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**Tony Evers, Governor**
**Dan Hereth, Secretary**

**HYBRID (IN-PERSON/VIRTUAL)**
**PHYSICIAN ASSISTANT AFFILIATED CREDENTIALING BOARD**
**Room N208, 4822 Madison Yards Way, 2nd floor, Madison**
**Contact: Tom Ryan (608) 266-2112**
**March 7, 2024**

*The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board. Be advised that board members may attend meetings designated as "Hybrid" in-person or virtually.*

**AGENDA**

**9:00 A.M.**

**OPEN SESSION – CALL TO ORDER – ROLL CALL**

**A) Adoption of Agenda (1-4)**

**B) Approval of Minutes of January 11, 2024 (5-8)**

C) Reminders: Conflicts of Interest, Scheduling Concerns

D) Introductions, Announcements and Recognition

**E) Administrative Matters – Discussion and Consideration**
1) Department, Staff and Board Updates
2) Board Members – Term Expiration Dates
   a. Collins, Clark A. – 7/1/2027
   b. Edwards, Jacqueline K. – 7/1/2025
   c. Elliot, Eric M. – 7/1/2024
   d. Fischer, Jean M. – 7/1/2027
   e. Holmes-Drammeh, Emelle S. – 7/1/2024
   f. Jarrett, Jennifer L. – 7/1/2024
   g. Martin, Cynthia S. – 7/1/2027
   h. Sanders, Robert W. – 7/1/2024
   i. Streit, Tara E. – 7/1/2027
3) Wis. Stat. § 15.085 (3)(b) – Affiliated Credentialing Boards' Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest – Update

**F) Administrative Rule Matters – Discussion and Consideration (9-11)**
1) Scope Statement: PA 4, Relating to Physical Examinations
2) Update:
   a) Med 26, relating to Military Medical Personnel
   b) Med 24, relating to Telemedicine and Telehealth
   c) N 6, relating to Delegated Acts
3) Pending or Possible Rulemaking Projects

**G) Legislative and Policy Matters – Discussion and Consideration**
1) Update on Senate Bill 145
2) Physician Assistant membership on the Controlled Substance Board

**H) Board of Nursing and Medical Examining Board Opioid Prescribing Guidelines – Discussion and Consideration (12-19)**

**I) FDA Advisory Letter to FSMB concerning Compounded Semaglutides – Discussion and Consideration (20-23)**

**J) Physician Assistant Interstate Compact Update – Discussion and Consideration**
1) PA Compact Webinar for State Boards, PowerPoint Slides **(24-68)**

**K) Federation of State Medical Board (FSMB) Matters – Discussion and Consideration**

**L) Professional Assistance Procedure (PAP) Discussion of Expansion to Include Mental Health Disorders Update – Discussion and Consideration**

M) Items Added After Preparation of Agenda:
1) Introductions, Announcements and Recognition
2) Administrative Matters
3) Election of Officers
4) Appointment of Liaisons and Alternates
5) Delegation of Authorities
6) Education and Examination Matters
7) Credentialing Matters
8) Practice Matters
9) Administrative Rule Matters
10) Public Health Emergencies
11) Legislative and Policy Matters
12) Liaison Reports
13) Board Liaison Training and Appointment of Mentors
14) Informational Items
15) Division of Legal Services and Compliance (DLSC) Matters
16) Presentations of Petitions for Summary Suspension
17) Petitions for Designation of Hearing Examiner
18) Presentation of Stipulations, Final Decision and Orders
19) Presentation of Proposed Final Decision and Orders
20) Presentation of Interim Orders
21) Petitions for Re-Hearing
22) Petitions for Assessments
23) Petitions to Vacate Orders
24) Requests for Disciplinary Proceeding Presentations
25) Motions
26) Petitions
27) Appearances from Requests Received or Renewed
28) Speaking Engagements, Travel, or Public Relation Requests, and Reports

**N) Public Comments**

**CONVENE TO CLOSED SESSION to deliberate on cases following hearing (s. 19.85(1)(a), Stats.); to consider licensure or certification of individuals (s. 19.85(1)(b), Stats.); to consider closing disciplinary investigations with administrative warnings (ss. 19.85(1)(b),**

**and 440.205, Stats.); to consider individual histories or disciplinary data (s. 19.85(1)(f), Stats.); and to confer with legal counsel (s. 19.85(1)(g), Stats.).**

O) Deliberation on DLSC Matters

P) Deliberation of Items Added After Preparation of the Agenda
1) Education and Examination Matters
2) Credentialing Matters
3) DLSC Matters
4) Monitoring Matters
5) Professional Assistance Procedure (PAP) Matters
6) Petitions for Summary Suspensions
7) Petitions for Designation of Hearing Examiner
8) Proposed Stipulations, Final Decisions and Orders
9) Proposed Interim Orders
10) Administrative Warnings
11) Review of Administrative Warnings
12) Proposed Final Decisions and Orders
13) Matters Relating to Costs/Orders Fixing Costs
14) Case Closings
15) Board Liaison Training
16) Petitions for Assessments and Evaluations
17) Petitions to Vacate Orders
18) Remedial Education Cases
19) Motions
20) Petitions for Re-Hearing
21) Appearances from Requests Received or Renewed

Q) Consulting with Legal Counsel

**RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION**

R) Open Session Items Noticed Above Not Completed in the Initial Open Session

S) Vote on Items Considered or Deliberated Upon in Closed Session if Voting is Appropriate

T) Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates

**ADJOURNMENT**

**VIRTUAL/TELECONFERENCE**

**ORAL INTERVIEW OF CANDIDATES FOR LICENSURE**

**10:00 A.M. OR IMMEDIATELY FOLLOWING THE FULL BOARD MEETING**

**CLOSED SESSION –** Reviewing Applications and Conducting Oral Interview of **Zero** (**0**) (at time of agenda publication) Candidates for Licensure – **Jean Fischer** and **Clark Collins**.

**NEXT MEETING: JUNE 27, 2024**

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MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held virtually unless otherwise indicated. In-person meetings are typically conducted at 4822 Madison Yards Way, Madison, Wisconsin, unless an alternative location is listed on the meeting notice. In order to confirm a meeting or to request a complete copy of the board's agenda, please visit the Department website at https:\\dsps.wi.gov. The board may also consider materials or items filed after the transmission of this notice. Times listed for the commencement of disciplinary hearings may be changed by the examiner for the convenience of the parties. Requests for interpreters for the hard of hearing, or other accommodations, are considered upon request by contacting the Affirmative Action Officer, or reach the Meeting Staff by calling 608-267-7213.

**VIRTUAL/TELECONFERENCE**
**PHYSICIAN ASSISTANT**
**AFFILIATED CREDENTIALING BOARD**
**MEETING MINUTES**
**JANUARY 11, 2024**

**PRESENT:** Clark Collins, Jacqueline Edwards, Eric Elliot, Jean Fischer, Emelle Holmes-Drammeh, Jennifer Jarrett, Cynthia Martin, Robert Sanders, Tara Streit

**STAFF:** Will Johnson, Executive Director; Jameson Whitney, Legal Counsel; Nilajah Hardin, Administrative Rules Coordinator; Tracy Drinkwater, Board Administrative Specialist; and other Department Staff

## CALL TO ORDER

Jennifer Jarrett, Chairperson, called the meeting to order at 9:02 a.m. A quorum was confirmed with nine (9) members present.

## ADOPTION OF AGENDA

**MOTION:** Robert Sanders moved, seconded by Eric Elliott, to adopt the Agenda as published. Motion carried unanimously.

## APPROVAL OF MINUTES OF NOVEMBER 16, 2023

**MOTION:** Cynthia Martin moved, seconded by Jacqueline Edwards, to approve the Minutes of November 16, 2023, as published. Motion carried unanimously.

## ADMINISTRATIVE MATTERS

**Election of Officers, Appointments of Liaisons and Alternates, Delegation of Authorities**

**Election of Officers**

***Slate of Officers***

**NOMINATION:** Robert Sanders nominated the 2023 slate of officers to continue in 2024. All officers accepted their nominations.

Will Johnson, Executive Director, called for nominations three (3) times.

The Slate of Officers was elected by unanimous voice vote.

| ELECTION RESULTS | |
|---|---|
| **Chairperson** | Jennifer Jarrett |
| **Vice Chairperson** | Eric Elliot |
| **Secretary** | Jacqueline Edwards |

**Appointment of Liaisons and Alternates**

| LIAISON APPOINTMENTS | |
|---|---|
| **Credentialing Liaison(s)** | Clark Collins, Jean Fischer<br>*Alternate:* Jaqueline Edwards, Eric Elliot |
| **Legislative Liaison(s)** | Jennifer Jarrett<br>*Alternate:* Eric Elliot |
| **Education, Continuing Education, and Examinations Liaison(s)** | Eric Elliot<br>*Alternate:* Emelle Holmes-Drammeh |
| **Monitoring Liaison(s)** | Jennifer Jarrett<br>*Alternate:* Eric Elliot |
| **Professional Assistance Procedure Liaison(s)** | Clark Collins<br>*Alternate:* Tara Streit |
| **MEB Liaison(s)** | Jennifer Jarrett<br>*Alternate:* Eric Elliot |
| **Administrative Rules Liaison(s)** | Eric Elliot<br>*Alternate:* Tara Streit |
| **Travel Authorization Liaison(s)** | Jennifer Jarrett<br>*Alternate:* Eric Elliot |
| **Website Liaison(s)** | Tara Streit<br>*Alternate:* Clark Collins |
| **Screening Panel** | Jean Fischer, Robert Sanders, Cynthia Martin<br>*Alternate:* Emelle Holmes Drammeh |

***Review and Approval of 2023 Delegations***

**MOTION:** Robert Sanders moved, seconded by Eric Elliot, to reaffirm all delegation motions from 2023 as reflected in the agenda materials. Motion carried unanimously.

***Document Signature Delegations***

**MOTION:** Eric Elliott moved, seconded by Jean Fischer, in order to carry out duties of the Board, the Chairperson (or in absence of the Chairperson, the highest-ranking officer or longest serving board member in that succession) has the ability to delegate signature authority for purposes of facilitating the completion of assignments during or between meetings. The members of the Board hereby delegate to the Executive Director, Board Counsel or DPD Division

Administrator, the authority to sign on behalf of a board member as necessary. Motion carried unanimously.

***Monitoring Delegations***

**Delegation of Authorities for Monitoring**

**MOTION:** Clark Collins moved, seconded by Jacqueline Edwards, to adopt the "Roles and Authorities Delegated for Monitoring" document as presented in the January 11, 2024, agenda materials. Motion carried unanimously.

***Credentialing Authority Delegations***

**Delegation to Department Attorneys to Approve Duplicate Legal Issue**

**MOTION**: Jennifer Jarrett moved, seconded by Jacqueline Edwards, to delegate authority to Department Attorneys to approve a legal matter in connection with a renewal application when that same/similar matter was already addressed by the Board and there are no new legal issues. Motion carried unanimously.

## ADMINISTRATIVE RULE MATTERS

**Possible Rule Project: PA 4, Relating to Physical Examinations**

**MOTION:** Jennifer Jarrett moved, seconded by Eric Elliot, to request DSPS staff draft a Scope Statement revising PA 4, relating Physical Examinations. Motion carried unanimously.

## FEDERATION OF STATE MEDICAL BOARD (FSMB) MATTERS

**Federation of State Medical Boards (FSMB) Annual Meeting April 18-20, 2024**

**MOTION:** Clark Collins moved, seconded by Jean Fischer, to designate Jennifer Jarrett and Eric Elliot to attend the Federation of State Medical Boards (FSMB) Annual Meeting April 18-20, 2024, in Nashville, TN. Motion carried unanimously.

## CLOSED SESSION

**MOTION:** Jacqueline Edwards moved, seconded by Eric Elliott, to convene to closed session to deliberate on cases following hearing (s. 19.85(1)(a), Stats.); to consider licensure or certification of individuals (s. 19.85(1)(b), Stats.); to consider closing disciplinary investigations with administrative warnings (ss. 19.85(1)(b), and 440.205, Stats.); to consider individual histories or disciplinary data (s. 19.85(1)(f), Stats.); and to confer with legal counsel (s. 19.85(1)(g), Stats.). Jennifer Jarrett, Chairperson read the language of the motion. The vote of each member was ascertained by voice vote. Roll Call Vote: Clark Collins-yes; Jacqueline Edwards-yes; Eric Elliot-yes; Jean Fischer-yes; Emelle Holmes-Drammeh-yes; Jennifer Jarrett-yes; Cynthia Martin-yes; Robert Sanders-yes; and Tara Streit-yes. Motion carried unanimously.

The Board convened into Closed Session at 10:36 a.m.

## DELIBERATION ON DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC) MATTERS

**Case Closing**

***23 PAB 001 – K.A.H. - No Violation***

**MOTION:** Cynthia Martin moved, seconded by Jennifer Jarrett, to close DLSC Case Number 23 PAB 001 against K.A.H, for No Violation. Motion carried unanimously.

## RECONVENE TO OPEN SESSION

**MOTION:** Jennifer Jarrett moved, seconded by Jean Fischer, to reconvene in Open Session. Motion carried unanimously.

The Board reconvened to Open Session at 10:40 a.m.

## VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION

**MOTION:** Cynthia Martin moved, seconded by Eric Elliot, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

## DELEGATION OF RATIFICATION OF EXAMINATION RESULTS AND RATIFICATION OF LICENSES AND CERTIFICATES

**MOTION:** Jean Fischer moved, seconded by Clark Collins, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

## ADJOURNMENT

**MOTION:** Jacqueline Edwards moved, seconded by Eric Elliot, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 10:42 a.m.

# State of Wisconsin
# Department of Safety & Professional Services

## AGENDA REQUEST FORM

| 1) Name and title of person submitting the request: | 2) Date when request submitted: |
|---|---|
| **Nilajah Hardin**<br>**Administrative Rules Coordinator** | **02/22/24**<br>Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting |

**3) Name of Board, Committee, Council, Sections:**

Physician Assistant Affiliated Credentialing Board

| 4) Meeting Date: | 5) Attachments: | 6) How should the item be titled on the agenda page? |
|---|---|---|
| **03/07/24** | ☒ Yes<br>☐ No | **Administrative Rule Matters Discussion and Consideration**<br>1. Scope Statement: PA 4, Relating to Physical Examinations<br>2. Update:<br>a. Med 26, Relating to Military Medical Personnel<br>b. Med 24, Relating to Telemedicine and Telehealth<br>c. N 6, Relating to Delegated Acts<br>3. Pending or Possible Rulemaking Projects |

| 7) Place Item in: | 8) Is an appearance before the Board being scheduled? *(If yes, please complete Appearance Request for Non-DSPS Staff)* | 9) Name of Case Advisor(s), if required: |
|---|---|---|
| ☒ Open Session<br>☐ Closed Session | ☐ Yes<br>☒ No | **N/A** |

**10) Describe the issue and action that should be addressed**

**Attachments:**

1. **Scope Statement – PA 4**

**Pending Rule Project Page:** https://dsps.wi.gov/Pages/RulesStatutes/PendingRules.aspx

**11) Authorization**

Nilajah D. Hardin — 02/22/24

**Signature of person making this request** — **Date**

**Supervisor (if required)** — **Date**

**Executive Director signature (indicates approval to add post agenda deadline item to agenda)** — **Date**

**Directions for including supporting documents:**
1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

# STATEMENT OF SCOPE

## PHYSICIAN ASSISTANT AFFILIATED CREDENTIALING BOARD

**Rule No.:** PA 4

**Relating to:** Physical Examinations

**Rule Type:** Permanent

**1. Finding/nature of emergency (Emergency Rule only): N/A**

**2. Detailed description of the objective of the proposed rule:**
The objective of the proposed rule is to update the unprofessional conduct requirements in Wisconsin Administrative Code Chapter PA 4 on the topic of standards of care for physical examinations.

**3. Description of the existing policies relevant to the rule, new policies proposed to be included in the rule, and an analysis of policy alternatives:**
Wisconsin Administrative Code Chapters PA 4 currently outlines unprofessional conduct requirements. In an effort to conform with the rules of the Medical Examining Board, the Physician Assistant Affiliated Credentialing Board will review standards of care and conduct for physical examinations and make changes to the Administrative Code accordingly.

**4. Detailed explanation of statutory authority for the rule (including the statutory citation and language):**
Section 15.085 (5) (b) states that "[each affiliated credentialing board] shall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains, and define and enforce professional conduct and unethical practices not inconsistent with the law relating to the particular trade or profession."

Section 448.973 (1) states that: "
- (a) The board shall promulgate rules implementing s. 448.9785.
- (b) The board shall promulgate rules establishing continuing education requirements for physician assistants.
- (c) The board may promulgate other rules to carry out the purposes of this subchapter, including any of the following
  1. Rules defining what constitutes unprofessional conduct for physician assistants for purposes of s. 448.978 (2) (d).
  2. Rules under s. 448.977 (2)."

**5. Estimate of amount of time that state employees will spend developing the rule and of other resources necessary to develop the rule:**
80 hours

**6. List with description of all entities that may be affected by the proposed rule:**
Physician Assistant credential holders and their employers.

**7. Summary and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:**
None.

**8. Anticipated economic impact of implementing the rule (note if the rule is likely to have a significant economic impact on small businesses):**
The proposed rule is likely to have minimal or no economic impact on small businesses and the state's economy as a whole.

**Contact Person:** Nilajah Hardin, (608) 267-7139, DSPSAdminRules@wisconsin.gov

Approved for publication:

Authorized Signature

Date Submitted

Approved for implementation:

Authorized Signature

Date Submitted

# State of Wisconsin
# Department of Safety & Professional Services

## AGENDA REQUEST FORM

| 1) Name and Title of Person Submitting the Request: | 2) Date When Request Submitted: |
|---|---|
| **Jameson Whitney, Board Counsel** | **2/8/24** |
| | Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting |

**3) Name of Board, Committee, Council, Sections:**
Physician Assistants Affiliated Credentialing Board

| 4) Meeting Date: | 5) Attachments: | 6) How should the item be titled on the agenda page? |
|---|---|---|
| **3/07/24** | ☒ Yes<br>☐ No | Board of Nursing Opioid Prescribing Guidelines – Discussion and Consideration |

| 7) Place Item in: | 8) Is an appearance before the Board being scheduled? | 9) Name of Case Advisor(s), if required: |
|---|---|---|
| ☒ Open Session<br>☐ Closed Session | ☐ Yes (Fill out Board Appearance Request)<br>☒ No | |

**10) Describe the issue and action that should be addressed:**

The Board will review the Board of Nursing's opioid prescribing guidelines as an example for consideration.

**11) Authorization**

**Signature of person making this request** **Date 2/8/24**
Jameson Whitney

**Supervisor (if required)** **Date**

**Executive Director signature (indicates approval to add post agenda deadline item to agenda)** **Date**

**Directions for including supporting documents:**
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*Revised 12/2016*

**Board of Nursing Best Practices for Prescribing Controlled Substances Guideline**

2015 Wisconsin Act 269 granted authority to the Board of Nursing to issue guidelines regarding best practices in prescribing controlled substances, as defined in s. 961.01 (4), Stats., for persons credentialed by the Board of Nursing who are authorized to prescribe controlled substances.

The purpose of this guideline is to provide guidance to advanced practice nurse prescribers for prescribing controlled substances. This guideline is intended to supplement and not replace the individual advanced practice nurse prescriber's clinical judgment. The guideline is not intended to address prescribing practices related to patients who are in active cancer treatment, palliative care, sickle cell or end-of-life care. Although not specifically designed for pediatric pain, many of the principles upon which they are based could be applied there, as well.

It is important for advanced practice nurse prescribers to routinely discuss with patients the effect their diagnosed medical conditions or recommended drugs may have on their ability to make decisions and to safely operate machinery or a vehicle in any mode of transportation. Patients should be informed that there could be an increased effect when the patient is sick or there is a change in medication dosage.

Prior to prescribing controlled substances, there should be a well-documented evaluation which includes reason to treat and a history and physical. A review of the Prescription Drug Monitoring Program should be completed for all prescriptions to mitigate the risk of concurrent prescribing. Further information on a practitioners' requirement to review monitored prescription drug history reports may be found in CSB 4.105. The patient should be provided with education and a notice regarding use of controlled substances including risks, benefits, prohibition on sharing and how to properly dispose of controlled substances.

Opioids pose a potential risk to all patients. Providers are encouraged to implement safe practices for responsible prescribing which includes prescribing the lowest effective dose for the shortest possible duration.

<u>Opioid Prescribing</u>

1. Non-pharmacologic therapies (such as yoga, exercise, cognitive behavioral therapy and complementary/ alternative medical therapies) and/or non-opioid (such as acetaminophen and anti-inflammatories) therapy should be strongly considered prior to prescribing opioids. Opioids should be used only if the expected benefits for pain and function outweigh risk to the patient. If opioids are prescribed, non-pharmacologic and/or non-opioid therapy should also be utilized as part of a multimodal approach.

2. Non-opioids should be considered first in treating acute pain. If non-opioid treatments are not efficacious, opioid therapy may be considered if benefits are anticipated to outweigh the risks. Realistic benefits and known risks of opioid therapy should be reviewed prior to prescribing opioid medications. Consultation should be considered if diagnosis and treatment is outside the scope of the prescribing practitioner.

3. When opioids are prescribed for acute pain, the quantity prescribed should be no greater than the expected duration of pain. Three days or less will often be sufficient.

4. Extended-release or long-acting opioids should not be prescribed for acute pain. When starting opioid therapy for chronic pain, advanced practice nurse prescribers should prescribe immediate-release opioids instead of extended-release or long-acting opioids.

5. If acute pain requires ongoing opioid therapy beyond the expected duration, the patient should be re-evaluated or referred to a pain management specialist.

6. Non-opioid therapy is preferred for subacute and chronic pain (greater than 3 months). If non-opioids are not adequate and expected benefits for pain and function outweigh risks, opioids may be considered acceptable. Risks and benefits should be reviewed. Opioids should be used in combination with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

7. Before starting opioid therapy for chronic pain, advanced practice nurse prescribers should establish realistic treatment goals with patients for pain and function, and discuss consideration for opioid therapy discontinuation if benefits do not outweigh risks. An advanced practice nurse prescriber should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. A patient should have at least 30% improvement in pain scores, functional improvement, no signs of abuse or aberrant behavior and screened for medication side effects including sedation and constipation.

8. The advanced practice nurse prescriber should consider a controlled substances agreement in chronic pain situations. The management plan should incorporate strategies to mitigate risk Components of ongoing assessment of risk should include:

a. Review of the Prescription Drug Monitoring Program (PDMP) information
b. Periodic urine drug screening (including chromatography) – at least yearly in low risk cases, more frequently with evidence of increased risk.
c. Violations of the opioid agreement
d. Periodic pill counts may also be considered for high-risk patients.

9. Advanced practice nurse prescribers utilizing sound clinical judgement should do all of the following:

a. Use caution when prescribing at any dosage.

b. Prescribe the lowest effective dosage.

c. (formerly 10) Before opioid dose changes, the advanced practice nurse prescriber should re-evaluate the patient, including benefits, harms and whether another drug is appropriate. If the harms outweigh the benefits of continued opioid therapy, the advanced practice nurse prescriber should use other therapies and work with patient to taper opioids to lower dose or discontinue

d. Patients should be re-evaluated ever 1-4 weeks during initial opioid titration. During chronic therapy, patients should be evaluated at least every 3 months, more frequently if they demonstrate higher risk.

e. Reassess individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents per day. Literature shows diminished return for doses above 50 morphine equivalents.

f. Avoid increasing to or maintaining dosage at ≥ 90 morphine milligram equivalents per day as there is no evidence base to support efficacy and there is significant increased risk of adverse effects.

g. Consider opioid taper, opioid detoxification, or pain management consultation prior to increasing to high doses.

10. Advanced practice nurse prescribers should review the patient's history of controlled substance prescriptions through the PDMP to determine whether the patient is receiving opioid dosages or dangerous combinations that put the patient at high risk. The PDMP data should be reviewed prior to starting a patient on opioid therapy and frequently during the opioid therapy. As of April, 2017, Wisconsin state law requires prescribers to review the PDMP before prescribing any controlled substance for greater than a three day supply.

11. Patients should not receive opioid prescriptions from multiple prescribers. There should be a dedicated provider such as a primary care or pain specialist to provide all opioids used in treating any patient's chronic pain, with existing pain contracts being honored.

12. The advanced practice nurse prescriber may consider ordering naloxone in individual cases at higher risk including:

a. History of overdose (a relative contraindication to chronic opioid therapy)
b. Opioid doses over 50 MME/day
c. Clinical depression
d. Evidence of increased risk by other measures (behaviors, family history, PDMP, UDS, risk questionnaires, etc.)

Family members can be prescribed naloxone for use with the patient. The recommended dose is 0.4mg intramuscular or intranasal, with a repeat dose available if the first dose is ineffective or wears off before Emergency Medical Services (EMS) arrive.

13. Prescribing of opioids is strongly discouraged for patients abusing illicit drugs due to the high risk of overdose, abuse and death. If prescribed, clear justification should be present.

14. If you have a patient with opioid use disorder, advanced practice nurse prescribers should offer or arrange evidence-based treatment, including direct treatment (buprenorphine, naltrexone, etc. plus behavioral therapy), methods of detoxification and referral to an appropriate treatment center or provider willing to accept the patient. It is not acceptable to discharge from a provider's practice solely due to an opioid use disorder.

15. A patient should not be prescribed opioid and benzodiazepines or other respiratory depressants (gabapentin, pregabalin, muscle relaxants, sleep aids) concurrently, whether the prescribing is done by one practitioner or multiple practitioners. If prescribed concurrently, clear clinical rationale must exist.

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**Tony Evers, Governor**
**Daniel Hereth, Secretary**

# Wisconsin Medical Examining Board Opioid Prescribing Guideline Amended 12/2022

## Guideline Scope and Purpose

To help providers make informed decisions about acute and chronic pain treatment -- pain lasting longer than three months or past the time of normal tissue healing.

Opioids pose a potential risk to all patients. The Guideline encourages providers to implement safe practices for responsible prescribing which includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely injured patients.

## Guideline Core Principles Identify and treat the cause of the pain, use non-opioid therapies

Use non-pharmacologic therapies (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) and non-opioid pharmacologic therapies (such as acetaminophen and anti-inflammatories) for acute and chronic pain. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

### Start low and go slow

When opioids are used, prescribe the lowest possible effective dosage and start with immediate release opioids instead of extended-release/long-acting opioids. Only provide the quantity needed for the expected duration of pain.

### Close follow-up

Regularly monitor patients to make sure opioids are improving pain and function without causing harm. If benefits do not outweigh harms, optimize other therapies and work with patients to taper or discontinue opioids, if needed.

## Guideline Focus Areas

The Guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, treating the cause of the pain, closely monitoring risks, and safely discontinuing opioids. The three main focus areas in the Guideline include:

**Determining when to initiate or continue opioids**

- Selection of non-pharmacologic therapy, non-opioid pharmacologic therapy, opioid therapy
- Establishment of treatment goals
- Discussion of risks and benefits of therapy with patients

**Opioid selection, dosage, duration, follow up and discontinuation**

- Selection of immediate-release or extended-release and long-acting opioids
- Dosage considerations
- Duration of treatment
- Considerations for follow-up and discontinuation of opioid therapy

**Assessing risk and addressing harms of opioid use**

- Evaluation of risk factors for opioid-related harms and ways to mitigate/reduce patient risk
  **-** Review of prescription drug monitoring program (PDMP) data
- Use of urine drug testing
- Considerations for co-prescribing benzodiazepines
- Arrangement of treatment for opioid use disorder

## Opioid Prescribing Guideline

1. **The guideline is not intended for patients who are in active cancer treatment, palliative care, sickle cell or end-of-life care.** Although not specifically designed for pediatric pain, many of the principles upon which they are based could be applied there, as well.

2. In treating acute pain, non-opioids should be considered first. If non-opioids are not efficacious, opioid therapy may be considered if benefits are anticipated to outweigh the risks. Before prescribing opioid therapy for acute pain, realistic benefits and known risks of opioid therapy should be discussed. Consultation should be considered if diagnosis and treatment is outside the scope of the prescribing practitioner. If a practitioner is not familiar with safe opioid prescribing, they are not required to prescribe.

3. Nonopioid therapy is preferred for subacute and chronic pain (pain greater than 3 months). If non-opioids are not adequate and expected benefits for pain and function outweigh risks, opioids may be acceptable. Risks and benefits should be discussed. The goal is to establish treatment goals and functional improvement and how opioid therapy will be discontinued. Therapies such as physical therapy, behavioral health, yoga etc. should be considered. If pain is beyond the expected healing period of surgery or trauma or etiology of pain is unclear, a consultation with a pain specialist (completed an ACGME fellowship) should be placed. A patient should have at least 30% improvement in pain scores, functional improvement, no signs of abuse or aberrant behavior and side effects screened for such as sedation or constipation.

4. Patients should not receive opioid prescriptions from multiple physicians. There should be a dedicated provider such as a primary care or pain specialist to provide all opioids used in treating any patient's chronic pain, with existing pain contracts being honored.

5. Physicians are encouraged to review the patient's history of controlled substance prescriptions using the Wisconsin Prescription Drug Monitoring Program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. As of April 2017, Wisconsin state law requires prescribers to review the PDMP before prescribing any controlled substance for greater than a three-day supply.

6. Prescribing of opioids is strongly discouraged in patients taking benzodiazepines or other respiratory depressants (gabapentin, lyrica, muscle relaxants, sleep aids). Benzodiazepines triple the already high increases in respiratory depression and annual mortality rates from opioids. If they are used concurrently, clear clinical rationale must exist.

7. Patients presenting for chronic pain treatment should have a thorough evaluation, which may include the following:

a. Medical history and physical examination targeted to the pain condition.
b. Nature and intensity of the pain.
c. Current and past treatments, with response to each treatment.
d. Underlying or co-existing diseases or conditions, including those which could complicate treatment (i.e., renal disease, sleep apnea, chronic obstructive pulmonary disease (COPD), etc.).
e. Effect of pain on physical and psychological functioning.
f. Personal and family history of substance abuse.
g. History of psychiatric disorders associated with opioid abuse (bipolar, attention deficit disorders (ADD/ADHD), sociopathic, borderline, untreated/severe depression).
h. Medical indication(s) for use of opioids.
i. Use of an opioid risk tool

8. Components of ongoing assessment of risk include:

    a. Review of the Prescription Drug Monitoring Program (PDMP) information.
    b. Periodic urine drug testing (including chromatography) – at least yearly in lowrisk cases, more frequently with evidence of increased risk.
    c. Violations of the opioid agreement.
    d. Periodic pill counts may also be considered for high-risk patients.

9. All patients on chronic opioid therapy should have informed consent consisting of:

    a. Specifically detailing significant possible adverse effects of opioids, including (but not limited to) addiction, overdose, and death. It is also recommended practitioners discuss with patients the effect opioid use may have on the ability to safely operate machinery or a vehicle in any mode of transportation.
    b. Treatment agreement, documenting the behaviors required of the patient by the prescribing practitioner to ensure that they are remaining safe from these adverse effects.

10. Opioids should be prescribed in the lowest effective dose. Literature shows diminished returns for doses above 50 morphine equivalents. This includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely injured patients. Given that there is no evidence base to support efficacy of doses over 90 MMEs, with dramatically increased risks, dosing above this level is discouraged, and appropriate documentation to support such dosing should be present on the chart. It is understood there is variation in response to opioid doses.

11. Prescribing of opioids is strongly discouraged for patients abusing illicit drugs. These patients are at extremely high risk for abuse, overdose, and death. If opioids are prescribed to such patients, a clear and compelling justification should be present.

12. During initial opioid titration, practitioners should re-evaluate patients every 1-4 weeks. During chronic therapy, patients should be seen at least every 3 months, more frequently if they demonstrate higher risk.

13. Practitioners should consider prescribing naloxone for home use in case of overdose for patients at higher risk, including:

    a. History of overdose (a relative contraindication to chronic opioid therapy).
    b. Opioid doses over 50 MMEs/day.
    c. Clinical depression.
    d. Evidence of increased risk by other measures (behaviors, family history, PDMP, UDS, risk questionnaires, etc.).

    The recommended dose is 0.4 mg for intramuscular or intranasal use, with a second dose available if the first is ineffective or wears off before Emergency Medical Services (EMS) arrives. Family members can be prescribed naloxone for use with the patient.

14. All practitioners are expected to provide care for potential complications of the treatments they provide, including opioid use disorder. As a result, if a patient receiving opioids develops behaviors indicative of opioid use disorder, the practitioner, when possible, should assist the patient in obtaining addiction treatment, either by providing it directly (buprenorphine, naltrexone, etc. plus behavioral therapy) or referring them to an appropriate treatment center or provider willing to accept the patient. Discharging a patient from the provider's practice solely due to an opioid use disorder is not considered acceptable.

15. If a patient has had chronic pain and has not been evaluated by a pain specialist (completed an ACGME fellowship) in the last 5 years, a referral should be placed.

# State of Wisconsin
# Department of Safety & Professional Services

## AGENDA REQUEST FORM

| 1) Name and Title of Person Submitting the Request: | 2) Date When Request Submitted: |
|---|---|
| **Jameson Whitney, Board Counsel** | **2/22/24** |
| | Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting |

**3) Name of Board, Committee, Council, Sections:**
Physician Assistants Affiliated Credentialing Board

| 4) Meeting Date: | 5) Attachments: | 6) How should the item be titled on the agenda page? |
|---|---|---|
| **3/7/24** | ☒ Yes<br>☐ No | FDA advisory letter to FSMB concerning compounded semaglutides—discussion and consideration |

| 7) Place Item in: | 8) Is an appearance before the Board being scheduled? | 9) Name of Case Advisor(s), if required: |
|---|---|---|
| ☒ Open Session<br>☐ Closed Session | ☐ Yes (Fill out Board Appearance Request)<br>☒ No | |

**10) Describe the issue and action that should be addressed:**

Informational item regarding FDA advisory to FSMB regarding compounded semaglutide drug products.

**11) Authorization**

**Signature of person making this request** **Date 2/22/24**
Jameson Whitney

**Supervisor (if required)** **Date**

**Executive Director signature (indicates approval to add post agenda deadline item to agenda)** **Date**

**Directions for including supporting documents:**
1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

*Revised 12/2016*

Oct. 10, 2023

Humayun J. Chaudhry, DO, MS, FACP, FACOI
President and Chief Executive Officer
Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, TX 76309

Dear Dr. Chaudhry:

The purpose of this letter is to bring to the attention of the Federation of State Medical Boards information related to compounded drug products containing semaglutide or semaglutide salts (e.g., semaglutide acetate or semaglutide sodium).

Semaglutide is a glucagon-like peptide-1 (GLP-1) receptor agonist and the active ingredient in several FDA-approved drug products: Rybelsus (semaglutide) tablets, indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus; Ozempic (semaglutide) injection, indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus and to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction or non-fatal stroke) in adults with type 2 diabetes mellitus and established cardiovascular disease; and Wegovy (semaglutide) injection, indicated as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management in certain adult and pediatric patients.

FDA is aware of increased interest in compounded semaglutide drug products. In some cases, compounded drugs can serve an important role for patients whose medical needs cannot be met by an FDA-approved drug product. However, compounded drugs, including compounded semaglutide drug products, are not FDA-approved and do not receive premarketing review for safety, efficacy, and quality. Ozempic and Wegovy currently appear on FDA's drug shortage list. When a drug is in shortage, compounders may be able to prepare a compounded version of that drug if they meet certain conditions in the Federal Food, Drug, and Cosmetic Act (FD&C Act). FDA has received adverse event reports and complaints concerning these compounded drug products.

There are currently no FDA-approved products containing a semaglutide salt (e.g., semaglutide acetate or semaglutide sodium) as an active ingredient. Although FDA has carefully evaluated the chemical and pharmacologic properties of semaglutide in the context of the approved drug products, FDA is not aware of information regarding the chemical and pharmacologic properties of the semaglutide salts (e.g., semaglutide sodium or semaglutide acetate) or whether the semaglutide salts have the same safety or efficacy profile as semaglutide.

## Compounded Drug Products Containing Semaglutide Salts

FDA is not aware of any basis in the FD&C Act for compounding a drug using semaglutide salts such as semaglutide sodium and semaglutide acetate.

Sections 503A and 503B of the FD&C Act describe the conditions that must be satisfied for compounded human drug products to be exempt from certain sections of the FD&C Act, including the requirements of premarket approval and labeling with adequate directions for use. Among the conditions of sections 503A and 503B are restrictions on the bulk drug substances (active pharmaceutical ingredients or APIs) that may be used to compound human drug products.

Specifically, under section 503A (which applies to drugs products compounded outside an outsourcing facility registered by FDA, e.g., by licensed pharmacists in a State licensed pharmacy or a Federal facility, or by licensed physicians), the drug product must be compounded using bulk drug substances that (1) comply with the standards of an applicable United States Pharmacopeia (USP) or National Formulary (NF) monograph, if a monograph exists, and the USP chapter on pharmacy compounding; (2) if such a monograph does not exist, are components of drugs approved by FDA; or (3) if such a monograph does not exist and the bulk drug substances are not components of a drug approved by FDA, appear on a list developed by FDA through regulations (the 503A Bulks List). Semaglutide salts are not the subject of an applicable USP or NF monograph, are not components of an FDA-approved drug product, and do not appear on the 503A Bulks List.

For compounded drug products to qualify for the exemptions under section 503B, they must be compounded in an outsourcing facility that does not compound drugs using bulk drug substances unless the bulk drug substance (1) appears on a list established by FDA identifying bulk drug substances for which there is a clinical need (the 503B Bulks List), or (2) the drug compounded from such bulk drug substances appears on FDA's drug shortage list at the time of compounding, distribution and dispensing. Semaglutide salts do not appear on the 503B Bulks List, nor do products containing semaglutide salts appear on FDA's drug shortage list.

## Compounded Drug Products Containing Semaglutide

Semaglutide is a component of an FDA-approved drug product and appears on FDA's drug shortage list. Therefore, compounded drug products containing this API are potentially eligible for the exemptions under sections 503A or 503B of the FD&C Act, provided they meet all of the conditions in those sections. These sections describe the conditions that must be satisfied for compounded human drug products to be exempt from certain sections of the FD&C Act, including the requirements of premarket approval and labeling with adequate directions for use.

While compounded drug products containing semaglutide may be lawfully marketed under federal law, please be advised that FDA does not evaluate the safety, effectiveness, or quality of compounded drug products before such drugs are marketed. As stated, FDA has received an increased number of adverse event reports and complaints concerning these compounded drug

products.

We are also sending this letter to the National Association of Boards of Pharmacy to facilitate communication among associations with shared goals regarding these matters.

We encourage you to share the information in this letter with your members. We look forward to continuing to work with you on matters related to drug compounding. If you have questions, please contact the Office of Compounding Quality and Compliance at compounding@fda.hhs.gov.

Sincerely,

F. Gail Bormel, RPh, JD
Director
CDER Office of Compounding Quality and Compliance

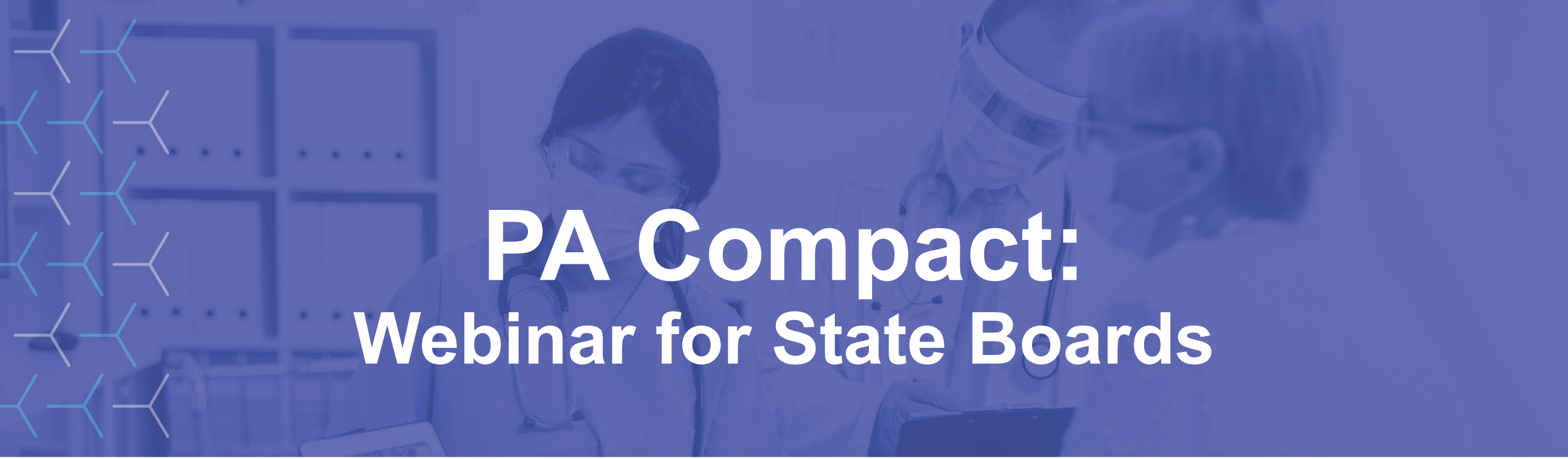
U.S. Food & Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993
w ww.fda.gov

# State of Wisconsin
# Department of Safety & Professional Services

## AGENDA REQUEST FORM

| | | | |
|---|---|---|---|
| **1) Name and title of person submitting the request:**<br>Tom Ryan | | **2) Date when request submitted:**<br>12/14/2023<br>**Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting** | |
| **3) Name of Board, Committee, Council, Sections:**<br>Physician Assistant Affiliated Credentialing Board | | | |
| **4) Meeting Date:**<br>March 8, 2024 | **5) Attachments:**<br>☒ Yes<br>☐ No | **6) How should the item be titled on the agenda page?**<br>Physician Assistant Interstate Compact Update – Discussion and Consideration<br>1. PA Compact Webinar for State Boards, Powerpoint Slides | |
| **7) Place Item in:**<br>☒ Open Session<br>☐ Closed Session | **8) Is an appearance before the Board being scheduled?** *(If yes, please complete Appearance Request for Non-DSPS Staff)*<br>☐ Yes ☒ No | **9) Name of Case Advisor(s), if applicable:**<br>N/A | |
| **10) Describe the issue and action that should be addressed:**<br>The Board will review and discuss the powerpoint slides as part of its Compact discussion | | | |
| **11)** | **Authorization** | | |
| *Tom Ryan* | | *12/14/2023* | |
| **Signature of person making this request** | | **Date** | |
| **Supervisor (Only required for post agenda deadline items)** | | **Date** | |
| **Executive Director signature (Indicates approval for post agenda deadline items)** | | **Date** | |

**Directions for including supporting documents:**
1. **This form should be saved with any other documents submitted to the Agenda Items folders.**
2. **Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.**
3. **If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.**



# PA Compact:
## Webinar for State Boards

December 14, 2023

PA COMPACT

fsmb FEDERATION OF STATE MEDICAL BOARDS

NCCPA Certification. Excellence.®

AAPA American Academy of PAs

CSG National Center for Interstate Compacts
THE COUNCIL OF STATE GOVERNMENTS

# Agenda

- Overview of the PA Compact
- Discussion of Select Compact Topics Areas
  - Scope of practice
  - Collaboration and supervision requirements
  - Background checks
  - Cost
- Similarities and differences with other licensure compacts
- Q&A

# The Council of State Governments

Founded in 1933, CSG is our nation's only organization serving all three branches of state government.

| Scope | Membership | Mission |
| --- | --- | --- |
| The nation's only organization serving all three branches of state government | CSG is a region-based membership organization that fosters the exchange of insights and ideas to help state officials shape public policy | Champion excellence in state governments in order to advance the common good |

@CSGovts | csg.org

# National Center for Interstate Compacts

- Serves as a technical assistance center in The Council of State Governments.
- Provides compact education, development and administration services.
- Works with:
  - Professional membership organizations.
  - Federal government.
  - Legislators.
  - Regulators.
  - Administrators.

# History of the PA Compact

The PA Compact is a joint initiative started in 2019 to improve licensure portability for PAs.

The initiative is made possible through the partnership with the following organizations:

- Federation of State Medical Boards (FSMB)
- American Academy of Physician Associates (AAPA)
- National Commission on Certification of Physician Assistants (NCCPA)

*This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of funding for grant #H1MRH24097. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.*

# Interstate Compacts

# What is an interstate compact?

**A legal, legislatively enacted contract between two or more states** that allows states to:


1. **Cooperatively address shared problems**
2. **Maintain sovereignty over issues belonging to states**
3. **Respond to national priorities with one voice**

# Interstate Compact Enactments

275+ compacts

Each state has enacted between 20-80 compacts

46 compact enactments per state on average

2,500 total compact enactments

METROPOLITAN WASHINGTON AIRPORTS AUTHORITY

EDUCATION COMMISSION OF THE STATES

EMAC®
Emergency Management Assistance Compact

Great Lakes Commission
des Grands Lacs

# Occupational Licensing Interstate Compacts

Facilitate Multistate Practice

Maintain or Improve Public Health and Safety

Preserve State Authority Over Professional Licensing

**50 jurisdictions have adopted at least 1 compact.**
**41 jurisdictions have adopted at least 3 compacts.**

**Over 290 pieces of occupational licensure compact legislation have been enacted since January 2016.**

**17 interstate compacts for occupational licensing.**

# Benefits for Practitioners

Authorizes practice in other member states

Provides consistency in policy and procedures

Reduces effort needed to maintain individual state licenses

Takes advantage of new telehealth opportunities

# Benefits for Patients

Increases access to services

Improves continuity of care

Promotes practitioner diversity

Enhances patient protection

# Benefits for Regulators

States retain control of scope of practice

States retain control of initial licensure process

Compacts facilitate the exchange of licensure and disciplinary information

Compacts improve cooperation in regulating the profession

# PA Licensure Compact

# How it Works

By enacting the compact legislation, compact member states agree to mutually recognize valid, unrestricted licenses of other compact member states via a Compact Privilege

The Compact Privilege is the authorization for a PA to practice in another compact member state

Qualified PAs in a compact member state may apply for a Compact Privilege in each compact member state they wish to practice in

# Compact Privileges

- A compact privilege must be obtained in each compact state where a PA wants to practice
- States and the Compact Commission may charge a fee for each compact privilege issued
- Compact privileges expire when the qualifying license expires (renewal fees may apply)
- PAs must meet the state specific requirements for practice (collaboration or supervision, prescription, jurisprudence exams, etc)
- PAs must abide by the laws and regulations of the state where services are being provided

# Compact Privilege Process

1. **PA decides to get a compact privilege**
2. **PA goes to the PA Compact website** to see list of compact member states, eligibility criteria, & fees
3. **PA completes application** for a compact privilege in a compact member state(s) and pays fees
4. **Compact privilege application is processed** by the Compact Commission. PA eligibility is confirmed with the compact member state of qualifying licensure through the compact data system.
5. **If eligible**, **PA is granted compact privilege** for the specific compact member state(s) applied for
6. **PA must meet any additional state specific practice requirements** before practicing

# Compact Requirements

## State Requirements to Join the Compact

- Includes prerequisites for a state to join the compact
- Includes participation requirements after a state joins

## Individual Requirements to Participate in the Compact

- Requirements to be completed prior to being issued compact privileges
- Include automatic disqualifiers which can prohibit PAs from obtaining a compact privilege

# State Requirements to Join the PA Compact

**A member state must:**

- License PAs
- Have a mechanism in place for receiving and investigating complaints against licensees and license applicants
- Fully implement a criminal background check requirement
- Utilize passage of a recognized national exam such as the NCCPA PANCE as a requirement for PA licensure

# State Requirements to Join the PA Compact

**A member state must:**

- Grant the compact privilege to a holder of a qualifying license in another state participating in the compact
- Comply with the rules of the compact commission
- Participate in the compact commission's data system
- Notify the commission of any adverse action against or significant investigation information of a licensee or license applicant

# Individual Requirements to Obtain Compact Privileges

**To exercise the compact privilege, a licensee must:**

- Hold an unrestricted license issued by a participating compact state to provide medical services as a PA
- Have graduated from an accredited PA program
- Hold current NCCPA certification
- Have a unique identifier as determined by the compact commission
- Notify the compact commission of their intent to seek the compact privilege in a remote state
- Meet any jurisprudence requirements in the remote state and pay any fees

# Individual Requirements to Obtain Compact Privileges

**To exercise the compact privilege, a licensee must:**

- Have no limitation or restriction on any state license or compact privilege in the previous two years
- Have no felony or misdemeanor convictions
- Have never had a controlled substance license or permit suspended or revoked
- Report to the commission any adverse action taken by a non-member state within 30 days after the action is taken

# Adverse Actions

- **A Participating State** in which a PA is licensed shall have exclusive power to impose adverse action against the qualifying license issued by that participating state

- **Remote states** shall have the authority to remove a compact privilege and issue subpoenas

- Compact member states may participate in joint investigations

# Provisions Respecting Individual State Laws and Regulations

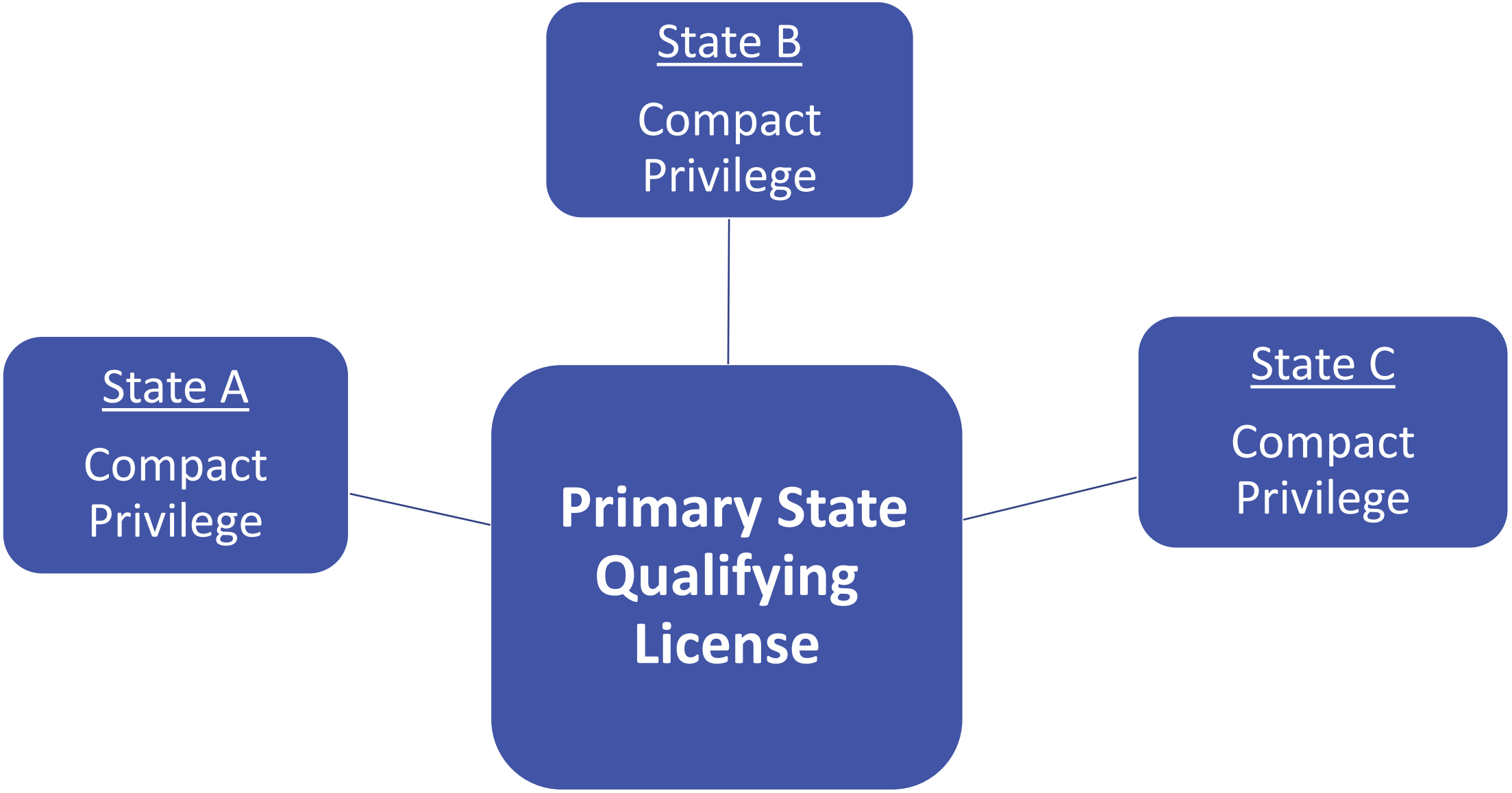
## States **CAN**

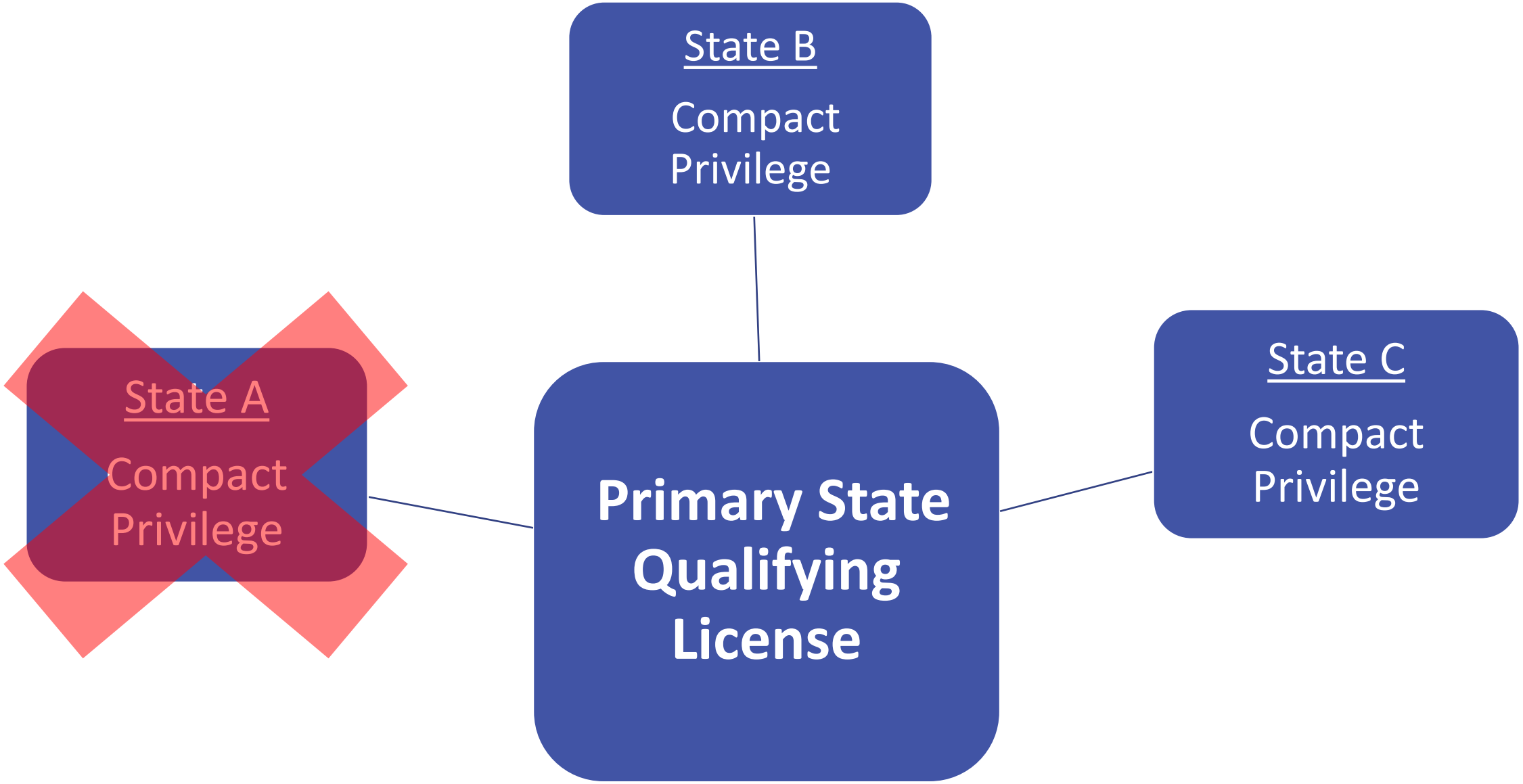
- ✓ Investigate compact privilege holders for action taken in their state
- ✓ Act on a privilege issued by their state
- ✓ Participate in joint investigations with other member states

## States **CAN'T**

- × Act on a privilege issued by another member state
- × Deny a privilege or investigate a PA for lawful action in another state
- × Specify the laws and regulations a PA must follow in a remote state

**PA Compact Privilege holders must always abide by the laws and regulations of the state where the patient is located**


State B
Compact Privilege
State A
Compact Privilege
Primary State Qualifying License
State C
Compact Privilege


State B
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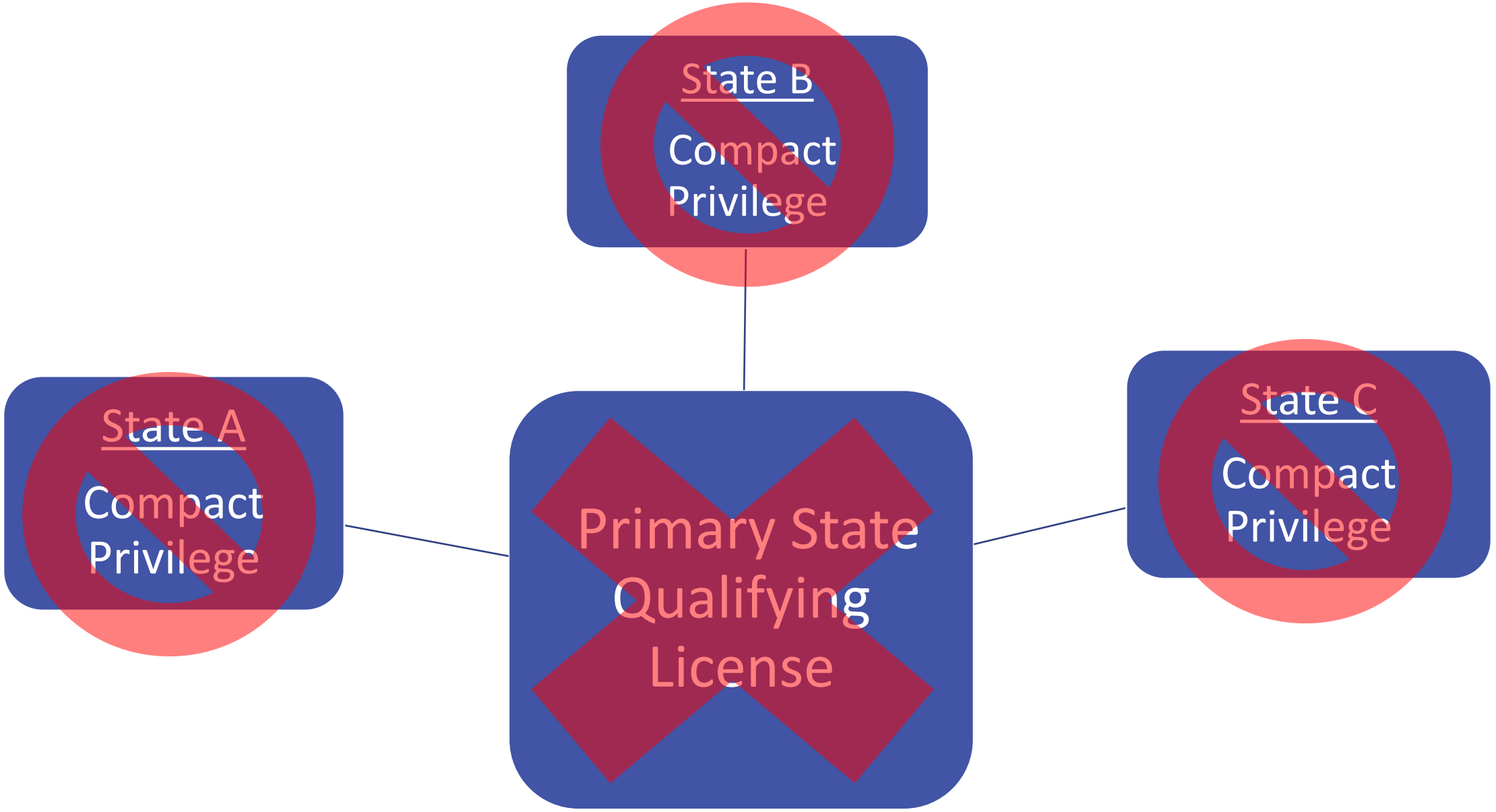
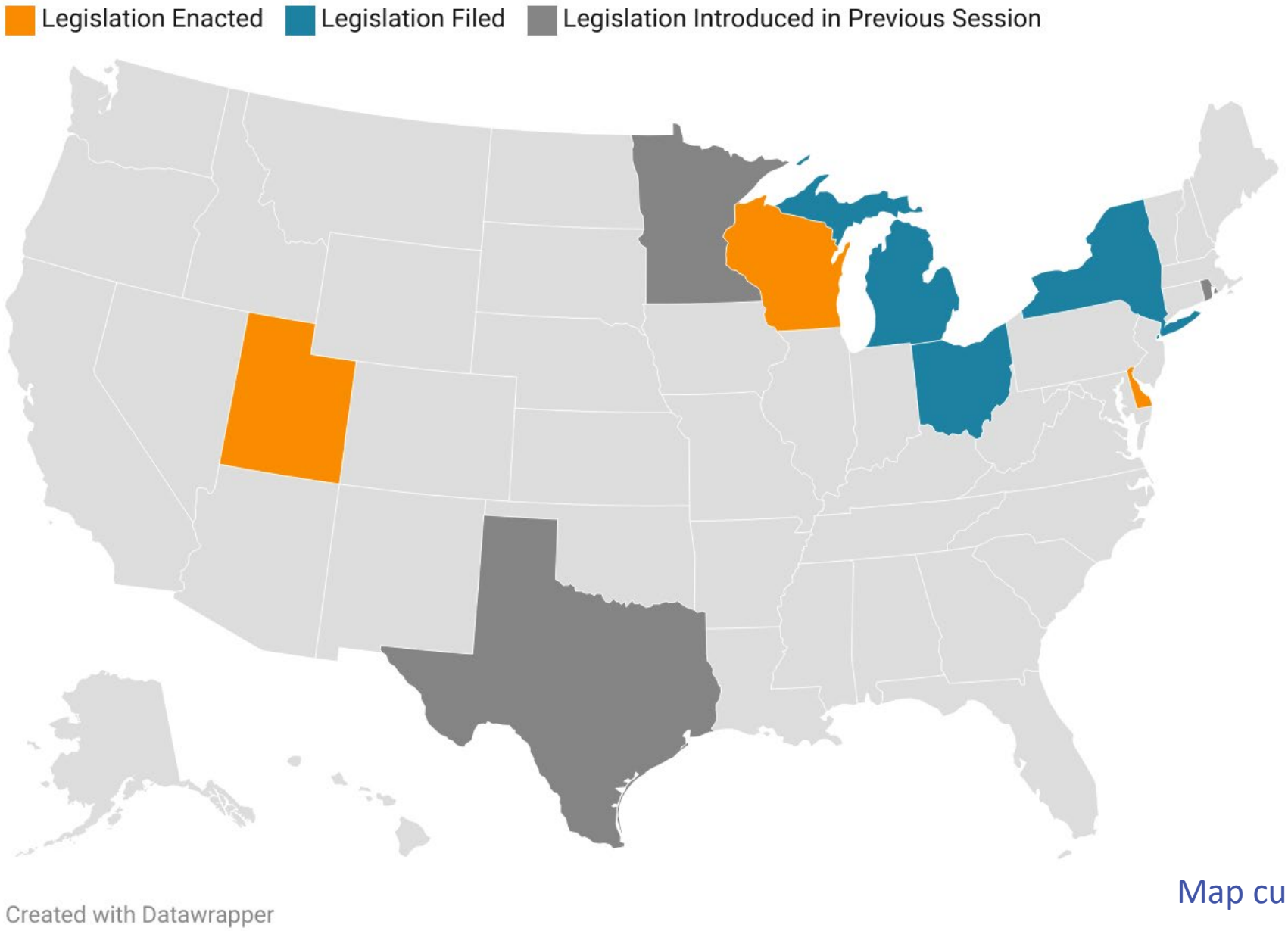

State B
Compact Privilege
State A
Compact Privilege
Primary State Qualifying License
State C
Compact Privilege

# Compact Status

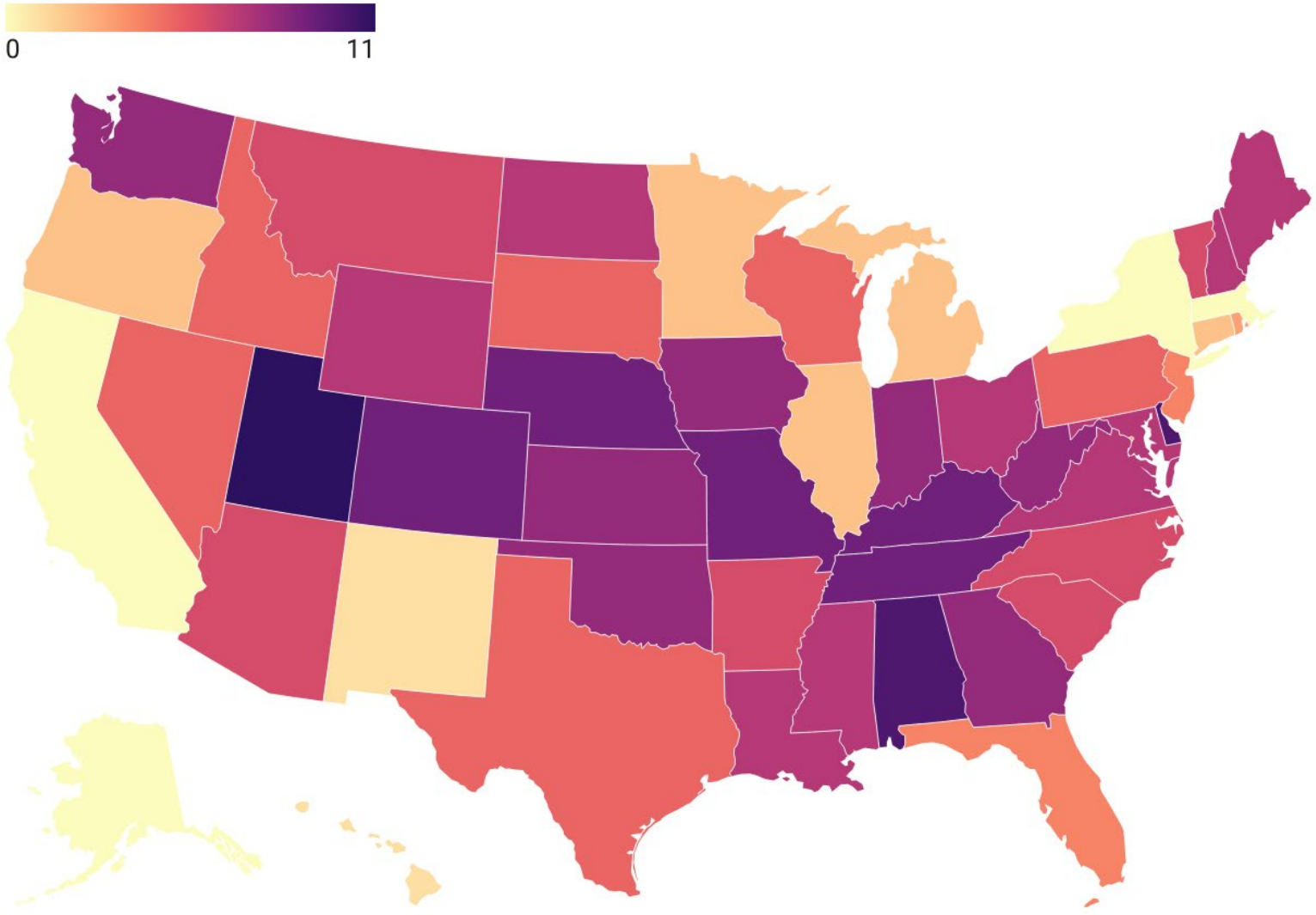
# The compact activation and operationalization process

- After the compact model legislation is finalized, it becomes available for state adoption
- It generally takes 2-3 years for a compact to reach the activation threshold (7 states for the PA Compact)
- The operationalization of a Compact Commission generally takes another 2-3 years




Map current as of 12/14/23

## Compact Enactments by State

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# Select Compact Topics

# Scope of Practice

- **Scope of practice is preserved with a state's participation in the PA Compact.**
- **PAs authorized to practice under the compact, must follow the laws and regulations of where patient is located.**

| | |
|---|---|
| **Section 2. Definitions** | **"Compact Privilege"** means the authorization granted by a Remote State to allow a Licensee from another Participating State to practice as a PA to provide Medical Services and other licensed activity to a patient located in the Remote State under the Remote State's laws and regulations. |

# Collaboration/Supervision Requirements

- **State collaboration and supervision requirements are preserved with a state's participation in the PA Compact.**

- **PAs must follow collaboration and supervision requirements of the state where the patient is located.**

- The compact provides PAs the authorization to practice from a licensure aspect. PA professionals may be subject to other requirements in order to legally practice, including supervision/collaboration and prescribing authority requirements.

# Compact Fees

- PAs pay two fees
  1. Fee to Commission (set by commission)
  2. Fee to state granting privilege (set by the state)

- Fees also applicable at renewal of Compact Privilege

- Compact Commissions may also raise revenue through grants, donations, etc.

- PA Compact Commission could charge a fee to member states (unlikely)
  - Only PsyPact and NLC currently charge (capped at $6,000 per state per year)

# Background Checks

- **Criminal Background Checks are required for initial licensure**
- **PA Compact requires the background check for initial licensure. Other compacts such as the PT Compact currently use this method.**

| | |
|---|---|
| **Section 2. Definitions** | Fully implement a Criminal Background Check requirement, within a time frame established by Commission Rule, by its Licensing Board receiving the results of a Criminal Background Check and reporting to the Commission whether the License applicant has been granted a License. |
| **Section 3. State Participation in this Compact** | **"Criminal Background Check"** means the submission of fingerprints or other biometric-based information for a License applicant for the purpose of obtaining that applicant's criminal history record information, as defined in 28 C.F.R. § 20.3(d), from the State's criminal history record repository as defined in 28 C.F.R. § 20.3(f). |

# Continuing Education

- PAs are required to meet the continuing education requirements of the state in which they hold a qualifying license.
- PAs must also maintain current NCCPA certification which requires continuing education.
- PAs will not need to complete additional continuing education units for states where they hold compact privileges.

# Compact Comparisons

# Licensure Compact Models

| | | | |
|---|---|---|---|
| **Mutual Recognition** (Multistate License) | **Mutual Recognition** (Privilege to Practice)* **Model used by the PA Compact* | **Expedited Licensure** | **Telepsychology and Temporary In-Person Practice** |

# Compact Comparison

| | PA Compact | IMLC | NLC |
|---|---|---|---|
| **Authorization Mechanism** | Privilege to practice | Expedited Licensure (via Letter of Qualification) | Multistate license |
| **Scope of Practice** | Where patient is located | Where patient is located | Where patient is located |
| **Background Check** | At initial licensure | At time of application for expedited licensure | At initial licensure |
| **Compact Commission** | Member or Administrator of Licensing Board | Member or Administrator of Licensing Board | Administrator of Licensing Board |
| **Fee Structure** | Compact Fee (Commission) + Compact Privilege Fee (State) | Compact Fee (Commission) + License Fee (State) | State sets fee |
| **Compact Eligibility Check** | State of qualifying licensure | State of principal licensure | Home state |

# Pathways to Practice for Healthcare Compacts

**Expedited Licensure** — Interstate Medical Licensure Compact

- Hold a License in the principal state of licensure
- Meet Compact Requirements
- Apply through the IMLC Commission
- Receive Letter of Qualification from State of Principal License
- Provide Letters of Qualification to Compact Member States to obtain licensure

**Multistate** — NLC (Interstate Commission of Nurse Licensure Compact Administrators, Est. 2000)

- Hold license in Home State
- Meet Compact Requirements
- Apply for multistate license through Home State

**Privilege to Practice** — PA Compact

- **Hold Qualifying License**
- **Meet Compact Requirements**
- **Apply for Compact Privileges in Remote Compact Member States**

**7 of the 17 licensure compacts utilize the privilege to practice model**

# Resources and Support Available to States

PA COMPACT

fsmb FEDERATION OF STATE MEDICAL BOARDS

NCCPA Certification. Excellence.®

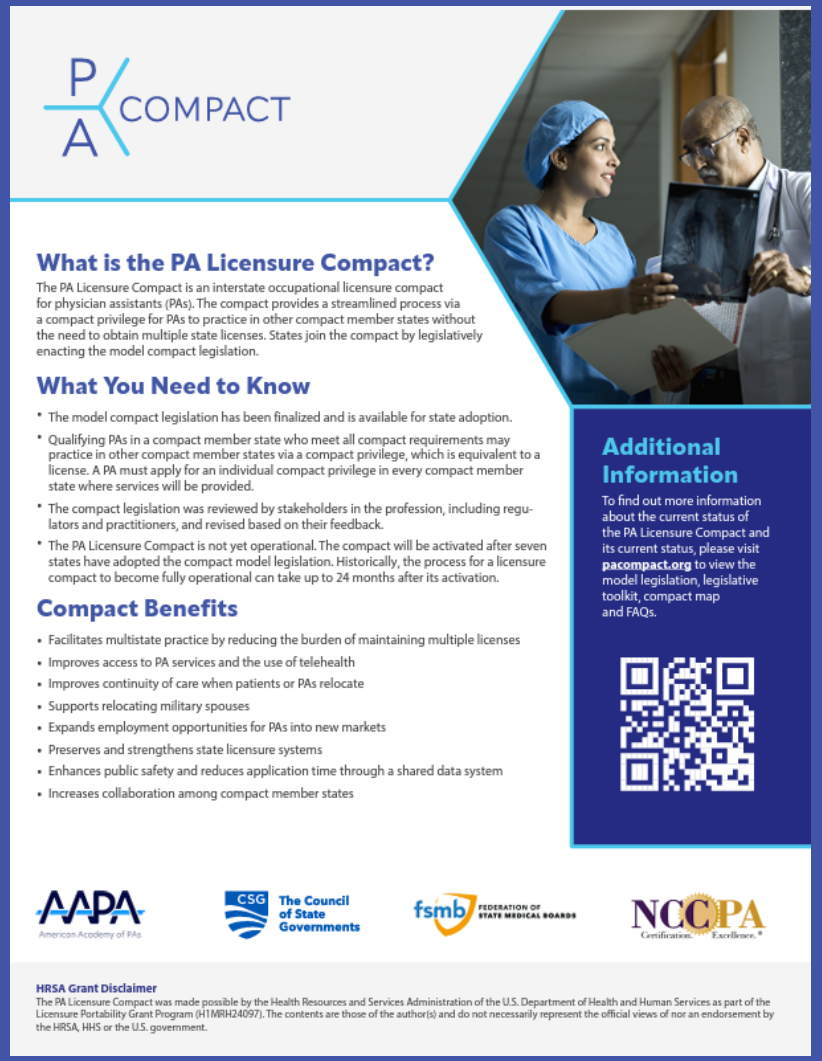
AAPA American Academy of PAs

CSG National Center for Interstate Compacts
THE COUNCIL OF STATE GOVERNMENTS

# Additional Resources

PACompact.org

- Model Legislation
- Section by Section Summary
- Reference Sheet for Legislative Testimony
- Compact Map
- FAQ



PA COMPACT

## What is the PA Licensure Compact?

The PA Licensure Compact is an interstate occupational licensure compact for physician assistants (PAs). The compact provides a streamlined process via a compact privilege for PAs to practice in other compact member states without the need to obtain multiple state licenses. States join the compact by legislatively enacting the model compact legislation.

## What You Need to Know

- The model compact legislation has been finalized and is available for state adoption.
- Qualifying PAs in a compact member state who meet all compact requirements may practice in other compact member states via a compact privilege, which is equivalent to a license. A PA must apply for an individual compact privilege in every compact member state where services will be provided.
- The compact legislation was reviewed by stakeholders in the profession, including regulators and practitioners, and revised based on their feedback.
- The PA Licensure Compact is not yet operational. The compact will be activated after seven states have adopted the compact model legislation. Historically, the process for a licensure compact to become fully operational can take up to 24 months after its activation.

## Compact Benefits

- Facilitates multistate practice by reducing the burden of maintaining multiple licenses
- Improves access to PA services and the use of telehealth
- Improves continuity of care when patients or PAs relocate
- Supports relocating military spouses
- Expands employment opportunities for PAs into new markets
- Preserves and strengthens state licensure systems
- Enhances public safety and reduces application time through a shared data system
- Increases collaboration among compact member states

## Additional Information

To find out more information about the current status of the PA Licensure Compact and its current status, please visit **pacompact.org** to view the model legislation, legislative toolkit, compact map and FAQs.

AAPA American Academy of PAs · CSG The Council of State Governments · fsmb Federation of State Medical Boards · NCCPA Certification. Excellence.

**HRSA Grant Disclaimer**

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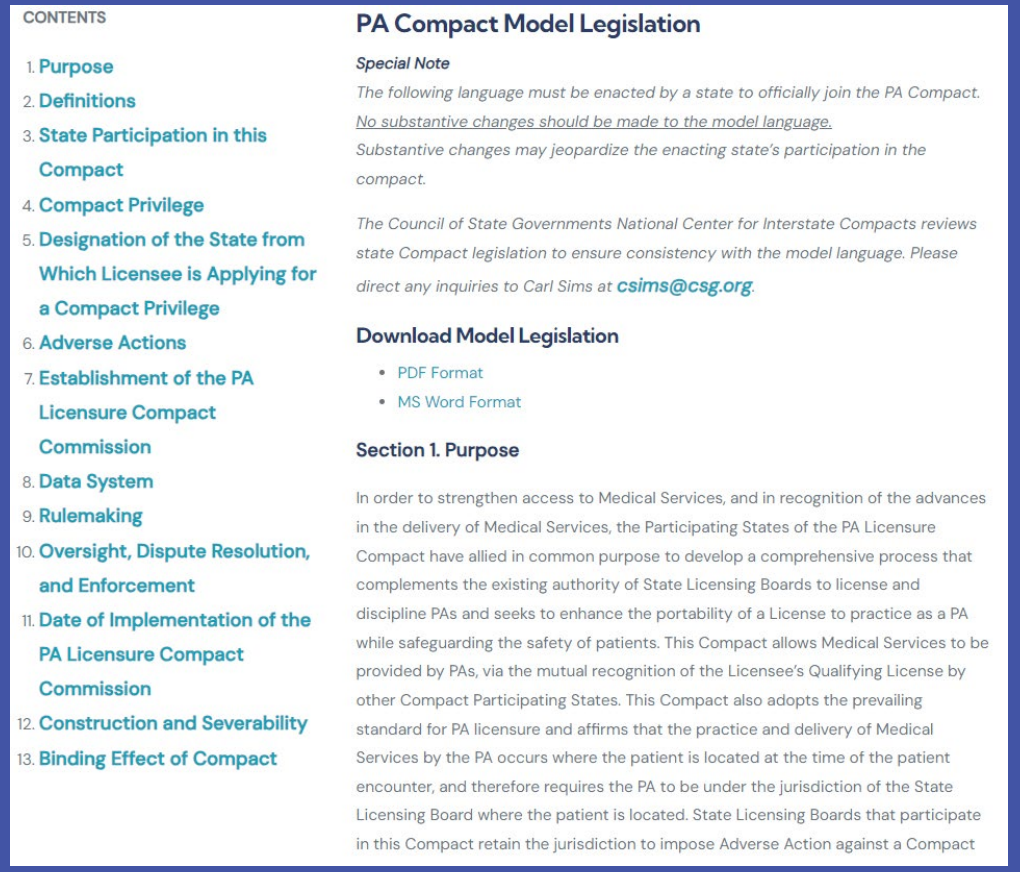
# Support Available

- Compact Bill Review
- Legislative Testimony
- Board Presentations
- Compact and state specific questions



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## PA Compact Model Legislation

***Special Note***

*The following language must be enacted by a state to officially join the PA Compact. No substantive changes should be made to the model language. Substantive changes may jeopardize the enacting state's participation in the compact.*

*The Council of State Governments National Center for Interstate Compacts reviews state Compact legislation to ensure consistency with the model language. Please direct any inquiries to Carl Sims at* ***csims@csg.org****.*

### Download Model Legislation

- PDF Format
- MS Word Format

### Section 1. Purpose

In order to strengthen access to Medical Services, and in recognition of the advances in the delivery of Medical Services, the Participating States of the PA Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing authority of State Licensing Boards to license and discipline PAs and seeks to enhance the portability of a License to practice as a PA while safeguarding the safety of patients. This Compact allows Medical Services to be provided by PAs, via the mutual recognition of the Licensee's Qualifying License by other Compact Participating States. This Compact also adopts the prevailing standard for PA licensure and affirms that the practice and delivery of Medical Services by the PA occurs where the patient is located at the time of the patient encounter, and therefore requires the PA to be under the jurisdiction of the State Licensing Board where the patient is located. State Licensing Boards that participate in this Compact retain the jurisdiction to impose Adverse Action against a Compact

# Questions?