The Future of PA Practice Authority and Responsibility
Discussion Forum Summary

March 2017

On Saturday, March 6, more than 200 PAs and students gathered in Arlington, Va., at AAPA's Leadership and Advocacy Summit, where they discussed the Joint Task Force on the Future of PA Practice Authority's proposal on full practice authority and responsibility (FPAR).

Attendees, by table groups, were asked (1) to provide feedback on the most significant concerns about the current proposal, and (2) to make specific suggestions regarding how the top seven concerns identified in the first round could be addressed. Individual participants were also invited to submit additional feedback to the Joint Task Force on cards that were provided. The feedback of each of the table groups is summarized below, followed by the feedback provided by individuals who attended the meeting.

Table 1:

- ***How to maintain relationships with physician colleagues risk of disrupting relationship?***
- Resources and speed to accomplish at state level low PA engagement.
- Danger of opening up practice act.

Table 2:

- ***Expectations and support for new grads to practice independently right after graduation.***
- Maintaining Physician/PA team aspect, setting ourselves apart from NPs. Not losing support of medical community.
- Establishing a PA Board on the state level to oversee FPAR. How can we ask for funds, etc.?
- Pushing FPAR in financially weak state.

Table 3:

- ***How will doctors react to #2, severing relationships and losing support?***
- What is the defined urgency on the physician end for them to support this - #2 Private practice versus hospital model - #4?
- Losing team-based practice, quality of providers (new).
- No need for separate PA board.

Table 4:

- ***Jeopardizing relationships with physician groups and stakeholders – we do not wish to be construed as disingenuous.***
- What will be the safety net for severing the PA/physician tie too early?

Table 5:

- ***Who are the stakeholders – uninvolved PAs, medical organizations, insurers, legislators – and how do we mitigate damage to existing relationships?***

- Cost to individual PAs, PA organizations, medical organizations.
- New graduates.
- Silent objectors – how do we decrease apathy and increase participation?

Table 6:

- ***How to handle "new specialty" and "new grad" situation in regards to patient safety and professional relationships?***
- Opposition from a state medical society.
- Opposition from PAs within your own state.
- Achieving full practice authority in law, but not in practice.
- How to prevent NCCPA from derailing progress made in regards to legislation?

Table 7:

- ***Concern of having autonomous state boards – runs the risk of having separate boards and, therefore, now risking our approach to team-based practice.***
- Supervising – not offending the physicians we have good collaborating relationships with now.

Table 8:

- ***Alienating physicians.***
- Perceived deviating from collaboration model.
- Increase in malpractice claims/costs (new expense for PAs).
- Failure to act would lead to PA profession being obsolete and patient perceptions that NPs are more qualified.
- Vulnerabilities to unintended outcomes by opening PA practice law.

Table 9:

- ***Education/Career Flexibility:***
    - ***How do we assure training to new graduates under this new "freedom?" Will PAs have the time to do such?***
    - ***How will this affect career flexibility? If you want to move from specialty to specialty, does the clock start over?***
        - ***Will they need to do a new residency program?***
        - ***Will we have enough residency programs?***
        - ***There are not residency programs in all specialties.***
- Doctors threatened by independent PA providers?
- How will this affect states' current legislative pushes (e.g. some states don't even have full prescriptive authority and now we are asking for something even larger).
- What is the financial impact to the state, employer, personal (own malpractice insurance)?

Table 10:

- ***Opposition from physicians, NPs, and stakeholders preventing FPAR from even reaching legislature.***
- Need for new graduates to have three years of supervised practice before moving to collaboration.
- Title creates a roadblock, Physician Assistant, PA conflicts with the concept of full practice authority.
- Reimbursement changes need to be changed (e.g. 85 percent) to make FPAR work.
- State specific medical liability rules/law conflict with FPAR implementation (e.g. Wisconsin Compensation Fund).
- Disrupting MSL progress.

Table 11:

- ***Policy will be misconstrued as independent practice and will create an adversarial relationship with physicians/employers/NPs.***
- Having work seen instead of being invisible.
- Support from AMA – collaborative instead of supervisory message.
- Alienation of physicians, concern for competition, rogue PAs.
- What would FPAR look like? Initially upon graduation, or after a certain number of practice years, or demonstrated competencies.

Table 12:

- ***Communicating in clear description/wording what FPAR really is to other PAs, Physicians, healthcare workers***
- Threatening relationships and physicians, physicians buy-in may be an issue.
- Reimbursement issue, billing.
- Insurance equality – same level of reimbursement for PAs, physicians.
- Promoting Six Key Elements in all states – Go Kentucky!

Table 13:

- ***FPAR could be a threat to the team model and reimbursement.***
- Concern for buy-in by the state medical boards for independent practice.
- FPAR could lead to lower reimbursement for care by PAs, which could reduce PA salary.
- Erosion of PA professional security and the connection with the physician.
- Aggressive pursuit of FPAR might eliminate our professional standing.

Table 14:

- ***Vocal minority of PA profession that will be adamantly opposed worried about fractionalization of profession.***
- ***Knee jerk reaction seen as PA advancement, seen as FPAR request for all APPs, harming physician relationships, collateral damage.***
- PA autonomous license board.
- How are we going to prepare students to be competent autonomous providers (possible increase tuition costs, increase in program length)?
- Once you open up any legislation, you open up to change in any legislation.

Table 15:

- ***Supervision of new grads (component #2).***
- Push back from other stakeholders (#2 and #3):
    - Organized medicine, physician, NP colleagues, and concern that will lead to compromised relationships.
- Concern for impact to PA solidarity and conflict within profession.
- Creation of autonomous state boards in the face of states wanting fewer boards (#3) and enough interest to fill them.
- Cost of implementation (all).

Table 16:

- ***Negative impact on work to obtain Six Key Elements.***
- Impact/policy of corporations on practice/legislation.
- State boards separate from medical boards - financial impact.
- Competing with NPs.
- Changing specialties, probationary periods for new grads.

Table 17:

- ***Foundation has not been laid in federal regulations to even be able to remit payments to PAs and supervisory limits.***
- "Full Practice Authority" language coined by NPs means independent practice and poisoned that term.
- Inexperience of new graduates.
- Fear of alienating our physician partners in all settings (i.e. political, practice level).
- FPA is disingenuous and not being honest around this being independent practice.
- PA portability is threatened by FPA.
- Majority of PAs practice in specialty and they are not prepared to practice independently.
- Decrease in quality and availability to train PAs because less of an incentive to hire a PA.

Table 18:

- ***#2 is independent practice concern about PA/MD relationships.***

Table 19:

- ***Could becoming independent affect our own ability to practice medicine as state practice acts clearly state, the practice of medicine is overseen by physicians – "What are we practicing?"***
- How will our physician organization perceive us (professional organization, MDs, etc.) as breaking apart the team?
- As FPAR prospers, we would need the educational institutions to teach this way. We are taught collaboration/supervision.

Table 20:

- ***Physician relationship.***

- Scope of practice.
- Variability of training.
- Similar to MD/DO profession.
- Cost of change to state chapters.

Table 21:

- ***Lack of data regarding whether independent practice is good/helpful.***
- Concern that incoming PA students aren't aware of changing positions.
- Is PA program curriculum ready for independent practice?

Table 22:

- ***How smaller state will pay for the lobbyist to achieve results.***
- ***Concern about push back from state medical society, physicians.***
- ***Concern that there is not a system in place to maintain quality, especially with new grads or PAs changing specialties.***
- ***What does this mean for liability?***
- ***Hospital practice physician reimbursement.***
- May get in the way of achieving current Six Key Elements.

Table 23:

- ***Removing supervision is viewed as independence and will be a non-starter.***
- Direct reimbursement will take money out of the doctors' pockets so they will oppose it.
- Does this redefine the profession?
- If NPs are getting jobs because of this, who is making these decisions? Fix that.
- It is already causing problems for Six Key Elements?

Solutions

Concern about damaging relationships with individual physicians and organized medicine.

Table 1:

- ***Public agreement with medical societies clearly define the relationship "committed to the relationship/team-based practice" – prioritize and promote message.***
- Frees the physician from administrative burden and inability from hiring PAs. Nothing will change in the relationship.
- Advertising our relationships with physicians/physician groups.
- Data that says the team/PAs is "Not inferior/equivalent" patient satisfaction, low readmission rates, PAs with full autonomy increase access to patients.
- Capitalize on similarities/synergies in medical model and training.
- Reinforce practice-level sets.

Table 2:

- ***Consistent and trusted core group for the proposal – a "face" of the FPAR. Where to go for the information – both for PAs and key stakeholders.***
- Clear message as to difference of full practice authority and independent practice.
- Communication with key stakeholders – make an offer as to how PAs are helping their organization/practice/lifestyle as independent providers.
- Report with stakeholders so that they understand benefit of FPAR. Build relationships first, then ask.

Table 3:

- ***Maintain practice model legislation, ability to adapt at the local level.***
- ***Demonstrate to the MD community why FPAR is urgent and how it benefits them (define the urgency).***
- Address the damage that has already been done.
- Reiterate the team-based care aspects, emphasize liability (decreased).

Table 4:

- ***Highlighting this does not change the current hierarchy.***
- ***Pros for physicians and patients assurances, no increased liability presenting in a non-confrontational and non-competitive way.***
- AAPA should reach out to each state medical society.
- Provide scientific based data to alleviate fears/concerns.

Concern that this proposal could threaten the team dynamic.

Table 5:

- ***Marketing campaign that promotes the benefits of FPAR including:***
  - ***Increased pool of available candidates.***
  - ***Employers' ability to determine how to implement team-based care when used in conjunction with AAPA's Six Key Elements.***
- Inter-professional education.
- Continue/maintain dialogue with stakeholders.

Table 6:

- ***The current language of "Full Practice Authority" is threatening the team relationship. We could change the language to "Enhanced teamwork practice or accountability" or "Full Practice Accountability."***
- Properly identify the members of the patient care team.
- Clearly identify the goals of the team to highlight the fact that we all have a common goal.
- Determine if "Full Practice Authority" is the phrase we need to use. If it is, we need to provide a clear and simple definition of what that means in legislation and in practice.

Table 7:

- ***Modify #3 Advocate for the advancement of further collaborative relationships on state medical boards, with more inclusion of PAs on medical boards, to license, regulate, and discipline the practice of medicine.***
- Make it a collaborative effort to provide better patient care.
- Reach out to AMA and other physician boards.
- Most physicians will fight with us/for us as long as we don't go for independent practice.
- All of our training is physician based. We don't think a separate board will help.

Concern about whether new graduates are prepared to practice under this proposal.

Table 8:

- ***Allowing for eligibility for collaboration after three years.***
- ***Provide language explaining accreditation of PA education related to PA readiness to enter workforce.***
- Creating distance education/fellowship programs for specialties.

Table 9:

- ***Develop tools for transition to practice to ensure safe patient care and competency.***
- Last two rotations in career choice.
- Determined at individual practice the level of autonomy of the new grad.
- State laws need to correlate with the AAPA goals.
- Entrustable Professional Activity (EPA):
    - Can't move on to the next level until show proficiency in the current level.
    - To be done at individual practice?
- Incentivizing practices/hospital programs to assist in bridging/education programs.

Table 10:

- ***Establish mandatory mentorship program for new grads or PAs in new specialty. Do not tie to licensure as this would cause adverse effect on new grad job options/hiring.***

Concern about the impact this proposal might have on PAs who want to change specialties.

Table 11:

- ***Being accountable for your practice transcends specialty and experience.***
- Need a clear definition of FPAR and how it would be achieved, keeping language for general practice.
- PAs always take full responsibility for their patients. This needs to be communication to stakeholders.
- PAs approach change of specialties now with full range of knowledge and intention required for practice.

Table 12:

- ***Work it out at practice level or with employers, not legislatively. PAs should be responsible for their own training.***
- Reservations by new employers – leave up to practice sites to determine practice agreements and discuss when taking job or interviewing.
- To not make legislation about this specifically.
- Fellowships/residencies.
- Team-based care should enable this to not be an issue.

Table 13:

- ***Team Practice.***
- PA Regulatory Board.
- Malpractice Insurance coverage.
- Organize on-site training.

Concern about potential negative impact on states that are trying to achieve the Six Key Elements.

Table 14:

- ***Frame potential benefits for all stakeholders (i.e. insurance companies, physicians, health systems, etc.) to ensure they understand how it will enable PAs to better serve them.***
- Frame FPAR as an all-encompassing model including the Six Key Elements.
- Determine FPAR conversation at a state level. Stray away from a one-size-fits-all model.

Table 15:

- ***Bundle FPAR with Six Key Elements and add additional FPAR elements and prioritize meaning = expand the number of elements.***
- Prioritize Six Key Elements and they start working on the others.
- The Six Key Elements can be used as a compromise to FPAR and gets states moving faster.

Table 16:

- ***Overton window – move it out in pieces, slowly over time, in steps.***
- Overarching plan that can be put in place over years/decades elements can be used as pillars to build upon.
- Rename it.
- Wait until a certain percentage of states have all Six Key Elements.
- Use pieces of it as additional elements.

Concern about state CO resources to achieve this and other priorities.

Table 17:

- ***Get rid of "FPAR" acronym and incorporate four recommendations of FPAR into model language and let each state achieve as able and appropriate, and AAPA to direct resources to obtain direct-to-billing through federal legislation.***
- Have CO only support certain aspects of FPAR that they are able or feel are beneficial.
- AAPA to develop and provide resources to push FPAR in each CO (i.e. legal counsel, legislative documentation, etc.).
- Strengthen model elements/language for PAs to achieve all six in each state (more achievable) and slowly push for FPAR language without using that language.
- Work at federal level.

Table 18:

- ***Resources to advocate - actively involves members (i.e. membership at state level, revenue sources).***
- AAPA-funded legislative grants. AAPA mentorship programs to states.
- Every state needs a lobbyist, assistance to states without AAPA.

Table 19:

- ***Don't ask each state to do this, work to push FPAR throughout the federal level and trickle down, especially impending legislation changes to ACA, patient relationships with stakeholders and organization.***
- Need to find a partner (like nursing partners, Robert Wood Johnson) to assist with lobbying, data collection and research.
- Identify and collaborate with other stakeholders (unions, teachers, EMTs, etc.) to assist with other priority achievement.

Concern about how to effectively communicate the proposal so it is not misconstrued.

Table 20:

- ***To effectively communicate and market to key stakeholders both what FPAR is <u>not</u> as well as what it is; an initiative to increase patient safety, quality of care, access to healthcare, and cost effectiveness.***
- Use data of autonomy within their organization or practice. Rely on existing models that are successful both at third-party payer level as well as at the functional PA/MD level (practice level).
- AAPA markets to physician leadership organizations, hospital management groups (AMA, MGMA, AMGA) to define and clarify what FPAR is and is not.
- Identify and communicate what the direct benefit of FPAR is to PAs on their individual practice level.

Table 21:

- ***Gather data regarding whether the proposal would be helpful (look at 22 states ENP Individual Practice, other clinicians).***
- ***Use the data gathered to guide discussion.***
- Better communication with external groups; transparency regarding that to guide discussion.
- Change to modernization of practice, not full practice rebranding.
- Stop comparing ourselves to NPs with this. What is in the best interest for the public instead?
- Most PAs are unaware that this is going on (poor response rate)

Table 22:

- ***We like the logo PA "partners in medicine."***
- ***Consider changing the name of FPAR to something less alienating and aggressive in order to express the true intent of collaboration over independent practice.***
- Don't propose it.
- Focus on patient care and access.
- Good for the practice, removes one more barrier.
- Impact on cost of delivery of healthcare.
- Not seeking independent practice – collaboration is most important.
- Change FPA to another name because it misleads.

Table 23:

- ***Tailor the message to the specific stakeholders/audience to decrease threat and emphasize the benefits.***
- Rename the issue - this is too harsh, bold.
- Consider this as a spectrum or journey, not a "now do this!" mentality.
- Reword the #2 issue to not sound like independence if you don't mean it.

Other Input from Individuals

- People have been saying today that they are concerned about new grads practicing safely with FPAR. But if we are saying that PAs and MDs already collaborate (i.e. are not supervised) then why would anything be different for new grads? New grads should still have the support and collaboration of other providers to practice safely even with FPAR. (P.S. I am a new grad!)

- Define how FPAR would promote autonomous self-governance and differentiate it from independent practice.

- What work has been done to look at the cost of implementing FPAR, federally, locally, etc.?

- Gather real data to supplement low quality survey data.

- This whole discussion was how to move forward, but no one even asked if we should move forward. I don't think we should, and I think you should have asked us.

- My concern is the perception that "Full Practice Authority" would negate the "Team-Based Practice" that the PA profession has been founded on. It has been a successful model at its core.

- Data from existing successful models both at third-party payer level as well as at the functional PA/MD level (practice level).

- Would like to see data on those states with NP practice ratio of NPs/PAs before/after law changes to independent practice.

- Instead of doing away with relationship MD/PA #2 = independent practice, can we not make easier arrangements? Like Facebook as example of a quick, easy development of reasonable relationships.

- Consideration must be given to the impact on reimbursement:
    - Will this result in physician loss of revenue?
    - Will this result in how PA and MD gets reimbursed?

- FPAR is NP language and triggers a visceral response in stakeholders:
    - Maybe responsibility in professional PA practice.
    - Maybe professional PA practice – I would focus on "professional"

- Change the language - it's confusing and implies independent practice. We cannot afford to alienate ourselves from our team partners – the physicians.

- Thank you to the task force for your hard work and dedication in advancing the profession and listening!

- The data provided by AAPA has numerous flaws and represents only a small portion of the PA universe. New policies for FPAR will negatively impact PA education. Agree there is a problem.

- Reconsider pushing forward with a separate PA board and rather focus on a PA-dominated subgroup under the board of medicine in order to better utilize resources and prevent opening up state licensing issues.

- Insurance reimbursement – payers will advocate for FPAR so they can reduce reimbursement and justify it, just on the wrongful idea that PAs should be reimbursed less. Address reimbursement first!

- FPAR is independent practice so just call it that. Physicians practice team-based care but every doctor I know would say they are independent practitioners. One practices alone but can still be independent.

- Changes that would be used to occur in the education system to prepare new PAs for full practice authority. Concern that FPAR will threaten the proportionality of the profession.

- NPs do not have mobility. Mobility of the profession will it still be a “hallmark” of the profession?

- Why are we concerned about the opinions of other professions when no other professions has worried about the opinion of PAs or AAPA has on the advancement of their professions?

- Mandating that PAs be reimbursed individually so can extrapolate data to move forward with accurate data.

- The poor execution of the data gathering has caused mistrust among many stakeholders.

- Sharing the stakeholder analysis would be beneficial! What is the urgency for each stakeholder? How does FPAR solve that urgency?

- The FPAR proposal focuses on PA employment with little, if any focus on assuring quality of care for patients.

- Regarding new grads and specialty changes – need thought on oversight, logistics and infrastructure in monitoring onset of increased practice authority for these two groups.

- “Accountability” is a better word than “Authority”

- EPAs - bridge educational outcomes to those in practice. Allows for easier transition between specialties.

- The program must conduct and document a summative evaluation of each student within the final four months of the program to verify that each student is prepared to enter clinical practice. The ARC-PA expects that a program measures if the learner has the knowledge, interpersonal skills, patient care skills, and professionalism required to enter clinical practice.