2019 HOUSE HUMAN SERVICES

HB 1175

2019 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB1175
1/28/2019
31576

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature: Nicole Klaman by Caitlin Fleck

Explanation or reason for introduction of bill/resolution

Relating to regulation of physician assistants (PA's).

Minutes

1,2,3,4,5,6,7,8,9,10,11,12

Chairman Weisz: Opened hearing.

Supportive testimony.

Representative Devlin: (**See attachment 1)**

Duane Houdeck, ND Academy of PAs: Introduced Dr. Leingang.

Dr. Gordy Leingang: (**See attachment 2)**

Mr. Houdek: (See attachment 3)

Representative Rohr: Section 2 excluding imaging, does that include chest X-rays or determine fractures?

Mr. Houdek: I better differ to the PA's here.

Representative Porter: You talked about the continuing education (CE) requirements. Typically, we have put that in the Century Code because some boards we're not going to impact. Do we need to reference back to maintain certification at national boards level? Their CE and those kinds of things like we've done with other professions as we have morphed them out onto their own.

Mr. Houdek: I believe it's already covered. In order to get a ND state license, you have to be nationally certified. And in order to be nationally certified you have to take the exams and do the CE.

Representative Porter: We have had issues in the past where we have expanded practitioners and then the board decides to break ties and continuing education is not being done because of the recertification requirements were to much. I feel due to history; we are leaving a lot of the rules part out.

Mr. Houdek: This is how it's been at the board forever, since the licensure. The CE is far greater for PA's than doctors or nurse practitioners, and I don't see anything on the horizon would cause them to look the other way. I know that doesn't address the future, but that hasn't been the position of the board.

Representative Porter: I appreciate that. The problem is when the move is happening to make the profession independent, then they used to be under the physician and under that umbrella, even though the national boards are still a requirement, it probably wasn't as important because the PA was under someone else. Now that we are moving towards the independence, the tie back top that national standard and CE needs to be independent as well.

Mr. Houdek: This bill, although it is seeking to get rid of that supervisory contract to one specific physician, is not seeking independent practice. It states that they will practice within a physician owned facility or within an institution that has a credential. The one exception to that is if the board of medicine finds an area of unmet or underserved and they find a PA to provide under met needs, they can specifically approve an independent practice. That will be very rare though. Otherwise they have to remain in the credential organized practice.

Representative Skroch: Section 4 pg. 4 describes PA and how they may describe themselves, I'm confused as to the wording in lines 30 and 31 on page 4 and lines 1 and 2 on page 5, can you explain those please?

Mr. Houdek: Understand your view. I believe it would be explained as someone who is not a licensed PA can't put themselves out to public as a practicing one or act as a PA or use that abbreviation. If someone is not licensed, but meets the qualifications, they can use the title of PA, but not act or practice. It was giving them the ability to cite their degree, but not practice.

Representative Skroch: What problem is this addressing?

Mr. Houdek: I don't know of any problem of abuse of title, but maybe one of the PAs can give us an example.

Representative Westlind: Right now they have to be supervised for 4000 hours? Correct? How many hours then, or how does this bill reduce the requirement?

Mr. Houdek: No, it doesn't reduce any requirement, that part was put in at the request of ND Medical Association. This is for that context of having an exceptionally approved independent practice for the underserved areas. And the hour requirements are for that situation so that a brand new graduate can't go practice in the unmet areas alone.

Bonnie Storbakken, Board of Medicine: Our board looked at the language and unanimously approved and stand in support of HB1175. To answer Representative Porter's question regarding the requirements for practice, PA's may not practice unless they are nationally accredited, and they have to have 100 CE hours to renew the license.

Jay Metzger, PA, President of ND Academy of Physician Assistant: (See attachment 4)

Representative Rohr: Is there any performance chart reviews that will be in this law?

Dr. Metzger: No. If I may answer a question from earlier about the PA title. It is more so a national thing than a state thing. If someone comes into the state saying that they are a PA, but not licensed, they can say they are a PA. It isn't a huge issue for us though.

Representative Rohr: When a PA is through with the didactic, is there a length of time before graduation and the licensing exam?

Dr. Metzger: Yes, PA students have to put PA Student for that as their title. It is mores to keep imposters out of the mix.

Kate Larson, PA: (see attachment 5)

Representative Porter: Being on the board of medicine and a PA, explain to me the steps that need to be taken for a PA to be licensed to be able to do a needle biopsy for a computed tomography (CT) scan or magnetic resonance imaging (MRI)?

Dr. Larson: We cannot receive certification in that area. We can order X-ray and we can look at them, but those films are also sent to a radiologist asking for those results. We may assist in those procedures. Never intended to look at those things but to help primary care, not to do our own procedures.

Representative Porter: Section 3 doesn't say what you just said. Even up through subsection 3 Pg. 3. I understand you aren't saying you are expanding into these procedures now, but nowhere in here does it say you can't either.

Dr. Larson: We have not ever been involved in actually performing MRIs. We can't perform x-rays because we are not licensed to do them.

Representative Rohr: Reimbursement change same level as Physicians?

Dr. Larson: National Level we will have a problem, until some things change nationally.

Representative Porter: What about ND Medicaid? Are those patients fully reimbursable for your services?

Dr. Larson: I would have to rely on Jay to answer the question.

Shirley Porter, President of the ND Medical Imaging and Radiation Therapy Board: (see attachment 6)

Ms. Porter: If a PA were interested in performing imaging, they could request to be limited x-ray operators.

Representative Rohr: Remove preforming, concerned about strep tests, stool cultures, those kinds of things that they can do in small clinics that they won't be able to do it we took out that word.

Ms. Porter: Noted.

Dr. Luke Roller, Bismarck Rad Associates, Independent: **(See attachment 7)**

Danielle Goetz, Vice President of the ND Society of Radiologic Technologists: (see attachment 8)

Carmen Barrios, Radiologist Assistant: (See attached 9)

Opposed Testimony.

Dr. Edward Fogarty, Chair of Radiology for the School of Medicine for University of ND: This is a scope of practice bill. I believe there has been a misrepresentation as to what goes on inside medicine. Brain tapping to help those that are not licensed as Radiologists and are specialized. Rural Hospitals where PAs are managing the care of patients and aren't as educated. With PAs they have 2 years of training VS. Physicians 7-11 years, if specialized. There could potentially be Medicare issues that arise when billing individuals for some of the procedures that are being done by a PA when they need to be done by a licensed physician instead. Our attorneys do not have the big picture as to how liable we are for certain Medicare billing violations. If PA is bending the rules, there much greater repercussions than if a licensed physician would. We need to have an opportunity to put language into the bill that protects the specialists. These are just some of the things that we need to pay close attention to when deciding if this bill should or shouldn't be passed. A PA doesn't have the same amount of knowledge or training as a physician does, yet this bill would allow them to run their own rural practice right out of school, while many of my own students wouldn't be able to do that because they are required to go to a residency before they can practice independently.

Testimonies 10-12 were handed in after the hearing was closed, and were not discussed.

No further testimony or questions.
Meeting closed.

2019 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1175
1/28/2019
31607

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature: Nicole Klaman by Caitlin Fleck

Explanation or reason for introduction of bill/resolution:

Relating to regulation of Physician assistants

Minutes:

Opened hearing.

Representative Porter: After the hearing, the board of radiology brought in the amendment that they thought would work. The board of medical examiners looked at the amendment and said they were in agreement with it, but would want to add "real time visual guidance for another procedure." That would be in the case of putting in an advanced airway using sonography or a different tool. That was then agreed upon and all other agreed upon language discussed in the hearing. I motion to move the amendment.

Representative Ruby: Second.

Representative Rohr: So if we remove the word performing, that doesn't disallow them to be doing blood tests or that kind of thing?

Representative Devlin: From the PA standpoint, they were okay with that, so I am okay with it.

Representative Weisz: Ok so it would read, "ordering and evaluating a diagnostic study and therapeutic procedure?

Representative Devlin: Correct.

Representative Weisz: Then add the new language after procedure.

Voice Vote. Motion carried.

Representative Devlin: Motion for a do pass as amended.

Representative Rohr: Second.

Representative Skroch: I'm wondering if anyone visited with Dr. Fogerty to see if he is ok with the changes?

Representative Porter: I believe that with the amendment, even though Dr. Fogerty went to along was to get to his opposition, I think the amendment, his concern would be addressed.

Representative Weisz: His other concern isn't addressed with this bill, which is in fact that any doctor should be allowed to practice without residency. That is a whole other issue.

Roll call vote: 12 Yes, 0 No, 2 Absent. Motion passed.

Representative Porter has floor assignment.

Meeting closed.

DA 1/28/19

19.0736.01001
Title.02000

Adopted by the Human Services Committee

January 28, 2019

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1175

Page 2, line 30, remove ", performing,"

Page 2, line 30, replace "interpreting" with "evaluating"

Page 3, line 1, after the underscored closing parenthesis insert: "Performing a diagnostic study or therapeutic procedure not involving the use of medical imaging as defined in section 43-62-01 or radiation therapy as defined in section 43-62-01;

(5) Performing limited sonography on a focused imaging target to assess specific and limited information about a patient's medical condition or to provide real-time visual guidance for another procedure;

(6)"

Page 3, line 2, replace "(5)" with "(7)"

Page 3, line 3, replace "(6)" with "(8)"

Page 3, line 5, after "measures" insert "not involving the use of medical imaging as defined in section 43-62-01 or radiation therapy as defined in section 43-62-01"

Renumber accordingly

Date: 1-28-19
Roll Call Vote #: 1

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1175

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 19.0736.01001

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Porter Seconded By Rep. Ruby

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman			Gretchen Dobervich	—	
Karen M. Rohr – Vice Chairman			Mary Schneider		
Dick Anderson	—				
Chuck Damschen					
Bill Devlin					
Clayton Fegley					
Dwight Kiefert					
Todd Porter					
Matthew Ruby					
Bill Tveit					
Greg Westlind					
Kathy Skroch					

Voice Vote

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Motion carries, adopt. amendment.

Date: 1-28-19
Roll Call Vote #: 2

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1175

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Devlin Seconded By Rep. Rohr

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman	X		Gretchen Dobervich	—	—
Karen M. Rohr – Vice Chairman	X		Mary Schneider	X	
Dick Anderson	—	—			
Chuck Damschen	X				
Bill Devlin	X				
Clayton Fegley	X				
Dwight Kiefert	X				
Todd Porter	X				
Matthew Ruby	X				
Bill Tveit	X				
Greg Westlind	X				
Kathy Skroch	X				

Total (Yes) 12 No 0

Absent 2

Floor Assignment Rep. Porter

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1175: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). HB 1175 was placed on the Sixth order on the calendar.

Page 2, line 30, remove ", performing,"

Page 2, line 30, replace "interpreting" with "evaluating"

Page 3, line 1, after the underscored closing parenthesis insert: "Performing a diagnostic study or therapeutic procedure not involving the use of medical imaging as defined in section 43-62-01 or radiation therapy as defined in section 43-62-01;

(5) Performing limited sonography on a focused imaging target to assess specific and limited information about a patient's medical condition or to provide real-time visual guidance for another procedure;

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Page 3, line 2, replace "(5)" with "(7)"

Page 3, line 3, replace "(6)" with "(8)"

Page 3, line 5, after "measures" insert "not involving the use of medical imaging as defined in section 43-62-01 or radiation therapy as defined in section 43-62-01"

Renumber accordingly

2019 SENATE HUMAN SERVICES

HB 1175

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1175
3/19/2019
Job # 33918

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to regulation of Physician assistants.

Minutes: Attachments #1-8

Madam Chair Lee opens the hearing on HB 1175.

(00:55-02:31) Representative Bill Devlin, District 23 introduces HB 1175 and provides testimony to the committee. Please see Attachment #1 for written testimony.

(03:31-09:53) Dr. Gordy Leingang, Emergency and Trauma Physician for the Mid-Dakota Clinic. Testifying in support of HB 1175. Testimony is as follows: My entire physician career I have been a very active mentor, teacher, and recruiter with clinical faculty and physician assistants. I work with and teach both physician assistants and nurse practitioners. In fact, I had the pleasure of marrying a nurse practitioner, my wife Jackie. I have to say for the record that my personal doctor is a physician assistant and I can get my medical care wherever I want to and it happens to be someone I helped train. Some of the PA's in the room were some of my students. I believe that I can offer some help when it comes to considering this important bill. As you consider this bill please understand that particularly in smaller 38 rural hospitals and 50 clinics in North Dakota, physician assistants are grouped in with primary and emergency care seeing patients of all ages. It's a for one conclusion that we could not provide these services if it were not for our physician assistants. They are absolutely the front line in our smaller communities as well as our larger cities. Physician assistants direly need to free themselves from the outdated rules that accomplish nothing and make it more difficult for PA's to do what it is they do and in particular it makes it very difficult for them to appeal to employers because the statute makes it quite burdensome. The original 1975 statute has been rendered obsolete. The younger nurse practitioners saw how such a model significantly encumbers the practice and early on sought and gained independent practice in 2001. I can cite several examples from clinics and hospitals that have passed on hiring excellent and high skilled physician assistants because (inaudible). The law is simply out of date. I can share numerous anecdotes from physician assistants who were sidelined and simply not hired because the hospitals and clinics didn't want to jump through the hoops that existed. Ultimately a little pushing and shoving St. Alexius of hiring physician assistants in the emergency department and we have hired some absolutely stellar clinical

physicians. The same is true for Mid Dakota Clinic and they are aligned in support with this bill. Time permitting, I could tell you about the stories of working with PA's in my Bismarck practice and working with them during my military appointments overseas. PA's often have skill sets that superior to the physicians that they are working with. Some of my best teachers were PA's and that by the way is why I decided to be here I wanted to give back. Today you are going to hear from a couple of PA's who I have had the privilege of accepting patients from, so I get to witness the exceptional care that they give every single day. You will meet Kate Larson who is well seasoned and a superb clinician PA who sends me patients all the time. It is no exaggeration when I say you hope that Kate is looking after you if you get hurt or sick in your community and she is just a small example of what goes on day by day in North Dakota. PA's and nurse practitioners are the front line. The point is that the safety net that ensures PA's is supervised or accountable with the care that they deliver is well in place by the rules established by the North Dakota Board of Medical Examiners. The 44-year-old statue does not facilitate that, it hinders that. Please understand that PA's get their supervision from the credentialing and privileging process through their employer. The supervisory contract is burdensome to doctors and causing employers hesitation in hiring PA's, the scope of practice for PA's stays the same it is determined by credentialing. You will see that the PA's have an exceptionally strong track record in our state. This bill is long overdue, well thought out, and well written. I hope the committee will give this a pass vote.

Senator Anderson: Talk to us about the program that you have where the PA would need to have contract of supervision up to the 4,000 hours, process for that, and why that is.

Dr. Leingang: I think that seeks to understand that all of the medical providers deserve a little bit of time to get their feet wet. Students right out of school need a little bit of TLC if you will to get started in their practices and that seeks to protect our citizens.

Senator Anderson: Originally most of our PA's came from a solid military training talk about the transition from that training that they had to the training that we have today.

Dr. Leingang: I have 44 years of military service and that is where I became to know PA's. They were birthed out of Vietnam where very seasoned medics were doing things that doctors wouldn't even do. That became the birthplace of PA's. You should also know that PA's in the military take care of the majority of medical care that is given in the combat setting. Half the time I would work in the trauma bay who were doing things that I just assumed were doctors but they were PA's.

Madam Chair Lee: You may be interested to know that there is a bill working its way through the legislature that will make it much easier for military veterans and spouses to be able to be licensed through reciprocity in a variety of occupations.

(13:39) Duane Houdek, representing the ND Academy of Physician Assistants. Testifying in support of HB 1175. Please see **Attachment #2** for written testimony.

Duane Houdek: I just want to clarify the question to Dr. Leingang about the 4,000 hours. When the bill was presented and gone through with the Board of Medical Examiners they were unanimously in favor of the removal of the supervisory contract and the PA's were stuck on not having their own private practice, they are trained to collaborate with physicians and

they intend to keep doing that. an exemption was made where on a case by case basis that if the Board of Medicine determines that there is an underserved area that can't otherwise be served then a PA could set up an independent practice to serve that area. It is that area you need the 4000 hours.

(25:00) Senator K. Roers: I am lax in my own knowledge about how it works today, what will really be the difference besides you not having to sign the contract if we pass this.

Duane Houdek: I've thought about that a lot; I don't think there will be any difference. They group PA's and NP's together right now. They are called advanced practice providers or allied health providers they do the same thing with both of them but they say you're not trained enough to do this so you can't do this and the bill re-enforcing that. There still must be that same collaboration.

Senator K. Roers: So there is no co-signing required with a PA.

Duane Houdek: When this all started cosigning had to be everywhere, chart review, on site presence. There is no cosigning they right their own scripts, they may want to be on under supervision for billing. it is not like any of those things that I talked about in the emergency room being done and co-signed by the physician.

Senator K. Roers: Do you know state by state comparison who has this and etc.

Duane Houdek: I do not, I know that there is a wide smattering of the way both NP's and PA's are treated in other states. I know there are other states where PA's can have their own clinics but I don't know if they have that specific supervisory contract.

Senator Anderson: Your description about the PA and how they work, we have a federally qualified health clinic in turtle lake, they have most of the time one physician who covers those 8 different branches I'm not sure if they have the same credential approval process. Do you see any impediments about the PA's working in that environments under your current criteria?

Duane Houdek: I really don't, when you look at most of the facilities in the state, they're either connected to a larger hospital somewhere and if there are smaller ones they would still have a credentialing process that says what all their employees can do. Let's say they don't, the rest of this bill addresses not only the collaboration but it also addresses the limitation on the ability to practice where they do not have adequate training and experience. Will everyone follow that exactly, I don't know. NP's have been practicing in those same places with the independence that they have and the sky hasn't fallen. We don't hear lots of cases about this where someone has suffered by the hands of a NP.

Madam Chair Lee: Their education is different as well.

Senator Anderson: I'm not saying that these PA's aren't qualified, I'm just wondering if your description having to work in this place where they have all this will be an impediment for them working in one of those eight federally qualified clinics that we have because there is only one physician who's had as I said sometimes there is one position the way the

government works of course somebody has to sign the paperwork. Previously we had a semi-retired physician and now we have one in Rolette long ways from all the other clinics but there it's one.

Duane Houdek: I'm sorry I misunderstood. No, I think this is what it could do they could be liberated where they could serve in those types of hospitals.

Madam Chair Lee: I also question your statement about them being affiliated with a hospital because at least in Fargo at the family healthcare center does not have a connection with just one hospital. If an individual wanted to go to a hospital or the other, it is up to the patient. I'm a big fan of FQHC's for a while and I don't think that there is any necessary tie because it's particularly looking at the circumstance that Senator Anderson was talking about, some of those outlined rural FQHC's satellites that you have are closer to one hospital than the other. I don't think it is there.

Duane Houdek: I may have used that hospital as too big a word, if you replace that with facility they are going to have those and I think we got a lot of support from those very institutions that we are talking about that will say this will make it better for us.

Madam Chair Lee: And we want that. Any more questions for Mr. Houdek? If not, thank you.

(33:40-39:03) Jay Metzger, Physician Assistant and President of the North Dakota Academy of Physician Assistants (NDAPA). Testifying in support of HB 1175. Please see **Attachment #3** for written testimony. Please see **Attachment #4** for additional written testimony provided by **Jay Metzger from multiple medical organizations and physicians supporting HB 1175.**

(39:52) Bonnie Storbakken, representing the North Dakota Board of Medicine. Testifying in support of HB 1175. Testimony is as follows: We had folks provide us with a draft of this and our board unanimously stated that we support this bill. When we receive complaints on any of our licensees, PA's in particularly though it's a little bit different because we look at the complaint not only on the side if the PA violated our practices act but also if the supervising position violated the practices act. I will tell you that historically since I have been there, it has been the focus of our board to look at the PA's behavior rather than the supervising physician. I believe there are times, prior to my time, where that supervising physician may have been disciplined for not supervising properly. That in and of itself speaks to why the PA's bring forward this bill and how our board looks at the supervising role and those documents that have to be filed with every renewal and any time that supervision changes, with that I would stand for any questions the committee may have.

Madam Chair Lee: Any questions, if not, thank you.

(42:18-45:25) Kate Larson, Physician Assistant. Testifying in support of HB 1175. Please see **Attachment #5** for written testimony.

Madam Chair Lee: The uniform interstate compact that passed the senate and believe was voted out of the house, does that include PA's?

Kate Larson: It does not.

(46:59-47:22) Aaron Birst, North Dakota Association of Counties. Testifying in support of HB 1175. Testimony is as follows: All the testimony has been great. I will just start off by saying the Association of Counties as you know has significant amount of member who are rural and we feel that this will impact our rural areas and we agree with this bill and recommend a do pass.

(47:40-49:51) Shirley Porter, President of the North Dakota Medical Imaging and Radiation Therapy Board (NDMIRT). Testifying in support of HB 1175. Please see **Attachment #6** for written testimony.

Senator Anderson: I noticed in the bill there were some exclusions. My understanding is PA's can order X-rays but they can't read them

Shirley Porter: PA's can more than certainly review images in their scope, it is the performance of the x-ray that they can't do.

Senator K. Roers: How many states have gotten rid of the supervisory contract? There are five states that are working on getting rid of them so is definitely the beginning stage.

(52:00-55:09) Stacy Pfenning, Executive Director for the North Dakota Board of Nursing (NDBON). Offering neutral testimony on HB 1175. Please see **Attachment #7** for written testimony.

Madam Chair Lee: I'm very appreciative of you both working on this because I think it is very interesting to see that it doesn't mean that two different disciplines can't do much of the same thing but we may have some differences as well.

Stacy Pfenning: I think was of the differences too that was interesting was, we have an eight-page scope of practice within our rules and I don't know if that is something that they will be doing but in our practices act we are required to do rules to implement. I can tell you the rules that we have help us a lot in the regulatory world, making sure everyone is staying in their lanes and doing what they are supposed to do. We also have the privilege of credentialing through the facilities that are required to do.

Madam Chair Lee closes the hearing on HB 1175.

Additional supporting testimony was provided to the committee from Carla Barrios, Radiologist Assistant (RA). Please see Attachment #8 for written testimony.

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1175
3/19/2019
Job # 33953

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to regulation of Physician assistants.

Minutes: No Attachments

Madam Chair Lee opens the discussion on HB 1175.

Senator Anderson: I move a **DO PASS** on HB 1175.
Seconded by Senator O. Larsen

Senator O. Larsen: I can remember that Dr. Wilson took care of me on the reservation and delivered my First Lady of district 3 and her other brothers and sisters and he was a Harvard graduate and did a wonderful job in New Town and that area. He is now gone, he was helping with the information area here and did some other things in his retirement. Now my nephew's wife is a PA at the farmstead and she reached out to me about this bill and I just think it was a great idea and I'm glad it passed.

Madam Chair Lee: Remarkable man, he was the doctor of the day here many times and a special person to a lot of us.

(01:44-03:05) The committee engages in an informal discussion.

Madam Chair Lee: Anything further before we move on with our vote on HB 1175? If not, please call the roll.

ROLL CALL VOTE TAKEN
6 YEA, 0 NAY, 0 ABSENT
MOTION CARRIES DO PASS
Senator Anderson will carry HB 1175 to the floor.

Madam Chair Lee: We will be hearing all of our bills by the end of the day tomorrow. Next week we will be on the floor until about 3:15 p.m. so that appropriations can go to work. We really need to get our ducks in a row so that we can get things done.

Madam Chair Lee closes the discussion on HB 1175.

Date: 3/19/19
Roll Call Vote #: 1

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1175

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. Anderson Seconded By Sen. O. Larsen

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee	X		Sen. Kathy Hogan	X	
Sen. Oley Larsen	X				
Sen. Howard C. Anderson	X				
Sen. David Clemens	X				
Sen. Kristin Roers	X				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen. Anderson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1175, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1175 was placed on the Fourteenth order on the calendar.

2019 TESTIMONY

HB 1175

HB1175
1/28/2019
#1

Rep. Bill Devlin Testimony – House Human Services Committee – HB 1175

Good morning, Chairman Weisz and esteemed members of the House Human Services Committee. For the record, I am Rep. Bill Devlin of District 23. Our district is a rural legislative district in eastern North Dakota.

I am proud to introduce HB 1175 at the request of Physician Assistants from my area and across the state for your consideration.

As I have watched medicine evolve to meet the needs of North Dakota citizens there is one undisputable fact that jumps out at me and everyone else observing. The practice of medicine in many rural areas of the state would not be possible without Physician Assistants. Without those highly trained professionals practicing medicine, many clinics and even hospitals would have a difficulty if not impossible time providing care to our residents and the facilities might not even survive.

The other fact that is undisputable is that we have come to recognize that certain practitioners of medicine do not need some of the over-sight originally spelled out in code to practice within their scope of practice, safely and effectively and to provide the best possible care for our citizens.

HB1175 recognizes that fact and calls for changes in the direct oversight of Physician Assistants by physicians. It was my understanding until 6:00 this morning that these changes were supported by everyone involved. I understand now there are concerns being expressed by some of the registered rad techs about part of this bill and I believe we can work through that after the completion of testimony.

The bill will not change how Physician Assistants already collaborate with physicians and other providers but will remove some of the unnecessary restrictions I want to you to know the proposed changes in HB 1175 were unanimously approved by the N.D. Board of Medicine at their November 16th, 2018, meeting.

Committee members, I know some of you might have questions but prefer to let you hear from the experts that will follow me to the podium. If there is specific information needed later, I can obtain it for the committee.

For now, I urge your thoughtful consideration of HB1175 and I hope eventually a unanimous do pass recommendation. Thank you, Chairman Weisz and esteemed members of the House Human Service Committee.

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House Bill 1175
House Human Services Committee
Testimony of Dr. Gordon Leingang in support of Proposed House Bill 1175
January 28, 2019

Mr. Chairman and members of the committee, my name is Dr. Gordy Leingang from Bismarck.

I'm residency trained and board certified in Emergency Medicine and have been in the practice of Emergency, Trauma, and Urgent Care Medicine since 1991. I'm also the recently retired State Flight Surgeon for the N. D. Army National Guard.

My entire Physician career, I've been a very active mentor, teacher, recruiter and clinical faculty of Physician Assistant Programs in North and South Dakota, Iowa, Michigan, and Ohio. I work with both Physician Assistants and Nurse Practitioners every day. In fact I have the good fortune of being married to a Physician Assistant, Jackie, who works for the Veteran's Administration. My personal "doctor" is a Physician Assistant.

I believe that I can offer some helpful information as you consider this very imperative bill.....

As you consider this bill, please understand that, particularly in the smaller rural hospitals and clinics in North Dakota, Physicians Assistants are who provide primary and emergency care of patients of all ages. It's a foregone conclusion that we could not provide these services without our midlevels, PAs and NPs. They are absolutely the "front line" there, and in our bigger city hospitals and clinics.

Mr. Houdek will bring perspective and history to how it is that we've come to this place, where Physician Assistants direly need to untether themselves from the antiquated and outdated rules that accomplish nothing but make it more difficult for PAs to do what they do, and in particular has now made it more difficult for them to appeal to employers because the statute on the books make it burdensome. The original 1975 statute has been rendered obsolete. The younger Nurse Practitioner profession saw how such a model significantly encumbers a practice, and early on fought for, and gained independent scope of practice in 2011.

I can cite several examples of clinics or hospitals who passed on hiring an otherwise excellent, highly skilled Physician Assistant because of the tedium in the rules that actually don't even provide a meaningful safety tool anymore. The law is simply out-of-date. I could share numerous anecdotes about Physician Assistants, my wife among them, who were side-lined or not hired because the hospital or clinic didn't want the hassle of jumping through these additional hoops, ostensibly denying a highly skilled Physician Assistant a job, and our patients the talents, training and experience of the

Physician Assistant. My own experience locally was the same. Ultimately, with a little pushing and shoving, St. Alexius began to see the huge benefit of hiring Physician Assistants in the Emergency Trauma Center and we've hired some absolutely stellar clinicians. The same is true of Mid Dakota Clinic, who is fully aligned with the bill and supports it 100%.

Time permitting, I could regale you with tales of the incredible talents and training of many of the PAs that I've worked with in my Bismarck practice, and in my multiple military deployments where PAs often have skill sets superior to the physicians they're working with. Some of my best teachers in my formative years as a Doctor were Physician Assistants.

Today, you're going to hear from a couple of PAs who I have the privilege of accepting patients from, in their rural/smaller clinics or hospitals, so I get to witness the exceptional care that's being delivered by these PAs. You'll meet Kate Larson, for example, a highly seasoned and superb clinician PA who sends me patients all the time. You'd better hope that Kate is looking after you if you ever get sick or injured in her community. And this plays itself out thousands of times in our North Dakota communities, big and small, where PAs are very, very often the front line.

The point is: The "safety net" that ensures that the Physician Assistant is supervised or accountable for the care that they deliver, is well-in-place with the rules established by the N. D. Board of Medical Examiners, and the credentialing processes that each clinic or hospital, or physician who hires the Physician Assistant goes through. The old statute does NOT facilitate that. It hinders it. Physician Assistants go through rigorous training, take rigorous boards, have to recertify their boards every 6 (now 10) years, have rigorous CME requirements, and are accountable to employers in credentialing.

This bill is long overdue. It's well thought out. It's well written. I'm hoping for the benefit of our North Dakota patients you'll give it a "pass" vote.

Thank you. Please call on me if you have questions.

Gordon Leingang, DO, FACEP, FACOEP
Colonel (Ret), Medical Corps, Senior Flight Surgeon, USA
e.mail: dopa@bis.midco.net Personal cell: 701-220-8029

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HOUSE HUMAN SERVICES COMMITTEE
HB 1175

Testimony of Duane Houdek for
North Dakota Academy of Physician Assistants

January 28, 2019

Chairman Weisz, Members of the House Human Services Committee, my name is Duane Houdek. I am representing the ND Academy of Physician Assistants with regard to HB 1175.

To accommodate the schedule of one of our presenters, Dr. Gordon Leingang, I would ask that I be permitted to introduce him to testify now, and resume my testimony when he is done. Thank you, Mr. Chairman.

Dr. Leingang is especially able to provide testimony regarding the training and regulation of Physician Assistants. He is an award-winning professor of Physician Assistants' courses at Des Moines University - Osteopathic Medical Center. He has also taught at the University of Mary in the Nurse Practitioner program. Additionally, he is a former member of the North Dakota Board of Medicine and has served two tours in Iraq as a flight surgeon for the North Dakota National Guard.

***

Mr. Chairman and members of the committee, this bill does two things:

1. It removes the requirement of a written supervisory contract between a physician and a physician assistant.

2. It ensures that, unless specifically approved by the Board of Medicine, no physician assistant will practice independently.

It does not enlarge the current scope of practice of physician assistants or affect in any way the current manner in which health care organizations regulate the practice of physician assistants in their employ.

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The statute HB 1175 seeks to amend was enacted in 1975, 44 years ago. Then, the legislature was dealing primarily with corpsmen who had returned from Viet Nam with extensive field medical skills which were being utilized by physicians in North Dakota by hiring the corpsmen as assistants. Prior to the 1975 statute, these assistants had no legal status in North Dakota, they were not licensed, they had no educational requirements. They could do nothing in their own name.

It was in this context that the language we still have in state law today was written, that their medical service to the public must be "rendered under the supervision, control, and responsibility of a licensed physician".

As we have seen with nurses, the training and practice of physician assistants has evolved to a greater extent than I believe anyone foresaw in 1975. Today, as Mr. Metzger will flesh out, physician assistants are trained at the University of North Dakota School of Medicine and Health Sciences, with thousands of hours of didactic and clinical training. They are licensed and disciplined by the Board of Medicine. They are, after extensive testing, certified nationally, as a condition of state licensure. To keep their state license, they must re-certify every 10 years. They are required to obtain 100 hours of continuing medical education every two years, most of which is provided by physicians. They practice in every aspect of medicine in North Dakota, from harvesting veins for heart bypass surgery to working in ER's and as hospitalists. They have full prescriptive authority.

In recognition of these advancements, and as they proved themselves, the Board of Medicine has, over time, eased its rules regarding their supervision. Once, chart reviews had to be conducted, supervision had to be on-site and personal. Today, none of that is true. By rule, PA's may practice in remote locations as long as they have a means to communicate, electronically or otherwise, with a physician. This type of collaboration is something PA's are trained to do from the outset of their education, regardless of rule. They are

taught to practice, and continue to practice, the collaborative team approach that we see occurring more and more in medicine today. They do not seek independent practice.

But because the legal requirement for a supervisory relationship and physician responsibility remains in statute, we see, as others will testify, that hiring of PA's is chilled. Some institutions will not advertise to hire them because they do not want to incur the potential legal responsibility for their physicians.

The supervisory relationship is not what it once was, nor is it as meaningful or necessary to ensure public safety. We see instances where as many as 30 physicians will have to sign on to a supervision contract, as they interact with a physician assistant. Other instances where the supervising physician is a temporary *locums* physician, who might be gone the next week. This is done to comply with the law. It does not improve practice or protect patients.

The truth is that all healthcare providers' practice — doctors, physician assistants, nurse practitioners — all of them are determined by the privileging process at the institution for whom they work. That determines who they will work with, how they will interact with them and to whom they report. This will not be changed by HB 1175.

In sum, it appears to me that we have an antiquated statute that is limiting access to proven, competent providers — especially in rural areas where we disparately need them — with no offsetting safety benefit to the public.

With that, I would like to introduce Jay Metzger, President of the NDAPA, and Kate Larson, who will provide testimony from the perspective of practicing physician assistants.

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WEST RIVER HEALTH SERVICES

January 17, 2019

DUANE HOUDEK
4400 ALAMO DRIVE
BISMARCK, ND 58504

RE: Support for House Bill 1175 regarding the supervisory regulation of physician assistants.

Dear Mr. Houdek and Members of Legislative Committee,

This is a letter of support in favor of proposed House Bill 1175 to revise supervisory conditions of physician assistants in North Dakota.

West River Clinics in Hettinger, North Dakota, has a long history of incorporating physician assistants as team members for care of patients in the West River area since the early 1980s when Sister Michael Emond was the first PA to work at West River. We have also been active in training and supervising physician assistants and have incorporated physician assistants in our satellite system for optimum care and access for our patients.

As stated in the bill, it does make sense that direct supervision of physician assistants should be based on site and scope of practice as determined by their place of employment and practice. This is much more direct and applicable to each situation as opposed to the broadly stated rules that exist currently. As medicine has evolved to utilize the electronic health record, there is more emphasis on patient management based on a team concept. As such, a single physician is supervising a number of PAs to better delegate responsibilities and care of the patient to meet quality metrics.

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WEST RIVER HEALTH SERVICES

I appreciate the governance of the Board of Medicine as a previous member of the board in reviewing any scope of practice by a physician assistant that would indicate solo practice and be approved by the board.

Thank you for your consideration.

Sincerely,

Kent R Hoerauf, MD

KRH/les

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TESTIMONY

TO

HOUSE HUMAN SERVICES COMMITTEE

66TH ASSEMBLY (2019) LEGISLATIVE ASSEMBLY

HB 1175

JAY METZGER, PA-C

NORTH DAKOTA ACADEMY OF PHYSICIAN ASSISTANTS

January 28, 2019

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HOUSE HUMAN SERVICES COMMITTEE

HB 1175

TESTIMONY OF JAY METZGER, PA-C

NORTH DAKOTA ACADEMY OF PHYSICIAN ASSISTANTS

January 28, 2019

Chairman Weisz, Members of the House Human Services Committee, my name is Jay Metzger and I am a physician assistant (PA) and current president of the North Dakota Academy of Physician Assistants (NDAPA). I am speaking on behalf of our members asking for your support on HB 1175.

As Mr. Houdek and Dr. Leingang have already mentioned, HB 1175 addresses some well overdue changes to the regulation of PAs in North Dakota. Our profession was created a mere 52 years ago. In the grand scheme of medicine, we are relative newcomers. Our profession has significantly evolved over the years and there have been hundreds of studies that prove our ability to safely practice medicine and fill a much-needed role in the care of our citizens. Most recently, the U.S. Department of Health and Human Services released a report detailing many complex issues within our health care system and specifically recommended the changes we are seeking. I have enclosed a few of

these studies for your review and list of others that may be of interest. I would be happy to provide full copies of any of these studies if you wish.

The intent of the bill is for PAs to practice where they are needed. As others testifying have and will explain, there are positions in numerous settings where employers will not consider hiring a PA because of the supervisory requirements. Administrators are becoming reluctant to even pursue PAs to practice in their clinics and hospitals because of the administrative burden supervision entails. Physicians are reluctant to sign supervisory agreements that say they will take full responsibility for the PAs actions even if they are not always working directly with the PAs they supervise.

PAs are trained in a medical model, similar to that of a physician but in a more condensed version. PA programs have a strong preference for students with previous experience in health care. I personally was an Army medic and paramedic for a total of nine years before I became a PA. There is a wide variety of backgrounds represented in the PA profession such as former respiratory therapists, nurses, paramedics, radiology technicians, and athletic trainers to just name a few. Nationally, PA students come into their PA training with an average of 8000 hours or approximately four years of full-time health care experience. North Dakota has only one PA program with an average of 12,000 hours of prior

healthcare experience or approximately six years of full-time health care experience. PA program length averages 28 months nationally and students complete approximately 2000 hours of classroom instruction and 2000 hours of clinical experience.

PAs practice in numerous settings from family medicine to sub-specialty surgery environments. The scope of our practice can differ significantly in each setting, but one thing remains constant throughout all areas; PAs only practice what they are educated, trained and privileged to do. If a PA does not meet those requirements, they cannot, and will not, be able to provide those services. This is the way it is now and will not change with this bill. HB 1175 requires that PAs practice within their training and that if there is something they need further assistance with, the PA must collaborate with physicians or appropriate members of the health care team.

Before I started as Board Member on the NDAPA, I had heard anecdotal stories of PAs not being able to practice in their communities because their supervising physician moved, retired, or became unable to practice themselves for whatever reason. These well trained and experienced PAs all of sudden could not take care of the patients they had helped for years. As a member of the

NDAPA Board of Directors, I now regularly hear firsthand of these actual occurrences.

HB 1175 was carefully drafted by the NDAPA with considerable input from the ND Board of Medicine, ND Medical Association, and the American Academy of PAs. The bill addresses all concerns that have brought forward to ensure that PAs will practice within their scope and be responsible for their actions. PAs will still have to collaborate with physicians and others to assure they are providing the best care possible. The intent of the bill is not for PAs to practice independently. Provisions within HB 1175 assure that if a PA is considering a stand-alone clinic, the must first prove they are adequately trained and ultimately have the approval of the ND Board of Medicine to do so. In all honesty, we do not anticipate that many PAs will even consider their own practices as it is difficult even for physicians to do so in our health care environment. I have also provided letters of support from physicians in North Dakota.

PAs are not physicians and we do not pretend to be. In our 50-plus years of existence, we have proven that we are reliable, competent and valuable members of the health care team. We are well trained in the areas that we practice and know when to consult with our physician colleagues. With more physicians going into non-primary care practices, PAs are especially needed to help alleviate access

to care issues. Chairman Weisz and Members of the House Human Services Committee, I and the members of the NDAPA ask for your support in passing HB 1175.

Thank you for your time.

Jay R. Metzger, PA-C

President, North Dakota Academy of Physician Assistants

NDAPAboard@gmail.com

House Human Services Committee
Studies Supporting Physician Assistant Practice
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Physician Assistants: Modernize Laws to Improve Rural Access

Executive Summary

Physician Assistants ("PAs") are one of three professions providing primary care in the United States, along with physicians and advanced practice registered nurses. The National Rural Health Association (NRHA) recognizes that, despite 50 years of high-quality cost-effective practice, there remain state and federal laws and regulations that prevent PAs from practicing to the fullest extent of their education and experience. Likewise, new and emerging models of care sometimes fail to fully recognize PAs, diminishing the value they could bring to rural patients and communities that are currently suffering from a dire shortage of qualified medical care.

As health care evolves into a system of vertical and horizontal integration with new focus on team-based care, PAs—working at the top of their licenses—will be indispensable providers in rural areas. Modernizing of regulations restricting practice privileges, mental health laws and payer policies that unnecessarily restrict PA practice will increase PA value to employers and enable PAs to more efficiently contribute to ending the shortage of health care professionals accessible to rural patients and communities.

Introduction

Analysts' predictions of physician workforce shortages paint a dire picture for rural America. For decades, rural communities have fought to maintain health care services. Even recent federal efforts to improve access to care by improving insurance coverage did not get to the heart of the rural access issue—a shortage of providers.

The number of physicians practicing in rural areas has been steadily declining for decades.[I] While the supply of doctors in rural areas have drained into more urban settings, the rural populations they've left behind have become increasing less healthy[ii] and less wealthy[iii] than their urban counterparts. This has created an increasing demand for medical care and a diminished ability to pay for it. Supply of medical care has decreased and demand for that care has increased, but much of the population cannot afford medical services at the new equilibrium price point, creating a massive shortage in care. Today, twenty percent of the U.S. population is rural, but only 11 percent of physicians practice in rural settings.[i]

Existing federal programs do not do enough to close this physician shortfall. Additional actions must be taken to increase the supply of medical professionals in rural areas as the demand for their services is projected to increase in the future. Estimates predict that America's rural population will continue to grow in both age and number in the coming years, further widening the gap between the amount of providers and the demand for services[iv].

PAs are one of three professions providing primary care in the United States, along with physicians and advanced practice registered nurses. Despite 50 years of high-quality, cost-effective practice, there are still state and federal laws and regulations that prevent PAs from practicing to the fullest extent of their education and experience. Likewise, new and emerging models of care sometimes fail to fully recognize PA contributions, diminishing the value they could bring to rural patients and communities. Fifteen percent of PAs already practice in rural areas,[ii] positioning them to make an immediate and substantial impact on the supply of care if these regulations can be lightened.

As healthcare evolves into a system of vertical and horizontal integration with a new focus on team-based care PAs working at the top of their licenses will be indispensable providers in rural areas.

PA Education, Certification, and Licensure

A large, well-qualified applicant pool allows PA programs to be very selective. Typical PA program

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appli-cants hold a bachelor's degree and have completed courses in the basic sciences and behavioral sciences as prerequisites to entering a program.[iii] This is analogous to the premedical studies required of medical students.

Comprehensive master's degree programs provide PAs with a broad, generalist medical education. Programs typically last 27 months[iv] and employ an intensive curriculum modeled on medical school. The classroom phase covers basic medical sciences, including anatomy, physiology, pharmacology, physical diagnosis, behavioral sciences, and medical ethics. PA students take more than 75 hours in pharmacology, 175 hours in behavioral sciences, more than 400 hours in basic sciences, and nearly 580 hours of clinical medicine. This is followed by clinical rotations in family medicine, internal medicine, general surgery, pediatrics, obstetrics and gynecology, emergency medicine, and psychiatry.[v]PA students complete at least 2,000 hours of supervised clinical practice by the time they graduate.[vi]

After graduation, PAs must pass a national certifying exam and obtain a state license. To maintain certification, PAs must complete 100 hours of continuing medical education (CME) every two years and must pass a national recertification exam every 10 years.[vii]

PA Scope of Practice

Their broad, generalist medical education prepares PAs to take medical histories, perform physical examinations, order and interpret laboratory tests, diagnose illness, develop and manage treatment plans for their patients, prescribe medications, and assist in surgery.[viii] In rural practices, PAs are likely to take call; provide home, nursing home, and hospital visits; provide direct emergency and urgent care services; perform office procedures; and provide after-hours telephone and internet/email consults.[ix]

State laws that include a broad scope of practice and allow specifics for each PA to be decided at the practice level are best for patients and providers. Studies show that the quality of care provided by PAs remains high when PA scope of practice is determined at the practice level by the collaborating physician (s).[x,xi,xii]

It has been demonstrated when State Laws which include a broad scope of practice and allow the specific duties and activities of specific PA to be determined by the collaborating physician within the collaborating physician's capabilities and PA abilities are best for the patients, providers and community. The scope of practice is then determined by the local practice level and the needs of the community and the local providers. This provides variance for specific privileges, years of experience, advanced education and local needs as Rural environments are widely variable and local needs are widely inconsistent.

In some rural communities, a PA is the only provider. Unnecessary restrictions increase costs, burden physicians and PAs, make recruiting physicians more difficult, and reduce patient access to care.

PA Workforce

The shortage of primary care physicians is expected to exceed 124,000 by 2025, while the PA profession has doubled every decade since the 1980s, reaching 115,500 in 2017.[xiii]

Fifteen percent of PAs in clinical practice (17,000 PAs) practice in rural or frontier counties.[xiv]Studies in Iowa, Texas, California, and Washington state have shown a higher proportion of PAs practice in rural areas than the percentages of other primary care providers.[xv,xvi,xvii]

The median age of certified PAs is 38 and the mean years since graduation is 10.6, indicating that the PA retirement rate will likely remain far less than the rate of production of new PAs for many years to come. The PA profession continues to be recognized as one of the most desirable professions in the U.S. and has top ratings for job market outlookwhich attracts a large quantity of high quality program applicants.[xviii,xix,xx]

As the PA profession grows, incentives are needed to ensure that adequate numbers of PAs are available, that laws allow providers to work at the top of their education and experience, and practice laws must

consider the needs of rural communities with inadequate access to medical care.

Barriers to Optimal Team Practice

There are many well-known factors impacting rural health care—provider shortage and maldistribution, aging of the workforce, long hours, lower pay than urban or specialty providers, professional isolation, and poor infrastructure such as schools, lack of broadband internet, fewer social opportunities and other issues around spouses' and children's needs. These affect every type of rural provider.

For PAs, there is an additional burden of outdated state and federal laws. For example:

- Medicare does not allow PAs to certify the need for hospice care or to provide or manage it, creating an obvious continuity issue for rural patients.
- PAs are not allowed to order or certify the need for home health services.
- PAs are the only professionals who are restricted from directly receiving payment for the services they deliver to Medicare beneficiaries. This restriction limits the flexibility of PAs to participate in various employment arrangements and obscures the volume and quality of services PAs provide.
- Medicare requires a physician co-signature for certain orders and services provided by PAs including inpatient hospital admission orders and hospital discharge summaries. This is a burden on physicians, obscures accountability, causes delays, and adds unnecessary steps and costs.
- Although state workers' compensation programs in all fifty states cover care provided by PAs, the Federal Employees' Compensation Act (FECA) has not been updated in over 40 years and will not permit PAs to diagnose and treat federal employees who are injured on the job.
- PAs diagnose and treat illnesses, manage complex medical care, prescribe medications in all states, and assist in surgery—but Medicare rules do not allow PAs to order diabetic shoes.
- Medicare law requires PAs to practice "under the supervision" of a physician. This language inhibits PA inclusion in team-based care innovations.

A cost analysis conducted in Alabama in 2015 found that even modest improvements in restrictive Alabama PA and NP laws would result in a net savings of $729 million over 10 years. "Underutilization of PAs and NPs by restrictive licensure inhibits the cost benefits of increasing the supply of PAs and NPs and reducing the reliance on a stagnant supply of primary care physicians in meeting society's health care needs."[xxi]

Modernizing laws and policies that unnecessarily restrict PA practice will make PAs more attractive to employers and will enable PA to more efficiently contribute to the health of rural patients and rural communities.

Improved Payment Policies Critical

A lack of transparency in billing and payment for services delivered by PAs obscures the PA contribution to care. Payers who do not enroll PAs but accept "incident to" billing or pay for PA-provided care under a physician's name and National Provider Identifier ("NPI") mask PA contributions to patient care. PA-provided services should be identifiable as such and should be measured in the same manner as that of other health care providers.

Greater transparency of data regarding medical care provided by PAs will improve understanding of workforce issues within the health care delivery system and may be achieved by:

- Modernizing Medicare payment practices to reimburse PAs directly for patient care in the same manner as all other Medicare providers.
- Requiring the identification of PAs as the rendering professionals for Medicare services they provide.
- Tracking PAs contributions and involvement in services billed "incident to" physicians as shared visits services that are billed under the physicians' names.

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- Encouraging public and private payers to adopt standards of transparency and accountability by identifying PAs when they deliver care to patients. Enrolling and credentialing PAs as rendering providers for tracking purposes will enhance the availability of health care data for meeting quality and outcomes metrics which will lead to improved care.
- Permitting PAs to order and provide hospice and home health carefor their patients and to be held directly accountable for that care, therebyeliminating the current practice of requiring physician certification or co-signature for hospice, home health care and hospital admissions.
- Repealing Medicare statutory language requiring that PAs practice "under the supervision of a physician," allowing state law to regulate PA practice.

Mental Health Coverage Lagging

There is a significant need for mental health services in rural America. While the prevalence of mental illness is similar between rural and urban populations, access is very different. Rural residents travel long distances to access mental health care and face a chronic shortage of mental health professionals. With few provider choices, the stigma of receiving care is heightened, creating another barrier.[xxii]

There are about 1,000 PAs practicing with psychiatrists nationwide. In addition, 14,000 PAs practice primary care in rural and frontier areas, many of whom routinely provide mental healthcare to their patients. Another 2,000 PAs practice rural emergency medicine, seeing many patients with mental healthcare needs.

The greatest hurdle is the need for more providers of mental health services in rural and frontier areas.[xxiii]The most significant barrier to PAs collaborating with psychiatrists is lack of third party payment. While Medicare includes PAs among the health professionals eligible to furnish outpatient diagnosis and treatment for mental disorders, many private behavioral health companies do not recognize or reimburse PAs.[xxiv]

Improving Rural Deployment

It is essential to attract and retain health care providers in rural areas if rural residents are to fully benefit from the transformation in health care delivery underway in the U.S. Varied strategies, from recruiting health professions students from rural areas and helping to fund their education to pooling community resources to create attractive recruitment packages, will help to increase the presence of rural providers, including PAs.

There are many federal programs that seek to ensure the availability of medical care to underserved rural communities, including the National Health Service Corps, federally certified Rural Health Clinics, Federally Qualified Health Centers, and Critical Access Hospitals, to name a few. It is essential that all federal programs supporting rural health care workforce—existing or yet to come—fully include PAs in their policies.

Scholarships and loan forgiveness programs offered at the state level and by the federal National Health Service Corps (NHSC) are examples of means to attract medical professionals to practice in rural medically underserved areas. 52 % of NHSC participants remain in the rural area in some capacity for up to 15 years after their commitment.[xxv] Other states offer grants and forgiveness loans to new attract students if they participate in a rural location for a designated amount of time based on the forgiveness loan requirement.

A new rural health care infrastructure model, the Community Outpatient Hospital, as proposed in the Save Rural Hospitals Act legislation, would be an innovative delivery model that will ensure emergency access to care for rural patients and which could also provide primary care services through a FQHC. This new model would have a new Medicare payment designation and could provide opportunities for PA

employment in areas where traditional rural hospitals may be in jeopardy.

Federal Policies and Programs

The Patient Protection and Affordable Care Act (ACA), enacted in 2010, encourages the use of PAs in rural areas in order to realize value and quality improvements. The ACA recognized PAs as a primary health care profession and furthermore provided financial support for the education of rural PAs, initiated temporary Medicare incentives for PA primary care services and integrated PAs into new value-based payment models including Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMH).[xxvi]

Federal programs have been utilized to improve both the supply and the distribution of PAs in the U.S, but are annually vulnerable to reductions in federal budget proposals. Better recognition of these programs importance during the budget appropriations process could impact the number of PAs practicing in rural areas. Programs and initiatives include:

- Title VII of the Public Health Service Act funding through the federal Health Resources and Services Administration (HRSA)
- Area Health Education Centers (AHEC)
- National Health Service Corps (NHSC)
- Medicare's Critical Access Hospital Flex program
- Rural Health Clinics Act (RHC)

The programs are part of the solution to the problem of appropriate distribution of health care providers. For example, from 1990 to 2009, Title VII funded PA grads were 47% more likely to work in rural health clinics.[xxvii]

In addition to burdensome laws, a lack of transparency in billing and payment for services delivered by PAs obscures the PA contribution to care. Payers who do not enroll PAs but accept "incident to" billing or pay for PA-provided care under a physician's name and NPI mask PA contributions to patient care. PA-provided services should be identifiable as such and should be measured in the same manner as that of other health care providers. Arguably, the greatest hurdle is the need for more providers of mental health services in rural and frontier areas. The most significant barrier to PAs collaborating with psychiatrists is lack of third party payment. While Medicare includes PAs among the health professionals eligible to furnish outpatient diagnosis and treatment for mental disorders, many private behavioral health companies do not recognize or reimburse PAs.

Encouragingly, Congress has recently removed one such unnecessary barrier to PAs providing care. The opioid abuse epidemic across the U.S. has severely impacted rural America. Until recently PAs could only legally prescribe buprenorphine for pain management but could not prescribe it for treatment of opioid addiction. Since the opioid abuse epidemic has hit rural America disproportionately hard, that regulation had been particularly problematic in rural areas that only had PA providers available. In July 2016, however, the passage of the Comprehensive Addiction and Recovery Act (P.L. 114-198) legislation changed federal law to provide PAs the legal authority to prescribe buprenorphine as an opioid addiction treatment.

A disproportionately higher number of Medicare beneficiaries in rural areas vs. urban areas makes it even more important to take into account reimbursement levels and particularly differences in rural versus urban actual costs for services in the move to new value-based payment models.

State Policies and Programs

State legislatures across the country modernize PA laws and regulations every year. Key areas of modernization include laws governing efficient collaboration between PAs and physicians, patient access to PAs, and enrollment of PAs as providers in state Medicaid programs.

Despite advances, improvements can still be made. Rural patients would particularly benefit from updated laws allowing practices to decide an individual PA's scope; eliminate legal requirements for PAs to have a specific relationship with a physician in order to practice and leave decisions about the necessary level of collaboration with a physician up to each practice.

All states have laws and regulations that explicitly authorize physicians to collaborate with PAs through electronic communication, but some states couple that authorization with requirements that a physician visit at particular intervals or be within a certain travel time or distance. Statutes and regulations that impose these types of restrictions interfere with patient access and provider availability.

For example, in Missouri, until 2013, the state required a physician to be onsite 66 percent of the time a PA spent with patients and had to otherwise be within 30 miles. The 2013 law reduced those requirements so that a physician must be onsite for a half-day every two weeks and must otherwise be within 50 miles. While this change is a laudable improvement, the law still imposes an unnecessary burden on physicians and PAs in a state where 97 percent of the land and 30 percent of the residents are rural.[xxviii]

In addition to removing barriers from PA practice laws, each state must define the regulatory agency responsible for implementation of those laws. The preferable regulatory structure is a PA licensing board composed of a majority of PA, and other members who are knowledgeable about PA education, certification, and practice. If regulation is administered by a multidisciplinary healing arts or medical board, the full voting membership must include PAs and physicians who practice with PAs.[xxix]

Team practice—with the ability to make referrals or collaborate and consult with physicians—is central to PA practice. However, state laws that require a PA to have a specific association with a designated physician or group of physicians limits both PAs and physicians, which are constraints rural communities cannot afford.

Summary

Providing adequate health care services in rural America is a complex challenge. Workforce analyses and recommendations should include every type of medical professional who can serve rural communities. Increased numbers and better distribution of PAs in rural areas can be achieved if practice barriers are removed and reimbursement and incentives payments are appropriate.

Many factors affect whether or not providers choose rural practice. The NRHA provides a neutral, collaborative setting where different interest groups can come together to discuss solutions to the challenges of delivering health care services in rural settings. NRHA's goal in the U.S. health care delivery system of the future is to ensure access to quality health care for all rural residents. To enable PAs to maximize their contribution toward achieving that goal, we offer the following recommendations.

1. **National and state workforce policies should ensure adequate supplies of PAs and other providers to improve access to quality care and to avert anticipated provider shortages.**
2. **All new and emerging care models and payment systems should fully recognize PAs as providers of medical services.**
3. **Laws and regulations should allow scope of practice details for individual PAs to be decided at the practice level.**
4. **PAs should be included in programs to recruit and retain rural providers.**
5. **Regulatory and policy updates are needed to remove barriers to optimal PA practice in rural**

communities. Public and private agencies and organizations, including NRHA, should work together to ensure that regulatory changes in publicly funded programs have a positive impact and do not adversely affect access to health care in rural areas.

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6. **Public and private payers should adopt standards of transparency and accountability, credentialing and enrolling PAs so that PA performance can be, and further, PAs should be eligible for direct payment from all public and private payers.**
7. **Public and private payers should cover mental health care services provided by PAs, which will help to increase access to mental health care for rural patients.**
8. **Health care workforce development programs should recognize and support PAs.**
9. **State legislatures and regulatory agencies should modernize PA practice laws by removing barriers to optimal team practice and ensure PA representation on regulatory boards.**

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. DEPARTMENT OF THE TREASURY
U.S. DEPARTMENT OF LABOR

The President
The White House
Washington, DC 20500

Dear Mr. President:

On October 12, 2017, through Executive Order 13813, you directed the Administration, to the extent consistent with the law, to facilitate the development and operation of a health care system that provides high-quality care at affordable prices for the American people by promoting choice and competition. We are pleased to provide you with this report, prepared by the Department of Health and Human Services (HHS) in collaboration with the Departments of the Treasury and Labor, the Federal Trade Commission, and several offices within the White House. This report describes the influence of state and federal laws, regulations, guidance, and polices on choice and competition in health care markets and identifies actions that states or the Federal Government could take to develop a better functioning health care market.

As health care spending continues to rise, Americans are not receiving the commensurate benefit of living longer, healthier lives. Health care bills are too complex, choices are too restrained, and insurance premiums and out-of-pocket costs are climbing faster than wages and tax revenue. Health care markets could work more efficiently and Americans could receive more effective, high-value care if we remove and revise certain federal and state regulations and policies that inhibit choice and competition.

The Administration has already taken significant steps to improve health care markets by addressing government rules and programs that limit choice and competition and produce higher prices for the American people. Among the most significant actions:

- In October 2018, the Departments of HHS, the Treasury, and Labor proposed a rule that would provide employers with significant new flexibility in how they fund health coverage through Health Reimbursement Arrangements (HRAs). If finalized, this flexibility would empower individuals to take greater control over what health insurance benefits they receive. The Treasury estimates that more than 10 million employees would benefit from this change within the next decade.

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Section 3: Government Healthcare Policies and Their Effect on Competition

Healthcare Workforce and Labor Markets

In competitive markets, suppliers of goods or services respond to market signals that suggest growing demand for the goods or services by increasing prices, which provides incentives to increase the supply of goods and services. Government policies that reduce the available supply of qualified healthcare service providers or the range of services they may safely offer can increase the prices paid for healthcare services, reduce access to care, and suppress the benefits of competition and innovation in healthcare delivery. Such regulations can also unnecessarily limit the types or locations of providers authorized to practice or the range of services they can provide.

Government rules restrict competition if they keep healthcare providers from practicing to the "top of their license"— i.e., to the full extent of their abilities, given their education, training, skills, and experience, consistent with the relevant standards of care. Such rules, including restrictions on the appropriate use of telehealth technologies, unnecessarily limit the types or locations of providers authorized to practice, or the range of services they can provide, in contrast to regulations tailored to address specific and non-speculative health and safety concerns.

With respect to physicians in particular, certain policies relating to graduate medical education (GME), as well as significant restrictions on the ability of foreign-trained doctors to practice in the United States may also unnecessarily limit the supply of physicians available to provide care to Americans. Reduced competition among qualified physicians inevitably leads to higher prices for physician services and generally reduces the quality of care. Consistent with overarching patient health and safety concerns, the discussion below examines potential benefits of more flexible approaches to GME and the treatment of foreign-trained doctors that could increase physician supply and promote additional competition and consumer choice.

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Scope of Practice

State licensing and scope-of-practice (SOP) restrictions are common components of state licensure statutes and regulatory codes for healthcare professions.[85] Licensure regulates entry into an occupation since a worker must obtain the permission of a government agency or government-authorized regulatory board before providing certain services.[86] For numerous healthcare occupations, a state licensing authority stipulates minimum education, training requirements, and certification, among other criteria, for those who seek to acquire or maintain a license to practice a given profession or provide certain services.[87] SOP regulations "describe the metes-and-bounds of licensure—what a given professional license permits a person to do and, often, prohibits others from doing."[88]

SOP laws and regulations, like other health and safety regulations, may be justified when there are substantial risks of consumer harm.[89] These regulations may be especially important with respect to certain healthcare professions, where consumers might be at risk of serious harm if they were treated by unqualified individuals, and where patients might find it difficult (if not impossible) to assess quality of care at the time of delivery.[90] Still, even well-intentioned regulations may impose unnecessary restrictions on provider supply and, therefore, competition. Oftentimes, too, SOP restrictions limit provider entry and ability to practice in ways that do not address demonstrable or substantial risks to consumer

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[90] See, e.g., *Prepared Statement of the Federal Trade Commission on Competition and Occupational Licensure, Before the H. Comm. on the Judiciary, Subcomm. on Regulatory Reform, Commercial, and Antitrust Law,* 115th Cong., 7-8 (Sept. 12, 2017). https://www.ftc.gov/system/files/documents/public_statements/1253073/house_testimony_licensing_and_rbi_act_sept_2017_vote.pdf. Accessed August 22, 2018; FTC Staff. Policy perspectives: competition and the regulation of advanced practice nurses. Federal Trade Commission. March 7, 2014. https://www.ftc.gov/reports/policy-perspectives-competition-regulation-advanced-practice-nurses. Accessed August 22, 2018.

health and safety.[91] When this happens, these undue restrictions are likely to reduce healthcare competition and harm consumers—including patients, and taxpayers more generally.[92]

When state regulators impose excessive entry barriers and undue restrictions on SOP for particular types of providers, they often are not responding to legitimate consumer protection concerns. There is a risk that healthcare professionals with overlapping skill sets will seek these restrictions; they view SOP restrictions as an easy, state-sanctioned opportunity to insulate themselves from competition.[93] The risk of anti-competitive harm may be even greater when the regulatory board that imposes SOP restrictions on one occupation is controlled by members of another, overlapping occupation that provides complementary or substitute services,[94] and the board members are themselves active market participants with a financial stake in the outcome.[95]

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[91] Occupational licensing: a framework for policy makers. U.S. Department of the Treasury, Council of Economic Advisors, and the Department of Labor. July 2015, at 12-13; Cox C, Foster S. Bureau of Economics, Federal Trade Commission. The Costs and Benefits of Occupational Regulation, at 3. 1990. http://www.ramblemuse.com/articles/cox_foster.pdf. Accessed August 22, 2018. Policy perspectives: competition and the regulation of advanced practice nurses. Federal Trade Commission. March 7, 2014, at 14-15. https://www.ftc.gov/reports/policy-perspectives-competition-regulation-advanced-practice-nurses. Accessed August 22, 2018.

[92] *Id. Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses, supra note 86, at 14.*; *Prepared Statement of the Federal Trade Commission on Competition and the Potential Costs and Benefits of Professional Licensure, Before the H. Comm. on Small Business*, 113th Cong. (July 16, 2014), https://www.ftc.gov/system/files/documents/public_statements/568171/140716professionallicensurehouse.pdf. Accessed August 22, 2018. Correspondingly, the adoption of regulations that recognize new provider categories can sometimes lower the average regulatory burden placed on certain healthcare services, to the extent that these newly licensed workers may compete with professionals in established licensure categories.

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[95] *License to Compete: Occupational Licensing and the State Action Doctrine, Hearing Before the S. Comm. on the Judiciary, Subcomm. on Antitrust, Competition Pol'y and Consumer Rights*, 114th Cong., 1 (Feb. 2, 2016); *cf. N.C. State Bd. of Dental Exam'rs v. FTC*, 135 S. Ct. 1101, 1114 (2015).

For example, advanced practice registered nurses (APRNs),[96] physician assistants (PAs),[97] pharmacists,[98] optometrists, [99] and other highly trained professionals can safely and effectively provide some of the same healthcare services as physicians, in addition to providing complementary services. Similarly, dental therapists and dental hygienists can safely and effectively provide some services offered by dentists, as well as complementary services.[100]

SOP statutes and rules often unnecessarily limit the services these "allied health professionals"[101] can offer. A 2011 Institute of Medicine (IOM) report surveyed "[e]vidence suggest[ing] that access to quality care can be greatly expanded by increasing

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[97] U.S. Congress, Office of Technology Assessment. *Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis.* Health Technology Case Study 37. OTA-HCS-37. Washington, DC: U.S. Government Printing Office; December 1982:39. https://www.princeton.edu/~ota/disk2/1986/8615/8615.PDF. Accessed August 22, 2018. ("Most observers conclude that most primary care traditionally provided by physicians can be delivered by [nurse practitioners and physician assistants].")

[98] Jorgenson D, Dalton D, Farrell B, Tsuyuki RT, Dolovish L. Guidelines for pharmacists integrating into primary care teams. *Can Pharm. J.* 2013 Nov;146(6):342-352; Durham MJ, Goad JA, Neinstein LS, Lou M. A comparison of pharmacist travel-health specialists' versus primary care providers' recommendations for travel-related medications, vaccinations, and patient compliance in a college health setting. *J Travel Med.* 2011 Jan-Feb;18(1):20-25; Hecox N. Tuberculin skin testing by pharmacists in a grocery store setting. *J Am Pharm Assoc.* 2008 Jan-Feb;48(1):86-91.

[99] FTC, Bureau of Consumer Protection. *Staff Report on Advertising of Ophthalmic Goods and Servs and Proposed Trade Reg. Rule*, 16 CFR Part 456, 17-19 (1977).

[100] For example, dental hygienists can provide preventive dental care, while dental therapists can provide limited restorative services as well as preventive services. Dentists can provide these services as well as the full range of more complex dental services. See, e.g., *FTC Staff Comment to the Ohio State Senate Regarding the Competitive Effects of SB 330 in Increasing Access to Quality Dental Care* (2017), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-ohio-state-senate-regarding-competitive-effects-sb-330-increasing-access-quality/v170003_ftc_staff_comment_to_ohio_state_senate_re_ohio_sb_330_re_dental_therapists_and_hygienists.pdf (accessed September 26, 2018); *FTC Staff Comment Before the Commission on Dental Accreditation Concerning Proposed Accreditation Standards for Dental Therapy Education Programs* (2013). https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-commission-dental-accreditation-concerning-proposed-accreditation-standards-dental/131204codacomment.pdf. Accessed September 20, 2018.

[101] We use the term broadly, acknowledging that "[t]he allied health workforce includes hundreds of professionals employed in different professions with different job duties and different levels of preparation, but there is no single definition of "allied health" or list of allied health occupations. All formulations exclude physicians and dentists, and most exclude nurses. Others exclude pharmacists, physician assistants, and more." IOM (Institute of Medicine). *Allied Health Workforce and Services: Workshop Summary*. Washington, D.C.: The National Academies of Sciences Engineering Medicine; 2011.

the use of . . . APRNs in primary, chronic, and transitional care,"[102] and expressed concern that SOP restrictions "have undermined the nursing profession's ability to provide and improve both general and advanced care."[103] In fact, research suggests that allowing allied health professionals to practice to the full extent of their abilities is not a zero sum game for other medical professionals, and may actually improve overall health system capacity.[104] The previously mentioned IOM report found that APRNs' scope of practice varies widely "for reasons that are related not to their ability, education or training, or safety concerns, but to **the political decisions of the state** in which they work."[105]

State decisions about scope of practice and reimbursement can also affect the development and utilization of allied health professionals, particularly in public programs. Private insurance has the flexibility to incentivize patients to find lower-cost, higher-quality provider alternatives when feasible. Public programs, more restricted by state regulations, can be less responsive to such changes in the healthcare workforce, even after scope of practice regulations accommodate them. Currently, for example, states vary widely in the degree to which they permit their Medicaid programs to reimburse allied health professionals directly for services. Services provided under the direct supervision of a physician are reimbursed as if the physician provided those services. State Medicaid programs can also pay for PA, nurse practitioner, and certified nurse midwife (CNM) services provided outside of a physician's office, but only if state scope-of-practice laws do not require onsite supervision by physicians. Some states allow allied health professionals to bill Medicaid directly, while other states require them to bill under the physician's number. For patients to realize the benefits of changes to state SOP restrictions, state Medicaid programs would need to reimburse allied health professionals independently for their services.

As noted by FTC staff, "when APRN access to the primary care market is restricted, healthcare consumers—patients and other payers—are denied some of the competitive

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[102] Institute of Medicine, National Acad. of Sciences. *The Future of Nursing: Leading Change, Advancing Health.* Washington DC: National Academies Press; 2011:27; see also IOM (Institute of Medicine). *Allied Health Workforce and Services: Workshop Summary.* Washington, D.C.: The National Academies of Sciences Engineering Medicine; 2011:88 ("Given current concerns about a shortage of primary care health professionals, the committee paid particular attention to the role of nurses, especially APRNs, in this area."). The extent to which APRNs and other professionals might augment the primary care workforce has been of policy interest for some time. See, e.g., U.S. Congress, Office of Technology Assessment. *Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis.* Health Technology Case Study 37. OTA-HCS-37. Washington, D.C.: U.S. Government Printing Office; December 1986. ("Most observers conclude that most primary care traditionally provided by physicians can be delivered by [nurse practitioners and physician assistants].")

[103] Institute of Medicine, National Academy of Sciences. *The Future of Nursing: Leading Change, Advancing Health.* Washington D.C.: National Academies Press; 2011:4.

[104] Improving efficiency in the healthcare system: removing anti-competitive barriers for advanced practice registered nurses and physician assistants. The Hamilton Project. Policy brief 2018-08. June 2018. http://www.hamiltonproject.org/assets/files/AM_PB_0608.pdf. Accessed August 22, 2018.

[105] Institute of Medicine, National Academy of Sciences. *The Future of Nursing: Leading Change, Advancing Health.* Washington D.C.: National Academies Press; 2011:5.

benefits that APRNs, as additional primary care service providers, can offer."[106] Slightly more than half the states require supervision and "collaborative practice" requirements, which can operate as de facto supervision requirements. These are a particular source of concern to the extent that they raise the cost of APRN-provided services.[107] In addition, rigid "collaborative practice agreement" requirements can impede collaborative care rather than foster it because they limit the ability of healthcare professionals to adapt to varied healthcare demands, thereby constraining provider innovation in team-based care.[108] Economic analysis indicates that expanding APRN SOP, consistent with APRN education, training, and experience, would have clear consumer benefits, particularly in rural and poorer areas:

> In underserved areas and for underserved populations, the benefits of expanding supply are clear: Consumers will have access to services that were otherwise unavailable. Even in well-served areas, the supply expansion will tend to lower prices for any given level of demand, thus lowering healthcare costs.[109]

Similar concerns about the competitive impact of supervision and "collaborative practice" requirements can apply to other healthcare occupations. Even when some form of collaboration or supervision might be desirable, particular requirements might be unnecessary, over-rigid, and costly barriers to the efficient delivery of healthcare services.[110]

Extremely rigid collaborative practice agreements and other burdensome forms of physician and dentist supervision are generally not justified by legitimate health and safety concerns. Thus, many states have granted full practice authority to APRNs, but there is significant room for improvement in other states and for other professions.[111] Emerging

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[106] FTC Staff. Policy perspectives: competition and the regulation of advanced practice nurses. Federal Trade Commission. March 7, 2014. https://www.ftc.gov/reports/policy-perspectives-competition-regulation-advanced-practice-nurses. Accessed August 22, 2018.

[107] Dep't Veterans Affairs, Economic Impact Analysis for RIN 2900-AP44, Advanced Practice Registered Nurses, attachment 1, 5-7 (Nov. 9, 2016), >https://www.va.gov/ORPM/docs/RegMgmt_ImpactAnalysis_AP44(F)_AdvancedPracticeRegisteredNurses.docx<.

[108] *Id.* at 20.

[109] *Id.* at 27.

[110] See generally, e.g., FTC Staff. Policy perspectives: competition and the regulation of advanced practice nurses. Federal Trade Commission. March 7, 2014. https://www.ftc.gov/reports/policy-perspectives-competition-regulation-advanced-practice-nurses. Accessed August 22, 2018, (regarding APRNs); *FTC Staff Comment to the Ohio State Senate Regarding the Competitive Effects of SB 330 in Increasing Access to Quality Dental Care* (2017). https://www.ftc.gov/policy/advocacy/advocacy-filings/2017/03/ftc-staff-comment-ohio-state-senate-regarding-competitive. Accessed August 22, 2018 (regarding dental therapy); *FTC Staff Comments to the Iowa Board of Physician Assistants on Proposed New Rules: 645—327.8: Definition of Physician Supervision of a Physician Assistant* (2016). https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-professional-licensure-division-iowa-department-public-health-regarding-proposed/v170002_ftc_staff_comment_to_iowa_dept_of_public_health_12-21-16.pdf. Accessed August 22, 2018 (regarding physician assistants).

[111] According to the American Academy of Nurse Practitioners, 22 states plus the District of Columbia now grant full practice authority to APRNs. https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment.

healthcare occupations, such as dental therapy, can increase access and drive down costs for consumers, while still ensuring safe care. States should be particularly wary of undue statutory and regulatory impediments to the development of such new occupations.

Recommendations: Broaden Scope of Practice

- States should consider changes to their scope-of-practice statutes to allow all healthcare providers to practice to the top of their license, utilizing their full skill set.
- The federal government and states should consider accompanying legislative and administrative proposals to allow non-physician and non-dentist providers to be paid directly for their services where evidence supports that the provider can safely and effectively provide that care.
- States should consider eliminating requirements for rigid collaborative practice and supervision agreements between physicians and dentists and their care extenders (e.g., physician assistants, hygienists) that are not justified by legitimate health and safety concerns.
- States should evaluate emerging healthcare occupations, such as dental therapy, and consider ways in which their licensure and scope of practice can increase access and drive down consumer costs while still ensuring safe, effective care.

Workforce Mobility

State-based licensing requirements, by their nature, inhibit provider mobility.[112] These requirements add time and expense when healthcare providers seek to move or work across state lines. Markets cannot be as responsive to economic change when workers cannot easily move to meet the demand for their services.[113]

Accessed August 22, 2018. For examples of state restrictions on SOP besides supervision requirement see, e.g., Institute of Medicine, National Academy of Sciences. *The Future of Nursing: Leading Change, Advancing Health*. Washington, D.C.: National Academies Press; 2011:100-102, Box 3-1 Variation in State Licensure Requirements; FTC Staff. Policy perspectives: competition and the regulation of advanced practice nurses. Federal Trade Commission. March 7, 2014. https://www.ftc.gov/reports/policy-perspectives-competition-regulation-advanced-practice-nurses. Accessed August 22, 2018, at notes 35-37 and accompanying text.

[112] Licensing rules are almost always state-based. See, e.g., *Dent v. West Virginia*, 129 U.S. 114 (1889) (upholding the authority of the State of West Virginia to license physicians); Health Resources and Services Administration, U.S. Department of Health and Human Services. Telehealth licensure report. Report 111-66. Special Report to the Senate Appropriations Committee (Requested by Senate). 2010. ("For over 100 years, health care in the United States has primarily been regulated by the states. Such regulation includes the establishment of licensure requirements and enforcement standards of practice for health providers, including physicians, nurses, pharmacists, mental health practitioners, etc.")

[113] See, e.g., *Occupational Licensing: Regulation and Competition: Hearing Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the House Comm. on the Judiciary,* 115th Cong. 1, 8-9 (2017) (statement of Maureen K. Ohlhausen, Acting Chairman, Federal Trade Commission). https://www.ftc.gov/system/files/documents/public_statements/1253073/house_testimony_licensing_and_rbi_act_sept_

State-based licensing also often inhibits delivery of healthcare services across state lines by making it more difficult for qualified healthcare professionals licensed in one state to work in another state, even though most healthcare providers complete nationally certified education and training programs and sit for national qualifying exams.[114] Appropriate standards of care do not differ from state to state. Yet, even when a profession's underlying standards are national in scope, and when state licensing requirements are similar throughout the United States, the process of obtaining a license in another state is often slow, burdensome, and costly.[115] There is little economic justification for the redundant licensing processes that many states impose on licensed, out-of-state applicants. Even when there may be plausible consumer-protection concerns, the harm to consumers likely outweighs any benefits.[116]

The effects of state-based licensing are especially apparent in fields where providers routinely communicate electronically and provide services in multiple states. For this reason, state-based licensing requirements can inhibit the efficient development and use of telehealth (discussed below), as well as in-person services.[117]

Interstate compacts and model laws can mitigate the effects of state-based licensing requirements by enhancing license portability. Professional associations and associations

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2017_vote.pdf. Accessed August 22, 2018; Occupational licensing: a framework for policy makers. U.S. Department of the Treasury, Council of Economic Advisors, and the Department of Labor. July 2015, at 12-16. https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf. Accessed August 25, 2018.

[114] See, e.g., Health Resources & Services Administration, U.S. Department of Health & Human Services. *Special Report to the Senate Appropriations Committee, Telehealth Licensure Report, Requested by Senate* Rep't 111-66 (2010), at 9, ("The basic standards for medical and nursing licensure have become largely uniform in all states. Physicians and nurses must graduate from nationally approved educational programs and pass a national medical and nursing licensure examination.")

[115] See, e.g., American Medical Association. Obtaining a medical license. http://www.ama-assn.org/ama/pub/education-careers/becoming-physician/medical-licensure.page. Accessed August 22, 2018. ("The process of obtaining a medical license can be challenging and time consuming.... Physicians seeking initial licensure or applying for a medical license in another state should anticipate delays due to the investigation of credentials and past practice as well as the need to comply with licensing standards."); U.S. Department of the Treasury and U.S. Department of Defense, Supporting our military families: best practices for streamlining occupational licensing across state lines. February 2012:12-13. http://archive.defense.gov/home/pdf/Occupational_Licensing_and_Military_Spouses_Report_vFINAL.PDF. Accessed August 22, 2018. ("Nurses moving across state lines must apply for licensure by endorsement and pay any applicable fees.")

[116] See, e.g., Nicholson S, Propper C. Medical workforce. In *Handbook of Health Economics*. Vol. 2. 1st ed. Waltham, MA: North Holland; 2012:885. (In medical labor markets, "[l]icensing is associated with restricted labor supply, an increased wage of the licensed occupation, rents, increased output prices, and no measurable effect on output quality.")

[117] See, e.g., *Comment from FTC Staff to Department of Veterans Affairs*, 3 (Nov. 1, 2017), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-department-veterans-affairs-regarding-its-proposed-telehealth-rule/v180001vatelehealth.pdf. Accessed August 22, 2018. ("State laws and regulations that require licensure of telehealth providers licensed in another state inhibit VA employees from delivering telehealth services to beneficiaries in states in which they are not licensed.")

of licensing boards typically draft model laws, which may be passed with minor variations between jurisdictions. Almost all states and other United States jurisdictions have adopted model laws with license portability provisions in other professions such as accountancy and pharmacy.[118] By contrast, interstate compacts, which are binding contracts between two or more states authorized by the United States Constitution, must be identical and have been used only recently to improve licensure portability.[119] The first interstate licensure compact, on nurse licensure, was initially implemented in 1999 and has been adopted by 30 states.[120] Other licensure compacts in the health professions are in the early stages of implementation.[121] Federal grants to state professional licensing boards have encouraged the development and implementation of various licensure compacts in several professions.[122]

Model laws and interstate compacts typically use one of two approaches to enhance licensure portability. One is reciprocity as practitioners licensed by one state are able to practice in other states without obtaining another license. Second, some states require a license in each state of practice but expedite the process.[123] By making it easier to practice in multiple states, interstate compacts and model laws can enhance access to healthcare services and improve provider mobility.

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[118] See, e.g., American Institute of Certified Public Accountants and National Association of State Boards of Accountancy. *Uniform Accountancy Act: Standards for Regulation*. 8th ed. Nashville, TN: American Institute of Certified Public Accountants; 2018. https://nasba.org/app/uploads/2018/02/Uniform-Accountancy-Act-%E2%80%93-Eighth-Edition-%E2%80%93-January-2018.pdf. Accessed August 22, 2018; Streamlining licensing across state lines: initiatives to enhance occupational licensing portability. FTC Economic Liberty Taskforce. July 27, 2017, at 19. https://www.ftc.gov/system/files/documents/public_events/1224893/ftc_economic_liberty_roundtable_-_license_portability_transcript.pdf. Accessed August 22, 2018 (transcript of roundtable). (UAA mobility provisions adopted by 53 jurisdictions.) See also National Association of Boards of Pharmacy ("NABP"). *Comment to the FTC* (2017), at 1-2, https://www.ftc.gov/system/files/documents/public_comments/2017/07/00016-141084.pdf. Accessed August 22, 2018. ("As required by the *NABP Constitution and Bylaws,* all NABP members participate in e-LTP and the NABP Clearinghouse.") The number of model laws with license portability provisions is unknown because they are not tracked by any organization.

[119] U.S. Constitution Art. I, § 10, cl. 3.

[120] See FTC Staff. Policy perspectives: options to enhance occupational license portability. Federal Trade Commission. September 24, 2018, at 9-10. https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper.pdf. Accessed September 26, 2018.

[121] See, e.g., Interstate Medical Licensure Compact. http://www.imlcc.org/. Accessed August 22, 2018, (adopted by 22 states); Physical Therapy Licensure Compact. http://www.fsbpt.org/FreeResources/PhysicalTherapyLicensurecompact.aspx. Accessed August 22, 2018, (adopted by 16 states).

[122] See 42 U.S.C. §254c-18; Office for the Advancement of Telehealth, U.S. Department of Health and Human Services. Funding Opportunity Announcement HRSA-16-014. 2016. https://grants.hrsa.gov/2010/Web2External/Interface/Common/EHBDisplayAttachment.aspx?dm_rtc=16&dm_attid=2f098e80-40a0-43ec-b4e7-2002033a031a. Accessed August 22, 2018.

[123] See, e.g., Streamlining licensing across state lines: initiatives to enhance occupational licensing portability. FTC Economic Liberty Taskforce. July 27, 2017, at 11-12, 16, 18-19. https://www.ftc.gov/system/files/documents/public_events/1224893/ftc_economic_liberty_roundtable_-_license_portability_transcript.pdf. Accessed August 22, 2018.

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HOUSE HUMAN SERVICES COMMITTEE

NORTH DAKOTA PHYSICIANS IN SUPPORT OF HB 1175

JANUARY 28, 2019

Physician Name	Location
Adam Nicholson, MD	Grand Forks
Andres Makarem, MD	Grand Forks
Anthony Chu, MD	Grand Forks
Anthony Johnson, MD	Mandan
Attas Boutrous, MD	Bismarck
Casey Ryan, MD	Grand Forks
Casmair Nwaigwe, MD	Minot
Chenelle Joseph, MD	Grand Forks
Cordell Davis, DO	Grand Forks
Corey Dean Arcelay, MD	Belcourt
Douglas Hess, DO	Fargo
Emmanuel A. Gaid, MD	Belcourt
Eric Johnson, MD	Grand Forks
Eric Tee, MD	Fargo
Frederick K. Ness, MD	Belcourt

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Jon W. Allen, MD	Grand Forks
Kate Kessler, DO	West Fargo
Kulvinder Sumra, MD	Cavalier
Lara Lunde, MD	Fargo
Mark Longmuir, MD	Stanley
Patrick Kane, MD	Grand Forks
Paula Bercier, MD	Belcourt
Richard Larson, MD	Belcourt
Ronald Knutson, MD	Bismarck
Ryan Hoovestol, MD	Bismarck
Sara Nausheen, MD	Grand Forks
Shannon Mark Sell, DO	Fargo
Shanta Gautham, MD	Grand Forks
Sreejith Gopi, MD	Fargo
Stefan Johnson, MD	Grand Forks
Steven Meek, MD	Fargo
Susan Thompson, MD	Cavalier
Tom Thorson, MD	Mandan
William Zaks, MD	Grand Forks

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Unanimous Approval by ND Board of Medicine Physicians on 11/18/2018	**Location**
Robert J. Olson, MD, Chair	Fargo
Genevieve Goven, MD, Vice Chair	Valley City
Rupkumar Nagala, MD, Treasurer	Oakes
Brenda Miller, MD	Bismarck
William Haug, Jr., MD	Grand Forks
Sara Solberg, MD	Williston
Thomas Carver, DO	Minot
Robert Sticca, MD	Grand Forks
Catherine Houle, MD	Hettinger
Gopal Chemiti, MD	Fargo

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#5

HOUSE HUMAN SERVICES COMMITTEE
HB 1175

Testimony of Kate Larson, PA-C
January 28, 2019

Chairman Weisz, Members of the House Human Services Committee, thank you for the opportunity to provide testimony on this important bill. My name is Kate Larson and I am a physician assistant (PA) and I am speaking in support on HB 1175.

I have been a physician assistant for the past 23 years, practicing for 21 years in rural health care in ND, and currently practice for the Veteran's Health Administration. I am also currently a Board Member on the North Dakota Board of Medicine. I am here representing North Dakota physician assistants.

This bill is an important step in improving access to care for patients in North Dakota. Currently, we are required to have a supervisory contract with a physician. HB 1175 would eliminate this contract and allow us to work with the healthcare team at the practice level. When working in rural health, this contract creates many difficulties. There may only be one physician in some rural areas or no physician at some satellite clinics. Physicians are sometimes supervising multiple providers and this creates an unnecessary burden for them. It also creates difficult situations when supervising physicians are on vacation, leave the country, or have their own emergent situations.

HB 1175 will also improve practice opportunities for physician assistants in North Dakota. This will improve patient access to the care they need. There have been recent instances where physician assistants were not considered for practice positions that they were more than qualified to fill due to the required supervisory contract obligation. There are physician assistants that are qualified to practice in rural emergency rooms, urgent care clinics, and hospitals, and the changes proposed in HB 1175 would provide opportunities for PAs to be considered for these open positions.

I believe we have proven ourselves as a profession and will continue to work collaboratively at the practice level with physicians and other members of the health care team.

Thank you again for this opportunity, your consideration for this bill, and for your service to North Dakota.

Sincerely,
Kate Larson, PA-C

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#6

House Human Services Committee

HB 1175

January 28, 2019

Chairman Weisz and Members of the House Human Services Committee, I am Shirley Porter and I serve as President of the North Dakota Medical Imaging and Radiation Therapy Board (NDMIRT).

The North Dakota Medical Imaging and Radiation Therapy Board has the responsibility to protect the public by licensing and regulating personnel performing medical imaging procedures and radiation therapy treatments. This responsibility includes setting minimum standards for licensure, establishing scopes of practice, enforcing disciplinary actions, further developing standards, and adopting rules for the improvement of the administration of medical imaging or radiation therapy procedures in North Dakota. As of January 2019 we currently have about 1500 medical imaging and radiation therapy professionals licensed.

The performance of medical imaging or radiation therapy is safely accomplished by Registered radiologic technologists — known as "R.T.s" — they must complete at least two years of formal education in an accredited hospital-based program or a two- or four-year educational program at an academic institution and must pass a national certification examination. To remain registered, they must earn continuing education credits. To briefly summarize, they are educated in anatomy, patient positioning, examination techniques, equipment protocols, radiation safety, radiation protection and basic patient care. They are responsible for accurately positioning patients and ensuring that a quality diagnostic image is produced. To further briefly explain a Registered radiation therapist is trained to perform radiation therapy, usually on cancer patients aiming high doses of precision radiation at the affected area, while also being required to earn continuing education credits. Continuing education allows imaging professionals to stay fluid with the ever-changing practice of medical imaging and radiation therapy as new areas evolve and other areas may phase-out with the arrival of new technologies.

We appear before you today in support of the spirit of HB 1175. We understand the need for providers in our rural communities and offer our assistance in making access easier and more convenient for our patients. When the Board reviewed HB 1175 we viewed it as overly broad in scope in order to achieve the goals of access. We feel there are some concerns with patient safety in the areas of medical imaging, specifically ionizing radiation. We would like to clarify some conflicting language on page 2, lines 13-17 within section 2 in regards to the intent of “performing”. This section appears to be in conflict with section 3, lines 30-31 and page 3, letter c., lines 5-6.

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It appears in section 2, page 2, lines 13-17 that PAs are not authorized to perform any services that must be performed by persons licensed pursuant to chapters 43-12.1 which is the Nurse Practices Act, 43-13 Optometrists, 43-15 Pharmacists, and 43-28 Dentists and **-this is the patient safety concern and concerning conflict language;** *"or services otherwise regulated by licensing laws, notwithstanding medical doctors need not be licensed specifically to perform the service contemplated under such chapters or licensing laws".*

This language appears to also conflict with language in section 3, page 2, lines 30-31 number (3) which states: *"(3) Ordering, performing, and interpreting a diagnostic study and therapeutic procedure;"* as well as page 3, lines 5-6, letter c. which states: *"Supervise, delegate, and assign therapeutic and diagnostic measures to licensed or unlicensed personnel;".*

Attached to this testimony are proposed amendments prepared by the Board's assistant attorney general to assist in clarifying the above conflicting language and patient safety concerns of the Medical Imaging and Radiation Therapy Board.

Brief overview of proposed amendments to HB 1175:

Page 2, line 30, removes ", performing," and replace the word "interpreting" with "evaluating".

Page 2, last line 31, after the word "procedures;" inserts **"not involving the use of medical imaging as defined in section 43-62-01 or radiation therapy as defined in section 43-62-01."**

- This insertion of language clearly defines that PAs are not authorized to perform any services otherwise regulated by licensing laws, such as medical imaging and radiation therapy, as stated in section 2, page 2, lines 15-17 and resolves the patient safety concerns and language conflicts.

Lastly page 3, line 5, letter c. after the word "measures" inserts the same language of **"not involving the use of medical imaging as defined in section 43-62-01 or radiation therapy as defined in section 43-62-01."**

- Again this insertion of language resolves the patient safety concerns and language conflicts.

Mr. Chairman and Committee members, the North Dakota Medical Imaging and Radiation Therapy Board would request that the Committee adopt this amendment, and recommend a DO PASS to amended HB 1175. That concludes my formal testimony and I would be happy to answer any questions you may have.

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PROPOSED AMENDMENTS TO HOUSE BILL NO.1175

Page 2, line 30, remove ", performing,"

Page 2, line 30, replace "interpreting" with "evaluating"

Page 2, line 31, after the semicolon insert "(4) Performing a diagnostic study or therapeutic procedure not involving the use of medical imaging as defined in section 43-62-01 or radiation therapy as defined in section 43-62-01;"

Page 3, line 5, after "measures" insert "not involving the use of medical imaging as defined in section 43-62-01 or radiation therapy as defined in section 43-62-01;"

Renumber accordingly

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#7

Testimony on Behalf of Bismarck Radiology Associates
House of Human Services Committee

My name is Dr. Luke Roller and I am here as a representative of a local radiologist group to express support for the proposed changes as being presented today by the North Dakota Society of Radiologic Technologists (NDSRT), the national American Society of Radiologic Technologists (ASRT) and the national Society of Radiologist Physician Extenders (SRPE). I would also specifically like to address the language within the bill regarding "interpret" diagnostic examinations and therapeutic procedures. I believe a language change to "evaluate" would be more appropriate. This is located on Scope of Practice line 30 in the HB1175 bill.

With medical imaging, Radiologists have at least 5 years of advanced training and education to perform the interpretation of medical imaging. This is after completion of medical school. In addition, often radiologist choose to do an additional 1 to 3 years of fellowship following residency in order to perform interpretation of all medical imaging. There is also a required continuing education component which covers the individual specific modalities the radiologist interprets in their working environment.

Interpretation of medical imaging includes advanced imaging modalities like Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) which are complex examinations that require advanced education and training to provide appropriate interpretation and to ensure the safety of patients.

Thank you for your time.

Respectfully,

Bismarck Radiology Associates

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#8

Testimony on Behalf of the North Dakota Society of Radiologic Technologists (NDSRT).

House of Human Services Committee

Mr. Chairman and members of the House of Human Services Committee. My name is Danielle Goetz and I am the current Vice President/ Interim President of the North Dakota Society of Radiologic Technologists. I would like to tell you about myself. I have been working in Radiology for 13 years and my current role is working as a Quality Management Technologist with the Sanford Physics Department. My unique roll allows me to work within all radiology modalities. I not only work in big town hospitals, but also all of our satellite clinics in the rural parts of North Dakota. My primary focus in my job is to optimize all our radiology machines and make sure we provide all patients with as low of radiation as possible.

I would first like to make known that we as a society are in support of HB 1175 with a few modifications made to the language currently being used. We propose to amend the language and make it more specific and clear.

The amendment is to the language under Scope of Practice line 30.

43-17-02.1. Physician assistant - ~~Limitations on prescribing drugs~~Scope of practice.

1. A physician assistant may ~~prescribe medications as delegated to do so by a supervising physician. This may include schedule II through V controlled substances. A physician assistant who is a delegated prescriber of controlled substances must register with the federal drug enforcement administration.~~:

   a. Provide a legal medical service for which a physician assistant is prepared by education, training, and experience and is competent to perform, including:

      (1) Obtaining and performing a comprehensive health history and physical examination;

      (2) Evaluating, diagnosing, managing, and providing medical treatment;

      (3) Ordering, performing, and interpreting a diagnostic study and therapeutic procedure;

We propose this to be changed to read " performing a diagnostic study or therapeutic procedure not involving the use of medical imaging as defined in 43-62-01.5 NDCC, or radiation therapy as defined in 43-62-01.9, NDCC."

Radiology is an ever-changing field and because of this we are required to receive two to four years of education depending on our specialty area. We also take a nationally accredited test to demonstrate our competency in addition to a mandatory 12 containing education credits annually that are specific to our specialty fields. Because of the increasing hazards of fluoroscopy, this year the Joint Commission is requiring everyone that operates a fluoroscopy producing machine to take additional training to ensure everyone understands their equipment and how to optimize them to safeguard against over radiation exposure. This is on top of other mandatory education that is required specific to our modalities of practice. This additional requirement is also being asked for all Physicians that operate fluoroscopy as well. Specialized training is being required for this specialty imaging modality because of the hazards of radiation. This demonstrates the severeness that radiation can induce and that even physicians are being required to take additional training.

The second amendment is to the language under Scope of Practice top of page two, subsection C, line 5.

(4) Educating a patient on health promotion and disease prevention;
(5) Providing consultation upon request; and
(6) Writing a medical order;
b. Obtain informed consent;
c. Supervise, delegate, and assign therapeutic and diagnostic measures to licensed or unlicensed personnel;
d. Certify the health or disability of a patient as required by any local, state, or federal program;

We propose to amend this language to be refined to read “supervise, delegate and assign therapeutic and diagnostic measures, not including medical imaging procedures as defined in 43-62-01.5, NDCC, or radiation therapy as defined in 43-62-01.9, NDCC, to licensed or unlicensed personnel.”

While we support the expansion of this profession and the intent of this bill, we believe it takes additional education and a specialized body of knowledge to safety operate and delegate these procedures. The amendments that we offer support and clarify our position. If a PA or other allied health professional may want to perform some of these studies they have the ability to use the already in place pathways.

NDSRT encourages the Health and Human Services committee to vote Do Pass with submitted amended language.

Thank you for your time,

Danielle Goetz, BSRT (R)(QM)

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Testimony on Behalf of Carla Barrios

House of Human Services Committee

Mr. Chairman and members of the House of Human Services Committee. My name is Carla Barrios and I am a Radiologist Assistant (RA) working in ND. This is to express my support for the language changes proposed by the NDSRT, ASRT and the SRPE to the bill HB1175.

To become a RA, I attended a Masters level graduate program specific to performing medical image guided exams and procedures. It is a 24 month program of educational and clinical requirements similar to PA programs for Allied Health professionals, except the training, education and clinical requirements are specific to the medical imaging profession. In fact, due to the subspecialty of the program, only a Radiologic Technologist with BSRT degree and experience are qualified to apply and enter these graduate programs. I had been a Radiologic Technologist for 20 years prior to obtaining RA certification. These programs include requirements of dedicated time spent directly with a radiologist that is equivalent to 2500-3000 hours working with a radiologist to perform image guided procedures and examinations. Following my completion of the program, I was required to pass a national board examination from the accrediting body to attain certification as a RA.

As a working RA, I need to be licensed by the state NDMIRT board also to perform imaged guided procedures and examinations. I have to attain 50 hours of continuing education specific to radiology and image guided performance standards every two years with required re-examination of national board examination every 10 years to maintain my professional license. All of these requirements are to ensure the safety, diagnosis and treatment of the patients who need to have these specialized image guided procedures that many times expose patients to large amounts of ionizing radiation.

Even with the vast experience prior, during and post RA graduate programs, RA's are explicitly forbidden to interpret final reports of medical image guided procedures and examinations. RA's also have to be under the "general supervision" of a physician during their employment to ensure the safety and efficacy of procedures that are performed. The national scope of practice along with the state licensing board, NDMIRT, explicitly state interpretation of medical imaging is not allowed. Interpretation of medical imaging is the sole responsibility of a Radiologist. The broad language within the HB1175 bill is concerning because not only should a scope of practice express what all a health care provider can do, sometimes it is just as important to ensure certain procedures are specifically excluded to ensure patient safety and health care is performed by individuals whose training and education specially included the performance of those examinations.

PA programs do not provide the in-depth education, clinical requirements or extensive experience in Radiology the RA programs provide. PA programs are mainly primary care and many differing allied health professionals are allowed to apply and attend. Many of these primary care health professionals have had no experience with the specialized area of Radiology, nor do they achieve the experience in the PA programs for any

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equivalencies to the RA programs. Nor do their ongoing continuing education have medical imaging requirements.

The medical industry is constantly changing with professionals needing to provide and treat increasing number of patients at a time when reimbursement is getting difficult. We need to have all mid level professionals to meet these increasing demands. But, we need to ensure patient safety, proper diagnosis and treatment is performed by qualified individuals. These mid level graduate programs do not cover all aspects of the medical profession which is why we also have speciality graduate programs to meet the needs of the patients and the industry. It will take a team of health care providers to meet the future needs of providing high quality and safe care while improving access for all patients. That doesn't necessarily mean creating "jacks of all trades and masters of none" approach. We need primary care providers to take care of the majority of patients needs and care, but sometimes it also requires collaborating with subspecialty care specialists to ensure high quality and safe care and access.

Respectfully,

Carla Barrios MS RRA, RPA, BSRT (R)(M)

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NDNPA
NORTH DAKOTA
Nurse Practitioner Association

17 Jan 2019

Physician Assistants are licensed and regulated by the Board of Medicine; whereas, Advance Practice Registered Nurses are licensed and regulated by the ND Board of Nursing. Thus, the North Dakota Nurse Practitioner Association is neutral on bill 1175.

North Dakota Nurse Practitioner Association
www.ndnpa.org
Legislation Tracking Team
Cheryl Rising: crisingnp@gmail.com 701-527-2583
Jenna Herman: jmherman@umary.edu 612-518-3647
Tara Brandner: tbrandner04@gmail.com 701-471-9745
Additional Legislative Committee
Tisha Scheuer: tscheuer28@gmail.com
Allison Peltier: allison.peltier@ndsu.edu
Paula Moch: paulamochfnp@gmail.com

CHAPTER 43-62
MEDICAL IMAGING AND RADIATION THERAPY

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43-62-01. Definitions.

As used in this chapter:

1. "Board" means the North Dakota medical imaging and radiation therapy board.
2. "Certification organization" means a national certification organization that specializes in the certification and registration of medical imaging and radiation therapy technical personnel and which has programs accredited by the national commission for certifying agencies, American national standards institute or the international organization for standardization, or other accreditation organization recognized by the board.
3. "Licensed practitioner" means a licensed physician, advanced practice registered nurse, chiropractor, dentist, or podiatrist.
4. "Licensee" means an individual licensed by the board to perform medical imaging or radiation therapy and operate medical imaging or radiation therapy equipment, including a nuclear medicine technologist, radiation therapist, radiographer, radiologist assistant, sonographer, or magnetic resonance imaging technologist.
5. "Medical imaging" means the performance of any diagnostic or interventional procedure or operation of medical imaging equipment intended for use in the diagnosis or visualization of disease or other medical conditions in human beings, including magnetic resonance imaging, fluoroscopy, nuclear medicine, sonography, or x-rays.
6. "Medical physicist" means an individual who is certified by the American board of radiology, American board of medical physics, American board of science in nuclear medicine, or Canadian college of physics in medicine in radiological physics or one of the subspecialties of radiological physics.
7. "Primary modality" means an individual practicing as a nuclear medicine technologist, radiation therapist, radiographer, radiologist assistant, sonographer, or magnetic resonance imaging technologist.
8. "Protected health information" has the same meaning as provided under section 23-01.3-01.
9. "Radiation therapy" means the performance of any procedure or operation of radiation therapy equipment intended for use in the treatment of disease or other medical conditions in human beings.
10. "Radiation therapist" means an individual, other than a licensed practitioner or authorized user, who performs procedures and applies ionizing radiation emitted from x-ray machines, particle accelerators, or sealed radioactive sources to human beings for therapeutic purposes.

(Contingent effective date - <u>See note</u>) Definitions.

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43-62-02. License required.

An individual may not perform or offer to perform medical imaging or radiation therapy on humans for diagnostic or therapeutic purposes or otherwise indicate or imply that the individual is licensed to perform medical imaging or radiation therapy unless that individual is licensed under this chapter.

43-62-03. Exemptions.

This chapter does not apply to the following:

1. A licensed practitioner performing medical imaging or radiation therapy.
2. A dental assistant or dental hygienist licensed under chapter 43-20.
3. A student enrolled in and attending a school or college of medicine, medical imaging, or radiation therapy who performs medical imaging or radiation therapy on humans while under the supervision of a licensed practitioner or a radiographer, radiation therapist, nuclear medicine technologist, radiologist assistant, sonographer, or magnetic resonance imaging technologist holding a license in the medical imaging or radiation therapy modality for which the student is enrolled or attending.
4. An individual administering medical imaging or radiation therapy and who is employed by the United States government when performing duties associated with that employment.
5. A nurse licensed under chapter 43-12.1 who performs sonography on a focused imaging target to assess specific and limited information about a patient's immediate medical condition or to provide real-time visual guidance for another procedure.
6. A limited x-ray machine operator who meets the requirements of rules adopted by the state department of health under section 23-20.1-04.
7. Medical imaging performed as a part of a post-mortem examination or on other nonliving remains.
8. Medical imaging performed by emergency medical services personnel certified or licensed under section 23-27-04.3.

(Contingent effective date - See note) Exemptions. This chapter does not apply to the following:

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NDAPA

North Dakota Academy of Physician Assistants

North Dakota Physician Colleagues:

North Dakota physician assistants (PAs) are asking for your support in the 2019 legislative session. A bill pertaining to the regulation of PAs, HB 1175, proposes to remove the current requirement of a state-mandated supervisory contract between a PA and a physician. The proposed changes in HB 1175 were unanimously approved by the N.D. Board of Medicine at their November 16th, 2018, meeting.

The amendment **will**:

- allow PAs to practice in areas where medical providers are needed most.
- improve access to care for the citizens of North Dakota.
- remove supervising physicians' legal and disciplinary responsibilities for PAs.
- keep PAs accountable for the care that they provide.
- remove unnecessary barriers to allow PAs to practice at the level they are trained.

The amendment **will not**:

- change how PAs already collaborate with physicians and other providers.
- allow PAs to open free-standing clinics unless approved by the Board of Medicine.
- change the way PAs already practice.
- allow PAs to practice outside of their scope and training.

By signing below, you are giving your support for these proposed amendments.

S. Gopi
Signature

SREEJITH GOPI, MD
Print Name

4110 51st Ave S, FARGO, ND 58104
Practice Location

Mark Sell D.O.
Signature

Sharon Mark Sell D.O. ND Lic #6693
Print Name

Essentia Health
52nd Avenue Clinic
4110 51st Avenue
Fargo, ND 58104
Practice Location

Doug Hess DO
Signature

Douglas J. Hess, DO
Print Name

510 4th Street S. Fargo ND 58103
Practice Location

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By signing below, you are giving your support for these proposed amendments.

Signature	West Fargo, ND
Kate Kessler, DO, FAAP	Practice Location
Print Name	
Signature	Practice Location
Print Name	
Signature	Practice Location
Print Name	

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By signing below, you are giving your support for these proposed amendments.

Signature	510 4th Street South Practice Location
Eric Tee Print Name	Fargo, ND 58103
Signature	510 4th Street South, Practice Location
Steven Meek Print Name	Fargo, ND 58103
Signature	Practice Location
Print Name	

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By signing below, you are giving your support for these proposed amendments.

Signature	Practice Location: Manlow East Manlow ND
Print Name: Anthony Johnson	
Signature: Tom Thorson MD	Practice Location: Sanford East Mandan
Print Name: TOM THORSON MD	
Signature	Practice Location
Print Name	

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Signature	Practice Location: Bismarck ND
Print Name: Ryan Hoovestol	
Signature	Practice Location
Print Name	
Signature	Practice Location
Print Name	

NDAPA
1412 Cottonwood Avenue
Minot, ND 58701
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Signature	Practice Location: MN ND Family Med Sc
Print Name: Dr Lara Lunde	
Signature	Practice Location
Print Name	
Signature	Practice Location
Print Name	

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Signature	Practice Location
Casmiar Nwaigwe	Minot, ND
Print Name	
Signature	Practice Location
Print Name	
Signature	Practice Location
Print Name	

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Signature	Practice Location
Print Name: Chenelle Joseph	
Signature	Practice Location
Print Name	
Signature	Practice Location
Print Name	

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By signing below, you are giving your support for these proposed amendments.

Casey Ryan, MD Signature	Altru Health System Practice Location
Casey Ryan Print Name	GRAND FORKS, ND.
W Zaks MD Signature	Altru Health System GFK
William Zaks MD Print Name	Practice Location
Sgaultra Signature	Altru health syste
Shanta Gautra Print Name	Practice Location

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Signature

Altru Health System

Practice Location Grand Forks

ERIC C. JOHNSON MD

Print Name

Signature

Altru Health System

Practice Location Grand Forks, ND

JON W. ALLEN

Print Name

Signature

Altru Health System

Practice Location

Andres Hathaem

Print Name

HB1175
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Signature

Paula Berzier MD
Print Name

Quentin N Burdick Health Care F...
Box 160 Belcourt ND 58316
Practice Location

Signature

Corey Dean Arcelay MD
Print Name

Belcourt IHS.
Practice Location

Signature

EMMANUEL AGAID
Print Name

Belcourt IHS
Practice Location

11

NDAPA

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HB1175
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By signing below, you are giving your support for these proposed amendments.

Signature

Anthony Chu MD

Print Name

Practice Location

Signature

Practice Location

Print Name

Signature

Practice Location

Print Name

NDAPA
1412 Cottonwood Avenue
Minot, ND 58701
Email to: NDAPAboard@gmail.com

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Adam Nicholson
Signature

Adam Nicholson
Print Name

Altru Health System
Practice Location

Patrick Kase
Signature

Patrick Kase
Print Name

Altru Health System
Practice Location

Signature

Print Name

Practice Location

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NDAPA

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#12

North Dakota Physician Colleagues:

North Dakota physician assistants (PAs) are asking for your support in the 2019 legislative session. A bill pertaining to the regulation of PAs, HB 1175, proposes to remove the current requirement of a state-mandated supervisory contract between a PA and a physician. The proposed changes in HB 1175 were unanimously approved by the N.D. Board of Medicine at their November 16th, 2018, meeting.

The amendment **will**:

- allow PAs to practice in areas where medical providers are needed most.
- improve access to care for the citizens of North Dakota.
- remove supervising physicians' legal and disciplinary responsibilities for PAs.
- keep PAs accountable for the care that they provide.
- remove unnecessary barriers to allow PAs to practice at the level they are trained.

The amendment **will not**:

- change how PAs already collaborate with physicians and other providers.
- allow PAs to open free-standing clinics unless approved by the Board of Medicine.
- change the way PAs already practice.
- allow PAs to practice outside of their scope and training.

By signing below, you are giving your support for these proposed amendments.

Richard Larson MD
Signature

Quentin Burdick Health Centers
Practice Location

LARSON, RICHARD MD
Print Name

Signature

Beloonnt Hospital
Practice Location

Frederic K. K. Versmo
Print Name

Signature

Practice Location

Print Name

14

NDAPA

North Dakota Academy of Physician Assistants

#B1175
1/28/2019
12

North Dakota Physician Colleagues:

North Dakota physician assistants (PAs) are asking for your support in the upcoming legislative session. We are submitting an amendment to the N.D. Century Code that will remove the current requirement of a supervisory contract with a physician. These changes were unanimously approved by the N.D. Board of Medicine at their November 16th, 2018, meeting.

The amendment will:

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- change the way PAs already practice.
- allow PAs to practice outside of their scope and training.

By signing below, you are giving your support for these proposed amendments.

Signature	Stanley ND Practice Location
Mark Langemeier MD Print Name	
Signature	Practice Location
Print Name	
Signature	Practice Location
Print Name	

HB1175
1/28/2019
12

NDAPA

North Dakota Academy of Physician Assistants

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- change the way PAs already practice.
- allow PAs to practice outside of their scope and training.

By signing below, you are giving your support for these proposed amendments.

Signature — Practice Location: Cavalier

Susan J. Thompson M.D.
Print Name

Signature — Practice Location: Cavalier ND

Judy Pegg, PA
Print Name

Signature — Practice Location: Cavalier, ND

Print Name

NDAPA
1412 Cottonwood Avenue
Minot, ND 58701
Send to: NDAPAboard@gmail.com

HB1175
1/28/2019
#12

NDAPA

North Dakota Academy of Physician Assistants

North Dakota Physician Colleagues:

North Dakota physician assistants (PAs) are asking for your support in the 2019 legislative session. A bill pertaining to the regulation of PAs, HB 1175, proposes to remove the current requirement of a state-mandated supervisory contract between a PA and a physician. The proposed changes in HB 1175 were unanimously approved by the N.D. Board of Medicine at their November 16th, 2018, meeting.

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- change the way PAs already practice.
- allow PAs to practice outside of their scope and training.

By signing below, you are giving your support for these proposed amendments.

Signature — Bismarck, ND (Practice Location)

Ron Knutson
Print Name

Signature — Bismarck ND (Practice Location)

Print Name

Signature — Practice Location

Print Name

NDAPA
1412 Cottonwood Avenue
Minot, ND 58701
Send to: NDAPAboard@gmail.com

Rep. Bill Devlin Testimony – Senate Human Services Committee – HB 1175

Good morning, Chairman Lee and esteemed members of the Senate Human Services Committee. For the record, I am Rep. Bill Devlin of District 23. Our district is a rural legislative district in eastern North Dakota.

I am proud to introduce HB 1175 at the request of Physician Assistants from my area and across the state for your consideration.

As I have watched medicine evolve to meet the needs of North Dakota citizens there is one undisputable fact that jumps out at me and everyone else observing. The practice of medicine in many rural areas of the state would not be possible without Physician Assistants. Without those highly trained professionals practicing medicine, many clinics and even hospitals would have a difficulty if not impossible time providing care to our residents and the facilities might not even survive.

The other fact that is undisputable is that we have come to recognize that certain practitioners of medicine do not need some of the over-sight originally spelled out in code to practice within their scope of practice, safely and effectively and to provide the best possible care for our citizens.

HB1175 recognizes that fact and calls for changes in the direct oversight of Physician Assistants by physicians. The bill will not change how Physician Assistants already collaborate with physicians and other providers but will remove some of the unnecessary restrictions I want to you to know the proposed changes in HB 1175 were unanimously approved by the N.D. Board of Medicine at their November 16th, 2018, meeting.

Committee members, I know some of you might have questions but prefer to let you hear from the experts that will follow me to the podium. If there is specific information needed later, I can obtain it for the committee.

For now, I urge your thoughtful consideration of HB1175 and I hope eventually a unanimous do pass recommendation. Thank you, Chairman Lee and esteemed members of the Senate Human Service Committee.

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SENATE HUMAN SERVICES COMMITTEE
HB 1175

Testimony of Duane Houdek for
North Dakota Academy of Physician Assistants

March 19, 2019

Madam Chairman, Members of the Senate Human Services Committee, my name is Duane Houdek. I represent the ND Academy of Physician Assistants with regard to HB 1175.

To accommodate the schedule of one of our presenters, Dr. Gordon Leingang, I request that I be permitted to introduce him to testify now, and resume my testimony when he is done. Thank you, Madam Chairman.

Dr. Leingang is especially able to provide testimony regarding the training and regulation of physician assistants. He is a multiple award-winning professor of Physician Assistant courses at Des Moines University-Osteopathic Medical Center. He has taught at the University of Mary in the Nurse Practitioner program. He is a former member of the North Dakota Board of Medicine. He is the former Flight Surgeon for the North Dakota National Guard, and has supervised medical personnel of all types of training during two tours of Iraq.

***

Madam Chairman and members of the committee, as we began to prepare testimony for this hearing, it became clear the committee wished to be informed about the education, training and practice of physicians assistants, especially as compared to nurse practitioners, to help you with your assessment of this bill. Through the generous collaboration of Stacy Pfenning of the North Dakota Board of Nursing, we have put together a table that we all agree compares the most meaningful components of

education and training of each profession. Jay Metzger, who works with the PA admission criteria and curricula at UND will address that portion of our testimony as those points of comparison relate to physician assistants. I understand Ms. Pfenning will testify with regard to the comparison points as they relate to nurse practitioners. It is our belief that this is the most objective and meaningful way we could help the committee understand the subject.

I will address only the current practice of physician assistants and the way the supervisory contract needlessly gets in the way of addressing North Dakota's shortage of health care providers, especially in rural areas.

This bill effects one essential change in the regulation of physician assistants in North Dakota: It removes the written supervisory contract that is now required between a specific physician and a physician assistant by the Board of Medicine, whose requirement is based on a statutory phrase passed 44 years ago when PA's were first licensed by the state in 1975.

Here's what the bill does not do:

1. It does not expand the permissible scope of practice of physician assistants in North Dakota.
2. With one exception I will explain, it does not authorize independent practice by physician assistants.
3. It does not remove the practice requirement that physician assistants must collaborate with all appropriate health care workers, especially physicians.

1. **Scope of Practice**. To help address the scope of practice, I have attached to this testimony a current Delineation of Privileges of a PA in an emergency room of one of the eight larger hospitals of the state.

Please note that this document is approved by both the department chair and the chief of staff of the hospital. It is the same document that delineates the practice of nurse practitioners and is based on a current assessment of that particular allied health professional's training, abilities and skills.

You will see this particular PA may institute emergency measures and treatment for all types of trauma care; may admit to the appropriate level of care (with supervision); formulate a diagnosis and establish priorities to meet patient's needs; perform and order and interpret non-invasive diagnostic tests; prescribe and order pharmacologic interventions; and do all types of splinting and casting, insertion of catheters, tubes and IV's, repair lacerations and perform many other general procedures you would expect to need to utilize in an ER. You will see some privileges are not granted, such as performing certain invasive procedures, lumbar punctures and airway management. Presumably, this PA was not felt to have the required training to do so.

You will also note that it requires consultation with a qualified medical staff member when the PA's expertise does not meet the clinical needs of the patient or it is otherwise in the patient's best interest. It requires independent insurance, DEA registration, current BLS, ACLS, PALS and ATLS certifications, in addition to a PA license and certification.

This is how the scope of practice of a PA or Advanced NP is determined. It is true in all departments of a facility. This will not change one iota by removing the supervisory contract of the board of medicine. PA's scope of practice will not change. Everything, and more, that is required by the supervisory contract is covered by the delineation of privileges and the balance of the bill before you.

2. **Practice independence.** The bill expressly states that PA's will not practice independently, with a possible exception if individually and specifically approved as a unique need by the Board of Medicine. PA's do not want to practice independently; that has never been part of their training nor is that their ambition.

3. **Physician collaboration.** PA's will continue to collaborate with qualified physicians in their area of practice. You have seen that this is required in privileging documents; it is a requirement in this bill. It is inherent in a PA's training. The physician contract now signed does not add to this collaboration at all. Let me give you an example: In the largest facility in North Dakota, Sanford Fargo, when I was at the Board of Medicine, I saw PA's with as many as 30 substitute physicians on the board's required contract —30, to be utilized when the main physician is not available. This is nothing more than a reflection of the reality that PA's now practice with all physicians of a department — it is a team effort. It renders the single physician/single PA contract antiquated and out of touch with today's practice realities.

So, in conclusion, the bill before you will not change the way PA's practice now and have practiced for years. There is no patient safety downside. And may I add, PA's are very safe providers. At the board of medicine, I was part of a team investigating disciplinary complaints filed against all physicians and physicians assistants for a period of over a decade. During that time and for about five years before, we had one quality of care disciplinary action against a PA. One. And we were no lax board. We took pride in protecting the public and were among the top disciplinary boards in the nation based on assessments made annually by patient advocates. There really is no patient safety downside to this bill.

But there is a tremendous upside: Because the current statute states PA's must perform services "under the supervision, control and responsibility" of a specific physician (emphasis supplied), and the board of medicine contract echoes those concepts, some, especially rural, facilities hesitate to hire PA's, not because they can't perform, but because of the potential liability and administrative impediments that language causes.

You can help healthcare access in North Dakota, that we all know needs improvement, by getting rid of this antiquated language. The Board of Medicine, which instituted the contract, has concluded that it is no longer necessary and unanimously endorses this bill. We urge your support of HB 1175 with a "Do Pass" recommendation.

Thank you.

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[redacted] PA-C
[applicant]

Primary Privileges: Physician Assistant - Emergency Room Care

Request ☐	*Request all privileges listed below.* *Uncheck any privileges that you do not want to request.*	Department Chair ☐	Chief of Staff ☐
	Assessment of Health Status, Diagnosis and Development of Treatment Plan		
☑	Institute emergency measures and emergency treatment or appropriate measures in situations such as cardiac arrest, shock, hemorrhage, convulsions, poisoning and trauma care	☐	☐
☑	Admit to the appropriate level of care with supervision	☐	☐
☑	Perform history and physical examination	☐	☐
☑	Provide patient education and counseling covering such things as health status, test results, disease process and discharge planning	☐	☐
☑	Perform, order and interpret preventive and non-invasive diagnostic tests	☐	☐
☑	Formulate a diagnosis and establish priorities to meet the patient's health and medical needs	☐	☐
☑	Prescribe/order pharmacologic and non-operative therapeutic interventions	☐	☐
☐	Complete official documents such as death certificates and birth certificates and other similar documents required by law	☐	☐
☑	Instruct and educate patients to reduce return visits to the Emergency Room	☒	☐
	General Procedures		
☑	Simple superficial debridement; wound closure and general care for wounds including performance of topical or field infiltration of anesthetic solutions. Select and apply appropriate wound dressings including liquid or spray occlusive materials, removal of drains, application of immobilizing dressing (soft or rigid)	☐	☐
☑	Incision and drainage of palpable superficial mass	☐	☐
☑	Management of blood component therapy	☐	☐
☑	Casting, strapping and splinting of routine orthopedic injuries	☐	☐
☑	Application of traction	☐	☐
☑	Foreign body removal	☐	☐
☑	Insert indwelling urinary catheters	☐	☐
☑	Insertion of nasogastric tubes	☐	☐
☑	Placement of intravenous lines	☐	☐
☑	Eye care, including superficial foreign body removal including cornea	☐	☐
☑	Local anesthesia, digital block	☐	☐
☑	Nasotracheal intubation	☐	☐
☑	Endotracheal intubation	☐	☐
☑	Initiation of Advanced Life Support in all patients and in all settings	☐	☐
☑	Anterior nasal packing for epistaxis	☐	☐
☑	Removal of impacted cerumen	☐	☐
☐	Tracheotomy	☐	☐
☑	Chest tube insertion	☐	☐
☑	Orthopedic devices, application/removal	☐	☐
☑	Slit lamp examination including removal of foreign body; Conjunctiva/Cornea	☐	☐
☑	Laceration repair including single and multilayer closures	☐	☐
☑	Incision and drainage of subungual hematoma, abscess and paronychia	☐	☐

[redacted] PA-C

[applicant]

☑	Removal of foreign body	☐	☐
☑	Trephination of nail including nail removal	☐	☐
☑	Care of simple fractues including extremity, rib and clavicle; including skeletal immobilization	☐	☐
☑	Care of simple strains and sprains including immobilization and application of splints	☐	☐
☑	Reduce simple dislocation including digital, radial head, shoulder, hip and patellar	☐	☐
☑	Posterior nasal packing and ~~cautery~~ mo	☐	☐
☑	Anterior nasal packing for epistaxis	☐	☐
☑	Emergent decompressive thoracostomy	☐	☐
☐	Direct fiberoptic laryngoscopy and airway managment including intubation	☐	☐
☑	Local anesthesia	☒	☑
☐	Lumber puncture	☐	☐
☑	Intraveneous/Intraosseous	☐	☑
☑	Cardioversion/defibrilation	☐	☑

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience and demonstrated competency I am entitled to perform and that I wish to exercise at the hospital at which I am requesting privileges.

I also understand that by making this request, I am bound by the applicable Medical Staff Bylaws and/or policies of the hospital. I also attest that my professional liability insurance covers the privileges I have requested.

I affirm that I will obtain consultation with a qualified medical staff member when it is in the best interest of the patient and/or when my expertise does not meet the clinical needs of the patient.

Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

[redacted]
Practitioner's Signature

11-21-17
Date

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

☒	Recommend all requested privileges
☐	Do not recommend any of the requested privileges
☐	Recommend privileges with the following conditions/modifications/deletions (listed below)

SENATE HUMAN SERVICES COMMITTEE

HB 1175

Testimony of Jay Metzger, PA-C

North Dakota Academy of Physician Assistants

March 19, 2019

Chairman Lee, Members of the Senate Human Services Committee, my name is Jay Metzger and I am a physician assistant (PA) and current president of the North Dakota Academy of Physician Assistants (NDAPA). I am speaking on behalf of our members and asking for your support on HB 1175.

As Mr. Houdek and Dr. Leingang have already mentioned, HB 1175 addresses some well overdue changes to the regulation of PAs in North Dakota. I would like to echo the sentiments from their testimonies and address a few different areas of our profession and this bill.

The PA profession was created a mere 52 years ago. In the grand scheme of medicine, we are relative newcomers. Our profession has significantly evolved over the years and there have been hundreds of studies that prove our ability to safely practice medicine and fill a much-needed role in the care of our citizens. PAs have been compared to physicians and/or nurse practitioners in most studies. The main take away from the studies as a whole: PAs practice safe and effective

medicine and are valued members of the health care team. I have provided a list that summarizes many of these studies for your reference.

From an educational perspective, PAs are trained in a medical model similar to that of a physician but in a more condensed version. PA programs have a strong preference for students with previous experience in health care. I personally was an Army medic and paramedic for nine years before I became a PA. There is a wide variety of backgrounds represented in the PA profession such as former respiratory therapists, nurses, paramedics, radiology technicians, and athletic trainers to just name a few. Nationally, PA students come into their PA training with an average of over 4000 hours of full-time health care experience. North Dakota has only one PA program with an average of 12,000 hours of prior healthcare experience or approximately six years of full-time health care experience. The North Dakota PA program is a 6 semester, 24-month, 90 credit hour Master's degree program. During their matriculation, students are committed full-time to their education and receive more than 1800 hours of hands-on, clinical experience. Once completed with their training, PAs must take a national certifying exam to be licensed in North Dakota and complete 100 hours of continuing medical education every two years and retest every 10 years. I would be happy to answer any questions on PA education at the conclusion of my testimony.

HB 1175 was carefully drafted by the NDAPA with considerable input from the ND Board of Medicine, ND Medical Association, and the American Academy of PAs. Other supporters of HB 1175 include the ND Rural Health Association, the Community HealthCare Association of the Dakotas (CHAD), multiple rural and urban ND health care facilities, and many physicians from across the state. I have provided these letters of support.

PAs are not physicians and we do not pretend to be. In our 50-plus years of existence, we have proven that we are reliable, competent and valuable members of the health care team. We are well trained in the areas that we practice and know when to consult with our physician colleagues. With more physicians going into non-primary care practices, PAs are especially needed to help alleviate access to care issues. Chairman Lee and Members of the Senate Human Services Committee, I and the members of the NDAPA ask for your support and a DO PASS on HB 1175.

Thank you for your time.

Jay R. Metzger, PA-C
President, North Dakota Academy of Physician Assistants
NDAPAboard@gmail.com

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University of North Dakota Physician Assistant Program Curriculum			
		Credits	Cr/Semester
Summer Year 1			
PA 507	Medical Human Anatomy and Radiology I	3	
PA 510	Human Physiology and Pathophysiology I	4	
PA 517	Pharmacology I	2	
PA 512	History and Physical Exam I	2	
			11
Fall Year 1			
PA 508	Medical Human Anatomy and Radiology II	3	
PA 511	Human Physiology and Pathophysiology II	4	
PA 518	Pharmacology II	2	
PA 513	History and Physical II	2	
PA 521	Diagnostic Studies I	2	
PA 516	EKG Interpretation	1	
			14
Spring Year 1			
PA 522	Diagnostic Studies II	2	
PA 540	Primary Care I Didactic	5	
PA 541	Primary Care I Clinical	5	
PA 550	Primary Care II Didactic	5	
PA 566	Professional Issues & Role Development I	2	
			19
Summer Year 2			
PA 523	Diagnostic Studies III	2	
PA 551	Primary Care II Clinical	4	
PA 567	Professional Issues & Role Development II	1	
PA 525	Scholarly Project Development	3	
PA 571	Rural Primary Care (clinical)	3	
PA 570	Primary Care Clinical Continuation (clinical)	2	
			15
Fall Year 2			
PA 560	Primary Care III Didactic	3	
PA 561	Primary Care III Clinical	4	
PA 570	Primary Care Clinical Continuation (clinical)	5	
PA 568	Professional Issues & Role Development III	1	
PA 995	Scholarly Project	3	
			16
Spring Year 2			
PA 580	Specialty Clerkship (clinical)	6	
PA 581	Emergency Department Clerkship (clinical)	4	
PA 582	General Surgery Clerkship (clinical)	4	
PA 569	Professional Issues & Role Development IV	1	
			15
		Total Credits	**90**

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3/19/19
#3 pg. 5

Physician Assistant Education Nationally

Background of PA students nationally at the start of matriculation[1]

- Average age of 26
- Healthcare experience: 4,032 hours average
- Must have Bachelor's degree to apply in 96% of schools

National PA Program Curriculum Overview

- Total average program length: 27 months
- **National PA School Didactic** (classroom) Averages[2]
    - 58 weeks
    - Average classroom hours in some of the specific areas of the curriculum
        - 450 in Basic Sciences
        - 650 in Clinical Prep
        - 90 in Behavioral and Social Sciences
        - 140 in Health Policy and Professional Practice
- **National PA School Clinical (patient contact) Hours:**[3]
    - 54 weeks average
        - Over 2000 hours average
        - Many programs use the number of full time weeks in reporting, no specific hours

University of North Dakota Physician Assistant Program

(Most Recent Graduating Class of 2018)

Background of PA students at UND at the start of matriculation[4]

- Average age of 31
- Healthcare experience: 12,000 hours average
- Must have Bachelor's degree to apply

UND PA Program Curriculum Overview

- 24-month program (104 weeks)
- 45 weeks of dedicated didactic, but unique design has didactic partially integrated in to clinicals
- 49 weeks of clinicals (patient contact)
    - 1,800 hours average of patient contact time.
    - Students also have didactic education during their clinical training
        - Those hours are not included in the 1800 hours listed.

Continuing Education for Physician Assistant Licensure in North Dakota

- PAs must be nationally certified for licensure in ND
    - National certification requires 100 hours of continuing education every 2 years and recertification testing every 10 years

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[1] *Physician Assistant Education Association, By the Numbers: Program Report 32: Data from the 2016 Program Survey, Washington, DC: PAEA; 2017. doi: 10.17538/PR32.2017*

[2] *Physician Assistant Education Association, By the Numbers: Curriculum Report 2: Data from the 2016 Didactic Curriculum Survey. Washington, DC: PAEA; 2018. doi: 10.17538/CR2.2018*

[3] *Physician Assistant Education Association, By the Numbers: Curriculum Report 3: Data from the 2017 Clinical Curriculum Survey, Washington, DC: PAEA; 2018. doi: 10.17538/CR3.2017.001.*

[4] UND PA Program – CASPA Statistics

SENATE HUMAN SERVICES COMMITTEE

HB 1175

March 19, 2019

Supporters of HB 1175

- North Dakota Board of Medicine
- North Dakota Rural Health Association
- Community HealthCare Association of the Dakotas
    - Coal Country Community Health Centers
        - Beulah, Center, Hazen, and Killdeer
    - Community Health Service Inc.
        - Grafton
    - Family HealthCare
        - Fargo, West Fargo, and Valley City
    - Northland Community Health Centers
        - Bismarck, Bowman, McClusky, Minot, Ray, Rolette, Rolla, Turtle Lake, and Williston
    - Valley Community Health Centers
        - Grand Forks and Larimore
- West River Health Services
    - Hettinger, Bowman, Mott, New England, and Scranton
- Mid Dakota Clinic
    - Bismarck
- Association of Counties
- Northwood Deaconess Health Center
    - Northwood, Binford, and Larimore
- American Academy of Physician Assistants

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SENATE HUMAN SERVICES COMMITTEE

North Dakota Physicians in Support of HB 1175

March 19, 2019

Physician Name	Location
Adam Nicholson, MD	Grand Forks
Andres Makarem, MD	Grand Forks
Anthony Chu, MD	Grand Forks
Anthony Johnson, MD	Mandan
Ashley Kremer, MD	Rugby
Attas Boutrous, MD	Bismarck
Casey Ryan, MD	Grand Forks
Casmair Nwaigwe, MD	Minot
Chenelle Joseph, MD	Grand Forks
Cordell Davis, DO	Grand Forks
Corey Dean Arcelay, MD	Belcourt
Douglas Hess, DO	Fargo
Emmanuel A. Gaid, MD	Belcourt
Eric Johnson, MD	Grand Forks
Eric Tee, MD	Fargo

Frederick K. Ness, MD	Belcourt
Jon W. Allen, MD	Grand Forks
Kate Kessler, DO	West Fargo
Kulvinder Sumra, MD	Cavalier
Lara Lunde, MD	Fargo
Mark Longmuir, MD	Stanley
Patrick Kane, MD	Grand Forks
Paula Bercier, MD	Belcourt
Richard Larson, MD	Belcourt
Ronald Knutson, MD	Bismarck
Ryan Hoovestol, MD	Bismarck
Sara Nausheen, MD	Grand Forks
Shannon Mark Sell, DO	Fargo
Shanta Gautham, MD	Grand Forks
Sreejith Gopi, MD	Fargo
Stefan Johnson, MD	Grand Forks
Steven Meek, MD	Fargo
Susan Thompson, MD	Cavalier
Tom Thorson, MD	Mandan

William Zaks, MD	Grand Forks
Steve Schoneberg, MD	Rugby
Gordon Leingang, DO	Bismarck
John Baird, MD	

Unanimous Approval by ND Board of Medicine Physicians on 11/18/2018	**Location**
Robert J. Olson, MD, Chair	Fargo
Genevieve Goven, MD, Vice Chair	Valley City
Rupkumar Nagala, MD, Treasurer	Oakes
Brenda Miller, MD	Bismarck
William Haug, Jr., MD	Grand Forks
Sara Solberg, MD	Williston
Thomas Carver, DO	Minot
Robert Sticca, MD	Grand Forks
Catherine Houle, MD	Hettinger
Gopal Chemiti, MD	Fargo

HB 1175
3/19/19
#4 pg. 5

CHAD

Community HealthCare Association of the Dakotas

March 15, 2019

Chairman Senator Judy Lee and Members of the Senate Human Services Committee
State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

Re: House Bill 1175, relating to the regulation of physician assistants.

Chairman Senator Judy Lee and Members of the Senate Human Services Committee

On behalf of the Community HealthCare Association of the Dakotas (CHAD), I am writing you in support of HB 1175 pertaining to the regulation of physician assistants (PAs). CHAD is a non-profit membership organization that serves as the Primary Care Association for North Dakota and South Dakota, supporting community health centers (CHCs) in their mission to provide access to quality health care for all Dakotans. CHAD member clinics employ a variety of providers including PAs, nurse practitioners, physicians and others to work as a team in the care of our patients.

Physician assistants are valuable clinicians on the health care teams at our member clinics. HB 1175 would improve our member clinics' ability to recruit and retain health care providers including PAs and physicians by allowing PAs to practice in the areas they are trained and competent to perform while taking away the administrative and regulatory burden our physicians have under the current regulations. Under the tenets of the bill, we feel that PAs will still collaborate with physicians when warranted as they have always.

In summary, CHAD supports HB 1175 and asks that the Senate Human Services Committee recommend a do pass.

Please feel free to contact me if you have any questions.

Sincerely,

Shelly Ten Napel, MSW, MPP
CEO, Community HealthCare Association of the Dakotas

300 S Phillips Ave, Suite L105 Sioux Falls, SD 57104 | 1800 E Broadway Ave, Suite 100A Bismarck, ND 58503
Phone: (605) 275-2423 | Phone: (701) 221-9824
www.communityhealthcare.net

SENATE HUMAN SERVICES COMMITTEE

Letter in Support of HB 1175

North Dakota Rural Health Association

Ben Bucher, FNP

The North Dakota Rural Health Association wishes to provide this letter in support of HB 1175. Ben Bucher, CEO of Towner County Medical Center in Cando and Mountrail County Medical Center in Stanley, ND wrote the following as testimony to why North Dakota, and specifically the critical access hospital and rural health clinic in Cando support HB 1175.

There is already a shortage of primary care access in North Dakota. Allowing physician assistants to practice collaboratively with physicians and other healthcare providers will improve access to patient care. According to North Dakota Century Code 50-03-01-06, "A PA may provide patient care only in those areas of medical practice where the supervising physician provides supervising care." Therefore, what that means for us is when one of our physician assistants on staff has a supervising physician, that PA's scope of practice is limited to the areas of where that supervising physician practices. Now, we know that the needs of patients in urban areas differ from the needs of patient in rural areas and so, with this bill, a PA is able to tailor care to the specific needs of the patient. For example, Grant Lannoye is a physician assistant in Cando. Grant has the required education, license,

certification and experience to prescribe medication assisted treatment for opioid use disorder. Unfortunately, after Mr. Lannoye obtained this training and certification he had to find a different supervising physician to oversee him in this area of medicine because his current supervising physician did not provide medication assisted therapy as a part of their practice. This led to a delay in patient care and it also led to an increase in cost for our facility to find, yet another, supervising physician. We have seen first-hand, here in our state, the increase in access to patient to care and the increase to quality of rural health care by allowing nurse practitioners to practice in a similar way. Allowing physician assistants this ability to practice collaboratively without a need for a specific supervisory agreement will improve the quality and access of healthcare in rural North Dakota and it will also decrease the cost of providing health care to rural North Dakota residents.

Thank you for your time.

For questions, please contact Ben Bucher at benb@tcmedcenter.org or (701) 968-4411.

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SENATE HUMAN SERVICES COMMITTEE

RE: HB 1175

TESTIMONY LETTER FOR GRANT LANNOYE, PA-C

March 19, 2019

Chairman Lee and Members of the Senate Human Service Committee,

My name is Grant Lannoye, I am a practicing physician assistant (PA) in Cando, ND at Towner County Medical Center. We area a rural health clinic and critical access hospital that provides emergency department services, outpatient services, inpatient services, long term care (such as swing bed, nursing home, basic care), primary/preventative (clinic-based) care and Medication Assisted Treatment for opioid use disorder.

I have composed this correspondence in hopes of gaining your support in the process of approving HB 1175. As you are aware, this bill pertains to the regulation of physician assistants (PAs) in North Dakota.

As I am sure all of you are aware, the opioid epidemic is here and it is an enormous problem that spans all ages, races, genders, and geographies without boundaries. I am one of few ND PAs that are DEA waivered to provide Medication Assisted Treatment (MAT) for opioid use disorder (OUD). I have personally witnessed tremendous success with my MAT patients. They have turned their lives around; from losing their job, their home, their spouse and even their children. I have personally had patients regain all of these and maintain a foreseeably sustainable sobriety/recovery. However, there is a lack of MAT providers and certainly a lack of MAT PAs.

One of the largest barriers of me becoming DEA waivered for MAT was the issue of having an appropriate supervising physician. At that time my current supervising physician was a primary care physician and under current ND century code, "A physician assistant may provide patient care only in those areas of medical practice where the supervising physician provides patient care." (ND century code 50-03-01-06). Therefore, I had to locate a physician who would be willing to become one of my supervising physicians and accept the liability for my practices. Fortunately, I had already developed an excellent professional

relationship with one of the State's leading chemical dependency physicians and she graciously took on the responsibility of becoming one of my supervising physicians, specifically for this area of my practice. However, not all PAs are fortunate enough to have these relationships as MAT physicians are relatively uncommon as well.

Eliminating the need for supervisory agreements would certainly increase the applicant pool for rural/underserved areas potentially expanding rural healthcare accessibility. It also has the strong potential to improve the number of MAT services via PAs. Treating opioid overdose survivors with MAT was linked to a 40% to 60% drop in mortality 1 year later (Larochelle MR, Bernson D, Land T, Stopka TJ, Wang N, Xuan Z, et al. *Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association with Mortality: A Cohort Study*. Ann Intern Med. ;169:137–145. doi: 10.7326/M17-3107).

Please strongly consider supporting HB 1175 and the positive influence this bill could have. I only touched on rural health access and MAT for OUD, however, I am certain that there is a vast amount of future gain for North Dakota to be had from the success of this bill.

I would be happy to speak with any of you further if you desire, please contact me via email or cell phone (listed below) if you have any questions. I will specifically be available for contact at the time of this meeting. Thank you for your time.

Sincerely,

Grant Lannoye, PA-C
Cando, ND
Mobile: (701) 230-1519
grantlannoye@outlook.com

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FAMILY HealthCare

"To provide affordable quality healthcare for every perso[redacted]

301 NP Ave Fargo ND 58102
phone: 701.271.3344 • fax: 701.271.1480
www.famhealthcare.org

March 6, 2019

Senator Judy Lee
North Dakota State Senate
1822 Brentwood Court
West Fargo, ND 58078-4204

Dear Senator Lee,

On behalf of Family HealthCare, I am providing this letter expressing our full support of HB 1175, which will repeal the required supervisory agreements between physician assistants (PAs) and physicians. The bill won't change how our PAs or physicians practice, but will allow PAs to practice to the level they are trained while taking the administrative and regulatory burden off our physicians. The bill will increase our ability to recruit and retain both physicians and PAs to help provide quality healthcare to our patients and communities.

Family HealthCare is a nonprofit, Federally Qualified Health Center that provides services in Cass and Barnes Counties, North Dakota and Clay County, Minnesota. Family HealthCare offers all patients access to comprehensive primary healthcare including medical, dental, and pharmacy services. Family HealthCare also administers the only federally funded Homeless Health Services program in North Dakota and western Minnesota.

We ask that you please support HB 1175.

Sincerely,

Patrick Gulbranson
Chief Executive Officer
Family HealthCare
(701) 239-2285
pgulbranson@famhealthcare.org

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NORTHWOOD DEACONESS HEALTH CENTER

4 North Park Street ~ P.O. Box 190 ~ Northwood, ND 58267
701-587-6060 ~ www.ndhc.net

701-587-6900 ~ Northwood Clinic & Binford Clinic 701-431-2999 ~ Larimore Clinic

March 15, 2019

Chairman Lee and Members of the Senate Human Services Committee,

Northwood Deaconess Health Center (NDHC) in Northwood, ND, would like to express our support for HB 1175. NDHC has clinics in Northwood, Larimore, and Binford, as well as a critical access hospital and nursing home in Northwood. All of our facilities have PAs and nurse practitioners that provide care to our communities. Without our PAs and nurse practitioners, we would not be able to provide the care we do to all the rural communities that we serve.

HB 1175 would improve our ability to recruit and retain health care providers including PAs and physicians by allowing PAs to practice in the areas they are trained and competent to perform while taking the administrative and regulatory burden that requires our physicians to take responsibility for the PAs actions. While we have full faith in our PAs, having to take on a supervisory role for some physicians is an unwanted burden. Under the tenets of the bill, we feel that PAs will still collaborate with physicians when warranted as they have always.

In summary, NDHC supports HB 1175 and asks that the Senate Human Services Committee recommend a do pass.

Please feel free to contact me if you have any questions.

Pete Antonson, CEO

Northwood Deaconess Health Center

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AAPA

March 16, 2019

Senator Judy Lee, Chair
Senate Committee on Human Services
State Capitol
600 East Boulevard
Bismarck, North Dakota 58505

In re: H.B. 1175, relating to PA (physician assistant) practice

Dear Senator Lee:

On behalf of the more than 131,000 PAs (physician assistants) represented by the American Academy of PAs (AAPA) – approximately 400 of whom are licensed in North Dakota – I am writing to express our support for H.B. 1175. This legislation would update several provisions related to PA practice in the state, and ultimately, improve patient access to health care.

Background

PAs are licensed to practice in all 50 states, the District of Columbia, all U.S. territories, and the uniformed services. PAs perform physical examinations, diagnose and treat illnesses, order and interpret lab tests, prescribe medications, perform medical procedures, assist in surgery, and enhance health care coordination. In North Dakota, PAs practice in primary care and all medical and surgical subspecialties, and they are authorized to prescribe Schedule II-V controlled medications.

Most PA educational programs award master's degrees, and those which do not will be required to do so by 2020. The typical PA program extends over approximately three academic years. During this time, PA students receive classroom training in anatomy, physiology, pharmacology, physical diagnosis, behavioral sciences, and medical ethics. This didactic phase is followed by at least 2,000 hours of supervised, clinical practice rotations in medical and surgical disciplines including family medicine, internal medicine, general surgery, pediatrics, obstetrics and gynecology, emergency medicine, and psychiatry.

H.B. 1175

Under H.B. 1175 as passed in the House of Representatives, PAs would continue to practice on health care teams with physicians and other providers. However, the PA-physician relationship would be described as "collaborative," rather than "supervisory." This change better reflects the nature of PA-physician practice. H.B. 1175 would also clarify that PAs are responsible for the health care they provide to patients.

Importance of H.B. 1175 to North Dakota Patients

North Dakota is experiencing a health care provider shortage, particularly in rural areas.[1] However, PAs – especially those who receive their education in the state – are working to mitigate this shortage. In fact, a

[1] University of North Dakota School of Medicine and Health Services Advisory Council. Fifth Biennial Report 2019: Health Issues for the State of North Dakota. https://med.und.edu/publications/biennial-report/_files/docs/fifth-biennial-report-interactive.pdf. Accessed February 22, 2019.

2318 Mill Road, Suite 1300, Alexandria, VA 22314 P 703.836.2272 F 703.684.1924 aapa@aapa.org
www.aapa.org

recent report by the University of North Dakota (UND) School of Medicine and Health Services Advisory Council showed that approximately half of PAs who graduated from UND (the sole PA program in the state) chose to practice in rural areas, and nearly 40 percent of UND PA program graduates practice rural primary care.[1] Improving PA flexibility through the provisions in H.B. 1175 would better allow these PAs to care for patients in high-need areas.

Summary

AAPA and the North Dakota Academy of PAs (NDAPA) urge your support of H.B. 1175, which will improve patient access to health care in the state. Thank you for this opportunity to comment on this important legislation, and should you have any questions, please do not hesitate to contact me at emiller@aapa.org or 571-319-4342.

Sincerely,

Erika Miller
Director, State Advocacy & Outreach
American Academy of PAs

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WEST RIVER HEALTH SERVICES

January 17, 2019

DUANE HOUDEK
4400 ALAMO DRIVE
BISMARCK, ND 58504

RE: Support for House Bill 1175 regarding the supervisory regulation of physician assistants.

Dear Mr. Houdek and Members of Legislative Committee,

This is a letter of support in favor of proposed House Bill 1175 to revise supervisory conditions of physician assistants in North Dakota.

West River Clinics in Hettinger, North Dakota, has a long history of incorporating physician assistants as team members for care of patients in the West River area since the early 1980s when Sister Michael Emond was the first PA to work at West River. We have also been active in training and supervising physician assistants and have incorporated physician assistants in our satellite system for optimum care and access for our patients.

As stated in the bill, it does make sense that direct supervision of physician assistants should be based on site and scope of practice as determined by their place of employment and practice. This is much more direct and applicable to each situation as opposed to the broadly stated rules that exist currently. As medicine has evolved to utilize the electronic health record, there is more emphasis on patient management based on a team concept. As such, a single physician is supervising a number of PAs to better delegate responsibilities and care of the patient to meet quality metrics.

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WEST RIVER HEALTH SERVICES

I appreciate the governance of the Board of Medicine as a previous member of the board in reviewing any scope of practice by a physician assistant that would indicate solo practice and be approved by the board.

Thank you for your consideration.

Sincerely,

Kent R Hoerauf, MD

KRH/les

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From: **Duane Houdek** dhoudek@bektel.com
Subject: Baird support letter
Date: March 15, 2019 at 4:56 PM
To: Jay Metzger ndapaboard@gmail.com

MEMORANDUM

TO: *SENATE HUMAN SERVICES COMMITTEE*

FROM: JOHN R. BAIRD, MD, MPH
1450 8TH ST. S.
FARGO, ND 58103

SUBJECT: HB 1175 – SUPPORT

DATE: 3/15/2019

I wish to support HB 1175 relating to regulation of physician assistants.

In 40 years as a physician licensed in North Dakota I have had the opportunity to work with and observe physician assistants as well as other health care professionals. I have practiced in a small family medicine group, in a residency program, in a federally funded community health center, as a county coroner, and in public health at the state and local level. I was a physician at West Fargo Medical Center, the Fargo Family Medicine Residency Program Director, the Family HealthCare Center Medical Director, a Section Chief and Field Medical Officer for the North Dakota Department of Health, the local Health Officer for Fargo Cass Public Health, and currently am still Cass County Coroner.

In most of those roles I practiced with, supervised, or observed physician assistants and advanced practice nurses. I have been impressed with the training, practice patterns, and competence of physician assistants I have known.

HB 1175 removes the requirement that a physician assistant function only under the supervision, control, and responsibility of a licensed physician, however it does require a physician assistant to practice at a licensed health care facility with a credentialing and privileging system. A physician assistant must still collaborate with and consult with a health care team.

The North Dakota Board of Medicine does an excellent job of licensing physicians and physician assistants. They regulate the practice of medicine for the good of the health of our state. I believe with the proposed changes in this bill, the Board of Medicine will still be very capable of regulating physician assistants and the high quality of our health care providers will be maintained.

The changes to statute proposed in HB 1175 are very reasonable and appropriate. I would urge passage of this bill.

SENATE HUMAN SERVICES COMMITTEE

HB 1175

Testimony of Kate Larson, PA-C

MARCH 19, 2019

Chairman Lee, Members of the Senate Human Services Committee, thank you for the opportunity to provide testimony on this important bill. My name is Kate Larson and I am a physician assistant (PA) and I am speaking in support on HB 1175.

I have been a physician assistant for the past 23 years, practicing for 21 years in rural health care in ND, and currently practice for the Veteran's Health Administration. I am also currently a Board Member on the North Dakota Board of Medicine, and have been on this board for nearly 8 years.

Physician Assistants are certified by the National Commission and Certification of Physician Assistants, or NCCPA. This certification is required to start practice, and must be completed every 10 years. We are then licensed by the North Dakota Board of Medicine. We must also maintain 100 hours of Continuing Medical Education every 2 years. These continuing education hours must be submitted to the National Commission and

Certification of Physician Assistants every 2 years for certification maintenance. This may also be audited by the NCCPA , and I know this is done as I have been audited twice, and may be also audited by the North Dakota Board of Medicine.

This bill is an important step in improving access to care for patients in North Dakota. Currently, we are required to have a supervisory contract with a physician. HB 1175 would eliminate this contract and allow us to work with the healthcare team at the practice level. When working in rural health, this contract creates many difficulties. There may only be one physician in some rural areas or no physician at some satellite clinics. Physicians are sometimes supervising multiple providers and this creates an unnecessary burden for them. Therefore, less physicians are chosing to supervise Physician Assistants. It is fortunate for rural communities, and in fact any community in North Dakota, to have adequate physician providers, however, that is not always possible. Statistics are showing that we are facing family practice provider shortages, and this is continuing to challenge us. Physician assistant's can continue to help fill this gap, and this bill will help us do that, by working at the practice level with all providers. The

supervisory contract also creates difficult situations when supervising physicians are on vacation, or emergent situations that arise.

HB 1175 will also improve practice opportunities for physician assistants in North Dakota. This will improve patient access to the care they need. There have been recent instances where physician assistants were not considered for practice positions that they were more than qualified to fill due to the required supervisory contract obligation. There are physician assistants that are qualified to practice in rural emergency rooms, urgent care clinics, and hospitals, and the changes proposed in HB 1175 would provide opportunities for PAs to be considered for these open positions.

I believe we have proven ourselves as a profession and will continue to work collaboratively at the practice level with physicians and other members of the health care team.

Thank you again for this opportunity, your consideration for this bill, and for your service to North Dakota.

Sincerely,

Kate Larson, PA-C

ND Medical Imaging and Radiation Therapy Board testimony
Presented by Board President Shirley Porter

Senate Human Services Committee

Engrossed HB 1175

March 19, 2019

Chairman Lee and Members of the Senate Human Services Committee, I am Shirley Porter and I serve as President of the North Dakota Medical Imaging and Radiation Therapy Board (NDMIRT).

The North Dakota Medical Imaging and Radiation Therapy Board has the responsibility to protect the public by licensing and regulating personnel performing medical imaging procedures and radiation therapy treatments. This responsibility includes setting minimum standards for licensure, establishing scopes of practice, enforcing disciplinary actions, further developing standards, and adopting rules for the improvement of the administration of medical imaging or radiation therapy procedures in North Dakota. As of January 2019 we currently have about 1500 medical imaging and radiation therapy professionals licensed.

The performance of medical imaging or radiation therapy is safely accomplished by a Registered radiologic technologists — known as "R.T.s" — they must complete at least two years of formal education in an accredited hospital-based program or a two- or four-year educational program at an academic institution and must pass a national certification examination. To remain registered, they must earn continuing education credits. To briefly summarize, they are educated in anatomy, patient positioning, examination techniques, equipment protocols, radiation safety, radiation protection and basic patient care. They are responsible for accurately positioning patients and ensuring that a quality diagnostic image is produced. A Registered radiation therapist is trained to perform radiation therapy, usually on cancer patients aiming high doses of precision radiation at the affected area, and are also required to earn continuing education credits. Continuing education allows imaging professionals to stay fluid with the ever-changing practice of medical imaging and radiation therapy; as new areas evolve other areas may phase-out with the arrival of new technologies.

We appear before you today in support of Engrossed HB 1175. We understand the need for providers in our rural communities and offer our assistance in making access easier and more convenient for our patients. When the Board reviewed HB 1175, we viewed it as overly broad in scope in order to achieve the goals of access.

We felt there were some concerns in regards to patient safety in the areas of medical imaging, specifically ionizing radiation. We worked with Mr. Duane Houdek who was representing the North Dakota Academy of Physician Assistants (NDAPA) to address the patient safety concern and conflicting language that was in the original bill.

The Board offered an amendment that was also agreed upon by the NDAPA during a previous hearing before the House Human Services Committee with a 12-0 Do Pass recommendation and the House vote of 92-0 Do Pass.

Once again compromises have been agreed upon by the NDMIRT Board and by the ND Academy of Physician Assistants in the House to clarify what we believed was conflicting language and a patient safety concern in regards to medical imaging.

Chairman Lee and Committee members, the North Dakota Medical Imaging and Radiation Therapy Board would request that the Committee adopt Engrossed HB 1175, and recommend a DO PASS. That concludes my formal testimony and I would be happy to answer any questions you may have.

Senate Human Services Committee
North Dakota Board of Nursing Testimony
HB 1175 Relating to Regulation of Physician Assistants

Chairperson Lee and members of the Committee. I am Dr. Stacey Pfenning, Executive Director for the North Dakota Board of Nursing (NDBON), and I am here today at the request of the committee.

The NDBON is neutral on HB 1175.

To address the committee's request for information related to the education of Advanced Practice Registered Nurses and Physician Assistant, the NDBON worked with the ND Academy of Physician Assistants to develop the table in attachment A. In addition, attachment B provides an example curriculum from a ND Family Nurse Practitioner program offering a Doctor of Nursing Practice degree.

I would be happy to answer any questions.

Dr. Stacey Pfenning DNP APRN FNP FAANP
Executive Director, North Dakota Board of Nursing
Phone: 701-328-9781
spfenning@ndbon.org

Attachment A

ND APRN and PA Definition, Licensure, Education, and Practice

		ND APRN	ND PA
Definitions		43-12.1-02 Advanced Practice Registered Nurse (APRN): Holds a current license to practice as an APRN, which includes nurse practitioner (NP), and functions in one of the population foci (family, adult-gero, neonatal, pediatrics, women's health, psych-mental health). AANP definition: "Clinicians who assess, diagnose and treat acute and chronic diseases as well as counsel, coordinate care and educate patients regarding their illnesses, NPs bring a comprehensive perspective to health care."	Physician Assistant (PA): PAs are medical professionals who diagnose illness, develop and manage treatment plans, prescribe medications, and often serve as a patient's principal healthcare provider in collaboration with physicians and other health care providers.
Licensure		ND Board of Nursing 43-12.1-09 (2, c) & NDAC 54-05-03.1-04: • Must possess a current, unencumbered license to practice as a registered nurse; • Evidence of completion of an accredited graduate level APRN program; • Evidence of current national certification in APRN role & population foci related to educational preparation; • Complete FBI criminal history record check.	ND Board of Medicine NDCC 43-17-02(9) & NDAC 50-03-01-14: • Evidence of current certification by the National Certifying Commission of Physician Assistants (NCCPA) • NCCPA requires recertification every 2 years and re-examination every 10 years. • Must graduate from a nationally accredited PA program to be eligible for NCCPA certification. • Complete FBI criminal history record check
Required Continuing Education		• Renewal of licensure occurs every 2 years ○ 15 continuing education hours in pharmacology, evidence of practice hours, and maintenance of national certification.	• Renewal of licensure occurs annually ○ 100 hours of continuing education (CME) required every 2 years (required in NDAC and for NCCPA certification)
Education for NPs and PAs in North Dakota		54-03.2-06-07 (5): Admission Requirements/Curriculum: • Admission requires graduation from a bachelor's in nursing program which is nationally accredited/State Board approved. Bachelor's degree in nursing consists of about 122 credit hours and about 600 hours of clinical experiences in direct patient care areas (long-term care, subacute and acute care, in-patient and out-patient settings, and community).	Admission Requirements/Curriculum in PA education are not defined in NDCC, therefore the UND PA Program will be used as an example: • Admission requires a bachelor's degree with clinical and science based pre-requisite courses from a regionally accredited institution within the United States. Most Bachelor's degrees are in the clinical or basic sciences. Bachelor degrees are typically 120 credit hours minimum. • PA programs must be accredited by the Accreditation Review Commission for PAs (ARC-PA).
Education Continued	**ND Programs**	• 3 universities offer graduate pre-licensure programs for NPs (4 Doctor of Nursing Practice (DNP), 1 MSN): ○ UND: DNP for family nurse practitioner (FNP) & adult-gero; MSN for Psych-mental health NP	• In ND, there is one PA program and it is a part of the School of Medicine and Health Sciences at UND. • Curriculum is at the graduate level and students obtain a Master's degree at completion.

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Attachment A

ND APRN and PA Definition, Licensure, Education, and Practice

		○ NDSU: DNP for FNP. ○ University of Mary: DNP for FNP.	
	Student experience prior to matriculation	• One ND FNP program reported years of RN experience of applicants ranged from 1.5-20.5 years with an average of 8.7 years.	• Students entering the UND PA Program average over 12,000 hours of prior healthcare experience. • Most common previous professions for PA students: ○ Respiratory therapists, paramedics, military medics, athletic trainers, nurses, radiology technicians, dieticians, nurse assistants, physical therapists, and medical lab scientists.
	Curriculum	• Advanced health assessment, advanced pathophysiology, advanced pharmacology. • Clinical courses with direct patient-care include comprehensive and problem focused assessments, pathophysiology, diagnostics (lab, radiographic, EKG interpretation), differential diagnoses, clinical management, pharmacologic/nonpharm interventions. • Evidence-based practice, theory, role development, and policy/legal/ethics courses.	• Foundation courses such as anatomy with radiology, physiology and pathophysiology, and pharmacology. • Clinical medicine courses such as patient assessment, diagnostic studies, primary care medicine, emergency medicine, general surgery, EKG interpretation. • Courses relating to PA professional practice and role developments.
	Program Credits and length	• Number of semesters for 5 of the 6 graduate degrees (DNP): ○ 8 semesters ○ 86 credits • One MSN program: 57 credits (2 years)	• Number of semesters: ○ 24 months, 6 semesters, full-time ▪ PA students are not permitted to work outside of their training for the duration of the PA program ○ 90 credits
	Required Clinical Hours	• Clinical hours: 600-900 hrs for MSN; 1000 hrs for DNP	• Clinical hours: 1800 hours of direct patient contact
Practice		• Practice according to 43-12.1 Nurse Practices Act, NDAC 54-05-03.1 APRN Standards for practice, and facility privileging. • Prescriptive authority • ATLS, PALS, ACLS as applicable	• The PA's scope of practice is determined at the practice level through the credentialing and privileging process as determined by their education and experience, and are required to have a state-mandated supervisory agreement with a physician. • Prescriptive authority • ATLS, PALS, ACLS as applicable

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Attachment B

FNP Doctor of Nursing Program Degree Plan

Fall Year 1 Institute 3 days			**Spring Year 1**			**Summer Year 1** Institute 5.5 days		
NUR 510	*Healthcare Across the Population*	*3*	NUR 567	Advanced Health Assessment	4	NUR 562	Pharmacology for Advanced Practice	4
NUR 519	Advanced Pathophysiology	4	NUR 569	Family Theory	2	NUR 589	Common and Chronic Health Management	4
NUR 551	*Critique and Design of Nursing Research*	*3*	NUR 584	Health Promotion and Clinical Prevention	3	NUR 614	Resilient Nursing Leadership *(80 Leadership Hours)*	4
NUR 586	Clinical Anatomy	3	*NUR 601*	*EBP and Strategic Healthcare Decision Making*	*2*			
Semester Credit Hours		**13cr**	**Semester Credit Hours**		**11cr**	**Semester Credit Hours**		**12cr**

Fall Year 2 Institute 5.5 days			**Spring Year 2**			**Summer Year 2** Institute 5.5 days		
NUR 582	Human Responses, Clinical Decision Making and Diagnostic Testing	3	NUR 830	DNP Project & Nursing Scholarship I *(75 Leadership Hours)*	7	*NUR 612*	*Professional Roles in Advanced Nursing*	*3*
NUR 620	Care of Women and Children	4	NUR 837	Acute and Emergent Health Problems	4	NUR 840	DNP Project & Nursing Scholarship II *(25 Leadership Hours)*	1
NUR 759	Primary Care Clinical *(200 Clinical Hours)*	4				NUR 859	Women and Children Clinical *(150 Clinical Hours)*	3
							or	
						NUR 869	Special Populations Clinical *(150 Clinical Hours)*	3
Semester Credit Hours		**11cr**	**Semester Credit Hours**		**11cr**	**Semester Credit Hours**		**7cr**

Fall Year 3			**Spring Year 3** Institute 4 days January, 4 days April			
NUR 648	*Healthcare Law and Policy*	*3*	NUR 940	DNP Project & Nursing Scholarship IV *(75 Leadership Hours)*	3	
NUR 850	Teaching and Learning in Nursing	3	NUR 960	Seminar and Practicum *(400 Clinical Hours)*	8	
NUR 859	Women and Children Clinical *(150 Clinical Hours)*	3	NUR 975	Program Competence Examination	0	
	or					
NUR 869	Special Populations Clinical *(150 Clinical Hours)*	3				
NUR 930	DNP Project & Nursing Scholarship III *(25 Leadership Hours)*	1	HUM 999	Doctorate Studies Assessment - Nursing	0	
Semester Credit Hours		**10cr**	**Semester Credit Hours**		**11cr**	

Program Total Credit Hours: 86

Program Total Clinical Hours: 1180

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CHAPTER 54-05-03.1
ADVANCED PRACTICE REGISTERED NURSE

Section

54-05-03.1-01. Statement of intent.

The 1977 legislative assembly enacted legislation that recognized the performance of additional acts to be performed by registered nurses practicing in expanded roles and gave the board of nursing the power to set standards for nurses practicing in specialized roles. From 1980 to 1991, the board licensed advanced practitioners in nursing as nurse clinicians, nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. The 1991 legislative assembly added prescriptive practices to the acts an advanced practice registered nurse may perform, if qualified. The 1995 legislative assembly further defined the educational requirements for the advanced practice registered nurse.

The scope of practice for a registered nurse with advanced licensure is based upon an understanding that a broad range of health care services can be appropriately and competently provided by a registered nurse with validated knowledge, skills, and abilities in specific practice areas. The health care needs of citizens in North Dakota require that nurses in advanced practice roles provide care to the fullest extent of their scope of practice. The advanced practice registered nurse retains the responsibility and accountability for that scope of practice and is ultimately accountable to the patient within the Nurse Practices Act.

The advanced practice registered nurse is responsible and accountable to practice according to the standards of practice prescribed by the board and the profession. The purpose of the standards is:

1. To establish practice parameters for safe nursing practice.
2. To serve as a guide for the board to regulate the practice of the advanced practice registered nurse.

History: Effective March 1, 1992; amended effective November 1, 1996; April 1, 2004.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-02(1)(7)

54-05-03.1-02. Board authority - Title - Abbreviation.

The board shall authorize advanced nursing practice to a registered nurse who has submitted evidence of advanced knowledge, skills, and abilities in a defined area of nursing practice. Individuals are licensed as advanced practice registered nurses in the roles of certified nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, or certified clinical nurse specialist and in the population foci of family across the lifespan, adult-gerontology, neonatal, pediatrics, women's health or gender related or psychiatric mental health. Each advanced practice registered nurse shall use the designation APRN and applicable role designation for purposes of identification and documentation. No person may use the advanced practice registered nurse (APRN) title plus the person's respective role title without the express authority of the board of nursing to do so.

History: Effective March 1, 1992; amended effective November 1, 1996; April 1, 2011; April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(1)

54-05-03.1-03. Definitions.

Repealed effective April 1, 2004.

54-05-03.1-03.1. Standards of practice for the advanced practice registered nurse.

The standards of practice for the registered nurse found in chapter 54-05-02 are the core standards of practice for all categories of advanced practice registered nurses. The advanced practice registered nurse has evolved into the roles of certified nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, or certified clinical nurse specialist.

The advanced practice registered nurse functions in any setting as a member of the interdisciplinary team and provides care to the fullest extent of the scope of practice which includes:

1. Complete the assessment of the health status and health needs based on interpretation of health-related data and preventive health practices;
2. Analyze multiple sources of data, identify alternative possibilities as to the nature of a health care problem and select appropriate treatment;
3. Coordinate human and material resources for the provision of care;
4. Maintain accountability and responsibility for the quality of nursing care provided; and
5. Collaborate with the interdisciplinary team.

History: Effective November 1, 1996; amended effective April 1, 2004; March 24, 2004; April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(1)

54-05-03.1-03.2. Scope of practice as an advanced practice registered nurse.

The scope of practice must be consistent with the nursing education and advanced practice certification.

1. Practice as an advanced practice registered nurse may include:
   a. Perform a comprehensive assessment of clients and synthesize and analyze data within a nursing framework;
   b. Identify, develop, plan, and maintain evidence-based, client-centered nursing care;

c. Prescribe a therapeutic regimen of health care, including diagnosing, prescribing, administering, and dispensing legend drugs and controlled substances;

d. Evaluate prescribed health care regimen;

e. Assign and delegate nursing interventions that may be performed by others;

f. Promote a safe and therapeutic environment;

g. Provide health teaching and counseling to promote, attain, and maintain the optimum health level of clients;

h. Communicate and collaborate with the interdisciplinary team in the management of health care and the implementation of the total health care regimen;

i. Manage and evaluate the clients' physical and psychosocial health-illness status;

j. Manage, supervise, and evaluate the practice of nursing;

k. Utilize evolving client information management systems;

l. Integrate quality improvement principles in the delivery and evaluation of client care;

m. Teach the theory and practice of nursing;

n. Analyze, synthesize, and apply research outcomes in practice; and

o. Integrate the principles of research in practice.

2. Notwithstanding the above, all services rendered by the licensee shall be commensurate with the academic preparation, knowledge, skills, and abilities of the advanced practice licensed nurse's experience, continuing education, and demonstrated competencies. The nurse must recognize individual limits of knowledge, skills, and abilities and plan for situations beyond the licensee's expertise.

History: Effective April 1, 2004; amended effective March 24, 2004; July 1, 2008; April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(1)

54-05-03.1-04. Initial requirements for advanced practice registered nurse licensure.

Applicants for advanced practice registered nurse licensure must:

1. Possess a current license to practice as a registered nurse in North Dakota or in a compact state;

2. Submit evidence of completion of an accredited graduate level advanced practice registered nurse program in one of the four roles and with at least one population focus;

3. Submit evidence of current certification by a national nursing certifying body in the advanced practice registered nurse role and population foci appropriate to educational preparation. Primary source verification of certification is required;

4. Not have an encumbered license or privilege to practice in any state or territory;

5. Submit a completed notarized application and pay the fee of one hundred dollars;

6. Certify that scope of practice is consistent with their nursing education and nursing certification; and

7. After December 31, 2015, all applicants for advanced practice registered nurse licensure must meet the licensure requirements in this chapter.

History: Effective March 1, 1992; amended effective November 1, 1996; December 1, 1997; June 1, 2001; April 1, 2004; July 1, 2008; April 1, 2011; April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-09(2)(c)(d)

54-05-03.1-05. Temporary permit.

An applicant for advanced licensure who possesses a current registered nurse license, and has submitted a complete application, the required fee, and evidence of meeting all educational requirements, may be issued a ninety-day temporary advanced practice registered nurse permit for practice in an advanced practice registered nurse category if the applicant:

1. Is applying for licensure under section 54-05-03.1-04;

2. Has applied as a first-time candidate to the next national nursing certification examination for the advanced practice registered nurse category;

3. Is awaiting certification results based upon initial application; or

4. Temporary permit will not include prescriptive authority.

History: Effective March 1, 1992; amended effective November 1, 1996; April 1, 2011.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-09(2)(c)(d)

54-05-03.1-06. Requirements for advanced practice registered nurse licensure renewal.

The advanced practice registered nurse license is valid for the same period of time as the applicant's registered nurse license. Applicants for renewal of the advanced practice registered nurse license must possess a current license to practice as a registered nurse in North Dakota or in a compact state and must comply with the following:

1. Complete the advanced practice registered nurse license renewal application;

2. Pay an advanced practice registered nurse licensure renewal fee of forty dollars; and

3. Submit evidence of current national certification in the appropriate advanced practice registered nurse role and with at least one population focus, or participate in a competence maintenance program recognized by the board.

Any individual holding a license to practice nursing as an advanced practice licensee in this state that is valid on December 31, 2015, shall be deemed to be licensed as an advanced practice registered nurse under the provisions of this chapter with the individual's current privileges and shall be eligible for renewal of such license under the conditions and standards prescribed in this chapter.

History: Effective March 1, 1992; amended effective November 1, 1996; June 1, 2001; April 1, 2004; April 1, 2011; April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10(1)

54-05-03.1-06.1. Reactivation of a license.

An advanced practice registered nurse previously licensed in North Dakota who applies for reactivation of APRN only must meet board requirements and includes the following:

1. Complete the application and submit to a criminal history record check according to section 54-02-12-01;

2. Pay the nonrefundable renewal fee and thirty dollar reactivation fee; and

3. Meet the requirements in section 54-02-05-05.1, practice requirements for license renewal, section 54-02-05-08, continuing education requirement for license renewal and section 54-05-03.1-06 requirements for advanced practice registered nurse licensure renewal; or

4. Submit other evidence the applicant wishes to submit which would provide proof of nursing competence acceptable to the board.

History: Effective July 1, 2008
General Authority: NDCC 12-60-24.2(o), 43-12.1-08
Law Implemented: NDCC 43-12.1-09.1, 43-12.1-10(1)

54-05-03.1-06.2. Scope of practice.

The scope of practice of the advanced practice registered nurse must be consistent with the nursing education and nursing certification.

History: Effective April 1, 2011; amended effective April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10(1)

54-05-03.1-07. Disciplinary action against advanced practice registered nurse license.

Repealed effective April 1, 2004.

54-05-03.1-08. Prescriptive authority review committee. Repealed effective October 1, 2011.

54-05-03.1-09. Requirements for prescriptive authority.

Applicants for prescriptive authority shall:

1. Be currently licensed as an advanced practice registered nurse in North Dakota.

2. Submit a complete, notarized prescriptive authority application and pay the fee of fifty dollars.

3. Submit a completed transcript with degree posted from an accredited graduate level advanced practice registered nurse program and which includes evidence of completion of advanced pharmacotherapy, physical assessment, and pathophysiology.

4. Provide evidence of completion of thirty contact hours of education or equivalent in pharmacotherapy related to the applicant's scope of advanced practice that:

   a. Have been obtained within a three-year period of time immediately prior to the date of application for prescriptive authority; or

   b. May otherwise be approved by the board.

History: Effective March 1, 1992; amended effective November 1, 1996; December 1, 1997; April 1, 2004; March 24, 2004; April 1, 2011; October 1, 2011.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-02(7), 43-12.1-09(2)(c)(d)

54-05-03.1-10. Authority to prescribe.

The advanced practice registered nurse plans and initiates a therapeutic regimen that includes ordering and prescribing medical devices and equipment, nutrition, diagnostic and supportive services including home health care, hospice, and physical and occupational therapy.

1. A permanent advanced practice registered nurse license with the addition of prescriptive authority shall be issued upon meeting all requirements.

2. The advanced practice registered nurse with prescriptive authority may prescribe drugs as defined by chapter 43-15-01 pursuant to applicable state and federal laws.

3. A prescriptive authority advanced practice registered nurse license does not include drug enforcement administration authority for prescribing controlled substances. Each licensee must apply for and receive a drug enforcement administration number before writing prescriptions for controlled substances.

4. An advanced practice registered nurse with prescriptive authority who prescribes controlled substances has access to the North Dakota prescription drug monitoring program and shall utilize the prescription drug monitoring program in the following manner:

    a. Shall evaluate a prescription drug monitoring program report for a client in the following situations:

        (1) New or unestablished client requiring prescription for controlled substance;

        (2) Every six months during treatment of client with a controlled substance;

        (3) Client requests early refills or engages in a pattern of taking more than prescribed dosage; and

        (4) Upon suspicion or known drug overuse, diversion, or abuse by client.

    b. Shall document evaluation of the prescription drug monitoring program reports made under this rule.

    c. May evaluate the prescription drug monitoring program report in the following situations:

        (1) Long-term care settings;

        (2) Controlled settings in which controlled substances are locked and administered to client;

        (3) Treatment of client with terminal illness, cancer, or cancer-related disorders; and

        (4) Hospice or palliative care settings.

5. The licensee may prescribe, administer, sign for, dispense over-the-counter, legend, and controlled substances, and procure pharmaceuticals, including samples following state and federal regulations.

6. The signature on documents related to prescriptive practices must clearly indicate that the licensee is an advanced practice registered nurse.

7. The advanced practice registered nurse with prescriptive authority may not prescribe, sell, administer, distribute, or give to oneself or to one's spouse or child any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug.

8. Notwithstanding any other provision, a practitioner who diagnoses a sexually transmitted disease, such as chlamydia, gonorrhea, or any other sexually transmitted infection, in an individual patient may prescribe or dispense, and a pharmacist may dispense, prescription antibiotic drugs to that patient's sexual partner or partners, without there having been an examination of that patient's sexual partner or partners.

History: Effective March 1, 1992; amended effective November 1, 1996; April 1, 2004; January 1, 2009; April 1, 2011; April 1, 2014; October 1, 2016.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(1)

54-05-03.1-11. Prescriptive authority renewal.

Prescriptive authority is valid for the same period of time as the applicant's advanced practice registered nurse and registered nurse license. The applicant for renewal must:

1. Renew the applicant's registered nurse license.

2. Submit verification of current certification by a national nursing certification body in the specific area of nursing practice.

3. Submit a completed advanced practice registered nurse with prescriptive authority renewal application.

4. Pay the advanced practice registered nurse renewal fee of forty dollars and the fifty dollar renewal fee for prescriptive authority.

5. Provide evidence of completion of fifteen contact hours of education during the previous two years in pharmacotherapy related to the scope of practice. These contact hours may fulfill the registered nurse renewal continuing education requirement. The education or its equivalent as approved by the board may include academic credits, attendance at approved seminars and courses, or participation in approved correspondence or home study continuing education courses.

History: Effective March 1, 1992; amended effective November 1, 1996; June 1, 2001; April 1, 2004; March 24, 2004; April 1, 2011.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10(1)

54-05-03.1-12. Change in physician collaboration regarding prescriptive authority.

Repealed effective October 1, 2011.

54-05-03.1-13. Suspension or enjoining of prescriptive authority.

The prescriptive authority granted to an advanced practice registered nurse may be temporarily suspended or enjoined according to provisions of North Dakota Century Code chapters 28-32 and 32-06, when the advanced practice registered nurse has:

1. Failed to maintain current licensure as an advanced practice registered nurse or failed to meet prescriptive authority requirements;

2. Prescribed outside the scope of practice or for other than therapeutic purposes;

3. Violated any state or federal law or regulation applicable to prescriptions; or

Following final board action notice of suspension or injunctive action regarding prescriptive authority will be forwarded to the board of pharmacy.

History: Effective March 1, 1992; amended effective November 1, 1996; October 1, 2011.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10(1)

54-05-03.1-14. Encumbered license.

Repealed effective April 1, 2004.

54-05-03.1-15. Recognition at effective date.

Any registered nurse with an advanced license as a nurse practitioner, clinical nurse specialist, nurse midwife, or certified registered nurse anesthetist on November 1, 1996, must continue to be recognized as an advanced practice registered nurse, and is eligible for renewal of the advanced practice registered nurse license under the provision of this title. These rules may not be construed to limit or restrict the advanced practice registered nurse's scope of practice statement previously approved by the board.

History: Effective March 1, 1992; amended effective November 1, 1996; April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08

Testimony on Behalf of Carla Barrios
Senate Human Services

Chair Senator Lee and members of the Senate Human Services Committee. My name is Carla Barrios and I am a Radiologist Assistant (RA) working in ND. This is to express my support for the bill HB1175, with the adopted amendment regarding medical image guided examinations and procedures that passed the House Chamber 92-0 do pass vote.

To become a RA, I attended a Masters level graduate program specific to performing medical image guided exams and procedures. It is a 24 month program of educational and clinical requirements similar to PA programs for Allied Health professionals, except the training, education and clinical requirements are specific to the medical imaging profession. In fact, due to the subspecialty of the program, only a Radiologic Technologist with BSRT degree and experience are qualified to apply and enter these graduate programs. These programs include requirements of dedicated time spent directly with a radiologist that is equivalent to 2500-3000 hours working with a radiologist to perform image guided procedures and examinations. Following my completion of the program, I was required to pass a national board examination from the accrediting body to attain certification as a RA.

As a working RA, I need to be licensed by the state NDMIRT board also to perform imaged guided procedures and examination. I have to attain 50 hours of continuing education specific to radiology and image guided performance standards every two years with required re-examination of national board examination every 10 years to maintain my professional license. All of these requirements are to ensure the safety, diagnosis and treatment of the patients who need to have these specialized image guided procedures that many times expose patients to large amounts of ionizing radiation.

Even with the vast experience prior, during and post RA graduate programs, RA's are explicitly forbidden to interpret final reports of medical image guided procedures and examinations. RA's also have to be under the "general supervision" of a physician during their employment to ensure the safety and efficacy of procedures that are performed. The national scope of practice along with the state licensing board, NDMIRT, explicitly state interpretation is not allowed. Interpretation of medical imaging is the sole responsibility of a Radiologist. The broad language within the HB1175 bill is concerning because not only should a scope of practice express what all a health care provider can do, sometimes it is just as important to ensure certain procedures are specifically excluded to ensure patient safety and health care is performed by individuals whose training and education specially included the performance of those examinations.

PA programs do not provide the in-depth education, clinical requirements or extensive experience in Radiology the RA programs provide. PA programs are mainly primary care and many differing allied health professionals are allowed to apply and attend. Many of these primary care health professionals have had no experience with the specialized area of Radiology, nor do they achieve the experience in the PA programs for any equivalencies to the RA programs. Nor do their ongoing continuing education have medical imaging requirements.

The medical industry is constantly changing with professionals needing to provide and treat increasing number of patients at a time when reimbursement is getting difficult. We need to have all mid level professionals to meet these increasing demands. But, we need to ensure patient safety, proper diagnosis and treatment is performed by qualified individuals. These mid level graduate programs do

not cover all aspects of the medical profession which is why we also have speciality graduate programs to meet the needs of the patients and the industry.

Respectfully,

Carla Barrios MS RRA, RPA, BSRT (R)(M)