



State of West Virginia *Board of Medicine*

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August 22, 2017

SUMMARY OF COMMENTS RECEIVED REGARDING PROPOSED AMENDMENTS TO 11 CSR 1B AND RESPONSES OF THE WEST VIRGINIA BOARD OF MEDICINE

On July 11, 2017, the West Virginia Board of Medicine filed a Notice of Comment Period on a Proposed Rule, 11 CSR 1B. The Notice established a thirty day comment period on the proposed rule, which concluded at 4:30 p.m. on August 10, 2017. During the comment period, the Board received eighteen comments from the following sixteen individuals/entities:¹

Commenter	Date Received
1. John P. Lubicky, MD	July 25, 2017
2. Cara Sedney	July 25, 2017
3. Thomas S. Miller, MD	July 25, 2017
4. Richard Vaglianti, MD	July 25, 2017
5. Diane Rader, PA-C	July 25, 2017
6. Robert Johnstone, MD	July 25, 2017
7. Michelle Abe, DO	July 26, 2017
8. Ashley Clay, MS, PA-C	July 26, 2017
	July 26, 2017 and August 8, 2017
9. Alok Gopal, MD, DBMA	July 26, 2017
10. Yashica Shah	July 26, 2017
11. Tahira Masood, MD	July 29, 2017
12. Mary Gainer, MD	August 1, 2017
13. Alan W. Cashwell, MD	August 2, 2017
14. West Virginia Association of Physician Assistant Board of Directors	August 9, 2017
15. Nicholas Vance, MS, PA-C	August 10, 2017
16. American Academy of PAs	August 10, 2017

¹ Copies of all comments received by the Board are attached hereto.

The Board has reviewed all comments received, and on August 21, 2017, the following responses were authorized. A copy of this summary is being provided to each commenter. The Board extends its sincere appreciation and gratitude to all individuals and groups who took the time to review and comment upon the proposed amendments to 11 CSR 1B.

General Comments

One commenter indicated that she feels that while SB1014 and the Board's proposed amendments are a step in the right direction, the regulatory hoops involved in practicing as a physician assistant in West Virginia are burdensome, and disadvantage physician assistants as compared to nurse practitioners. By way of a follow-up submission, this commenter also indicated that she supports the statement of the AAPA regarding Optimal Team Practice, which supports the removal of laws and regulations that require a PA to have and/or report a supervisory, collaborating or other specific relationship with a physician in order to practice. This commenter does not believe that SB1014 or the Board's proposed amendment to 1B reflect this ideal. [8]²

One commenter supports the proposed amendments, as it is a "burden to the daily lives of physicians trying to keep their head above the water on a daily basis taking care of patients." [9]

Another commenter, who indicates that she has experience working with excellent physician assistants, is concerned that increased independence and less stringent oversight of physician assistants, particularly in rural areas where there are fewer specialists and a need for a vast fund of medical knowledge to treat a variety of medical conditions, will not benefit patients. [12]

While also offering some specific proposed modifications to the proposed amendments, another commenter "supports and commends this significant revision and modernization of PA practice in West Virginia." [16]

Response: The Board appreciates the broad spectrum of general comments it has received. The changes which increase physician assistant independence, and which are incorporated in the Board's amendments, implement the provisions of SB1014. This bill sought to ensure parity between physician assistants and advance practice registered nurses, specifically with regard to prescribing and signature authority. No changes were made to the Board's proposed rule amendments based upon these comments.

Specific Comments

Modification of Terminology from Supervising/Supervising Physician to Collaboration/Collaborating Physician and the Definition of Collaboration (Section 2)

Section 2 of the proposed amended rule incorporates SB1014 terminology into the definitions section to facilitate the transition from the term "supervision" to the term "collaboration" in the

² The bracketed number reference provided after a comment summary identifies the commenter by reference to the itemized list at the beginning of this summary.

description of the working relationship between a physician assistant and a physician. Collaboration is defined in subdivision 2.1.i. as:

2.1.i. “Collaboration” means overseeing the activities of, and accepting responsibility for, the medical services rendered by a physician assistant. Constant physical presence of the collaborating physician is not required as long as the collaborating physician and physician assistant are, or can be, easily in contact with one another by telecommunication. Collaboration does not require the personal presence of the collaborating physician at the place or places where services are rendered.

Two commenters expressed serious concerns about changing the physician/ physician assistant dynamic from “supervision” to “collaboration.” The first commenter indicated that she does not support the changes as written, specifically to the extent that the amendments change “the role of physicians from ‘supervising’ to ‘collaborating.’” This commenter contends that “being legally responsible for, and overseeing, PA is, by definition, “supervision.” She further opines that the change in terminology “diminishes the very real responsibility of the physician supervisor.” [2] The second commenter indicated that changing the term “supervising” to “collaborating” “implies that we as physicians would also be asking their opinions on our own patients,” and that this legislation is “leading down a dangerous path” towards independent practice by physician assistants. This commenter considers the proposed amendments, and the bill upon which they are based, as diminishing patient safety by permitting expanded practice by physician assistants. [7]

Without specific reference to the change in terminology from supervising to collaborating, a third commenter wrote that it would be dangerous for patient safety to permit physician assistants to practice without physician supervision. [10]

Response: The transition from “supervision” to “collaboration” was decided by the legislature during the first special session and incorporated into SB1014. The proposed amendments to Series 1B reflect this statutory change. No changes were made to the Board’s proposed rule amendments based upon these comments.

A fourth commenter wrote that the “definition of ‘collaboration’ is essentially the same as ‘supervision.’ There should be definition at beginning defining collaboration as other states have defined it. 2.1.i and 10.1 definitions of collaboration could be added, as the current draft definition in 2.1.B is not reflective of the term collaboration.” This commenter did not offer any specific proposed language for the modification of the definition of “collaboration.” [14]

Response: Subdivision 2.1.b is the definition of alternate collaborating physician, not the definition of collaboration. Subdivision 2.1.i, which the commenter favorably references, provides a definition for collaboration. It is accurate that the definition of collaboration is similar to the current definition of supervision. The proposed definition of collaboration incorporates the statutory definition of collaboration adopted by the legislature in SB1014. No changes were made to the Board’s proposed rule amendments based upon this comment.

Reporting NCCPA Status on License Renewal (Sections 5)

Pursuant to SB1014, PAs are no longer required to maintain continuous NCCPA certification to maintain licensure with the Board, and NCCPA certification is no longer required to renew a license. The Board's proposed amended rule comports with this change in statute. As set forth in Section 5, NCCPA certification is no longer required for renewal. The Board's amended rule does require, however, that a PA report his or her NCCPA status on his or her renewal application.

In pertinent part, Subsection 5.6, provides:

5.6. The Board's physician assistant renewal application form shall include, and applicants must provide, the following information:

5.6.f. ~~Documentation of current and continuous~~ The renewal applicant's NCCPA certification status;

One commenter "finds the general requirement for PAs to report their NCCPA certification status and the mandate to do so as a license renewal applicant unnecessary and inequitable." The commenter points out that physicians are not required to report board certification status for license renewal, and equates NCCPA certification to Board certification. The commenter proposes that subdivision 5.6.f be stricken from the proposed amendments in its entirety. [16]

Response: While the Board appreciates this thoughtful comment, it does not consider the collection of NCCPA certification status unnecessary or inequitable. Unlike, physicians, who are not required to be board certified for licensure, a physician assistant must hold NCCPA certification to obtain an initial license to practice as a physician assistant in West Virginia. Collection of information regarding continuing certification status permits the Board to maintain accurate information on licensees after initial licensure, and ensures that the appropriate professional designation is utilized by the Board when identifying physician assistants on the Board's website, and elsewhere. (A physician assistant with NCCPA certification may use the professional designation of "P.A.-C. whereas a physician assistant without current certification uses the professional designation of "P.A."). No changes were made to the Board's proposed rule amendments based upon this comment.

Reporting Loss of NCCPA Status (Section 6)

For the PA profession, certification status determines whether a PA uses the professional designation of PA or PA-C, and the Board uses the appropriate designation to identify licensees on the Board's website and in other correspondence. Section 6 is amended to remove the provision that a license terminates if NCCPA certification is lost. However, the amendment maintains the requirement that a licensee report loss of NCCPA certification.

Proposed Section 6 provides:

§11-1B-6. Termination of License Reporting of NCCPA Certification Status.

6.1. A licensed physician assistant must immediately notify the Board, in writing, ~~upon losing NCCPA certification~~ if the licensee is no longer certified by the NCCPA. Failure to immediately report the loss of NCCPA certification shall constitute unprofessional, dishonorable and/or unethical conduct which may result in the imposition of discipline against the licensee. Notification to the Board shall be considered to have occurred as required if such notification is received within ~~one~~ five business days of the effective date of the ~~loss of~~ end date of the licensee's NCCPA certification.

6.2. If a licensee is no longer certified by the NCCPA, ~~his or her license automatically terminates without notice to the physician assistant~~ the licensee shall utilize the professional designation of PA, and shall immediately cease use of the professional designation of PA-C.

6.3. ~~Upon loss of NCCPA certification and/or license termination, a physician assistant must immediately cease practicing as a physician assistant and notify all supervising physicians of the loss of NCCPA certification, licensure and Board authorization to practice. All practice agreement authorizations issued by the Board automatically terminate with the expiration of NCCPA certification and the termination of licensure.~~

6.4. ~~A physician assistant becomes eligible for reinstatement of a terminated license once he or she becomes recertified by the NCCPA.~~

One commenter proposes that subsection 6.1 be stricken in its entirety. The commenter writes that the inclusion of a mandatory reporting requirement, which makes failure to report loss of NCCPA certification a disciplinary offense, could have the potential to affect the livelihood of a physician assistant who unintentionally failed to make the requisite report. [16]

Response: The Board understands the concerns raised by the commenter, but has determined that immediate reporting of loss of NCCPA certification is sufficiently important to support the reporting requirements set forth in subsection 6.1. A physician assistant's certification status may change for a variety of reasons, including revocation of NCCPA certification for disciplinary reasons. Timely reporting of the loss of NCCPA certification, in certain circumstances involving disciplinary revocations, may assist the Board in discharging its responsibility to protect the public. At a minimum, it permits the Board to maintain up-to-date and accurate professional designation information on all physician assistant licensees. After thoughtful consideration of this comment, the Board has concluded that the equities lie in favor of maintaining the provisions of subsection 6.1 without further amendment.

Physician Assistant Scope of Practice/Signature Authority (Section 9)

This section sets forth the general scope of practice of a physician assistant. The modifications to this section relate to the transition from the term “supervision” and its variants to “collaboration” at its variants. The amendments also incorporate the expansion of signature authority adopted by the legislature in SB1014.

One commenter asked how the term “stable condition” is “being defined” in subdivision 9.1.g. [14]

This subdivision reads:

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

9.1.g. Make decisions regarding data gathering and appropriate management and treatment of patients being seen for the initial evaluation of a problem or the follow-up evaluation of a previously diagnosed and stabilized condition;

Response: The language of subdivision 9.1.g has not been amended, and has been part of Series 1B for several years. The term “stabilized condition” is defined at the practice level in collaboration with the practice location and collaborating physician.

The commenter also indicated that the language of 9.1.q. “has not been completed the way it is written” and the “and” at the end of the subdivision should be removed. [14]

Response: Subsection 9.1 begins an enumerated list of core duties physician assistants should be educated and trained to perform with appropriate physician collaboration. Subdivision 9.1.q. is the next to last subdivision of this enumerated list (Subdivision 9.1.r is the last subdivision). The referenced “and” is properly included. No changes were made to the Board’s proposed rule amendments based upon this comment.

The Board received three comments regarding Subsection 9.5, which relates to physician assistant signature authority.

Proposed subsection 9.5 provides:

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. A physician assistant may provide an authorized signature, certification, stamp, verification, affidavit or endorsement on documents within the scope of his or her practice, including, but not limited to the following:~~

9.5.a. Unless prohibited by the place of practice, a physician assistant may sign orders within the scope of his or her practice, including discharge orders for patients personally treated by the physician assistant;

9.5.b. Medical certifications for death certificates if the physician assistant has received training on the completion thereof;

9.5.c. Instruments related to scope and limitation of treatment, including:

9.5.c.1. Physician orders for life sustaining treatment;

9.5.c.2. Physician orders for scope of treatment; and

9.5.c.3. Do not resuscitate forms and/or orders.

9.5.d. Disability medical evaluations and/or certifications for persons with disabilities in support of a hunting or fishing permit;

9.5.e. Utility company forms or certifications requiring maintenance of utilities regardless of ability to pay; and

9.5.f. Governmental forms as permitted by law including, but not limited to parking applications for mobility impaired persons.

One commenter opposes giving physician assistants any signature authority and suggests that this change, in concert with other set forth in SB1014 would result in “legalized quackery” and physician assistants, nurse practitioners and psychologists replacing or supplanting physicians. [11].

Response: The signature authority set forth in the proposed amendments to Section 9 are consistent with the expansion of signature authority as set forth in SB1014, and are appropriate to the education, training and experience of physician assistants.

One commenter asked whether the provisions of Section 9.5 authorize physician assistants to sign orders for durable medical equipment, as authority to sign orders for DME is not explicitly set forth in subsection 9.5. [14]

Response: As set forth in the subsection, this is not intended to be an exhaustive list. However, for clarity, and in consideration of this comment, the Board has modified its proposed amendments to include durable medical equipment as subdivision 9.5.f.

Another commenter suggests modifying Subdivision 9.5.a to include “admission and/or discharge” orders to clarify that PAs may admit and discharge patients they personally treat. The commenter avers that the language would be helpful if a suspended CMS rule that limits reimbursement to

practitioners authorized to admit patients by state law/rules and hospital bylaws is reinstated in the future. [15]

Response: Having considered this comment, the Board has elected to modify the language of subdivision 9.5.a as follows:

9.5.a. If permitted by the place of practice, a physician assistant may sign orders within the scope of his or her practice, including admission and/or discharge orders for patients that the physician assistant has been involved in treating;

The modified language makes it clear physician assistants may sign orders, including admission and discharge orders within the PA's scope of practice and as permitted by the practice location and so long as the physician assistant has participated in the treatment of the patient. This ensures maximum flexibility at the practice level, which is the appropriate place for such a determination to be made.

One commenter suggested specific modification to Subsection 9.9. [15]

The Board's proposed amended 9.9 reads:

9.9. A physician assistant may not independently delegate a task assigned to him or her by his or her supervising collaborating physician to another individual.

The commenter proposes that this section be modified as follows:

9.9. A physician assistant may not independently delegate a task assigned to him or her by his or her supervising collaborating physician to another individual. Nothing shall prohibit a PA from delegating orders including but not limited to: registered nurses, licensed practical nurses, medical technicians, medical assistants, radiology technologists, etc.

The commenter suggests that the proposed modified language "may help clarify that a PA may provide orders to be carried out by nursing and/or ancillary staff within their education and training."

Response: Subsection 9.9 is designed to deal with tasks delegated by a collaborating physician to a physician assistant. The addition of language relating to the delegation of orders to this section would be confusing. The Board has concluded that lawfully issued orders of a PA will be delegated as appropriate at the practice location through regular processes, and specific language would not operate to enhance the authority of lawfully issued orders. However, and in light of this comment, the Board has considered whether subsection 9.9 could be read to constrain full collaboration with other team members, and has therefore modified subsection 9.9 to reflect the ability, and necessity, of a physician assistant appropriately engaging and collaborating with other health care providers. The modified language is:

9.9. A physician assistant may not independently delegate a task assigned to him or her by his or her ~~supervising~~ collaborating physician to another individual. Nothing in this subsection shall prohibit a physician assistant from engaging in appropriate collaboration with other treatment team members.

Responsibilities of the Collaborating Physician (Section 10)

The Board received two comments regarding Subdivision 10.5.d.
Proposed 10.5.d provides:

10.5.d. Periodic, in person, education and review sessions discussing specific conditions, protocols, procedures and specific patients shall be held by the ~~supervising~~ collaborating 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 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~~ collaborating physician and physician assistant must retain written documentation of these meetings.

One commenter asks whether the “in person” requirement of this subsection applies to all physician assistants, or only to PAs who have been practicing for less than one year. [8]

Another commenter raised a similar question about this un-amended portion of this section (erroneously referencing subdivision 10.5.d as 12.5.d). The commenter asks: “is the extent of ‘collaboration’ between the PA and Physician automatically transitioning to a frequency to be defined at the practice level once the 6 month parameter has been met for newly practicing Pas (without further petitioning the board)?” [14].

Response: The provisions of subdivision 10.5.d referenced by the commenters are currently in effect, and have not been modified by the Board’s proposed amendments. The in-person requirement for periodic education and review sessions applies to all physician assistants, and can transition from monthly after the first year of practice without petitioning the Board. No changes were made to the Board’s proposed rule amendments based upon these comments.

A commenter identified one instance of “supervision” that has not been amended to “collaboration” in subdivision 10.5.d and one instance of “supervisory” that has not been amended to “collaborative” in subsection 10.8. [14]

Response: The Board appreciates the commenter identifying these needed modifications, and the Board’s agency approved version of 11 CSR 1B incorporates modifications to 10.5.d and 10.8 to change supervision/supervisory to collaboration/collaborative.

Prescribing Authority for Physician Assistants (Section 12)

The Board's proposed amendments to Section 12 implement the expansion in prescribing authority authorized by SB1014 to ensure parity between PAs and APRNs. All of the comments the Board received regarding this section related to the expansion in prescribing authority.

Proposed Subsection 12.3 provides:

12.3. On an annual basis, the Board shall approve and publish on its website a list classifying pharmacologic categories of all drugs which physician assistants are prohibited from prescribing. This list shall, at a minimum, prohibit physician assistants from prescribing:

12.3.a. Schedules I and II of the Uniform Controlled Substances Act;

12.3.b. ~~Greater than a non-refillable seventy-two hour supply of a drug listed under Medications listed under Schedule III of the Uniform Controlled Substances Act~~ are limited to a 30 day supply without refill;

12.3.c. ~~Antineoplastics and chemotherapeutic agents used in the active treatment of current cancer; and~~

12.3.d. ~~Radio-pharmaceuticals, general anesthetics and radiographic contrast materials; and~~

12.3.e. General Anesthetics.

One commenter indicated that "if the board is contemplating making it easier for PAs to prescribe opioids, I'm totally against it," and concluded that PAs "should not be given the right to prescribe narcotics for chronic pain." [3] A second commenter requested that the Board "consider replacing the opioid prescribing portion with even stricter limitations." [7] A third commenter indicated that, based upon her personal knowledge and a comparison of the education received by physicians and physician assistants, it is "not ok to allow them [PAs] to prescribe meds without a physician overseeing their work." This commenter is concerned about drug interactions which may occur pursuant to unsupervised PA prescribing. [10] A fourth commenter also disfavors an expansion in physician assistant, nurse practitioner and/or psychologist prescribing authority. [11]

Response: The prescribing authority incorporated into Subsection 12.3 is based upon statute, and is consistent with the education, training and experience of the physician assistant profession. These amendments do not authorize physician assistants to prescribe Schedule II narcotic/opioid medications. To prescribe medications within the physician assistant formulary, a PA must have an authorized practice agreement with a collaborating physician which delegates prescribing authority. No changes were made to the Board's proposed rule amendments based upon this comment.

Another commenter commented that "physician assistants should have all of the privileges that a nurse practitioner has for mediations and procedures and any other modality." [4]

Response: SB1014 and the associated proposed amendments to Series 1B provides prescribing parity between PAs and APRNs. No changes were made to the Board’s proposed rule amendments based upon this comment.

Another commenter advocates permitting physician assistants to write for Schedule IIs, and eliminating the prohibition on no refills for Schedule III medications. This commenter works with a PA and APRN, who he believes could appropriately prescribe Schedule II medications. He further suggests that expanding prescriptive authority would help fill a critical need for psychiatric patients. [13]

Response: SB1014 prohibits PAs from prescribing Schedule II medications, and prohibits refills for Schedule III medication. The Board’s proposed amendments to Series 1B are in accord with this statutory prohibition.

An additional commenter wrote: “12.3 and 12.3B conflict with each other, we feel the first appears most appropriate.” [14]

Response: Subsection 12.3 indicates that the Board will create an exclusionary formulary regarding the categories of medications and drugs physician assistants may not prescribe. This subsection then identifies, and enumerates, in subdivisions, the categories of medications which physician assistants are prohibited from prescribing by statute, and which must be part of the exclusionary formulary. Subsection 12.3 and 12.3.b are not in conflict. No changes were made to the Board’s proposed rule amendments based upon this comment.

Continuing Education (Section 13)

The Board received three comments regarding continuing education. Proposed Subsections 13.1 and 13.2 provide:

13.1. Successful completion of a minimum of one hundred hours of continuing education satisfactory to the Board during the preceding two-year period is required for the biennial renewal of a physician assistant license.

13.2. Types and categories of continuing medical education satisfactory to the Board for physician assistants are:

13.2.a. Continuing medical education designated as Category I by either the American Medical Association, American Academy of Physician Assistants or the Academy of Family Physicians.

13.2.b. Continuing medical education designated as Category II by either the American Medical Association, American Academy of Physician Assistants or the Academy of Family Physicians. A maximum of fifty hours of continuing medical education credit may be awarded for this category of activity.

13.2.c Obtaining a master's degree from an accredited program of instruction for physician assistants within one year of the expiration of an initial license. A maximum of one hundred hours of continuing education credit may be awarded for this category of activity, but a physician assistant shall only be awarded ninety-seven hours of credit if the physician assistant is a mandatory participant in the continuing education activity described in subsection 13.3 of this rule.

13.2.d. Passing a recertification examination by the NCCPA during the reporting period. A maximum of one hundred hours of continuing medical education credit may be awarded for this category of activity, but a physician assistant shall only be awarded ninety-seven hours of credit if the physician assistant is a mandatory participant in the continuing education activity described in subsection 13.4 of this rule.

There are no other types or categories of continuing education activity for physician assistants satisfactory to the Board.

One commenter sought clarification regarding whether the Academy of Family Physicians is the same as the American Academy of Family Physicians. [5]

Response: These are the same entity. For clarity, the agency approved version of the rule includes modifications to 13.2.a and 13.2.b which insert the word American in front of Academy of Family Physicians.

One commenter indicated that it is important to have strict standards of continuing education of physician assistants. [12]

Response: The Board agrees that health professionals, including physician assistants, should have high continuing education standards which provide for meaningful and useful continuing education. The Board believes the requirements of this section are consistent with that goal. Accordingly, no changes were made to the Board's proposed rule amendments based upon this comment.

Another commenter suggested that the Board modify this section to accept proof of NCCPA certification in satisfaction of CME requirements (except for the three hour drug diversion best practice prescribing CME). This commenter would also modify 13.2.b to remove the requirement that a licensee may only obtain 50 hours of credit for Category II CME, permitting all CME to be Category II. The commenter suggests that such a modification would also eliminate the need for 13.2.d. The commenter also suggest permitting submission of proof of NCCPA certification in satisfaction of CME would eliminate the need for a PA to notify the Board within five business days of losing NCCPA certification. [15]

Response: While the Board appreciates these comments, it has elected not to incorporate any of the proposed suggestions. The Board notes that PAs who elect to maintain NCCPA certification will need to complete the same number continuing education hours as required by this rule, so a

large number, if not all, continuing education hours will serve dual purposes for the certified PA. However, now that continued certification is not a requirement of license renewal, it is important to ensure that clear and unequivocal categories of continuing education are explicitly defined, and which apply to all licensees, regardless of certification status. Additionally, there is a substantial difference in Category II CME and Category I, and the Board has determined that a maximum of 50 hours of category II will be accepted per continuing education cycle. Finally, and for all of the reasons set forth hereinabove at pages five and six, even if the Board had adopted the proposed amendments, they would not have obviated the need for NCCPA certification status at times other than renewal. No changes were made to the Board's proposed rule amendments based upon these comment.

Questions

In the form of comments, the Board also received the following questions:

“Where does the Board stand on this bill? Support or not?” [1]

Response: The Board favors permitting physician assistants to utilize their education, training and experience to provide quality healthcare to West Virginia's citizens as part of a health care team and in collaboration with a physician. The Board believes that SB1014 and the Board's proposed amendments to Series 1B facilitate that goal.

One commenter asked whether the proposed rules would apply to “anesthesiology assistants, a particular subcategory of physician assistants.” [6]

Response: The West Virginia Board of Medicine does not license or certify any specialty or subspecialty of physician or physician assistant practice. A physician assistant license is a general license to practice as a physician assistant pursuant to an authorized practice agreement and in collaboration with a collaborating physician. The changes to Series 1B would apply to all physician assistant license holders licensed by the Board.

A third commenter asked what the scope of PAs will be regarding medical cannabis. [8]

Response: The West Virginia Bureau of Public Health is responsible for the implementation of the Medical Cannabis Act. It is the Board's understanding, based upon a review of SB386, that physicians are the only health practitioner who may register to issue certifications to patients for the medical use of cannabis. The proposed amendments to Serie 1B do not address this issue and do not establish any role for physician assistants in the issuance of medical cannabis certifications.

In conclusion, based upon the comments received, the Board's agency approved filing contains seven modifications as set forth hereabove.

1B Comment

-----Original Message-----

From: Lubicky, John [mailto:jlubicky@hsc.wvu.edu]

Sent: Tuesday, July 25, 2017 9:18 PM

To: Spangler, Mark A <Mark.A.Spangler@wv.gov>

Subject: New PA rules

Where does the board stand on this bill? Support or not?

Sent from my iPhone

John P. Lubicky, MD

1B Comment

-----Original Message-----

From: Sedney, Cara [mailto:csedney@hsc.wvu.edu]

Sent: Tuesday, July 25, 2017 5:38 PM

To: Spangler, Mark A <Mark.A.Spangler@wv.gov>

Subject: Comment regarding 11 CSR 1B

Hello,

This is a comment regarding legislative rule 11 CSR 1B, Licensure, Disciplinary and Complaint Procedures, Continuing Education, Physician Assistants. I do not support the changes as written, specifically changing the role of physicians from "supervising" to "collaborating". While I recognize and support the role of PAs in the care of West Virginia's patients, being legally responsible for, and overseeing, PAs is, by definition, "supervision". While good physician/PA relationships are obviously collaborative in nature, the change in terminology diminishes the very real responsibility of the physician supervisor.

Thanks for the opportunity to comment,

Cara Sedney

Sent from my iPhone

From: Thomas [mailto:tsmillermd@gmail.com]
Sent: Tuesday, July 25, 2017 5:01 PM
To: Spangler, Mark A <Mark.A.Spangler@wv.gov>
Subject: New rules proposed by board.

Very hard for me to determine what rules are being changed. If the board is contemplating making it easier for PAs to prescribe opioids, I'm totally against it. We should be making it harder to prescribe opioids, except for treating terminal cancer pain. PAs should not be given the right to prescribe narcotics for chronic pain.

Thomas S Miller, MD
Fairmont, WV
Sent from [Mail](#) for Windows 10

From: Vaglienti, Richard [mailto:vaglientir@wvumedicine.org]

Sent: Tuesday, July 25, 2017 2:18 PM

To: BOM Newsletter <bomnewsletter@wv.gov>

Subject: Re: Comment Period Under Way for Proposed Amendments to Board of Medicine Rule 11 CSR 1B

Physician assistants should have all privileges that a nurse practitioner has for medication and procedures and any other modality. They should have absolute parity with ANPs.

Rick Vaglienti MD

Sent from my iPhone

On Jul 25, 2017, at 1:55 PM, WV Board of Medicine <bomnewsletter@wv.gov> wrote:

**COMMENT PERIOD UNDER WAY FOR PROPOSED AMENDMENTS TO BOARD OF
MEDICINE RULE 11 CSR 1B**

During the First Special Session of 2017, the Legislature passed SB1014. This bill makes changes to the West Virginia Code that relate to physician assistant practice in West Virginia. SB1014 authorizes the Board of Medicine to engage in rulemaking, including emergency rule making, to implement these legislative changes. The bill was signed by Governor Justice on June 19, 2017, and becomes effective on September 7, 2017.

The West Virginia Board of Medicine is currently accepting written comments on proposed amendments to the Board's legislative rule 11 CSR 1B, *Licensure, Disciplinary and Complaint Procedures, Continuing Education, Physician Assistants*. The proposed changes to this rule are intended to implement the provisions of SB1014, including an expansion of PA prescriptive authority and signature authority. To view the proposed rule please click [here](#).

All comments must be received by 4:30 p.m. on August 10, 2017, and should be submitted to:

Mark A. Spangler, Executive Director
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, West Virginia 25311
Mark.A.Spangler@wv.gov

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From: eddyout@canaantv.tv [mailto:eddyout@canaantv.tv]
Sent: Tuesday, July 25, 2017 2:44 PM
To: Spangler, Mark A <Mark.A.Spangler@wv.gov>
Subject: 11CSR1B

Hello Mr. Spangler

I received the proposal draft of 11SCR1B and had a comment with sections 13.2a and 13.2b. The section discussed where CME hrs could be obtained. The Academy of Family Physician was mentioned. I receive a monthly home study activity for 5 CME hrs a month, but use The American Academy of Family Physicians-AAFP. I did not know how specific this list will be to obtain our CME hrs. I was not sure if the two different titles were interchangeable- The Academy of Family Physicians versus The American Academy of Family Physicians. I live and work in a rural area, and don't attend many conferences. I like the home study program with AAFP. I would like the proposed bill to include the AAFP for CME hrs.

I have been a practicing PA since 1994, and have been certified by the NCCPA numerous times. I am due to take the exam next year, but realize if new bill goes into effect, will no longer need the certification. I was under impression that the CME hrs still needed to be logged under NCCPA, but reading proposal, would need to be logged or ready for audit by the WVBOM. Let me know when convenient if my understanding is correct.

Best Regards

Diane Rader, PA-C

1 B Comment

From: Johnstone, Robert [mailto:johnstoner@wvmedicine.org]
Sent: Tuesday, July 25, 2017 2:37 PM
To: Spangler, Mark A <Mark.A.Spangler@wv.gov>
Subject: FW: Comment Period Under Way for Proposed Amendments to Board of Medicine Rule 11 CSR 1B

Does this apply to anesthesiologists assistants, a particular category of physician assistant? I know most states have them, and I'm not sure what rules apply to them in WV. Seems like an opportunity to better define their station in WV.
Robert Johnstone, MD
Morgantown

From: WV Board of Medicine [mailto:boardnewsletter@wv.gov]
Sent: Tuesday, July 25, 2017 1:30 PM
To: Johnstone, Robert
Subject: Comment Period Under Way for Proposed Amendments to Board of Medicine Rule 11 CSR 1B

COMMENT PERIOD UNDER WAY FOR PROPOSED AMENDMENTS TO BOARD OF MEDICINE RULE 11 CSR 1B

During the First Special Session of 2017, the Legislature passed SB1014. This bill makes changes to the West Virginia Code that relate to physician assistant practice in West Virginia. SB1014 authorizes the Board of Medicine to engage in rulemaking, including emergency rule making, to implement these legislative changes. The bill was signed by Governor Justice on June 19, 2017, and becomes effective on September 7, 2017.

The West Virginia Board of Medicine is currently accepting written comments on proposed amendments to the Board's legislative rule 11 CSR 1B, *Licensure, Disciplinary and Complaint Procedures, Continuing Education, Physician Assistants*. The proposed changes to this rule are intended to implement the provisions of SB1014, including an expansion of PA prescriptive authority and signature authority. To view the proposed rule please [click here](#).

All comments must be received by 4:30 p.m. on August 10, 2017, and should be submitted to:

Mark A. Spangler, Executive Director
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, West Virginia 25311
Mark.A.Spangler@wv.gov

From: Chellie Abe <chellie.abe@gmail.com>

Date: July 26, 2017 at 10:41:37 PM EDT

To: mark.a.spangler@wv.gov

Subject: 11CSR1B

Mr. Spangler,

I am a Family Medicine Physician in Martinsburg, WV. I am very upset by the adjustments to 11CSR 1B. Physician Assistants are by title - Physician Assistants. They need constant supervision. Just like Nurse Practitioners do. They do not have the training or expertise to practice independently. Their training lacks a strong science background and they work off of algorithms developed to make medicine "bread and butter". They are not able to think outside the box and their critical thinking skills are often lacking. I can't tell you the number of times I have been told that a mid levels providers at an urgent care completely missed the boat on a serious diagnosis and the patient was sent home with narcotics and antibiotics, neither of which was needed. Removing the limits on prescriptions for controlled substances will only worsen our states current opoid epidemic. Changing the word "supervising" to "collaborating" implies that we as physicians would also be asking their opinions on our own patients. That is not going to happen. Our role is to supervise. This legislation is leading down a dangerous path where once again, like the Nurse Practitioners, an non qualified group will be working towards independent practice. The only people that are going to suffer are the patients. Our families. Please consider replacing the opoid prescribing portion with even stricter limitations. Change the wording back to supervising because that is truly what needs to be happening for safe patient care.

Sincerely,
Michelle Abe, DO

From: Ashley Clay [mailto:ashley.clay@medcor.com]
Sent: Wednesday, July 26, 2017 10:23 AM
To: Spangler, Mark A <Mark.A.Spangler@wv.gov>
Subject: Re: Licensure, Disciplinary and Complaint Procedures, Continuing Education, Physician Assistants.

I also fully support this statement from the AAPA regarding Optimal Team Practice:

"It also supports the removal of state laws and regulations that require a PA to have and/or report a supervisory, collaborating or other specific relationship with a physician in order to practice."

I do not feel that the proposed bill neither reflects this ideal nor promotes the possibility of this becoming reality.

Kind Regards,

Ashley Clay, MS, PA-C | Physician Assistant | Medcor, Inc.
ashley.clay@medcor.com | ashley.clay@alcon.com | [Medcor, Inc.](http://Medcor.com)
6065 Kyle Lane Huntington, WV 25702 | 2 Vision Lane Lesage, WV 25537
Huntington South Office: 304.733.8655 | Huntington North Office: 304.733.8318
Huntington South and North Fax: 815.759.5245

From: Ashley Clay
Sent: Wednesday, July 26, 2017 10:13 AM
To: mark.a.spangler@wv.gov
Subject: Licensure, Disciplinary and Complaint Procedures, Continuing Education, Physician Assistants.

Mr. Spangler--

I've reviewed the amendments to the proposal regarding Physician Assistant practice. I have a few concerns with some of the amendments, in particular:

"10.5.d. Periodic, in person, education and review sessions discussing specific conditions, protocols, procedures and specific patients shall be held by the supervising collaborating 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 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 collaborating physician and physician assistant must retain written documentation of these meetings. "

The areas of concern are: requirements to be "in person" as well as if this is intended to be for *all* new authorized practice agreements OR only those new practice agreements with PAs who have been practicing for less than 1 year.

Also, as a PA with concrete roots to WV, I am concerned for the overall growth of the PA profession. I feel that this proposed amendment is in the right direction, but I also feel that PAs are restricted significantly when compared to NPs. Just yesterday I was discussing with my employer regarding per diem coverage. They have a PA applicant, but secondary to such strict requirements from the BOM they have elected to hire a NP instead of the more qualified PA for this position. I see this happening across various practices in WV and I fear that this will ultimately result in me moving from the state that I was born, raised, and educated. I love WV and I love practicing medicine as a PA, but the hoops we (as a profession) are having to jump thru to even be in the same ball park as other PAs in other states is getting cumbersome. I fear that rural Appalachia will continue to be in serious need of medical providers, but secondary to constraints on regulations-- this will remain an issue.

When I initially heard about the Senate Bill regarding this issue, I was extremely hopeful. Now, as time as passed and the proposals have been examined, I am hopeful that they will continue to evolve (because personally I feel as though we are making positive steps, but great strides are required in order to advance the PA profession and ensure that myself and other PAs can remain in WV and flourish).

Thanks,

Ashley Clay, MS, PA-C | Physician Assistant | Medcor, Inc.

1111 E. Liberty Road, Lesage, WV 25758 | 2 Vision Lane Lesage, WV 25537

6065 Kyle Lane Huntington, WV 25702 | 2 Vision Lane Lesage, WV 25537

Huntington South Office: 304.733.8655 | Huntington North Office: 304.733.8318

Huntington South and North Fax: 815.759.5245

PA Comment

From: Ashley Clay [mailto:ashley.clay@medcor.com]
Sent: Tuesday, August 08, 2017 10:51 AM
To: Spangler, Mark A <Mark.A.Spangler@wv.gov>
Subject: Additional question

I also wanted to include a question regarding medical marijuana:

What will the scope of the PA-C be in regards to this new introduction into WV?

Ashley Clay, MS, PA-C | Physician Assistant | Medcor, Inc.
ashley.clay@medcor.com | ashley.clay@alcon.com | Medcor, Inc.
6065 Kyle Lane Huntington, WV 25702 | 2 Vision Lane Lesage, WV 25537
Huntington South Office: 304.733.8655 | Huntington North Office: 304.733.8318
Huntington South and North Fax: 815.759.5245

From: alokgopal@gmail.com [mailto:alokgopal@gmail.com] On Behalf Of alok gopal
Sent: Wednesday, July 26, 2017 12:35 PM
To: Spangler, Mark A <Mark.A.Spangler@wv.gov>
Subject: thank you for considering changes to prescriptive authority

Dear sir

I support this amendment as it is a bid burden to the daily lives of physicians trying to keep their head above the water on a daily basis taking care of patients

thanking you in anticipation

alok gopal,MD,DBMA
Director Pain service Winchester medical center
Senior executive NSPC

From: yashica shah [mailto:yashicashah@gmail.com]

Sent: Wednesday, July 26, 2017 2:19 PM

To: Spangler, Mark A <Mark.A.Spangler@wv.gov>

Subject: Amendment to 11 CSR 1B

Dear West Virginia Board of Medicine

Please consider the safety of the patients in West Virginia and do not allow physician assistants to practice without physician supervision- it would be very dangerous.

I am a physician and I studied along side PA students and our training does not even compare. It is not ok to allow them to prescribe meds without a physician overseeing their work. Drug interactions can cause severe irreparable damage and their training does not have the rigor and the depth required to do this safely -my uncle has been a victim of this and now his kidneys are failing - he was told it was due to his diabetes when in reality he was receiving the wrong combination of meds - this was picked up by an MD but a little too late! please protect the citizens of West Virginia!

Sincerely

Yashica Shah

Sent from my iPhone

From: tahira masood <mtahirah1@hotmail.com>

Date: July 29, 2017 at 4:09:29 PM EDT

To: WV Board of Medicine <bomnewsletter@wv.gov>, "Mark.A.Spangler@wv.gov" <Mark.A.Spangler@wv.gov>

Subject: Re: Comment Period Under Way for Proposed Amendments :Sorry ,No way

Dear Mr.Spangler,

I am currently outside USA. Due to some internet problems , I am not having access to the details of legislature SB1014B through wv board of medicine website and otherwise also.

However I am penning down my opinion very honestly about the prescriptive or signature authority to physician assistants or nurse practioners and even psychologists.

SORRY ,NO PRESCRIPTIVE OR SIGNATURE AUTHORITY COULD BE OR SHOULD BE GIVEN TO PHYSICIAN ASSISTANTS BE IT RESTRICTED ?

THIS IS LEGALIZING OF QUACKERY; THAT IS QUACK PRACTICE.

THIS WOULD ALSO LEAD TO CROSSING OF BOUNDARIES OR LIMITS BY THE PHYSICAN ASSISTANTS WHO WOULD TRY TO OVER RIDE THE RECOMMENDATIONS OF PHYSICIANS JUST TO SHOW THAT THEY ARE QUITE EXPERTS WITHOUT DOING MEDICAL STUDIES LIKE US PHYSICIANS WHO STUDY FOR HOURS AND YEARS AND SACRIFICE LOT OF RECREATIONAL ACTIVITIES JUST FOR THIS PROFESSION.

SAME IS FOR NURSE PRACTITIONERS AND PSYCHOLOGISTS WHO ALSO COULD NOT /SHOULD BE ALLOWED TO PRESCRIBE

THIS PRACTICE WOULD LEAD TO UNNECESSARY HASSLE AND UNCOMFORTABLE WORKING ENVIRONMENT DUE TO THE UNDERLYING TUSSLE OF WHO IS THE EXPERT AND UNULTIMATELY MAKE THE DOCTOR RUN AWAY OR RESIGN .

I AM A FOREIGN DOCTOR(MUSLIM, PAKISTANI).
WHEREVER I HAVE PRACTIED OUTSIDE PAKISTAN, ONE THING IS COMMON BESIDES GENDER DISCRIMINATION.

NATIVES FEEL FOREIGNERS ARE INVADING THEIR COUNTRY AND TAKING THEIR JOBS.

NATIVES CONSIDER THEMSELVES TO BE ENTILTLED TO SUPERIOR TREATMENT .(SOMETHING NATURAL AS THEIR COUNTRY IS HIRING US AND GIVING US JOBS)

GENERALLY ,NATIVES DON'T LIKE TAKING ORDERS OR FOLLOWING RECOMMENDATIONS FROM FOREIGN DOCTORS .

THIS IS NOT SOMETHING ONLY ABOUT AMERICANS .THIS IS SOMETHING I HAVE COME ACROSS EVEN WHEN I WAS WORKING IN A PREDOMINANETLY MUSLIM COUNTRYR OUTSIDE PAKISTAN FROM 2014-2016.

WHEN IT COMES TO COMPLAINING OR ANYTHING WRONG HAPPENS TO THE PATIENTS, THE STAFF IS VERY QUICK TO PUT THE ENTIRE BLAME ON DOCTORS, EVEN IF CERTAIN STEP HAD BEEN TAKEN BY STAFF WITHOUT KNOWLEDGE OF THE ON CALL PHYSICIAN.

ALSO TO BE KEPT IN MIND NURSES AND PHYSIAN ASSISTANTS HAVE STRONG UNIONS AND LOBBIES AND THEY CAN CREATE PROBLEMS FOR DOCTORS VERY EASILY IF THEY WANT TO.
So unofficially we treat them very nicely and give them the feeling that that they are our boss.

BRIEFLY , I WANT TO EMPHASIZE THAT NO SHORT CUTS COULD BE/SHOULD BE ALLOWED TO PEOPLE BE IT AMERICANS, IF THEY ARE NOT QUALIFIED AS DOCTORS /PHYSICIANS.

if physician assistants are going to be allowed prescriptive and signature authority, then tomorrow OT technicians will also ask that they should also be allowed to do major surgeries like cholecystectomy and appendectomy .

By years of assisting surgeons, OT technicians also know and learn lot of skills even if they do not have the bookish/theoretical knowledge

Does that make them surgeons or equivalent to surgeons?

I AM NOT IN FAVOUR OF THIS AT ALL.

IF WEST VORGINIA BOARD OF MEDCINE WANTS THIS TO HAPPEN, THEN THERE IS NO NEED TO HIRE DOCTORS, BE IT FOREIGN PHYSICIANS.

CLINICS COULD BE VERY WELL RUN BY PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS ALONE.WHY HIRE US THEN?

LOOK AT THE CASES OF MEDICARE FRAUD IN PAST 6 YEARS ALL OVER USA.

FIND OUT THE RATIO OF DOCTORS /PEOPLE INVOLVED :FOREIGNERS VERSUS AMERICANS.

ITS MORE AMERICANS INVOLVED IN MEDICARE FRAUD THEN FOREIGNERS PER MY KNOWLEDGE.

Summary:

I am against any prescriptive or signature authority to physician assistants or nurse practitioners and even psychologists, be it restricted.

Kindly please consider revoking/repealing any such bill that favors / legalizes quackery.

Sincerely,
Dr.Tahira Masood,MD.
License #23963.

From: WV Board of Medicine <boardnewsletter@wv.gov>
Sent: Tuesday, July 25, 2017 10:37 PM
To: jrtalup@tgg@hotmail.com
Subject: Comment Period Under Way for Proposed Amendments to Board of Medicine Rule 11 CSR 1B

COMMENT PERIOD UNDER WAY FOR PROPOSED AMENDMENTS TO BOARD OF MEDICINE RULE 11 CSR 1B

During the First Special Session of 2017, the Legislature passed SB1014. This bill makes changes to the West Virginia Code that relate to physician assistant practice in West Virginia. SB1014

authorizes the Board of Medicine to engage in rulemaking, including emergency rule making, to implement these legislative changes. The bill was signed by Governor Justice on June 19, 2017, and becomes effective on September 7, 2017.

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All comments must be received by 4:30 p.m. on August 10, 2017, and should be submitted to:

Mark A. Spangler, Executive Director
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, West Virginia 25311
Mark_A.Spangler@wv.gov

From: Mary Gainer <[redacted]>
Date: August 1, 2017 at 12:38:54 PM EDT
To: "[redacted]" <[redacted]>
Subject: HCSP1B
Reply-To: Mary Gainer <[redacted]>

Hi there Mark,

My name is Mary Gainer, I am an MD working in 2 different clinics in Preston county, Newburg Clinic and Rowlesburg Clinic. I currently supervise 2 PAs, one in each clinic. Both PAs are excellent and I enjoy working with them, however, I'm concerned about the new changes to their licensing rules. While I understand that care in rural areas is desperately needed, and I also realize that clinic and hospital administrators prefer hiring PAs because of the budget constraints, I firmly believe that PAs must be held to strict standards of continuing education and that increased independence and less stringent oversight will not benefit our patients. PAs have scant training, especially with the large scope of practice that is required of a rural doctor out here where we don't have specialists to rely on. I do not agree with the changes made to the licensure requirements for PAs, especially when they are practicing entirely under my medical license. You might find that doctors are less willing to supervise, or "collaborate", with PAs that are not held to the very best standards.

Thanks for the opportunity to share my thoughts.

Mary Gainer, MD

From: Alan Cashell [mailto:alanwcashell@gmail.com]
Sent: Wednesday, August 02, 2017 2:37 PM
To: Spangler, Mark A <Mark.A.Spangler@wv.gov>
Subject: Comments regarding physician assistant licensing and practice

Dear Sir:

I have practiced for the past 7 years seeing primarily Medicaid mental health patients at the Appalachian Community Health Center. This clinic serves Randolph, Upshur, Barbour, and Tucker counties. I was recruited part time to this clinic in 2011 because of a shortage of providers. In 2013 I retired from my practice as a pathologist at Davis Medical Center in Elkins. I began with very little knowledge of the medications that I had to manage. During the last few years, though, I have been the only on site provider serving these 4 counties. Currently, there are part time Telemed services from one psychiatrist, one nurse practitioner, and one physician assistant. I am leaving the clinic at the end of this month because I have a faculty position at both Alderson Broaddus University in Philippi, WV and The George Washington University in DC to teach anatomy. My recommendation regarding the legislation is to expand prescribing authority to include Schedule II medications consistent with that of other states. There does not appear to be adequate psychiatric coverage especially in WV to meet demand. I have had the experience several times of trying to obtain psychiatric consultation for a student in my anatomy course. I can't even get psychiatry offices to return my calls. I recently attended a psychopharmacology conference in DC where I was told that, the market being what it is, there are psychiatrists throughout the country that do not accept insurance of any kind. The restriction of NPs and PAs in writing Schedule II medications delays and potentially makes impossible the care of some rural patients. The prohibition of writing refills means that these patients have to have frequent appointments. Our clinic treats many children and some adults with stimulant medications such as Adderall, Concerta, etc., some of them long term. The PA and NP on staff are perfectly capable of managing these medications. Their knowledge of these drugs is better than mine and I trust their judgement completely. I appreciate the opportunity to send my comments.

Sincerely,

Alan W. Cashell, MD
cell: 304-642-9104



West Virginia Association of Physician Assistants

WVAPA comments for the BOM/BOOM regarding Drafted Rules

Mr. Spangler,

Below, please find our collective comments regarding the drafted rules for SB 1014 "Physician Assistant Modernization Act" for the board's consideration.

- 2.1B Definition of "collaboration" is essentially the same as "supervision." There should be definition at beginning defining "collaboration" as other states have defined it. 2.1i and 10.1 definitions of collaboration could be added, as the current draft definition in 2.1B is not reflective of the term "collaboration"
- 9.5 We did not see durable medical equipment included in the signature authority section, however the leader sentence refers to the following list as "including but not limited to". Does this allow for an assumption that the PA signature authority also extends to DME? APRNs have this authority, thus the signature and billing "parity" should include DME....we request clarification of this.
- Page 21 12.3 and 12.3B conflict with each other, we feel the first appears most appropriate
- Page 15 12.5D Is the extent of "collaboration" between the PA and Physician automatically transitioning to a frequency to be defined at the practice level once the 6 month parameter has been met for newly practicing Pas (without further petitioning of the board)?
- 10.5D the term "supervisor" should be changed to "collaborating physician"
- 9.1G how is "stable condition" being defined?
- 10.8 "supervisory" should be changed to "collaborative"
- 9.1Q the sentence has not been completed the way written. Would suggest omitting "and" and leaving as is otherwise

We look forward to responses from the board regarding the bulleted points contained above,

Respectfully,

West Virginia Association of Physician Assistant Board of Directors

Nicholas Vance, PA-C

PO Box 679
Pecks Mill, WV 25547
304-688-5100
nvanccpa@gmail.com

August 10, 2017

Mark A. Spangler, Executive Director
West Virginia Board of Medicine
101 Dee Dr., Suite 103
Charleston, WV 25311

Re: Comments for WVBOM Rule 11 CSR 1B

Dear Mr. Spangler,

I've had the pleasure to review the West Virginia Board of Medicine (WVBOM) proposed rules for 11 CSR 1B. I would like to take the time to make a few comments besides the ones submitted by the West Virginia Association of Physician Assistants (WVAPA).

Under section 11-1B-13, I would recommend adding that anyone holding current NCCPA certification be accepted as having the 100 hours of CME required for recertification. The PA can send confirmation with their application process. They would still be required to complete the 3 hours of Drug Diversion and Best Prescribing Practices as required in 11-1B-13.3. If they didn't present current NCCPA certification, they would submit 100 hours of CME to the WVBOM. This would also allow the WVBOM to keep track of NCCPA certification. Then, there wouldn't be a need for PAs to deliver that information within 5 days of certification loss, as written in 11-1B-6.1.

Additionally, in 11-1B-13, it may decrease confusion to state the following;

13.1 Successful completion of a minimum of one hundred hours of continuing education satisfactory to the Board during the preceding two-year period is required for the biennial renewal of a physician assistant license or current NCCPA certification.

13.2.a Continuing medical education designated as Category I by either the American Medical Association, American Academy of Physician Assistants or the Academy of Family Physicians. A minimum of 50 hours continuing medical education credit is required, which may include the 3 hours required CME stated in 13.3.

13.2.b. Continuing medical education designated as Category II by either the American Medical Association, American Academy of Physician Assistants or the Academy of Family Physicians. A maximum of fifty hours of continuing medical education credit may be awarded for this category of activity.

Commenter 15

~~13.2.d. Passing a recertification examination by the NCCPA during the reporting period. A maximum of one hundred hours of continuing medical education credit may be awarded for this category of activity, but a physician assistant shall only be awarded ninety-seven hours of credit if the physician assistant is a mandatory participant in the continuing education activity described in subsection 13.4 of this rule.~~

13.2.d wouldn't be required since anyone with NCCPA certification must complete 100 hours CME every 2 years, with at least 50 being Category 1. Currently, passage of the recertification exam is required in only the 9th or 10th years of the 10 year cycle. By showing current NCCPA certification, it proves that all CME and any recertification testing has been completed to maintain certification.

Under 11-CSR-1B-9.5.a, suggest adding admission orders to the sentence as well;

9.5.a. Unless prohibited by the place of practice, a physician assistant may sign orders within the scope of his or her practice, including admission and/or discharge orders for patients personally treated by the physician assistant;

A couple years ago, CMS created a rule siting that if state law/rules and hospital bylaws allowed for admissions and admitting orders by non-physicians, then they would accept them. This rule wasn't intended to limit what PAs could do, but it would have had a large effect not allowing PAs or NPs to write admission orders for CMS covered patients. This rule has been indefinitely suspended. However, it would be helpful to clarify that both admission and discharge orders may be handled by PAs in case that rule is implemented at some time.

Under 11-CSR-1B-9.9, I would suggest the following addition;

9.9. A physician assistant may not independently delegate a task assigned to him or her by his or her collaborating physician to another individual. Nothing shall prohibit a PA from delegating orders including but not limited to; registered nurses, licensed practical nurses, medical assistants, radiology technologists, etc.

This may help clarify that a PA may provide orders to be carried out by nursing and/or ancillary staff within their education and training.

I would like to thank you for the opportunity to provide comments and suggestions for proposed rule 11-CSR-1B, and the hard work provided by the West Virginia Board of Medicine. Please feel free to contact me if you have any questions, or if I could be of any further assistance.

Regards,

Nicholas Vance, MS, PA-C

WVAPA Past President



August 10, 2017

Mark A. Spangler, Executive Director
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, West Virginia 25311

Re: Proposed amendments to 11 CSR 1B, Licensure, Disciplinary and Complaint Procedures,
Continuing Education, Physician Assistants

Dear Mr. Spangler,

The American Academy of PAs (AAPA) is the national professional society for PAs (physician assistants). In this capacity AAPA represents more than 115,500 PAs across all medical and surgical specialties throughout the United States, U.S. territories and the uniformed services. AAPA appreciates the opportunity to provide comments on the proposed rule to amend Title 11 Code of State Rules 1B to reflect the recent legislative changes enacted by Senate Bill 1014 during the 2017 1st Special Session of the 83rd Legislature.

In a time when more patients are seeking care, but a physician shortage looms, it is imperative that states enact laws and rules that more accurately reflect the way PA-physician teams practice medicine and assure that patients will have increased access to the care that they need.¹ AAPA supports and commends this significant revision and modernization of PA practice in West Virginia. AAPA shares the commitment to team-based collaborative practice between PAs and physicians that is demonstrated in these proposed amendments, as well as the improvements to provisions governing PA prescribing authority and form authentication, which are particularly important to patients and families in rural or medically underserved areas of the state. AAPA applauds the elimination of the requirement of passage of a high-stakes recertification examination as a condition of license renewal.

In accordance with the new law effective on September 7th, 2017 which provides the authority for these rules and any subsequent revisions pertaining thereto, this proposal accurately reflects

¹ A shortage of 35,000-44,000 primary care physicians by 2025 has been predicted by some researchers. The Association of American Medical Colleges has forecast a much more critical projection: a shortage of approximately 45,000 primary care physicians by 2020, expanding to approximately 66,000 by 2025. See *The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025*, ASS'N OF AM. MED. COLL., available at https://www.aamc.org/download/158076/data/updated_projections_through_2025.pdf (last visited October 2, 2014). See also, *Physician Shortages to Worsen Without Increases in Residency Training*, ASS'N OF AM. MED. COLL., available at https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf (last visited July, 17, 2017) (further predicting greater shortages due to funding constraints on postgraduate training for residents and fellows).

that PAs are no longer required to provide proof of current and continuous certification by the National Commission on Certification of PAs (NCCPA) as a condition of license renewal. However, these proposed rules *would* require renewal applicants to provide their NCCPA certification status to the Board. In addition, the proposal would mandate licensed PAs to immediately notify the Board in writing if they are no longer NCCPA certified. According to the proposed amendments, failure to report the loss of NCCPA certification constitutes unprofessional, dishonorable and/or unethical conduct which may result in disciplinary action against the licensee.

AAPA finds the general requirement for PAs to report their NCCPA certification status and the mandate to do so as a license renewal applicant unnecessary and inequitable. AAPA is also concerned that a PA's unintentional failure or omission to make the requisite report has the potential to affect their livelihood via the subsequent imposition of disciplinary action, particularly for those PAs who work in facilities in which credentialing and privileging is required. Such unintentional omissions can also affect patient access to care since those PAs who will be subject to disciplinary action may be prevented by their facility from working. In short, the providing this information has no public protection value. Currently, physicians licensed by the Board are not required, either generally or as a condition of license renewal, to notify the Board of their board certification status or any change in certification status.² As a result, in this regard, physicians cannot be accused of unprofessional, dishonorable and/or unethical conduct which may subject them to disciplinary action. In addition, the Board does not capture or maintain information for members of the public to determine if a physician is board certified in a particular specialty. In fact, the Board's website requires such information to be obtained by calling the American Board of Medical Specialties (ABMS) directly or visiting the ABMS website.³ The same requirements and processes can and should be applied to PAs. Since current and continuous NCCPA certification is not required for license renewal, it is no longer relevant for the Board to require PAs to report a change in this status to the Board. Similar to physicians, the organization responsible for capturing, updating and affording members of the public with access to this information is more than sufficient. NCCPA is the appropriate repository of this information and already provides members of the public, including the Board, with the opportunity to determine if a PA is certified.⁴ Furthermore, the West Virginia rules as proposed, provide the Board with the authority to appropriately discipline any PA who misrepresents their certification status. For all the aforementioned reasons, AAPA proposes that the rules be amended as provided below. New language appears in bold underlined font; language that should be deleted has been struck through.

² W.VA. CODE § 30-3-12 and W. VA. CODE R. § 11-1A-10. Physicians renew their license upon paying a renewal fee, submission of an application, and certification of participation in and successful completion of continuing medical or podiatric education satisfactory to the Board.

³ Website for the West Virginia Board of Medicine <http://www.wv.gov/public-search/index.asp> (Accessed August 8, 2017).

⁴ Website for the National Commission on Certification for PAs, *Verify PA Certification* <http://www.nccpa.org/certification> (Accessed August 8, 2017).

§11-1B-5. License Renewal.

[...]

5.6. The Board's physician assistant renewal application form shall include, and applicants must provide, the following information:

[...]

~~5.6.f. Documentation of current and continuous~~ The renewal applicant's NCCPA certification status

5.6.~~fg.~~ Certification of successful completion of all continuing education requirements;

5.6.~~g,h.~~ An attestation by the physician assistant that, to the extent he or she has been authorized to work pursuant to a practice agreement during the last two years, the physician assistant has practiced ~~under supervision and~~ within the delegation of duties set forth in the licensee's authorized practice agreement(s); and

5.6.~~h,i.~~ Other information required by the Board for renewal of a license.

[...]

§11-1B-6. Termination of License Reporting of Loss of NCCPA Certification Status.

~~6.1. A licensed physician assistant must immediately notify the Board, in writing, upon losing NCCPA certification if the licensee is no longer certified by the NCCPA. Failure to immediately report the loss of NCCPA certification shall constitute unprofessional, dishonorable and/or unethical conduct which may result in the imposition of discipline against the licensee. Notification to the Board shall be considered to have occurred as required if such notification is received within one five business days of the effective date of the loss of end date of the licensee's NCCPA certification.~~

6.2. If a licensee is no longer certified by the NCCPA, ~~his or her license automatically terminates without notice to the physician assistant~~ the licensee shall utilize the professional designation of PA, and shall immediately cease use of the professional designation of PA-C.

~~6.3. Upon loss of NCCPA certification and/or license termination, a physician assistant must immediately cease practicing as a physician assistant and notify all supervising physicians of the loss of NCCPA certification, licensure and Board authorization to practice. All practice agreement authorizations issued by the Board automatically terminate with the expiration of NCCPA certification and the termination of licensure.~~

~~6.4. A physician assistant becomes eligible for reinstatement of a terminated license once he or she becomes recertified by the NCCPA.~~

The Academy appreciates this opportunity to comment on the proposed rule. AAPA is readily available to provide additional information on PAs, and is eager to continually work with the Board to assure that PAs maintain and enhance their capacity as key resources in caring for the patients of West Virginia.

Sincerely,



Stephanie M. Radix, JD
Senior Director, Constituent Organization Outreach & Advocacy