



STATE OF IOWA

TERRY BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

IOWA BOARD OF MEDICINE
MARK BOWDEN, MPA, EXECUTIVE DIRECTOR

March 9, 2016

Iowa Board of Physician Assistants
Bureau of Professional Licensure
Iowa Department of Public Health
Lucas State Office Bldg., 5th Floor
321 East 12th Street
Des Moines, IA 50319-0075

RE: ARC2417C

The Board of Medicine appreciates the opportunity to provide public comment on the Board of Physician Assistants' ARC2417C, which is identical to ARC2372C, a rule promulgated by the Board of Medicine on December 10, 2015.

The Board of Medicine believes this jointly noticed rule on specific minimum standards for the appropriate supervision of physician assistants achieves the legislative intent 2015 Iowa Acts, Senate File 505, Division 31, Section 113.

More especially, the Board of Medicine believes the rule is a sorely needed joint regulation for the safe practice of medicine in Iowa.

The long-standing reins on the Board of Medicine to provide regulatory guidance to its licensees to delegate medical services to be performed physician assistants has had many adverse effects on medical care in Iowa.

- It has created a reluctance among physicians to agree to supervise physician assistants.
- It has caused confusion among the health care systems about the responsibilities and the accountabilities of both the physician and the physician assistant.
- It has borne a false sense of belief in the public's mind that physician assistants are, in fact, adequately supervised, especially those physician assistants who are practicing in clinics where the supervising physician is seldom, if ever present, present.

- It has rendered two important health professions regulatory boards less effective in one area of their legislative mandate to safeguard the public's health, safety and welfare.

The Board of Medicine has demonstrated and will continue to demonstrate a good-faith effort to work cooperatively with the Board of Physician Assistants.

More than a year ago, the Board of Medicine agreed to support the controversial and ill-fated ARC1741C, which eliminated the on-site visitation requirements for physicians supervising physician assistants in remote clinics. That support was contingent upon the Board of Physician Assistants agreeing to establish a publicly accountable metric to ensure that physician assistants in these remote clinics are appropriately supervised. Unfortunately, the Board of Medicine's recommendation was summarily rejected and the Board of Physician Assistants moved forward with the rulemaking, which was recently terminated.

Now, as both Boards are focused on jointly promulgating specific minimum standards for appropriate supervision of a physician assistant, the Board of Medicine is concerned about the Board of Physician Assistants' commitment to complete the legislative mandate of SF 505. Subcommittees of both Boards accepted a compromise on the specific minimum standards on December 4, 2015, after numerous meetings, only to see that compromise rejected, then only reluctantly accepted, by the Board of Physician Assistants.

The compromise requirements embodied in both ARC2417C and ARC2372C are existing supervisory requirements found in the Iowa Code and the Iowa Administrative Code (see Attachment No. 1). Yet, now it seems the Board of Physician Assistants is at odds with its own rules, causing the Board of Medicine to be concerned that the Board of Physician Assistants may continue to erode its supervisory requirements, as witnessed by the Physician Assistant Board's pursuit of ARC 1741C, the controversial rulemaking that brought the supervisory dysfunction to the fore.

The Board of Medicine asserts that the public purposes of the joint rule outweigh any adverse effect -- real or perceived -- caused by ARC2417C and ARC2372C. The Board concludes this rulemaking **will not cause a negative impact on private sector jobs and employment opportunities within the state of Iowa.**

The Board of Medicine is hopeful that there can be one final meeting between the two Boards to finalize any appropriate amendments of the joint rule before it is collectively adopted by each Board prior to April 19, 2016, the 100th calendar day of the 2016 legislative session.

The Board of Medicine is encouraging the Board of Physician Assistants to identify specific areas of ARC1741C that might be amended and to submit those potential amendments to the Board by April 1, 2016. The Board of Medicine will provide a similar review and response to the Board of Physician Assistants concerning ARC2372C by the same date.

A joint meeting of the Boards or of the Boards' subcommittees working on this rulemaking could be scheduled after April 1, but prior to April 19, to take file action on "ARC 1741C and ARC2372C.

Thank you,

A handwritten signature in black ink, appearing to read "Mark E. Bowden". The signature is written in a cursive style with a large initial "M".

Mark Bowden
Executive Director
Iowa Board of Medicine

enc.



Fields of Opportunities

STATE OF IOWA

TERRY BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

IOWA BOARD OF MEDICINE
MARK BOWDEN, EXECUTIVE DIRECTOR

February 5, 2016

TO: Administrative Rules Review Committee

FR: Mark Bowden, Board of Medicine

RE: ARC2372C

The Board of Medicine concludes the proposed amendment establishing minimum standards for appropriate supervision of a physician assistant by a physician will not cause a negative impact on private sector jobs and employment opportunities within the state of Iowa. ARC2372C expresses existing physician assistant supervisory requirements found in Iowa law and administrative code. ARC2372C places these requirements under joint control by the Boards of Medicine and Physician Assistants.

A. REVIEW OF REQUIREMENTS. 645 IAC 326.8(4) –
“The physician assistant and the supervising physician are each responsible for knowing and complying with the supervision provisions”

B. FACE TO FACE MEETINGS. 645.327.4(2) – “A supervising physician must visit a remote site to provide additional medical direction, medical services and consultation at least every two weeks”

C. ASSESSMENT OF EDUCATION, TRAINING. 645 IAC 326.8(4) “d” – “... medical procedures may be delegated to a physician assistant after a supervising physician determines that the physician assistant is competent to perform the task.” **645 IAC 327.1(1) –** “... a supervising

physician determines the physician assistant's proficiency and competence."

D. COMMUNICATION. 645 IAC 326.8(4) "a," "b" –

"Patient care provided by the physician assistant shall be reviewed with a supervising physician on an ongoing basis as indicated by the clinical condition of the patient"

"Patient care provided by the physician assistant may be reviewed with a supervising physician in person, by telephone or by other tele-communicative means." 653

IAC 21.4(3) – *"The physician ... ensure[s] that the physician assistant is adequately supervised, including being available in person or by telecommunication to respond to the physician assistant."*

E. QUARTERLY REVIEW. 645 IAC 326.8(4) "a" – "...

Although every chart need not be signed nor every visit reviewed, nor does the supervising physician need to be physically present at each activity of the physician assistant, it is the responsibility of the supervising physician and physician assistant to ensure that each patient has received the appropriate medical care."

F. ANNUAL REVIEW. 645 IAC 327.1(1) – "... Diagnostic

and therapeutic medical tasks for which the supervising physician has sufficient training or experience may be delegated to the physician assistant after a supervising physician determines the physician assistant's proficiency and competence." 645 IAC 326.8(4) – "It shall be the responsibility of the physician assistant and a supervising physician to ensure that the physician assistant is adequately supervise" "Patient care provided by the physician assistant shall be reviewed with a supervising physician on an ongoing basis"

G. DELEGATED SERVICES. Iowa Section 148C.3(3) –

“A licensed physician assistant shall perform only those services for which the licensed physician assistant is qualified by training or not prohibited by the board.” 645

IAC 327.1(1) – “... the physician assistant possess[es] the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting.” “Diagnostic and therapeutic medical tasks ... may be delegated to the physician assistant after a supervising physician determines the physician assistant’s proficiency and competence.”

H. TIMELY CONSULTATION. 653 IAC 21.4(3) –

“The physician ... ensure[s] that the physician assistant is adequately supervised, including being available in person or by telecommunication to respond to the physician assistant.”

I. ALTERNATE SUPERVISION. Iowa section 148C/3(2)

– “... a licensed physician assistant [is required] to be supervised by physicians.” 645 IAC 326.8(4) – “In regard to scheduling, the physician assistant may not practice if supervision is unavailable”

J. GROUNDS FOR DISCIPLINE. 645 IAC 329.2(30) –

“The performance of a medical function without approved supervision” 653 IAC 21.4(3) – “The physician fails to ensure that the physician assistant is adequately supervised, including being available in person or by telecommunication to respond to the physician assistant.”

JOBS IMPACT STATEMENT

1. BACKGROUND INFORMATION

Agency: Iowa Board of Medicine

Citation: 653 IAC 21.4

Contact: Mark Bowden, 515-242-3268, mark.bowden@iowa.gov

Authority: 2015 Iowa Acts, Senate File 505, Division 31, Section 113, Iowa Code 147.76 and 148.13

Date: December 24, 2015

2. OBJECTIVE

2015 Iowa Acts, Senate File 505, Division 31, Section 113, commands the Boards of Medicine and Physician Assistants to jointly adopt rules pursuant to Chapter 17A to establish specific minimum standards or a definition of supervision for appropriate supervision of physician assistants. The Boards shall jointly file notices of intended actions pursuant to section 17A.4, subsection 1, paragraph "a", on or before February 1, 2016, for adoption of such rules.

3. SUMMARY

A physician assistant must work under the supervision of a physician (Section 148C.4). A qualified physician may supervise not more than five physician assistants at one time (148C.3(2)). Supervision means that a supervising physician retains ultimate responsibility for patient care (645 IAC 326.1). The Board of Medicine may discipline a physician for inadequate or inappropriate supervision of a physician assistant (Section 148.13(2) and 653--21.4). The joint rule reviewed and analyzed in this filing was developed by and approved by subcommittees of the Boards of Medicine and Physician Assistants on December 4, 2015. The rule establishes specific minimum standards for appropriate supervision of a physician assistant by a physician. The standards are intended to ensure Iowa patients receive medical services within the expected standard of care.

4. REVIEW

The following is a review of applicable subrules within the proposed amendment to Iowa Administrative Code 653--21:

21.4(2) "a". *Review of requirements.* Before a physician can supervise a physician assistant practicing in Iowa, both the supervising physician and the physician assistant shall review all of the requirements of physician assistant licensure, practice, supervision, and delegation of medical services as set forth in Iowa Code section 148.13, Iowa Code chapter 148C, and Iowa Administrative Code chapters 653--21, 645--326, 645--327, 645--328, and 645--329. **This requirement is an existing, basic expectation for the supervising physician and a supervised physician assistant in the delegation of medical services. All licensees are expected to know and understand the regulations applicable to the practice of their respective professions.**

21.4(2) "b". *Face-to-face meetings.* The physician and physician assistant shall meet face-to-face a minimum of twice annually. If the physician assistant is practicing at a remote site, at least one of the two meetings shall be at the remote site. The face-to-face meetings are for the purpose of discussing topics deemed appropriate by the physician or the physician assistant, including supervision requirements, assessment of education, training, skills, and experience, review of delegated services, and discussions of quarterly and annual reviews. **This requirement is an existing, basic expectation for a supervising physician and a supervised physician assistant in the delegation of medical services. An important detail in this particular requirement concerns physician assistants who practice in remote sites, which are practice sites where the supervising physician is present less than 50 percent of the time. An existing subrule established by the**

Board of Physician Assistants and recognized by Board of Medicine 645--327.4(2) requires 26 meetings per year (645--327.4(2)). The proposed subrule herein would reduce that requirement to 1 visit to the remote site per year for a physician who supervises a physician assistant practicing in a remote site. This is a reduction of 25 site visits per year to the remote site.

21.4(2) "c". *Assessment of education, training, skills, and experience.* The physician and physician assistant shall each ensure that the other party has the appropriate education, training, skills, and relevant experience necessary to successfully collaborate on patient care delivered by the team. **This requirement an existing and basic expectation for a supervising physician and a supervised physician assistant in the delegation of medical services.**

21.4(2) "d". *Communication.* The physician and the physician assistant shall communicate and consult on medical problems, complications, emergencies, and patient referrals as indicated by the clinical condition of the patient. **This requirement an existing and basic expectation for a supervising physician and a supervised physician assistant in the delegation of medical services.**

21.4(2) "e". *Quarterly review.* There shall be a documented quarterly review of a representative sample of the physician assistant's patient charts encompassing the scope of the physician assistant's practice. **While this requirement specifies a minimum frequency of chart reviews, this requirement, in general, is an existing and basic expectation for a supervising physician and a supervised physician assistant in the delegation of medical services.**

21.4(2) "f". *Annual review.* The supervising physician shall annually review the physician assistant's clinical judgment, skills, and performance. The review shall be documented and shall contain feedback and recommendations as appropriate. **While this requirement specifies a documented review, this requirement, in general, is an existing and basic expectation for a supervising physician and a supervised physician assistant in the delegation of medical services. The new rule establishes a minimum frequency for the documented review.**

21.4(2) "g". *Delegated services.* The medical services and medical tasks delegated to and provided by the physician assistant shall be in compliance with Iowa Administrative Code 645—327.1(1). All delegated medical services shall be within the scope of practice of the physician and the physician assistant. The physician and the physician assistant shall have the education, training, skills, and relevant experience to perform the delegated services prior to delegation. **This requirement an existing and basic expectation for a supervising physician and a supervised physician assistant in the delegation of medical services.**

21.4(2) "h". *Timely consultation.* The physician shall be available for timely consultation with the physician assistant, either in-person or by telephonic or other electronic means. **This requirement an existing and basic expectation for a supervising physician and a supervised physician assistant in the delegation of medical services.**

21.4(2) "i". *Alternate supervision.* If the supervising physician will not be available for any reason, an alternate supervising physician will be available to ensure continuity of supervision. The physician will notify the alternate supervising physician that they are to be available for a timely consult and will notify the physician assistant of the means to reach them. The physician assistant shall not practice if supervision is not available. **This requirement an existing and basic expectation for a supervising physician and a supervised physician assistant in the delegation of medical services.**

21.4(2) "j". Failure to supervise. Failure to adequately direct and supervise a physician assistant or failure to comply with the minimum standards of supervision in accordance with this rule and Iowa Code chapter 148C, Iowa Code section 148.13, and Iowa Administrative Code chapters 653—21, 645—326, 645—327, 645—328, and 645—329 may be grounds for disciplinary action for both the physician and the physician assistant. **The Board of Medicine already may discipline a physician for inadequate or inappropriate supervision of a physician assistant (Section 148.13(2) and 653--21.4).**

5. ANALYSIS

The Board believes this rulemaking will not adversely impact private sector jobs in Iowa as the proposed rule does not add to the burden or cost of supervising physician assistants, as demonstrated in the review. The specific minimum supervisory requirements expressed in the proposed amendment to Chapter 21 are not additional requirements, per se, but they do provide clarity to the physician, physician assistant and the public concerning the delegation of medical services to and supervision of a physician assistant. A core function of supervision is to assess the physician assistant's knowledge, skills, and abilities against recognized medical practice standards. The **goals** of appropriate supervision are to ensure public safety, expand healthcare services and strengthen performance of the physician assistant. A periodic review of performance of the physician assistant would include assessing the appropriate levels of training, education and skills for the medical services being delegated to the physician assistant to achieve those goals. The annual review is intended to provide common reference points to guide coordinated collaboration among the supervising physician, the supervised physician assistant, patients, and families — ultimately helping to accelerate inter-professional team-based care. In the formation of this rule, subcommittees of the Boards of Medicine and Physician Assistants met five times over approximately 20 hours and received significant comment from the public and stakeholders. It was generally recognized that this rule, while establishing **minimum** standards for appropriate supervision of a physician assistant by a physician, is not onerous to the physician. It was repeatedly averred that tenets of the rule are mostly redundant to existing rules in Iowa Administrative Code 645 Chapters 326, 327, 328 and 329. The Board of Medicine's overarching goal for this rule is to provide clarity to supervising physicians and to the public regarding the Board's expectations for physicians who choose to supervise physician assistants. No information was presented or cited that these existing rules (654 IAC 326, 327, 328 and 329) are, in fact, having an adverse impact on private sector jobs in Iowa.



Approximately 1 in 10 physicians practicing in Iowa report they are supervising a physician assistant. This percentage has not changed over the past 3 1/2 years when legislation changed the physician-to-physician assistant supervision ratio from 1:2 to 1:5. However, during this same period the Board has seen an increase in inquiries from physicians and healthcare facility administrators seeking clarity on the common core principles of appropriate supervision of physician assistants by a physician.

6. CONCLUSION

The Board concludes the proposed amendment establishing minimum standards for appropriate supervision of a physician assistant by a physician **will not cause a negative impact on private sector jobs and employment opportunities within the state of Iowa.**

Iowa Osteopathic Medical Association



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leah@ioma.org • www.ioma.org

March 9, 2016

Susan Koehler, P.A. Chair
Iowa Board of Physician Assistants
400 SW 8th Street, Suite C
Des Moines, IA 50309-4686

Dear Ms. Koehler,

Thank you for allowing us to provide comments today on the proposed amendments to Chapter 327 regarding the "Practice of Physician Assistants". IOMA thanks you and the other subcommittee members for all the time and effort put into this and the opportunity you provided interested parties to give input in the process.

IOMA applauds the Herculean effort made to homogenize the rules to fit all situations, however, IOMA continues to have concerns about these rules regarding supervision at remote settings and large groups.

In the same location, the physician has an opportunity to directly observe and collaborate with the physician assistant(s) on a nearly continuous basis. The physician assistant consults with the physician daily and the physician provides continual feedback on their performance. IOMA believes that in these situations an annual review would be sufficient.

For those physician assistants working in remote locations, IOMA still feels that written protocols need to be in place. IOMA also believes that two in-person visits per year with only one of those being at the remote location is insufficient. The physician needs to talk with the staff, view the clinic, and see the interaction of the physician assistant with the patients on a regular basis. IOMA believes the current supervisory requirements for a remote clinic should remain in place. It would also be our request that language be added that assures that all communication by various means is documented by both parties.

IOMA would ask that language be added to the rules to designate that in large groups or in settings with multiple supervising physicians, a mechanism be put in place to document physician supervision. It should be clear which physician is supervising the physician assistant during their shift.

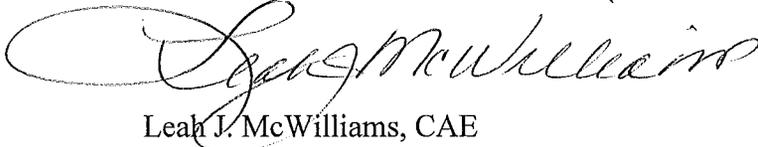
Susan Koehler, P.A., Chair

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March 9, 2016

Again, thank you for the opportunity to comment and for all the work you have put into these rules. IOMA feels that the rules are going in the correct direction and with a few amendments would be acceptable.

Sincerely,

A handwritten signature in cursive script, reading "Leah J. McWilliams". The signature is written in black ink and is positioned above the printed name and title.

Leah J. McWilliams, CAE
Executive Director

cc: IOMA Board of Trustees
Greg Cohen, IOMA Government Relations Committee Chair

Reisetter, Sarah [IDPH]

From: Jeremy Nelson <jeremy-l-nelson@uicms.com>
Sent: Wednesday, March 09, 2016 11:40 AM
To: Reisetter, Sarah [IDPH]
Subject: Evidence of anticompetitive PA rules

Ms Reisetter,

First and foremost I want to thank you for your work to keep Iowa citizens safe and taking the time to hear the evidence/experience based input from the public before making your decisions.

I contact you on behalf of many PAs I work with to discuss major concern I have for ARC 2417C. I definitely understand the need to define supervision in the sense it provides a feeling of security for those who fear lawsuit or reprimand, but these rules will not solve this problem/fear from the few physicians who have raised this issue.

The questionnaire I filled out recently was not applicable to my work. I work for a private ER group that staffs an urban and a rural ER. I also work for a chain of urgent care clinics. I have over 20 supervising physicians. Many of whom I have not met.

In the urban ER, there are always two physicians present to guide me as needed. THEY each decide for themselves who they will see and discuss with me. They each have their own level of comfort with the way I practice medicine. For instance yesterday I had to emergently protect a patient's airway by performing sedation and intubation. My supervising doc came in, agreed, and said out loud "I know you've got this, I have another case in room 3. send someone over if you need". She would not have done this for half of my colleagues who do not provide this level of care. In my rural ER I saw the supervising doc my first few shifts and he reviews or signs all of my notes (per HOSPITAL RULE) they don't come by anymore because they believe I know what I'm doing.

I am the Lead PA/NP for UICMS and am mostly in charge of the orientation process for new providers. There are 6 locations, an online practice, and one video remote site. They have a different family doc assigned to be "supervisor" for the PAs at each clinic, although our medical director typically fields all calls. PAs and NPs are supervised equally, PAs just have burdensome rules that limit the ratio of PAs they can hire. Years ago this company really supported to increase the ratio of PAs per delegatory physician or they wouldn't have been able to hire more PAs. There are NO physicians on site. My medical director has struggled with not wanting to hire new grad NPs because she doesn't think they get on their feet as quick but she has to. I spend a lot of time with the new providers ensuring their clinical comfort and skill, as does the medical director when she can.

I apologize for the long message but I really want you to grasp that PAs are medically trained and physicians are smart people who don't want to harm anyone and do not want to be sued so they should be trusted to define adequate supervision based on individual provider skill.

Below is a chain of emails most interesting to what is currently happening. UICMS has a rural family practice in Sigourney, staffed by one PA and one NP. Our part time medical director is retiring and now there is no one to go to the

remote clinic as required by law. The PA has been there for over 15 years, he is on the Board of UICMS and is very well respected in this community. UICMS has ALWAYS advertised for both NP/PA and they send the postings internally. Naturally I was curious why only an NP this time.

I don't believe she is referring to the upcoming rules changes either, which only exacerbates the problem.

Thank you for your time. Please contact me with questions. But Please consider putting a stop to ARC 2417C unfounded non evidence based rules proposal.

Jeremy L Nelson

Begin forwarded message:

From: "Schulte, Barbara" <barbara-schulte@uicms.com>
Date: March 8, 2016 at 8:01:27 AM CST
To: "Nelson, Jeremy L" <Jeremy-Nelson@uicms.com>, "Woeste, Lori A" <Lori-Woeste@uicms.com>
Cc: Mark A Graber <mark-graber@uiowa.edu>
Subject: RE: Nurse Practitioner position available at UI Health Care - Sigourney

I believe the decision was made due to the PA supervision requirements. Thank you!

From: Nelson, Jeremy L
Sent: Tuesday, March 08, 2016 7:54 AM
To: Woeste, Lori A
Cc: Schulte, Barbara; Mark A Graber
Subject: Fwd: Nurse Practitioner position available at UI Health Care - Sigourney

Just curious,
Why is this posted for just an NP?
This may be helpful in many ways (legislatively).
Thanks for your input.

Jeremy L Nelson

Begin forwarded message:

From: "Northouse, Emily L" <emily-northouse@uiowa.edu>
Date: March 4, 2016 at 8:10:59 AM CST
Subject: Nurse Practitioner position available at UI Health Care - Sigourney

To All:

Please see below for a new position open within UICMS.

Location: UI Health Care - Sigourney	Date Posted: 3/4/16
Position: Nurse Practitioner	Date Removed: 3/7/16
UI Health Care - Sigourney is seeking a <u>Full-Time</u> Nurse Practitioner to perform physical exams, propose and initiate treatment for patients, order appropriate lab procedures and to provide patient education. Provider will prescribe appropriate medications and manage medical	

treatment plans. Applicant must have Master's degree in nursing. If a Master's degree is in a related field, a Baccalaureate degree in nursing is required. Must have current license to practice nursing in the state of Iowa. Current certification in specialty area and licensure as ARNP in the state of Iowa. Knowledge of EPIC a plus. One to two years primary care experience preferred. Candidate must display professional appearance and be self-motivated. Patient satisfaction must be first on the list of priorities! EOE.

A Transfer Request Application can be found by clicking the link below if you are interested in transferring from your position to the one listed above.

Transfer Application

Nurse Practitioner

Thank you!

Emily Northouse

UI Community Medical Services
2346 Mormon Trek Blvd.
Suite 1500
Iowa City, IA 52246
319.467.7034
319.339.1449 Fax

Notice: This e-mail (including attachments) is covered by the Electronic Communications Privacy Act, 18 U.S.C. 2510-2521, is confidential and may be legally privileged. If you are not the intended recipient, you are hereby notified that any retention, dissemination, distribution, or copying of this communication is strictly prohibited. Please reply to the sender that you have received the message in error, then delete it. Thank you.

Notice: This UI Health Care e-mail (including attachments) is covered by the Electronic Communications Privacy Act, 18 U.S.C. 2510-2521, is confidential and may be legally privileged. If you are not the intended recipient, you are hereby notified that any retention, dissemination, distribution, or copying of this communication is strictly prohibited. Please reply to the sender that you have received the message in error, then delete it. Thank you.

Reisetter, Sarah [IDPH]

From: Edfriedman <edfriedman@aol.com>
Sent: Wednesday, March 09, 2016 5:44 PM
To: Reisetter, Sarah [IDPH]
Subject: Fwd: Standard of Care document comment
Attachments: StandardofCaredocument3-8-16.pdf

This comment was about ARC 2417C.

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

From: Edfriedman <edfriedman@aol.com>
To: sarah.reisetter <sarah.reisetter@idph.iowa.gov>
Sent: Wed, Mar 9, 2016 4:31 pm
Subject: Standard of Care document comment

Dear PA Board members,

As can be seen by the attached document standards of care are fraught with difficulties so are best not used.

Ed Friedmann, PA

Goodbye Standard of Care, Hello Reasonable Practice

By [William Sullivan, DO, JD](#) ON February 3, 2016

[Twitter](#) [Facebook](#) [Google+](#) [LinkedIn](#) [Email](#)

6 Comments

The term “Standard of Care” has been misused and abused. It is time to replace it with a phrase which more accurately conveys the realities of modern medicine.

The term “standard” has become ubiquitous in our everyday conversation. In some cases, the term is used appropriately. For example, it is standard treatment to give antibiotics for bacterial pneumonia, and it is standard management to provide PCI or thrombolytics for a STEMI. However, the more that we look at syntax and semantics, the more we realize that the term “standard” isn’t quite ... well ... standardized. Standard socket sets all have the same sizes, but standards of living vary dramatically between countries. Even in what we consider “standard” treatment for pneumonia, there is considerable variance. Should patients with bacterial pneumonia receive ceftriaxone, levofloxacin, piperacillin/tazobactam, azithromycin, vancomycin, another antibiotic or a combination of antibiotics? The answer can’t be defined by a single “standard” but instead becomes an inquiry as to what is a reasonable practice under the specific circumstances. Perhaps a healthy patient with a community-acquired pneumonia might only need azithromycin, a child would benefit from high-dose amoxicillin, a patient with multiple co-morbidities would require hospitalization and multidrug treatment and a patient with HIV might also need pentamidine and prednisone. In another variation on the theme, statisticians created the concept of a “standard deviation” realizing that samples in a data set may vary considerably.

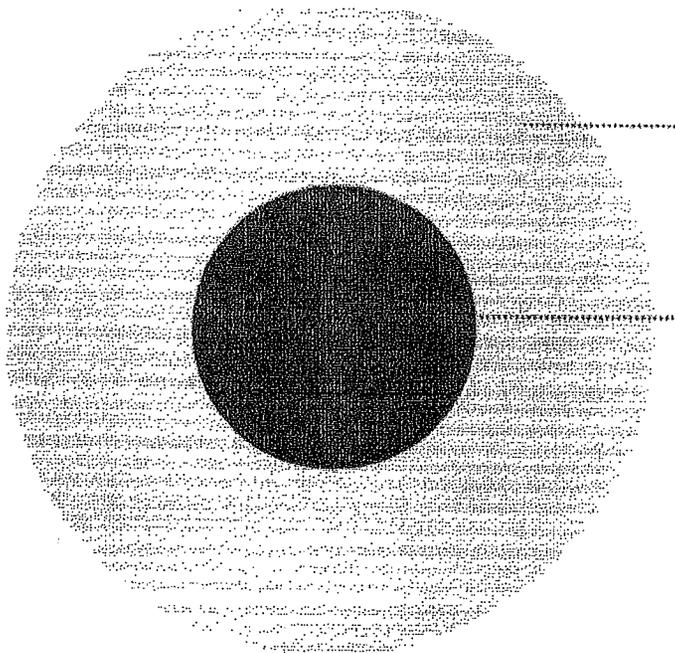
Within the medical community, one phrase that is frequently misused is “standard of care.” It’s easy to allege that a practitioner failed to meet the “standard of care,” but in doing so, we have to consider the meaning behind those words. A standard is a “model” or “example” to be emulated. But there simply aren’t many “standards” in medicine. For example, there are many acceptable ways to manage hypertensive patients, to prescribe medications and even to physically examine patients. The problem with the notion of a “standard” is that it assumes everyone should be doing it all the time. That simply isn’t the case ... legally or professionally.

Not only is the term “standard of care” often misused, it is often misunderstood. Consider a patient suffering from an acute ST elevation myocardial infarction. While the “standard of care” may dictate that the patient receives aspirin (even though, with a NNT of 42 [1], it is clear that not everyone benefits from this intervention), the same “standard of care” would dictate that the patient NOT receive aspirin if the patient was aspirin-allergic, the same “standard of care” would dictate that the patient SHOULD receive aspirin if the same “allergy” was merely GI upset, the same “standard of care” would be that the patient NOT be given aspirin if the patient already received aspirin in the ambulance on the way to the hospital, and there probably wouldn’t be a “standard of care” at all regarding whether the patient should receive aspirin in the hospital if he

took aspirin with his other morning medications 6 hours prior to symptom onset. An expert who testified that there is a single “standard of care” regarding aspirin administration in acute myocardial infarction is either being untruthful or is incredibly naïve.

The legal definition of the “standard of care” is that which a reasonably competent and skilled physician would administer under the same or similar circumstances. Failing to meet the standard of care is simply another way of stating that a physician was negligent. However, it seems that many people don’t understand this nuance. In more than one deposition, I have seen experts testify that a physician acted “reasonably” but also violated the “standard of care” – as if these are mutually exclusive concepts. Another problem with the idea of a “standard” of care is that it may penalize innovators and early adopters who advance the knowledge of medicine. If a paper is published today that strongly supports a new intervention, and you order that intervention tomorrow, you’re providing reasonable medical practice and probably helping a patient, even though what you’re doing cannot yet be called “standard.”

Finally, medicine is as much an art as it is a science [2], focusing not only upon the medical pathophysiology but also upon each patient’s unique body, mind and soul. For this reason alone, each medical interaction is distinct, and there can be no “standard” that applies in every circumstance.



def. **REASONABLE**

1. Having sound judgment; fair and sensible
2. As much as is appropriate or fair; moderate; suitable; practicable

def. **STANDARD**

- 1: something established by authority, custom, or general consent as a model or example; criterion
- 2: something set up and established by authority as a rule for the measure of quantity, weight, extent, value, or quality

When the meanings of words become prone to misunderstanding or misuse, they should be removed from our lexicon. It is time to retire the notion that there is some mythical “standard” of care to which every physician should adhere and be judged. The “standard” by which all human interactions are judged is one of “reasonableness,” and medical care should be no different. Reasonableness does not require perfection. Reasonableness only requires ordinary care and prudence.

For these reasons, we propose that the term "standard of care" be retired and replaced with "reasonable practice." The terms are legally equivalent, but "reasonable practice" is far less prone to misinterpretation by experts and juries.

Beginning next month, we will be running a new column in EP Monthly by the same name: "Reasonable Practice." We encourage you not only to adopt this new terminology for judging medical practice, but also to read the column to weigh in on whether the cases presented represent reasonable medical practices.

REFERENCES

1. Lancet. 1988 Aug 13;2(8607):349-60. Randomised trial of intravenous streptokinase, oral aspirin, both, or neither among 17,187 cases of suspected acute myocardial infarction: ISIS-2. ISIS-2 (Second International Study of Infarct Survival) Collaborative Group. <http://www.ncbi.nlm.nih.gov/pubmed/2899772>
2. Panda SC 'Medicine: Science or Art? Mens Sana Monogr 2006 Jan-Dec; 4(1):127-138 <http://www.msmonographs.org/article.asp?issn=0973-1229;year=2006;volume=4;issue=1;spage=127;epage=138;aulast=Panda>

ABOUT THE AUTHOR



William Sullivan, DO, JD

SENIOR EDITOR Dr. Sullivan, an emergency physician and clinical assistant professor at two residency programs in Illinois, is EPM's resident legal expert. As an attorney specializing in healthcare issues, Dr. Sullivan represents physicians and has published many articles on legal aspects of medicine. He is a past president of the Illinois College of Emergency Physicians and a past chair and current member of the American College of Emergency Physicians' Medical Legal Committee.

Reisetter, Sarah [IDPH]

From: no-reply@iowa.gov
Sent: Wednesday, March 09, 2016 5:25 PM
To: Reisetter, Sarah [IDPH]
Cc: linda.merickel@gmail.com
Subject: Public Comment Received on ARC 2417C

A new public comment has been received on **ARC 2417C**. The comment and contact information are listed below.

Comment

Thank you for the opportunity to present oral testimony this morning about ARC 2417C the proposed amendment to physician supervision of a PA in Iowa. I graduated from the University of Iowa PA program in 1976 and worked in direct patient care for 20 years before moving back to Iowa. Most of my Professional licensure as a PA has actually been through Boards of Medicine. Accompanying my husband, who was on the university faculty in engineering, led me to practice in rural Illinois (FP), to Baylor College of Medicine (general outpatient Medicine and Pediatrics) and to Charlottesville, VA (sub specialty medicine). After returning to Iowa, I have done graduate work in Public Health, epidemiology and ethics. As I look at the proposed amendment to the Iowa Rules and Regulations, I always consider how I would implement the required changes in any of the settings of my more than 20 years of clinical practice. I have heard many comments from both PA's and their supervising doctors that these new changes would require a great deal of expensive administrative time and would take time away from the ongoing good quality medical care in day to day clinical practice. Supervision of a PA is an ongoing interactive process, some of the documentation that is proposed seems contradictory to current practice and burdensome to both supervising physician and to PA. Iowa is the first state in which I have been licensed through a Board of Physician Assistants in conjunction with the Board of Medicine for the supervising physicians, and the oversight of the IDPH. This is a model that has been working exceptionally well for many years to benefit the health of Iowans. It is in fact a model for high quality, safe and effective health care that is recognized beyond our state. There appears to be no evidence for any actual problem with the system as it currently stands. Let us not create problems by trying to over regulate at the state level, things that have been and continue to be, well worked out at the practice level by competent qualified PA's and supervising physicians.

Contact Information

Name: **Linda Merickel PA**
Email: linda.merickel@gmail.com
Phone: **(319) 338-5641**

Reisetter, Sarah [IDPH]

From: Nancy Buckalew <clinic@hamburgia.net>
Sent: Wednesday, March 09, 2016 4:38 PM
To: Reisetter, Sarah [IDPH]
Subject: letter for PA Board
Attachments: 20160309163744802.pdf

Sarah,

I have enclosed a letter I have written as the President of the Iowa Association of Rural Health Clinics. As you know, rural health clinics greatly depend on Physician Assistants to work in our clinics. We are against any more requirements adding extra work to our already overburdened employees.

Thank you for your help in this matter.

Nancy Buckalew
Medical Clinic PC
1219 Main ST
Hamburg, IA 51640
712-382-2626

March 9, 2016

Dear Physician Assistant Board Members,

On behalf of Iowa's 142 federally certified Rural Health Clinics (RHCs) represented by the Iowa Association of Rural Health Clinics, I am writing to express concerns about the many additional and costly regulatory requirements proposed in ARC 2417C. What would work best for rural Iowa is allowing the physician to decide how frequently to visit our PA staffed small town clinics. That has been proven to work in the 29 states that already allow physician to decide how often to visit PA clinics. That would increase access to care by allowing supervision to be accomplished by other means such as the electronic health record or telemedicine or smart phones.

After all with PA care, both the physician and the PA are responsible and liable for the care provided. That method of protecting the public and providing quality care has worked well in Iowa for more than 40 years. It should be continued.

Since the current PA regulatory system is working well, there is no objective basis for further regulations. Those extra requirements only add costs to already financially marginal small town clinics threatening rural people's access to care.

Reducing the face to face visit mandate while increasing other PA requirements with no evidence of need, only makes it more difficult to deliver care in already challenging circumstances. Furthermore requiring face to face meetings prevents RHCs from fully utilizing our PAs for tele-emergency and tele-psychiatry to the detriment of our patients.

It makes no sense to remove the barriers for NPs, while increasing the obstacles for PAs when both are utilized interchangeably, just as MDs and DOs are.

Please allow us to fully utilize our PAs by not creating more barriers to care like ARC 2417C. Allow us to utilize our PAs fully. That would be most appreciated by our rural patients.

Sincerely,

A handwritten signature in cursive script that reads "Nancy Bucklew".

Nancy Bucklew, IARHC President

March 9, 2016

Dear PA Board members,

RE: PA rules, ARC 2417C

Regarding these new PA rules, I am unaware of any problems with the current PA regulations so wonder why all these additional rules are being proposed. It seems that keeping the present rules would be best since those appear to be working.

Thank you for considering my ideas.

Sincerely,

Wilda Orewiller, PA

Craig O. Sieverding
CraigSieverding@davisbrownlaw.com
phone: 515-288-2500
Des Moines Office

March 9, 2016

Iowa Board of Physician Assistants
Bureau of Professional Licensure
Iowa Department of Public Health
Lucas State Office Bldg., 5th Floor
321 East 12th Street
Des Moines, IA 50319-0075

**RE: Notice of Intended Action - ARC 2417C - Specific Minimum Standards for
Appropriate Supervision of a Physician Assistant by a Physician**

Dear Members of the Board:

On behalf of the Iowa Physician Assistant Society (IPAS), we appreciate the opportunity to provide additional comment on ARC 2417C, which is the effort of the Iowa Board of Physician Assistants to adopt a rule (jointly with the Iowa Board of Medicine) on “specific minimum standards ... for appropriate supervision of physician assistants by physicians,” in accordance with Section 113 of 2015 Iowa Acts, Senate File 505 (“SF 505”).

My comments represent concerns that I am not aware of being fully vetted and discussed during the rule-making process, and namely that ARC 2417C, as currently written, (a) is in conflict with existing Iowa Code provisions and long-standing legislative intent and (b) creates an anti-competitive effect that does not appear supported by a credible, evidentiary basis of serving the public interest.

The Iowa Code, Legislative Intent & Supervision of Physician Assistants

Iowa’s current legislative scheme on supervision of physician assistants is the product of well-thought out changes that the Iowa legislature has put in place over the past thirty (30) years. In 1988, the Iowa legislature removed the authority to regulate the registration and oversight of physician assistants from the Iowa Board of Medicine and placed it with a newly established Iowa Board of Physician Assistants. 88 Acts, ch 1225. Since then, the legislature has progressively taken measures to remove restrictions on the authority of the Iowa Board of Physician Assistants and the practice of its licensees. See, e.g., 2003 Acts, ch 93, §13.

As it stands today, I see three significant directives in the Iowa Code regarding the licensure and practice of physician assistants which, I believe, are in conflict with the language and intent of ARC 2417C.

First, the Iowa Code places the authority to regulate the supervision requirement with the Iowa Board of Physician Assistants. As in other states, that is the licensing board in Iowa

designated to regulate the practice of physician assistants and given the express authority to adopt rules governing the supervision requirement. Iowa Code §§ 147.13, 148C.3(1) & (2). With respect to the Iowa Board of Medicine, the Iowa Code grants that licensing board the authority to adopt rules on two aspects of supervision: (a) the determination of which physicians are eligible to supervise and (b) the discipline of physicians who inappropriately supervise. Iowa Code § 148.13.

Second, the Iowa Code restricts the general supervision requirement from including the specific “personal presence” of a physician. Supervision “does not require the personal presence of the supervising physician” unless it is “expressly required by this chapter or required by rules of the board adopted pursuant to this chapter.” Iowa Code § 148C.1. Other than Iowa Code § 148C.9 (which requires the personal presence of the physician if the physician assistant performs certain eye examinations), no provision in the Iowa Code requires personal presence. As for the administrative rules, the professional licensing board that has the authority to adopt a rule in this regard is the Iowa Board of Physician Assistants (see Iowa Code § 148C.1(2)) and that board (a) has adopted a requirement for a supervision physician to visit “remote medical sites” at least every two weeks and (b) has not adopted a similar requirement in other practice settings. See Iowa Admin. Code 645-327.4(2).

Third, the Iowa Code limits the role of the Iowa Board of Medicine to “consulting” on regulations concerning the licensure and the supervision requirement for physician assistants. Iowa Code § 148C.6; see also Iowa Code § 147.107 (limiting the role of the Iowa Board of Medicine to consulting on rules regarding the authority of physician assistants to prescribe drugs or medical devices).

In light of these directives in the Iowa Code and the long-standing trend in Iowa to remove restrictions on the practice of physician assistants, I believe that there is a legitimate concern that aspects of ARC 2417C at least represent a departure from that trend — and may unintentionally represent a conflict with existing Iowa law. While Iowa courts grant licensing boards discretion in adopting rules, courts will not entertain rule making “beyond or in contravention of the language of [an] enabling act, or contrary to legislative intent.” Davenport Cmty. Sch. Dist., in Scott & Muscatine Counties v. Iowa Civil Rights Comm'n, 277 N.W.2d 907, 910 (Iowa 1979). Aspects of ARC 2417C that may run afoul of this well-established proscription include: (a) additional face-to-face meeting requirements, (b) requirement of Iowa Board of Medicine approval for amendments, and (c) elimination of any waiver or variance.

Anti-Trust Concerns with Licensing Board Action

In 2015, the U.S. Supreme Court upheld the Federal Trade Commission’s (“FTC”) determination that a state dental board violated the federal antitrust laws by preventing non-dentists from providing teeth whitening services in competition with the state’s licensed dentists. N.C. State Bd. of Dental Exam’rs v. FTC, 135 S. Ct. 1101 (2015). The reasoning was that the board’s anti-competitive rule could not be protected as “state action” because (a) the board was

controlled by market participants (i.e. practicing professionals) and (b) the board's rulemaking process was not "actively supervised" by the state.

This decision cast new emphasis on anti-competitive effects of regulatory board action and should be carefully considered through any licensing board rule-making process. Indeed, the Iowa Board of Medicine and Iowa Board of Physician Assistants are controlled by market participants and any proposed rule on supervision could have an anti-competitive effect. While the Office of Iowa Attorney General has opined in formal guidance to state agencies that there are processes in place to help insulate a licensing board's decision from a challenge, the office as well as the FTC in subsequent guidance, placed the emphasis less on the process — and more on the substance of the licensing board's and supervising state agency / committee's review.

The board and state entity supervising the board should review any potential anti-competitive effect, including whether there was a credible, evidentiary basis upon which to conclude that any anti-competitive rule-making was in the public's interest. The Iowa Board of Physician Assistants engaged in a Jobs Impact Analysis, which does not appear to provide much justification — let alone any evidence-based explanation — as to why more restrictions on the practice of physician assistants are in the public's interest, particularly at the estimated cost of implementing ARC 2417C. Among other things, at least twenty percent (20%) of respondents who were hospitals and/or physicians indicated that the new requirements in ARC 2417C would negatively impact physician assistants and their professional prospects. The cost of the new regulations on Iowa's healthcare system was also estimated by respondents to be at least \$3.1 million.

Given these concerns, I think many interested and inquiring parties will question why the Board (and the Iowa Board of Medicine) did not opt to simply define "supervision." That effort would plainly meet the directive of SF 505 — and would not create additional regulations that conflict with long-standing Iowa law and negatively impact Iowa jobs, particularly where the additional regulations are without apparent need or justification.

Thank you for allowing us to provide additional comments.

Sincerely,

DAVIS, BROWN, KOEHN, SHORS & ROBERTS, P.C.



Craig O. Sieverding

cc: Iowa Physician Assistant Society

March 8, 2016

Dear Board of Physician Assistants

I am writing to you about problems with the proposed rules for supervision for physician assistants that are being proposed by the PA board ARC 2417C and also by the medical board, ARC 2372C.

My concerns about these rules stem from several different issues.

1. The rules are not based on evidence that there were any problems with current PA regulation. There have been no complaints and no evidence that the PA Board has not been doing a fine job of protecting the public over the last 29 years. What evidence is there that these new rules will improve supervision and also improve patient care? The studies of the rules indicate that it would be more expensive care without any benefit to the public. In the Medical Board memo of March 2013, the Medical Board outlined the components of proper PA supervision which were based on the current PA Board rules. Additionally, the medical board suggested in their memo that they needed to do a better job of informing physicians what the current supervision rules for PAs were. I agree with this conclusion and think education of physicians by both the physician assistant and medical board would solve this problem without having to unnecessarily change the rules governing physician assistants practice.
2. The proposed Medical Board rules (ARC 2372C 21.4(1)b) are in conflict with existing Iowa Code 148C which states that only the PA board has the authority to require personal presence of the physician. The Medical Board rules in (ARC 2372C) may not contravene statute. This one does. And the Iowa Attorney General office advises that board action is to reflect state policy as expressly stated in the statute. (Pam Griebel Assist. Attorney General 3-23-15 memo to regulatory boards page 7). The PA board does have the authority to require personal presence of the physician but the Medical Board does not. Therefore, further change to this rule cannot be held hostage by the Medical Board who would have control over the face to face visit in the future because of amendment 327.8(2) which requires that these rules can only be amended by agreement of both board.
3. Many of the new rules 327.8(1)b, 327.8(1)c, 327.8(1)d, 327.8(1)e, 327.8(1)f, 327.8(1)g, 327.8(1)h, 327.8(1)i, 327.8(1)j restate issues already dealt with in existing PA rules. These sections are unnecessary and should be deleted.
4. 327.8(1)e and 327.8(f) do not even allow the medical practice to use their existing methods of review. I know of no other profession that has their performance review set as one of the criteria for maintaining their license. It should also be clear that these reviews do not have to be repeated multiple times if the PA has multiple supervising physicians. Input from all should be included in the process but not mandated by rule
4. New rule 327.8(2) and (3) will prohibit the use of waivers or the request for a variance to the rules in special cases. The PA Board had already awarded several waivers in the past 6 months. What happens to these waivers which have already been approved? What happens to mental health telemedicine program where the psychiatrist may be practicing in another state and supervising the PA by telemedicine? Does this mean that the physician would have to travel to the PA's practice site 2 times a year to be compliant with these rules. There would also be no way to give this practice a waiver from this requirement. There are also other special medical sites or outreach clinics such as correction facilities that may rely on telemedicine and may find it harder to operate with these restrictive face to face requirements. In the telemedicine rules, a face to face visit means the physician and PA are communicating face to face over the computer or TV hookup. It does not require being in the same room or location. The Medical Board already had authority over telemedicine rules. Also I think it is unwise to not allow flexibility in the rules (through a waiver system). We do not know what new technology is right around the corner. The PA Board is being asked to refuse to even consider alternative models of health care that could be allowed under a waiver system. In the future, these may

save the system money and make health care access easier for patients. We should not reject possible future innovations..

5. These rules are not evidence based. Furthermore, they put PAs at a competitive disadvantage to NPs who have none of these restrictions. Two of the criteria that the Iowa Attorney General's Office said needed to be considered when writing rules. By failing to follow these two fundamental principles of rulemaking, the board members are in conflict with the US Supreme Court decision in North Carolina (the North Carolina Dental Board v. the FTC) and putting themselves at risk of personal liability.
6. I think the new rule, 327.8(1)a about reviewing the supervising requirements is the only rule which has merit. This rule should be modified to require both boards to educate licensees about the law. The other 9 rules (327.8(b-J) are restatements of what is already in the PA rules but are more restrictive and vary enough to be confusing to licensees. These redundant rules should be deleted. Both 237.8(2) and 237.8(3) are contrary to statute which requires the PA board be the only board that may require face to face visits. Iowa Statute also has specific limitations on what the Medical Board authority over the PA profession is in Iowa Code 148.13 and none of the above rules falls within this statutory authority of the Medical Board. If the medical Board is to regulate the PA profession then the legislature needs to pass a bill that would delete 148.13 restrictions on the Medical Board and actively return the control of the PA profession to the Medical Board. The rules before you were a product of a sentence slipped into a funding bill at the end of the session (505) and it did not get a full hearing by the legislature. There were three bills discussed in this legislature which would have given the Medical Board various amount of control over the PA profession. All were discussed in the House Human Resources committee and were not voted out of committee, nor voted on by the full House nor even considered in the Senate. These proposals are dead for this session.
7. I request that the PA Board listen to the voices of the PAs, physicians and administrators who work with PAs and not approve the rules that were filed in January. There is no evidence that there is a problem with the current PA rules and that additional rules are needed to protect the public. Finally 505 only required that rules be jointly adopted but there was no specific requirement that the rules adopted needed to be the same rules. This is impossible anyway since the PA Board's authority over the PA profession and the Medical Board's authority over the PA profession by law are very different so they can't adopt the same rules.

Libby Coyte, PA
Former Iowa PA Board Chair
Former Iowa Medical Board member
Former President of the American Academy of PAs

Reisetter, Sarah [IDPH]

From: no-reply@iowa.gov
Sent: Wednesday, March 09, 2016 2:36 PM
To: Reisetter, Sarah [IDPH]
Cc: ryan.sundermann@unitypoint.org
Subject: Public Comment Received on ARC 2417C

A new public comment has been received on **ARC 2417C**. The comment and contact information are listed below.

Comment

I am the medical director at St Luke's hospital in Cedar Rapids Iowa. We are one of the three busiest ERs in the state. The review that is proposed is ridiculous. Physicians Assistants go through rigorous training and should be able to practice side by side with physicians. We already have review procedures in place at every hospital for ongoing provider review (OPPE). We also have our credentialing systems. To have any review beyond this scope is overly punitive. After training and licensure, review should be left in the hands of the hospitals. This will place an undue cost and unnecessary burden on physician and PAs both.

Contact Information

Name: **Ryan Sundermann**
Email: ryan.sundermann@unitypoint.org
Phone: (248) 227-6198

Reisetter, Sarah [IDPH]

From: James Earel PA-C <jearel@qcora.com>
Sent: Wednesday, March 09, 2016 2:16 PM
To: Reisetter, Sarah [IDPH]
Subject: ARC 2417C

Dear PA Board Members,

I am writing you today in regards to the proposed rules ARC 2417C regarding PA supervision rules. I am firmly against the rules as currently proposed. They place an unneeded and unjustified burden on PAs, their supervising physicians (especially if a PA has multiple supervising physicians), and the practices that employ PAs. Estimates have shown a negative cost impact between 3 million and 6 million dollars if the proposed rules are adopted. This increase in cost shows no promise of increasing patient safety or care, nor is there any documentation that there is a problem with patient safety or care. Why would the board agree to rules that would provide such a significant cost increase when there is no expectation that it will improve care or safety? Additionally, the survey conducted by the board showed a 20% negative impact on PA hiring as a result of the proposed rules. To adopt these rules would be a blatant dismissal of the Iowa Attorney General and FTCs recommendations stating that any new rules must be anticompetitive. Given the negative cost impact of the rules, the lack of evidence that they are needed or will provide any benefit, and the negative impact on PA hiring, I hope that the board will agree that these rules are not in the best interest in PAs in the State of Iowa. An article in forbes.com just came out the other day (<http://www.forbes.com/sites/brucejapsen/2016/03/06/states-remove-barriers-to-physician-assistants/#862b0f014e71>) highlighting how many states are loosening regulation of PAs to provide better access to quality healthcare, and here in Iowa we are having to defend our current practice, rather than expanding it to provide better access to quality care for patients. The legislation referred to across the country is allowing PAs to practice up to the level of their training and not beyond. We in Iowa also need to be moving in the direction of allowing PAs greater flexibility in our practice and allowing us to practice at the fullest level of our training. We are moving in the wrong direction.

Sincerely,

James Earel



James Earel PA-C | Certified Physician Assistant

Phone: (563) 322-0971 | Fax: (563) 324-0615

www.qcora.com

2300 53rd Avenue | Bettendorf, IA 52722



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The disclosure of medical information is strictly prohibited by federal regulation. Unauthorized release of medical information may result in administrative, civil and criminal sanctions.

Reisetter, Sarah [IDPH]

From: Edfriedman <edfriedman@aol.com>
Sent: Wednesday, March 09, 2016 4:51 PM
To: Reisetter, Sarah [IDPH]
Subject: ARC 2417C comment - executive order 71
Attachments: 4987_0001.pdf

Dear PA Board members,

As you can see from attached executive order 71 the governor directs that the less restrictive rules be considered and utilized when possible. Given the many difficulties with standards certainly a definition of supervision like the hospital association suggested has great merit. It has the flexibility recommended by many national physician organizations and has worked well in Iowa for more than 40 years.

Sincerely,

Ed Friedmann, PA

EXECUTIVE ORDER NUMBER SEVENTY-ONE

- WHEREAS, while new policies that encourage a job-friendly environment can take Iowa a significant way forward in our effort to compete for new jobs, much of that work can be undone by a bureaucracy that fails to understand the critical relationship between burdensome regulation and job creation; and
- WHEREAS, when adopting regulations to protect the health, safety and welfare of the people of the State of Iowa, state agencies should seek to achieve statutory goals as effectively and efficiently as possible without imposing unnecessary burdens that reduce jobs and hurt job growth;
- WHEREAS, small businesses are the greatest generators of job growth and are also disproportionately burdened by regulations; and
- WHEREAS, proposed rules and regulations should contain a jobs impact statement so we can identify those that hurt jobs before they impact our job retention and development; and
- WHEREAS, now is the time to make Iowa's main streets truly open for business with the jobs we so desperately need.

NOW, THEREFORE, I, Terry E. Branstad, Governor of the State of Iowa, declare that the best interests of our state would be well served if our government would promote private sector jobs and eliminate impediments to economic growth imposed by burdensome administrative rules and regulations. I hereby order and direct that:

1. For purpose of this Order, the following definitions shall apply:
 - a. "Benefit" means the reasonably identifiable and quantifiable positive effect or outcome that is expected to result from implementation of a rule.
 - b. "Cost-Benefit Analysis" means regulatory analysis to provide the public with transparency regarding the cost-effectiveness of a rule, including the economic costs and the effectiveness weighed by the agency in adopting the rule. "Cost-Benefit Analysis" includes a comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of less intrusive or expensive methods that exist for achieving the purpose of the proposed rule.
 - c. "Cost" means reasonably identifiable, significant, direct or indirect, economic impact that is expected to result from implementation of and compliance with a rule.
 - d. "Jobs" means private sector employment including self-employment and areas for potential for employment growth.
 - e. "Jobs Impact Statement" means a statement that must:
 - i. identify the objective of the proposed rule and the applicable section of the Code of Iowa that provides specific legal authority for the agency to adopt the rule; and

- categories of jobs and employment opportunities that are affected by the proposed rule, the number of jobs or potential job opportunities and the regions of the state affected; and
- v. identify, where possible, the additional costs to the employer per employee for the proposed regulation; and
 - vi. include other relevant analysis requested by the Administrative Rules Coordinator.
2. Each Agency, as defined by Iowa Code Section 17A.2(1), must take steps to minimize the adverse impact on jobs and the development of new employment opportunities before proposing a rule. Evidence of such steps would include a Cost-Benefit Analysis of the proposed regulation.
 3. Each Agency shall provide a Jobs Impact Statement to the Administrative Rules Coordinator in the Office of the Governor prior to publication of notice of intended action pursuant to Iowa Code Chapter 17A.
 4. The Jobs Impact Statement shall be published as part of the preamble to the notice of rulemaking in the Iowa administrative bulletin, unless the Administrative Rules Coordinator determines that publication of the entire Jobs Impact Statement would be unnecessary or impractical.
 5. Each Agency shall accept comments and information from stakeholders prior to the Jobs Impact Statement. Any concerned private sector employer or self-employed individual, potential employer, potential small business, or member of the public is entitled to submit information relating to Jobs Impact Statement upon a request for information or notice of intended action by a Department or Agency.
 6. If the Jobs Impact Statement is revised after notice, it shall be published as part of the preamble to the proposed rule, unless the Administrative Rules Coordinator determines that publication of the entire Jobs Impact Statement would be unnecessary or impractical.
 7. The analysis in the Jobs Impact Statement should give particular weight to jobs in production sectors of the economy which includes the manufacturing, and agricultural sectors of the economy and include analysis, where applicable of the impact of the rule on expansion of existing businesses or facilities. The Administrative Rules Coordinator may waive the Jobs Impact Statement requirement for rules proposed on an emergency basis or if unnecessary or impractical.
 8. If any provision of this Order, or the application of such provision to any person or circumstance, is held to be invalid, the remaining provisions, as applied to any person or circumstance, shall not be affected thereby.
 9. This Order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity, by any party against the State of Iowa, its Departments, Agencies, or Political Subdivisions, or its officers, employees, or agents, or any other person.

IN TESTIMONY WHEREOF, I have
hereunto subscribed my name and caused
the Great Seal of Iowa to be affixed. Done
at Des Moines this ___ day of March, in the
year of our Lord two thousand eleven.

TERRY E. BRANSTAD
GOVERNOR

ATTEST:

Reisetter, Sarah [IDPH]

From: Michael Schnurr <mschnurr@mcfarlandclinic.com>
Sent: Tuesday, March 08, 2016 12:59 PM
To: Reisetter, Sarah [IDPH]
Subject: ARC 2417C

Ms. Reisetter,

I would like to comment about the potential rule change for physician Assistants. I am unsure how this came about and would like to know if there was any documented incidents that would require such changes. I have been a licensed PA in the state of Iowa for nearly 20 years. The majority of this time I have spent practicing in small more rural communities. I have taken my role very seriously and worked very hard to provide quality care for all of my patients. I do not see any need to change the current oversight of PA's and the cost projections will not only affect my employer but ultimately make it harder to provide care for the people that are served by PA's in rural areas. Those people with already poor access to care will pay the highest price. Care will likely become more difficult to obtain. I would urge all those involved to think this through clearly before proceeding.

Thank You,
Michael

--
Michael Schnurr PA-C
McFarland Clinic
705 8th Street
Story City, Iowa
50248

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University of Iowa Health Care

Department of Family Medicine

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March 8, 2016

Sarah Riesetter
PA Board Director
Iowa Board of Medicine
400 SW 8th Street, Suite C
Des Moines, IA 50309-4686

Dear Ms. Riesetter,

I am writing to provide input on the proposed "Specific Minimum Standards for Appropriate Supervision of a Physician Assistant by a Physician." I am the Chairman of the Department of Family Medicine at the University of Iowa and have practiced clinical family medicine for almost 30 years. I have practiced in three states and have had PA supervision responsibilities in each of them. I am deeply concerned about access to care for Iowans, especially rural Iowans; I am concerned about the quality of care that Iowans receive and I am concerned about the rising costs of health care in Iowa. It is thus important for me to express my concern and opposition to legislation found in the appropriations bill (SF 505) that will require onerous administrative requirements by supervising physicians and PA's that will reduce access, yet not improve quality of care.

For example, at the Family Medicine Clinic at the University of Iowa Hospitals and Clinics, there are over twenty different supervising physicians for two highly trained PA's. These PA's are under the direct observation of physicians every day, seeking guidance or reassurance in the course of caring for patients. We do have a medical director who has administrative oversight and meets regularly with the PA's. However, expecting the PA to set aside time to meet with every faculty member for whom they may seek counsel may actually reduce access to oversight as we limit the faculty who can supervise. This is an unintended consequence to this legislation.

I thus ask that members of the Medical Board not support the joint rule for "minimum standards" as currently stated. It is important that we not micromanage and add more bureaucracy to a process that has not shown itself to be broken. One recommended approach would be to support a joint definition of supervision like: "Supervision means an ongoing process by which a physician and physician assistant

jointly ensure the medical services provided by a physician assistant are appropriate, pursuant to 645 IAC 327.1(1) and 645 IAC 326.8(4).” If specific minimum standards are required, I encourage the Medical Board to consider the location and specifically designate high-risk locations that are noteworthy (though I hope this would be based on sound evidence and not conjecture.)

I specifically hope to develop and test innovative team-based delivery care models and I fear that legislation such as that proposed can make it more difficult to implement these types of team-based processes. Thank you for your consideration of my request.

Sincerely,

A handwritten signature in cursive script that reads "Paul James M.D.".

Paul A. James M.D.
Donald J. and Anna M. Otilie Chair Department of Family Medicine
Chair & Department Executive Director

Reisetter, Sarah [IDPH]

From: Russell Marquardt PA-C <rgmpacsr@metc.net>
Sent: Tuesday, March 08, 2016 12:29 PM
To: Reisetter, Sarah [IDPH]
Subject: No the the new rules proposal (ARC 2417C)

A survey showed about 20% of the physicians, hospitals and group practices acknowledged the proposed rules would have a negative effect on PA jobs.
It also adds unnecessary cost .

--

Russell G Marquardt, MPAS, PA-C
712-764-4070 home
712-764-4642 office
712-249-2702 cell

Reisetter, Sarah [IDPH]

From: Jankovich, Christopher J <Christopher.Jankovich@alegent.org>
Sent: Tuesday, March 08, 2016 8:35 AM
To: Reisetter, Sarah [IDPH]
Subject: Proposed PA rules

March 7, 2016

Re: Proposed PA rules, ARC 2417C

Dear PA board members,

I am writing to ask that the proposed PA rules (ARC 2417C) not be accepted. The proposed rules add many new PA requirements with no evidence of need or that the current PA rules are not sufficient. Finally, these rules are anti-competitive as none of these extra requirements apply to NPs who are utilized interchangeably with PAs and, unlike PAs, have no physician site visit requirement. Having a deadline is not a good reason for adding unnecessary restrictions that create difficulties providing care.

Unnecessary and restrictive regulation creates barriers to innovation, access, and efficiency. Thank you for considering these suggestions.

Sincerely

Chris Jankovich, PA
Logan, IA

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Reisetter, Sarah [IDPH]

From: no-reply@iowa.gov
Sent: Tuesday, March 08, 2016 9:11 AM
To: Reisetter, Sarah [IDPH]
Cc: info@iapasociety.org
Subject: Public Comment Received on ARC 2417C

Follow Up Flag: Follow up
Flag Status: Flagged

A new public comment has been received on **ARC 2417C**. The comment and contact information are listed below.

Comment

Dear Vice Chair and Members, On behalf of the Iowa PA Society (IPAS), thank you for this opportunity to comment on the board's intention to adopt an amendment to administrative code relating to PA supervision. The society appreciates your time and consideration of our comments. Summary IPAS respectfully urges the board not to proceed with the proposed rules in their present form. The society respectfully suggests that the board modify the rule draft to:

- Require the board to compile and distribute applicable PA laws to physicians and PAs;
- Create a definition of supervision consistent with best practice and national trends ;
- Decline to adopt administrative rule amendments that restate existing requirements or create requirements not supported by evidence that the rule will increase patient safety; and
- Not bind future boards from amending administrative rules or grant waivers for compelling situations.

Please find a summary of our suggestions as well as our specific suggestion attached. Background Senate File 505 (SF 505), passed by the Iowa legislature in its 2015 session, directs the board of medicine and the board of physician assistants to “jointly adopt rules pursuant to chapter 17A to establish specific minimum standards or a definition of supervision for appropriate supervision of physician assistants by physicians.” [emphasis added] This is a narrowly focused directive to both boards by the legislature. Any proposed regulation that goes beyond defining supervision or minimum standards exceeds the legislature's intent and directive. We fully support creating a legal environment that enhances patient safety, encourages innovation, and enables PAs to practice to the top of their education and experience. However, many of the proposals, such as:

- Requiring physicians to review and document an ambiguous number of patient records;
- Imposing mandatory in-person and meeting onsite requirements; and
- Duplicating existing parts of both the code and administrative code would add administrative burden to team practice without enhancing public protection or patient care.

Additionally, as presented, neither board would have the authority to waive these requirements should a compelling case be presented. The society strongly opposes these and any similar proposals. As we reviewed this draft (and similar proposals), the society could not find evidence that these additional requirements will increase patient safety or enhance access to care provided by PA-physician teams. This troubles us. At face value, these proposals would restrict the activities of PAs without evidence that these restrictions protect the public. In fact, we have yet to see the problem any of these proposals seek to remedy. A physician or PAs' limited time should be spent treating patients, not on completing onerous administrative requirements not complying with requirements that lack evidence. The argument for these additional requirements seems to rest primarily on the fact that they exist in some form in another jurisdiction instead of actual evidence that they will create any form of improvement here in Iowa. As an alternative, the society is suggesting to the boards that a definition of what supervision means in the PA context be adopted. Additionally, to assist both physicians and PAs in complying with the requirements found in both the code and administrative code, we suggest the PA board compile the appropriate legal requirements and distribute them. Thank you in advance for allowing us to share our perspective with you. Please let me know if you have any question. You

may contact me at info@iapasociety.org or 515-282-8192. Best regards, Laurie Clair, PA-C President Iowa PA Society

Contact Information

Name: **Laurie Clair**

Email: info@iapasociety.org

Phone: **(515) 282-8192**

Reisetter, Sarah [IDPH]

From: Stacey Manderscheid Reichling <Stacey@iapasociety.org>
Sent: Tuesday, March 08, 2016 9:11 AM
To: Reisetter, Sarah [IDPH]
Subject: Comments on ARC2417C
Attachments: ARC2417C.pdf; ATT00001.htm; 2016_0303 IA ARC 2417C PA board comments.pdf; ATT00002.htm

I've attached comments from the Iowa Physician Assistant Society and the American Academy of Physician Assistants regarding ARC 2417C from the IPAS President, Laurie Clair, and Adam Peer, American Academy of PAs.

Please let me know if you have any questions or issues with the attached documents. Thank you for the opportunity to submit comments.

Sincerely,
Stacey Reichling

Stacey Reichling
Iowa Physician Assistant Society
6919 Vista Drive
West Des Moines, IA 50266
p. 515 .282 .8192
f. 515 .282 .9117
tf. 877 .837 .6982
stacey@iapasociety.org
www.iapasociety.org



Iowa Physician Assistant Society

6919 Vista Drive
West Des Moines, IA 50266
ph: (515) 282-8192 fax: (515) 282-9117

March 3, 2016

Susan Koehler, Vice Chair, and
Members, Board of Physician Assistants,
State of Iowa
321 E 12th Street, 5th Floor
Des Moines, Iowa 50319-0075

In re: Iowa PA Society Comments on ARC 2417C

Dear Vice Chair and Members,

On behalf of the Iowa PA Society (IPAS), thank you for this opportunity to comment on the board's intention to adopt an amendment to administrative code relating to PA supervision. The society appreciates your time and consideration of our comments.

Summary

IPAS respectfully urges the board **not** to proceed with the proposed rules in their present form. The society respectfully suggests that the board modify the rule draft to:

- Require the board to compile and distribute applicable PA laws to physicians and PAs;
- Create a definition of supervision consistent with best practice and national trends ;
- Decline to adopt administrative rule amendments that restate existing requirements or create requirements **not** supported by evidence that the rule will increase patient safety; and
- Not bind future boards from amending administrative rules or grant waivers for compelling situations.

Please find a summary of our suggestions as well as our specific suggestion attached.

Background

Senate File 505 (SF 505), passed by the Iowa legislature in its 2015 session, directs the board of medicine and the board of physician assistants to “jointly adopt rules pursuant to chapter 17A to establish specific minimum standards or a definition of supervision for appropriate supervision of physician assistants by physicians.” [emphasis added]

This is a narrowly focused directive to both boards by the legislature. Any proposed regulation that goes beyond defining supervision or minimum standards *exceeds the legislature's intent and directive*.

We *fully support* creating a legal environment that enhances patient safety, encourages innovation, and enables PAs to practice to the top of their education and experience. However, many of the proposals, such as:

- Requiring physicians to review and document an ambiguous number of patient records;
- Imposing mandatory in-person and meeting onsite requirements; and
- Duplicating existing parts of both the code and administrative code

would add administrative burden to team practice without enhancing public protection or patient care. Additionally, as presented, neither board would have the authority to waive these requirements should a compelling case be presented.

The society **strongly opposes** these and any similar proposals. As we reviewed this draft (and similar proposals), the society could **not** find evidence that these additional requirements will increase patient safety or enhance access to care provided by PA-physician teams.

This troubles us.

At face value, these proposals would restrict the activities of PAs *without evidence* that these restrictions protect the public. *In fact, we have yet to see the problem any of these proposals seek to remedy.*

A physician or PAs' limited time should be spent treating patients, not on completing onerous administrative requirements not complying with requirements that lack evidence.

The argument for these additional requirements seems to rest primarily on the fact that they exist in some form in another jurisdiction instead of *actual evidence* that they will create any form of improvement here in Iowa.

As an alternative, the society is suggesting to the boards that a definition of what supervision means in the PA context be adopted. Additionally, to assist both physicians and PAs in complying with the requirements found in both the code and administrative code, we suggest the PA board compile the appropriate legal requirements and distribute them.

Thank you in advance for allowing us to share our perspective with you. Please let me know if you have any question. You may contact me at info@iapasociety.org or 515-282-8192.

Best regards,



Laurie Clair, PA-C
President
Iowa PA Society

Suggestions to Working Document

Topic	Suggestion	Remarks
(a) Physician and PA review laws	<p>Require the PA board to compile and supply each supervising physician and PA with a compendium of relevant PA laws.</p> <p><u>“The board of physician assistants shall compile a compendium of the requirements of physician assistant licensure, practice, supervision and delegation of medical services as set forth in the code and administrative code.”</u></p>	<p><i>Existing requirement</i>, under s. 645-326.8 (4) IA admin. code, “[...] The physician assistant and the supervising physician are each responsible for knowing and complying with the supervision provisions of these rules. [...]”</p> <p>What would be more useful, however, would be for the board to compile the relevant PA laws and distribute them to physicians and PAs.</p>
(b) Biannual in-person meeting at practice or remote site.	<p>Delete. Create a definition of “supervision”.</p> <p><u>“ ‘Supervision’ means an ongoing process by which a physician and physician assistant jointly ensure the medical services provided by a physician assistant are appropriate, pursuant to 645 IAC 327.1(1)¹ and 645 IAC 326.8(4)”</u></p>	<p>Unclear how this would benefit patients. Not consistent with PA practice and new delivery models, e.g. telemedicine.</p> <p><i>Creating a definition of supervision</i> (based on best practices) complies with the legislative mandate “to establish [...] a definition of supervision [...]”.</p>
(c) PA and physician to ensure the education, et al., of the other.	Delete	<p><i>Existing law provides</i>, under s. 645-327.1(1), “The medical services to be provided by the physician assistant are those delegated by a supervising physician. The ultimate role of the physician assistant cannot be rigidly</p>

¹ “The medical services to be provided by the physician assistant are those delegated by a supervising physician. The ultimate role of the physician assistant cannot be rigidly defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. The physician assistant's services may be utilized in any clinical settings including, but not limited to, the office, the ambulatory clinic, the hospital, the patient's home, extended care facilities and nursing homes. Diagnostic and therapeutic medical tasks for which the supervising physician has sufficient training or experience may be delegated to the physician assistant after a supervising physician determines the physician assistant's proficiency and competence. The medical services to be provided by the physician assistant include, but are not limited to, the following: [...]”

		<p>defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. The physician assistant's services may be utilized in any clinical settings including, but not limited to, the office, the ambulatory clinic, the hospital, the patient's home, extended care facilities and nursing homes. Diagnostic and therapeutic medical tasks for which the supervising physician has sufficient training or experience may be delegated to the physician assistant <u>after a supervising physician determines the physician assistant's proficiency and competence.</u>"</p> <p>[emphasis added]</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(d) Timely communication	Delete	<p><i>Existing requirement</i>, under s. 645-326.8 (4)(a), IA admin. code, "Patient care provided by the physician assistant shall be reviewed with a supervising physician on an ongoing basis as indicated by the clinical condition of the patient. [...] it is the responsibility of the supervising physician and physician assistant to ensure that each patient has received the appropriate medical care."</p> <p>Required physician notification should be determined at the practice-level not mandated by the administrative code. It would be impossible to determine every situation.</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(e) Mandated chart review	Delete	<p><i>Existing minimum chart review</i>, under s. 645-327.4, IA admin. code, "A physician assistant may provide medical services in a remote medical site if one of the following three conditions is met: [...] b. The physician assistant with less than one year of practice has a permanent license and meets the following criteria: [...] (4) The supervising physician signs all patient charts unless the medical record documents that direct consultation with the supervising physician occurred; or [...]"</p>

		<p>Additionally, there is <u>no evidence</u> that this improves patient care. Any additional chart review should be determined at the practice-level.</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(7) Annual review	Delete	<p>As defined, "supervision" is an ongoing joint process.</p> <p>As created by this suggested rule, "' Supervision' means an ongoing process by which a physician and physician assistant jointly ensure the medical services provided by a physician assistant are appropriate, pursuant to 645 IAC 327.1(1) and 645 IAC 326.8(4)"</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(g) PA services to comply with the code	Delete	<p>The first part of this language requires compliance with several sections of the administrative code. At face value, these are <u>existing</u> requirements.</p> <p>The second part of this suggestion limits PA practice and encourages PAs <u>not</u> to practice to the fullest extent of their education, training, and experience. A PA may provide services with physician supervision, that are delegated, and for which the PA has been qualified by training.</p> <p>It is possible for a PA have acquired a skill in one practice setting that under this proposal would <u>not</u> be allowed in a different practice setting if that physician was not able to perform.</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(h) Physician to be available	Delete	<p>Existing requirement, under s. 645-326.8(4)(b.), "Patient care provided by the physician assistant may be reviewed with a supervising physician in person, by telephone or by other telecommunicative means."</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(i) Alternative physician	Delete	<p>Covered by existing requirements, under s. 645-326.8 (4), "It shall be the responsibility of the physician assistant and a supervising physician to ensure that the physician assistant is adequately supervised."</p>

		<p>Instead of mandating <i>how</i> this will occur, current law allows the PA-physician assistant team the flexibility to meet this requirement which could include additional supervising physicians as permitted under current law.</p> <p>Additionally, physicians are already permitted to review patient care via telecommunicative means, per s. 645-326.8(4)(b.), "Patient care provided by the physician assistant may be reviewed with a supervising physician in person, by telephone or by other telecommunicative means."</p>
(j) Noncompliance with administrative code	Delete	How each profession should be disciplined should be determined by each respective board. Boards currently have authority to discipline for non-compliance.
(k) Joint amendment	Delete	<p>Either board should <u>not</u> have the authority to bind future boards. A part of the purpose of administrative rules is to allow the law to evolve quicker to adopt to changing circumstances and public needs.</p> <p>This language is also beyond the legislative scope of SF 505.</p> <p>Either board should be able to amend each board respective rules subject to the existing administrative rules promulgation process.</p>
(l) No waiver	Delete	<p><i>Existing law provides</i>, under s. 645-327.1(1), "[...] The ultimate role of the physician assistant <u>cannot be rigidly defined because of the variations in practice requirements</u> due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. [...]" [emphasis added]</p> <p>One of the hallmarks of PA regulation in Iowa has been the ability of the board to grant waivers when a compelling situation has been presented which is recognized by s. 645-327.1(1). No compelling reason or evidence has been presented supporting this language.</p>



3 March 2016

*Electronic Delivery
USPS First Class*

Susan Koehler, Vice Chair, and
Members, Board of Physician Assistants,
State of Iowa
321 E 12th Street, 5th Floor
Des Moines, Iowa 50319-0075

In re: Public Comments to ARC 2417C, relating to: amending ch. 327, practice of physician assistants of the administrative code; request for oral presentation via electronic means.

Dear Vice Chair and Members,

On behalf of the American Academy of PAs (AAPA), thank you for this opportunity to comment on the above-captioned proposed amendment to the administrative code. The AAPA is the national professional organization for physician assistants (PAs) that advocates on behalf of the profession and patient care provided by physician-PA teams and analyzes laws and regulations that impact PA practice. AAPA represents a profession of more than 100,000 PAs across all medical and surgical specialties and has extensive experience with state regulation of PA practice.

AAPA joins the Iowa PA Society (IPAS) in respectfully requesting the board not to proceed with the above-captioned rules. AAPA and IPAS respectfully request the proposed rule amendment be modified to:

- Require the PA board to compile and distribute applicable PA laws to physicians and PAs;
- Create a definition of supervision consistent with best practice and national trends;
- Decline to adopt administrative rule amendments that restate existing requirements or create requirements **not** supported by evidence that the rule will increase patient safety; and
- Not bind future boards from amending administrative rules or grant waivers for compelling situations.

After carefully reviewing the proposed administrative rule amendment, the Academy and the Society also disagree with the jobs impact statement of the board. Based on economic impact estimates as well as a review of peer-reviewed literature, AAPA and IPAS have concluded that the proposed administrative rules amendment will lead to:

- A \$3.1 million burden on Iowa's healthcare system;
- A loss of nearly 54,500 patient encounters; and
- The equivalent loss of 10.6 physicians and PAs practicing in Iowa.

Please find attached:

- Economic Impact of Draft PA Rules: More Administrative Burdens, Less Access;
- Draft PA Rule will be Trouble for Iowa; and
- AAPA and IPAS joint suggestions to improve the proposed administrative rules.

in support of the Academy and Society's position.

AAPA and IPAS urge the board not to proceed with the proposed administrative rule amendments in its current form.

Again, thank you for your consideration. If you have any questions or if I may be of further assistance, please feel free to contact me at 571-319-4315 or apeer@aapa.org.

Best regards,



Adam S. Peer, Director
Constituent Organization Outreach and Advocacy
American Academy of PAs

Attachments

cc: Sarah Reisetter, sarah.reisetter@idph.iowa.gov
Ed Friedmann, PA, Chair, Legislative Committee, Iowa PA Society

ASP:AD:ef

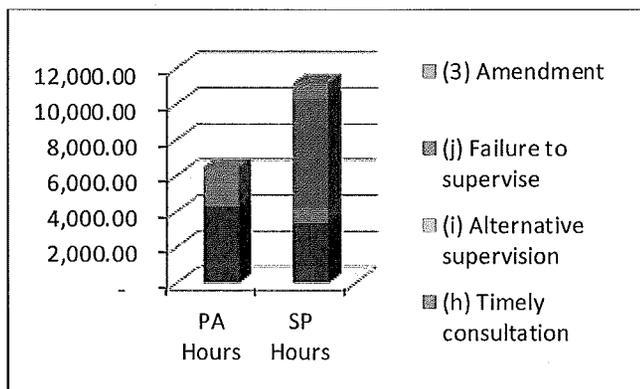
Economic Impact of Draft PA Rules: More Administrative Burdens, Less Access

Summary

The Iowa Society of PAs (IPAS) and the American Academy of PAs (AAPA) have closely reviewed the current draft PA rule for its Iowa economic impact and have estimated that if promulgated in its current form the rule will lead to:

- A **\$3.1 million** burden on Iowa's healthcare system;
- A loss of nearly **54,500 patient encounters**; and
- The equivalent of a loss of **10.6 physicians and PAs practicing** in Iowa.

There has been no independent, peer-reviewed documentation that demonstrates any benefit derived from the additional requirements mandated by the draft rule. IPAS and AAPA continue to urge policy makers not to proceed with the PA rule draft in its current form¹.

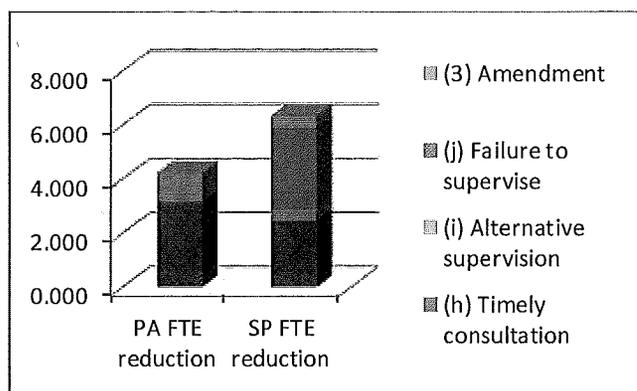


Background

PAs are healthcare providers who are nationally certified and state licensed to practice medicine and prescribe medication in every medical and surgical

specialty and setting. PAs practice and prescribe in all 50 states, the District of Columbia and all U.S. territories with the exception of Puerto Rico. PAs are educated at the graduate level, with most PAs receiving a Master's degree or higher. In order to maintain national certification, PAs are required to recertify as medical generalists every 10 years and complete 100 hours of continuing medical education every two years.

Towards the close of the last session, the Iowa state legislature enacted legislation that included a provision that requires the PA board and the medical board to jointly adopt rules that either define supervision or create minimum standards of supervision by February 2016.



Estimated impact²

The impact of this draft rule was measured in PA and physician time spent complying with administrative work instead of treating patients (measured in both work-hours and billable hours). The lost time is also measured in lost full-time equivalent employees or FTEs³. Based on industry estimates there are approximately 1100 PAs (100 that practice in rural settings) and at an average ratio of two PAs per physician, an estimated 850 supervising physicians per the Iowa Medical Board (about 85 supervising a rural PA). Based on these variables the draft rule yields the following new burdens on Iowa's healthcare system.

¹ This briefing focuses on the economic impact of the current PA rule draft, for policy considerations, please see our briefing "Draft PA Rule will be Trouble for Iowa" dated December 22, 2015.

² These estimates are similar to the methodology used in "Effects on Rural Health and Primary Care Providers and Suppliers", Federal Register, dated May 12, 2014.

³ An FTE is the hours worked by one employee on a full-time basis.

Requirements	Physician assistants (PA)				Supervising physicians (SP)			
	PA Hours	PA FTE reduction	Cost	Lost patient encounters	SP Hours	SP FTE reduction	Cost	Lost patient encounters
(a) Review of requirement	1,177.71	0.589	\$169,590.67	3,533.14	910.051	0.455	\$174,729.78	3,640.204
(b) Face-to-face meetings	3,100.00	2.550	\$471,100.00	9,095.00	2465.000	1.998	\$492,575.00	9,860.000
(c) Assessment of education (et al)	1,100.00	0.550	\$158,400.00	6,600.00	850.000	0.425	\$163,200.00	6,800.000
(d) Communication	-	-	-	-	0.000	0.000	-	-
(e) Quarterly review	-	-	-	-	6092.778	3.046	\$1,169,813.33	1,523.194
(f) Annual review	1,100.00	0.550	\$158,400.00	6,600.00	850.000	0.425	\$163,200.00	6,800.000
(g) Delegated services	-	-	-	-	-	-	-	-
(h) Timely consultation	-	-	-	-	-	-	-	-
(i) Alternative supervision	-	-	-	-	-	-	-	-
(j) Failure to supervise	-	-	-	-	-	-	-	-
(3) Amendment	-	-	-	-	-	-	-	-
Total:	6,477.71	4.239	\$957,490.67	25,828.14	11167.829	6.349	\$2,163,518.11	28,623.398

Draft PA Rule will be Trouble for Iowa

December 22, 2015

Summary

The Iowa Society of PAs (IPAS) and the American Academy of PAs (AAPA) jointly urge policy makers **not** to proceed with the draft PA rule created by a subcommittee of the board of medicine and the physician assistant (PA) board. IPAS and AAPA respectfully suggest that the draft be modified to:

- Require the PA board to compile and distribute applicable PA laws to physicians and PAs;
- Create a definition of supervision consistent with best practice and national trends;
- Decline to adopt administrative rule amendments that restate existing requirements or create requirements **not** supported by evidence that the rule will increase patient safety; and
- Not bind future boards from amending administrative rules or grant waivers for compelling situations.

Please find a summary of our suggestions as well as our specific suggestions⁴.

Background

PAs are healthcare providers who are nationally certified and state licensed to practice medicine and prescribe medication in every medical and surgical specialty and setting. PAs practice and prescribe in all 50 states, the District of Columbia and all U.S. territories with the exception of Puerto Rico. PAs are educated at the graduate level, with most PAs receiving a Master's degree or higher. In order to maintain national certification, PAs are required to recertify as medical

⁴ See Attachment 1: IAPS and AAPA Suggestions to Current Language

generalists every 10 years and complete 100 hours of continuing medical education every two years.

Towards the close of the last session, the Iowa state legislature enacted legislation⁵ that included a provision that requires the PA board and the medical board to jointly adopt rules that either define supervision **or** create minimum standards of supervision by February 2016. To this end, subsets of the boards begun meeting over the summer facilitated by medical board staff to craft a proposal for the full boards to consider. The proceedings of the subsets did not entirely follow the procedure of notice, appearance, and public participation usually expected of public bodies.

Despite a narrow focus, the drafting group has recommended and the respective boards are expected to advance proposed administrative rules unfavorable to PAs, including creating requirements that will:

- Likely **decrease** the number of PAs practicing in Iowa;
- Reduce flexibility and taxpayer savings;
- Fail to allow for emerging models of care;
- Fail to comply with legislative scope;
- Not comply with the recent FTC SCOTUS decision; and
- Duplicate existing requirements and will likely lead to the boards disciplining PAs and physicians for failure to comply with confusing requirements.

⁵ "SF505, DIVISION XXXI PHYSICIAN ASSISTANT SUPERVISION Sec. 113. ADMINISTRATIVE RULES — PHYSICIAN SUPERVISION OF PHYSICIAN ASSISTANTS. The boards of medicine and physician assistants shall jointly adopt rules pursuant to chapter 17A to establish specific minimum standards **or** a definition of supervision for appropriate supervision of physician assistants by physicians. The boards shall jointly file notices of intended action pursuant to section 17A.4, subsection 1, paragraph "a", on or before February 1, 2016, for a adoption of such rules." [emphasis added]

Problems with Current Suggested Language

Significant problems exist with the draft as currently presented. These problems have been previously communicated to the subcommittee and both boards.

Potential Loss of PA Jobs

Included in the proposed rule notice submitted to each board for its consideration was the following impact statement:

“After analysis and review of this rule making, **no impact on jobs has been found.**”⁶

[emphasis added]

During the deliberations of the PA board, **no one** could provide any evidence that either:

- Any analysis was performed, especially on such a short timeframe; or
- That there was any evidence that this draft would not have a negative impact on PA jobs in Iowa.

In fact, a survey of the literature suggests the opposite, “States identified as ‘unfavorable’ for PA practice were found to have notably lower PA supply compared to other states. [...] Conclusions: Substantial variation exists in the PA-to-population ratio among states, which may be related in part to state practice laws.”⁷

The American Academy of PAs has identified Six Key Elements of a Modern PA Practice Act, a metric that has been widely acknowledged as a measure of appropriate PA regulation. Currently, Iowa has only one Key Element (licensure as a regulatory term). The current draft would make two other Key Elements (scope determination and adaptable supervision requirements) much worse. There is a “[r]elationship between PA supply and state law. AAPA identified six key elements that enable a practice environment where physician-PA teams are

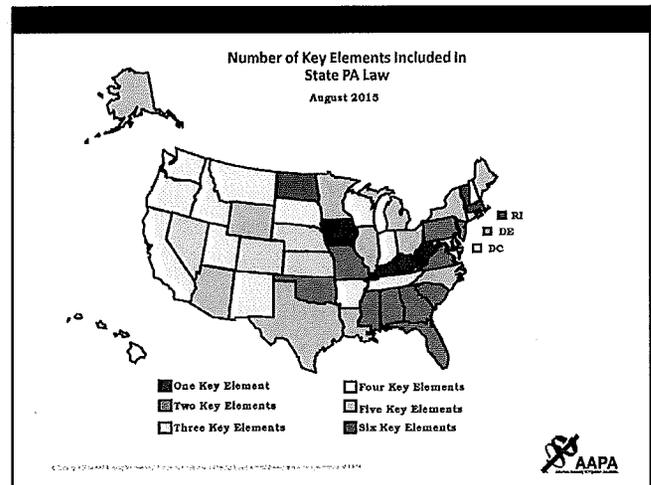


Figure 1: AAPA's Six Key Elements

able to care for patients as effectively and efficiently as possible. In general, the greater the number of these elements that are contained in the practice act, the more favorable a state’s laws are considered to PA practice.”⁸

Other research has drawn similar conclusions:

*Although much state variation in use of PAs and NPs in PCP (primary care physician) offices was associated with physician practice characteristics, higher use of PAs or NPs in primary care physician offices was associated with state scope-of-practice laws favorable to PA practice. Uniformity in PA and NP scope-of-practice laws across states could expand access in primary care shortage areas.*⁹

*Improved state legislation has been noted as an influencing effect on deployment of PAs and NPs for 2 decades (Emelio, 1993; Kuo et al., 2013).*¹⁰

As presented, the draft rule would make it much more difficult to employ PAs in Iowa and likely lead to fewer jobs for PAs.

⁶ See Attachment 2: Draft Rule Amendment, Medical Board and PA Board Subcommittee

⁷ (Sutton, PhD, Ramos, MPH, & Lucado, MPH, 2010)

⁸ (Sutton, PhD, Ramos, MPH, & Lucado, MPH, 2010)

⁹ (Hing & Hsiao, 2015, p. 53)

¹⁰ (Hooker & Muchow, 2015)

Flexibility and Savings

States are increasingly deciding that the specific elements of PA-physician interaction should be decided at the practice. This is in response to concerns about patient access to care, and the strong track record of PA practice. Adopting regulations with new restrictions on PA-physician practice would be regressive and out of sync with national trends.

In just the last six months:

- Ohio repealed a statutory requirement that the physician be within 60 miles of the PA
- Oklahoma repealed a statutory requirement that the physician be on-site a half day per week
- Texas repealed a regulation that required 10 percent on-site physician presence

A recent analysis¹¹ concludes that states could save millions in healthcare costs by removing PA and NP practice barriers. The cost analysis found that even modest changes to Alabama PA and NP laws would result in a net savings of \$729 million over a 10-year period.

Conversely, AAPA is not aware of any PA-related study that demonstrates that additional practice barriers either increase patient safety or reduce healthcare costs.

Emerging Models of Care

PAs are uniquely qualified to adapt to new models of care – especially primary care delivery and areas or specialties of provider shortage. PAs directly contribute to:

- Improved access to services;
- Reduced wait times; and
- Improved quality of care

Enacting regulations that require physicians and PAs to meet administrative requirements rather than using

¹¹ (Hooker & Muchow, 2015)

practice hours to care for patients diminishes the ability of teams to meet quality and access goals.

Compliance with Recent Legislative Mandate and SCOTUS Decision

Pursuant to section 113 of Senate File 505, the board of medicine and the board of physician assistants have been directed to “jointly adopt rules pursuant to chapter 17A to establish specific minimum standards or a definition of supervision for appropriate supervision of physician assistants by physicians.” [emphasis added] Additional restrictions would be beyond the directive enacted by the legislature.

Additionally, this will be an early administrative action after the US Supreme Court decision in *NC State Board of Dental Examiners v. FTC*. It will be critical to adhere to the recent guidance¹² issued by the Iowa attorney general, to regulatory boards:

- Is the action anticompetitive? Does it restrict competition?
- Does the action reflect state policy as expressly stated in statute?
- Is there a credible, evidence based demonstration of public need?

IPAS and AAPA urge the board to only adopt rules that are truly addressing a demonstrated issue and to do so with evidenced-based solutions rooted in statutory authority.

A lack of evidence in PA and NP laws in general was noted in one article on PA and NP regulations, “Of primary concern is that the scope with which NPs and PAs may practice depends largely on idiosyncratic political and regulatory considerations, rather than practitioner ability and education¹³.”

¹² Memo from Pam Griebel, Assistant Attorney General, State of Iowa to Professional Licensing and Regulation Bureau, in re: Questions Related to *N. Carolina State Bd. of Dental Examiners v. FTC* dated March 23, 2015.

¹³ (Gadbois, Miller, Tyler, & Intrator, 2014, pp. 3 - 4)

Ease of Compliance

Lastly, to assure ease of compliance, laws and regulations should be easy to understand. The current proposal duplicates or restates many current requirements found in the code and the administrative code. This would require PAs and physicians, in addition to current legal and administrative requirements, to now review several different places in the law to understand how to remain compliant.

Enacting confusing, duplicative or unnecessary requirements may result in the boards disciplining well-intended PAs and physicians not for acts that affect patient safety or health care quality, but for failing to comply with an arcane provision that was difficult to understand.. Additionally, with any new requirements created, PAs and physicians will have to dedicate additional time and resources toward documenting compliance instead of caring for lowans.

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IAPS and AAPA Suggestions to Current Proposed Language

Topic	Suggestion	Remarks
(a) Physician and PA review laws	Require the PA board to compile and supply each supervising physician and PA with a compendium of relevant PA laws.	<i>Existing requirement</i> , under s. 645-326.8 (4) IA admin. code, “[...] The physician assistant and the supervising physician are each responsible for knowing and complying with the supervision provisions of these rules. [...]”
	<u>“The board of physician assistants shall compile a compendium of the requirements of physician assistant licensure, practice, supervision and delegation of medical services as set forth in the code and administrative code.”</u>	What would be more useful, however, would be for the board to compile the relevant PA laws and distribute them to physicians and PAs.
(b) Biannual in-person meeting at practice or remote site.	Delete. Create a definition of “supervision”.	Unclear how this would benefit patients. Not consistent with PA practice and new delivery models, e.g. telemedicine.
	<u>“ ‘Supervision’ means an ongoing process by which a physician and physician assistant jointly ensure the medical services provided by a physician assistant are appropriate, pursuant to 645 IAC 327.1(1)¹⁴ and 645 IAC 326.8(4)”</u>	<i>Creating a definition of supervision</i> (based on best practices) complies with the legislative mandate “to establish [...] a definition of supervision [...]”.

¹⁴ “The medical services to be provided by the physician assistant are those delegated by a supervising physician. The ultimate role of the physician assistant cannot be rigidly defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills

Topic	Suggestion	Remarks
(c) PA and physician to ensure the education, et al., of the other.	Delete	<p><i>Existing law provides, under s. 645-327.1(1), "The medical services to be provided by the physician assistant are those delegated by a supervising physician. The ultimate role of the physician assistant cannot be rigidly defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. The physician assistant's services may be utilized in any clinical settings including, but not limited to, the office, the ambulatory clinic, the hospital, the patient's home, extended care facilities and nursing homes. Diagnostic and therapeutic medical tasks for which the supervising physician has sufficient training or experience may be delegated to the physician assistant <u>after a supervising physician determines the physician assistant's proficiency and competence.</u>"</i> [emphasis added]</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(d) Timely communication	Delete	<p><i>Existing requirement, under s. 645-326.8 (4)(a), IA admin. code, "Patient care provided by the physician assistant shall be reviewed with a supervising physician on an ongoing basis as indicated by the clinical condition of the patient. [...] it is the responsibility of the</i></p>

and abilities necessary to provide those services appropriate to the practice setting. The physician assistant's services may be utilized in any clinical settings including, but not limited to, the office, the ambulatory clinic, the hospital, the patient's home, extended care facilities and nursing homes. Diagnostic and therapeutic medical tasks for which the supervising physician has sufficient training or experience may be delegated to the physician assistant after a supervising physician determines the physician assistant's proficiency and competence. The medical services to be provided by the physician assistant include, but are not limited to, the following: [...]"

Topic	Suggestion	Remarks
		<p>supervising physician and physician assistant to ensure that each patient has received the appropriate medical care.”</p> <p>Required physician notification should be determined at the practice-level not mandated by the administrative code. It would be impossible to determine every situation.</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(e) Mandated chart review	Delete	<p><i>Existing minimum chart review, under s. 645-327.4, IA admin. code, “A physician assistant may provide medical services in a remote medical site if one of the following three conditions is met: [...] b. The physician assistant with less than one year of practice has a permanent license and meets the following criteria: [...] (4) The supervising physician signs all patient charts unless the medical record documents that direct consultation with the supervising physician occurred; or [...]”</i></p> <p>Additionally, there is <u>no evidence</u> that this improves patient care. Any additional chart review should be determined at the practice-level.</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(7) Annual review	Delete	<p>As defined, “supervision” is an ongoing joint process.</p> <p>As created by this suggested rule, “Supervision’ means an ongoing process by which a physician and physician assistant jointly ensure the medical services provided by a physician assistant are</p>

Topic	Suggestion	Remarks
		<p>appropriate, pursuant to 645 IAC 327.1(1) and 645 IAC 326.8(4)”</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
<p>(g) PA services to comply with the code</p>	<p>Delete</p>	<p>The first part of this language requires compliance with several sections of the administrative code. At face value, these are <u>existing</u> requirements.</p> <p>The second part of this suggestion limits PA practice and encourages PAs <u>not</u> to practice to the fullest extent of their education, training, and experience. A PA may provide services with physician supervision, that are delegated, and for which the PA has been qualified by training.</p> <p>It is possible for a PA have acquired a skill in one practice setting that under this proposal would <u>not</u> be allowed in a different practice setting if that physician was not able to perform.</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
<p>(h) Physician to be available</p>	<p>Delete</p>	<p>Existing requirement, under s. 645-326.8(4)(b.), “Patient care provided by the physician assistant may be reviewed with a supervising physician in person, by telephone or by other telecommunicative means.”</p> <p>Additionally, under s. 326.8(4), IA admin. code, “[...]In regard to scheduling, the physician assistant may not practice if supervision is unavailable, except as otherwise provided in Iowa Code chapter 148C or these rules, and must be in compliance with the requirement that</p>

Topic	Suggestion	Remarks
		<p>no more than five physician assistants shall be supervised by a physician at the same time, pursuant to subrule 326.8(3)."</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(i) Alternative physician	Delete	<p>Covered by existing requirements, under s. 645-326.8 (4), "It shall be the responsibility of the physician assistant and a supervising physician to ensure that the physician assistant is adequately supervised."</p> <p>Instead of mandating <i>how</i> this will occur, current law allows the PA-physician assistant team the flexibility to meet this requirement which could include additional supervising physicians as permitted under current law.</p> <p>Additionally, physicians are already permitted to review patient care via telecommunicative means, per s. 645-326.8(4)(b.), "Patient care provided by the physician assistant may be reviewed with a supervising physician in person, by telephone or by other telecommunicative means."</p>
(j) Noncompliance with administrative code	Delete	<p>How each profession should be disciplined should be determined by each respective board. Boards currently have authority to discipline for non-compliance.</p>
(k) Joint amendment	Delete	<p>Either board should <u>not</u> have the authority to bind future boards. A part of the purpose of administrative rules is to allow the law to evolve more quickly to adapt to changing circumstances and public needs.</p>

Topic	Suggestion	Remarks
		<p>This language is also beyond the legislative scope of SF 505.</p> <p>Either board should be able to amend each board's respective rules subject to the existing administrative rules promulgation process.</p>
(I) No waiver	Delete	<p><i>Existing law provides, under s. 645-327.1(1), “[...] The ultimate role of the physician assistant cannot be rigidly defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. [...]” [emphasis added]</i></p> <p>One of the hallmarks of PA regulation in Iowa has been the ability of the board to grant waivers when a compelling situation has been presented which is recognized by s. 645-327.1(1). No compelling reason or evidence has been presented supporting this language.</p>

Reisetter, Sarah [IDPH]

From: Lori Ziegenhorn <loriz@mchsi.com>
Sent: Tuesday, March 08, 2016 9:18 AM
To: Reisetter, Sarah [IDPH]
Subject: Medical board rules restrictions on PAs

The restrictions that are proposed to restrict physician assistants and require supervision by the medical board will impact the care for Iowans. These regular meetings proposed between the board, the supervising physicians and physician assistants impose an undeserved burden on practices utilizing PAs, taking time away from patients and practice. Electronic medical records have already cut into practice time, now this will take more time away for a problem that does not exist. It will impact patient care by removing the physician and physician assistant from practice time and cause economic impact on the practice. I worked in one of the few practices left in Johnson county that are still independent. This proposed rule taking regulation of PAs out from PA Board regulation and putting them under Medical Board regulation would have had a great impact on our busy practice. We already have a shortage of medical care providers in Iowa. Are you trying to create a bigger shortage and drive more qualified providers from the state? Many providers are retiring and this creates an even bigger shortage. There has not been a problem, do not create one.

Many PAs have more than one supervising physician. Are you going to have to meet with ALL of them?

This is ill conceived and a disservice to the people of Iowa.

Lori Ziegenhorn
Physician Assistant-C
Retired

Sent from Lori's iPad

Reisetter, Sarah [IDPH]

From: no-reply@iowa.gov
Sent: Tuesday, March 08, 2016 9:22 AM
To: Reisetter, Sarah [IDPH]
Cc: twalker@mercyare.org
Subject: Public Comment Received on ARC 2417C

A new public comment has been received on **ARC 2417C**. The comment and contact information are listed below.

The comment was made on paragraph **17**.

Document Content

b. Face-to-face meetings. The supervising physician and the physician assistant shall meet face-to-face a minimum of twice annually. If the physician assistant is practicing at a remote site, at least one of the two meetings shall be at the remote site. The face-to-face meetings are for the purpose of discussing topics deemed appropriate by the physician or the physician assistant, including supervision requirements, assessment of education, training, skills, and experience, review of delegated services, and discussions of quarterly and annual reviews.

Comment

In the age of telemedicine, face to face visits should not be a requirement for all PAs. There is no evidence that this will improve quality of care or decrease physician liability. However, given the varying spectrum of PA experience, site visits may be deemed necessary for new graduates or certain experienced PAs new to a particular field of medicine. The need for sites visits should be determined at the practice level, not dictated to all PA-Physician teams. This flexibility is consistent with the trend nationally and is supported by the AAPA for modern PA practice.

Contact Information

Name: **Tod Walker**
Email: twalker@mercyare.org
Phone: (319) 929-4654

Reisetter, Sarah [IDPH]

From: no-reply@iowa.gov
Sent: Tuesday, March 08, 2016 9:24 AM
To: Reisetter, Sarah [IDPH]
Cc: twalker@mercyare.org
Subject: Public Comment Received on ARC 2417C

A new public comment has been received on **ARC 2417C**. The comment and contact information are listed below.

The comment was made on paragraph **20**.

Document Content

e. Quarterly review. There shall be a documented quarterly review of a representative sample of the physician assistant's patient charts encompassing the scope of the physician assistant's practice.

Comment

Making a requirement of chart review does not improve the quality of care or improve patient safety. This is extra administrative burden that is unnecessary and should not apply to all PA-Physician teams.

Contact Information

Name: **Tod Walker**
Email: twalker@mercyare.org
Phone: **(319) 929-4654**

Reisetter, Sarah [IDPH]

From: no-reply@iowa.gov
Sent: Tuesday, March 08, 2016 9:28 AM
To: Reisetter, Sarah [IDPH]
Cc: twalker@mercyare.org
Subject: Public Comment Received on ARC 2417C

A new public comment has been received on **ARC 2417C**. The comment and contact information are listed below.

The comment was made on paragraph **26**.

Document Content

327.8(2) Amendment. Rule 645—327.8(147,148,148C,86GA,SF505) may only be amended by agreement of the board of medicine and the board of physician assistants through a joint rule-making process.

Comment

This takes authority away from the PA regulatory board in such a manner that is not necessary and actually punitive to PAs. The Iowa Board of Medicine has put forth anti-PA legislative efforts for years and when PAs were under the Board of Medicine, many PAs left the state as a result of their authority. The PA regulatory board has physician representation on it already to have both sides of the PA-Physician team accounted for.

Contact Information

Name: **Tod Walker**
Email: twalker@mercyare.org
Phone: **(319) 929-4654**

March 5, 2016

Dear PA Board members,

Thank you for this opportunity to comment on the proposed PA rules, ARC 2417C. While writing rules is challenging, these proposed regulations have a number of problems and therefore, should not be adopted.

- 1) The problems with these proposed rules go well beyond what is authorized by the statute:
 - b): requiring *face to face meetings* would disrupt tele-psychiatry practices in the state, outreach clinics, free clinics, and other practices that have been increasing access to care.
 - c): requires the supervisee to assess whether the supervisor has adequate education and relevant experience
 - e): *quarterly review* would mean an extra requirement and documentation with no evidence of need.
 - f): *annual review* would mean an extra requirement and documentation beyond current rules and no evidence of need. Current rules require ongoing supervision and review
 - g): delegated services - conflicts with IAC 645-327.1(1) which states the "ultimate role of the PA cannot be defined... This section also changes training or experience to training and experience.
 - h): consultation - already in the PA rules but adds the vague term "timely". No evidence of need provided.
 - i): alternate supervision – adds another requirement with no evidence of need.
 - j): failure to supervise- already in existing rules. This puts PA disciplinary rules; IAC 645-328 and PA CME rules; IAC 645-329 under the medical board with no justification.

4) waiver prohibited – eliminates the flexibility needed to meet the needs of the ever changing practice of medicine.

NPs have none of these requirements and no physician site visit mandate. SF 505 requires rules to be jointly noticed but does not require joint rules. Since the current PA rules are working and there is no objective evidence that these additional requirements will improve patient care or safety, or that these proposals are not anti-competitive, these regulations should not be promulgated. Furthermore, these new requirements conflict with existing PA rules. PA rules should be flexible to allow medical innovations and individual differences in physician practices necessary to best meet the needs of the patients.

Since the current PA rules are working and there is no evidence that new rules are needed. And there is no legislative mandate to add these additional PA restrictions, these new requirements should be dropped. A clear and succinct definition of supervision should be added to the PA rules with the medical board authority to enforce the PA rules for supervising physicians.

I am a former chair of the Iowa PA Board who has practiced in Iowa for more than 35 years. So I am quite familiar with PA practice, and PA rules and regulations.

Thank you for your attention to these comments.

Sincerely,

Bob Witt, PA
Marshalltown

Reisetter, Sarah [IDPH]

From: no-reply@iowa.gov
Sent: Tuesday, March 08, 2016 9:40 AM
To: Reisetter, Sarah [IDPH]
Cc: twalker@mercyare.org
Subject: Public Comment Received on ARC 2417C

A new public comment has been received on **ARC 2417C**. The comment and contact information are listed below.

The comment was made on paragraph **10**.

Document Content

After analysis and review of this rule making, the Board of Physician Assistants is concerned that the rule making may have a negative impact on jobs. Further analysis is in progress at this time.

Comment

Overall, these new proposed rules are just not necessary. There is no evidence that the current Iowa law governing PA practice is not appropriate. There have not been increased complaints about PA practice, increased legal actions taken, or concern for patient/community safety. There is an increased demand for healthcare providers overall and these laws would serve to make Iowa a less attractive state to practice for PAs. It would also create an anti-competitive environment with our nurse practitioner colleagues. The Iowa Attorney General has stated that any new laws or rules of this nature should be evidence based and not anti-competitive. This is the exact opposite of what is being proposed. There is significant cost impact of this law as well. It is estimated that there will be an additional 3.1 million dollar burden on the Iowa healthcare system and a loss of 54,500 patient visits from the Iowa PA society and the American Academy of Physician Assistant review of the economic impact of these rules. Also the Iowa Board of Physician Assistants own survey conducted on the issue showed that 20% of respondents in this small sampling would be less likely to hire PAs if they were passed. That is significantly negative jobs impact. These rules just don't have any positive impact on healthcare in Iowa that can be demonstrated objectively.

Contact Information

Name: **Tod Walker**
Email: twalker@mercyare.org
Phone: **(319) 929-4654**

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March 7, 2016

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Sarah Reisetter
Professional Licensure Division
Department of Public Health
Lucas State Office Building
Des Moines, Iowa 50309
Via email: sarah.reisetter@idph.iowa.gov

RE: Notice of Intended Action – ARC 2417C – Minimum Standards for
Appropriate Supervision of a Physician Assistant by a Physician

Dear Ms. Reisetter and Members of the Board:

On behalf of the 6,200 physician, resident and medical student members of the Iowa Medical Society (IMS), thank you for this opportunity to comment on the Iowa Board of Physician Assistant's (IBPA) noticed rules regarding appropriate supervision of a physician assistant (PA) by a physician. IMS commends the IBPA and the Iowa Board of Medicine (IBM) for working together to craft reasonable supervision standards to guide both physicians and PAs as they care for Iowans.

IMS recognizes, without question, the valuable role of physician assistants (PAs) in physician-led patient care teams. Given the rural nature of Iowa's population, PAs fill a valuable role in providing Iowans with greater access to quality care. Consultation and supervision by a highly-trained physician, however, is essential to ensuring that patients with complex healthcare needs receive appropriate care in their local communities. In Iowa Code Chapter 148C.4(1), the Iowa Legislature codified the role of PAs in our healthcare delivery system: "A physician assistant may perform medical services when the services are rendered under the supervision of a physician." Further, IAC 645-326.1 clearly states the "supervising physician is ultimately responsible for the medical care provided by the physician/physician assistant team."

Until this point, however, the Board of Medicine has not had the clear authority to define what constitutes proper supervision. Instead, the IBM has been relegated to relying on a loose standard of "we know it when we see it" as it pertains to improper supervision, which is an arbitrary standard at best. Supervising physicians need and deserve clear, minimum supervisory standards from their licensing board. As such, IMS stands in support of the joint action by the boards of medicine and physician assistants to establish supervisory standards for physicians and believes the action is consistent with policy stated in statute.

Recent changes to the PA supervision requirements, including the decision to raise the maximum supervision ratio from two PAs practicing under a single physician to five, further underscores the absolute necessity of establishing in administrative code clear standards for appropriate supervision. Given that physicians are ultimately responsible for the care provided, it is imperative that minimum expectations are clear. It is unacceptable to subject physicians to discipline for improper supervision without providing supervising physicians with standards upon which charges are based. The recent changes have only served to further erode physicians' understanding of what constitutes adequate supervision.

The proposed joint rules represent minimum supervisory standards that are already in practice in many PA-physician working relationships. According to the Jobs Impact Analysis Survey conducted by the IBPA, 44% of physicians reported that they saw their PA on a daily basis. All reported that they saw their PA at least several times a year. PAs made a similar report: only six percent reported meeting with their physicians in person less than two times per year; the remaining 94% of PAs reported meeting more frequently than two times per year.

The proposed requirement of one in-person meeting annually reflects a practice already in place. These periodic meetings, whether in-person or virtual, as well as performance reviews, are important components of an effective and dynamic supervisory relationship in any field. In the healthcare field, however, they are imperative. Iowans deserve a healthcare team that meets at least the supervisory standards in other, less-critical fields.

In practice, physicians and remote-practice PAs regularly engage in real-time communication and consultation through the use of modern audio and video technology, including electronic medical records. In fact, zero physicians reported that they do not review any of their PAs charts. These rules standardize across the state what many physicians and PAs are already doing – or should be doing – to ensure quality care for their patients, and they provide the necessary guidance physicians have long sought.

The requirements do not create new unnecessary burdens on physicians or PAs; rather, they articulate and define a proper supervisory relationship between a physician and a PA. The requirements address the question supervising physicians have long asked: What level and type of supervision is expected and appropriate? The survey confirms that there will be no negative impact. Specifically, 79% of hospital respondents believe the new rules will have no effect on their willingness to hire or supervise a PA. In fact, 9% of licensed physicians indicated that the new rules make them *more likely* to hire or supervise a PA.

The IBM's ad hoc committee in the summer of 2012, chaired by Jeffrey Snyder, MD, convened to review expectations for supervising physicians in the wake of

Sarah Reisetter
March 7, 2016
Page 3

the law increasing the number of PAs a physician may supervise. The committee met with the IBPA and concluded that more education and guidance about existing laws and rules of physician assistant supervision would be helpful to physicians. The recommendation of this ad hoc committee underscores the fact that physicians need and have long sought guidance for their role in supervising PAs.

IMS believes these rules are necessary as they are in the best interest of Iowans. The core purpose of the Iowa Medical Society is to assure the highest quality health care in Iowa through our role as physician and patient advocate. Enactment of ARC 2417C will continue the high standard of care Iowans have come to expect and deserve. It is for these reasons that IMS supports ARC 2417C.

Thank you for this opportunity to comment.

Sincerely,

A handwritten signature in black ink that reads "Kate Strickler". The signature is written in a cursive, flowing style.

Kate Strickler, JD, LLM
General Counsel

Reisetter, Sarah [IDPH]

From: Theresa Hegmann <t_hegmann@hotmail.com>
Sent: Monday, March 07, 2016 1:59 PM
To: Reisetter, Sarah [IDPH]
Cc: Kaufmann, Bobby [LEGIS]
Subject: Comments on ARC 2417C (for 3/9/16 public hearing)

Dear PA Board Members,

As a practicing PA and an educator of both physician assistants and medical students, I would like to express my opposition to the proposed new rule (ARC 2417C). These comments are similar to those that I made to the medical board about ARC 2372C.

Neither the PA board nor the medical board have presented any evidence for why it is necessary to micromanage the PA supervision process in Iowa with a one-size-fits-all approach that really does not fit all situations well, and which is going to create mountains of paperwork without any evidence that the increased regulatory burden is necessary to improve the quality or safety of care provided to patients.

What this rule IS very likely to do is to discourage physicians and clinics in Iowa from hiring PA's. It is also likely to result in lost patient care time, lost revenue and added costs for employers, and decreased patient access to care, due to the added regulatory burden.

For example, the urgent care system that I work for currently employs several PA's who work in six clinics. One physician serves as the medical director and currently does all yearly evaluations for all of the PA's and provides most of the direct patient care consultation / supervision in real time by phone or videoconferencing. He also makes rotating visits to the six clinic sites on a regular schedule. Four other physicians serve as back-up supervisors (mainly for weekends, holidays, and vacations) and they also provide regular daily QI/QA through random chart review for individual clinics.

The system of supervision described above clearly provides more than adequate supervision for the PA's, but will not even come close to meeting the requirements laid out in ARC2417C. Under the new rule, each of those four back-up supervising physicians will have to start taking time away from their own patient schedules to meet face-to-face with each of the PA's (which requires traveling to multiple clinic sites in different cities), and the medical director will have to start documenting quarterly chart reviews for all of the PA's -- even though none of these activities will improve patient care quality or safety.

No other state that I'm aware of has rules that micromanage the process of PA supervision to this extent -- and most states that have changed PA supervision rules over the last few years have ADDED flexibility to the supervision process, not removed it. As examples, two states with very conservative governors chose to decrease their regulatory burdens on the profession in 2015: **New Jersey** removed a mandatory countersignature requirement, leaving it to the discretion of the local practice¹, and **Oklahoma** dropped their minimum onsite supervision requirement and chose to allow electronic collaboration and leave decisions about the extent of onsite supervision to the discretion of the local practice.² Even the federal government in 2014 removed the requirement for an in-person visit to RHC's once every two weeks, as it was felt to be costly and unnecessary given the availability of videoconferencing technology!³

Why is Iowa going backwards in time? Iowans need rules that increase practice flexibility and increase access to care. We certainly do not need rules that unnecessarily add to the regulatory burden for physicians who are already overworked.

One way to improve this rule would be to limit the criteria about chart reviews and face-to-face visits and annual reviews to PA's who work in RHC's, as that is the main setting where these issues apply. It would also be helpful to include exceptions to this proposed rule for institutions that already have specific local policies and practices in place addressing chart review for quality control and annual reviews.

However, in my opinion, the best way to "fix" this rule would be to *replace it with a joint rule that defines supervision in a very straight-forward and clear way*, which would meet the requirements of SF505 without adding unnecessary

regulations that will harm PA's, employers of PA's, and patients of PA's, in the state of Iowa.

Thank you for the opportunity to comment on the proposed rule.
Respectfully submitted,

Theresa Hegmann, PA-C, MPAS
1396 Plato Road
West Branch, IA 52358
319-643-3141

References:

1. <https://www.njsspa.org/news/details.asp?tid=84&cid=&nid=1090&name=LEGISLATION-SIGNED-TO-MODERNIZE-THE-PA-PRACTICE-ACT->

2. <https://www.aapa.org/twocolumn.aspx?id=2147485260>

3. Federal Register: <https://www.federalregister.gov/articles/2014/05/12/2014-10687/medicare-and-medicaid-programs-regulatory-provisions-to-promote-program-efficiency-transparency-and#h-35>

Reisetter, Sarah [IDPH]

From: Gorney, Carol S <carol-gorney@uiowa.edu>
Sent: Monday, March 07, 2016 3:23 PM
To: Reisetter, Sarah [IDPH]

Dear Iowa PA Board

Both proposed rules would increase PA-physician practice costs \$3-6 million yearly, create unnecessary paperwork and decrease time available for patient care. Furthermore, these proposals go far beyond what was authorized by the legislature by giving the medical board veto authority over PA rules.. *The rules would make PAs the only profession required to be evaluated quarterly to maintain their license.*

Giving the medical board veto power over PA rules is unneeded bureaucratic and anti-competitive PA regulations that decrease access to care

No evidence that the current PA regulations are not working or that the proposed rules would improve care or patient safety. With PA care there is the double safety factor of having both the PA and their physician responsible and liable for the care provided.

Carol Gorney MPAS, PA-C
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Reisetter, Sarah [IDPH]

From: Rand, Joel <Joel.Rand@dmu.edu>
Sent: Monday, March 07, 2016 8:47 AM
To: Reisetter, Sarah [IDPH]
Subject: ARC 2417C PA Rules

Dear PA Board Members,

Thank you for working to clarify PA-physician supervision rules. Clearly defined expectations help prevent miscommunication and allow all parties to work towards the same goal. That being said, the rules proposed fail to recognize the fact that PAs and physicians have already been working towards the same goal for nearly 50 years.

The burdensome and arbitrary requirements outlined by the most recent version of these rules will only bog down the provision of care and cost the state of Iowa millions of dollars. There is no cookbook for medicine, and as such, there is no one best set of rules to govern every PA-physician team. As professionals, PAs and physicians have the ability to self-regulate and make critical decisions everyday about how to approach a variety of challenging situations. Caring for peoples' lives is an enormous responsibility and in my 15 years of clinical practice, I have never witnessed an example of where intrusive governmental regulations have changed the provider's intrinsic desire to do the right thing.

These rules are redundant, anti-competitive, and deleterious to the PA-physician team model. Students are already voicing concerns that Iowa will no longer be the attractive practice state it has been. Experienced providers are talking about early retirement, as their history of providing quality care and collaborating with their supervising physician at a level that works for them, has been completely disregarded.

Please work to create a flexible set of rules that allow clinicians, not legislators, to determine how the people of Iowa are best served. Thank you.

Joel E. Rand, MPAS, PA-C
Program Director/Department Chair
Assistant Professor
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Office: 515-271-1693
Cell: 515-205-6786

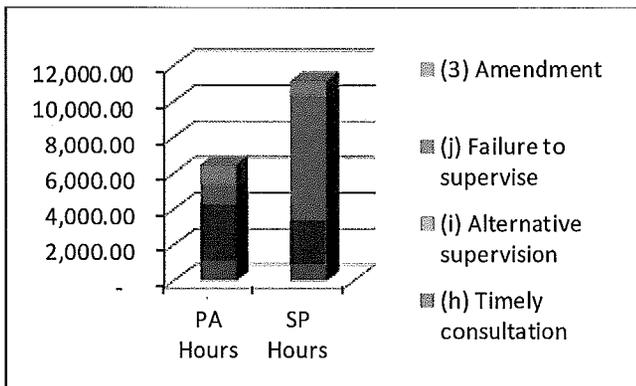
Economic Impact of Draft PA Rules: More Administrative Burdens, Less Access

Summary

The Iowa Society of PAs (IPAS) and the American Academy of PAs (AAPA) have closely reviewed the current draft PA rule for its low economic impact and have estimated that if promulgated in its current form the rule will lead to:

- A **\$3.1 million** burden on Iowa's healthcare system;
- A loss of nearly **54,500 patient encounters**; and
- The equivalent of a loss of **10.6 physicians and PAs practicing** in Iowa.

There has been no independent, peer-reviewed documentation that demonstrates any benefit derived from the additional requirements mandated by the draft rule. IPAS and AAPA continue to urge policy makers not to proceed with the PA rule draft in its current form¹.

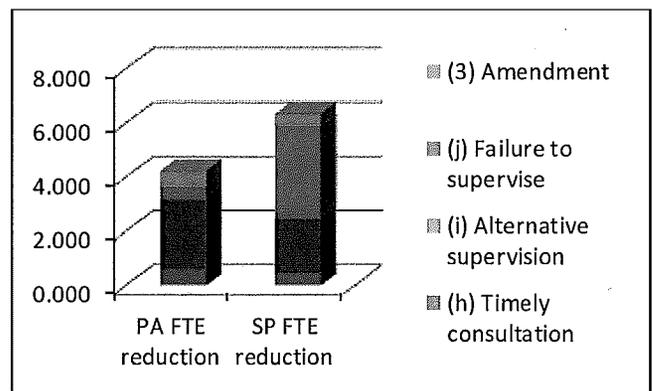


Background

PAs are healthcare providers who are nationally certified and state licensed to practice medicine and prescribe medication in every medical and surgical

specialty and setting. PAs practice and prescribe in all 50 states, the District of Columbia and all U.S. territories with the exception of Puerto Rico. PAs are educated at the graduate level, with most PAs receiving a Master's degree or higher. In order to maintain national certification, PAs are required to recertify as medical generalists every 10 years and complete 100 hours of continuing medical education every two years.

Towards the close of the last session, the Iowa state legislature enacted legislation that included a provision that requires the PA board and the medical board to jointly adopt rules that either define supervision **or** create minimum standards of supervision by February 2016.



Estimated impact²

The impact of this draft rule was measured in PA and physician time spent complying with administrative work instead of treating patients (measured in both work-hours and billable hours). The lost time is also measured in lost full-time equivalent employees or FTEs³. Based on industry estimates there are approximately 1100 PAs (100 that practice in rural settings) and at an average ratio of two PAs per physician, an estimated 850 supervising physicians per the Iowa Medical Board (about 85 supervising a rural PA). Based on these variables the draft rule yields the following new burdens on Iowa's healthcare system.

¹ This briefing focuses on the economic impact of the current PA rule draft, for policy considerations, please see our briefing "Draft PA Rule will be Trouble for Iowa" dated December 22, 2015.

² These estimates are similar to the methodology used in "Effects on Rural Health and Primary Care Providers and Suppliers", Federal Register, dated May 12, 2014.

³ An FTE is the hours worked by one employee on a full-time basis.

Requirements	Physician assistants (PA)				Supervising physicians (SP)			
	PA Hours	PA FTE reduction	Cost	Lost patient encounters	SP Hours	SP FTE reduction	Cost	Lost patient encounters
(a) Review of requirement	1,177.71	0.589	\$169,590.67	3,533.14	910.051	0.455	\$174,729.78	3,640.204
(b) Face-to-face meetings	3,100.00	2.550	\$471,100.00	9,095.00	2465.000	1.998	\$492,575.00	9,860.000
(c) Assessment of education (et al)	1,100.00	0.550	\$158,400.00	6,600.00	850.000	0.425	\$163,200.00	6,800.000
(d) Communication	-	-	-	-	0.000	0.000	-	-
(e) Quarterly review	-	-	-	-	6092.778	3.046	\$1,169,813.33	1,523.194
(f) Annual review	1,100.00	0.550	\$158,400.00	6,600.00	850.000	0.425	\$163,200.00	6,800.000
(g) Delegated services	-	-	-	-	-	-	-	-
(h) Timely consultation	-	-	-	-	-	-	-	-
(i) Alternative supervision	-	-	-	-	-	-	-	-
(j) Failure to supervise	-	-	-	-	-	-	-	-
(3) Amendment	-	-	-	-	-	-	-	-
Total:	6,477.71	4.239	\$957,490.67	25,828.14	11167.829	6.349	\$2,163,518.11	28,623.398

Reisetter, Sarah [IDPH]

From: Diane S. Frakes-Julius <juliusds@mercyhealth.com>
Sent: Friday, March 04, 2016 9:37 AM
To: Reisetter, Sarah [IDPH]
Subject: PA board proposals

Sarah, I have been a PA for nearly 30 years. The PA board has been doing a great job in governing and regulating the PA's in the state of Iowa. There is no need to change or become more restrictive. There has been no justification or need for change. I recommend that things just stay the same as they are. Why try to fix something that is not broken. Diane Julius, PA mason city, iowa

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January 19, 2016

Iowa Board of Physician Assistants
321 E. 12th St.
Des Moines, IA 50319

RE: Cost Analysis of impact of Proposed Joint Rules for PA Supervision per SF505

Dear members of the Iowa Board of Physician Assistants,

When developing new regulations for a profession, regulatory boards are often forced to walk a delicate line in balancing potential risks and benefits. Without a doubt, patient safety and the needs of the people of Iowa must have first priority. However, the current administrative rules governing the physician assistant profession are quite comprehensive and have a good track record of protecting patient safety and promoting access to care in our state. There is no objective evidence that additional administrative restrictions are necessary for the specific purpose of protecting public safety. With that in mind, it becomes imperative to carefully consider the costs of adding to the regulatory burden in a state where the PA profession is already more heavily regulated than in neighboring states.

Attached please find a simple cost analysis for the UIHC system which projects the added costs involved in implementing the proposed joint rules for "Specific Minimum Standards for Appropriate Supervision of a Physician Assistant by a Physician."

A conservative estimate of the yearly cost to the UIHC system, which currently employs about 75 PA's, is \$502,200, or \$6696 per PA per year. Extrapolating the model to cover the approximately 1000 PA's actively employed in Iowa would provide a figure of \$6,696,000 annually.

Of note, this model assumes only one physician has to complete the required chart reviews and meetings – which may not be the case. It also assumes only 30 minute meetings, and zero travel time or mileage costs. It also assumes that scheduling and documentation will all be handled by support staff working at a much lower hourly wage than PA's or physicians. If any of these assumptions are incorrect, costs could easily be much higher.

Thank you for this opportunity to provide input into the rule-making process.

Respectfully Submitted,

Faculty of the University of Iowa Carver College of Medicine Department of Physician Assistant Studies & Services (David Asprey, Anthony Brenneman, Theresa Hegmann, Carol Gorney, Katie Iverson)

Projection of Additional Costs Related to Implementation of Proposed Joint Rules for Supervision of PA's by Physicians in the UIHC System - 2016

Executive Summary: A conservative estimate of the total yearly cost to UIHC for implementing the proposed joint rule for supervision of the 75 PA's supervised by UIHC physicians comes to a total of **\$502,200**, or \$6,696 per PA. Extrapolating this model to the approximately 1000 PA's employed in Iowa: $(\$502,200 \times 1000)/75 = \mathbf{\$6,696,000}$ statewide.

Explanation: UIHC currently employs about 75 physician assistants (PA's). Between physician time, PA time, and administrator time required for scheduling, conducting, and documenting the required meetings that are added by the new proposed joint regulations, approximately 1800 fewer patients would be seen over a year's time, even assuming only 2 - 3 patients per provider per hour of time lost to added administrative requirements. This estimate does not include any travel time and mileage costs that might be involved in the required "face-to-face" visits. This model also uses a conservative estimate for cost per visit, in line with outpatient family practice or internal medicine visits. Lost revenue from specialty clinics, surgical consults, ER visits, etc. would likely be much higher.

This model makes the assumption that only one supervising physician per PA is required to conduct the 2 face-to-face visits, yearly performance review and quarterly chart reviews specified in the proposed regulations. As currently worded in the proposed administrative rule, it appears that all supervising physicians on a PA's license would be required to complete and document these tasks, potentially at least doubling or tripling the patient care time lost to red tape.

Employee category	Hourly wage	Extra administrative hours per year per PA ²	Added administrative cost per year	Patient visits lost	Lost revenue	Overall yearly cost to UIHC
Supervising Physician (SP) (Multiple depts affected, including: FP, IM, ETC, outpt specialties, inpatient specialties, surgical)	\$98 - \$171 ¹	~ 6 hrs (4 chart reviews x 1 hr, 2 face-to-face scheduled meetings x 0.5 hr, 1 annual review x 1 hr)	None, if meetings scheduled during work week and admin. asst. handles scheduling and documentation	75 SP's x 3 pt/hr x 6 hr/yr = 1350 patients/yr	1350 pt/yr x \$300/pt = \$405,000	\$405,000
Physician Assistant (multiple depts.)	\$58	~ 3 hrs		75 PA's x 2 pt/hr x 3 hr/yr = 450 patients/yr	450 pt/yr x \$200/pt = \$90,000	\$90,000
Administrative Asst.	\$32	(0.25 hr/mo x 12 mo) = 3 hr	\$32 x 3hr x 75 PA's = \$7200	NA	NA	\$7,200
Totals:	--	12 hrs	\$7,200 admin cost	1800 pt visits	\$495,000 lost revenue	\$502,200/yr

¹Figures utilize examples of current salaries of a family medicine physician and surgeon who currently manage multiple PA's (available as a matter of public record). ²Note that travel time and travel costs for the required face-to-face meetings are not included in this model but could be very significant for physician - PA teams working in rural areas.

Reisetter, Sarah [IDPH]

Subject: FW: financial impact data, PA Supervision Rule

From: Hegmann, Theresa [<mailto:theresa-hegmann@uiowa.edu>]

Sent: Thursday, March 03, 2016 12:13 PM

To: Susan Koehler

Cc: Reisetter, Sarah [IDPH]

Subject: RE: financial impact data, PA Supervision Rule

Hi Susan & Sarah,

We tried to be very clear in the letter accompanying that financial impact analysis that we were just estimating the **ADDITIONAL** cost for the specific supervisory requirements that are added by the joint rule. The current supervision process for PA's at UIHC no doubt has some cost to it (just as there is a cost to supervising NP's, nurses, residents and fellows), but those costs have not been measured to my knowledge. They are taken as a general background cost of doing business – and whatever that current cost is, UIHC currently finds it very cost-effective to hire PA's in multiple patient care settings. This baseline "cost of doing business" is taken as the baseline for this financial impact estimate. VPMA and Dean, Dr. Robillard, is fully aware of the financial impact estimate and has supported it as reasonable, though his office did not create it.

Here is a step-by-step explanation of the financial impact analysis:

- UIHC has about 75 physician assistants currently, **all** of whom have more than one supervising physician (abbreviated as SP in the estimate). Many of the PA's at UIHC have between 10 and 30 SP's.
- For each PA that they supervise, our assumption was that the SP would need 4 hours per year to do the required additional retrospective quarterly chart reviews (all departments have robust QI systems in place currently, but they would not meet the requirements of the proposed new rule) + two scheduled & documented 30 minute face-to-face meetings (most UIHC physicians talk with their PA's daily, but this proposed rule mandates documented "meetings", and there is no way to prove to the medical board that you talked with someone in the hall!) + 1 hour/year for a yearly evaluation (again, there is a system in place for these for all employees, but it would not meet the rule's requirements).
- 4 hours chart review + 2 x(30 minute meetings) + 1 hour annual review = **6 hours per year additional supervisory time per supervising physician, per PA.**
- Each PA would need to be available for the meetings and would need to prepare charts for the reviews, so we assumed **3 additional hours per year per PA.**
- All of these meetings will have to be scheduled and documented in a big system like UIHC, so we assume that a lower-paid administrative assistant would spend about 15 minutes per month per PA in scheduling, or about **3 additional hours per year per PA in the system administrative time**

Assuming only a single physician has to do all of this extra stuff for each PA (which is not a good assumption according to Mark Bowden), that comes to 75 PA's x 6 hours physician time per year = *450 hours of physician time that could have been used to see patients is now going to be spent doing additional paperwork and meetings.* At 3 patients per hour, and \$300 per patient, you get **\$405,000** lost patient revenue for physicians per year.

If you assume that each PA only sees 2 patients per hour at \$200 per patient (probably an underestimate for specialty PA's), that is 75 PA's x 3 hours/year x 2 patients/hr x \$200/patient = **\$90,000** in lost patient revenue for PA's in the UIHC system.

If you assume an administrative assistant makes about \$32/hour and spends 3 hours per year x 75 PA's in scheduling and documentation, that's **\$7200** per year additional administrative cost.

OVERALL: For UIHC, the approximate ADDITIONAL cost burden created by the new administrative rule, in terms of lost patient revenue and additional administrative time, for 75 physicians supervising 75 PA's, comes out to \$405,000 + \$90,000 + \$7200 = **\$502,200 per year, or \$6696 per PA** (and 1800 lost patient visits per year for the institution).

Extrapolating that figure to about 1000 PA's in Iowa is how we got the \$6,696,000 figure. Even if you cut our relatively conservative assumptions in half, that's still 3.3 million.

And if you require ALL supervising physicians to complete these additional tasks for all of the PA's that they supervise, the figure balloons exponentially!!

*Theresa Hegmann, MPAS, PA-C
Clinical Professor
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Dept. of Physician Assistant Studies & Services
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Reisetter, Sarah [IDPH]

From: Firch, Marvin [IDPH]
Sent: Friday, March 04, 2016 9:23 AM
To: Reisetter, Sarah [IDPH]
Subject: FW: Letter from chairman of the UIHC Family Medicine Dept - please distribute
Attachments: IA Board of Medicine_PA_2-1-16_FM Department UIHC.docx

Public comment

Marvin L. Firch
Interim Board Executive | Bureau of Professional Licensure | APL | Iowa Department of Public Health | 321 East 12th Street | Des Moines, IA 50319 | Office: 515-281-4830 Fax: 515-281-3121 | marvin.firch@idph.iowa.gov

Bureau of Professional Licensure web site: www.idph.iowa.gov/
Bureau of Professional Licensure online services web site: <https://ibplicense.iowa.gov/>

Promoting and Protecting the Health of Iowans

From: Susan Koehler [<mailto:skoehlerpac@gmail.com>]
Sent: Tuesday, February 02, 2016 10:56 AM
To: Firch, Marvin [IDPH]
Subject: Fwd: Letter from chairman of the UIHC Family Medicine Dept - please distribute

Hello Marvin, please forward this to the PA Board and BOM contacts. Thanks
Susan Koehler
acting chair

----- Forwarded message -----

From: **Hegmann, Theresa** <theresa-hegmann@uiowa.edu>
Date: Tue, Feb 2, 2016 at 10:15 AM
Subject: Letter from chairman of the UIHC Family Medicine Dept - please distribute
To: "skoehlerpac@gmail.com" <skoehlerpac@gmail.com>
Cc: "jon.ahrendsen@iaspecialty.com" <jon.ahrendsen@iaspecialty.com>, "pjmolnar@aol.com" <pjmolnar@aol.com>, "mgentry@mahaskahealth.org" <mgentry@mahaskahealth.org>

Hi Susan,

Since Susan Reynolds is on medical leave, and you are currently filling in as chairperson of the PA Board, I thought I'd send this letter to your attention and ask that you distribute it to other members of the PA Board as part of the public comment period process.

Dr. Paul James is planning to fax the attached letter directly to the PA Board, but with the PA board's executive director on leave, there was concern that it might not get distributed in a timely way. (The letter has already been sent to the Medical Board for their consideration.)

If Dr. Ahrendsen and/or Dr. Molnar would like to talk directly with Dr. James about the "minimum standards" joint administrative rule, I think he would welcome the opportunity to speak with them about his concerns. Other

departments at UIHC that will be impacted in a similar way include Internal Medicine and Emergency Medicine, among others.

Dr. Robillard (Vice President for Medical Affairs, UIHC) and the Dean of Carver College of Medicine, Dr. Debra Schwinn, have already publicly announced opposition to both the joint rule (in its current form) and to HF 2041 (the proposal by Rep. Pettengil to eliminate the PA Board), and have asked the Board of Regents to register against HF2041.

In regard to SF505, Drs. Robillard and Schwinn suggested in a letter to the Iowa Medical Society (IMS) that, **“We encourage parties to let the Iowa Board of Medicine and Iowa Board of Physician Assistants work together and come to an acceptable *definition* of supervision.”** Dr. James also recommends this approach in the attached letter. It is not too late to propose a joint definition of supervision to fulfill the requirements of SF505. Such an approach would not be controversial at all, and would allow individual physicians the flexibility to determine supervision requirements that meet the needs of their own practice setting, rather than going down the route of micromanaging physician oversight of PA's in our state, which potentially limits the utilization of PA's and may decrease access to care and increase costs.

Respectfully,
Theresa Hegmann

*Theresa Hegmann, MPAS, PA-C
Clinical Professor
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5171 WL, Iowa City, IA 52242
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University of Iowa Health Care

Department of Family Medicine

*Roy J. and Lucille A.
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200 Hawkins Drive, 01286-D PFP
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www.uihealthcare.com/familymedicine*

February 1, 2016

Iowa Board of Medicine
400 SW 8th Street, Suite C
Des Moines, IA 50309-4686

Dear Members of the Iowa Board of Medicine,

I am writing to provide input on the proposed "Specific Minimum Standards for Appropriate Supervision of a Physician Assistant by a Physician." I am the Chairman of the Department of Family Medicine at the University of Iowa and have practiced clinical family medicine for almost 30 years. I have practiced in 3 states and have had PA supervision responsibilities in each of them. I am deeply concerned about access to care for Iowans, especially rural Iowans; I am concerned about the quality of care that Iowans receive and I am concerned about the rising costs of health care in Iowa. It is thus important for me to express my concern and opposition to legislation found in the appropriations bill (SF 505) that will require onerous administrative requirements by supervising physicians and PA's that will reduce access, yet not improve quality of care.

For example, at the Family Medicine Clinic at the University of Iowa Hospitals and Clinics, there are over twenty different supervising physicians for 2 highly trained PA's. These PA's are under the direct observation of physicians every day, seeking guidance or reassurance in the course of caring for patients. We do have a medical director who has administrative oversight and meets regularly with the PA's. However, expecting the PA to set aside time to meet with every faculty member for whom they may seek counsel may actually reduce access to oversight as we limit the faculty who can supervise. This is an unintended consequence to this legislation.

I thus ask that members of the Medical Board not support the joint rule for "minimum standards" as currently stated. It is important that we not micromanage and add more bureaucracy to a process that has not shown itself to be broken. One recommended approach would be to support a joint definition of supervision like: "Supervision means an ongoing process by which a physician and physician assistant jointly ensure the medical services provided by a physician assistant are appropriate, pursuant to 645 IAC 327.1(1) and 645 IAC 326.8(4)." If specific minimum standards are required, I encourage the Medical Board to consider the location and specifically designate high risk locations that are noteworthy (though I hope this would be based on sound evidence and not conjecture.)

I specifically hope to develop and test innovative team-based delivery care models and I fear that legislation such as that proposed can make it more difficult to implement these types of team-based processes. Thank you for your consideration of my request.

Respectfully Submitted,

Paul A. James M.D.
Donald J. and Anna M. Otilie Chair Department of Family Medicine
Chair & Department Executive Director



3 March 2016

*Electronic Delivery
USPS First Class*

Susan Koehler, Vice Chair, and
Members, Board of Physician Assistants,
State of Iowa
321 E 12th Street, 5th Floor
Des Moines, Iowa 50319-0075

In re: Public Comments to ARC 2417C, relating to: amending ch. 327, practice of physician assistants of the administrative code; request for oral presentation via electronic means.

Dear Vice Chair and Members,

On behalf of the American Academy of PAs (AAPA), thank you for this opportunity to comment on the above-captioned proposed amendment to the administrative code. The AAPA is the national professional organization for physician assistants (PAs) that advocates on behalf of the profession and patient care provided by physician-PA teams and analyzes laws and regulations that impact PA practice. AAPA represents a profession of more than 100,000 PAs across all medical and surgical specialties and has extensive experience with state regulation of PA practice.

AAPA joins the Iowa PA Society (IPAS) in respectfully requesting the board not to proceed with the above-captioned rules. AAPA and IPAS respectfully request the proposed rule amendment be modified to:

- Require the PA board to compile and distribute applicable PA laws to physicians and PAs;
- Create a definition of supervision consistent with best practice and national trends;
- Decline to adopt administrative rule amendments that restate existing requirements or create requirements **not** supported by evidence that the rule will increase patient safety; and
- Not bind future boards from amending administrative rules or grant waivers for compelling situations.

After carefully reviewing the proposed administrative rule amendment, the Academy and the Society also disagree with the jobs impact statement of the board. Based on economic impact estimates as well as a review of peer-reviewed literature, AAPA and IPAS have concluded that the proposed administrative rules amendment will lead to:

- A \$3.1 million burden on Iowa's healthcare system;
- A loss of nearly 54,500 patient encounters; and
- The equivalent loss of 10.6 physicians and PAs practicing in Iowa.

Please find attached:

- Economic Impact of Draft PA Rules: More Administrative Burdens, Less Access;
- Draft PA Rule will be Trouble for Iowa; and
- AAPA and IPAS joint suggestions to improve the proposed administrative rules.

in support of the Academy and Society's position.

AAPA and IPAS urge the board not to proceed with the proposed administrative rule amendments in its current form.

Again, thank you for your consideration. If you have any questions or if I may be of further assistance, please feel free to contact me at 571-319-4315 or apeer@aapa.org.

Best regards,



Adam S. Peer, Director
Constituent Organization Outreach and Advocacy
American Academy of PAs

Attachments

cc: Sarah Reisetter, sarah.reisetter@idph.iowa.gov
Ed Friedmann, PA, Chair, Legislative Committee, Iowa PA Society

ASP:AD:ef

Draft PA Rule will be Trouble for Iowa

December 22, 2015

Summary

The Iowa Society of PAs ([IPAS](#)) and the American Academy of PAs ([AAPA](#)) jointly urge policy makers **not** to proceed with the draft PA rule created by a subcommittee of the board of medicine and the physician assistant (PA) board. IPAS and AAPA respectfully suggest that the draft be modified to:

- Require the PA board to compile and distribute applicable PA laws to physicians and PAs;
- Create a definition of supervision consistent with best practice and national trends;
- Decline to adopt administrative rule amendments that restate existing requirements or create requirements **not** supported by evidence that the rule will increase patient safety; and
- Not bind future boards from amending administrative rules or grant waivers for compelling situations.

Please find a summary of our suggestions as well as our specific suggestions⁴.

Background

PAs are healthcare providers who are nationally certified and state licensed to practice medicine and prescribe medication in every medical and surgical specialty and setting. PAs practice and prescribe in all 50 states, the District of Columbia and all U.S. territories with the exception of Puerto Rico. PAs are educated at the graduate level, with most PAs receiving a Master's degree or higher. In order to maintain national certification, PAs are required to recertify as medical

⁴ See Attachment 1: IAPS and AAPA Suggestions to Current Language

generalists every 10 years and complete 100 hours of continuing medical education every two years.

Towards the close of the last session, the Iowa state legislature enacted legislation⁵ that included a provision that requires the PA board and the medical board to jointly adopt rules that either define supervision **or** create minimum standards of supervision by February 2016. To this end, subsets of the boards began meeting over the summer facilitated by medical board staff to craft a proposal for the full boards to consider. The proceedings of the subsets did not entirely follow the procedure of notice, appearance, and public participation usually expected of public bodies.

Despite a narrow focus, the drafting group has recommended and the respective boards are expected to advance proposed administrative rules unfavorable to PAs, including creating requirements that will:

- Likely **decrease** the number of PAs practicing in Iowa;
- Reduce flexibility and taxpayer savings;
- Fail to allow for emerging models of care;
- Fail to comply with legislative scope;
- Not comply with the recent FTC SCOTUS decision; and
- Duplicate existing requirements and will likely lead to the boards disciplining PAs and physicians for failure to comply with confusing requirements.

⁵ "SF505, DIVISION XXXI PHYSICIAN ASSISTANT SUPERVISION Sec. 113. ADMINISTRATIVE RULES — PHYSICIAN SUPERVISION OF PHYSICIAN ASSISTANTS. The boards of medicine and physician assistants shall jointly adopt rules pursuant to chapter 17A to establish specific minimum standards **or** a definition of supervision for appropriate supervision of physician assistants by physicians. The boards shall jointly file notices of intended action pursuant to section 17A.4, subsection 1, paragraph "a", on or before February 1, 2016, for adoption of such rules." [emphasis added]

Problems with Current Suggested Language

Significant problems exist with the draft as currently presented. These problems have been previously communicated to the subcommittee and both boards.

Potential Loss of PA Jobs

Included in the proposed rule notice submitted to each board for its consideration was the following impact statement:

“After analysis and review of this rule making, **no impact on jobs has been found.**”⁶

[emphasis added]

During the deliberations of the PA board, **no one** could provide any evidence that either:

- Any analysis was performed, especially on such a short timeframe; or
- That there was any evidence that this draft would not have a negative impact on PA jobs in Iowa.

In fact, a survey of the literature suggests the opposite, “States identified as ‘unfavorable’ for PA practice were found to have notably lower PA supply compared to other states. [...] Conclusions; Substantial variation exists in the PA-to-population ratio among states, which may be related in part to state practice laws.”⁷

The American Academy of PAs has identified Six Key Elements of a Modern PA Practice Act, a metric that has been widely acknowledged as a measure of appropriate PA regulation. Currently, Iowa has only one Key Element (licensure as a regulatory term). The current draft would make two other Key Elements (scope determination and adaptable supervision requirements) much worse. There is a “[r]elationship between PA supply and state law. AAPA identified six key elements that enable a practice environment where physician-PA teams are

⁶ See Attachment 2: Draft Rule Amendment, Medical Board and PA Board Subcommittee

⁷ (Sutton, PhD, Ramos, MPH, & Lucado, MPH, 2010)

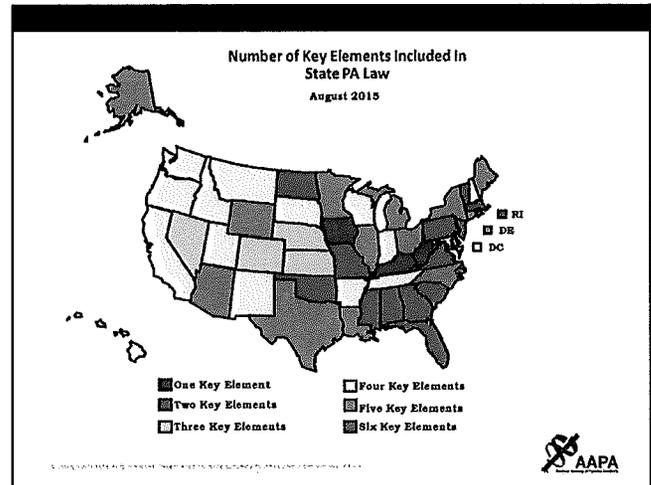


Figure 1: AAPA's Six Key Elements

able to care for patients as effectively and efficiently as possible. In general, the greater the number of these elements that are contained in the practice act, the more favorable a state's laws are considered to PA practice.”⁸

Other research has drawn similar conclusions:

*Although much state variation in use of PAs and NPs in PCP (primary care physician) offices was associated with physician practice characteristics, higher use of PAs or NPs in primary care physician offices was associated with state scope-of-practice laws favorable to PA practice. Uniformity in PA and NP scope-of-practice laws across states could expand access in primary care shortage areas.*⁹

*Improved state legislation has been noted as an influencing effect on deployment of PAs and NPs for 2 decades (Emelio, 1993; Kuo et al., 2013).*¹⁰

As presented, the draft rule would make it much more difficult to employ PAs in Iowa and likely lead to fewer jobs for PAs.

⁸ (Sutton, PhD, Ramos, MPH, & Lucado, MPH, 2010)

⁹ (Hing & Hsiao, 2015, p. 53)

¹⁰ (Hooker & Muchow, 2015)

Flexibility and Savings

States are increasingly deciding that the specific elements of PA-physician interaction should be decided at the practice. This is in response to concerns about patient access to care, and the strong track record of PA practice. Adopting regulations with new restrictions on PA-physician practice would be regressive and out of sync with national trends.

In just the last six months:

- Ohio repealed a statutory requirement that the physician be within 60 miles of the PA
- Oklahoma repealed a statutory requirement that the physician be on-site a half day per week
- Texas repealed a regulation that required 10 percent on-site physician presence

A recent analysis¹¹ concludes that states could save millions in healthcare costs by removing PA and NP practice barriers. The cost analysis found that even modest changes to Alabama PA and NP laws would result in a net savings of \$729 million over a 10-year period.

Conversely, AAPA is not aware of any PA-related study that demonstrates that additional practice barriers either increase patient safety or reduce healthcare costs.

Emerging Models of Care

PAs are uniquely qualified to adapt to new models of care – especially primary care delivery and areas or specialties of provider shortage. PAs directly contribute to:

- Improved access to services;
- Reduced wait times; and
- Improved quality of care

Enacting regulations that require physicians and PAs to meet administrative requirements rather than using

¹¹ (Hooker & Muchow, 2015)

practice hours to care for patients diminishes the ability of teams to meet quality and access goals.

Compliance with Recent Legislative Mandate and SCOTUS Decision

Pursuant to section 113 of Senate File 505, the board of medicine and the board of physician assistants have been directed to “jointly adopt rules pursuant to chapter 17A to establish specific minimum standards or a definition of supervision for appropriate supervision of physician assistants by physicians.” [emphasis added] Additional restrictions would be beyond the directive enacted by the legislature.

Additionally, this will be an early administrative action after the US Supreme Court decision in *NC State Board of Dental Examiners v. FTC*. It will be critical to adhere to the recent guidance¹² issued by the Iowa attorney general, to regulatory boards:

- Is the action anticompetitive? Does it restrict competition?
- Does the action reflect state policy as expressly stated in statute?
- Is there a credible, evidence based demonstration of public need?

IPAS and AAPA urge the board to only adopt rules that are truly addressing a demonstrated issue and to do so with evidenced-based solutions rooted in statutory authority.

A lack of evidence in PA and NP laws in general was noted in one article on PA and NP regulations, “Of primary concern is that the scope with which NPs and PAs may practice depends largely on idiosyncratic political and regulatory considerations, rather than practitioner ability and education¹³.”

¹² Memo from Pam Griebel, Assistant Attorney General, State of Iowa to Professional Licensing and Regulation Bureau, in re: Questions Related to *N. Carolina State Bd. of Dental Examiners v. FTC* dated March 23, 2015.

¹³ (Gadbois, Miller, Tyler, & Intrator, 2014, pp. 3 - 4)

Ease of Compliance

Lastly, to assure ease of compliance, laws and regulations should be easy to understand. The current proposal duplicates or restates many current requirements found in the code and the administrative code. This would require PAs and physicians, in addition to current legal and administrative requirements, to now review several different places in the law to understand how to remain compliant.

Enacting confusing, duplicative or unnecessary requirements may result in the boards disciplining well-intended PAs and physicians not for acts that affect patient safety or health care quality, but for failing to comply with an arcane provision that was difficult to understand.. Additionally, with any new requirements created, PAs and physicians will have to dedicate additional time and resources toward documenting compliance instead of caring for lowans.

Works Cited

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- Hing, M. E., & Hsiao, P. C.-J. (2015, September). In which states are physician assistants or nurse practitioners more likely to work in primary care? *Journal of the American Academy of PAs*, 28(9), 46 - 53.
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IAPS and AAPA Suggestions to Current Proposed Language

Topic	Suggestion	Remarks
(a) Physician and PA review laws	Require the PA board to compile and supply each supervising physician and PA with a compendium of relevant PA laws.	<i>Existing requirement</i> , unders. 645-326.8 (4) IA admin. code, “[...] The physician assistant and the supervising physician are each responsible for knowing and complying with the supervision provisions of these rules. [...]”
	<u>“The board of physician assistants shall compile a compendium of the requirements of physician assistant licensure, practice, supervision and delegation of medical services as set forth in the code and administrative code.”</u>	What would be more useful, however, would be for the board to compile the relevant PA laws and distribute them to physicians and PAs.
(b) Biannual in-person meeting at practice or remote site.	Delete. Create a definition of “supervision”.	Unclear how this would benefit patients. Not consistent with PA practice and new delivery models, e.g. telemedicine.
	<u>“ ‘Supervision’ means an ongoing process by which a physician and physician assistant jointly ensure the medical services provided by a physician assistant are appropriate, pursuant to 645 IAC 327.1(1)¹⁴ and 645 IAC 326.8(4)”</u>	<i>Creating a definition of supervision</i> (based on best practices) complies with the legislative mandate “to establish [...] a definition of supervision [...]”.

¹⁴ “The medical services to be provided by the physician assistant are those delegated by a supervising physician. The ultimate role of the physician assistant cannot be rigidly defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills

Topic	Suggestion	Remarks
(c) PA and physician to ensure the education, et al., of the other.	Delete	<p><i>Existing law provides</i>, under s. 645-327.1(1), “The medical services to be provided by the physician assistant are those delegated by a supervising physician. The ultimate role of the physician assistant cannot be rigidly defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. The physician assistant's services may be utilized in any clinical settings including, but not limited to, the office, the ambulatory clinic, the hospital, the patient's home, extended care facilities and nursing homes. Diagnostic and therapeutic medical tasks for which the supervising physician has sufficient training or experience may be delegated to the physician assistant <u>after a supervising physician determines the physician assistant's proficiency and competence.</u>” [emphasis added]</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(d) Timely communication	Delete	<p><i>Existing requirement</i>, under s. 645-326.8 (4)(a), IA admin. code, “Patient care provided by the physician assistant shall be reviewed with a supervising physician on an ongoing basis as indicated by the clinical condition of the patient. [...] it is the responsibility of the</p>

and abilities necessary to provide those services appropriate to the practice setting. The physician assistant's services may be utilized in any clinical settings including, but not limited to, the office, the ambulatory clinic, the hospital, the patient's home, extended care facilities and nursing homes. Diagnostic and therapeutic medical tasks for which the supervising physician has sufficient training or experience may be delegated to the physician assistant after a supervising physician determines the physician assistant's proficiency and competence. The medical services to be provided by the physician assistant include, but are not limited to, the following: [...]”

Topic	Suggestion	Remarks
		<p>supervising physician and physician assistant to ensure that each patient has received the appropriate medical care.”</p> <p>Required physician notification should be determined at the practice-level not mandated by the administrative code. It would be impossible to determine every situation.</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(e) Mandated chart review	Delete	<p><i>Existing minimum chart review</i>, under s. 645-327.4, IA admin. code, “A physician assistant may provide medical services in a remote medical site if one of the following three conditions is met: [...] b. The physician assistant with less than one year of practice has a permanent license and meets the following criteria: [...] (4) The supervising physician signs all patient charts unless the medical record documents that direct consultation with the supervising physician occurred; or [...]”</p> <p>Additionally, there is <u>no evidence</u> that this improves patient care. Any additional chart review should be determined at the practice-level.</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(7) Annual review	Delete	<p>As defined, “supervision” is an ongoing joint process.</p> <p>As created by this suggested rule, “Supervision’ means an ongoing process by which a physician and physician assistant jointly ensure the medical services provided by a physician assistant are</p>

Topic	Suggestion	Remarks
		<p>appropriate, pursuant to 645 IAC 327.1(1) and 645 IAC 326.8(4)”</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(g) PA services to comply with the code	Delete	<p>The first part of this language requires compliance with several sections of the administrative code. At face value, these are <u>existing</u> requirements.</p> <p>The second part of this suggestion limits PA practice and encourages PAs <u>not</u> to practice to the fullest extent of their education, training, and experience. A PA may provide services with physician supervision, that are delegated, and for which the PA has been qualified by training.</p> <p>It is possible for a PA have acquired a skill in one practice setting that under this proposal would <u>not</u> be allowed in a different practice setting if that physician was not able to perform.</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(h) Physician to be available	Delete	<p>Existing requirement, under s. 645-326.8(4)(b.), “Patient care provided by the physician assistant may be reviewed with a supervising physician in person, by telephone or by other telecommunicative means.”</p> <p>Additionally, under s. 326.8(4), IA admin. code, “[...]In regard to scheduling, the physician assistant may not practice if supervision is unavailable, except as otherwise provided in Iowa Code chapter 148C or these rules, and must be in compliance with the requirement that</p>

Topic	Suggestion	Remarks
		<p>no more than five physician assistants shall be supervised by a physician at the same time, pursuant to subrule 326.8(3)."</p> <p>If a PA had more than one supervising physician, it is unclear how this provision would apply.</p>
(i) Alternative physician	Delete	<p>Covered by existing requirements, under s. 645-326.8 (4), "It shall be the responsibility of the physician assistant and a supervising physician to ensure that the physician assistant is adequately supervised."</p> <p>Instead of mandating <i>how</i> this will occur, current law allows the PA-physician assistant team the flexibility to meet this requirement which could include additional supervising physicians as permitted under current law.</p> <p>Additionally, physicians are already permitted to review patient care via telecommunicative means, per s. 645-326.8(4)(b.), "Patient care provided by the physician assistant may be reviewed with a supervising physician in person, by telephone or by other telecommunicative means."</p>
(j) Noncompliance with administrative code	Delete	<p>How each profession should be disciplined should be determined by each respective board. Boards currently have authority to discipline for non-compliance.</p>
(k) Joint amendment	Delete	<p>Either board should <u>not</u> have the authority to bind future boards. A part of the purpose of administrative rules is to allow the law to evolve more quickly to adapt to changing circumstances and public needs.</p>

Topic	Suggestion	Remarks
		<p>This language is also beyond the legislative scope of SF 505.</p> <p>Either board should be able to amend each board's respective rules subject to the existing administrative rules promulgation process.</p>
(I) No waiver	Delete	<p><i>Existing law provides, under s. 645-327.1(1), "[...] The ultimate role of the physician assistant <u>cannot be rigidly defined because of the variations in practice requirements</u> due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. [...]" [emphasis added]</i></p> <p>One of the hallmarks of PA regulation in Iowa has been the ability of the board to grant waivers when a compelling situation has been presented which is recognized by s. 645-327.1(1). No compelling reason or evidence has been presented supporting this language.</p>



February 19, 2016

Sarah Reisetter
Professional Licensure Division
Department of Public Health
Lucas State Office Building
Des Moines, Iowa 50319-0075
sarah.reisetter@idph.iowa.gov

Re: ARC 2417C

Dear Ms. Reisetter:

On behalf of Iowa's 118 community hospitals, the Iowa Hospital Association (IHA) writes to provide comments on the proposed amendment to IAC Chapter 21 "Physician Assistant Supervision".

Item 1: 645—327.8(147,148,148C,86GA,SF505): Specific Minimum Standards for Appropriation Supervision of a physician assistant by a physician

IHA believes a definition of "supervision" and "supervising physician" needs to be included in this section. No definition of "supervision" or "supervising physician" is offered in the proposed rule and lends no clarity to which relationships are under the rule's purview.

IHA suggests adopting the same definition of supervision found at IAC 645—326.1 (148C), which provides:

"Supervising physician" means a physician who supervises the medical services provided by the physician assistant and who accepts ultimate responsibility for the medical care provided by the physician/physician assistant team.

"Supervision" means that a supervising physician retains ultimate responsibility for patient care, although a physician need not be physically present at each activity of the physician assistant or be specifically consulted before each delegated task is performed. Supervision shall not be construed as requiring the personal presence of a supervising physician at the place where such services are rendered except insofar as the personal presence is expressly required by these rules or by Iowa Code chapter 148C.

Without this clarification, IHA believes the rule is not clear. IHA believes that with this additional language it will be clear to both the physician and physician assistant, who is a supervising physician and who is not. In many practices throughout Iowa, a physician assistant may consult with a physician who is not their supervising physician; this does not make that physician their supervising physician. The physician(s) accepting ultimate responsibility for the care provided by the physician assistant does qualify as a supervising physician.

Thank you for allowing IHA to provide comments.

Sincerely,

A handwritten signature in black ink that reads 'Sara Allen'.

Sara Allen
Director of Government Relations/Staff Attorney
allens@ihaonline.org

Reisetter, Sarah [IDPH]

From: Shawn Janssen <SJanssen@mcclinic.com>
Sent: Monday, February 29, 2016 11:07 AM
To: Reisetter, Sarah [IDPH]
Subject: PA rule changes

This email is in regards to the upcoming proposed changes in PA rules regarding supervision, chart review, etc. Why is there a need for this change when no infractions or concerns have occurred to indicate a problem in the current practicing methods? As a Physician Assistant I am working as a team member in promoting and expanding our practice in service to the patients, not trying to compete with the physician or any referring physician. It is not cost effective for physicians to be in the rural areas constantly and has been shown over time that they do not wish to practice there without a large benefit package! Thus the reason for Physician Assistants practicing in those areas as a cost effective method.

These rule changes only cause more cost to practices and time consumment away from patient care. In a specialty office this means taking time either away from the clinical day or the surgical schedule and thus leads to loss of revenue! There is no physician in this state that is willing to allow this to frequently occur in their practice.

There is a reason that the legislature had made a separate Physician Assistant Board for this state in the past and it has been very effective to date. Allowing the Medical Board to have say over the Physician Assisyant Board is only going to lead to ridiculous and unnecessary issues being brought forth.

Lastly, we must all use common sense in this matter and remember it is ultimately the patient who we are here for, not ourselves and greed. If I do not have a sound, comfortable, communicative relationship with my supervising physicians already to which I know when to reach out for advice, then why would I have taken or stayed in the present working environment and why would I want to stay and practice in this state??

Sincerely,

Shawn Janssen, PA-C
Mason City Clinic
Department of Plastic and Reconstructive Surgery

Reisetter, Sarah [IDPH]

From: Firch, Marvin [IDPH]
Sent: Friday, March 04, 2016 9:23 AM
To: Reisetter, Sarah [IDPH]
Subject: FW: New Physician Assistant Regulation

Public comment

Marvin L. Firch
Interim Board Executive | Bureau of Professional Licensure | APL | Iowa Department of Public Health | 321 East 12th Street | Des Moines, IA 50319 | Office: 515-281-4830 Fax: 515-281-3121 | marvin.firch@idph.iowa.gov

Bureau of Professional Licensure web site: www.idph.iowa.gov/
Bureau of Professional Licensure online services web site: <https://ibplicense.iowa.gov/>

Promoting and Protecting the Health of Iowans

From: Danie Frazee [<mailto:fsdfrazee@aol.com>]
Sent: Monday, February 01, 2016 6:29 AM
To: Firch, Marvin [IDPH]
Cc: Gronstal, Mike [LEGIS]; Hanusa, Mary Ann [LEGIS]
Subject: New Physician Assistant Regulation

Dear PA Board members,

Thanks very much for this opportunity to comment on the proposed additional PA rules. These proposed regulations would add eleven new requirements for PAs and their physicians without any evidence that the current regulatory system is not working or that these new rules will improve patient care or safety.

These proposed regulations would shift authority from the PA Board to a board with no PAs on it, the medical board. Historically, the medical board opposed PA legislation and was unfamiliar with the scope and merits of the physician assistant profession. Previous oversight by the medical board not only limited patient access but also caused PAs to leave Iowa. Thus, legislature created the PA Board with both physicians and PAs on it. That has worked well for the past 28 years. Let us learn from the past.

These new PA requirements would increase our costs and paperwork while decreasing time available to see patients. These additional rules would impose one size fits all rules and unfunded mandates at no benefit to our patients. They would remove the very flexibility, local control and innovation needed for medical progress to occur. Furthermore, none of these new requirements are imposed on NPs who are utilized interchangeably with PAs. This means it will be less expensive to employ an NP than a PA even though both have a similar scope of practice and provide similar care. That puts PAs at a disadvantage in the job market.

Since there is no evidence that the new rules are needed or improve care they should not be adopted as the current PA/physician regulation system is working well it should be maintained.

Additionally, a bill introduced by Reps. Pettengill, L Miller and Vander Linden, HF 2041, would strike the authority of the Board of PAs to adopt rules on the supervision of PAs by physicians and require the Board of Medicine to adopt emergency rules on the matter. I am asking you to oppose this effort to put PAs under the authority of a group opposed to PAs. Iowa tried regulation of PAs by the medical board years ago and it did not work. In fact, there is documentation of PAs leaving the state in the past because of this.

Thanks for considering these comments on this important issue.

Sincerely,

Danie Frazee, PA
Council Bluffs

Sent from my iPhone

Sent from my iPhone

Reisetter, Sarah [IDPH]

From: Baker, Rob <rob-baker@uicms.com>
Sent: Friday, March 04, 2016 9:01 AM
To: Reisetter, Sarah [IDPH]
Subject: PA Board Rules ARC 2417C

Good morning Sarah Reisetter,

As you are well aware of the new rules being proposed, I thought I would just comment on how the "Additional Oversight" will NOT help the PA's in the state of Iowa. The current restrictions in place work WELL! Since these new laws seem to be forced upon us since 2010, I seen NO end to MORE control and senseless paperwork. I've been practicing for the University of Iowa Hospitals and Clinics since January, 1998. I moved here to Iowa as the rules were much more favorable than California, where I was practicing. I've now made a decision to leave Rural Family Practice here in Sigourney, Iowa. I've decided on Emergency Medicine, as the state is MUCH more favorable to NP's than PA's regarding "Billing and Supervision", which favors NP's. This will allow me the opportunity to seek employment in & out of the state of Iowa. Please DO NOT allow these unproven regulations to prevent further PA's from leaving Family Practice of even the state of Iowa.

Thank you for your time,

Robert Baker BS. PA-C
Iraqi Freedom I Veteran

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Reisetter, Sarah [IDPH]

From: Cheryl Cronin PA-C <Cheryl.Cronin@floydvalley.org>
Sent: Friday, March 04, 2016 8:36 AM
To: Reisetter, Sarah [IDPH]
Subject: PA Rules ARC 2417C

I oppose the change in PA regulations for the following reasons:

Both proposed rules would increase PA-physician practice costs \$3-6 million yearly, create unnecessary paperwork and decrease time available for patient care. Furthermore, these proposals go far beyond what was authorized by the legislature by giving the medical board veto authority over PA rules. The medical board continues to be opposed to PA-physician delivered patient care as evidenced by their very restrictive PA rules proposed in November 2015 and support for putting PAs under the medical board again. These proposed rules both duplicate and conflict with existing rules and statutes, are anti-competitive, and are contrary the governor's order that least restrictive regulations be used. *The rules would make PAs the only profession required to be evaluated quarterly to maintain their license.*

Giving the medical board veto power over PA rules and mandating costly, unneeded bureaucratic and anti-competitive PA regulations that decrease access to care is an offer PAs must not accept.

Of course, there is no evidence that the current PA regulations are not working or that the proposed rules would improve care or patient safety. With PA care there is the double safety factor of having both the PA and their physician responsible and liable for the care provided.

Cheryl Cronin PA-C
Floyd Valley Clinics

712-546-3624
712-786-1114



Reisetter, Sarah [IDPH]

From: Haag, James <James.Haag@wfhc.org>
Sent: Friday, March 04, 2016 8:35 AM
To: Reisetter, Sarah [IDPH]
Subject: PA board rules ARC2417C

The proposed PA board rules ARC2417C would increase PA-Physician practice costs, create unnecessary paperwork, and decrease time for patient care. There has been no evidence that the current PA regulations are not working or that the proposed rules would improve care or patient safety. I urge you to keep the current PA regulations in place. If you don't, Iowa will NOT be a PA friendly state. This will lead to the loss of experienced PAs leaving for other states, and will make it very difficult to recruit quality PAs into the state of Iowa. Sincerely, James Haag PA-C.

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Iowa Board of Physician Assistants

Jobs Impact Analysis - ARC 2417C



Iowa Board of Physician Assistants Jobs Impact Analysis – ARC 2417C

Background

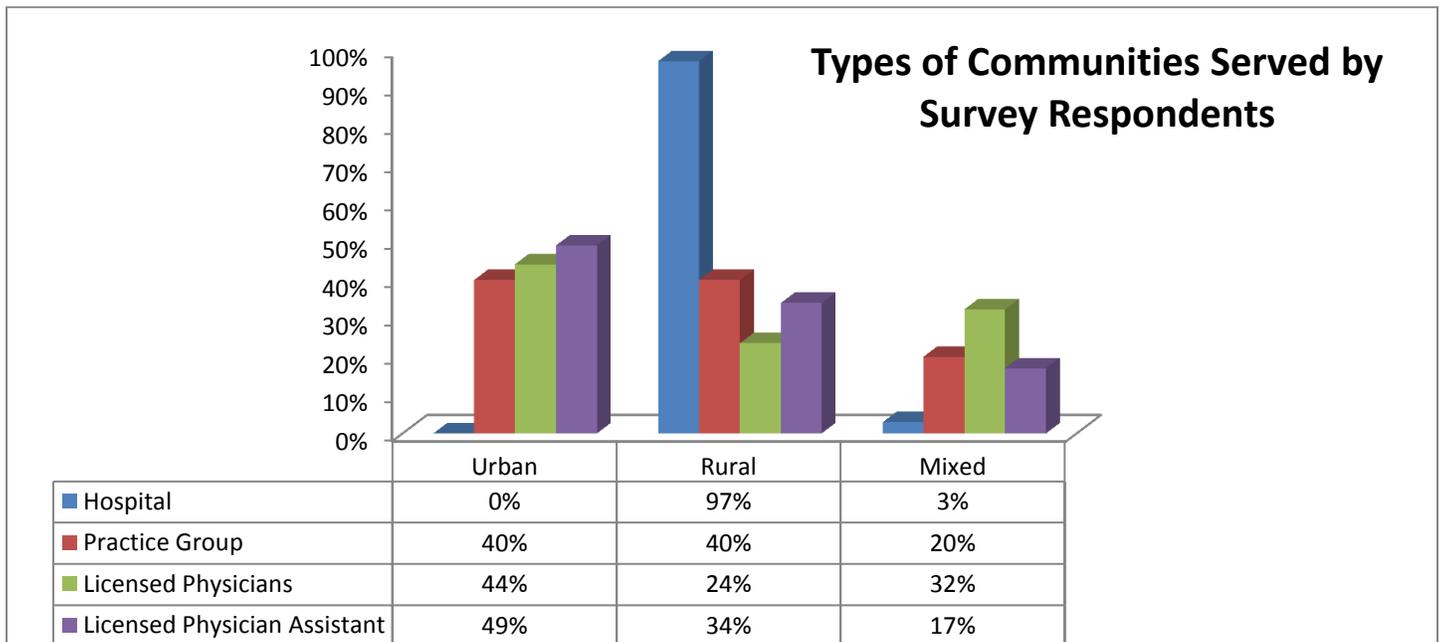
ARC 2417C is the result of a General Assembly rulemaking mandate prescribed by 2015 Iowa Acts, Senate File 505, division XXXI, section 113. Executive Order 71 requires agencies to analyze proposed administrative rules to determine the regulation’s likely impact on jobs in the state of Iowa. The Board originally approached Iowa Workforce Development (IWD) for assistance with analyzing the jobs impact of **ARC 2417C**. IWD indicated this is not a service the agency is able to provide. Therefore, the Iowa Board of Physician Assistants conducted surveys of hospitals, physician practice groups, licensed physicians and licensed physician assistants to determine whether **ARC 2417C**, as proposed by the Iowa Board of Physician Assistants would have an impact on jobs in Iowa.

Survey Respondents

The Board distributed surveys to Iowa hospital CEOs, Iowa physician practice groups, licensed Iowa physicians and licensed Iowa physician assistants.

Survey Group	Number of Survey Respondents
Hospitals	34
Physician Practice Groups	30
Licensed Physicians	34
Licensed Physician Assistants	367

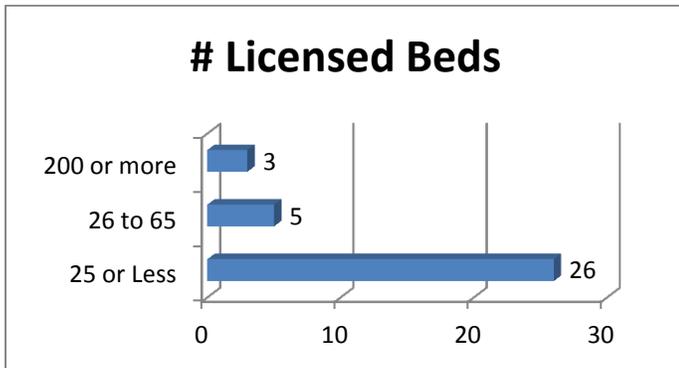
Respondents generally represented both urban and rural Iowa; there was only one hospital respondent from an urban area.



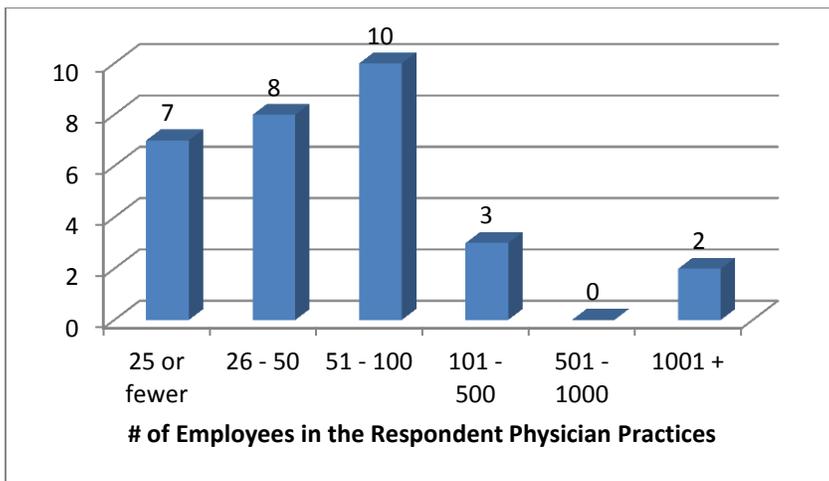


Iowa Board of Physician Assistants Jobs Impact Analysis – ARC 2417C

The hospital respondents were largely rural, with the following number of beds:



The physician practice groups were evenly mixed between urban and rural practices, and ranged in number of employees from fewer than 25 to more than 1,000.

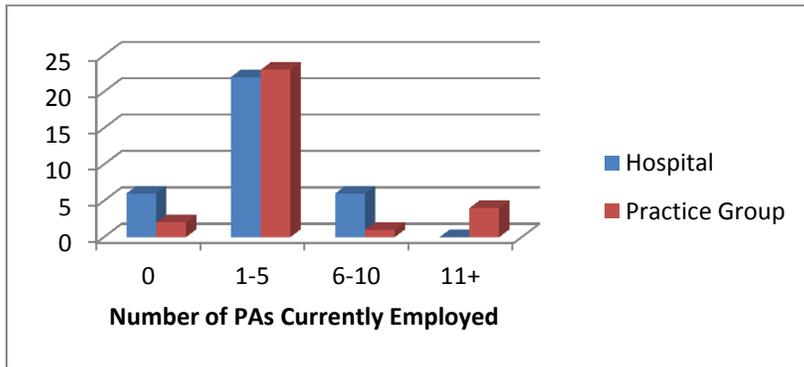




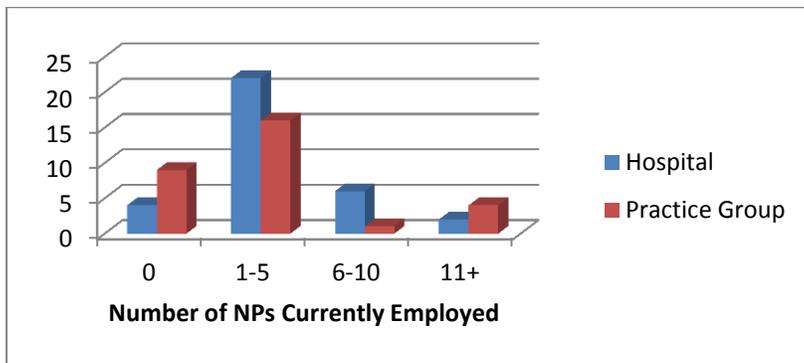
Iowa Board of Physician Assistants Jobs Impact Analysis – ARC 2417C

The responding hospitals and physician practice groups employ physician assistants and nurse practitioners in the following numbers:

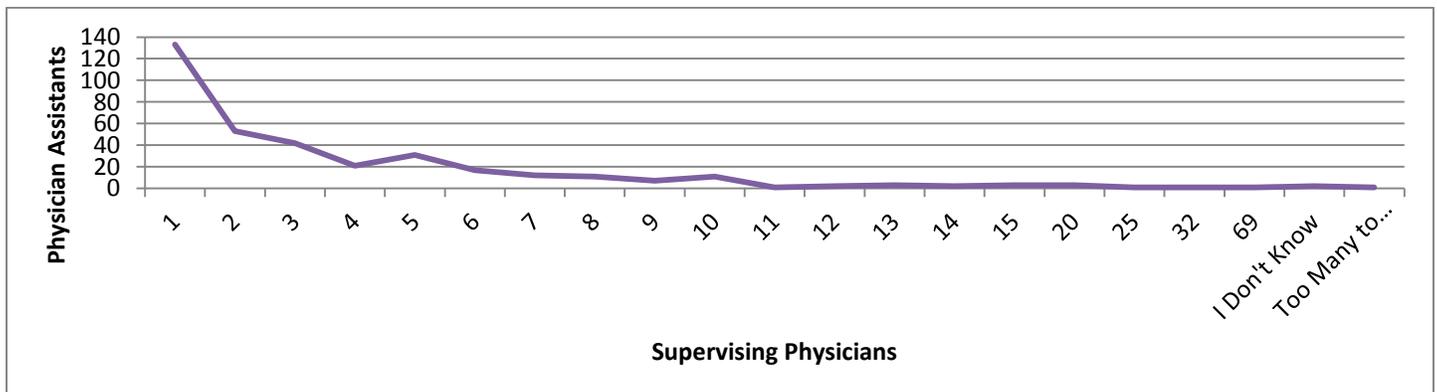
Numbers of Employed Physician Assistants



Numbers of Employed Nurse Practitioners



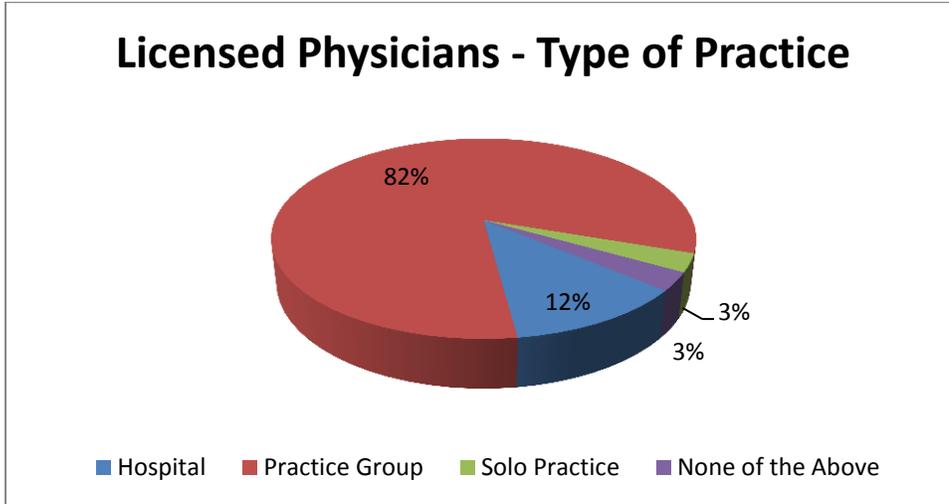
The physician assistants provided information about the number of supervising physicians each currently has, ranging from 1 to a high of 69 in a hospital setting. Two respondents answered that s/he does not know how many supervising physicians s/he has and one respondent indicated s/he has too many to count.



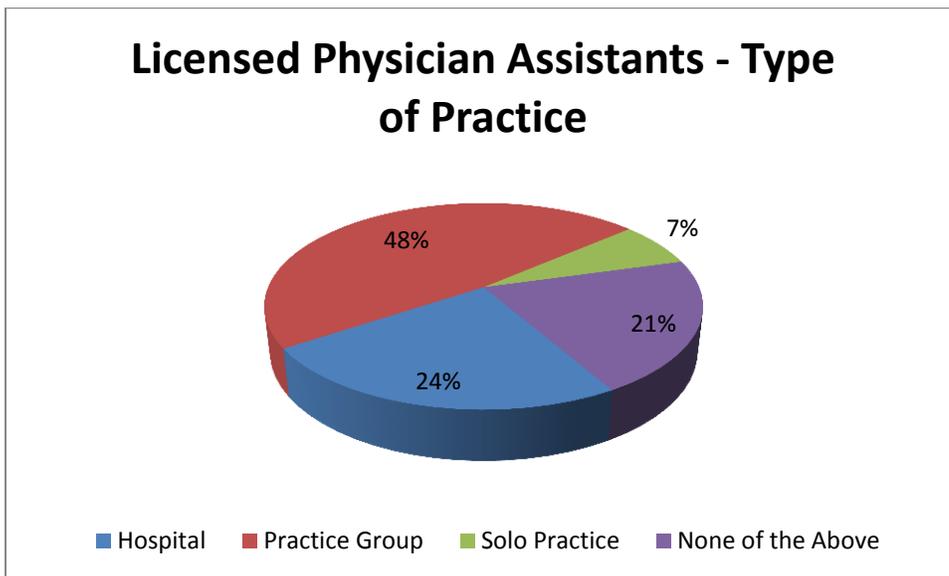


Iowa Board of Physician Assistants Jobs Impact Analysis – ARC 2417C

The licensed physicians who responded to the survey are primarily members of physician practice groups:



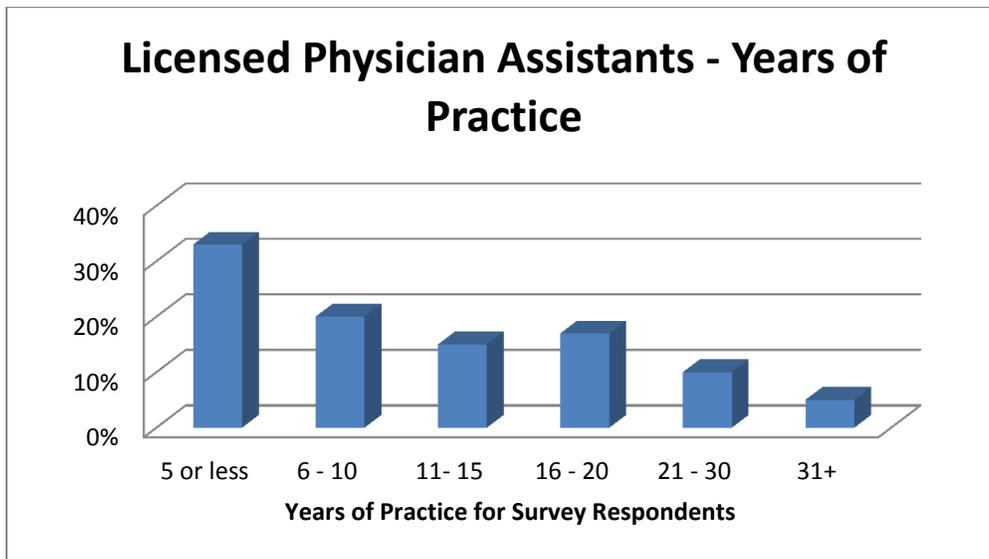
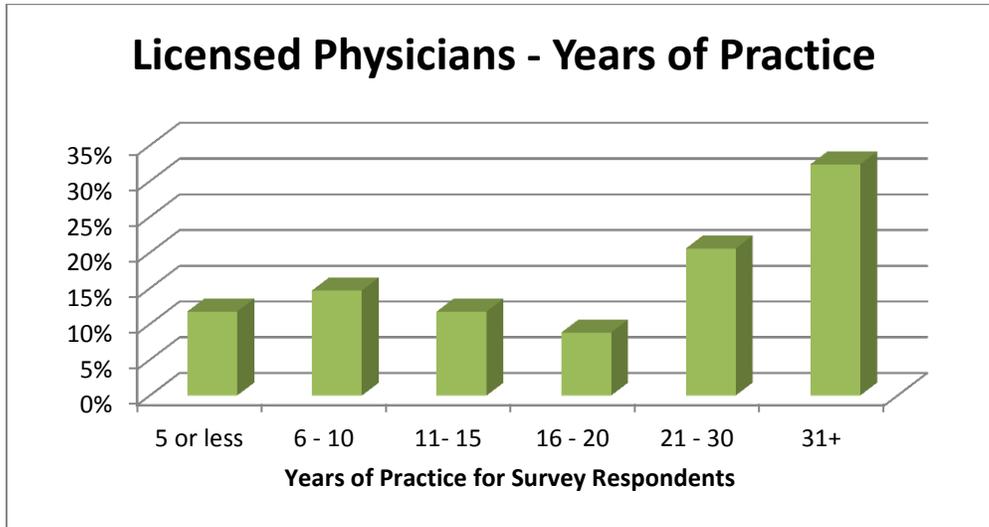
The licensed physician assistants that responded to the survey work in more varied areas:





Iowa Board of Physician Assistants Jobs Impact Analysis – ARC 2417C

Data was also collected from survey respondents regarding years of practice.



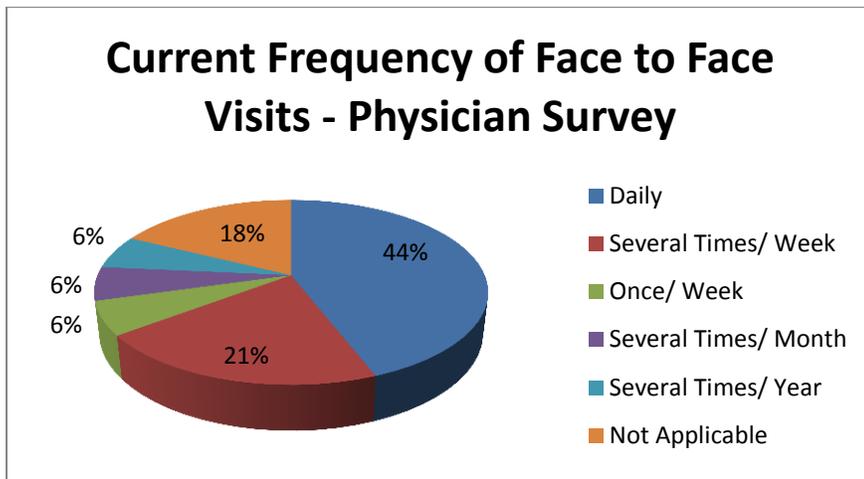


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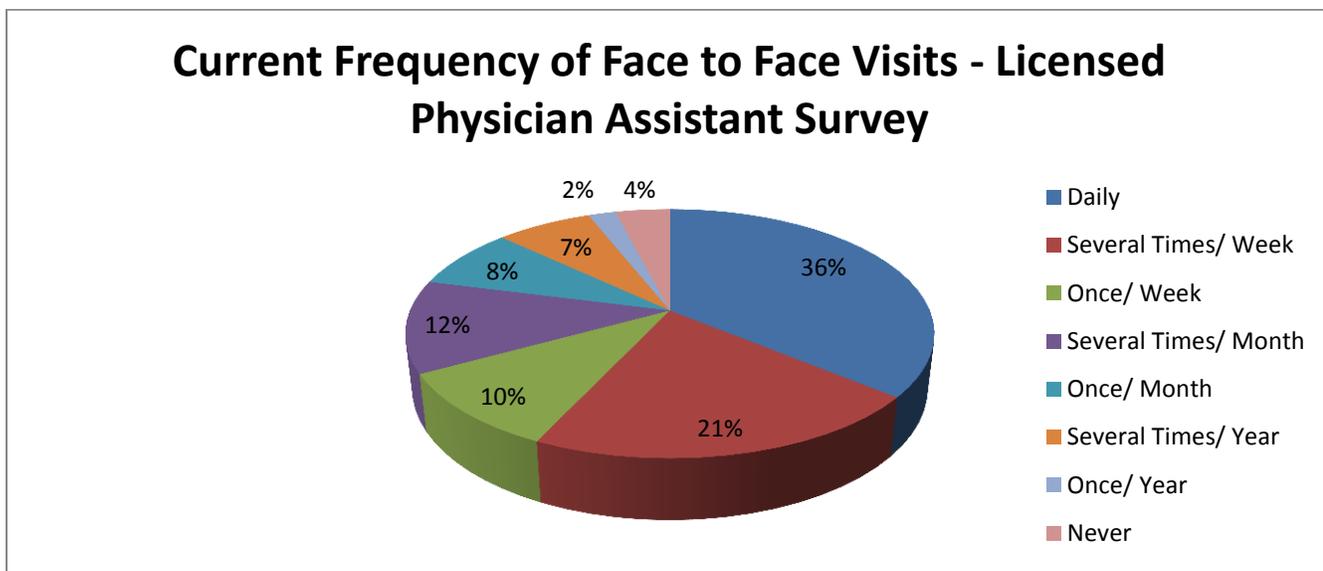
Current Practices

To evaluate the likely effect of the proposed regulations, the Board asked survey respondents to provide information about their current practices.

Frequency of Face to Face Visits - Physicians were asked how often they have face to face meetings with the physician assistants they supervise. Forty-four percent of the physicians that responded to the survey meet face to face with the physician assistants they supervise on a daily basis.



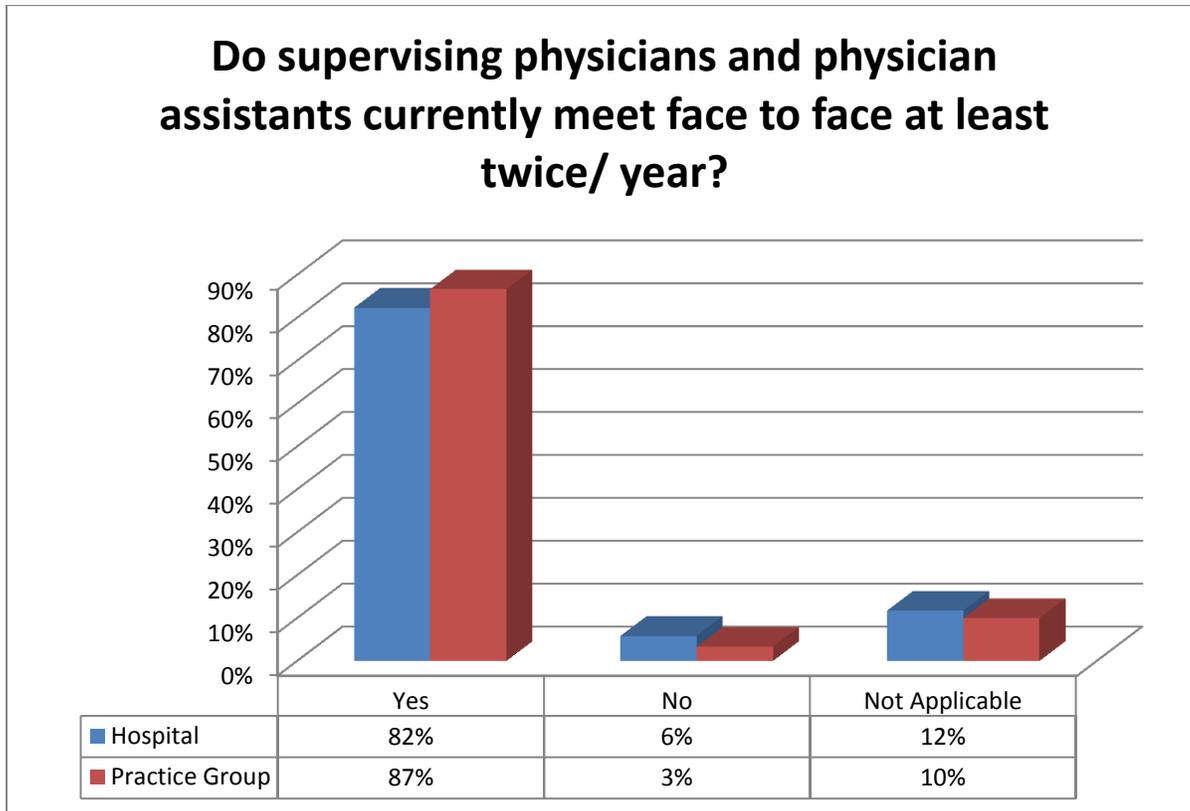
Physician assistants were also asked how often they have face to face meetings with the supervising physician. Thirty-six percent of the physician assistants indicated face to face meetings on a daily basis. Six percent indicated meeting with a supervising physician less than two times/ year.





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Hospital and physician practice group survey respondents were asked whether supervising physicians and physician assistants currently meet face-to-face at least twice a year. Face to face visits at least twice each year would be a new requirement for 6% of hospital respondents and 3% of physician practice group respondents.

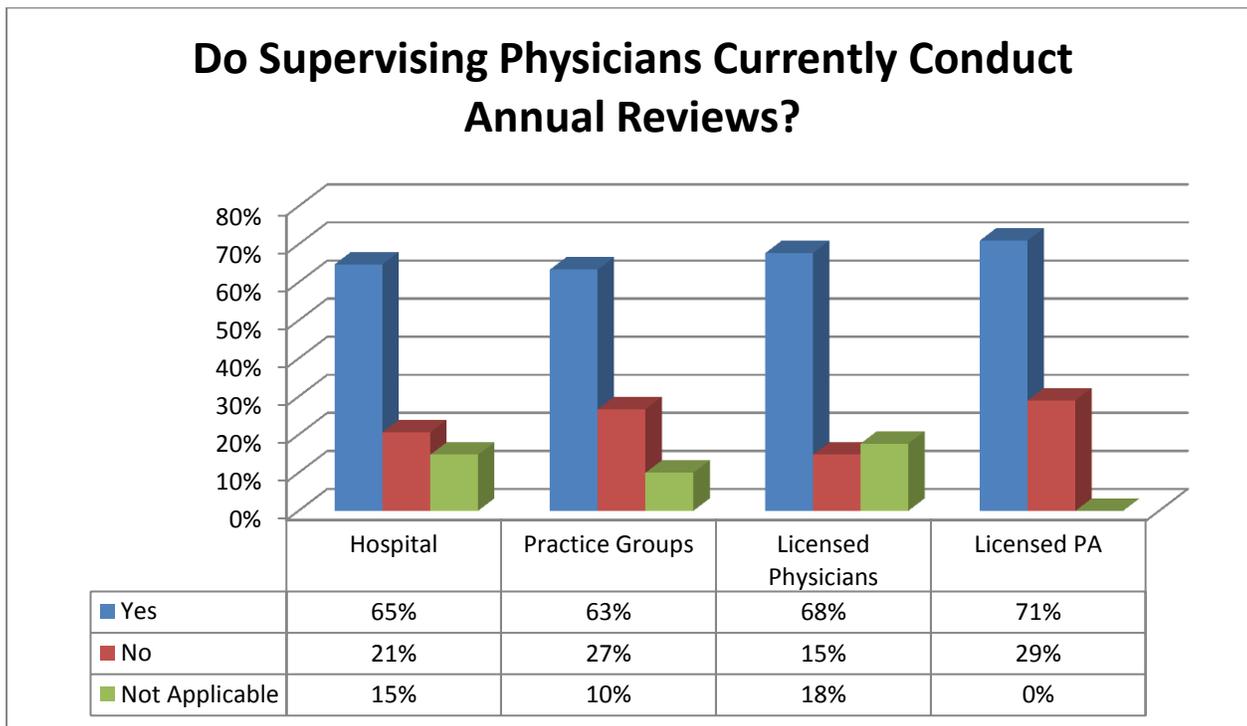




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Annual Reviews by Supervising Physicians

All four survey groups were asked whether supervising physicians are currently conducting annual reviews of the physician assistants supervised. While the majority of respondents indicated annual reviews of physician assistants by supervising physicians are already occurring, a significant number of respondents indicated this would be a new requirement which would need to be implemented if the rule is adopted in its current form.



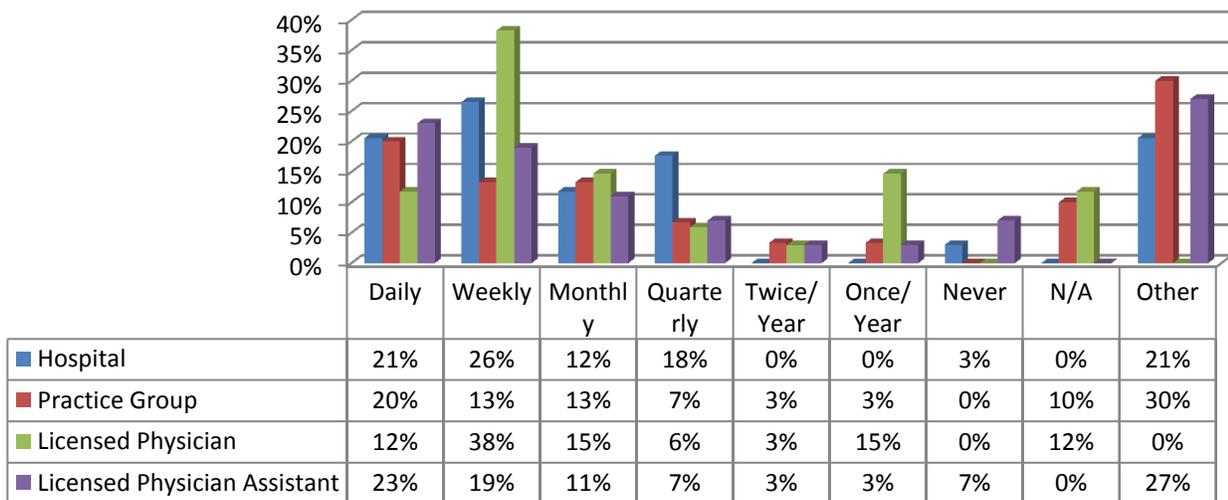


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Frequency of Chart Review

All four survey groups were asked the frequency with which supervising physicians currently review charts of physician assistants. Comments for survey respondents that answered “Other” to this question can be found at the end of this document.

Current Frequency of Chart Review by the Supervising Physician



■ Hospital
 ■ Practice Group
 ■ Licensed Physician
 ■ Licensed Physician Assistant



Iowa Board of Physician Assistants Jobs Impact Analysis – ARC 2417C

Effect of Proposed New Supervision Requirements

Survey respondents were asked whether the proposed new requirements would have an effect on the hospital or physician practice group’s physician assistant hiring practices or on the willingness of licensed physicians to supervise physician assistants. Twenty-one percent of responding hospitals and 20% of responding physician practice groups indicated that the proposed new requirements would either prevent them from continuing to hire physician assistants or would make it less likely that the hospital would hire a physician assistant. Similarly, 26% of responding physicians indicated that the proposed new requirements would make it less likely s/he would be willing to supervise the practice of a physician assistant.

Effect of Proposed Rules on Willingness to Hire or Supervise a Physician Assistant



■ Hospital	79%	6%	15%	0%
■ Practice Group	73%	10%	10%	7%
■ Licensed Physician	65%	0%	26%	9%



Iowa Board of Physician Assistants Jobs Impact Analysis – ARC 2417C

Conclusion

In conducting this jobs impact analysis, the Board of Physician Assistants focused primarily on the 3 proposed requirements the Board considers to be new, additional regulation which does not otherwise currently exist: 1) Face-to-face visits required for all physician assistants at least twice a year, 2) Quarterly reviews of a representative sample of patient charts and 3) Annual review of the physician assistant's clinical judgment, skills and performance by the supervising physician.

The face to face visit requirement appears to be the new regulation that will have the smallest impact as most survey respondents indicated this is already occurring today. The other two new regulations, quarterly review of a representative sample of charts and annual reviews of the physician assistant by the supervising physician will have a greater impact as fewer responding physicians indicated these two tasks are currently occurring.

Most concerning to the Board are the responses to the question about the proposed new requirements having an impact on the employer's willingness to hire or a physician's willingness to supervise a physician assistant. At least 20% of responding hospitals, physician practice groups and licensed physicians indicated these new regulations would either prevent or make it less likely that a physician assistant would be hired or supervised. The Board acknowledges a relatively small number of survey respondents. However, if one were to extrapolate these percentages to develop a statewide projection, there is the potential for a clearly significant (approximately 20%) negative impact on physician assistant jobs in Iowa should this rule making continue to move forward in its current form.

**Comments Regarding Frequency of
Current Physician Assistant Chart
Reviews by Supervising Physicians**

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for survey question about current frequency of chart review by the supervising physician for respondents that marked, "Other, please describe".
1	Physician Assistant	Charts are available for a review as needed. Physician available for questions
2	Physician Assistant	For the first 2 years when I started working with my current supervising physician, we met quarterly and reviewed 10 random charts. That formal practice was dropped when he was comfortable with my skills. At that point I had already been in practice for 10 years.
3	Physician Assistant	Unsure.
4	Physician Assistant	But we talk about treatment and diagnosis several times a week they do not sign off on charts. I have feedback from each sub specialist in there field
5	Physician Assistant	My position was a one on one with the staff covering the service. Minimal charting done by me, my data added to daily note. Clinic notes were open to staff to examine at will.
6	Physician Assistant	Unsure how often our charts are reviewed
7	Physician Assistant	I am not aware if my supervising physician reviews my charts.
8	Physician Assistant	every 2 weeks
9	Physician Assistant	Unsure
10	Physician Assistant	Each day I work I select 2 or 3 or so encounter notes and email them to a supervising doctor. I pick charts that involve more complicated cases and also charts of patients who typically see one of the doctors.
11	Physician Assistant	For complicated issues, I ask specific reviews on cases we discuss.
12	Physician Assistant	After an initial period of reviewing all charts, they now review when I've specifically documented that a consult with them took place, or otherwise as needed.
13	Physician Assistant	If I have any concerns I ask them to look it over. If I have seen one of their pt for a chronic follow up they review that note the next time they see their pt
14	Physician Assistant	as needed
15	Physician Assistant	we submit one chart a day
16	Physician Assistant	I am on contract for PTE and in a unique situation...I believe my notes in EHR are reviewed, but so far there has been no discussion about my work or clinical acumen. In my previous job, my supervising physician signed things PAs can't sign themselves, and also any particular chart we discussed.
17	Physician Assistant	Has to review and cosign all hospital notes
18	Physician Assistant	Only EHR filed records.
19	Physician Assistant	review is done by a combination of the providers at our practice, not just my my supervising physicians
20	Physician Assistant	All charts automatically go to supervising physician as a result of our EMR. I don't know if they actually read the charts or just sign off.
21	Physician Assistant	My organization conducts quarterly chart reviews on all providers. For PAs, half are done by a physician and half by a peer. Otherwise, only if needed or requested.
22	Physician Assistant	unknown
23	Physician Assistant	Every site is different. The trauma center, each chart is reviewed by our supervising physician. In the others, it is quarterly.
24	Physician Assistant	Only when I ask them too in specific cases
25	Physician Assistant	Whenever I see patients from his panel... I write those charts and he reviews those charts before signing off..

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for survey question about current frequency of chart review by the supervising physician for respondents that marked, "Other, please describe".
26	Physician Assistant	twice monthly - every other Friday, my charts from that day are given to him for review
27	Physician Assistant	While my supervising physicians do not do a formal chart review, they are frequently reading my notes and reviewing the care given as we share patients.
28	Physician Assistant	We staff patients every 2 weeks.
29	Physician Assistant	I don't know, we had a process previously but don't know if there is one currently
30	Physician Assistant	Bi-monthly
31	Physician Assistant	They cosign every note
32	Physician Assistant	occasionally for more serious patient problems/visits other than routine issues
33	Physician Assistant	Supervising Physician signs all charts.
34	Physician Assistant	Interaction is ongoing, approximately once per month or more.
35	Physician Assistant	It depends on who the delegating physician is and which hospital or location. Some
36	Physician Assistant	When requested by me personally.
37	Physician Assistant	Unsure
38	Physician Assistant	As needed. This typically occurs when I consult them during a patient's care, when they refill medications for a patient of mine in my absence, clinic wide chart review on specified topics (Diabetes care, HTN care, coding/billing).
39	Physician Assistant	Review 50 percent
40	Physician Assistant	As a new PA my supervising physicians review every chart I complete.
41	Physician Assistant	They co-sign the charts, but rarely review them in the sense that you are asking.
42	Physician Assistant	My supervising physician is the billing coder so she does see all my charts to code them out.
43	Physician Assistant	unsure
44	Physician Assistant	we have a specific QI review here so random charts are pulled on an ongoing basis.
45	Physician Assistant	I send all charts to his inbox and he reviews at his discretion. I flag any chart I think he should particularly be aware of and attach any questions or concerns through electronic staff messaging. He is available by phone or page if a consult is needed urgently.
46	Physician Assistant	As needed, at least monthly is the plan. Also for Q 7, the plan is to do an annual review.
47	Physician Assistant	In the clinic - daily review of x-rays. Daily in-office supervision/review of cases as needed with supervising physician.
48	Physician Assistant	Uncertain
49	Physician Assistant	Unknown, I just started my job last October
50	Physician Assistant	I don't know
51	Physician Assistant	Not on a regular basis - as indicated.
52	Physician Assistant	Again i don't work in iowa
53	Physician Assistant	Varies. Some reviewing weekly, some may review monthly.
54	Physician Assistant	over 90% of charts sent for co-signature electronically
55	Physician Assistant	They review my work but not patient charts unless requested
56	Physician Assistant	Nothing formal, only if he sees one of my patients, or I discuss a case with him.
57	Physician Assistant	one chart each day from that rural clinic

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for survey question about current frequency of chart review by the supervising physician for respondents that marked, "Other, please describe".
58	Physician Assistant	case by case based on pathology findings or complexity of the case
59	Physician Assistant	Occasionally, as the need arises. It could be three times a week, it could be once a month.
60	Physician Assistant	supervising clinicians do quarterly audits, (supervising physician may sign off but the other "senior clinicians who happen to be NPs do the actual audit) other personnel complete other audits on prn basis
61	Physician Assistant	As they deem necessary. Probably once yearly. They read and sign my dictation.
62	Physician Assistant	My supervising physician reviews all of my charts/dictation in Occupational Medicine and a good 30% through Express Care
63	Physician Assistant	Basically never. I do not generate "charts" under my own name. Supervising physicians cosign my EMR entries (discharge summary, h&p,etc.) on a as needed basis--probably at least weekly by above criteria.
64	Physician Assistant	she has access to all charts always.
65	Physician Assistant	Review 20 charts per month
66	Physician Assistant	All notes and work related issues are reviewed as I perform my duties.
67	Physician Assistant	as needed per my discretion with cases
68	Physician Assistant	not scheduled, but challenging patients are discussed several times per week
69	Physician Assistant	we see interchangeable patients often so they are looked at frequently, but per our organization, a case review is done monthly
70	Physician Assistant	no set standard but we share patients so often
71	Physician Assistant	Reviews a percentage of admissions and transfers
72	Physician Assistant	Initially it was daily, I am not aware of how frequent it is currently
73	Physician Assistant	All are co-signed with ER shifts, About 15-20% for Urgent Care shifts
74	Physician Assistant	I ask her to cosign 40-60 a year.
75	Physician Assistant	occasionally - as the need arises
76	Physician Assistant	If there is a problem or concern or if there is an on call issue with patients
77	Physician Assistant	Unknown
78	Physician Assistant	As needed. Sometimes it is daily for some complex patients. Sometimes it is less for more straightforward returns.
79	Physician Assistant	As needed
80	Physician Assistant	also during peer review other charts are reviewed.
81	Physician Assistant	I don't know.
82	Physician Assistant	Two days per week.
83	Physician Assistant	Charts are not reviewed but notes are read as my supervising physician (surgeon) sees each patient again at subsequent surgical follow-ups.
84	Physician Assistant	At least one of my charts is reviewed every time that I work at the urgent care setting and random chart reviews averaging a chart per every other clinic at the other setting.
85	Physician Assistant	We make hospital rounds together daily, I review his notes and orders, he reviews mine. We feel that way we make extremely few mistakes because we catch each other if anything
86	Physician Assistant	once every two months as we are short staffed within our organization and he is the only internist.
87	Physician Assistant	I do not know the answer to this
88	Physician Assistant	once every two weeks on site

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for survey question about current frequency of chart review by the supervising physician for respondents that marked, "Other, please describe".
89	Physician Assistant	usage.
90	Physician Assistant	10% of charts monthly or any pt I staffed with him
91	Physician Assistant	Inpatient unit joint notes
92	Physician Assistant	prn
93	Physician Assistant	My main job my charts are reviewed once weekly. My part time job all of my charts are reviewed because it is a small womens health clinic so the numbers are not high therefore chart review is not time consuming.
94	Physician Assistant	1) The physician who is covering the clinic that I work in for a particular day (there are 6 clinics) reviews a chart for each provider at that clinic each day for QI purposes, through the EMR system. This is needed because there are 39 APP's -> 17 PA's and 22 ARNP's. 2) Occasionally the medical director for the practice group will have all mid-level providers send a sample of about 5 electronic charts (it varies) for review. But some of my backup supervising physicians don't review any of my charts. 3) If any of the PA's or NP's in the practice have concerns about a particular patient, we will send that chart for review through the EMR system to one of the main supervising physicians -- these are often patients that we talked to the SP about by phone already, or patients that we want them to be aware of, or that we have specific questions about.
95	Physician Assistant	At one time 5 random charts reviewed from each shift, but for several years there has been no formal review process.
96	Physician Assistant	As indicated by the acuity of the patients they are directly involved with the care of. This amount of chart review and an annual review of performance is adequate given my experience and our team based approach to patient care.
97	Physician Assistant	As needed, not on a set schedule
98	Physician Assistant	Only if care issue found
99	Physician	You do not define "review", but everyone is reviewed Monthly in some way.
100	Physician	Ongoing...daily, weekly, monthly, (quarterly at a minimum)...as the condition of the patient warrants.
101	Physician	Regularly
102	Physician	I review every chart on every patient they see during their shift with me (Emergency Medicine).
103	Physician	For our NP/PA we are supervising in specialties (nephrology, dermatology, oncology), the specialist in that area does an annual review; for the PA in general medicine, we look at 5 charts/PA/quarter and different primary care providers review their documentation and make comments. Also, these patients are seen periodically by general physician so their is indirect oversight
104	Hospital	We employ 3 pa in our group. We are not hospital based. I do not know how answer.
105	Hospital	one chart daily
106	Hospital	Bimonthly
107	Hospital	Or as needed.
108	Hospital	Do not use PA
109	Hospital	We are in the process of hiring a PA-C to work in our ER, so right now this is not applicable.

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for survey question about current frequency of chart review by the supervising physician for respondents that marked, "Other, please describe".
110	Hospital	We do not hire PA-Cs for the mere fact that there has to be a supervising physician. With the physician shortage it is impossible to have this relationship so we choose not to hire PA-Cs.
111	Practice Groups	New= weekly, experienced = a few times/month
112	Practice Groups	as needed
113	Practice Groups	Twice a month
114	Practice Groups	one chart daily
115	Practice Groups	A few charts each day, not every single chart
116	Practice Groups	With the EMR, it's really easy to electronically send documents each day.
117	Practice Groups	When a PA is new to our practice all charts are reviewed daily. After a period of time and comfort level with documentation, maybe after 3-6 months they are no longer reviewed by the supervising physician unless requested or needed. We have a small practice so there is regular interaction with the PA's and supervising physicians on patient cases informally.
118	Practice Groups	We use EMR, all documentation by the PA in EMR is counter signed the PCP of that patient, if the patient's PCP is the PA then that counter signature is rotated by physician call schedule. Then monthly we have a formal meeting PA, but if there are coaching points noted as the charts are counter signed those are immediately shared with PA. Then a minimum of annually we have full evaluation of the PA including clinical but also behavioral issues (which we find can be more indicative of the quality of care then just clinical knowledge).
119	Practice Groups	The APP's work is reviewed continually as they normally provide shared services in the hospital setting and work incident to in the office setting. Our APP's do not have patients assigned directly to them.

**Other Comments Received on Jobs
Impact Surveys Sent to Hospitals,
Physician Practice Groups, Licensed
Physicians and Licensed Physician
Assistants**

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for the question, "Any additional comments or feedback about the subject matter of this survey can be provided here."
1	Physician Assistant	There is currently no reason for there to be any change with how PA's are supervised in Iowa. There is also no reason for the Board of Medicine to be the sole regulatory board over PA's. The current system has been functioning very well for 20plus years. As a former member of the PA regulatory board, I see no reason to change how the system is functioning. I have heard no logical reasons, or any reasons for that matter, as to why there needs to be a change.
2	Physician Assistant	In regards to question 6 and meeting with EACH supervising physician: I meet face to face with a supervising physician within the same office on a daily basis. As a back up within my call group, I have another supervising physician on my license but have rare face to face contact with him.
3	Physician Assistant	While on service my duties were observed daily and I was instructed on new activities. Part of my position was to train med students, pgy 1-2-3 and fellows in my specialty in conjunction my staff.
4	Physician Assistant	Question #7 Supervision is ongoing as required by the PA law. The annual evaluation is that required of all clinicians and that of the over all RHC performance. No evidence has been provided that the current system of PA regulation is not work. Therefore, this is trying to fix something that is not broken. The proposed additional PA rules (ARC 2372C) are unneeded, not evidence based, highly anti competitive, both duplicate and conflict with existing rules and statutes, contrary to the guidance of the Federal Trade Commission and Iowa Attorney General's Office and national physician organizations, go far beyond what is explicitly required by the statute and are opposed by most of those who will have to take time away from patients to meet these new requirements.
5	Physician Assistant	I currently work with one physician who is a recent grad and she has declined to be my supervisor because she already believes it will take too much of her time to supervise me. Increasing restrictions will only make it harder for me and my supervising doctors and they will be less likely to want to supervise a PA. Already there are certain mid-level positions that my employer only considers NPs for because of the supervision requirements currently in place for PAs. When my employer wanted to hire a provider at a rural single-provider clinic they would only consider an NP and not a PA because of the supervision requirement. If restrictions on PAs are further increased I strongly believe this will diminish job opportunities for PAs in favor of NPs. I am on the verge of retirement and this would be one more thing that would push me toward retirement sooner.
6	Physician Assistant	I have a unique set of skills and more experience than my supervising physician in my specialty, but a new physician has been hired in that specialty so things will most likely change in future.

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for the question, "Any additional comments or feedback about the subject matter of this survey can be provided here."
7	Physician Assistant	Communication occurs daily with my physicians and the evaluation is done by all the providers in the practice not just by one physician. The rules are not needed and It would cost my practice a lot of unnecessary physician time and effort to follow the rules as outlined. It would also interfere with our outreach clinics - would the supervising physician need to visit all the homeless camps that PAs go to. There is nothing wrong with the current rules. The proposed rules would give the Medical Board control over the direction of the profession which would be disasterous. Also with the extra requirments in the rules, the practice will have to start employing NPs and not PAs which would terrible. No other profession in Iowa or in the country that I am aware of, requires evaluations by the supervising physicians in order to be licensed and practice. This is over-regulation at its worst.
8	Physician Assistant	I am face to face with my supervising physicians often due to our proximity at work. I typically work very autonomously and am not usually reviewing charts when we are face to face.
9	Physician Assistant	I think it's important to remember that flexibility is key. A set of specific, directive rules may not work in every setting in which PAs practice.
10	Physician Assistant	Staff an ED, There are 1 or 2 physician on duty at all times, 1 specified Supervising Physician but other are constantly there that are part of the group
11	Physician Assistant	The "Meeting face to face" is only by chance. There is no set meeting. If I have a question or concern I can always call or go find them to discuss a case. I always feel free to ask for help if needed.
12	Physician Assistant	Supervisors are busy, they do not have enough time to do their own charts and see patients., they will not like any strict rule about PA's supervision for time restraints, instead will prefer to hire Nurse practitioners because they do not need supervision. In other words any rule for PA's supervision will make PA professionals less wanted and will also affect PA's salary on the name of supervised practitioners. Also experienced PA's do not need or may need minimal supervision... Experienced PA's see more or equal number of patients then their supervisor but get much less salary on the ground of supervision.... Finally I wants to say we have so many important aspects to think about PA's working situations but NCCPA is more focused about making strict CME and supervision rules... Please be open minded ???? Do you know several of your PA's have MD or MBBS or a physicians degree from other countries... Do you have some rules for them??? I have lot more to say... Please contact me if you feel so...
13	Physician Assistant	With respect to question #6, While I do not see each supervising physician face to face daily (they are not all in the office every day), I meet face to face with a supervising physician several times daily. I do not see how the proposed rules will improve patient care and safety. They will, however, create yet another paper work burden for me and my supervising physicians. My supervising physicians also employ two nurse practitioners. The nurse practitioners and I have the same level of training and the same job responsibilities. Why would my employers choose to hire another PA with they can hire a NP without these types of unnecessary rules? This definitely places PAs at a disadvantage. Iowa has very well respected PA programs. If find it ironic that rules are being considered that will encourage new graduates to seek employment out of state. The current rules are working well and should not be changed.

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for the question, "Any additional comments or feedback about the subject matter of this survey can be provided here."
14	Physician Assistant	As a PA who has practiced almost 24 years it is quite a hassle for my staff, myself and especially the surgeon who is my supervising physician to have to review a "reasonable" number of charts bi-monthly. He knows I would contact him with any patient concerns I may have. We both believe it should be based on the supervising physicians discretion.
15	Physician Assistant	Dissolving the PA board will not give our profession fair representation.
16	Physician Assistant	The current Iowa Physician Assistant's scope of practice oversight is quite adequate. There is published data about the good medical care provided by PAs and over 4 decades of PA provided care which further supports maintaining the current care system. Implementing additional restrictions will place a significant burden on an already swamped health care system and will result in increased health care cost without any evidence of benefit. Restricting Physician's Assistance care by increased monitoring will limit the ability of PAs to care for patients and will likely result in an unintended increase in unmonitored/independent alternate care providers as well. Any consideration of change should include an assessment of Iowa's and other states' current policies and procedures. At this time there is every reason to continue as per national established guidelines and even consider LESS regulated healthcare for Physician Assistant practice. The quality of healthcare provided, both in Iowa's rural and urban settings, will be compromised if additional oversight were to be implemented.
17	Physician Assistant	Some hospitals require very strict chart review which is very tedious for the physicians. Bottom line is when I was new at each position the physicians spent a lot of time reviewing and staffing cases. Now they know my skill and sometimes seek my help. I would also like to point out that NPs don't have all the red tape, which currently makes them easier to hire as well as presents to employers they may be 'better trained' evaluate of the lack of supervision requirements.
18	Physician Assistant	In a group practice it might be hard to identify one physician that is the designated supervising physician. There are 10 practitioners in the group. Many of our physicians have other responsibilities and are not in clinic full time. If PA supervision is assigned to one physician, would patients have to see the PA associated with the physician? Our group works together well and collaborates to provide the best care for the patient on any given day.
19	Physician Assistant	Only one physician conducts an annual review. If the laws would change, this would significantly impact my ability to practice in this state. It would make hiring a PA a burden to this system, so they would switch to NPs.
20	Physician Assistant	for question 6 I meet with my primary supervising physician yearly and as needed she reviews my QI. Because I have over 30 I do not meet with all of them. It would be logistically impossible and very impractical. IK meet with the supervisor of the shift as needed it is not scheduled.
21	Physician Assistant	I work very independently. It has been years since I needed for my supervising physician to actually come into the exam room but I ask for his opinion, advice, and consult a few times a month.
22	Physician Assistant	The over-regulatory burden will cripple our national and state healthcare system. There is no substantiated evidence for a need to change. PA's have become a trusted component to our healthcare team with multiple data points to indicate improved patient access and quality of care. From a training basis alone there is no rational need for more regulation than NPs.

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for the question, "Any additional comments or feedback about the subject matter of this survey can be provided here."
23	Physician Assistant	I have worked for 21yrs with a group practice that was bought by a hospital ~6 years ago.
24	Physician Assistant	I would check over the Nebraska statues....we are comfortable with our legislation.
25	Physician Assistant	I'm not sure if supervising physician does annual review or not. I do have annual review with Chief Medical Officer, and I'm sure he discusses with supervising physician. Supervising physician visits every couple weeks, lets me know if there are any questions, or if he has any additions to various treatments I might provide for patients. I contact him if I have questions. When he is out of office I have a different supervising physician in his group who covers when he is gone. I can always get a hold of someone by phone if needed.
26	Physician Assistant	I think that it is beneficial for supervising Physician's, patients and PAs to have broad supervisory regulations. I think that being restrictive will hurt our practice. We are vital to healthcare in Iowa. I appreciate being attentive and it's important to protect all of us, patients and providers alike, but I would disagree with anything that made the work environment more favorable to hiring nurse practitioners instead. It is my feeling that we are well trained and provide vital services
27	Physician Assistant	My supervising Physician treats me no different than he would if I was a Physician. In fact its not unusual for me to have more challenging cases in my practice than he does.
28	Physician Assistant	I am unclear what help this survey is going to be in providing any analysis of jobs impact for PAs in the state of Iowa if the current rules are implemented. It does not ask any questions that would tell you if the rules are affecting PAs, their supervising physicians, or their patients. Moreover, there is no mention of how many patients a PA sees in a week in this survey. If the intent is truly to determine how many patients would be affected by these rules, then there should be some information on the number of patients a PA sees in a week.
29	Physician Assistant	I work for a group practice with almost 100% of my duties in the hospital/OR with 5 surgeons.
30	Physician Assistant	Why are these additional rules being proposed when the current system IS working? My employer requires review of care provided. Why are the changes being sought when no other health professional's license requires this? NPs do not have these requirements and function similarly to PAs and have less formal training.
31	Physician Assistant	my understanding is that the current system works well
32	Physician Assistant	I think the process should stay the same with the PA board. If it's not broken , then don't try to fix it. The PA board has done a great job, and I have had no problems with it.

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for the question, "Any additional comments or feedback about the subject matter of this survey can be provided here."
33	Physician Assistant	We don't need more regulations. Physician assistants provide high quality healthcare. The proposed rule changes are not evidence based, only political. They will not change the quality of healthcare, but will only serve to restrict access and add unnecessary healthcare costs. Two main points: #1 - It is already VERY difficult to compete with nurse practitioners because they do not have the supervisory regulations we do. These are the same people that do all of their education on line. It can not be made more difficult for us to compete for and get jobs. #2 The telemedicine world is bursting on the scene and we can not be restricted from it. If any change should be made - physician assistants should be released from any physician supervision at all. We should be made autonomous.
34	Physician Assistant	I have worked multiple jobs in the past in both clinic and ER/Urgent care settings. In the ER/Urgent care situations, there are multiple supervising physicians and in those cases, having to meet face-to-face with each one, and have reviews with each one would be nearly prohibitive to our professional practice. Nurse practitioners, who receive less clinical education than PA's do (usually 80 credit hours, compared with 115-130 for PA's depending on the program), have no such requirement. It clearly favors one professional designation over the other, and is certainly not merit based. Please look closely at the facts, and consider why it would be reasonable to adopt restrictive PA-physician rules when the current system is working very well? Why favor one professional designation over the other, (PA vs. NP), especially considering that educational requirements for PA's is clearly more thorough?
35	Physician Assistant	The current proposed rules would be a significant burden in my current clinical setting (hospital based). I have some supervising physicians that I work with frequently and others only rarely if at all.
36	Physician Assistant	I have tried to follow closely the issue of "new rules" for PA practice in Iowa. Sadly, the PA Board was intimidated by legislation passed essentially in secret; then threatened with dissolution to do the Medical Board's bidding. The Iowa Code as it is written now, and the rules prior to June 30, 2015, and our PA Board, have provided competitive PA practice, quality patient care, ACCESS to care in rural Iowa, and NO evidence that public health or patient safety has ever been threatened. Thanks for letting me take your survey. I support the PA Board in holding firm against intimidation. We all support you and wish many more would take your survey. Thank you again for your service.
37	Physician Assistant	I live in a Tri-state area and I primarily work in South Dakota now. I use my Iowa license primarily for Urgent Care PRN shifts that I pick up. I don't have much if any contact with the supervising physician.
38	Physician Assistant	The question 'face to face' does not include the fact that I consult with my supervising physicians often over the phone. This can include them reviewing the appropriate information on the patient's electronic medical record, or a photo of their skin lesion, etc.
39	Physician Assistant	I work independently, but the supervising psychiatrist reviews my charts daily. If he is off, then nobody reviews my charts.

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for the question, "Any additional comments or feedback about the subject matter of this survey can be provided here."
40	Physician Assistant	As a long-practiced PA and well educated I feel any increase in supervision requirements would be time and cost prohibitive for those in rural practice. We already have safeguards for the supervision of new grads. As we move forward in the "ACA world " fewer physicians wish to practice in rural areas and midlevel providers are the answer to this shortage. As PA's we are required to log 100 hours of CME every two years--that is more than Physicians and NP's.
41	Physician Assistant	What the state of Iowa & PA Board currently requires is MORE than adequate for supervision between PA & MD/DO's.
42	Physician Assistant	We need to stay comparative with our NP coworkers and making it harder to practice do to supervision requirements, does not help and makes it less attractive to hire PA and we are in a health crisis where we need all the APP we can to meet pt needs.
43	Physician Assistant	I have so many supervising physicians but some actually never supervise although we must have the option for them to if needed
44	Physician Assistant	Physician assistants were initially meant to provide care in rural areas which still remains a difficult area for recruitment. If supervision rules are changed those who are changing them need to come out to the rural area and work!! Do not put more demands on the doctors or PA in the rural area. Do not make changes that have negative effect on healthcare! Promote the PA as the NP is promoted. We are an important part of the medical world. Survey patients who prefer to see PA's and will miss their provider if rules are enforced that dont make sense.
45	Physician Assistant	Questions 6 & 7 were written in a way that was difficult to answer for my situation, so here is a clarification: I see my main supervising physicians about every other month, usually at provider meetings. One of the two main supervising physicians does an annual review on all PA's and NP's yearly. But I don't see my backup supervising physicians at all (just phone contact or chart review), and the backup supervising physicians don't do annual reviews on any of the 17 PA's and 22 ARNP's in the practice group, but they are listed on everyone's license so that we always have immediate access to a physician for questions.
46	Physician Assistant	Current state law has appropriate level of flexibility for any given PA-physician team to determine what looks best for them. I see the current rule making process as a way to make a clear concise summary of the current law. Any additional rule/requirements would add cost, decrease patient access and is not evidence based to improve patient safety or quality of care provided.
47	Physician Assistant	I have been a PA for 37 years and worked in 3 different states, in various roles and this level of supervision has worked very well for these many years. I have never had any board disciplines nor law suits. Can the members of the Iowa board of medicine make the same claim?
48	Practice Group	Physician Assistant current practices for physician supervision are working. More attempts by the medical board, board of PA's to further promote restricted practice with more supervision will make it even more difficult for PA's to find/retain employment. If the medical board wants to improve things, they would find a way to supervise the state nursing board and quite promoting further practice obstacles for PA's.
49	Practice Group	The main issue is that ARNPs and PAs are used interchangeably here. We believe PAs should mirror the rules for ARNPs currently in place. ARNPs currently have more independence and are therefore a bit more attractive than PAs. That being said- in most of our locations docs and PAs are working side by side so meetings and some supervision/collaboration is not too difficult.
50	Practice Group	Our systems approach is pragmatic for us.

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for the question, "Any additional comments or feedback about the subject matter of this survey can be provided here."
51	Practice Group	Currently, our medical director handles all reviews of PAs and ARNPs. Our supervising physicians review charts and provide feedback as needed.
52	Practice Group	The physicians and advance practitioners (PAs and NPs) working in our clinic see each other daily and have a very good working relationship. The advance practitioners are very comfortable with seeking guidance as needed from the supervising physician.
53	Practice Group	Please do not layer on additional administrative documentation requirements that serve no patient care purpose. Our physician assistants works as a team with our physicians in the care of the our patients. They are supervised and mentored. Do not create additional administrative burdens for our practice.
54	Practice Group	I am the first PA hired at my location. They have used ARNPs typically. I work in our remote site as a solo provider. I go to our home base usually weekly one day a week where I do see my supervising provider, but I do not discuss my clinical skills, etc at this time. This is to see other patients, and another doctor will cover my location. I send a few charts daily electronically for my supervising physician to review.
55	Practice Group	PA's do take a lot of extra supervision so it's always a thought do we hire a PA or NP.
56	Practice Group	Our experience with PA's is they are very informed just like the ARNP's and don't need supervision. They ask other providers or call the supervising physician if any issues.
57	Practice Group	We have hired only PA's in our independent clinic. Through a contract with the local hospital we serve also as Medical Directors for remote clinics staffed by hospital employed ARNP's in remote locations. We have also sponsored ARNP's in their education to become an ARNP through clinical rotations. Quite honestly we find some of the educational programs for ARNP's less than our standards (Online courses then with only 40 hours per clinical rotation). We have also seen some good educational programs for ARNP as well - significant variance We feel as a general observation that the PA is more consistently and better baseline educated than ARNP's, therefore we have restricted to hiring PA's for our clinic. When we hire a new graduate we understand they need added oversight and that does not scare us. Experience has shown them to be willing for that oversight. When it comes to the periodic meetings with the PAs the more experienced with greater real world knowledge, we find those meetings easy to prepare for. Why would you be concerned about additional meetings if the staff you are meeting with is competent and the meetings support that? If our clinic were to hire an ARNP we would require the same oversight requirements as PA's. We could understand a reduction of formal oversight requirements after years of service in the specialty they are working for. Example after 5 years in Family Medicine position then reduce need, but then if they then take cardiology position then oversight starts over.
58	Physician	1. I previously worked in a rural setting x15 years and spent 1day/week at the more remote site supervising the PA there. While I feel 48 visits/year may be in excess of what is necessary to supervise, it provided our rural patients another set of eyes and ears and an alternative practitioner to visit on a regular basis. I believe the desires and best interests of the patients are being left out of this discussion. 2. For the remote sites, I propose 10-12 visits/year (averaging 1/month but allowing leeway for vacation scheduling), with a structured chart review 2-4x/year and a formal review 1x/year (taking place at the remote site). That formal review can be one of the 10 visits. 3. My employer had no defined policy re chart review. I employed the policy I had as a former CMO of an FQHC to review the chart of any patient on whom there was a question from my PAs or regarding whom I received calls as the on- call physician. My PAs also called me regularly re questions (easier to manage with an EMR) and kept a list of patients whom they wanted to discuss face-to-face re long-term management.

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for the question, "Any additional comments or feedback about the subject matter of this survey can be provided here."
59	Physician	<p>Actually I am retired and you may want to discard my survey reply. I hired a PA in 1975 and fought very hard to get approval and blessing by my colleagues. I supervised him as a solo doc until I sold practice to the hospital who then hired the PA, and I (as an independent contractor) supervised him until my retirement in 2005. I believe our relationship was as the original PA concept was intended. He recently retired and felt that his supervision after my retirement was "superficial" at best, and "non-existent" at worst. I'm certain that the present medical climate would not agree that daily contact between PA and supervising physician was necessary or even wise. I firmly believe, having worked with a very capable PA for 30 years, that both of us practiced better medicine than is being practiced by today's loosely supervised PAs or by those Doctors who are loosely supervising a PA. Who bears responsibility for such (i.e. with twice a year "face-to-face") PA's decisions and care? I would refuse to be in any way involved if such a loose arrangement existed and I do not think that the Medical community should tolerate it. I believe it is an abrogation of responsibility for good medical care! Medical doctors should determine and define, good medical care, not PAs, or government officials. The public should not stand for any (PA) "lobby" dictating how medical care should be administered or paid for.</p>
60	Physician	<p>I already review 5 charts a day from each of the providers I supervise. Adding a reporting requirement would just complicate things.....</p>
61	Physician	<p>I am at the Iowa Medical and Classification Center (IMCC), in Coralville. We have some infirmary/inpatients as well as long term and all of the male intake offenders for the State DOC. We have a PA that has a split-shift (10:30A-7P). He is by himself, after 4:30P and does very well. He always has access to the on-call physician, as needed. I see him daily during the early portion of his shift and we can discuss anything that we feel needs to be addressed. His annual evaluation is completed by the DOC Medical Director, with input from myself and the other physicians at the facility. With the new rules, the face-to-face visits would be conducted by the DOC Medical Director since he does the evaluation and one of those could count as one of the face-to-face encounters.</p>
62	Physician	<p>seek the advice of the physician on staff for moderately complex cases because they understand their limits and what they don't know. At a previous practice with PA and NP supervision dictated by my employer who offered minimal time for supervision, many of the midlevels referred themselves to their patients as "doctor" and assumed a posture of independence losing a sense of their limits and offering substandard care on chart reviews. The ones who did not self identify as "doctor" were often stressed by NOT having adequate supervision.</p>
63	Physician	<p>In my previous practice, I oversaw three PAs. I would visit them every two weeks and feel that the rule should remain.</p>
64	Physician	<p>It will be easier to hire NPs if that becomes the new requirement</p>
65	Physician	<p>PA's I've worked with seem well trained. NP training seems much much more variable, and it is frustrating that NP's have such a free reign to do what they want in practice and there are such supervisory requirements for PA's. It makes the NP's seem more desirable, but they aren't.</p>
66	Physician	<p>Physician assistants are not independent practitioners. There are well-established educational pathways to become an independent practitioner: medical school or ARNP training. PAs should not ask the legislature to change by rule what they have not done in education.</p>

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for the question, "Any additional comments or feedback about the subject matter of this survey can be provided here."
67	Physician	Right now, looking at 4 charts/PA/quarter is reasonable and I think it is helpful. However, the degree of helpfulness varies with who is doing the chart review. I think the best feedback to have the supervising physician shadow a single encounter once per quarter and make comments based on that observation and documentation. That is reasonably easy and may actually affect beneficial change.
68	Physician	Specialty practices should have a higher standard of oversight....This often goes unaddressed....As a dermatologist, many offices in Iowa and other states with lax regulation do not have adequate oversight of extenders....Patient's right to know is not addressed in Iowa... https://www.aad.org/File%20Library/Global%20navigation/Member%20tools%20and%20benefits/AADA%20advocacy/State%20affairs/Policies/AADA-PAD-ID-Badge-Regulations-Support.pdf Many patients do not realize that they are getting billed specialty rates when they are not even seeing a physician....
69	Physician	The clearer rules may create some more effort, but in my opinion simply codify best collaborative practices.
70	Physician	The language in the proposal is so poorly defined that it is hard to judge how to answer these questions, as are these questions themselves. To get meaningful feedback takes a conversation, not this kind of Monkey survey. (Questions 7 & 10 do not have an appropriate answer for me/us, but the system forced me to answer.) My basic question from the beginning remains unanswered - what problem are we trying to solve with these new rules?? As an outsider, it appears at issue are egos, and not any quantifiable health risk to the public.
71	Physician	The physician assistants I supervise are top notch and very thorough and thoughtful in their patient care and documentation.
72	Physician	The system we have currently works quite well. Does the Iowa PA board have no better use for their time than to fix something that is not broken? The new requirements certainly make me more likely to hire nurse practitioners in the future, despite the fact that I believe the training of PAs to be superior to that of NPs. If you're not careful, you'll regulate yourselves right out of a job.
73	Physician	(regardless of what the paperwork shows) and more importantly, with inappropriate supervision, such as when a plastic surgeon supervises PAs practicing dermatology. Although many people might think that expanding PAs and their practice scope would improve access to care, especially for rural Iowans, my experience is that these providers are often motivated by financial incentives and practice lucrative, high-cost, procedure-heavy specialties without the same standard of care or knowledge base. And patients don't know the difference.
74	Physician	There are substantial gaps in their knowledge and they feel free to ask what they should do. Which is discussed in a professional manner
75	Physician	Though the face-to-face encounter would certainly make things easier from one perspective, the quarterly chart review and annual review would likely be more labor intensive than the current face to face encounter and patient care discussions every 2 weeks
76	Hospital	Because our mid-levels work side by side with our physicians their work is being evaluated on an on-going basis. Additional formal chart review beyond the chart review we already provide would essentially an exercise in pushing additional paper around in order to meet requirement and would not improve quality.
77	Hospital	defining supervision is difficult and if both the Nurse Practitioner and the PA had the same supervision requirements it would make it much easier for the physicians.

Iowa Board of Physician Assistants
Jobs Impact Analysis - ARC 2417C

	Survey	Comments for the question, "Any additional comments or feedback about the subject matter of this survey can be provided here."
78	Hospital	Not sure how #9 would impact us, but it seems like it could put a physician in an awkward spot. In our case the PA-C we are looking to hire has been excellent in our ER, has had higher reviews than our physicians at times.
79	Hospital	Our Pa are great. We would keep them for sure if we had to meet twice a year. However, it may be different in hospital setting.
80	Hospital	The current oversight requirements make employing PAs difficult and work intensive for physicians. Anything to reduce the burden of this oversight would be a benefit for hospitals, physicians, and PAs.
81	Hospital	The new rules would impact the PA profession negatively. It would increase the demand on the supervising physicians to hold the extra reviews, review a greater number of charts, decrease the amount of time PA's could see patients, and cause further time constraints on the supervising physicians. It would be a serious detriment to the profession to enact such legislation. Thanks for your time and consideration in this matter.
82	Hospital	This level of oversight seems important and appropriate to enhance collaboration, increase opportunities for development and growth in the practice, and support of an effective approach to team-based care.
83	Hospital	We do not hire PA-Cs because of the regulatory requirements.
84	Hospital	What are the concerns? MD or DO review all documentation for PA's currently. I don't think we need to add additional oversight unless there is a safety issue. Also if this is going to be done on PA's then MD's and DO's should have the similar review process, because if it is a safety concern for treatment that is not only confined to midlevels.

February 29, 2016

Dear PA Board members,

Thank you for this opportunity to comment on proposed PA regulation ARC 2417C. Since the current system of PA regulation is working well there is no need to create additional rules. Such action will only increase costs and decrease time to see patients. Certainly there is no need evaluate PAs quarterly. No other profession has such a frequent requirement.

I am a physician and surgeon who supervised PAs in rural Iowa for more than 15 years. I have found PAs well trained, conscientious practitioners who often were the only source of medical care in a small town. Today with PA-physician communication is readily accessible through means that include smart phones, electronic health records, and telemedicine.

Physicians should decide how frequently a doctor visits a PA staffed clinic, not a one size fits all regulation. Allowing doctors to decide PA clinic visit frequency has already been proven to work in 29 states. Such flexibility is recommended by national physician organizations. And it is allowed by the 2014 regulations for federally certified rural health clinics. Physician supervision is still required in these clinics but can occur via telemedicine, smart phones and remotely accessible medical records

With PA care, there is a double safety factor because physicians and PAs are both responsible and liable for the care provided. That has proven to work well for more than 40 years in Iowa. Such care should be continued and encouraged as it is in the best interest of patients.

The physician-PA method of care delivery is working well. That is providing medical care to many small towns in Iowa. There is no evidence that such care needs to be further regulated and restricted. That would only increase costs and decrease availability of care. Instead measures to increase regulatory flexibility such as allowing a physician to decide how frequently to visit their PA clinic should be implemented. The use of modern communication technology like telemedicine should be encouraged as that would benefit patient care instead of restricting it. Thank you for considering my suggestions.

Sincerely,



Walter Eidbo, M.D.

3201 Wauwatosa Drive
Des Moines, IA 50321

Reisetter, Sarah [IDPH]

From: Joshua Pruitt <pruitt.eciac@gmail.com>
Sent: Thursday, March 10, 2016 10:07 PM
To: Reisetter, Sarah [IDPH]
Subject: ARC 2417C

Follow Up Flag: Follow up
Flag Status: Flagged

Sarah,

I am writing to humbly request that the PA Board and the IA medical board find something better to do with their time than try to fix something that isn't broken, namely our PA oversight rules. The business in which I am a partner currently employs 9 PAs. If these proposed rules go into effect, we will be forced to move to hiring solely ARNPs as our allied health providers. The proposed rules are ridiculously time-intensive and burdensome. In our business, time certainly equals patient encounters which equals money. This means that ARNPs will be less expensive to employ with broader patient care privileges. The PA Board is about to regulate their members out of a job if they approve these measures.

Sincerely,
Josh Pruitt

JOSHUA PRUITT, MD, FAAEM

Medical Director, Jones Regional Medical Center Emergency Department/Anamosa Area Ambulance

Medical Director, LifeGuard Air Ambulance

Deputy Medical Examiner, Linn County, Iowa

Emergency Physician & Treasurer, East Central Iowa Acute Care

Board Member, American Academy of Emergency Medicine, Great Lakes Chapter

Pruitt.ECIAC@gmail.com

Cell: (319) 899-2794

Reisetter, Sarah [IDPH]

From: James Rusch <ruschpa@longlines.com>
Sent: Saturday, March 05, 2016 10:26 PM
To: Reisetter, Sarah [IDPH]
Subject: Proposed rules

I am once again disappointed that the state I have lived in since birth continues to be short-sighted with regard to my profession. I am proud of the Physician Assistant profession. I spent a great deal of time and money to get qualified to work as a PA. I continue to spend countless hours and dollars maintaining the education and training to provide quality health care. All PA's in this state are required to work under the supervision of a physician and are closely supervised by that physician. What is the purpose of restricting the physician - PA relationship? The physicians in this state are more than qualified to assure quality care by themselves and any of their PA's. Nurse practitioners are not required to function with supervision at all. PA's are more qualified and train with Physicians. Why are they deemed to be less capable when they perform their duties with a physician who is aware of their capabilities and routinely monitors their activities? We need legislation which allows the physician - PA relationship more latitude not less.

Reisetter, Sarah [IDPH]

From: Frankie <frankie@integrativemc.com>
Sent: Wednesday, March 09, 2016 8:26 PM
To: Reisetter, Sarah [IDPH]
Subject: ARC2417C

To whom it may concern:

Physician assistant rules are currently clear, adequate and appropriate to regulate physician assistant practice in Iowa. The proposed rules (ARC 2417) achieve no purpose and will create increased costs and decreased provider access. Those promoting these rules fail to understand that PA supervision is ongoing at all times regardless of the proximity of the supervising physician. The PA is responsible for appropriate medical practice all the time and concurrently the physician is continuously responsible for that appropriate medical practice by delegated authority. The idea that signatures in a chart reviewed once week or once a month represent supervision fails to understand the ongoing duty of the PA and physician supervisor. How is it we can trust someone to safely and competently provide care to patients every day only if an arbitrary schedule of in-person physician oversight occurs? These rules are ridiculous and expensive and will damage the good PA practice rules currently in force. Worse than that, these rules will damage PA practice in Iowa. This state really can't afford to worsen provider access.

Sincerely,

Mary F Winegardner, PA-C, MPAS
IA 722

Reisetter, Sarah [IDPH]

From: Mike Farley & Mary Timp <mikemaryjean@gmail.com>
Sent: Monday, February 29, 2016 3:08 PM
To: Reisetter, Sarah [IDPH]
Subject: Ill advised ARC2372C

Please add my name to those other Iowans and health care organizations AND the vast majority of the Iowa Legislature who oppose new administrative rules as they are superfluous and harmful to patient care delivered by PAs in our state.

Access to care, timely effective care, emergency care, preventive care, chronic disease management and care close to home have been EXPONENTIALLY improved in Iowa in the 40 years since PAs have been practicing here.

Why would the Iowa Board of Medicine, or the Board of Physician Assistant Examiners want to do anything to harm PA practice in Iowa? You can NOT show that ACCESS to care, patient SAFETY, or cost SAVINGS will result with the adoption of these rules. So, why are these proposals on the table? The legislature did NOT intend this result.

PAs favor common sense rules and regulations to practice in Iowa. We have championed the Physician-PA team concept of patient care and will continue to do so, if allowed.

Please vote down the current noticed rules for PA supervision and practice as unneeded, onerous, anti competitive, and a thinly veiled attempt to make our Board meaningless. Do not be intimidated by their lawyers and the VERY FEW legislators who support a vendetta against PAs.

Consider rewriting common sense rules that are either similar to the status-quo or in line with federal guidelines of Physician-PA supervision. I will support you. Your IPAS supports you. The vast majority of the legislature supports you and the vast majority of Iowans support you. I will attend the 4/20/16 BPAE meeting to support you.

Thank you for your work for PAs and all Iowans.

Sincerely,

Michael Farley, PA-C
3221 SW 33rd Street
Des Moines, Iowa 50321

Please forward this letter to the individual PA Board members, and counsel for the PA Board.