Episode 16 – Our very first mailbag episode

Intro music: 0:00

Podcast introduction: 0:10

Hello, and thanks for joining me. I'm Jean Fisher Brinkley, Communications Director for the North Carolina Medical Board, and this is MedBoard Matters. On this episode, we are going to do something a little different and answer some frequently asked questions. Before we jump into it, I want to send out a big thank you to all the individuals and organizations that sent in questions. We got so many. More than I thought we would. So many, in fact, that we're not going to be able to answer all of them in a single episode. Some questions were so big and so important that we may even do whole episodes to answer them in future. So again, thank you. All right. Let's get started.

FAQs: 0:51

The first question I'm going to address has to do with mandatory use of the North Carolina Controlled Substances reporting system. In recent weeks NCMB has gotten calls and emails from licensees who received concerning letters from the state. In the letters, the North Carolina Department of Health and Human Services warns that the recipient seems not to be checking patients' prescription histories before prescribing certain controlled substances. Doing this check is required by a provision of the North Carolina Stop Act that went into effect in July. The letters go on to say that DHHS has notified the North Carolina Medical Board. So, as you might guess, the burning question on licensees' minds is what is the medical board going to do with this information? Hopefully, I can put a lot of minds at ease because the answer is that the Board is not doing anything with the information other than reviewing it. The information provided by administrators of the North Carolina Controlled Substances Reporting System is not currently being used to verify compliance with the law. Why? Well, NCMB is aware that the data flags multiple licensees who are actually exempt from the requirement to check prescription histories. Hospice physicians, for example. we have also heard that some licensees who use delegates to run their prescription checks have been inappropriately flagged as non-compliant. NCMB will work with DHHS to improve the accuracy of its report once we've determined a reasonable way to verify compliance and NCMB will inform licensees of that process.

On to question number two. As you may know, the use of telemedicine has exploded over the last couple of years due to the ongoing coronavirus pandemic. A lot more medical practices are offering telemedicine visits, and a lot more patients are saying yes to them. One of the most frequent questions we get related to telemedicine is does a medical provider have to live in North Carolina in order to provide care via telemedicine to a North Carolina patient? The short answer is no. A medical provider does not need to physically be in the state of North Carolina to provide care via telemedicine to a patient. However, what the medical provider does need, no matter where they are, is a North Carolina license. By law, North Carolina residents must be seen by North Carolina licensed clinicians. And thanks to some rules that NCMB adopted early in the pandemic, it's never been easier to get a North Carolina license. The rules allow medical professionals who are licensed in states other than North Carolina to quickly get an emergency temporary license. And, it's free. The application takes just minutes to fill out online, and licenses are typically issued within a week. Emergency temporary licenses are good for as

long as North Carolina remains in a state of emergency due to COVID 19, plus 30 days. If you're interested in an emergency temporary license or know someone else who is. Go to www.ncmedboard.org/COVID and look under licensure for more information.

OK, Question three. This is a big one. What do I do if I get a letter from the medical board that says a complaint has been filed against me? Well, first, don't panic. A complaint is an allegation of wrongdoing, not proof of it. NCMB has a statutory obligation to investigate complaints if there's even the smallest chance care was below standard or that there was unprofessional or unethical conduct. A letter from the Board has two main purposes. First, it's to let you know that a complaint has been made against you. And second, it's your opportunity to tell your side of the story. I say opportunity, but you really don't want to ignore a request for information from the medical board. You will need to respond, and there could be consequences if you don't. I have a little advice. Even if the complaint is, in your opinion, completely without merit, keep your comments factual and professional. Many licensees ask whether they need to consult with an attorney before responding. Well, that's up to you. Before you make that decision, I will remind licensees in the audience not to overlook other resources that may be available. If you're employed by a hospital or a health system, for example, ask your risk management department to advise you. Your professional liability insurance carrier may be another good option. Give them a call and ask if anyone can advise you on preparing a response. Finally, just to put this whole process in context, I'll note that the vast majority of complaints from patients and the public (up to 70% in a given year) are closed, with no action against the provider. Usually, this is because there's not sufficient evidence that a violation occurred.

Physician Assistant Q&A: 5:48

Now we're going to shift gears and answer several questions about a single topic, physician assistants. When we looked over all of the questions received, it quickly became clear that there were quite a few about. So, in the interest of clearing those up, I've brought in an in-house expert Assistant Medical Director, Memory Dossenbach. Memory is PA with more than 25 years of clinical experience in a variety of practice settings. She joined NCMB staff in 2020 and has made herself absolutely indispensable. In addition to her work reviewing cases for the Board and responding to inquiries from licensees, Memory presents on PA licensure and practice to graduating students at all of North Carolina's PA programs.

JFB: Memory, welcome to Med Board Matters. Thank you for joining me.

MD: Thank you very much. Thanks for having me.

JFB: Of course. I wonder if we could start with the basics. Could you explain to me what exactly is a physician assistant and what do they do in terms of providing patient care?

MD: Absolutely. So, PAs are considered medical professionals. They can diagnose, develop and carry out treatment plans, prescribe medication. So really, covering the whole gamut of providing health care in a health care setting. They often serve as the primary or the principal health care provider in that we see that a lot in rural underserved areas, for example, and they're also very versatile and collaborative. They do not specialize in a particular area like a physician would in a residency. So, for me, just by nature of that training, these are considered very versatile. They practice in every state, in the country and in every medical setting and specialty. So, they are not strictly restricted or limited to primary care, for

instance. And so, for all of those reasons, PAs have been found to improve access to health care, quality and access, and that is actually been proven in studies which have been conducted nationwide.

JFB: And what level of training does PAs have?

MD: PAs are educated at the master's degree level. And a lot of people, I think, are not aware of that. So, a master's degree, an undergraduate degree is required. So, it is a graduate level training and there are over 277 programs…rapid expansion. There will be close to 300 programs very soon. Admission is very competitive. It's…it's a very competitive field. And another thing that I think a lot of people are not aware of is that incoming students average over 3,000 hours of direct patient contact experience, and that's before they even start school. So, they typically come from the health care setting. That they have had experience in an emergency department as a technician or a nursing assistant in a nursing home. But that is invaluable. That's…that's a lot of…of hands on health care experience that they bring in prior to being trained as a P.A. to the training program. The actual curriculum is modeled similar to medical school curriculum, and so that that means that there's a didactic or a classroom setting. And in addition to clinical education, training programs are approximately to average it out across the country 27 months long. So, they are longer than two year programs and a good portion of that over 2,000 of those hours required are clinical rotations. So, students are out on clinical rotations just like medical students and often with medical students on rotations or internal medicine, emergency medicine, surgery, the same clinical experiences. Once they complete that training, they have to pass a national certification exam. And in most states, they have to retake that exam every ten years. And then in addition to that, continuing medical education is required to be up to date every two years. So, it's not just the initial training, but there is ongoing training and expertise that is required.

JFB: Great. Well, that is a great, great overview. I was just going to note that North Carolina has certainly seen growth in the training programs. I think we're up to twelve or possibly even 13 schools, and we've certainly seen that directly contribute to the growth of the number of people licensed by the North Carolina Medical Board. It is in fact one of the fastest growing licensee groups that the medical board licenses.

MD: Absolutely. And you will see, all of us will see even more programs emerging in the state of North Carolina in the very near future. There are there are several currently in the early stages of accreditation.

JFB: Gotcha. OK. And then another point that some of our listeners may not realize is that in the state of North Carolina, a PA can even own his or her own practice. Correct?

MD: That is correct. And you know, it's interesting that you bring that question up because there has been a significant increase in that area and in part ownership in recent years. And I think that that is a result of the increasing demographics, just sheer numbers in North Carolina, and there's just been interest in ownership of practices nationwide. You know, it still requires physician supervision, even if the PA is the sole owner, and I think that's a very important take-home point. But I think as medicine in general has become specialized, PAs have been provided more opportunity outside of strictly clinical practice that it follows that you would see increased interest in PA ownership. That being said as well, for me personally, the take home is it still requires physician supervision.

JFB: You've mentioned supervision a couple of times. Can you discuss what supervision of a PA actually entails?

MD: Absolutely. So, in North Carolina, and I will say this can vary from state to state, so specific to North Carolina, supervision of a physician assistant requires that the supervisor be a licensed medical doctor or osteopathic doctor, so it has to be one of our physician licenses. And so, the physician assistant and that physician have to establish what we call a collaborative agreement. And that's…that's essentially saying that I am going to practice in the field of surgery or whatever, and I will…I will, by rules and regulations, have to have a supervising physician. That physician does not have to be standing by my side in the building, directly supervising the medical care that I provide, but they have to be available. And so, there are some parameters and some rules and regulations that have been set forth to make sure that that relationship is legitimate, that it's not just an administrative form that has been…been signed by two individuals, and it's intuitive that it benefits everyone involved. It's to allow that physician assistant to have a competent, clinically trained physician that they can consult and collaborate with, that they can reach out to with any questions or concerns. That they can have ongoing collaboration and meetings and conversation and dialog, current practices, current trends and it is again, regulated by us, the North Carolina Medical Board.

JFB: Right. OK, here's a tough one. What if a patient doesn't want to see a can a patient ask to see a physician instead?

MD: That as well is a great question, and I will tell you it's…it's one that I encountered, often over my 25 years in clinical practice. It is, as health care has evolved, different roles have developed. Of course, we collectively are more in a team based health care system, so to speak. But the answer is certainly the patient always has that right. They have that right to request a physician if they feel that that best meets their needs. It's important to note, however, that a practice may not have a physician available in all circumstances or settings. Some practice models are set up so such that the PA may, for instance, see the patient initially with the follow up schedule with the physician. A good example of that would be an orthopedic setting where the PA may do the initial exam, ensure that the appropriate MRI has been ordered, and then schedule the patient to follow up with the surgeon in anticipation that surgery may be the outcome. Another good example is, as I've mentioned previously, rural health care settings. There just simply are many areas in this state where the only access to a provider is a physician assistant or a nurse practitioner. But it's always within that patient's right to ask. In those practices, I have found will understand this and will try to accommodate that patient. That may mean rescheduling the patient to see a physician or referring out to a practice or a setting where a physician is available. It really, again to me comes down to communication, explaining what a physician assistant is, what they can and cannot do, and then allowing that patient to make an informed decision that meets their health care needs.

JFB: Now I'd like to pivot a little bit and talk through some of the PA inquiries that NCMB gets from medical professionals. And I wanted to start with some questions about supervision. We've discussed that all NC PAs are required by law to have a supervisor and that the supervisor doesn't have to be on site or in the same practice location with the patient. How does a PA establish with a primary supervising physician?

MD: So, once that relationship is determined, to put it simply, once the PA has accepted a job or a position and has identified that physician or the practice has identified the physician for them, that relationship has to be officially filed or recognized by the medical board. And that involves actually a very easy process, is an online process, filing what's called an intent to practice. And that is just telling the medical board; Who am I, the physician assistant. Who am I going to be practicing with? Who is my supervisor going to be. The practice setting. And that essentially suffices in that regard. The next step to that is a written document has to be developed and signed by both parties. It's semantics, but some people will call them at a supervisory agreement. Some people call it a collaborative practice arrangement. You will see different terms, but there is essentially an agreement, so to speak, between these two providers in terms of what the physician assistant will or will not do, what medical tests they will perform or can perform. For instance, what they may be able to prescribe, procedures that they may or may not be able to perform. I mean, it's good guidance for both parties in North Carolina. One thing that makes us unique as well is that we are a flexible state in that we allow that practice arrangement to be developed at the practice level between the PA and the physician. It's not mandated from above. It's not so structured that it prevents there being flexibility in the arrangement. Once that agreement or that arrangement is developed and written and signed, then it needs to be reviewed periodically as things change over the course of one's practice. So, it's important that…that that is reviewed periodically by both the PA and the physician. If any changes need to be made there, you need to be made or written into the agreement. And again, just serves as a good foundation for the practice.

JFB: Mm-Hmm. OK. And who is responsible for notifying the medical board when that supervisory relationship ends? I ask because NCMB frequently hears from both physicians and PAs that a supervisor is still listed as active even after the PA has moved on.

MD: It's funny, Jean. You have impeccable timing because literally last late last week, I had this come up in dialog with the PA. And so, the take home point is that it's the responsibility of the PA and they are solely responsible for removing that physician from the intent to practice form. Once that arrangement ends, the physician cannot do it. And in some frustration, I know that we sense from some physicians, as you noted, is that no longer supervising this person, you know, needs to be taken off. You know, fortunately, it's an easy online process. It literally takes less than a minute. I believe truly one of the staff members told me it's…it's a very quick process just to deactivate or remove that, that supervisor. You're in the midst of change. You're leaving a job, perhaps starting a new job or you've lost your longstanding supervisor position because they've moved away or whatever the circumstances are. It's very easy to forget this simple step. I, as you know, do outreach to physician assistant programs across the state, and one of the things that I remind all these new soon to be licensees is put a reminder in your phone, put it on your calendar, somehow remind yourself to when you…when you know you're going to be changing jobs, make that a reminder to yourself. Because I will be honest and admit that I have forgotten to do it. It happens, but it's just worth reminding people again that it is solely their responsibility to do so.

JFB: OK, great. I just want to throw out there that we do have a resources page on the medical board website that you can visit www.ncmedboard.org/PAresource. The intent to practice form is linked right on that page can bookmark it and visit it anytime they need to make a change. Now I have a question that's a little bit complicated, so bear with me. Let's say a primary supervising physician retires or leaves a practice, and the PA gets another physician in the same practice to supervise them. Is this considered a

new supervisory relationship? And thus, is it subject to rules that require monthly quality improvement meetings for the first six months?

MD: Yet again, a very good question and one that really I have noticed a lot of physician assistants that have brought this question up are very passionate about. But as to your point, when you look at the way the rules are written and the way the law is stated, it's the relationship, not the clinical setting. And so that's what I remind people. It's a new collaborative relationship. You may have been in the same endocrinology setting for 14 years and your physician has moved away, and you have a new physician coming into that setting. So, your clinical setting or your practice has not changed, but your relationship with that physician has. So, you do have to have the quality improvement meetings and have the rewritten or new collaborative practice arrangements. You know, I also see this as benefiting both parties, both the PA and the physician. I as a PA, I ought to know the practice patterns of my supervising physician and their communication style and their clinical background, just as much as I'm sure they want to know mine. And so, I think that again, it's just important to remind everyone that it's not to be onerous or overly restrictive. It's really in the best interest of both parties. So, it is any new collaborative relationship, and that should be the key take-home point for people. I will say, even as a PA with 25 years of experience, even in my most recent clinical position, prior to joining the medical board, I wanted to know more about my supervising physician and I wanted to know certain topics where I wanted to make sure that we agreed clinically and philosophically, and if nothing else, I really needed to be, especially in this virtual world, very comfortable in how to communicate with that physician. So, a short meeting once a month for 6 months and then every six months beyond is not too much to ask.

JFB: Great. OK. While we're on the topic of QI meetings, the state of North Carolina enacted a waiver that actually temporarily suspends the requirement to conduct these meetings really at all during the coronavirus pandemic. What is the status of that waiver?

MD: The legislation that you refer to 2020-03 legislation that in part, you know, with original intent, was to ease the administrative burden of practicing medicine during the pandemic. And several provisions are one that was, to your point, really initiated by the Board of Nursing as they regulate nurse practitioners, is to temporarily suspend those required quality improvement meetings. So yes, we've spent this time discussing these quality improvement meetings, but they are on hold. And so that executive order has now been extended from December 31st of this year, 2021 until December 31st of 2022. And so, it's important to stress that this is a temporary suspension and that the board encourages PAs and their supervising physicians to continue those meetings, if at all possible. They're important. It's a good habit to get into. There's no reason not to do it if you can do it. And that's another point when I've met with several of these students who will soon who are applying and will soon be licensees in North Carolina, I encourage them to start doing it even though legally and technically they're not required right now. It's a very good habit to get into. But yes, to your point, the extension is in effect and so they are not required by law at this time.

JFB: OK, well, great because that is something that we have received questions about. So good to know where things stand. Here is another question that we've had from both supervisors and supervisors. May a physician assistant practice a particular modality or in an area of practice that his or her

supervising physician is not trained or authorized in? For example, if the PA has DEA privileges, but the supervising physician does not can operate controlled substances.

MD: That's a really good question, and one that I think comes up again more often is medicine in general becomes more specialized. The answer is no. Short and sweet, the answer is no. The PA is not allowed to practice above the level of their supervisor. And the DEA prescribing is an excellent example that you brought up. I think another good example is performing procedures that the physician does not perform or is not comfortable or competent in doing so intuitively. If the PA has a question or concern that arises, they need to be assured that their supervisor is capable of addressing that question or concern. And so, I've been asked before, how would the Board even know what I'm doing if I'm a practicing above the level of my, of my supervisor? And I say, well, most likely the Board would not unless or until a complaint is brought forth. And unfortunately, that is when we discover these situations. When a situation arises, there may be a quality of care concern regarding something that the PA has or has not done. And in the investigation of this or a collection of information, it is determined that the physician themselves, the supervisor does not perform that procedure or is not comfortable or capable. And so that gets into a second area of concern, which can be a supervisory concern. So very good question again. And it's just important again for the PA to have that collaborative practice agreement in writing that clearly delineates what they can and cannot do. And it also, to a second point, is important for that physician assistant to have honest conversations with their supervisor. I have already encountered a situation where a PA was not aware that their physician did not have those DEA privileges, and so it's important that you don't assume and that you ask those questions and that you get that in writing in the collaborative agreement. So again, you're all on the same page.

JFB: Wow. I hadn't even considered that, and we could probably do a whole other episode on this. But you know, and maybe we should about, you know, how does a PA go about finding a supervising physician who's a good match for them? Because it seems to me that as the PA, you need to be as careful and inquisitive about them as the supervising physician might be about you.

MD: Absolutely. And I think again, it's…it's a challenge for some people and especially young new graduates in a perceived hierarchy. But one thing that I suggest that all the students do, the new licensees do is actually go to the physician licensing landing page on our website. They look up a doctor or look up a provider function and look. It is very unusual, but it can happen that a physician licensee is part of a condition or sanction, so to speak by the board is not allowed to supervise a nurse practitioner. If that's the case, that most likely would show up under the public documents section of our website. But again, it should be a two way conversation. And if you are as a physician assistant asked to perform a procedure that's a little bit outside the cutting edge, or it's something that is not FDA approved or it's something that's new, and yet your supervising physician does not perform that procedure, that warrants a deeper conversation. Yes, ideally and prescribing as well. And that's why it is stipulated in that written collaborative agreement that prescribing be included in that agreement. So, it's an important part of the equation, and it is not easy to determine someone's DEA privileges. There's no one quick site that you can go verify or confirm that. So, it does come down to simply asking, “Just want to make sure we're both on the same page here. We both have the same level of schedule prescribing with the DEA” and then move on from there.

JFB: Memory, I think I could probably keep you here forever answering questions, but I'll have mercy on you and let it rest there.

MD: Well, thank you, Jean. I appreciate all your communications department does to get these important topics out in front of people.

Podcast wrap-up: 27:13

Well, that brings us to the end of the very first question and answer episode of MedBoard Matters. I hope you learned something useful. If you did, don't forget to share our podcast with your friends and colleagues. Send them to www.ncmedboard.org/podcast to listen to the episode and see related resources posted on our show page. If you have questions or comments about anything we covered on this episode, or if you have a question of your own you'd like us to answer on a future podcast, send email to podcast@ncmedboard.org. Thank you for listening, and I hope you'll join me again.