PUBLIC COMMENT HEARING

ON THE PROPOSED PERMANENT PHYSICIAN

ASSISTANT ADMINISTRATIVE RULE AMENDMENTS

OKLAHOMA ADMINISTRATIVE CODE 435:15

SUBCHAPTERS 1,3, 5 AND 11

HELD ON OCTOBER 5, 2022

AT 9:00 A.M.

STATE OF OKLAHOMA BOARD OF MEDICAL

LICENSURE AND SUPERVISION

101 NORTHEAST 51st STREET

OKLAHOMA CITY, OK 73105

Board Staff: Lyle Kelsey, Executive Director
Barbara Smith, Executive Secretary
Linda Hall, Executive Assistant

REPORTED BY: JANA C. HAZELBAKER, CSR

(On October 5, 2022, the following proceedings were had.)

MR. KELSEY: Okay. Good morning. Appreciate all of you being here.

My name is Lyle Kelsey. I'm the director of the Oklahoma Medical Board.

To my left is Barbara Smith, who is executive secretary.

To my right is Linda Hall, who is administrative assistant, be helping this morning, as well.

And then we have a court reporter, Jana Hazelbaker. Nice to have you with us. And so she will be taking an official transcript of this morning's comments and will make those available, too.

So welcome again to everybody in attendance this morning, taking time out of your workday and attending here.

As of yesterday we received 146 written responses. Copies of those will be tabulated and electronically available by email upon request. So you might make note of that.

Public hearing will be transcribed, as I mentioned, and available to those upon request as

well after that is transcribed.

Pursuant to the notice published by the Secretary of State, PA Rules Subchapter 1, 3, 5 and 11 will be considered the talking points for this morning.

Here are some of the guidelines for this hearing. We closed the sign-up list at 9:05, so if you were in the line at 9:05 you will be allowed to speak.

In fairness to everybody, we're taking the speakers in the order of their sign-up list. When your name is called, please come up to the center chair at the counter and you will have three minutes to deliver your comments. We'll take a timed presentation. At one minute left, the yellow light will go on, and then at three minutes the red light will go on. So just be aware of the time. We're not going to be sticklers about it, but at the same time -- just to give everybody a fair amount of time.

And then we'll call up the next person after that.

If you have written comments that you're speaking today, go ahead and sign those and date them and put them at the end of the -- at your right to the table there by Ms. Smith and we'll take those in

accordance as well.

Also, if your name is called and you decide not to speak, let us know and we will call the next person on the list.

If, again, your comments are in writing and you just decide not to speak this morning, you can also date and sign the written comments, put them at the counter to the right side by Ms. Smith and we'll call the next person.

I don't think I need to say it, but obviously with the attendance it's pretty assured that this is an emotional and important topic that we're talking about today, so we expect professional, courteous decorum during this hearing. Every speaker is important. So I just caution you, as far as any kind of audible comments or murmuring or so on in the audience. We're all respected professionals and I think we need to conduct ourselves accordingly.

So let's start with the first person, Ms. Smith.

MS. SMITH: Bruce Storms, M.D. And if you'd like to have a seat here.

And please state your name for the record.

BRUCE STORMS: I'm Dr. Bruce Storms, M.D. from Chickasha, Oklahoma.

MR. KELSEY: Okay.

BRUCE STORMS: My background is I was the emergency medicine director at the emergency room in Chickasha for 41 years. About the last 15 years we have helped train PAs and had them rotate through our emergency room for a two-month stint.

I've also worked with PAs in my practice and I've been in Chickasha now for 45 years.

I think PAs are an integral part of our healthcare team, but the emphasis there is "team." We work together as a team. All of our mid-level providers have physician supervisors or people that they collaborate with, and we -- I feel that it needs to stay the way it is where they do not have full prescriptive authority for Class II drugs.

We've been in the midst of an opioid crisis for a number of years and we're finally beginning to get that under control. Giving them full authority to go out and prescribe Level II narcotics without supervision would add -- about 20 percent more people would be able to write for opioids. And I'm worried about patient safety.

The Fentanyl coming on the market is a very scary drug. You know, as an emergency room physician we see many drug overdoses, and those that overdose

on Fentanyl are almost always lethal.

So we don't need to be prescribing more opioids, we need to be prescribing less. And I think in certain circumstances a PA should be allowed to. If they go back and do a pain management fellowship or they have additional training, then I think we can look at those on an individual basis in the future.

But to come out with a blanket change in the rules that gives them prescriptive authority I think puts our patients at risk. And I'm a firm believer that we put our patients first. And if it is a little inconvenient, sometimes that's okay because safety's the most important thing.

So I speak against some of the rule changes, especially in giving PAs full prescriptive authority over Schedule II. And I think we can look at it on an individual basis and maintain patient safety.

Thank you for hearing my comments.

MR. KELSEY: Thank you.

MS. SMITH: Cori Loomis, J.D.

CORI LOOMIS: My name is Cori Loomis. I'm an attorney with Christensen Law Group and I do mostly healthcare work -- or pretty much all healthcare work.

One of my clients is the OSMA, but I also represent small, rural hospitals, physician groups, all types of healthcare providers, and including physician assistants.

And in looking through the rules, as an attorney and advising clients, I want to be as precise and clear as I can, which sometimes is not possible. I realize that. But in looking at the rules there's some issues that I was hoping the Board would provide some clarification or more detail on. And so I'll just go through some of those right now.

In regard to delegation, the delegation right now is very broad. There's basically no parameters on how physicians and physician's assistants are to implement that. There is a sample delegation agreement, but it's two pages, doesn't have a lot of detail.

And so my question for the Board is, in advising clients, are there any things that should never be delegated and should there be some guardrails or parameters put into place that, you know, we all hope that at the practice level good judgment will be used, but we all know there's that small, small percentage of time that maybe it's not.

And so should there, for example -- and

these are just examples. You should never delegate surgery or never delegate general anesthesia, and how should those be defined in the agreement. So that is one issue I had.

Another issue comes up often -- in fact, physician's assistants ask me this all the time -- and that's about the ability of physician assistants to establish their own entity to practice through and in.

And I -- Lyle knows I called him about this a few weeks ago, and checked the PA website and they're "Frequently Asked Questions," I think, had a question that was not necessarily correct on there. And it's whether you can establish.

There doesn't seem to be anything in Oklahoma law that says a PA cannot, under the current law, so go out and establish their own practice. They cannot form a professional entity, but they could still use a regular entity.

And in light of the new delegation requirements and the fact that we've now, in 2015, removed the on-site supervision requirement, how does the Board view that, establishing your own practice? So that's the second one.

On prescriptive authority, to me -- and

this is very -- again, I'm looking at the law -- the letter of the law. It is still not clear. And I would like very specific guidance because I understand that Senate Bill 1322 was amended and that reference to a subsection in the PA Act was stricken.

But then you go to the Physician Assistant Act and the exact same language appears to be there. It was unchanged on the on-site administration. So I'm trying to reconcile those for my clients and would like input on that.

In regard to the formularies and things like that, I did serve a term on the nursing board and so I know from my experience there that -- well, APRNs cannot still statutorily -- I'm sorry, I'll wind this up -- cannot statutorily prescribe Schedule IIs.

And so there seems to be -- because, again, in my mind PAs and APRNs have similar training. That -- somebody could debate that, I know, but -- so what is the difference, and explain the fact that PAs would be able to, under these rules, prescribe Schedule IIs and APRNs wouldn't?

And then in regard to the formulary, I know that advanced practice nurses do an exclusionary formula. And the proposed rules reference the

American Hospital Formulary Service Information book, which I guess is proprietary, so I could not look at it.

So it's not clear, again, to me, trying to interpret it out to my client. Did the rule mean that you could -- a PA would be able to prescribe everything listed in that book, which I assume is everything, or that it could be categorized -- the formula would be developed and hasn't yet, but with those categories in mind?

I know that the APRNs put a lot of time in their formulary and looking at it. And even within the drug classes they can prescribe, not every drug is included in their formulary. There are some exclusions, in other words.

For example, Ketamine. An APRN can -- that's a Schedule III. APRNs can do Schedule IIIs but they can't do Ketamine.

So those are the issues that I had -- would like the Board to consider providing additional clarification on.

MR. KELSEY: Do you have that in writing?

CORI LOOMIS: I have my outline. I could leave it, yeah.

MR. KELSEY: Okay. If you want to. And

date it and sign that and then turn it over, that would be great. Thank you.

MS. SMITH: Pat Hall.

PAT HALL: Thank you, Mr. Kelsey.

My name's Pat Hall. I've been the lobbyist for the Oklahoma State Medical Association almost 22 years. I was the lead lobbyist for OSMA on opioids reform for the last five years.

I'm here today representing OSMA and asking for the Medical Licensure Board to reject the rules. And we stand in opposition, and our reasoning is, for the last five years the House of Medicine collectively has worked to lower the amount of opioid pills and narcotic pills that have actually been dispensed.

If you'll bear with me for a second, by allowing full prescriptive authority for PAs of Schedule IIs will increase the amount of eligible prescribers by approximately 20 percent. But since 19 -- or since 2018, pills are down 26 percent. This information was provided by the Oklahoma Bureau of Narcotics and Dangerous Drugs. Prescriptions are down 24 percent. Daily MMEs, or Morphine Milligram Equivalents are -- are down 26 percent.

But I think the real key, since 2015 we had

372 deaths. The deaths on the last date of 2020 are down to 219 deaths.

I think the Oklahoma State Medical Association is still very concerned by opening up the narcotic prescriptions to another 20 percent of eligible prescribers are going to push the pill limits back up, pill numbers up, prescriptions back up and, sadly, we believe deaths are going to go up.

The Fentanyl is a dangerous thing. It's not by prescription, it's certainly -- the majority of Fentanyl is coming in by illegal methods, so we're not here today to talk about that narcotic.

We're here to really talk about Schedule IIs. We're here to talk about Hydrocodone, OxyContin, and the other Schedule IIs. We've made tremendous strides in Oklahoma.

The AMA -- the American Medical Association just recently put out a notice throughout the country, "Opioid prescriptions are down 46.4 percent since 2012."

I do not think Oklahoma wants to be a leader back in opioid usage, opioid prescriptions, and certainly opioid deaths.

Thank you very much for your time.

MR. KELSEY: Thank you.

MS. SMITH: Mr. Hall, would you like to leave this with me or --

PAT HALL: No.

MS. SMITH: You want to keep it. Okay.

Lexie Norwood.

LEXIE NORWOOD: Hi. Good morning. Lexie Norwood with Glenn Coffee & Associates, and I represent the Oklahoma Academy of Physician Assistants, the OAPA.

And we did submit written responses here, so I won't go all the way through it, but I will make a few comments here.

The OAPAs respectfully requests that the medical board adopt the proposed changes here because they are consistent with current Oklahoma law.

Senate Bill 1322 provides clarification on the authority of physician assistants to prescribe Schedule II drugs, including opioids.

The OAPA has been told several times of what they need to do to be able to prescribe Schedule II drugs, and they've done everything that's been required of them.

I would like to say that the plain language of SB 1322 allows physician assistants to prescribe these Schedule II drugs as long as they have been,

number one, approved by the medical staff committee of the facility, or, number two, by direct verbal order of a delegating physician.

So PAs can't just prescribe these Schedule II drugs, it has to be through a delegating agreement with a physician. And if that physician does not want to delegate that authority to the physician assistant, they don't have to.

So, for instance, if they want to limit Fentanyl prescriptions, they can put that in their delegating agreement that their PAs don't have the ability to prescribe Fentanyl, if that is what the delegating physician is worried about.

In addition, there's already protocols on prescriptions, including Fentanyl drugs and opioids and things like that that the physician assistants do have to abide by to date.

And, you know, with all that being said, you will hear from other physician assistants here today, including the president of the OAPA, Keith Plummer, and he will go into what we are seeing as far as prescribers having problems with opioids and what those numbers actually look like, where M.D.s are prescribing opioids versus physician assistants.

So thank you for hearing us today.

MR. KELSEY: All right. Thank you.

MS. SMITH: Keith Plummer.

KEITH PLUMMER: Good morning. My name's Keith Plummer. I am a practicing PA, have been practicing rural emergency medicine for the past 26 years, currently practice in Stigler, Oklahoma, and I'm a resident of Tishomingo, Oklahoma.

And on behalf of the academy, I want to express very strong support for the current proposed rules as drafted and being considered by this Board.

I can personally attest to the necessity of adapting the rules to allow physician assistants to have full Schedule II prescriptive authority as outlined in the delegating agreement between PA and the physician they practice.

Oklahoma is only one of six states in the United States that does not allow PAs to prescribe Schedule IIs. There are 44 other states. There's absolutely zero data that suggest that that causes problems with patient safety.

In fact, according to the National Practitioner Databank, over the past 20 years there have been 4,366 adverse reports for physicians and 186 reports for physician assistants. And correcting for the difference in numbers between physicians and

PAs, that's approximately a 3.6 multiple of adverse events reported for physicians rather than PAs.

Up until 2014, PAs could prescribe HCPs, Hydrocodone Combination Products, and there wasn't a problem then. It was rescheduled in 2014 to Schedule II and then it was taken away.

Just as an example -- and this is just one of many -- I had a patient that had a kidney stone. Came in on a Friday night. Couldn't prescribe Schedule II, sent him home, came back the next day and I had to admit him to the hospital for pain control because we couldn't give him a decent pain medication.

Patients we serve in rural Oklahoma deserve to receive the very best treatment possible. This includes the ability for PAs to prescribe Schedule IIs, and only when the delegating agreement with a physician reflects this authority.

Also, the academy supports the proposed rules to ratios between PAs and their physicians. The PA practice model has changed dramatically over time and certainly in my career. The proposed rules allow for the ratios to more accurately reflect modern practice.

Finally, I value my relationship with my

physician I work with and I believe these physicians should have the authority and power to determine how we practice with the team.

In closing, there is no data to support that having PAs -- giving PAs the ability to prescribe Schedule IIs would, in fact, affect patient safety, and anyone that says otherwise is ignorant of the data or has ulterior motives. Thank you.

MR. KELSEY: Thank you.

MS. SMITH: Jeff Burke.

JEFF BURKE: All right. Thanks for allowing me to speak today. This is my first public comment period, so just interesting and fascinating to see the process go forward, so -- just how our -- our government works.

So my name is Jeff Burke. I'm a PA. I've been a practicing PA for 13 years. I spent my entire practice working in cardiac electrophysiology at the Oklahoma Heart Hospital, so -- and I truly love what I do.

And I am the chair of the PA advisory committee and was involved pretty heavily with -- with drafting the current rules. And, of course, you know, this was -- been going on for, you know, about three years now. These rules are reflecting the

changes in Senate Bill 1915 to both -- that our government -- you know, both houses of the legislature and signed by the governor.

So -- and just -- and the framework of this -- and, you know, this has been talked extensively -- is that the statute or the law trumps the rules. So -- so, you know, the statute is the "skeleton" and the rules are "fill in the gaps."

And the reason this is done -- and this is, like, a lot of, you know, legal precedent here -- is that this doesn't task our legislature with the minutia of everyday practice. And that's where, you know, a medical board with -- you know, made up of professionals, whether it be pharmacists or physicians or PAs, can fill in those finer details. So that's the framework and that's how this was -- the rules were drafted and that's where the perspective is coming from.

So a few things. Delegating physician that goes from supervising physician, that is just a -- merely updating that language from Senate Bill 1915.

A few other things as far as Schedule IIs. So the statute has actually said that PAs can write for Schedule IIs since about 2001.

The rules, on the other hand, have left

that out as far as that's concerned.

Now, PAs can and have during this time, been able to write for inpatient Schedule IIs. And we do this with the sickest patients, right? The highest acuity, life-threatening situations. And we have to do that as part of daily practice. And so these are the patients who you would be most concerned about writing a Schedule II with, and it's been done so safely and for -- for many years.

Keith Plummer and many other people have said that PAs have, you know, a very, very low reporting to the National Provider Database.

We also have the lowest, or extremely low, of DA adverse events. Now, this is in Oklahoma specifically, but this is not just Oklahoma. This is a national trend, and specifically this occurs in other states that have Schedule IIs. There's an extremely high percentage of the country that has Schedule II outpatient prescriptive authority. They also have the lowest. Some of them have, you know, no ratios and a few have independent practice. There's no difference in those states.

So, basically, PAs are very safe prescribers, very careful, cautious. They have the education, training and experience to do so and do so

well. They've done it for many years already in the highest acuity setting, the sickest patients.

There's already pretty significant guardrails that are up. There is Section 2309(i) that guides all prescribers. Okay? So, you know, it gives very specific details and restrictions as far as what any person can write for any narcotic. Okay? And this does not, you know, limit to Schedule II specifically. So -- and this is an increase and I think that's where we've had some positive improvement in -- in the opioid issues.

So now -- and there's also a waste of resources. So Keith has said -- and he gave one example where -- we've heard from a lot of different people throughout -- a lot of different PAs throughout the state and they've had similar things where instead of able to give an outpatient Schedule II, they have to admit the patient to give pain control. This can be with a child, this can be with an adult. And so that's a waste of our healthcare resources and time. And if you're that person, if you're that patient, or if that's your family member or loved one, you don't want to see them suffering and have to do something and waste their time doing all of that.

So -- and on top of that --

MR. KELSEY: I'm going to need to call time, so --

JEFF BURKE: Three minutes is what you said?

MR. KELSEY: Yeah. Yeah.

JEFF BURKE: Okay. I'll wrap it up. Thank you.

So with that, in the efforts of time, you know, saves -- saves -- best practice. Okay? So -- so really improves the lives and -- of our fellow Oklahomans. And that's what we're all about. We're all about patients.

I can go on at length about the details, but I don't think time will allow.

But I fully support the rules. It was a collaborative process with multiple different groups over three years. Okay? So -- so we've included as many people as possible to do all of that.

And so the rest of it is updating, you know, language, kind of streamlining that and reflecting our current practice.

Thank you all very much for your time. Appreciate it.

MR. KELSEY: Thank you.

MS. SMITH: If you want to provide your written comments to me, I'll make sure that --

JEFF BURKE: I have them kind of chicken-scratched (indicating), so --

MS. SMITH: Oh, I see. Okay. All right.

JEFF BURKE: I can do something for later, though.

MS. SMITH: Okay. All right. Thank you.

James Kennedye, M.D.

MR. KENNEDYE: Thank you very much. Good morning. So those of you that don't know me, my name is James Kennedye. I'm an emergency physician here in Oklahoma representing the Oklahoma College of Emergency Physicians. And I am from Oklahoma and I was trained at the University of Oklahoma College of Medicine, did my residency training at Washington University in St. Louis, and had fellowship training and graduate training at Harvard School of Public Health and Harvard Medical School.

I am current president of the Oklahoma College of Emergency Physicians and I spent the last -- been a physician for 24 years, having spent the last 20 years here in Oklahoma practicing in large trauma centers, including the University of Oklahoma Medical Center, Trauma 1, Saint Francis

Hospital, the largest emergency department in our state of Oklahoma, Hillcrest Medical Center, Baptist Medical Centers, and I worked with Dr. Storms at Chickasha at one point in time. Also worked at Indian Health.

And I'm here to read a statement from the Oklahoma College of Emergency Physicians. And this has gone through our Board and through our entire membership throughout the state. So we -- we got -- we got okay on this.

So I'm saying, "Dear Ms. Smith and the Oklahoma Board of Medical Licensure and Supervision, the American College of Emergency Physicians is the largest emergency medicine specialty organization in the world and our annual scientific assembly is the largest gathering of emergency physicians worldwide.

"The Oklahoma College of Emergency Physicians, OCEP, is the state chapter of ACEP. It is made up collectively of our most highly trained board-certified emergency specialists practicing in tertiary, community, rural, military and Indian Health facilities statewide.

"Most of us had the opportunity to work closely with emergency department physician assistants, or PAs, as well as advanced practice

nurse practitioners, APRNs sometimes collectively referred to as APPs or Advanced Practice Providers or MLPs, Mid-Level Providers, in emergency departments across the state.

"We feel that PAs are a highly trained medical provider that work extremely well in a collaborative physician-led practice environment. We depend on their expertise and valuable assistance daily. However, given that the training and experience of a board-certified physician far exceeds that of a physician assistant, we feel that we are uniquely qualified to weigh in on some of the proposed changes and language to physician assistant administrative rules.

"Number 1: With regards to 435:15-1.1.1, Differing Roles, Definitions and Languages.

In days past, medical diagnosis, treatment and personnel was limited to physicians, nurses, and a few ancillary staff. Today the proliferation of a multitude of providers in clinics and hospitals have provided much-needed assistance in the clinical world, but also confusion to the patients and consumers.

"The physician assistant profession was created by physicians in the late 1960s and 1970s

initially from a pool of Army combat medics and Navy corpsmen with experience in the Vietnam War to assist with procedures and tasks performed by physicians.

"Eventually, robust curricula were established at medical universities across the U.S. and they began their intended role of assisting physicians in necessary clinical work. They had and still do have far fewer academic requirements for the PA degree than the academic requirements, rigor and time required in a physician, M.D. or D.O. training and never were intended to be a replacement for a physician. However, in our experience there has been a slow drift of PAs being utilized as independent providers in clinics and hospitals, a practice usually driven by economic incentives both by the employer and the employee, or the PA.

"Following this, there's also been an accompanying drift in the language describing the role of the PA and the relationship with the physician. Some PAs are also calling for a change in the profession title from physician assistant to physician associate.

"We maintain that the gold standard for patient care is one led by a board-certified physician in whatever clinical area may be relevant

for the patient at hand.

"This is no slight on our PA colleagues. Again, they are an invaluable resource with a great deal of general expertise that is highly valued to physicians.

"We also acknowledge that there is a great deal of variation between PAs in their clinical acumen as well as age and experience. We believe most emergency physicians in Oklahoma have had the opportunity to work with many PAs and feel like -- most of us feel like we do supervise them and not merely delegate tasks to them, much in the manner we supervise our resident or physicians in training.

"Therefore, we disagree with the characterization and we feel it would codify in law language that is misleading and feel that the supervisory language should remain as is.

"While you may, at times, simply delegate a patient care task to a PA, the overall relationship is still that of supervision and should never be looked at as an overarching simple delegation of patient care.

"Additionally, physicians are ultimately responsible and legally liable for patient outcomes. It's important to emphasize that this stance is not

merely protecting physicians' scope of practice or their turf. There is a marked and quantifiable difference in PA and physician training and experience.

"This is an opinion held, not only by most physicians but by, most poignantly, among physicians who used to practice as PAs and now we're in -- and now we're physicians that are in position to know the difference firsthand.

"A common sentiment that we hear these folks say is, 'I didn't know what I didn't know when I was a PA.'

"Indeed, PAs have access to attend medical school, the terminal degree, if and whenever they feel the calling to become a physician, and many do just that.

"As mentioned, there is a growing confusion among the general public. What is the difference between differing providers? At the end of the day, our patients are all Oklahomans who have a medical need or are ill and simply want to feel better and want the best for themselves and their families."

MR. KELSEY: Dr. Kennedye. I'm going to need to call time.

MR. KENNEDYE: "We offer this advice to

help stem the tide of confusion and ensure patient safety."

And I'll turn this statement in to you.

MR. KELSEY: Great. Thank you.

MR. KENNEDYE: Thank you very much.

MS. SMITH: Would you like to sign and date it, please?

MR. KENNEDYE: Sure.

MS. SMITH: Sheila Walker.

SHEILA WALKER: Good morning, my name is Sheila Walker. I appreciate the opportunity to speak before this committee and in this public hearing.

I'm a child of Oklahoma. My parents descended from Native Americans and from folks that were in the back of a wagon during land runs.

I have lived in rural Oklahoma. I still own property in a ranch endeavor, but I have primarily, since graduating from at that time the one and only physician associate program in Oklahoma, been in specialty care, primary care, and tertiary care in the largest medical systems in the state.

I strongly endorse -- ask the Board to endorse the law it is presented. As some things are, at times, addressed with fear, in trepidation, cautiousness and planning are a different approach.

Also, my physician colleagues here have voiced their concern over blanket writing of Schedule IIs. The comments and facts have been presented that in states that allow Schedule IIs there's not a overwhelming issue with PAs writing for those drugs.

Likewise, what it said with Hydrocodone being a prescribed drug under PA authority, that is delegated by their physician team. I am trained in a team practice by a profession that, by their own instigation, made it a law that we have annual mandatory training to maintain our licensure on controlled substances and addiction medicine.

In 1993, before this was ever an issue, I also have a profession that, indeed, was generated because of the lack of medical care available in rural areas and as a complete issue across the nation, which also still is ahead of us, but I also was trained in the team model. I don't propose to be a physician. I am a PA. However, during this time I have -- during my practice -- seen physicians encourage that unmatched graduates of a medical program be allowed to practice medicine without any additional training.

I have seen and personally -- from the time

we could look at the database when it was not mandated -- reached out to what I would liken to puppy mills of physician practices that wrote hundreds of prescriptions of medication, encouraging them to look at the patients who I shared with them in care on concerns that I had on the number of Hydrocodone, Oxycodone, Xanax, and other things all at the same time. And I will be quite frank, I was belittled and ridiculed when I made those phone calls.

Again, I think that there is absolutely a team model for what I do and what my profession does. I think that decisions on ratios and on any prescriptive ability should be at the practice level. I have done adult medicine. My master's training before this was in geriatrics. I had no desire to practice pediatrics and will not. I know that's a simplest (sic) statement, but I think as a practitioner and as someone that is an Oklahoman, has family with deep roots in this state, appreciates the rural and the metropolitan needs of patients, for us to sustain a quality of healthcare, the ratio, the prescribing rules in law should be endorsed and adopted.

I thank you for your time and opportunity

to speak.

MR. KELSEY: Thank you.

MS. SMITH: Arnulfo Garcia.

I probably didn't pronounce your name correctly.

ARNULFO GARCIA: That's fantastic.

MS. SMITH: I apologize. You can get it right.

ARNULFO GARCIA: That is fantastic. That's why I go by "Alex."

Good morning. And before I begin, I'd just like to say to all my colleagues here, and these D.O.s or M.D.s, the doc, I believe that we are here with the same purpose.

In my mind, this is not about PAs or about docs, this is about my patients. And I explain -- by the way, my name -- I am a practicing PA and I endorse the -- the rules as stated. I have been practicing in critical access hospitals, emergency medicine for my entire career, and I have seen more cases than can be described in a whole day here that will benefit from these changes.

MS. SMITH: I'm sorry to interrupt, but could you please state your name correctly on the record?

ARNULFO GARCIA: Yes.

MS. SMITH: Thank you.

ARNULFO GARCIA: Yes. My name is Arnulfo Alexander Garcia.

MS. SMITH: Thank you.

ARNULFO GARCIA: Thank you.

And I will address this in the same way that I used when I taught students at the University.

I will begin with a case. And just entertain for a moment and imagine this is a 64-year-old male that tripped and fell and lived with the diagnosis of a humerus fracture. In this day and age, the treatment for those is just in a sling and pain control until they follow up with their orthopedic physician.

And I will refer back to this case as we move along, but I'd like to then move to talk to you about my oath. I remember all of us swearing that oath and I remember that the primary purpose of our career was our patients and to care for them.

Then I'd like to move to speak about evidence-based medicine. Those who actually endorse it and practice it realize that at the end, you come up with a diagnosis, you come up with treatment plans, and you're intended to sit down and speak to

the patient or their families and explain to them what the options are for them. You -- you share the pros and cons of each and then they help you to choose a path where you're going to go.

Now I'd like to imagine that that 64-year-old male is you.

And all I'm asking here is to be able to offer you all of the options so that you get the -- you get to choose which one is best for your case. Given all the information, the pros and cons of each, so that we can -- so that I can fulfill my oath. I can practice evidence-based medicine and all of this under the supervision and collaboration with my supervising doc. He or she can decide, on my practice disagreement, whether or not she even permits it.

So the issue today is really not about any of this -- this other distracting ideas that are being presented.

And with this I'll close, and I thank you for your time.

MR. KELSEY: Thank you.

MS. SMITH: Allison Garrison.

ALLISON GARRISON: Good morning. My name is Allison Garrison. I'm a PA, have been a PA for 20

years -- a little over 20 years. I have been a practicing PA in family practice, I have taught for the PA program, and then I have also worked for the OAPA as a leadership and advocacy liaison for the last few years.

I worked very hard on this law -- these laws, as well as helped with these rules and worked with Lyle Kelsey and Michael Leake with the D.O. board on trying to negotiate and come to some terms on a few of these things.

There is, of course a lot of passion that's involved, I think, on all sides with all of these things and I would just like to address a few of the concerns that I've heard this morning.

I want to thank the physicians who have spoke this morning. Thank you for the things that you have said, of course, about PAs, and I want to echo a lot of those sentiments about the way that we feel about physicians and the team-based practice. That is something that we, as PAs, also feel very strongly about. We value our relationships with physicians and agree with you that it is a team.

We love to collaborate and work with physicians as a team and we -- none of these rules, none of these laws talk about practicing without

supervision, so I want to make sure that that is reiterated.

These -- there has to be a practice agreement in place for a PA to practice. You have to have a license, you have to be in good standing. The physician or physicians that you are working with also have to have a license and be in good standing.

If the PA -- this has been said, but if the PA is going to prescribe outpatient Schedule IIs, the physician has to agree with that. And that can be outlined in that delegation of practice agreement.

A PA cannot establish their own practice without a delegating physician. That is a big difference between PAs and nurse practitioners. I think something was said about nurse practitioners or APRNs and PAs having similar training. That could not be further from the truth, actually. PAs and nurse practitioners are trained very differently.

PAs are trained in the medical model under medical schools. PAs are trained in the classroom, not online.

Most nurse practitioner schools are online.

PA practice is -- PA training is in the classroom. Also, our training is extremely rigorous. You cannot work. You cannot take a job. Your job is

PA school.

That schooling is about half -- nurse practitioner school is about half to a third of what PA school is, both in the didactics and in the clinical rotations.

And so there is a huge difference between PAs and nurse practitioners, yet PAs -- or nurse practitioners -- excuse me -- nurse practitioners can open their own practice. PAs cannot.

Nurse practitioners do not have to have a practice agreement with a physician. PAs do.

Nurse practitioners only have to have a physician on their license for prescriptive authority only. That is their only tie to a physician. Vastly different from a PA.

PAs very much enjoy their practice with physicians. Unfortunately, in the state of Oklahoma we are a very largely rural state. And if you look on this Board's medical -- this Board's website you can see that currently more than half of the counties in Oklahoma are underserved. There are just not enough physicians to go around.

That is why we have to have the ability for PAs to go out into those areas. We have to have the ability for these ratio provisions so that PAs can

serve those populations, not without supervision, but with a delegation agreement.

I think it was said that we would be increasing the eligible prescriptions by 20 percent. That is just not right. PAs already have the ability to write for Schedule IIs, both inpatient and outpatient. We've been writing for Schedule IIs inpatient for decades. I believe, in fact, since the PA profession was born 50 years ago. The way that it has been is that PAs would then have to find their delegating or supervising physician to prescribe those prescriptions for the patient/outpatient. And so we're not increasing that at all.

MR. KELSEY: I'm going to need to call time.

ALLISON GARRISON: Sure. I understand. I appreciate your time. Thank you very much.

MR. KELSEY: If you have those written comments and would like to turn those in, you're certainly welcome to.

ALLISON GARRISON: Thank you very much.

MR. KELSEY: Thank you.

MS. SMITH: And Sandhu.

IFTIKHAR SANDHU: Good morning. My name is Iftikhar Sandhu. And my colleagues have already said

enough, but I -- I'm actually from Pakistan, was born in Pakistan, made United States my home 32 years ago. And I've lived -- lived in Oklahoma for 31 years and, unfortunately, one of the things I'm seeing when I grew up in a village, that in rural area there is enough -- there is not enough healthcare.

So I remember when I was a child my mother had asthma and I had no clue what to do with her. So there was a guy, he was not (phonetic) medically trained, so I used to take my mother to him at 1:00 in the morning and he will give her some sort of shot. I am pretty sure it was a steroid shot, so she would start feeling better.

And I was -- served in Oklahoma in inpatient cardiology, inpatient internal medicine, rural ER, and currently I work in urgent care.

And as my colleague and our physician colleague have said, because we are a team. And this -- these proposed rules I strongly support them because it would modernize our physician and PA and medical team and will serve us, our patient, in future better.

Thank you for your time.

MR. KELSEY: Thank you.

MS. SMITH: Was there anyone who signed in

to speak that I have missed calling?

All right. I think that's it.

MR. KELSEY: Okay. That concludes the public hearing. If you have some comments that you wrote out but decided not to speak, you certainly can turn those in. Date and sign those.

If there's no other comments -- okay. We are adjourned. Thank you for coming.

(Hearing adjourned at 10:56 a.m.)

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C E R T I F I C A T E

STATE OF OKLAHOMA)
) SS:
COUNTY OF OKLAHOMA)

I, Jana C. Hazelbaker, Certified Shorthand Reporter within and for the State of Oklahoma, do hereby certify that the above and foregoing Public Comment Hearing was by me taken in shorthand and thereafter transcribed; that the same was taken on OCTOBER 5, 2022, in Oklahoma City, Oklahoma; that I am not an attorney for nor relative of any of said parties or otherwise interested in the event of said action.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal this 10th day of October, 2022.

Jana C. Hazelbaker, CSR
State of Oklahoma CSR No. 1506