# Full Practice Authority and Responsibility (FPAR)

## Frequently Asked Questions

**What exactly is the Task Force proposing?**
The Task Force believes AAPA should adopt policy to do four things:

- Emphasize our profession's continued commitment to team-based practice.
- Support the elimination of provisions in laws and regulations that require a PA to have and/or report a supervisory, collaborating or other specific relationship with a physician in order to practice.
- Advocate for the establishment of autonomous state boards, with a voting membership comprised of a majority PAs, to license, regulate, and discipline PAs.
- Ensure that PAs are eligible to be reimbursed directly by public and private insurance.

FPAR is a straightforward concept: PAs should be responsible for what they do each day; PAs should regulate their own profession; and services provided by PAs should be covered by public and private insurance. All of this can and should occur within the construct of team practice.

**Why does the task force think this is necessary?**
The healthcare system is transforming, and the task force believes that these changes are required to protect the profession's future. Years ago, many solo physicians hired PAs. It was a nice relationship, especially for a new profession. It will not work in the future. Going forward, most physicians will be employees, not employers. Physicians will not want to work with someone who will increase their liability but not their income. They will look to providers who can be colleagues and who carry no risk to their license.

Additionally, hospital systems and other PA employers are beginning to favor hiring NPs who do not have to have a registered physician supervisor over PAs who are required to do so. Not only does full practice authority reduce the amount of paperwork involved in hiring NPs, but it also gives employers more flexibility in redeploying staff, as may be required to meet patient needs.

We are seeing this now as physicians and hospital systems across America are beginning to turn increasingly to NPs in states where they have full practice authority. And recently, the nation's largest employer of PAs – the Veterans Administration – gave APRNs full practice authority. The fact is, if we wait much longer, we will be too late.

**Does this mean the profession is pursuing independent practice?**
While the FPAR proposal suggests removing a legal tie to a specific physician or group of physicians, it does not propose that PAs practice alone. In fact, it commits PAs to team practice with physicians and others.

The task force does not view or promote FPAR as independent practice and agreed unanimously that reinforcing team practice should be the first pillar of the proposal. The PA profession is committed to

team practice. We think it's good for PAs, other members of medical teams, and most importantly for patients. People who choose to become PAs are team players and PA education reinforces team practice. The task force does not see a need to change any of that. It has a 50 year track record of success.

**How would FPAR change my practice?**
The task force doesn't anticipate much will change in day to day practice. If FPAR is enacted into policy and subsequently enacted as federal and state law, PAs who work in licensed facilities will still go through credentialing and privileging, and will function as team members on services that include physicians and others. PAs who work in outpatient medicine will consult and refer just as they do now.

What would change is a PA's ability to change jobs or work with new physicians without getting signatures or filing paperwork without risking being in violation if signatures are delayed or missed.

FPAR would also mean that you would be licensed by a board with a majority of PAs, who understand your education, training and practice. Right now, only five states (Arizona, Iowa, Massachusetts, Rhode Island and Utah) have autonomous PA boards, and only one, the Iowa board, has a majority of PAs.

**How did the Task Force get started?**
Last May, the House of Delegates considered a resolution on full practice authority that was submitted by the Association of Family Practice PAs, but decided at that time that it deserved additional thought. In addition, the Board included an examination of the issue in its latest Strategic Plan. The confluence of these two actions led to the creation of the Joint Task Force on the Future of PA Practice Authority. The task force, which is comprised entirely of PAs, devised the current Full Practice Authority and Responsibility proposal.

**How would a PA's scope of practice be determined under FPAR?**
AAPA's new Guidelines for State Regulation of PAs , adopted by the 2016 House of Delegates define PA scope of practice very broadly, and no longer limits it to a physician's scope of practice or physician delegation. That is already AAPA policy. An individual PA should include in their scope those aspects of care that are within their education, experience and competence. Like all health professionals, that changes over time.

**Who would be responsible for care provided by PAs under FPAR?**
Just as now, PAs are responsible for care they provide. Requiring a physician to also be responsible for PA-provided care is no longer part of AAPA policy. The new Guidelines for State Regulation of PAs call on PAs to be solely responsibility for their actions, unless they are implementing a direction from a physician. This brief explains why PAs should be responsible for PA-provided care and this video shows the changes in the new Model State Legislation and the Guidelines for State Regulation of PAs.

While removing physician-responsibility is now AAPA policy, it has not been implemented in many state laws or regulations. FPAR takes this concept one step further by clarifying that a PA does not have to have a supervising/collaborating physician who is willing to take responsibility for the autonomous clinical decisions made by a PA. FPAR is a way to implement the concept that physicians should not be responsible for PA-provided care.

**What evidence do you have that PAs can practice safely and effectively without having to have or report a specific supervising/collaborating physician?**

Studies show that the care provided by PAs (who make autonomous clinical decisions daily) and NPs (who are already permitted to practice without designating a supervising physician in many states) is equivalent in quality to care provided by physicians. We've included a bibliography of studies on quality, cost effectiveness and access to care as a link on this page. We think that under FPAR, PAs and physicians will work very similarly to current practice patterns. But neither will be burdened by administrative hassles that have no value to improving patient care.

**Does the task force foresee any changes to the PANCE/PANRE if FPAR were to be implemented? Does the task force foresee any additional examinations that PAs would have to take?**

FPAR would not, in and of itself, expand a PA's scope of practice. PAs will continue to have to practice within the bounds of their education, training, and competence. PAs who work in licensed facilities will still go through credentialing and privileging, and PAs who work in outpatient medicine will work within the bounds set by their employer and continue to consult and refer, just as they do now. While we cannot speak for what NCCPA (the organization that determines PANCE/PANRE requirements and content) may do in the future, we see no reason that FPAR would impact those exams.

**Will FPAR make it harder for new grads to get a job?**

We think that FPAR is likely to make it easier for PAs to get employment. Right now, either you or the hospital that wants to employ you has to convince a physician to enter into a "Supervisory Agreement" with you -- and agreement that requires the physician to accept liability for all of the care you provide. That is a significant ask, and it is something that fewer and fewer physicians are willing to do. The reason physicians are less willing to do that is because they are more and more likely to be employees, rather than owners, so they don't personally share in the additional revenue and profit that you will contribute to the practice or hospital. Yet they are being asked to put their own license on the line for you.

Under FPAR, you or your employer would only have to convince a physician to supervise you in the more traditional sense of the word -- not to accept liability for care that they do not direct or provide. This should make it easier for you to get a job... and put you on the same footing as NPs who work in the 21 states where NPs are not required to have a supervisory agreement with a physician.

The reality is that PAs will continue to work for hospitals, health systems, clinics and physician groups. And at your place of employment, you will have a supervisor or a manager from whom you will take direction and feedback, and with whom you will discuss treatment plans and patient concerns. You will also consult with and refer patients to many other clinicians and team members – from physician specialists and other PAs to social workers and physical therapists. In licensed facilities like hospitals, PAs would still be subject to credentialing and privileging decisions that define practice scope and oversight requirements. FPAR would not and does not seek to change any of those standard employment and practice relationships.

**Would adoption of the FPAR proposal mean that PA programs would need to move to offer doctorate degrees or that PAs would need to pursue doctorates?**

The task force supports the AAPA policy that endorses the master's degree for PA education. The task force does not believe that a change in degree or additional residencies would be required simply because PAs would no longer need to identify or document a supervising or collaborating physician. FPAR would not give a PA permission to practice beyond his/her education, training and competency.

Furthermore, even without the legal requirement to identify or document a supervising physician, we anticipate that PAs will continue to practice in teams (consistent with the FPAR proposal), and new graduate PAs will seek and secure professional positions that afford them adequate contact with physicians, PAs and others with whom they can collaborate and confer.
Additionally, employers have systems in place to on-board, train, and support less experienced providers – whether they are PAs, NPs or others. We do not believe there is a need to prescribe in law or regulation what those systems should consist of – those decisions are best made at the practice level.
Finally, we believe it is part of every professional's ethical obligation to assure that they are not practicing beyond their area of professional competency. That applies to all PAs, regardless of whether they are newly graduated or have practiced for many years. And it applies whether FPAR is adopted or not.

**Won't implementation of full practice authority and responsibility expose PAs to more medical malpractice claims?**
PAs are already liable for their medical decisions. There is no reason to believe that implementation of full practice authority and responsibility will create an incentive for PAs to practice outside of their demonstrated scope of competency. That's prohibited and unethical now, and will continue to be.
At the same time, this change might make it more likely that physicians will be willing to work with PAs, because they will no longer be liable for medical decisions made by PAs in which they played no role. The task force thinks that's a good thing.

**How much will this affect the cost of PA malpractice insurance?**
Since PAs are currently liable for the medical decisions they make, we do not believe there will be cause for PA malpractice insurance rates to increase. Since a supervising physician will not be automatically liable for the care provided by a PA, it's possible that there could be some shift in the malpractice insurance market. We are in contact with malpractice insurance companies to get a more informed response to this question.

**We have built some good relationships with physician groups, and this may cause them concern. Wouldn't it be better to just continue to make the slow and steady progress that we have been?**
Times have changed. Younger physicians and physicians who work as employees (rather than practice owners) – both a growing percentage of the physician workforce – do not want to "supervise" and take responsibility for the decisions of PA co-workers and colleagues. We will need to work to ensure that physicians understand our vision and intent. We are not abandoning our commitment to working in teams with physicians and other healthcare providers.

We believe that FPAR has significant benefits for physicians. Administrative headaches and paperwork will decline because PAs would no longer be tied by law to a supervising or collaborating physician. Physicians won't have to undertake useless tasks like filing meaningless paperwork. The change would reinforce the notion, long backed by AAPA, that PAs should be liable for their own medical decisions. We think these changes are better for both physicians and PAs.

**Under the FPAR proposal, will PAs work without supervision or collaboration?**
There seems to be confusion about the term "Supervising Physician" and what it means in the context of the task force proposal for PA Full Practice Authority and Responsibility.
When the task force says it seeks to eliminate the requirements for PAs to have a "Supervising Physician" or a "Collaborating Physician", we are referring to the laws and regulations that require a PA

to identify or register a specific physician or group of physicians who are willing to enter into a "Supervisory Agreement" or "Collaboration Agreement" and accept legal liability and responsibility for all of the care the PA provides.

Eliminating these requirements in law would not mean that PAs will work "alone", nor does it mean that physicians would not supervise PAs at their places of employment. The reality is that PAs will continue to work for hospitals, health systems, clinics and physician groups. And at your place of employment, you will have a supervisor or a manager from whom you will take direction and feedback, and with whom you will discuss treatment plans and patient concerns. You will also consult with and refer patients to many other clinicians and team members – from physician specialists and other PAs to social workers and physical therapists. In licensed facilities like hospitals, PAs would still be subject to credentialing and privileging decisions that define practice scope and oversight requirements. FPAR would not and does not seek to change any of those standard employment and practice relationships.

Some PAs currently own their own practice and others would like to. What FPAR means for them is that they would not need to identify (and pay) a physician to enter into a "Supervisory Agreement" and serve as their "Supervising Physician" in order to comply with the current legal or regulatory requirements for PA practice. They may decide to hire a physician to work at their practice, and they will, most certainly, continue to consult with and refer to physicians when a patient's condition requires it.

In addition, many PAs would like to volunteer as clinicians and are held back by state requirements for a "Supervision Agreement" or, in a few cases, a "Collaboration Agreement". Under FPAR, PAs would be able to volunteer, consulting with and referring to physicians and others as indicated to meet patient needs. That's a big advantage to PAs and to patients seen by PA volunteers.

**How will FPAR increase patient access?**

If FPAR were implemented, a number of patient access issues would be addressed, including:

- In some states, initial PA licensing can be delayed by weeks or even months in order to convince a physician to enter into a "Supervisory Agreement" with the PA, file the appropriate paperwork, and obtain license approval. This delay represents time that could be spent caring for patients.
- In rural areas in particular, but also in cases where PAs own a practice but pay a physician to serve as a "Supervising Physician", when the physician who has signed the PA's "Supervisory Agreement" becomes incapacitated, moves or dies can create significant periods when the PA is not legally able to practice and must deny service to patients.
- PAs are often unable to or significantly delayed in their efforts to provide volunteer medical services to people in need because they must have a physician who is willing to be designated as the supervising (or collaborating) physician and take responsibility for the care provided by the PA.
- Finally, the elimination of the requirement to have a designated supervising physician (or group of physicians) would allow physicians to spend more time seeing and treating additional patients, because they would not feel compelled to perform unnecessary review and oversight activities in order to meet supervisory expectations.

**What can/should I be saying to my employer about FPAR?**

If asked about the FPAR proposal, we suggest that you discuss the following basic points:

The PA community is currently discussing a proposal by an AAPA task force that has recommended PA Full Practice Authority and Responsibility. The task force proposal includes four suggestions for AAPA policy:

- Emphasize the PA profession's continued commitment to team-based practice.
- Support the elimination of provisions in laws and regulations that require a PA to have and/or report a supervisory, collaborating or other specific relationship with a physician in order to practice.
- Advocate for the establishment of autonomous state boards, with a voting membership comprised of a majority PAs, to license, regulate, and discipline PAs.
- Ensure that PAs are eligible to be reimbursed directly by public and private insurance.

The task force believes that this proposal will benefit patients, physicians, and PA employers, as well as PAs.

- PAs have a demonstrated track record of providing high quality care to patients.
    - A recent study of the impact of changes in PA and NP scope of practice laws on Medicaid patient outcomes and costs over a 14-year period found that "broadened scope of practice increased access to care without infringing on the quality of service delivered to Medicaid patients, and in states that broadened PAs' scope of practice specifically, costs associated with outpatient services fell".[1]
- Changes in the health care system are putting PAs at a disadvantage relative to NPs. In many states (21 at this time), NPs don't have to take the extra step of formally tying themselves to a physician, so it is easier for employers to hire and utilize NPs.
- At the same time, physicians are increasingly employees, rather than employers, and are less willing to assume legal responsibility for the medical care provided by PAs. And, frankly, there is no reason they should; PAs should be responsible for the care they provide.
- As a result of both of these factors, employers are finding it more difficult to utilize PAs, which affects their bottom line, as well.
    - For patients, eliminating the supervisory requirement is expected to result in more time for both PAs and physicians to spend with patients, rather than on unnecessary and unhelpful paperwork.
    - Further, if FPAR were implemented, employers would have more flexibility to have PAs move to other departments/specialty areas within the organization/hospital/hospital system.

After explaining the basics of the proposal and the reasons behind it, you may want to ask something like: Are there any changes to the proposed policy that you believe would make it more beneficial to [name of organization]?

**What are the chances for the implementation of full practice authority and responsibility?**
That depends on how hard PAs work to pass new laws and what kinds of alliances we are able to build. But our first job is to achieve as wide a consensus as possible within the PA profession. That is why we are asking PAs like you to give us your feedback and suggestions for improvement.

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[1] http://contemporaryclinic.pharmacytimes.com/newsviews/hownpsandpasprovidequalitycareto-medicaidbeneficiaries

We believe Full Practice Authority and Responsibility is absolutely within our grasp. But we're going to have to work hard to adopt thoughtful policy and to implement it.

**Can the profession embrace FPAR without changing its title?**

The task force recognized that changing the name of the profession is an important topic that could gain added urgency if Full Practice Authority and Responsibility becomes AAPA policy. However, while there is considerable dissatisfaction with the title of "Physician Assistant", we recognized that no clear consensus on an alternate title has emerged. The task force believes that moving to FPAR is critical for the profession's viability and should not be delayed by the issue of changing the profession's title. Additionally, we agreed that tackling the name change topic is outside the scope of our charges. We believe that another group should be convened to undertake the research and PA community engagement on the topic of name change, and invite your feedback on that suggestion. In the interim, the Task Force intends to use the acronym "PA", consistent with the current AAPA convention.

**What are the next steps?**

It is clear that changing state and federal laws and regulations, as well as the policies and practices of employers and insurance companies, will be challenging and take time. The first step, however, is to reach agreement, as a profession, about the future that we will work to achieve.

Just as PAs do in their everyday practice, the Joint Task Force on the Future of PA Practice Authority recognizes the limits of our collective and individual experiences. For that reason, we seek the feedback and input of our fellow PAs and the full range of AAPA constituent organizations. We hope that you will engage in dialogue with us and with each other through Huddle or through social media. We seek your views through email or letter. And we intend to send out a survey to individual PAs. And we expect to discuss these important issues with you at the Leadership and Advocacy Summit (LAS) in early March. Once we hear from you, we will come together again to reconsider and, if necessary, revise our position. It is our expectation and intent to offer a resolution to the AAPA Board of Directors and the AAPA House of Delegates for their consideration in May 2017.