to be consistent with state law.

Our review of the proposal also resulted in the discovery of several provisions that would not allow for optimal utilization, efficiency or flexibility physician-PA teams. We therefore respectfully request consideration for amendments to the following provisions that are discussed below.

With the enactment of Senate Bill 425, the PA law in West Virginia was modernized for the first time in over three decades. Thus the Board has a unique opportunity to continue to streamline provisions governing PA practice via the adoption of regulations to implement the law. In that spirit, any and all references to the level of supervision that a physician must apply, i.e., "direct" and "personal" within the regulation are unnecessary and regressive. Physician supervision is a fundamental aspect of PA practice. It is essential that practicing PAs have access to their supervising physicians when patients present problems that require a physician's expertise and input. However, if PAs are to practice in the most efficient and effective way possible, it is equally essential that state laws and regulations do not delineate supervision restrictions that may work well in some practices but not in others. Although there is some variation, most state laws have abandoned the concept that a medical board or other regulatory agency should micromanage physician-PA teams. The PA, supervising physician, and any relevant licensed facility policy should decide what the PA can do and the applicable level of physician supervision that is required, not the regulatory agency, which has no ability to assess the patients in the practice nor the skills and preferences of the providers. Furthermore, state law already prohibits a PA from practicing and a physician from delegating medical acts to a PA unless and until the Board has reviewed the agreement and the physician-PA team has received written authorization from the Board that they may commence practice. Lastly, under § 30-3E-10 of the new law all Board approved practice agreements must describe the "continuous physician supervision mechanisms that are reasonable and appropriate for the practice setting and experience and training of the PA" among numerous other criteria. For all of these reasons, the regulatory delineations of supervision within the proposed rule are superfluous and excessive and should be deleted from the proposal as follows:

§11-1B-2 Definitions.

2.1. For purposes of this rule, the following words and terms mean:

...

~~2.1.j. "Direct supervision" means the supervising physician must be present on site and immediately available to furnish assistance and directions to the physician assistant.~~

...

~~2.1.u. "Personal supervision" means the supervising physician must be in attendance in the room with the physician assistant throughout the rendering of care by the physician assistant.~~

§11-1B-9. Scope of Practice.



9.1. A physician assistant shall have, as a minimum, the knowledge and competency to perform the following core duties under appropriate physician supervision:

...

9.1.r. Assist physician under personal supervision in a manner by which to learn and become proficient in new procedures.

§11-1B-11. Practice Agreements.

~~41.8. Where necessary to ensure patient safety, the Board may authorize a physician assistant to practice or perform certain medical acts under direct supervision or personal supervision for a period of time so that the Board and the supervising physician may assess the ability of the physician assistant to perform the tasks safely.~~

§11-1B-10. Responsibilities of the Supervising Physician

Under the proposal a new requirement would be instituted under subsection 10.5.d to require PAs in the first six (6) months of an authorized practice agreement to have monthly, in person meetings with their supervising physician and maintenance of written documentation of said meetings. Only one other state—North Carolina—has the same requirement. Since PAs *always* practice with physician supervision, language that mandates specific requirements for personal meetings is not only unnecessary but also inflexible. In addition such mandates often impose restrictions that have no added value for many teams because they are already routinely meeting by virtue of the way that physician-PA teams provide care. Thus, this aspect of team practice can best be addressed at the practice level by the physician and PA within the practice agreement. This is particularly the case given that state law prohibits a PA from practicing and a physician from delegating medical acts to a PA until the Board has reviewed the practice agreement and the physician-PA team has received written authorization from the Board that they may commence practice. The proposed language should be deleted and perhaps replaced with the following language:

10.5.d. Periodic, in person, education and review sessions discussing specific conditions, protocols, procedures and specific patients, held by the supervising physician for the physician assistant under his or her supervision. ~~For physician assistants in the first six (6) months of an authorized practice agreement, such periodic in person meetings must occur monthly, and the supervising physician and physician assistant must retain written documentation of the meetings.~~ *Each team of physician(s) and physician assistant(s) shall ensure that the relationship of, and access to, each supervising physician is defined; and that a process for evaluation of the physician assistant's performance is established and detailed within the written practice agreement.*

The proposed regulations also seek to establish a new mandate under subsection 10.7 to require a physician to initially see a patient who is being treated for a life-threatening, chronic degenerative or disabling condition and every 5th visit or 180 days thereafter, whichever comes first. Currently, only six states have provisions in law or regulation to require patients to visit a supervising physician, rather than the PA. Only *one* other state—Maryland—*had* the exact language the Board currently proposes in these regulations within its laws governing physician-PA teams. That Maryland law was repealed in 2012 via the enactment of House Bill 584 and Senate Bill 479. Prior to its repeal, the law imposed significant access to care barriers because it was by its very nature prohibitive and negatively affected the healthcare workforce. Requiring the physician to see a patient that could be seen by the PA took the physician away from other patients, who were in greater need of the physician's expertise. The provision also proved especially problematic in rural and urban underserved settings. As physician-PA teams advocated for and the legislature ultimately came to understand as evidenced via the enactment of H.B. 584 and S.B. 479 over two years ago, it is most appropriate for supervising physicians to choose the frequency of seeing patients with such illnesses, using their medical judgment and knowledge of the patient. As with subsection 10.5.d, this aspect of team practice can best be addressed at the practice level by the physician-PA team and accounted for in the Board approved written practice agreement. Therefore this provision should be deleted in its entirety and a new subparagraph with new language should be added to **§11-1B-11. Practice Agreements** as provided below.

It is important to note that the recommended attestation language below reinforces physician supervision and team practice. In addition it is the exact amended language that was supported by MedChi, the Maryland State Medical Society, with regard to H.B. 584 and S.B. 479 and appears in the current laws governing physician-PA teams.



~~10.7. A patient being treated regularly for a life-threatening, chronic, degenerative, or disabling condition shall be seen initially by the supervising physician and as frequently as the patient's condition requires, but no less than within every five appointments or within 180 days, whichever occurs first.~~

§11-1B-11. Practice Agreements

11.2. The proposed practice agreement shall include

...

11.2.g. A description of how the physician assistant's performance will be evaluated; and

11.2.h. The following statement: "The [primary] supervising physician and the physician assistant attest that: (i) they will establish a plan for the types of cases that require a physician plan of care or require that the patient initially or periodically be seen by the supervising physician and (ii) the patient will be provided access to the supervising physician on request."; and

~~11.2.i. Any other information deemed necessary by the Board to carry out the provisions of the West Virginia Physician Assistants Practice Act, W. Va. Code §30-3E-1 et seq.~~

§11-1B-11. Practice Agreements

In reviewing the Board's proposal it is quite clear that the concepts of "core" and "advanced duties" have taken several steps further in the regulations than in the statutes. It is also clear that some of the language applicable to these concepts mirrors language that is currently embodied within the Maryland PA laws and regulations. Although such language may seem quite appealing to the Board, it is on the contrary, very antithetical. The trend in modern medicine is to move away from the concept that regulators need to approve each and every procedure a PA may perform. Moreover, there is certainly no need for regulators to engage in such micromanagement of physician-PA team practice when the team will be providing care in licensed facilities. A more flexible and streamlined approach to the practice agreement process would at the very least create an exception from the need to obtain prior Board approval or written authorization from the Board for advanced duties that are to be performed in these facilities for which there is already a rigorous credentialing and privileging process. Perhaps the amended language could read as follows:

§11-1B-11. Practice Agreements.

11.1. A proposed practice agreement shall be completed on a form provided by the Board and shall be accompanied by the appropriate fee. The fee for the submission of a practice agreement shall be one hundred dollars (\$100) until such time as a different fee is established by the Board under West Virginia Board of Medicine Rule 11 CSR 4, Fees for Services Rendered by the Board of Medicine.

11.2. The proposed practice agreement shall include:

11.2.a. A description of the qualifications of the supervising physician, the alternate supervising physicians, if applicable, and the physician assistant;

11.2.b. The scope of practice of the supervising physician;

11.2.c. The settings in which the physician assistant will practice and a list of the physician assistant's primary place(s) of practice;

11.2.d. A description of the continuous physician supervision mechanisms that are reasonable and appropriate for the practice setting, and the experience and training of the physician assistant;

11.2.e. The delegated medical acts which the physician assistant will perform, including:



11.2.e.1. Core duties;

11.2.e.2. Any advanced duties;

11.2.e.3. Any prescriptive privileges; and

11.2.e.4. A description of any medical care the physician assistant will provide in an emergency, including a definition of an emergency;

11.2.f. An attestation by the supervising physician that the medical acts to be delegated are:

11.2.f.1. Within the supervising physician's scope of practice; and

11.2.f.2. Appropriate to the physician assistant's education, training and level of competence;

11CSR1B

14

11.2.g. A description of how the physician assistant's performance will be evaluated; and

11.2.h. Any other information deemed necessary by the Board to carry out the provisions of the West Virginia Physician Assistants Practice Act, W. Va. Code §30-3E-1 et seq.

11.3. If a practice agreement includes delegation of one or more advanced duties, the practice agreement shall include the following additional information and documentation:

11.3.a. For advanced duties to be performed at hospital or ambulatory surgical facility:

11.3.a.1. A description of the advanced duty and the education, training, and experience that qualifies the physician assistant to perform the advanced duty;

11.3.a.2. Certification that the supervising physician and physician assistant are credentialed by the hospital or ambulatory surgical facility; and

11.3.a.3. A copy of the approved delineation of duties from the governing board of the health care facility stating that the physician assistant has been approved by the facility to perform the advanced duty;

11.3.a.4. Nothing herein shall require Board approval of practice agreements that contain advanced duties to be performed at a hospital or ambulatory surgical facility. Such agreements need only be filed with the Board and are excluded from the requirement under §30-3E-9(b)(3) to obtain Board written authorization to commence practicing as a physician assistant pursuant to the practice agreement.

11.3.b. For all other practice locations:

11.3.b.1. A description of the advanced duties to be delegated;

11.3.b.2. Documentation of the specialized education, training or experience received by the physician assistant in order to perform the advanced duties; and

11.3.b.3. The level of supervision that the supervising physician will use when the physician assistant is performing the advanced duty.

11.4. A physician assistant may not commence practice pursuant to a practice agreement until he or she receives written authorization from the Board to do so.

11.5. With the exception of practice agreements containing advanced duties that will be performed in hospitals or ambulatory surgical centers that do not require prior Board approval or authorization, Upon receipt of a proposed practice agreement and the appropriate fee the Board, through its staff, shall issue a letter of authorization to practice pursuant to the proposed practice agreement if:



11.5.a. The proposed practice agreement is adequate;

11.5.b. The physician assistant holds an unrestricted license;

11.5.c. Based upon the submitted information, it appears that the physician assistant is able to perform the proposed delegated duties safely; and

11.5.d. The practice agreement:

11.5.d.1. Does not contain the proposed delegation of any advanced duties;

11.5.d.2. Proposes the delegation of advanced duties at a hospital or ambulatory surgical center;

11.5.d.3. Proposes the delegation of advanced duties that the physician assistant has previously been authorized by the Board to perform; or

11.5.d.4. Proposes only those advanced duties for which general approval protocol has been established by the Board and the physician assistant has met such protocol.

11.6. Proposed practice agreements which are not approved pursuant to the criteria established in subsection 11.5 of this rule shall be considered by the Board. The Board will not consider a proposed practice agreement until it has had at least fifteen (15) days to review the application. When a practice agreement is to be reviewed by the Board because of the inclusion of certain proposed advanced duties, Board staff may issue the physician assistant authorization to practice pursuant to all portions of the practice agreement which do not require Board review.

11.7. Prior to making a determination with regard to a proposed practice agreement, the Board may request additional information from the supervising physician and/or the physician assistant, either through an appearance or through written documentation, to evaluate the proposed delegation of duties.

11.8. Where necessary to ensure patient safety, the Board may authorize a physician assistant to practice or perform certain medical acts under direct supervision or personal supervision for a period of time so that the Board and the supervising physician may assess the ability of the physician assistant to perform the tasks safely.

11.9. The Board may decline to authorize a physician assistant to commence practice pursuant to a proposed practice agreement if the Board determines that:

11.9.a. The practice agreement is inadequate and/or incomplete;

11.9.b. The proposed delegation exceeds the appropriate scope of practice; or

11.9.c. The supervising physician and physician assistant have failed to establish that the physician assistant is able to perform the proposed delegated duties safely.

11.10. A new practice agreement, with the required fee, must be filed for approval by the Board if:

11.10.a. A supervising physician and physician assistant seek to alter, amend or add to the delegated medical acts incorporated into an approved practice agreement;

11.10.b. A supervising physician and physician assistant seek to alter the physician assistant's practice setting and/or principle place of practice;

11.10.c. A physician assistant seeks to enter into a practice agreement with a different supervising physician;



11.10.d. A physician assistant seeks to resume practice after reinstatement of licensure; or

11.10.e. The Board has requested the submission of a revised practice agreement as a result of any investigation, discipline or audit activity it has undertaken.

11.11. A supervising physician may amend a physician assistant's authorized list of alternate supervisors on a Board approved form without resubmitting the entire practice agreement for approval. The Board may designate a fee for the submission of changes to a physician assistant's alternate supervisors. Any such fee shall be established by the Board under West Virginia Board of Medicine Rule 11 CSR 4, Fees for Services Rendered by the Board of Medicine.

11.12. A physician assistant may simultaneously maintain practice agreements with more than one supervising physician if:

11.12.a. The physician assistant's scope of professional duties requires multiple physician supervisors; or

11.12.b. The physician assistant has more than one employer.

11.13. A supervising physician or a physician assistant may terminate a practice agreement. A physician assistant shall immediately cease practicing upon the termination of a practice agreement. The physician assistant must notify the Board, in writing, within ten (10) days of the termination of any practice agreement.

§11-1B-12. Delegation of Prescriptive Authority

Under the new regulatory proposal, a PA must successfully complete an accredited course of instruction in clinical pharmacology approved by the Board of not less than four (4) semester hours in order for a physician to delegate limited prescriptive authority to a PA in a practice agreement. The Board, at its discretion, may grant up to one credit hour equivalent for two (2) or more years of prescribing experience in other jurisdictions. This language should be deleted in its entirety. We suggest the deletion of this provision because the law requires PAs who desire a West Virginia license to have: (i) passed the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA) and (ii) current certification. Thus, any pharmacology concerns that the Board may have are more than adequately addressed. The PA therefore not only has training in pharmacotherapeutics, but also current knowledge as evidenced via PANRE testing. AAPA therefore suggests the following amendment:

§11-1B-12. Delegation of Prescriptive Authority.

12.1. A supervising physician may delegate limited prescriptive authority to a physician assistant in a practice agreement if:

~~12.1.a. The physician assistant has successfully completed an accredited course of instruction in clinical pharmacology approved by the Board of not less than four (4) semester hours. The Board may, at its discretion, grant up to one credit hour equivalent for two (2) or more years of prescribing experience in other jurisdictions; or~~

12.1.ab. The physician assistant provides evidence of successful completion of a minimum of three (3) hours of drug diversion training and best practice prescribing of controlled substances training through a Board approved course within two (2) years prior to his or her application submission to the Board for limited prescriptive privileges; and

12.1.be. The supervising physician and physician assistant attest that:

...

On this issue, the Academy is also curious about the four (4) semester hours contained in the proposal. In speaking with leadership of the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), the accrediting agency that defines the standards for PA education and evaluates PA educational programs



to protect the interests of both the public and the PA profession, it is clear that the accreditation *Standards* (formerly titled *Essentials*) have never mandated a number of credit hours (or any predetermined amount) of instruction in any area. Prior to 1990, the *Essentials* included the following language:

"It is desirable, however, that this background include basic concepts in anatomy, physiology, patho-physiology, pharmacology and clinical laboratory medicine, inasmuch as the subsequent understanding of clinical medicine depends upon a knowledge of these content areas."

The intent of the above statement was to "forewarn" that the didactic curriculum builds upon what should be a strong science background, because the identified content areas will be incorporated and were within clinical medicine coursework or as specific free-standing courses. It is presumed that the aforementioned language reflected the change and reliance of PA's prescribing within institutions and the movement toward expanded prescriptive authority for PAs. The 1990 *Essentials* Edition and subsequent *Standards* carried forward this expectation with more definitive expectations of program curriculum. The 1990 *Essentials* provided:

Section II A

"At a minimum, however, physician assistants are educated in areas of basic medical science and clinical disciplines. Exposure to family medicine, internal medicine, pediatrics, obstetrics, gynecology and surgery, and to the concepts of behavioral medicine and psychiatry, pharmacotherapeutics, health maintenance, and ambulatory, emergency and long term care provides the breadth of educational preparation needed to function as a physician assistant"

Section II B 1a.

...

(5) Principles of clinical pharmacology and pharmacotherapeutics appropriate to the medical therapy for common problems in clinical practice.

More recently, the current 4th Edition *Standards* provide:

SECTION B: CURRICULUM AND INSTRUCTION
INTRODUCTION

"Programs need not have discrete courses for each of the instructional areas discussed within this section. However, learning outcomes related to all instructional areas are important elements of the curriculum and course syllabi."

B2.02 The program curriculum must include instruction in the following areas of applied medical sciences and their application in clinical practice:

...

d) pharmacology and pharmacotherapeutics,

The current *Standards* therefore allow PA programs to determine sufficiency of education (sufficient is defined by the ARC-PA as: enough to meet the needs of a situation or proposed end.) In addition, the *Standards* do not mandate a separate course in clinical pharmacology, just instruction in the area. This means that it may not always be easy to determine the amount of instruction any program provides by just looking at a PA's transcripts. The 4th Edition *Standards* currently include:

B1.02 The curriculum *must* include core knowledge about established and evolving biomedical and clinical sciences and the application of this knowledge to patient care.

B1.03 The curriculum *must* be of *sufficient* breadth and depth to prepare the student for the clinical practice of medicine.

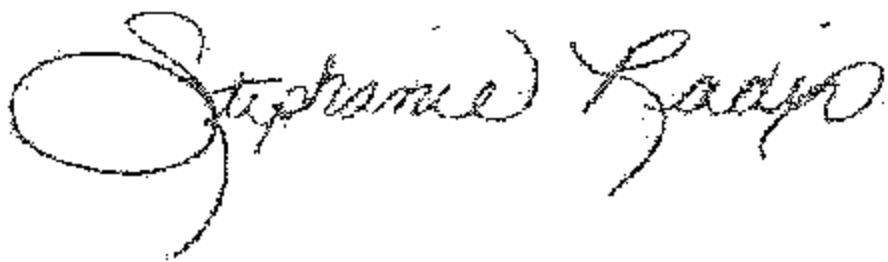


B2.02 The program curriculum *must* include instruction in the following areas of applied medical sciences and their application in clinical practice:

- a) anatomy,
- b) physiology,
- c) pathophysiology,
- d) pharmacology and pharmacotherapeutics,
- e) the genetic and molecular mechanisms of health and disease.

The Academy appreciates the opportunity to comment on these proposed regulations.

Sincerely,

A handwritten signature in cursive script that reads "Stephanie Radix". The signature is written in black ink and is positioned above the typed name and title.

Stephanie Radix
Director, Constituent Organization Outreach & Advocacy





Lincoln Primary Care Center Inc.
Southern West Virginia Health System

7400 Lynn Avenue • Hamlin, WV • P: 304.824.5806 • F: 304.824.5885 • swvhs.com

May 27, 2014

Robert C. Knittle
Executive Director
West Virginia Board of Medicine
101 Dee Drive, Ste. 103
Charleston, WV 25311

Dear Mr. Knittle:

I am writing you regarding the proposal legislative rule which would repeal and replace 11CSR1B. I am a Family Practice Physician who has been a supervising physician for a physician assistant in rural West Virginia for over 20 years. I am also the medical director for a Community Health Center which provides care to underserved patients in 5 counties in southwestern West Virginia. It is from both of the positions that I write you in concern for the consequences of Provision 10.7 of the new rule.

While it is true that physician assistants have various levels of training and skills, they should all be capable of managing patients with uncomplicated, but chronic, medical conditions (such as hypertension) for periods of over 180 days without the patient requiring a visit with the supervising physician. The physician assistant I have supervised for years manages patients with multiple problems with my assistance (which most often is a conversation in one of our offices, but seldom involves me seeing the patient).

The way this provision is written, the most stable of patients who have chronic problems and only require one or two visits per year could not be followed by a physician assistant but would need to be seen on each visit by the physician, while more complicated patients requiring as many as 10 visits per year could be seen by a physician assistant for as many as 80% of those visits. This does not seem to be a good allocation of resources.

For years Community Health Centers have provided care in underserved areas by utilizing physician assistants. In addition to the problem outlined above, Provision 10.7 would require more physician time in those underserved and often rural areas to provide the same level of care currently provided as well as being more expensive. Recruiting physicians for these sites is not only more costly than physician assistants, but is often

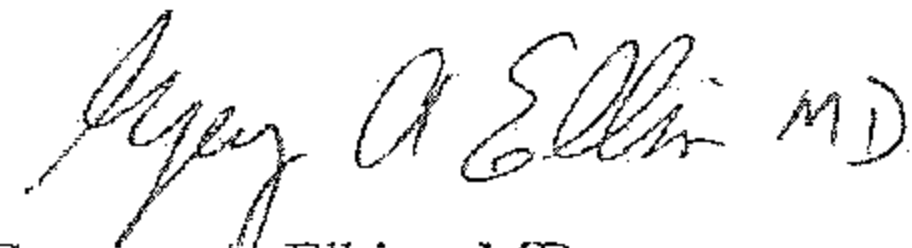


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nearly impossible to do. As the number of patients seeking access in our sites increases as a result of recent legislation, rules should be made to help our primary care physicians work with physician assistants, not restrict the number of patients the physician assistant can see. Such restrictions as listed in Provision 10.7 can only serve to decrease access to care at a time when increased access is sorely needed.

While there are additional areas of concern in the new rule it is my understanding that others have commented about those problems and it is my intent that my comments remain focused on Provision 10.7 of 11CSR1B. As such, I would ask that for the good of the patients served by physician assistants in rural and underserved areas in the past and for those who would benefit from those services in the future, that the Board of Medicine reconsider and remove Provision 10.7 from 11CSR1B

Sincerely,

A handwritten signature in black ink that reads "Gregory A. Elkins MD". The signature is written in a cursive style with a large, stylized initial 'G'.

Gregory A. Elkins, MD
Lincoln Primary Care Center, Inc.
Southern West Virginia Health System

May 25, 2014

Mr. Robert C. Knittle, Executive Director

West Virginia Board of Medicine

101 Dee Drive, Suite 103

Charleston, WV 25300

Dear Mr. Knittle,

I am writing to you in regards to the recently completed rules following the passage of Senate Bill 425.

As a former member of the West Virginia Board of Medicine I wish to thank you for all the hard work that has gone into the completion of these regulations.

I remember the difficult work of the Legislative committee in former years from my tenure on the Board prior to Mr. Dean Wright PA-C's term. Serving under Mr Ron Walton for 7 years the board addressed many issues regarding PA practice. I was pleased during my tenure and service on the Complaint Committee and as Chair of the Physician Assistant Committee that quality of care PA's provided was not an issue. I can not recall a single complaint brought against a PA for poor quality of care during that time.

It is with this in mind and based on my own experience as a Physician Assistant serving in a Primary Care Clinic for 28 years that I feel I need to comment on a few of the newly written rules.

I am concerned that the proposed regulations in particular are not reflective of the current PA educational standards. They do not take into consideration the challenges of initial PA certification, or the value of recertification and CME requirements.

As the regulations stand they are markedly more restrictive than nearly every other state where

Physician Assistants practice in the United States.

Please consider changing rule 2.1bb. by allowing the supervising Physician to approve protocols in addition to "preparing protocols" as there are many excellent protocols available for Physicians to rely on in their supervisory role in the Physician/PA team.

Please consider adding language to rule 10.5.b. which lists the alternate supervising Physician in addition to the supervising Physician in the event that the supervising Physician is unavailable do to unforeseen cause.

Please consider removing regulation 10.5.d. which appears as if the Board has decided to micromanage the Physician/ PA team giving little credit to the day to day oversight the Physician demonstrates or the Protocols he or she has established. This rule is unnecessary and burdensome.

I would ask that Rule 10.7 also be removed from the regulations completely.

This rule would effectively eliminate Physician Assistants providing continuity of care for the myriad of West Virginian's with chronic medical conditions. This does not appear to be the intent of Senate Bill 425.

Most stable patient with chronic medical conditions like high blood pressure, Copd, DJD, to name a few only return once every 6 months for a follow up visit. Requiring the supervising Physician to see each stable patient every 180 days would make the use of Physician Assistants in most Primary Care settings superfluous. Please be assured PA's are well trained and competent to evaluate and initially treat patients with routine chronic medical problems and have been doing so for these past 40 years in WV with quality care.

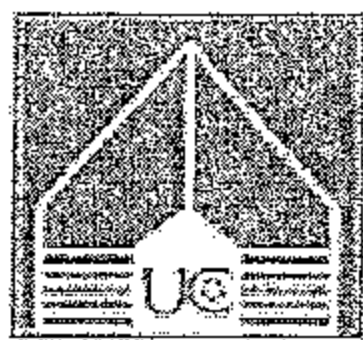
It has been my honor to work as a Physician Assistant these past 28 years serving the people of Lincoln County, WV.

I marvel at having been present while the rural Primary Care Center in which I started working went from a small rural health clinic in a revamped grocery store to a National Rural Health Clinic of the year using the Physician/PA team model, and now 28 years later that clinic encompasses multiple clinics in numerous counties in southern WV still building on the Physician/PA proven team concept to succeed. It is my hope that the WV Board of Medicine will continue to support and foster good PA practice without becoming overly restrictive.

Thank you again for considering these changes.

Sincerely,

Michael Grome PA-C



UNIVERSITY OF CHARLESTON

PHYSICIAN ASSISTANT PROGRAM

May 20, 2014

Mr. Robert C. Knittle, Executive Director
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, WV 25300

On behalf of the University of Charleston Physician Assistant Program, I appreciate the opportunity to comment on the WV Board of Medicine's proposed changes to 11CSR 1B, Licensure, Disciplinary and Complaint Procedures, Continuing Education, Physician Assistants.

I appreciate the work that the Boards have done to modernize the licensing and regulation of PAs. I have reviewed the comments made by Stephanie Radix on behalf of the AAPA, and am in agreement that some of the proposed changes are less than optimal.

While I support all of her comments, I would like to specifically comment on a few such changes.

1. §11-1B-10 Responsibilities of the Supervising Physician

Each Physician/PA team should define and document their own processes for evaluation of the PA's performance. With such defined restrictions, I feel that this would deter physicians from hiring new graduates and force them to leave the state.

Forcing physicians to see patients every five appointments or within 180 days, whichever occurs first, would restrict PAs from seeing a lot of patients with chronic illnesses. Some patients, who are fairly well controlled, may only come in every 6 months. In that situation, a PA could never see that patient. This would severely restrict PAs from providing chronic care, especially in rural areas. Again, I feel that the Physician/PA team should decide on how they monitor patients.

2. §11-1B-11 Practice agreements

The Board should not be required to approve advanced duties performed at a hospital or ambulatory surgical facility.

3. §11-1B-12 Delegation of Prescriptive Authority

Our PA curriculum at the University of Charleston includes a 2-hour Clinical Pharmacology course in which basic pharmacology is introduced during the first semester. After the first semester, we integrate our curriculum into Clinical Medicine modules. Within each module (and other courses), we address pharmacotherapeutics of disease states specific to that module or course. So, while we only offer a 2-hour Pharmacology course, we include pharmacotherapeutics in a variety of modules and courses. Our accrediting body, the ARC-PA, has evaluated our curriculum and determined it to meet the requirements for the following *Standards*:

B1.02 The curriculum *must* include core knowledge about established and evolving biomedical and clinical sciences and the application of this knowledge to patient care.

B1.03 The curriculum *must* be of *sufficient* breadth and depth to prepare the student for the clinical practice of medicine.

B2.02 The program curriculum *must* include instruction in the following areas of applied medical sciences and their application in clinical practice:

- a) anatomy,
- b) physiology,
- c) pathophysiology,
- d) *pharmacology and pharmacotherapeutics*,
- e) the genetic and molecular mechanisms of health and disease.

I am grateful that we have been given the opportunity to provide thoughts on the proposed regulations.

Sincerely,

Jennifer Pack

Jennifer Pack, MMS, PA-C
Program Director
Physician Assistant Program
University of Charleston
304-357-4790
jenniferpack@ucwv.edu



BELINGTON COMMUNITY MEDICAL SERVICES ASSOCIATION, INC.

210 Sturmer Street, Belington, West Virginia 26250 (304) 823-2800 FAX: (304) 823-2703

May26, 2014

Mr. Robert C. Knittle, Executive Director
West Virginia Board of Medicine
101 Dee drive, Suite 103
Charleston, WV 25300

Dear Mr. Knittle,

I recently reviewed the proposed Physician Assistant regulations related to the passage of Senate Bill 425. I have some concerns and suggestions I that I hope the Board will consider. My perspective is that of a primary care physician assistant of over thirty years; as a clinic administrator of twenty years; and as a former Board of Medicine member. I am currently the Belington Clinic's Associate Administrator and Clinical Director while continuing to practice as a physician assistant. I respect the Board and do not want to be perceived as confrontational. Nevertheless, I honestly believe that these regulations, if they remain unchanged, will unquestionably be harmful to primary care PA practice in this state.

I do not believe the proposed regulations reflect the West Virginia primary care PAs quality of care record; are not reflective of current PA educational standards; nor do they take into consideration the rigorous initial PA certification, recertification and CME requirements. They are more restrictive than the overwhelming majority of other state's regulations. If they move forward in their present form, an unintended effect will be to impact primary care access and make nurse practitioners, who do not have the same supervisory or the recertification requirements, more attractive to physician and clinic employers. I do not think this was the intention of the Senate Bill 425 sponsors.

I respectfully request that the Board and its staff consider the following suggestions for changes to the proposed regulations and the rationale for these changes:

11-1B-2. Definitions

2.1.bb. Please consider inserting "or approved by" after "prepared by a" and before "supervising physician". There are many excellent protocols available and most supervising physicians do not actually prepare their own protocols. Additionally, FQHC and RHC clinics are required to have protocols which both physicians and physician assistants are expected to comply with.

11-1B-9. Scope of Practice

10.5.b. Please consider inserting "or alternate supervisor" after "supervising physician" and before ", either". This is simply a clarification if the supervising is ill, unavailable or does not have cell service.

10.5.d. This is an unnecessary requirement. Physicians and their PAs interact on a day by day, week by week, and year by year basis as part of a career long learning process. The emphasis is most often focused on more complicated patients, treatment options and diagnostic modalities. Additionally, it does not take into consideration the CME required of PAs, the practice ability of experienced PAs, nor the yearly protocol review required of both physicians and PAs working in FQHC and RHC clinics. If any

part of this has reason to remain, it should be restricted to recent graduates and those who are changing their area of practice and limited to a period of six months.

10.7. This section, as written, is unwarranted and not well worded. It diminishes the effectiveness of primary care PAs far out of proportion to any perceived additional safety for patients. It is not consistent with current or past physician-PA medical practice as PAs routinely see each and every patient described in this section. A large portion of these patients present as routine appointments or urgent visits with no idea of what their problem may be. It is impossible to assure that each of these patients will be seen initially by a supervising physician. PAs are trained to distinguish serious urgent problems, the unstable patients and the potentially life threatening illnesses and get these people immediately to the care they need whether it's the supervising physician, the emergency department or specialist care.

Additionally, PAs are trained and competent to evaluate and initially treat routine chronic illnesses that present in primary care. The majority of PAs in primary care clinics and practices will have a caseload of regular patients that they follow under the supervision of a physician. The requirement that a supervising physician see a patient every 180 days effectively eliminates an experienced PA from seeing the most stable, overall healthiest chronic patient where the supervising physician is least needed. The every five appointments requirement does not take into account acute care visits and other unrelated medical problems. Patients who want or need to see a physician are not denied that opportunity.

The advent of the electronic medical record, when properly used, increases the effectiveness of primary care medical practice. It also provides an excellent means for a supervising physician to monitor physician assistant practice. It can be utilized from another room or another location. It provides the physician supervisor with a patient's encounter historical information; the physical exam results; lab tests and other diagnostic information. It gives the supervisor the ability to assess what remains to be done or what should have been done. This tool, which is just about universal today, clearly enhances physician supervision.

Since physicians and their physician assistants should and are expected to practice evidence based medicine, it seems only reasonable the Board should examine carefully the quality of care provided by West Virginia PAs and examine the evidence. I believe that, in the 40 years PAs have practiced in West Virginia, the record is good. In my ten years on the Board of Medicine, while on both the PA and Complaint Committee, I do not recall any quality of care complaints against PAs. This was also the case in later years when I served as an expert in complaints involving PAs.

The issue of patient by patient supervising physician review in Section 10.7. should be addressed in the "Practice Agreement" and be dependent on the practice setting and the experience of both the physician and PA.

10.8. There is a relationship between this section and section 11.12. They both impact supervision and section 11.12 has the potential to solve "alternate supervision" for a significant number of PAs. Additionally, unless I am misreading Senate Bill 425, there is not a mandate for an "Alternate supervising physician" to be legally responsible for his or her supervision of a PA in the absence of the supervising physician. While this is not an issue for larger clinics, group practices or hospitals where the physicians and PAs have the same malpractice coverage, it is a significant issue for small clinics and private practices when a supervising physician is away. It makes obtaining alternate supervision much more difficult or impossible to obtain.

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Please consider striking "An alternate supervising physician, jointly.....is providing supervision for the physician assistant" and substitute "The supervising physician shall be legally responsible for the acts of a physician assistant which occur during periods of time where the alternate supervising physician is providing supervision for the physician assistant." If there is an issue with irresponsible behavior of an alternate supervising physician in the future, both the Board and the courts could make that call. It is not likely that either will be overburdened with complaints of this nature.

11.12. Many of the PAs practicing in West Virginia work in group practices where the physicians have the same specialties or practice family medicine. These physicians and the PAs who work with them often share and see the same patients. It makes sense to allow PAs in these practices have more than one, or at least two, supervisors. This would deal with the issue of supervision when one supervising physician is absent and is realistic in these practice environments. It would not be burdensome for the Board.

Please consider adding a section 11.12.c. "The physician assistant is employed in a clinic or group practice where the supervising physicians have the same specialty or area of area of practice and provide coverage to their respective patients".

Thank you for your consideration. I hope I do not present as an unreasonable grump. I am a lucky man, have enjoyed a wonderful, rewarding career and the medical community has been good to me. I have had the opportunity to watch our rural clinic transition from a single PA with a part-time physician to three physicians and three PAs; been able to interact with three generations of patients; and now get to practice with a WVU family physician I held as an infant. It has been great.

Sincerely Yours,



Tom Harward, PA-C

Cc:

Rev. O. Richard Bowyer, President
Kenneth Dean Wright, PA-C

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