Talking Points to Include in Public Comment:
Please take a look at the following categories of issues with the proposed regulation changes. Choose a few that you feel passionate about and prepare to speak or write about those. Thank you for your support!

Scope

- Requires a description of practice – acts, tasks, or functions. All tasks must be in **both** PA and collaborating physician's scope of practice.
    - Talking point: exhaustive lists of what is permitted are never exhaustive and lead to constant updating. Limits what PA can do. Overly prescriptive (legally).
    - We do not agree with the proposed more restricted changes for scope of practice. Scope of practice should be based on education, training, and experience of the provider. If PA has extra training this should be able to compliment the practice.
- Scope of practice tied to **primary** collaborating physician.
    - Talking Point: scope language further limiting. May require additional plans with state if alternate provider has varying scope.
- Prescriptive rights: adds "within the collaborating physicians scope of practice". Also adds language "granted by the **primary** collaborating physician" in practice agreement.
    - We do not agree with prescriptive authority being tied to physicians. We are educated on prescribing and pharmacology. We are responsible for our prescribing practices.

Assessments

- Still 2 annual reviews & 4 reviews for PAs with less than 2 years of practice experience. Is now tied to PAs experience not collaborating plan.
    - Talking Point: this really doesn't change anything, the frequency stays the same. *Good that it is now tied to PA experience not practice agreement, and does not require an specific time frame (4 hrs).
- New additional requirement that MUST be included in assessments:
    - "Other health care provider or patient feedback" – not currently included on the assessment form provided by the state. Will require practice level implementation.

Collaboration

- Changes notification period of practice agreement to 3 business days from the previous 14 days.
    - Talking point: state already cannot keep up with the 14 day notice, 3 seems like it would overburden a system that is already failing.
    - We do not agree with 3 business days vs 14 days.
- Additional requirement for "contact protocol" for consulting physician, if no alternate and primary collaborating physician is not available.
    - We do not support the requirement of a third physician contact protocol and this is contradicted by the fact that an alternative is required within 3 months - making this essentially a third physician named.

- Alternate collaborating physician named within 3 months.
    - Talking point: Alternate contact had to be established and is adequate for 3 months but not after that point? What changes after three months and why is this needed?
- "Active" practice for collaborating physicians increased from "at least 200 hrs direct patient contact" – to "not less than 480 hrs **documented**, direct, patient contact" for each year of practicing medicine.
    - Talking point: Safety? What added protection does this provide patients? Periodic assessment requirements do not change - so still same contact with PA.
    - Would active plans between PAs and physicians with less than 200 hours be grandfathered or become invalid?
    - We do not support requiring additional hours (200 to 480) for collaborative physicians to be "active".
    - Talking Point: this will require extra gathering of information, making hiring PAs more cumbersome and time consuming with no credible way to show improved patient safety or care.
- States in person or by videoconference
    - Only allows video conferences for PAs with in-state collaborating physicians.
    - Talking Point: This drastically limits subspecialty care and creates a financial burden when collaborators must come to Alaska twice a year to meet with their PAs or 4 times a year if they hire a new PA.

Remote

- Remote practice definition change
    - Definition: 30 miles by road from nearest "tertiary" care facility OR the primary collaboratives main place of practice.
    - Talking point: Limited definition of tertiary.
- Additional requirement for documentation of "a process for communication availability and decision making responsibility when providing medical treatment to a patient in an acute health care crisis".
    - Talking point: Medevac plan basically but only for PAs in remote practice. No other provider has that stipulated. May be hard to anticipate every situation, overly prescriptive.
- Remote practice location – deletes prior option to have increased supervision and start practicing in remote locations, now only option for PAs is 2400 hrs (14 months) general medical practice within 2 years prior to beginning date of employment.
    - Talking point: "general medicine" not well defined. Does it mean primary care, family practice, urgent care, emergency care, OBGYN, pediatrics?
    - Health Aides, 4 months training. No other providers have these types of stipulations, new or specialty.
    - Example: If a PA has 20 years of experience in "general medicine" but practices in a specialty for 14 months they are then ineligible for remote work until going back to the "general" medicine for 14 months. Does not seem to increase patient

safety, just limits access to care by restricting experienced PAs from practicing in remote clinics.
    - Example: A health aide works in a rural community for years then goes to PA school. Must work 14 months elsewhere before they can return and give care in their hometown.
    - Medicine is not the same it was 20 yrs ago, or even 5. Technology allows us to practice safely and effectively from remote locations.

Misc

- Redundancy addressed, attestation (vs verification), temporary permit (vs license), removes size of sign requirements for identification.
    - These changes are not controversial. We appreciate that the SMB has addressed the redundancy or the regulations and has streamlined electronic signature and attestations. We agree with the language changes from temporary license to permit, and collaboration plan to practice agreement.

Cost

- There will be costs associated with creating a practice agreement form to be provided by the state, and the new assessment form to add new requirements.
- More staff will be needed to make sure all the new practice agreements, and practice agreements with changes, are received and processed in three days. Right now the 14 days does not seem to be enough for the state.
- The increased audits of at least 10% will need additional staff to perform. Approximately 75-80 audits per year. This is 70-80 more than in previous years. Verifying tertiary facilities & primary office locations, qualifying 2400 hrs of general medicine, “active” documented pt contact hours of collaborating physicians, confirming scope of practices in detail,

Questions

- Define “general medicine”.
- Define “tertiary care facilities”.
- Define “good standing with board”.