Optional Autonomy For Experienced PAs In Nevada

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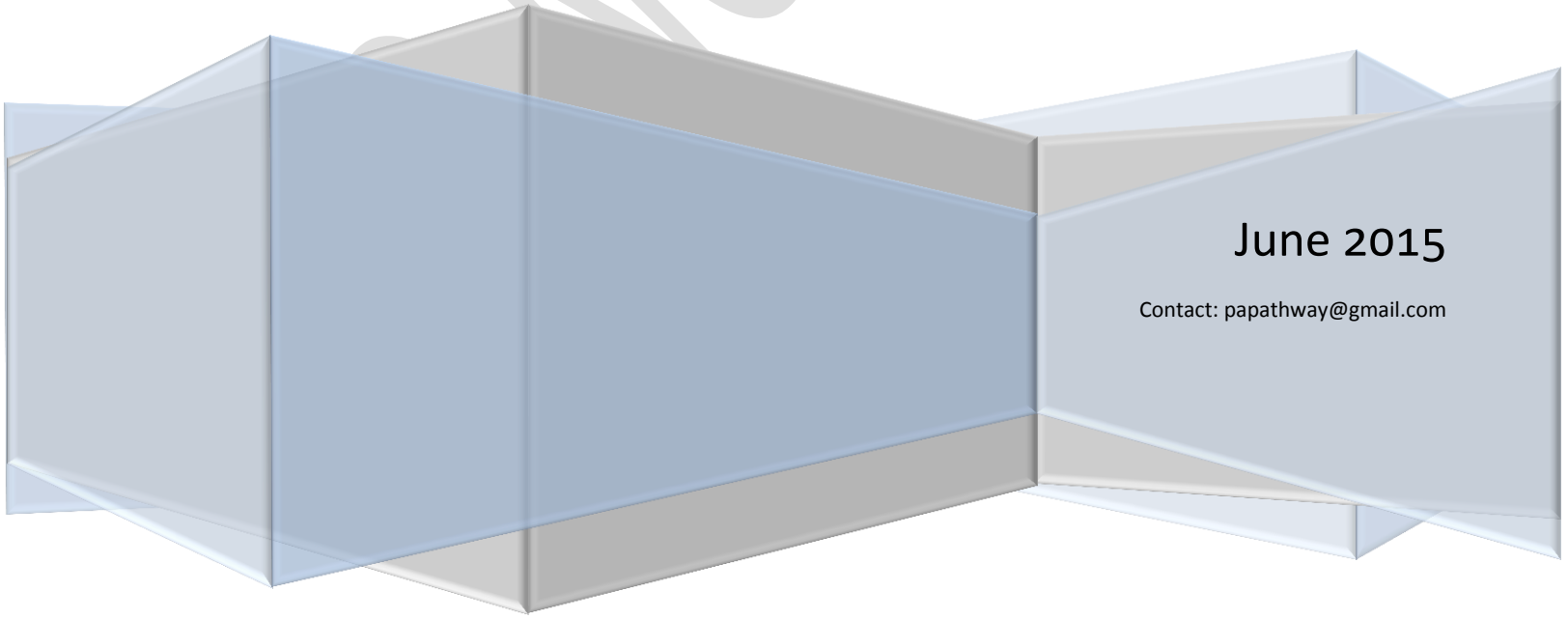

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Introduction……2

Opposition To Expansion Of Scope……4

PA Education And NP Precedents……5

Defining Primary Care……7

The Proposal Specifics ……8

Conclusion……8

Introduction

Nevada's healthcare system is in a state of crisis. Nevada currently ranks 47th in the nation for number of primary care physicians to 100,000 population.[1] Due to the Affordable Care Act, another 265,000 patients in Nevada who did not access primary care due to being uninsured, now have access to an already overburdened healthcare system.[2] To make matters worse, at the time of writing, 25% of Physicians in Nevada are over the age of 60 years.[3] With no way to replace these physicians quickly, shortages will soon worsen rapidly.

PAs can be an important part of the solution to Nevada's healthcare crisis, but new and improved legislation will be necessary. Having restrictive legislative language for PAs is affectively decreasing access to care for the general population. A Federal Trade Commission March 2014 report states, "restrictive requirements exacerbate provider shortages", "excessive supervision requirements may increase health care costs and prices", "mandated collaboration agreements are not needed", and "fixed supervision may constrain innovation in health care".[4] Nevada needs to explore new options to maximize the use of Physician Assistants. The Taskforce on Health Care Workforce Regulation stated the following, "States should explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills."[5] A recent study showed by removing restrictive legislation for PAs/NPs in the state of Alabama, and affectively increasing their numbers, the state could save an estimated $729 million dollars over a ten year period in health care expenditures.[6]

1. United Health Foundation – America's Health Rankings: *A Call To Action For Individuals And Their Communities*, 25th Anniversary edition 2014, p. 112. Retrieved on 6/22/15 from: http://cdnfiles.americashealthrankings.org/SiteFiles/PressReleases/Americas%20Health%20Rankings%202014%20Edition.pdf
2. Service Employees International Union, *The State Of Healthcare In Nevada*. Retrieved on 6/22/15 from: http://www.seiu.org/a/the-state-of-healthcare-in-nevada.php
3. Association of American Medical Colleges, *2013 State Physician Workforce Data Book: Center for Workforce Studies*, November 2013, p. 21. Retrieved on 6/22/15 from: https://members.aamc.org/eweb/upload/State%20Physician%20Workforce%20Data%20Book%202013%20(PDF).pdf
4. FED. TRADE COMM'N STAFF, *POLICY PERSPECTIVES: COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES*, March 2014, p. 20, 27, 31. Retrieved on 6/22/15 from: http://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf
5. Finocchio L J, Dower C M, McMahon T, Gragnola C M and the Taskforce on Health Care Workforce Regulation. *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*. San Francisco, CA: Pew Health Professions Commission, December 1995, page 10. Retrieved on 6/22/15 from: http://www.futurehealth.ucsf.edu/Content/29/1995-_12_Reforming_Health_Care_Workforce_Regulation_Policy_Considerations_for_the_21st_Century.pdf
6. Roderick S. Hooker, PHD,MBA,PA; and Ashley N. Muchow. *Modifying State Laws for NPs and PAs Can Reduce Cost of Medical Services*; Nursing Economics 2015, 33(2):88-94. Retrieved on: 6/22/15 from: http://www.nursingeconomics.net/necfiles/14ND/Hooker.pdf

Currently under Nevada law a PA must have a supervising physician regardless of how many years the PA has been practicing. One idea being proposed in this white paper is to bring forth new legislation in the state that would allow PAs in primary care to practice fully autonomously without physician supervision after three years of supervised or collaborative practice. Patient outcome reviews support the safe and effective care provided by PAs.

In 2008 the Colorado Health Institute's Scopes of Care Advisory Committee was tasked with completing a comprehensive review for non-physician providers in the state of Colorado.[7] The study included an extensive literature review on PA's safety and outcome data. The review found that PAs patient care was equal to that of physicians. The care PAs provided was deemed to be the same level of quality as physicians. The review also found no decline in patient satisfaction levels, and noted that PAs were more likely to practice in underserved areas.

In January 2007 Pennsylvania's Office of Health Care Reform linked scope of practice to overall healthcare reform bills being proposed by the governor's office. Upon review of Pennsylvania's scopes of practice for several different providers, including PAs, the Office of Health Care reform concluded that most restrictive scope of practice laws have no clinical evidence backing the legislative language. They also concluded that often restrictive laws regarding scope of practice were enacted due to personal motives by those in positions to enact those laws. The office looked at other states with more liberal scopes of practice, for PAs and other providers, and found no decline in the quality of care in those states.[8]

One of the largest employers of PAs, the Veteran's Association, recently published a document stating that full autonomy for experienced PAs is completely appropriate. VHA directive 1063, appendix A-5 from December of 2013 states, "Full autonomy is appropriate for an experienced PA."[9] The document went on to say that experienced PAs rarely need to consult their supervising physicians. The only quality control measure that the VA recommends for PAs at this level is a simple 5 chart per quarter review. These types of quality control measures may be implemented, for all types of providers, at the practice level and therefor do not need to be in state statutes.

7. Colorado Health Institute. (2008). *Collaborative Scopes of Care Advisory Committee: Final Report of Findings*, Dec 2008, p. 6-7. Retrieved on 6/22/15 from: http://www.coloradohealthinstitute.org/key-issues/detail/health-care-workforce/collaborative-scopes-of-care-advisory-committee-final-report-of-findings
8. Rebecca LeBuhn, David A. Swankin, Esq. *Reforming Scopes of Practice: A White Paper*, July 2010, p. 4, 6-8,10. Citizen Advocacy Center. Retrieved on 6/22/15 from: http://www.cacenter.org/files/ReformingScopesofPractice-WhitePaper.pdf
9. Department of Veteran's Affairs - Veteran's Health Administration. *VHA DIRECTIVE 1063 Utilization Of Physician Assistants,* Appendix A-5 December 24, 2013. Retrieved on 6/22/15 from: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2958

Opposition To Expansion Of Scope

Many who oppose legislation that would expand scopes of practice for PAs often use safety concerns to validate their opposition. Studies looking at patient outcomes for PAs show that this argument is not supported by any data. Raising safety concerns regarding PAs without any data to support these claims are being met with stiff resistance.

On April 21, 2015 in a letter to a Missouri legislator, the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition cautioned legislators to "scrutinize" any and all claims of "safety concerns" not backed by data regarding non-physician providers.[10] In a 2009 article titled, "Does the Employment of Physician Assistants and Nurse Practitioners Increase Liability", the study found no evidence that PAs or NPs increase malpractice liability. The authors also noted that adding a PA or NP to a practice may actually lower rates of malpractice claims. Lastly the article states that overall, PAs and NPs seem to be a safe and positive addition to the healthcare system in the US.[11]

Physician interest groups and medical society executives are well aware that non-physician providers have many studies backing their safety and efficacy. They are also aware that virtually no studies or evidence exists to support an argument of safety concerns regarding PAs. In an article titled, "Accept No Substitute: A Report on Scope of Practice", the authors interviewed many executives of state medical societies.[12] They admitted they had no data to back safety claims regarding non physician providers. Many admitted that requests for expansion of scopes for PAs and NPs ultimately would not be able to be denied because of large bodies of evidence showing that patient outcomes for non-physician providers, such as PAs, were equal to those of physicians. If executives of medical societies understand that PAs and NPs are safe providers with good outcomes, than why are they trying to hold back expansions of scope which could increase access of care for patients and reduce healthcare expenditures?

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10. Letter from the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition to Representative Kirkton. April 21, 2015. Retrieved on 6/10/15 from: https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-representative-jeanne-kirkton-missouri-house-representatives-regarding-competitive/150422missourihouse.pdf

11. Hooker, Roderick S., PhD, PA, Nicholson, Jeffrey G., PhD., PA, Le Tuan, MD, DrPH, *Does the Employment of Physician Assistants and Nurse Practitioners Increase Liability*, Journal of Medical Licensure and Discipline, Federation of State Medical Boards, Vol. 95, Number 2, 2009, p.6-15. Retrieved on 6/22/15 from: http://www.paexperts.com/Nicholson%20-%20Hooker%20Article.pdf

12. Isaacs, Stephen and Jellinek, Paul. *Accept No Substitute: A Report on Scope of Practice*. November, 2012, p. 14-15. Retrieved on 6/22/15 from: http://www.sc.edu/study/colleges_schools/nursing/centers_institutes/center_nursing_leadership/sc_onevoice_oneplan/a_report_on_scope_of_practice.pdf

Most opposed to practice expansion for Physician Assistants often do so for their own self- interests and not for the benefit of patients or increasing access of care. Often opposing parties have financial motivations, or simply feelings of insecurity and fear of change. Reforming Scopes of Practice: A White Paper, published in 2010, made the following comments: "as a number of prestigious groups have reported, scope of practice laws too often protect the economic interests of healthcare professionals by unnecessarily restricting other professions from providing competent, affordable, and accessible care."[8], "States should be encouraged to experiment with new approaches to scope of practice as part of healthcare reform."[8]

PA Education And NP Precedents

Physician Assistants are the only medical providers in the state of Nevada that do not have an option for full autonomy. In July of 2014 Nevada enacted NRS 632.237 which allows Nurse Practitioners to see patients without physician supervision or collaboration immediately after graduating from an accredited nurse practitioner program, and allows prescription privileges for schedule 3-5 narcotics and other prescription medications. The law does have a requirement of 2000 hours, roughly equivalent to one year full time practice, clinical experience with a collaborating physician if the NP wants to write for schedule 2 narcotics.[13] The proposal being put forth by this whitepaper would allow experienced PAs in primary care with 3 years, or roughly 6000 hours, of physician supervised clinical experience as a practicing PA to obtain full autonomy.

A comparison of education hours between master's degree level programs for Physician Assistants (PA) and Nurse Practitioners (NP) also lends support for autonomy for Physician Assistants in Nevada. The average classroom hours in a master's level nurse practitioner program are 500, and the average classroom hours for a master's level PA program are 1000. The average clinical rotation hours an NP student spends seeing patients is 500-700 hours, and the average clinical rotation hours a PA student spends seeing patients is 2000 hours.[14,15,16] According to the Physician Assistant Education Association's 28th Annual Report, PA students also have an additional 3500 hours of direct patient contact before matriculating into a PA program. Under the criterion listed in this white paper's proposal a PA would have a minimum of 11,500 supervised hours of patient contact and care, 6000 of those hours supervised as a board certified PA, to qualify for full autonomy.[16]

13. Nevada NRS Chapter 632 – Nursing, NRS 632.237. https://www.leg.state.nv.us/NRS/NRS-632.html
14. http://www.nursepractitionerschools.com/faq/np-vs-physician-assistant
15. A Report Of The National Task Force on Quality Nurse Practitioner Education. *Criteria for Evaluation of Nurse Practitioner Programs 2012*. Washington, DC: National Organization of Nurse Practitioner Faculties, p.3-17. Retrieved on 6/22/15 from: http://www.aacn.nche.edu/education-resources/evalcriteria2012.pdf
16. PAEA 28th Annual Report. *Physician Assistant Education Programs in the United States 2011-2012, p. 43*. Retrieved on 6/22/15 from: http://www.paeaonline.org/index.php?ht=a/GetDocumentAction/i/156969

Other state's laws enacted for NPs can act as a template for Nevada regarding autonomy for PAs. Connecticut enacted legislation for Nurse Practitioners that is very similar to the proposal in this white paper. SB 36 in 2014, "An Act Concerning The Governor's Recommendations To Improve Access To HealthCare", did not address practice settings, or make use of a definition of primary care. The legislation stated the following:

> "An advanced practice registered nurse having (A) been issued a license pursuant to section 20-94a, (B) maintained such license for a period of not less than three years, and (C) engaged in the performance of advanced practice level nursing activities in collaboration with a physician for a period of not less than three years in accordance with the provisions of subdivision (2) of this subsection, may, thereafter, **alone or in collaboration** with a physician, perform the acts of diagnosis and treatment of alterations in health status."[17]

Using the phrase "alone or in collaboration" for the proposal for PA autonomy in Nevada legislation would allow the PA to have choice in their collaboration model depending on their comfort level and training just as the law presently does for NPs.

After passing in the state senate by a margin of 2 to 1, the Connecticut house voted to pass the 2014 SB 36, 110 to 34 votes. Many different community members supported 2014 Bill 36 for the same reasons mentioned throughout this paper. Testimony presented by commissioner Jewel Mullen, MD, MPH,MPA in support of 2014 SB 36 summarized the reasons for expanding scopes of practice regarding the state of Connecticut:

> "The Health Resources and Services Administration of the United States Department of Health and Human Services projects a shortage of 20,400 primary care physicians nationwide by 2020. Other organizations set that projection much higher. Analyses conducted by the DPH Office of Health Care Access reveal that although the availability of primary care providers in our state is somewhat better than the national average, geographic distribution of and access to primary care providers is uneven. Moreover, access is particularly challenging for un- and underinsured individuals. Implementation of the Affordable Care Act will increase demand for services among the newly insured. Our commitment to ensuring they receive care is the basis for the Governor's proposal."[18]

When one considers that Connecticut is ranked 6th in the nation for number of primary care physicians to 100,000 population and Nevada is ranked 47th, the urgency for all solutions to increase access to care in Nevada cannot be overstated.[1]

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17. 2014 Connecticut Senate Bill No. 36. *An Act Concerning The Governor's Recommendations To Improve Access To HealthCare*. Taken on 6/22/15 from: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.cga.ct.gov%2Fasp%2Fcgabillstatus%2Fcgabillstatus.asp%3FselBillType%3DPublic%2BAct%26which_year%3D2014%26bill_num%3D12&ei=eVkYVYqfMIqZNuO4gvgN&usg=AFQjCNGkZ57wtxsY3zR6g3D_QtaJ06v2mw&sig2=nn_6k0wFWN2TAf3lvT1eow

18. Mullen, Jewel MD, MPH, MPA Public hearing testimony given before Public Health Committee for 2014 Connecticut Senate Bill No. 36. *An Act Concerning The Governor's Recommendations To Improve Access To HealthCare*. Retrieved on 6/22/15 from: http://www.cga.ct.gov/2014/PHdata/Tmy/2014SB-00036-R000228-Commissioner%20Jewel%20Mullen,%20MD,%20MPH,%20MPA,%20Department%20of%20Public%20Health-TMY.PDF

Defining Primary Care

Another issue to consider is how to define primary care settings in relation to full autonomy for experienced PAs. Johns Hopkins primary care policy center defines primary care as the following:

> "Primary care is the level of a health services system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care, **regardless of where the care is delivered and who provides it**."[19]

The Institute of Medicine Committee on the Future of Primary Care defined primary care as the following:

> "Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[20]

Finally, the Affordable Care Act section 5405 defines primary care as the following:

> "The term 'primary care provider' means a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services for **men, women, and children of all ages**, developing a sustained partnership with patients, and practicing in the context of family and community."[21]

There are clear implications in the above definitions of primary care. Primary care is broad and includes care for all ages and genders. Primary care is not defined by practice setting names such as primary care office, internal medicine office, urgent care, or retail clinic. Primary care is a gateway for all patients to enter the healthcare system and establish ongoing care with which ever provider they choose, including Physician Assistants.

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19. Johns Hopkins Primary Care Policy Center, Bloomberg School of Public Health. Taken on 3/26/15 from: http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/definitions.html

20. National Research Council. *Defining Primary Care: An Interim Report*. Washington, DC: The National Academies Press, 1994, p. 16. http://www.nap.edu/openbook.php?record_id=9153&page=16

21. American Academy of Physician Assistants website page titled: *PCMH and the Affordable Care Act*. Retrieved on 3/28/15 from: https://www.aapa.org/threecolumnlanding.aspx?id=1705#sthash.lp9iEuQs.dpuf

The above definitions of primary care seem to imply maximum utilization of all medical providers to the full scope of their abilities and training, and to maintain as much flexibility as possible for patients and providers to adapt to an ever evolving healthcare system. Finally, when looking at precedents in Nevada and other states, such as Connecticut mentioned above, in regards to NP autonomy laws, it would seem that most states chose not to define primary care or primary care settings in the statutes. Not defining primary care in a statute may be the best option for maximizing fully autonomous PAs in Nevada as well.

The Proposal Specifics

The proposal for optional autonomy for experienced PAs in primary care has several components and requirements. The first requirement is that the PA would have to be approved for licensure in the state of Nevada. The state requires all PAs applying for licensure to have graduated from an accredited PA program, be board certified by the NCCPA, and to have a background check.

The PA would have to show that he/she had been practicing in a primary care setting for a minimum of 3 years while supervised by, or in collaboration with a physician. This could easily be accomplished by reviewing the listed supervising physician's specialty and practice address listed at a state's board. PAs in Nevada, or in another state, in good standing with the corresponding board would be allowed to practice fully autonomously in primary care.

The PA would have to maintain NCCPA national board certification. In order to maintain the NCCPA status the PA must retake boards every 10 years, like most physicians do, and perform 100 hours of continuous medical education every 2 years.[22] The 100 hours required by the NCCPA is currently more than the Nevada minimum requirements for Physician Assistants to maintain their state license. A fully autonomous PA would be allowed to write for schedule two through five narcotics and all other prescription medications without physician supervision or collaboration.

Conclusion

Almost 50 years ago, when the PA profession was created, there was a shortage of health care providers. Today in Nevada, and across the nation, we are readying ourselves for the next decades' increasing healthcare provider shortages. Nevada must use all healthcare providers and healthcare workers to the full extent of their training and abilities to provide healthcare to an ever aging population while trying to manage increasing healthcare costs.

22. National Commission on Certification of Physician Assistants. Webpage title, *About CME Requirements.* Retrieved on 6/22/15 from: https://www.nccpa.net/continuingmedicaleducation

When the first class of PAs began their education so long ago, they were awarded certificates. Today the profession has evolved into master's degree graduate medical education with programs often being more selective than medical schools. Other non-physician providers are receiving expansion of scopes supported by the Federal Trade Commission, AARP, the Veteran's Association, and other citizen advocacy groups. PAs have almost 50 years of safety and efficacy data that can justify the expansion of scope for experienced PAs to have full autonomy in primary care. By making PAs autonomous in Nevada we may increase the numbers of PAs in the state, thereby lowering healthcare expenditures, and increasing access of care to patients.