Report of the Joint Task Force on the Future of PA Practice Authority

March 2017
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Report of the Joint Task Force on the Future of PA Practice Authority
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Background
In July 2016, AAPA’s Board of Directors and House Officers appointed a Joint Task Force on the Future of PA Practice Authority (JTF) to make a recommendation with regard to the disposition of Resolution A-08-2016; help AAPA better understand the range of issues involved; document the current statutory, legislative, and operational context of the issues; identify options and opportunities; and make AAPA policy recommendations to the Board of Directors and the House of Delegates. (See Appendix A: Charge to the Joint Task Force on the Future of PA Practice Authority.)

The members of the JTF were:

Chair: Jeffrey A. Katz, PA-C, DFAAPA, North Carolina
David Bunnell, PA-C, Maryland
Scot Burroughs, PA-C, Iowa
Alan Bybee, PA-C, DFAAPA, CPAAPA, Utah
Bob Cummings, PA-C, DFAAPA, Wyoming
Leslie Milteer, MPAS, PA-C, DFAAPA, Minnesota
Marc Moote, MS, PA-C, Michigan
Todd Pickard, MMSc, PA-C, DFAAPA, Texas
Brian Sady, MMSc, PA-C, Nevada
Beth Smolko, MMS, PA-C, Maryland
Mark Zender, MPAS, PA-C, New York

Serving as staff advisers to the task force were Ann Davis, MS, PA-C, and Lois Fu, MPP. Lisa Harlow provided administrative and advisory support to the task force.

Initial Work of the JTF
The JTF met in person and by phone in October 2016. It released a draft proposal in November 2016 and requested feedback from the broad community of PAs and PA students. The proposal included the following four components:

- 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 of PAs, to license, regulate, and discipline PAs.
- Ensure that PAs are eligible to be reimbursed directly by public and private insurance.
The proposal, along with the feedback received, was shared on a webpage [http://news-center.aapa.org/fpar/] devoted to this issue, which was open to both AAPA members and nonmembers. In addition, the JTF undertook a review of the relevant literature and sought input from PAs, PA students, AAPA constituent organizations, several physician organizations, and others on the implications to PAs of the changing healthcare provider marketplace. This information was also shared on the webpage, as well as through other communications channels.

Feedback on Initial Draft JTF Proposal

As noted in the tables below, a significant majority of people who commented on social media (Huddle and Facebook) or emailed to fparfeedback@aapa.org expressed support for the JTF proposal, which the JTF called “Full Practice Authority and Responsibility” (FPAR).

### Huddle Feedback - Counts of Individuals

**As of March 9, 2017**

<table>
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<tr>
<th>Month</th>
<th>Support</th>
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<th>Concerns</th>
<th>Questions Only</th>
<th>Neutral</th>
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<td><strong>7</strong></td>
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<tr>
<td><strong>Percent</strong></td>
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<td><strong>18%</strong></td>
<td><strong>17%</strong></td>
<td><strong>2%</strong></td>
<td><strong>4%</strong></td>
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### Facebook Feedback - Counts of Individuals

**As of March 9, 2017**

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<th>Support, with concerns/questions</th>
<th>Concerns</th>
<th>Questions Only</th>
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<tr>
<td><strong>Percent</strong></td>
<td><strong>68%</strong></td>
<td><strong>8%</strong></td>
<td><strong>14%</strong></td>
<td><strong>7%</strong></td>
<td><strong>3%</strong></td>
<td><strong>100%</strong></td>
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In January 2017, a survey was conducted on behalf of the JTF by the AAPA Research department. The survey was available from January 12 through February 1, 2017, and was open to PAs, PA students and retired PAs for whom AAPA had valid email addresses. The survey was sent to 102,101 individuals, and a total of 12,485 individuals completed at least some portion of the survey (12.6% response rate). The overall margin of error for the survey was +/-0.83 at the 95% confidence level.

A significant majority of survey respondents (71%) expressed overall support for the proposal, with 13% opposed and 16% undecided. In its original form, the JTF proposal included four components, and survey respondents were provided the opportunity to express their support or opposition to each component. The vast majority of respondents expressed support for a continued commitment to team-based practice (96%) and for ensuring that PAs are eligible to be reimbursed directly by public and private insurance (93%). A slightly smaller majority (79%) of respondents said they supported establishing autonomous state boards, with a voting membership comprised of a majority of PAs, to license, regulate, and discipline PAs. And a still smaller majority (63%) said they supported eliminating 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, with 17% of respondents saying they had not yet formed an opinion on that component of the proposal.

A review of factors that might have an impact on respondents’ views about the last component found that:

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• There were no statistically significant differences between PAs practicing in primary care versus other specialties with regard to their view on eliminating laws and regulations requiring a supervising, collaborating, or other specific relationship with a physician.
• Years of experience as a PA was not associated with large differences in support for or opposition to the elimination of laws and regulations than requiring a supervising, collaborating, or other specific relationship with a physician. Late-career PAs were slightly more likely than students or other PAs to say they support the elimination of supervisory agreements. Students were least likely to oppose the elimination of supervisory agreements, and they were most likely to say they had not yet formed an opinion.
• The number of Key Elements in their state practice law was not associated with a large difference in PA support for eliminating laws and regulations requiring a supervising, collaborating, or other specific relationship with a physician.
• PAs who work in states where NPs have full practice authority (68%) were more likely than PAs who work in states where NPs do not have full practice authority (62%) to support the elimination of laws and regulations requiring a supervising, collaborating, or other specific relationship with a physician.
• PAs who have personally experienced NPs being hired over PAs due to supervisory requirements were almost twice as likely to support the elimination of laws and regulations requiring a supervising, collaborating, or other specific relationship with a physician. Seventy-eight percent of PAs who have experienced preferential NP hiring supported the elimination of PA supervisory agreements, compared to 40% of PAs who have not personally experienced preferential NP hiring.

Several important points emerged from the feedback received from PAs and PA students, including comments provided on the survey, Huddle comments, letters and emails from constituent organizations and individual PAs, as well as feedback from more than 220 PAs at AAPA’s Leadership and Advocacy Summit in early March. Among the key take-aways were:

• PAs should not be disadvantaged in the healthcare provider marketplace.
• The proposal must be distinguished from “independent practice” and NP’s “full practice authority”, in both name and content.
• The proposal must communicate that PAs highly value PA-physician teams, even as we seek to eliminate the burdensome paperwork and liability issues involved in state-required supervisory agreements.
• The proposal must recognize and reflect an understanding of PAs who are early career and those PAs who are in specialty practice or changing specialties.
• The proposal must offer each state the flexibility to adapt to the political and marketplace environment in the state and to move forward at its own pace.

3 For a description of the Six Key Elements, please see https://www.aapa.org/wp-content/uploads/2016/12/Issue_Brief_Six_Key_Elements.pdf
The JTF also sought feedback from several physician organizations, including the American Medical Association (AMA), the American Osteopathic Association, and the American Academy of Family Physicians. The objective was to have an opening conversation about the issues facing PAs in the marketplace and the JTF’s initial thinking about ways to address those issues, as well as to develop a plan for continuing dialogue. The JTF representatives emphasized that the JTF proposal is not an AAPA policy and did not request an endorsement. While communication is ongoing, the initial discussions were well received, and several themes emerged:

- While recognizing changes in the healthcare landscape, they were unaware of the challenges PAs face in the current marketplace.
- They appreciated the outreach and understood the need for the PA profession to plan for its future.
- They expressed support for the PA profession.
- They expressed a willingness to consider the issues raised and engage in a continued dialogue as the PA profession moves forward.

The JTF Proposal: Optimal Team Practice

As a result of the input and feedback received, the JTF modified its proposal. Rather than stand-alone policy statements, the JTF recommended modifications to AAPA’s Guidelines for State Regulation of PA Practice (Guidelines). (See Appendix B: Proposed Changes to Guidelines.) This document more clearly articulates both the intent and practical implications of the JTF recommendations, and will facilitate translation of policy into Model State Legislation. Furthermore, the Guidelines clearly recognize that a state’s unique political and healthcare climate may require modification of some provisions, and offers state constituent organizations the freedom to craft and promote alternative provisions.

The final JTF proposal for “Optimal Team Practice” emphasizes the PA profession’s desire to continue to work closely in teams with physicians, while relieving PAs, physicians, and employers from the burdens imposed by unnecessary requirements to have or report a specific relationship with a physician or group of physicians in order for the PA to be able to practice. The JTF is not proposing independent practice, and offers the following definitions to clarify the distinction between “independent practice” and the JTF proposal for Optimal Team Practice:

- **Independent Practice:** Practice without the benefit of physicians or other providers for collaboration, consultation, referral, or team-based care.
- **Optimal Team Practice:** Practice with access to physicians and other qualified medical professionals for collaboration, consultation, and referral, as indicated by the patient’s condition and consistent with the standard of care, and in accordance with the PA’s education, training, and experience.

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4 A report on outreach to physician groups can be found on the News Center page under the “Outreach to Physician Groups” tab.
The JTF also refined its recommendation regarding the creation of a majority-PA board to oversee PA licensing and discipline to reflect concerns raised about the potential cost of creating a completely autonomous state PA board. The proposal now expresses a strong preference for an autonomous board composed of a majority of PAs, but also acknowledges that regulation of PAs may be administered by a multidisciplinary healing arts or medical board and strongly recommends that PAs and physicians who practice with PAs be full voting members of the board.

Finally, in keeping with the strong support for ensuring that PAs are eligible for direct reimbursement by both public and private payers, the JTF recommends that this be included in the Guidelines and in the subsequent version of the Model State Legislation. This recommendation is consistent with current AAPA policy, but its inclusion in state laws and regulations will help ensure that services provided by a PA can be billed under the PA’s name and NPI. This will allow the services provided by PAs to be measured and attributed to PAs in the key databases used by government agencies, employers, and insurers to set payment policies, assess quality, and conduct other policy-related research.

**Trends Driving the JTF Recommendations: PAs in a Changing Healthcare Provider Marketplace**

It is the strong view of the JTF that AAPA must refuse to let PAs be disadvantaged in the marketplace. Over the past 30 years, the healthcare provider marketplace has changed substantially. Notably, two trends are significantly affecting PAs’ ability to effectively compete for high-quality jobs in which they can fully utilize their education, experience, and competencies: Fewer physicians are employers and NPs are gaining ground as independent practitioners.

**Fewer Physicians Are Employers.** When the PA profession was created 50 years ago, physicians were likely to be solo or joint practice owners. As owners, physicians saw multiple benefits from hiring and entering into supervisory agreements with PAs. Such agreements not only reduced the day-to-day burdens on the physician-owner to provide patient care and coverage of call, but also allowed the practice to care for a larger number of patients at a lower cost than if another doctor were added. Although these physician-owners may have been burdened with higher potential liability due to the supervisory agreement with the PA, this was offset by the financial benefits of additional profits generated by the PA.

Over the last 30 years, however, market forces and government policies have changed the incentives for practice ownership. Muhlestein and Smith (2016) identified at least three factors that are contributing to the trend toward larger practice groups and hospital ownership. First,

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5 See AAPA HP 3600.1.1 – HP 3600.1.5
they cite the strong incentive created by financial and administrative costs associated with the adoption of electronic medical records necessary to comply with meaningful use requirements under Medicare. These costs, they argue, tend to be more than smaller practices can bear; the economies of scale gained by larger practices and hospital ownership make these options financially viable. Second, the movement toward population-based contracting arrangements (i.e., Accountable Care Organizations) and fee-for-value payment arrangements are driving physicians to become part of a larger group practice in order to aggregate the number of patients necessary to protect against loss. Finally, they cite evidence\(^7\)\(^8\) that younger physicians tend to prefer working in larger, rather than smaller, group practices, and older physicians in smaller practices are moving out of the workforce.

Using the AMA’s Physician Practice Benchmark Surveys as their data source, recent studies\(^9\) (Kane et al., 2015) have documented a significant decline in the percentage of physicians who are owners of their practices, down from 76% in 1983 to 51% in 2014. This decrease is related to two phenomena: an increase in practice size and an increase in hospital ownership of physician practices. In 1983, 80% of physicians worked in practices with 10 or fewer physicians; by 2014, that number had fallen to 61%. Solo practice fell from more than 40% of physicians in 1983 to less than 20% in 2014. At the same time, the percent of physicians who work in practices owned by hospitals has increased substantially. While detailed data on practice ownership structure is not available for 1983, other research suggests that only 16% of physicians worked directly for a hospital or in practices that were partially or wholly owned by a hospital in 2007-2008. By 2014, that number had more than doubled to 33%. Other studies corroborate this trend. Using data from an annual survey of approximately 75% of U.S. office-based physicians conducted by SK&A, Baker et al.\(^10\) (2016) found that the number of physicians who reported being part of a hospital-owned practice increased from 31,710 in 2008 to 105,538 in 2012 — a 230% increase in just four years. The author’s analysis of the American Hospital Association’s annual survey of all U.S. hospitals suggests that this trend may be even more pronounced, most likely because the SK&A survey samples only office-based physicians.

Finally, the 2016 Medscape Physician Compensation Report\(^11\), which is based on responses from more than 19,200 physicians in over 26 specialties, found a gender difference in employment. Among male physicians, 35% were self-employed, and 59% were employed by hospitals or other practice-owner; among female physicians, only 23% were self-employed, while 72% were employed by hospitals or other practice owners. As a greater percentage of physicians are female, the trend toward physicians as employees can be expected to increase.

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\(^8\) Harris, G. “Family physicians can’t give away solo practice” New York Times 2011 April 22.

\(^9\) Kane, Carol K. “Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership” AMA Economic and Health Policy Research, July 2015.

\(^10\) Baker, Laurence C, M. Kate Bundorf, Aileen M. Devlin, and Daniel P. Kessler. “Hospital Ownership of Physicians: Hospital Versus Physician Perspectives” Medical Care Research and Review 1-12, October 3, 2016.

These dramatic changes in practice ownership mean fewer physicians — who are now employees rather than employers — are able to take advantage of the financial benefits that accrue to a medical practice that employs PAs because they do not share in the overall profits generated by the practice. Yet if a physician agrees to enter into the supervisory agreement now required by states for PA practice, the physician will still incur the potential malpractice liability that accompanies that agreement. Unless they are compensated by their employers for the added liability exposure and other burdens associated with PA oversight, physicians are increasingly unwilling to enter into such agreements, particularly if they can work with NPs, who are not required to have such agreements.

**NPs Are Gaining Ground as Independent Providers.** Over the same period that incentives for physicians to enter into supervisory agreements with PAs have been declining, NPs have been gaining ground as independent providers. Beginning in the 1970s, states began to change their laws to permit PAs and NPs to prescribe drugs under physician supervision. Today, thanks to the advocacy efforts of AAPA and its state constituent organizations, every state permits PAs to do so. Beginning in 1999, however, some states began to permit NPs to practice and prescribe without physician supervision or supervisory agreements. Today 22 states and the District of Columbia give NPs full practice authority, permitting NPs to evaluate patients, diagnose, order and interpret diagnostic tests, and initiate and manage treatments — including prescribe medications — under the exclusive licensure authority of the state board of nursing and without a requirement for physician supervision or collaboration.13

**PAs Are Being Disadvantaged in the Marketplace.** Relatively little research has been done on how the shifts in physician practice ownership and changing NP practice laws are affecting PA hiring practices. However, several studies and the recent JTF survey of PAs shed some light on this issue.

In a recently published article, Pittman et al.14 (2016) describe the results of structured interviews with a stratified sample of CEOs of community health centers (CHCs) intended to shed light on what factors influence their medical staff configurations. Specifically, the authors investigated the factors in the decisions about the choice and balance of providers (physicians versus NPs and PAs). The authors found that scope of practice laws are important in hiring decisions. Specifically, they found:

- Although about half of the CHCs in the sample were in states that allow NPs to practice independently of physicians, across all sites (regardless of practice laws), the CEOs

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12 AK, AZ, CO, CT, HI, ID, IA, MD, ME, MN, MT, ND, NE, NH, NM, NV, OR, RI, SD, VT, WA, WY
“agreed that the scope of practice laws [for NPs and PAs] were too restrictive and burdensome.”

- The CEOs considered scope of practice regulations “as a factor in choosing between [NPs and PAs].”
- Insurance company payment policies regarding reimbursement for nursing services affects CEOs’ decisions regarding staffing choices.

Notably, the CEOs “did not perceive the decision to hire MAs, NPs, or PAs as a function of physician shortages; they valued NPs and PAs for the different qualities they brought to a practice.” This finding, according to the authors, “contrasts with the dominant portrayals of [NPs and PAs] as substitutes for physicians or ‘physician extenders.’” In fact, they observe that “No respondent described NPs and PAs as ‘second best,’ to be hired only when a CHC is unable to attract physicians.”

In the survey of PAs and PA students\(^{15}\) conducted at the request of the AAPA JTF on PA Practice Authority, respondents were specifically asked whether they had “personally experienced NPs being hired over PAs due to supervision requirements.” Of the more than 12,000 individuals who responded to the survey, more than 45% reported that they had personally experienced this situation, which suggests that the many anecdotes relating these experiences are indicative of a fairly prevalent phenomenon. PAs whose current primary place of employment is in a state where NPs have full practice authority were more likely than PAs in other states to report that they had personally experienced NPs being hired over PAs due to practice authority differences (53% vs. 42%).

Not surprisingly, PAs who had personally experienced NPs being hired over PAs because of the supervision requirement were almost twice as likely to agree (71%) that state law should not require PAs to have a specific, identified relationship with a physician in order to practice, compared to those who had not had that experience (39%).

The question has also been asked whether PAs living in states with more of the Six Key Elements of a Modern PA Practice were less likely to support the FPAR proposal, since they might perceive that the Key Elements are sufficient. An analysis of the survey data suggests that this is not the case. In fact, the survey found no statistically significant difference in the percentage of respondents who supported the FPAR proposal among PAs living in states with one to two Key Elements (71% support), three to four (73% support), or five to six (71% support). Specifically, with regard to the proposal to 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, states with more Key Elements were slightly more likely to support the proposed change (64% of those in states with four to six Key Elements,

65% of those in states with three to four Key Elements, and 61% of those in states with one to two Key Elements).

**Implications of Optimal Team Practice**

Because there are no states where PAs can currently practice without a supervisory, collaborating, or other agreement with a physician, data specific to PAs that would allow researchers to examine the effect of such laws is not available. However, it is reasonable to examine and draw implications from studies that have been conducted about the effects of laws that permit NPs to practice without such agreements (often called NP full practice authority laws).

**Implications for Malpractice Premiums and Rates of Malpractice.** Information provided by AAPA’s malpractice insurance partner, CM&F Group Inc., indicates that NP malpractice premiums are not established based on the degree of NP practice authority in the state and that PA insurance premiums are unlikely to change in the next few years even if PAs obtain expanded practice authority in a state. They note, in fact, that “Premiums might actually decrease for PAs if more PAs buy individual malpractice insurance. Today, most PAs have coverage through their employer; only about 4,000 PAs purchase their own individual liability policies. Insurance premium rates are to some extent based on strength in numbers; the more who buy insurance, the more you can spread the risk.”

CM&F estimates that only about 4,000 PAs currently purchase an individual malpractice policy. Most PAs rely on employer-provided malpractice insurance, and “there is no reason to think that employers will stop providing liability coverage for their PA employees” if PA practice authority is expanded or otherwise modified. CM&F has assured AAPA that it will continue to offer liability insurance products to meet PA needs, regardless of any changes.

According to CM&F, physicians have historically paid the highest malpractice premiums, typically about 10 percent of their income. NPs have historically paid lower malpractice insurance premiums than PAs because of the very large pool of nurses who buy individual insurance. However, over time, NP premium rates are coming into line with PA premium rates. CM&F notes that the average policy for a full-time PA in primary care is approximately $4,000 per year, or about 4.4% of the mean PA salary. Most PAs purchase $1 million in liability protection, but lower and higher coverage options are available. CM&F also offers a new graduate liability policy that starts at just $300 per year.

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A recently published study by McMichael et al. (2016) analyzed whether and to what extent there is a connection among scope-of-practice laws, malpractice reforms, and physician malpractice occurrence rates. Similar to PAs, NPs may be sued by patients just as physicians may be sued. As the authors explain, while physicians are responsible for their own malpractice liability across all 50 states, the same is not true of NPs. NPs (and PAs) can be held directly liable for malpractice just like physicians, but NPs may pass a substantial portion of their liability to their supervising physicians in states that require supervisory agreements. The authors note that because legal theories of liability “generally require plaintiffs to show some level of supervision or control, plaintiffs will be more likely to succeed on a claim against a physician when state SoP [scope-of-practice] laws require a greater degree of physician involvement in an NP’s practice. Therefore, depending on a state’s SoP laws, physicians may find themselves defending lawsuits and making damages payments for errors they did not commit. ... a state law requiring physician supervision of an NP’s practice is not necessary to prove negligent supervision, but such a law will significantly ease a plaintiff’s legal burden in establishing her case.”

The authors used national longitudinal data to examine the effect of physician supervision requirements for NPs on physician malpractice claims. Because a number of states changed their NP scope-of-practice laws between 1999 and 2012, the authors were able to create a natural experiment to test the effect.

Using a two-way fixed effects regression model, the authors found that “the physician malpractice rate [defined as the number of malpractice payments made per practicing physician] in states allowing NPs to practice independently is 31% lower than the rate in states that require complete physician supervision in the absence of tort reform. Similarly, the physician malpractice rate in states requiring only that physicians supervise NPs when they are prescribing medications is 26% lower relative to states that require complete physician supervision” in the absences of tort reform. Based on their analysis of the effect of tort reform on physician malpractice rates, the authors further conclude that “allowing NPs to practice with greater independence is associated with more than twice the reduction in physician malpractice rates than is enacting a noneconomic damages caps or JSLR [joint and several liability reform].”

A 2016 study by Brock et al. used regression analysis to compare trends in malpractice awards and adverse actions (e.g., revocation of license) using 2005-2014 data from the National Practitioner Data Bank. Noting that “PAs must practice under the supervision of a physician, while in many states, NPs may practice with autonomy,” the authors, nevertheless, found that “across the past 10 years, there has been a significant decrease in the rate of malpractice

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Implications for Patient Outcomes, Costs and Access. Numerous studies have documented that PAs provide high-quality patient care and are cost-effective medical providers. The question that has been raised is whether such high-quality patient care depends on continuing to operate under supervisory agreements with physicians. Like other issues, this question cannot be answered empirically utilizing data on PA patient care because all PAs are currently required to have such agreements in order to practice. However, one can reasonably draw inferences about likely effects of implementing PA full practice authority and responsibility based on studies comparing the outcomes, costs, and other effects of NPs practicing in states that require physician supervision versus those practicing in states that do not require physician supervision. In addition, some studies use differences in scope of practice laws for PAs (i.e., prescription authority) to estimate the effects on patient outcomes, costs, and access. This section reviews such recent research studies.

A 2015 RAND report that reviewed the then-available literature on the effect of changing NP scope-of-practice laws from restrictive to full practice authority summarized the results of the literature assessment. Table 2.1 of the report, shown below, provides an overview of its conclusions.

Since 2015, however, several additional research studies on the topics of patient outcomes, access, and cost have been published. The results of those studies are discussed in the sections that follow.

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**Patient Outcome Implications.** Seeking to fill a void in the research base, Kurtzman et al. \(^{21}\) (2017) used patient care and outcome records for randomly selected physicians, NPs, PAs, and nurse midwives practicing at 104 community health centers between 2006 and 2011. They modeled nine outcomes, including three quality measures \(^{22}\), four service utilization measures \(^{23}\), and two referral pattern measures \(^{24}\). Highlights of the study findings include the following:

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\(^{22}\) Quality measures included number of patients who received smoking cessation counseling (nicotine replacement therapy or medication ordered, supplied, administered, or continued and/or smoking cessation counseling) per visit by adults who were identified as smokers; number of patients for whom antidepressants were ordered, supplied, administered, or continued and/or psychotherapy or mental health counseling per visit by adults with depression: statin for hyperlipidemia ordered, supplied, administered, or continued per visit by adults with hyperlipidemia.

\(^{23}\) Service utilization measures included physical examination (binary); total number of health education/counseling services (count); imaging services (binary); and total number of medications ordered, supplied, administered or continued (count).

\(^{24}\) Referral pattern measures included return visit at a specified time (binary) and physician (MD) referral (binary).
• Since economic theory suggests that if restrictions on scope of practice are effective in protecting consumers from suboptimal care, one would expect patients who see NPs in states with more restrictive scope-of-practice laws to receive higher quality of care than those who see NPs in unrestricted states. The findings of the study did not support that hypothesis. NP independent scope-of-practice laws had no statistically significant effect on any of the three quality indicators.

• There was a positive relationship between NP independence and service utilization measures, which the authors conclude lend support to the theory that “guild [physician] efforts to persuade states to limit entry into specific professions [are] for the benefit of those in the guild profession and at the expense of the public.”

• Independent prescriptive authority was associated with an increase in the number of medications, suggesting that “restrictions — which, in some states, require NPs to obtain physician co-signatures on prescriptions — might prove sufficiently burdensome to change these practitioners’ prescribing habits.”

• NP practice independence was associated with an increase in the odds of receiving a physician referral. The authors speculate that this finding could simply reflect differences in patient’s medical complexity, the lack of a supervising physician with whom the NP could informally confer, or NP concerns about liability and/or malpractice incentivizing NPs in independent practice states to refer at higher rates.

The authors conclude that the “Study findings — which did not demonstrate a scope of practice-quality effect — do not substantiate the use of restrictions for the sole purpose of consumer protection.”

A 2014 study (Kleiner et al.) found that more restrictive scope-of-practice laws have “no noticeable effect on the quality of service” provided by NPs, as measured by infant mortality and malpractice insurance premiums.25

**Healthcare Costs and Access to Care Implications.** A 2014 study (Strange) found “little evidence that increases simply in the number of PAs and NPs have improved healthcare access” but shows that when expanded scope of practice is accounted for, there is “some evidence that access has improved.”26

More recently, Timmons27 (2016) matched Centers for Medicare and Medicaid Services data from 1999 to 2012 with state regulatory information on NPs and PAs to examine the effect of expanded scope of practice of NPs and PAs on access to healthcare for Medicaid patients.

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Using multiple regression analysis, Timmons found “consistent evidence that expanded scope of practice for PAs is associated with lower outpatient claims [costs] per Medicaid beneficiary” and that the “reduction in cost is quite large ($109-$133).” Timmons concludes that “the results of this paper, combined with findings of other researchers, suggest that broader scope of practice for NPs and PAs has little effect on the quality of care delivered, increases access to health care, and also potentially reduces the cost of providing health care to patients.” More generally, he notes that “broadening the scope of practice of nonphysician healthcare providers ... is very likely to improve consumer welfare.”

A naturally occurring experiment allowed Liu et al.\(^28\) to examine the effect of imposing more stringent physician oversight requirements on PAs and NPs. In 2008, Kaiser Permanente changed its practice (in effect from 2006 to early 2008) of allowing NPs and PAs to manage a patient panel and removed NPs and PAs from all face-to-face primary care in Georgia. Using regression analysis to analyze 2006-2008 patient utilization data compared with 2008-2010 patient utilization data, the authors estimated the incremental benefit of adding NPs and PAs to existing physician clinics. The study found that “greater NP/PA use in primary care visits ... was not associated with higher specialty referrals, advanced imaging, ED [emergency department] visits, or inpatient stays.”

**Implications for New Graduates and Early Career PAs.** As medical providers, PAs are trained at the graduate level in programs modeled after medical school curricula, which include more than 2,000 hours of clinical rotations. They are nationally certified and state-licensed providers who practice medicine — they diagnose, write prescriptions, order and interpret tests, treat patients, and assist in surgery. As a profession, PAs are uniquely equipped to play a leading role in the new healthcare paradigm focusing on the quality of outcomes, not simply on the number of medical services provided. PAs practice team-based care, make prevention as important as treatment, and help keep healthcare costs down.

Under the proposed policy, new graduates and early-career PAs, as well as PAs who are switching specialties, would continue to practice in teams with physicians, and, like every PA, their scope of practice would be determined at the practice level. Regardless of whether a PA is early career, changing specialty, or simply encountering a condition with which they are unfamiliar, the PA is responsible for seeking consultation as necessary to assure that the patient’s treatment is consistent with the standard of care. It is not necessary or helpful to require that a PA enter into a formal supervisory agreement with a single physician or group of physicians, because such requirements can negatively affect team flexibility and therefore limit patient access to care without improving patient safety. Further, supervisory agreement requirements put all providers involved at risk of disciplinary action for paperwork infractions that are unrelated to patient care or outcomes.

Implementation Considerations

The JTF has identified a number of issues related to implementation, should the proposed JTF policy be adopted, and offers the following ideas for AAPA consideration.

Communicating With Physicians and Physician Organizations. While the JTF believes that the policy language regarding team-based patient-centered practice in teams that include physicians will provide assurance to individual physicians and physician organizations that PAs want and intend to continue practicing in teams, some may be concerned that physicians will reject this proposal as “PAs seeking independent practice.” Therefore, should the JTF recommendations become policy, AAPA should develop explanatory materials for PAs to use as they speak with physician colleagues, practice administrators, and physician organizations with whom they may interact.

Meeting the Needs of Early-Career PAs. We understand that Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), Physician Assistant Education Association (PAEA), and individual PA programs may be concerned that there is a need for additional restrictions on early-career PAs despite policy language that explains each PA’s obligation to assure that he or she has access to physicians and other qualified providers for collaboration, consultation, and referral, as indicated by the patient’s condition and consistent with the standard of care, and in accordance with the PA’s education, training, and experience. To address this concern, AAPA should work closely with ARC-PA and PAEA to ensure that PA programs, preceptors, PA students and new graduates, and employers understand the expectation that early-career PAs will need to work closely with physicians and experienced PAs to gain the clinical experience that is critical to success.

Federal Advocacy Requirements. In addition to changes in state law, AAPA will need to address changes in federal laws and regulations that have historically relied on state laws. For example, while Medicare authorizes delivery of services by a PA who is licensed as a PA by a state, it still requires a PA to have a “supervising” physician in order to be reimbursed. Given the 2016 modifications to the AAPA Guidelines for State Regulation of PAs and the subsequent enactment of state laws that define the relationship between PAs and physicians as something other than supervising (i.e., “collaborating” or “participating”), this Medicare provision will need attention regardless of whether Optimal Team Practice is adopted as AAPA policy.

Advocacy Support. To the extent that AAPA, state chapters, and other constituent organizations are already pursuing changes to PA practice acts and government regulations (at both state and federal levels), pursuit of the changes recommended by the JTF may substitute for already planned advocacy-related activities. If AAPA, state chapters, and other constituent organizations seek to change laws and regulations more rapidly, additional resources may be required for advocacy efforts. AAPA should explore the need for and feasibility of new avenues for advocacy support to pursue Optimal Team Practice.
Changes to Related AAPA Policy. The JTF has identified numerous other AAPA policies that include language inconsistent with Optimal Team Practice. (See Appendix C: AAPA Policy Related to Optimal Team Practice.) If Optimal Team Practice is adopted as AAPA policy, the House Officers may want to consider accelerating the review of these policies (rather than wait until each is up for 5-year review) in order to reduce the potential for confusion.
APPENDIX A

Charge to the Joint Task Force on the Future of PA Practice Authority

BACKGROUND:

As discussed by the Board at its October 2015 retreat and reiterated in the AAPA strategic plan, one critical issue facing the profession is PA practice authority. As described in the strategic plan, “PAs practice medicine in collaboration with other members of the healthcare team; however, there is a wide spectrum of clinical autonomy in PA practice, depending on specialty and setting. As other professions in healthcare strive for and attain independent practice, some believe the PA profession should attempt to sever any legal link with physicians.” In addition to the AAPA’s Model State Legislation, as well as the recently approved Guidelines for State Regulation of PAs provide a foundation for continued and substantial progress in this area. As well, the House of Delegates recommended further study of the issue of full practice responsibility, referring resolution 2016-A-08 at its May 2016 meeting.

The Task Force on the Future of PA Practice Authority is intended to help AAPA better understand the range of issues involved; document the current statutory, legislative, and operational context; identify options and opportunities; and make AAPA policy recommendations to the Board of Directors and the House of Delegates.

OBJECTIVE:

To consider and make a recommendation to the Board of Directors and House of Delegates with regard to the following foundational questions:

Should AAPA go beyond its current position that:

• PAs should be able to practice autonomously; and
• Individual state COs may pursue full practice authority/full practice responsibility/independent practice for PAs?

If so, what should that practice authority be called, and how should it be defined and described?

For the purpose of understanding this objective, the Task Force is asked to define or redefine terms, as it deems necessary.

SPECIFIC CHARGES:

1. Consistent with the findings and recommendations of the Task Force, develop a resolution and accompanying rationale for the Board of Directors to consider prior to the May 2017 House of Delegates meeting and for the House of Delegates to consider at the May 2017 House of Delegates meeting.
2. In developing its report and recommendations, the Task Force should:
   a. Understand and document the current federal, state, and employer context of the practice authority of PAs, APRNs, and other relevant healthcare providers.
   b. Obtain input and/or feedback from PA stakeholders.
   c. Develop or select appropriate terms and definitions for different types of PA practice authority.
   d. Consider and describe what, if any, limitations or requirements should be established for PAs under the Task Force’s recommended PA practice authority (i.e., differences for primary care PAs vs. surgical PAs, contingent upon number of years practicing or number of years practicing in a specialty, etc.).
   e. Consider and describe the potential benefits of its recommendations for PAs, patients, PA employers, as well as any potential risks and obstacles that should be taken into account (i.e., malpractice insurance).
EXPLANATORY NOTE: In order to implement its recommendations, the JTF proposed that AAPA’s Guidelines for State Regulation of PAs be modified as indicated below, where red font capitalized text (CAPITALIZED TEXT) indicates insertion and red font strikeout text (strikeout text) indicates deletion.

Guidelines for State Regulation of PAs

Executive Summary of Policy Contained in this Paper

Summaries will lack rationale and background information, and may lose nuance of policy. You are highly encouraged to read the entire paper.

- Inclusion of PAs in state law and delegation of authority to regulate their practice to a state agency serves to both protect the public from incompetent performance by unqualified medical providers and to define the role of PAs in the healthcare system.
- AAPA, while recognizing the differences in political and healthcare climates in each state, endorses standardization of PA regulation as a way to enhance appropriate and flexible professional practice.
- This document discusses key concepts of state regulation.

Introduction
Recognition of PAs as medical providers led to the development of state laws and regulations to govern their practice. Inclusion of PAs in state law and delegation of authority to regulate their practice to a state regulatory body serves two main purposes: (1) to protect the public from incompetent performance by unqualified medical providers, and (2) to define the role of PAs in the healthcare system. Since the inception of the profession, dramatic changes have occurred in the way states have dealt with PA practice. In concert with these developments has been the creation of a body of knowledge on legislative and regulatory control of PA practice. It is now possible to state which specific concepts in PA statutes and regulations enable appropriate practice by PAs as medical providers while protecting the public health and safety.

What follows are general guidelines on state governmental control of PA practice. The AAPA recognizes that the uniqueness of each state’s political and healthcare climate will require modification of some provisions. However, standardization of PA regulation will enhance appropriate and flexible PA practice nationwide. This document does not contain specific language for direct incorporation into statutes or regulations, nor is it inclusive of all concepts generally contained in state practice acts or regulations. Rather, its intent is to clarify key
elements of regulation and to assist states as they pursue improvements in state governmental control of PAs. To see how these concepts can be adapted into legislative language, please consult the AAPA’s model state legislation for PAs.

**Definition of PA**
The legal definition of PA should mean a healthcare professional who meets the qualifications for licensure and is licensed to practice medicine.

**Qualifications for Licensure**
Qualifications for licensure should include graduation from an accredited PA program and passage of the PA National Certifying Examination (PANCE) administered by the National Commission on Certification of PAs (NCCPA).

PA programs were originally accredited by the American Medical Association’s Council on Medical Education (1972-1976), which turned over its responsibilities to the AMA’s Committee on Allied Health Education And Accreditation (CAHEA) In 1976. CAHEA was replaced in 1994 by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). On January 1, 2001, The Accreditation Review Commission on Education for the PA (ARC-PA), which had been part of both the CAHEA and CAAHEP systems, became a freestanding accrediting body and the only national accrediting agency for PA programs.

Because the law must recognize the eligibility for licensure of PAs who graduated from a PA program accredited by the earlier agencies, the law should specify individuals who have graduated from a PA program accredited by the ARC-PA or one of its predecessor agencies, CAHEA or CAAHEP.

The qualifications should specifically include passage of the national certifying examination administered by the NCCPA. No other certifying body or examination should be considered equivalent to the NCCPA or the PANCE.

The NCCPA, since 1986, has allowed only graduates of accredited PA programs to take its examination. However, between 1973-1986, the exam was open to individuals who had practiced as PAs in primary care for four of the previous five years, as documented by their supervising physician. Nurse practitioners and graduates of unaccredited PA programs were also eligible for the exam. An exceptions clause should be included to allow these individuals to be eligible for licensure.

**Licensure**
When a regulatory board has verified a PA’s qualifications, it should issue a license to the applicant. Although, in the past, registration and certification have been used as the regulatory term for PAs, licensure is now the designation and system used in all states. This is appropriate because licensure is the most stringent form of regulation. Practice without a license is subject
to severe penalties. Licensure both protects the public from unqualified providers and utilizes a regulatory term that is easily understood by healthcare consumers.

Applicants who meet the qualifications for licensure should be issued a license. States should not require employment or identification of a supervising, collaborating, or other specific relationship with a physician(s) as a condition or component of licensure. A category of inactive licensure should be available for PAs who are not currently in active practice in the state. If issuance of a full license requires approval at a scheduled meeting of the regulatory agency, a temporary license should be available to applicants who meet all licensure requirements but are awaiting the next meeting of the board.

If the board uses continuous clinical practice as a requirement for licensure, it should recognize the nature of PA practice when determining requirements for PAs who are reentering clinical practice (defined as a return to clinical practice as a PA following an extended period of clinical inactivity unrelated to disciplinary action or impairment issues). Each PA reentering clinical practice will have unique circumstances. Therefore, the board should be authorized to customize requirements imposed on PAs reentering clinical practice. Acceptable options could include requiring current certification, development of a personalized re-entry plan, mandating specific requirements for collaboration or oversight, or temporary authorization to practice for a specified period of time. Although it has not yet been determined conclusively that absence from clinical practice is associated with a decrease in competence, there is concern that this may be the case. Reentry requirements should not be imposed for an absence from clinical practice that is less than two years in duration.

Because of the high level of responsibility of PAs, it is reasonable for licensing agencies to conduct criminal background checks on individuals who apply for licensure as PAs. Licensing agencies should have the discretion to grant or deny licensure based on the findings of background checks and information provided by applicants.

**Collaboration**

The definition of collaboration should convey a process in which PAs and physicians jointly contribute to the healthcare and medical treatment of patients with each collaborator performing actions he or she is licensed to otherwise perform. Collaboration shall be continuous but shall not be construed to require the physical presence of the physician at the time and place that services are rendered. It is imperative, however, that the PA and a collaborating physician have access to each other. Even when practicing in collaboration with a physician, PAs are responsible for the care they provide. Nothing in the law should require or imply that the collaborating physician is responsible or liable for the care provided by the PA unless the PA is acting on the specific instructions of a physician.

Collaborating physician should be defined as an allopathic or osteopathic physician (MD or DO) licensed to practice in the state, who agrees to collaborate with PA(s). For PAs who
practice in federal jurisdictions, collaboration may be provided by a physician (MD or DO) who meets the licensing requirements of the federal agency. Licensure in the state should not be required for federal collaborating physicians if it is not required by the federal agency. In group practice situations or in the hospital or its emergency department, provisions should be made for all staff physicians who so choose to collaborate with PAs who practice in the group or institution.

The guiding principles of team practice must be that it (a) protects the public health and safety, and (b) preserves the PA’s access to physician consultation when indicated. Consequently, it is recommended that the ratio of PAs to collaborating physicians be determined by physician(s) and PAs according to the nature of the services being provided and according to the tenets of good patient care. Language that specifies mandatory ratios of PAs to collaborating physicians should be avoided. In addition, there should be no limit on the number of collaborating physicians each PA may have.

Because the state licenses both physicians and PAs and can discipline or revoke or restrict the license of both types of providers, it is redundant and unnecessary for the law to require physicians or PAs to file notice of collaborative arrangements with an agency.

OPTIMAL TEAM PRACTICE

SINCE THE INCEPTION OF THE PROFESSION, PAS HAVE EMBRACED TEAM-BASED PATIENT-CENTERED PRACTICE AND CONTINUE TO DO SO. BECAUSE BOTH PAS AND PHYSICIANS ARE TRAINED IN THE MEDICAL MODEL AND USE SIMILAR CLINICAL REASONING, PA/PHYSICIAN TEAMS ARE ESPECIALLY EFFECTIVE AND VALUED.

OPTIMAL TEAM PRACTICE OCCURS WHEN PAS HAVE THE ABILITY TO CONSULT WITH A PHYSICIAN OR OTHER QUALIFIED MEDICAL PROFESSIONAL, AS INDICATED BY THE PATIENT’S CONDITION AND THE STANDARD OF CARE, AND IN ACCORDANCE WITH THE PA’S TRAINING, EXPERIENCE, AND CURRENT COMPETENCIES.

THE EVOLVING MEDICAL PRACTICE ENVIRONMENT REQUIRES FLEXIBILITY IN THE COMPOSITION OF TEAMS AND THE ROLES OF TEAM MEMBERS TO MEET THE DIVERSE NEEDS OF PATIENTS. THEREFORE, THE MANNER IN WHICH PAS AND PHYSICIANS WORK TOGETHER SHOULD BE DETERMINED AT THE PRACTICE LEVEL.

THE PA/PHYSICIAN TEAM MODEL CONTINUES TO BE RELEVANT, APPLICABLE AND PATIENT-CENTERED. HOWEVER, STATE LAW SHOULD NOT REQUIRE A SPECIFIC RELATIONSHIP BETWEEN A PA, PHYSICIAN, OR ANY OTHER ENTITY IN ORDER FOR A PA TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION, TRAINING AND EXPERIENCE. SUCH REQUIREMENTS DIMINISH TEAM FLEXIBILITY AND THEREFORE LIMIT PATIENT ACCESS TO CARE, WITHOUT IMPROVING PATIENT SAFETY. IN ADDITION, SUCH REQUIREMENTS PUT ALL PROVIDERS INVOLVED AT RISK OF DISCIPLINARY ACTION FOR REASONS UNRELATED TO PATIENT CARE OR OUTCOMES. LIKE EVERY CLINICAL PROVIDER, PAS ARE RESPONSIBLE FOR THE CARE THEY PROVIDE. NOTHING IN THE
LAW SHOULD REQUIRE OR IMPLY THAT A PHYSICIAN IS RESPONSIBLE OR LIABLE FOR CARE PROVIDED BY A PA, UNLESS THE PA IS ACTING ON THE SPECIFIC INSTRUCTIONS OF THE PHYSICIAN.

OPTIMAL TEAM PRACTICE IS APPLICABLE TO ALL PAS, REGARDLESS OF SPECIALTY OR EXPERIENCE. WHETHER A PA IS EARLY CAREER, CHANGING SPECIALITY OR SIMPLY ENCOUNTERING A CONDITION WITH WHICH THEY ARE UNFAMILIAR, THE PA IS RESPONSIBLE FOR SEEKING CONSULTATION AS NECESSARY TO ASSURE THAT THE PATIENT’S TREATMENT IS CONSISTENT WITH THE STANDARD OF CARE.

Notwithstanding the above provisions, these guidelines recognize that medicine is rapidly changing. A modified model may be better for some states and they should therefore feel free to craft alternative provisions. PAs practice team-based medicine with a wide variety of team members to include physicians. Language in state law should acknowledge consultation and/or collaboration between physicians and PAs in a manner that assures quality medical care and promotes access.

PA Practice Ownership and Employment
Employment and collaboration should be regarded as separate entities. A physician’s ability to collaborate with a PA is independent of the specifics of PA employment. In the early days of the profession the PA was commonly the employee of the physician. In current systems physicians and PAs may be employees of the same hospital, or health system, OR LARGE PRACTICE. In some situations, the PA may be part or sole owner of a practice. PA practice owners may be the employers of their collaborating physicians.

To allow for flexibility and creativity in tailoring healthcare systems that meet the needs of specific patient populations, a variety of practice ownership and employer-employee relationships should be available to physicians and to PAs. The PA-physician relationship is built on trust, respect, and appreciation of the unique role of each team member. No licensee should allow an employment arrangement to interfere with sound clinical judgment or to diminish or influence their ethical obligations to patients. State law provisions should authorize the regulatory authority to discipline a physician or a PA who allows employment arrangements to exert undue influence on sound clinical judgment or on their professional role and patient obligations.

Disasters, Emergency Field Response and Volunteering
PAs should be allowed to provide medical care in disaster and emergency situations. This may require the state to adopt language THAT PERMITS PAS TO exempting PAs from collaboration provisions when they respond to medical emergencies that occur outside the place of employment. This exemption should extend to PAs who are licensed in other states or who are federal employees. Physicians who collaborate with PAs in such disaster or emergency situations should be exempt from routine documentation or collaborative
PAs should be granted Good Samaritan immunity to the same extent that it is available to other health professionals.

PAs who are volunteering without compensation or remuneration should be PERMITTED TO PROVIDE MEDICAL CARE AS INDICATED BY THE PATIENT’S CONDITION AND THE STANDARD OF CARE, AND IN ACCORDANCE WITH THE PA’S EDUCATION, TRAINING, AND EXPERIENCE. STATE LAW SHOULD NOT REQUIRE A SPECIFIC RELATIONSHIP BETWEEN A PA, PHYSICIAN, OR ANY OTHER ENTITY IN ORDER FOR A PA TO VOLUNTEER. Similarly exempted from collaboration provisions.

**Scope of Practice**

State law should permit PA practice in all specialties and settings. In general, PAs should be permitted to provide any legal medical service that is within the PA’S skills, education, training and experience. Medical services provided by PAs may include but are not limited to ordering, performing and interpreting diagnostic studies, ordering and performing therapeutic procedures, formulating diagnoses, providing patient education on health promotion and disease prevention, providing treatment and prescribing medical orders for treatment. This includes the ordering, prescribing, dispensing, administration and procurement of drugs and medical devices. PA education includes extensive training in pharmacology and clinical pharmacotherapeutics. Additional training, education or testing should not be required as a prerequisite to PA prescriptive authority. PAs who are prescribers of controlled medications should register with the Federal Drug Enforcement Administration.

Dispensing is also appropriate for PAs. The purpose of dispensing is not to replace pharmacy services, but rather to increase patient ability to receive needed medication when access to pharmacy services is limited. Pharmaceutical samples should be available to PAs just as they are to physicians for the management of clinical problems.

State laws, regulations, and policies should allow PAs to sign any forms that require a physician signature.

**Title and Practice Protection**

The ability to utilize the title of “PA” or “asociado médico” when the professional title is translated into Spanish should be limited to those who are authorized to practice by their state as a PA. The title may also be utilized by those who are exempted from state licensure but who are credentialed as a PA by a federal employer and by those who meet all of the qualifications for licensure in the state but are not currently licensed. A person who is not authorized to practice as a PA should not engage in PA practice unless similarly credentialed by a federal employer. The state should have the clear authority to impose penalties on individuals who violate these provisions.
**Regulatory Agencies**

Each state must define the regulatory agency responsible for implementation of the law governing PAs. Although a variety of state agencies can be charged with this task, the preferable regulatory structure is a separate PA licensing board comprised of a MAJORITY OF PAS, WITH OTHER a group of members who are knowledgeable about PA education, certification, and practice. Consideration should be given to including members who are representative of a broad spectrum of healthcare settings — primary care, specialty care, institutional and rural based practices.

If regulation is administered by a multidisciplinary healing arts or medical board, it is strongly recommended that PAs and physicians who PRACTICE collaborate with PAs be full voting members of the board.

Any state regulatory agency charged with PA licensure should be sensitive to the manner in which it makes information available to the public. Consumers should be able to obtain information on health professionals from the licensing agency, but the agency must assure that information released does not create a risk of targeted harassment for the PA licensee or their family.

Although there is no conclusive evidence that malpractice claims history correlates with professional competence, many state regulatory agencies are required by statute to make malpractice history on licensees available to the public. If mandated to do so, the board should create a balance between the public’s right to relevant information about licensees and the risk of diminishing access to subspecialty care. Because of the inherent risk of adverse outcomes, medical professionals who care for patients with high-risk medical conditions are at greater risk for malpractice claims. The board should take great care in assuring that patient access to this specialized care is not hindered as a result of posting information that could be misleading to the public.

Licensee profiles should contain only information that is useful to consumers in making decisions about their healthcare professional. Healthcare professional profile data should be presented in a format that is easy to understand and supported by contextual information to aid consumers in evaluating its significance.

**Discipline**

AAPA endorses the authority of designated state regulatory agencies, in accordance with due process, to discipline PAs who have committed acts in violation of state law. Disciplinary actions may include, but are not limited to, suspension or revocation of a license or approval to practice. In general, the basic offenses are similar for all health professions and the language used to specify violations and disciplinary measures to be used for PAs should be similar to that used for physicians. The law should authorize the regulatory agency to impose a wide range of disciplinary actions so that the board is not motivated to ignore a relatively minor infraction due to inadequate disciplinary choices. Programs and special
provisions for treatment and rehabilitation of impaired PAs should be similar to those available for physicians. The Academy also endorses the sharing of information among state regulatory agencies regarding the disposition of adjudicated actions against PAs. The medical practice act should authorize the physician regulatory agency to impose appropriate measures on doctors for failing to comply with the legal requirements placed on those who collaborate with PAs. Such measures should include restrictions on a physician’s authority to collaborate with PAs.

Inclusion of PAs in Relevant Statutes and Regulations
In addition to laws and regulations that specifically regulate PA practice, PAs should be included in other relevant areas of law. This should include, but not be limited to, laws that grant patient-provider immunity from testifying about confidential information; mandates to report child and elder abuse and certain types of injuries, such as wounds from firearms; provisions allowing the formation of professional corporations by related healthcare professionals; and mandates that promote health wellness and practice standards. Laws that govern specific medical technology should authorize those appropriately trained collaborating physicians and PAs to use them.

FOR ALL PROGRAMS, STATES SHOULD INCLUDE PAS IN THE DEFINITION OF PRIMARY CARE PROVIDER WHEN THE PA IS PRACTICING IN THE MEDICAL SPECIALTIES THAT DEFINE A PHYSICIAN AS A PRIMARY CARE PROVIDER.

IT IS IN THE BEST INTEREST OF PATIENTS, PAYERS AND PROVIDERS THAT PA-PROVIDED SERVICES ARE MEASURED AND ATTRIBUTED TO PAS; THEREFORE, STATE LAW SHOULD ENSURE THAT PAS WHO RENDER SERVICES TO PATIENTS BE IDENTIFIED AS THE RENDERING PROVIDER THROUGH THE CLAIMS PROCESS AND BE ELIGIBLE TO BE REIMBURSED DIRECTLY BY PUBLIC AND PRIVATE INSURANCE.
APPENDIX C

AAPA Policy Related to Optimal Team Practice

**EXPLANATORY NOTE:** The JTF has identified the following AAPA policies that may require modification, if the JTF-proposed changes to the State Guidelines for State Regulation of PA Practice are adopted as AAPA policy by the House of Delegates.

**HP-3100.2.1**

**HP-3100.3.1**
PAs are health professionals licensed or, in the case of those employed by the federal government, credentialed to practice medicine in collaboration with physicians. PAs are qualified by graduation from an accredited PA educational program and/or certification by the National Commission on Certification of Physician Assistants.

Within the physician-PA relationship, PAs provide patient-centered medical care services as a member of a health care team. PAs practice with defined levels of autonomy and exercise independent medical decision making within their scope of practice. *Adopted 1995, reaffirmed 2000, 2005, 2010, amended 1996, 2014*

**HP-3300.1.1**
PAs, by virtue of their education and legal scope of practice as professionals who provide medical care in teams with physicians, are qualified to order and monitor the use of patient restraint and seclusion. This applies to restraints when used in conjunction with a medical or surgical procedure and when used for behavioral reasons. Restraint or seclusion should only be for the purpose of protecting the patient or others or to improve a patient's functional well-being, and only if less intrusive interventions have been determined to be ineffective. *Adopted 2000, reaffirmed 2005, 2010, amended 1996, 2014*

**HP-3400.1.1**
It is the obligation of each PA to ensure that:
- The individual PA’s scope of practice is broadly identified;
- The scope is appropriate to the individual PA’s level of training and experience;
- Access to the collaborating physician is defined;
- A process for collaboration is established.

AAPA is committed to the concept of team-based collaborative practice between the PA and physician to achieve the highest level of quality, cost effective care for patients and

HP-3400.1.2
AAPA believes that the physician-PA team relationship is fundamental to the PA profession and enhances the delivery of high-quality health care. As the structure of the health care system changes, it is critical that this essential relationship be preserved and strengthened. [Adopted 1997, reaffirmed 2002, 2007, 2012]

HP-3400.1.3
AAPA supports expanded health care access for all people. AAPA encourages innovation in health care delivery, but remains committed to the model of physician directed team care. AAPA maintains that continuity of care is a high priority; therefore communication between the episodic care provider and the primary provider should be maximized within the constraints of regulation, patient confidentiality and patient preference. [Adopted 2003, reaffirmed 2008, 2013]

HP-3400.2.1
AAPA supports measures that allow for flexible and efficient utilization of PAs consistent with the provision of quality health care. More specifically, PA employment and supervision are separate issues. The regulatory requirements of PA supervision should be unrelated to any aspect of employment. [Adopted 1996, amended 1997, reaffirmed 2001, 2007, 2012]

HP-3400.2.4
AAPA shall promote the PA profession to hospital administrators, health care leaders and PA employers as a cost-effective, team-based and patient-centered way to improve the quality, access and continuity of patient care. [Adopted 2000, reaffirmed 2005, amended 2010, 2015]

HP-3600.1.1
AAPA seeks to modernize the Social Security Act through amendments to authorize coverage of all physician services provided by PAs and to reimburse PAs directly for covered medical services in the same manner as all other Medicare providers. [Adopted 1981, reaffirmed 1990, 1995, and 2000, amended 1982, 1997, 2005, 2010, 2015]

HP-3600.1.2
AAPA believes that the cost-based reimbursement mechanism for Rural Health Centers should be continued or an equivalent payment mechanism should be developed to cover the costs of providing services to rural Medicare and Medicaid patients and protect the financial viability of rural clinics. [Adopted 1996, reaffirmed 2001, 2006, 2011]

HP-3600.1.3
AAPA believes it is essential that all public and private insurers enroll PAs and cover medical and surgical services provided by PAs in all practice settings.

HP-3600.1.4
AAPA believes it is vital to track the volume and quality of medical and surgical services provided by PAs to assess the impact of those services on patients and on the health care system. To facilitate that effort, AAPA supports the recognition of, and direct payment to, PAs by public and private third party payers and health care organizations. AAPA is committed to maintaining the established supervising physician-PA relationship that is a central concept in the PA profession and incorporated into every state’s law. [Adopted 2011]

HP-3600.1.5
AAPA believes that services provided by physician-PA teams should be counted when federal and state governments determine the primary health care service needs of medically underserved and health professional shortage areas. Recognition of physician-PA team productivity should not be done in such a way as to decrease patient access to care. [Adopted 1998, reaffirmed 2003, 2008, 2013]

HP-3700.1.1
AAPA believes that PAs must acknowledge their individual responsibilities to patients, society, other health professionals, and to themselves; and in meeting their responsibilities, their actions should be guided by the Guidelines for Ethical Conduct for the PA Profession. AAPA believes the endorsement of the Guidelines for Ethical Conduct is a professional responsibility that underscores the principle of self-regulation. [Adopted 1990, amended 1991, 2001, reaffirmed 1996, 2006, 2011, 2016]

HP-3700.3.1
Guidelines for PAs Working Internationally
1. PAs should establish and maintain the appropriate physician-PA team.
2. PAs should accurately represent their skills, training, professional credentials, identity, or service both directly and indirectly.
3. PAs should provide only those services for which they are qualified via their education and/or experiences, and in accordance with all pertinent legal and regulatory processes.
4. PAs should respect the culture, values, beliefs, and expectations of the patients, local health care providers, and the local health care systems.
5. PAs should be aware of the role of the traditional healer and support a patient’s decision to utilize such care.
6. PAs should take responsibility for being familiar with, and adhering to the customs, laws, and regulations of the country where they will be providing services.
7. When applicable, PAs should identify and train local personnel who can assume the role of providing care and continuing the education process.
8. PA students require the same supervision abroad as they do domestically.
9. PAs should provide the best standards of care and strive to maintain quality abroad.
10. Sustainable programs that integrate local providers and supplies should be the goal.

11. PAs should assign medical tasks to nonmedical volunteers only when they have the competency and supervision needed for the tasks for which they are assigned. [Adopted 2001, amended 2011, reaffirmed 2006, 2016]

HX-4100.1.8
AAPA endorses the 1975 World Medical Association Declaration of Tokyo which provides guidelines for physicians and, by nature of their dependent relationship, for PAs, in cases of torture or other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment. [Adopted 1987, reaffirmed 1992, 1997, 2003, 2008, 2013]

HX-4500.1
AAPA believes that telemedicine can improve access to cost-effective, quality health care and improve clinical outcomes by facilitating interaction and consultation among providers. Because of the potential of telemedicine to enhance the practice of medicine by physician-PA teams, AAPA encourages PAs to take an active role in the utilization and evaluation of this technology. AAPA supports further research and development in telemedicine, including resolution of problems related to regulation, reimbursement, liability, and confidentiality. [Adopted 1997, reaffirmed 2002, 2007, 2012]

HX-4500.3
AAPA believes that electronic health record (EHR) systems, computerized provider order entry (CPOE) systems, reimbursement and claims systems, and other health information technology systems should individually recognize and support the optimal utilization of PAs, and, when appropriate, provide attribution to PAs.

Health information technology systems should be designed, developed, and implemented with appropriate PA input in a manner that benefits patients, the physician-PA team, and the health care system by improving quality, encouraging patient-centered care, and reducing costs. [Adopted 2013]

HX-4600.1.3
Coverage for the treatment of mental health and substance use disorders should be available, nondiscriminatory and covered at the same benefit level as other medical care. Reimbursement for PAs providing mental health and substance use disorder care should be provided in the same manner as other physician services provided by PAs. [Adopted 2003, reaffirmed 2008, amended 2013]

HX-4600.3.5
AAPA recognizes the shortage of health care services in the United States and its expected impact on the quality, availability, and cost of health care in this country. AAPA is committed to raising awareness of this issue nationally and to increasing the importance of this issue on the policy agenda at all levels of government and in the private sector. AAPA supports efforts
that promote and foster creative solutions to health care shortages that include expansion and access to physician-PA teams to meet anticipated requirements for health care services. [Adopted 2006, reaffirmed 2011, 2016]

**HX-4700.4.2**

AAPA supports the medical home concept as a means to expand access, reduce long-term cost, and improve the quality of patient care and the health of populations by allowing improved patient care coordination and interdisciplinary communication.

A medical home provides coordinated and integrated care that is patient- and family-centered, culturally appropriate, committed to quality and safety, and is cost-effective. This care is provided by a team led by a health care professional that includes PAs.

The principles of the medical home can apply to any setting where continuing, longitudinal primary or specialty care is provided. By virtue of their education, credentials, and fundamental support for team care, PAs are qualified to serve as patients’ personal providers in the patient-centered medical home. PAs are qualified to lead the medical home and are committed to physician-PA team practice.

AAPA believes that coordination of care has value that requires a reasonable level of payment. [Adopted 2008, amended 2010, 2015]

**Comprehensive Health Care Reform**
AAPA supports health care that is delivered by qualified providers in physician-directed teams.

**Accreditation and Implications of Clinical Postgraduate PA Training Programs**  
*Highlights of Findings from Data Collection and Stakeholder Engagement*  
Systematic review for published/disseminated literature relevant to clinical postgraduate PA training produced a small yield, considering the length of time such programs have existed, and key findings include the following. The term limited study here acknowledges publications that have limited generalizability, such as being conducted at a single site, evaluating small sample sizes, or study designs that are not intended to demonstrate cause and effect.

- Limited study in critical care demonstrates clinical postgraduate PA (and APRN) training positively impacted patient care and enhanced the training of other healthcare professionals in critical and intensive care settings
- Limited study in emergency medicine demonstrated that the vast majority program faculty surveyed felt PA students had sufficient training from entry level PA education for emergency medicine practice and more than half did not see a need for clinical postgraduate PA training
Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs
(Adopted 2012)

Definition of PA
The following definition [of a PA] serves as an example.

A PA is an individual who is a graduate of a PA program approved by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or one of its predecessor agencies, and/or has been certified by the National Commission on Certification of Physician Assistants (NCCPA). The individual meets the necessary legal requirements for licensure to practice medicine as delegated by a licensed physician.

Credentialing PAs
Medical staff bylaws specify professional criteria for medical staff membership and clinical privileges. The Joint Commission specifies four core criteria that should be met when credentialing licensed independent practitioners, including:
- current licensure
- relevant training or experience
- current competence and
- the ability to perform privileges requested.

This serves as a reasonable guideline. As applied to PAs, these criteria might include:
- evidence of national certification
- letters from previous employers, supervising physicians, PA peers, or PA programs attesting to scope and level of performance
- verified logs of clinical procedures
- personal attestation as to physical and mental health status
- evidence of adequate professional liability insurance
- information on any past or pending professional liability or disciplinary actions
- a letter from a sponsoring physician (MD or DO) who is a member of the medical staff.

PA Privileges
The fundamental premise of the PA profession is a solid educational foundation in medicine and surgery that prepares PAs to work with physicians in any specialty or care setting.
Expanding Privileges
PAs are educated in the medical model of evaluation, diagnosis, and treatment. They are committed to life-long learning through clinical experience and continuing medical education. Recognition that new tasks and responsibilities can be taught and delegated to the PA by physicians as a PA gains experience, and as the physician and PA grow as a team, are key to effective utilization of PAs.

Participation in Disaster and Emergency Care
The bylaws should include language enabling PAs to provide care during emergency or disaster situations. The bylaws should state that the chief executive or his or her designee may grant temporary clinical privileges when appropriate and that emergency privileges may be granted when the hospital’s emergency management plan has been activated. The hospital’s emergency preparedness plan should include PAs in its identification of care providers authorized to respond in emergency or disaster situations. Bylaws language might state:

In case of an emergency, any member of the medical staff, house staff, and any licensed health practitioner, limited only by the qualifications of their license and regardless of service or staff status, shall be permitted to render emergency care. They will be expected to do everything possible to save the life of a patient, utilizing all resources of the hospital as necessary, including the calling of any consultations necessary or desirable. Any PA acting in an emergency or disaster situation shall be exempt from the hospital’s usual requirements of physician supervision to the extent allowed by state law in disaster or emergency situations. Any physician who supervises a PA providing medical care in response to such an emergency or declared disaster does not have to meet the requirements set forth in these bylaws for a supervising physician.

AAPA believes that the medical knowledge and training necessary to ensure competence as an MRO are not limited to licensed physicians. As practitioners trained in the medical model to provide physician services, PAs have the background necessary to perform successfully the duties of an MRO.


Recommendations
PAs, practicing with physician supervision, are a critical part of the health workforce providing care for Medicaid patients. To facilitate the continued delivery of services to these patients, AAPA believes that states should include the following provisions in Medicaid managed care plans:
• PAs should be recognized as primary care providers, either by naming them individually, or in conjunction with their supervising physicians, or by naming them within a group.
• To maintain and improve continuity of care, PAs should be included on the list of health care professionals in order to allow Medicaid beneficiaries the option of seeking care from a physician-PA team that may in fact already be serving as their current provider of care.
• States should assign a maximum patient panel that recognizes the proven productivity of PAs and physicians and does not provide a disincentive for utilizing PAs on the health care team. This can be achieved by increasing a supervising physician’s panel size by an appropriate number or by directly paneling the PA.
• State Medicaid programs should establish regulations that are consistent with PA state law to allow for the maximum efficiency of physician-PA teams.


Competence, Competencies and Competency-based Education
An overarching competency PAs must possess is the ability to practice interdependently in the physician/PA team: A skill that requires medical knowledge, professionalism, and interpersonal and communication skills, but is more than the sum of these parts.


Special Concerns for PAs
(95) The patient is the central figure in end-of-life decision making, but PAs have an important role to play. In some cases, the PA will be the dying patient’s primary health care provider and chief advocate. All medical caregivers have a prime responsibility to ensure the patient’s well-being. In doing so, however, they must act in accordance with their own ethical principles. PAs also have a unique responsibility arising from their relationship with supervising physicians, who share liability for the PA’s actions.
(100) A PA has two supervising physicians who share call and hospital duties, but have widely divergent moral and/or ethical views on end-of-life issues.
(101) A precarious spot and divided loyalties may characterize the PA’s position in such circumstances. The optimal course is to discuss end-of-life issues with the supervising physician before potential conflicts arise. When discord persists, the PA must remember that the physician bears the ultimate liability and, therefore, the final responsibility for clinical decision making. A PA who believes that legal or ethical precepts are being violated is responsible for speaking out in an appropriate and timely manner.

Conclusion
(109) PAs have a legal and ethical responsibility to the supervising physician, as well as to the patient. PAs should inform and involve the physician in all near-death planning. The PA should not withdraw life support without the supervising physician’s agreement.

Introduction
When faced with an ethical dilemma, PAs may find the guidance they need in this document. If not, they may wish to seek guidance elsewhere, possibly from a supervising physician, a hospital ethics committee, an ethicist, trusted colleagues, or other AAPA policies.

PA Role and Responsibilities
PA practice flows out of a unique relationship that involves the PA, the physician, and the patient. The individual patient–PA relationship is based on mutual respect and an agreement to work together regarding medical care. In addition, PAs practice medicine with physician supervision; therefore, the care that a PA provides is an extension of the care of the supervising physician. The patient–PA relationship is also a patient–PA–physician relationship.

Initiation and Discontinuation of Care
A PA and supervising physician may discontinue their professional relationship with an established patient as long as proper procedures are followed. The PA and physician should provide the patient with adequate notice, offer to transfer records, and arrange for continuity of care if the patient has an ongoing medical condition.

Disclosure
A PA should disclose to his or her supervising physician information about errors made in the course of caring for a patient. The supervising physician and PA should disclose the error to the patient if such information is significant to the patient’s interests and well being.

End of Life
While respecting patients’ wishes for particular treatments when possible, PAs also must weigh their ethical responsibility, in consultation with supervising physicians, to withhold futile treatments and to help patients understand such medical decisions.

PAs should involve the physician in all near-death planning. The PA should only withdraw life support with the supervising physician’s agreement and in accordance with the policies of the health care institution.

PA-Physician Relationship
Supervision should include ongoing communication between the physician and the PA regarding patient care. The PA should consult the supervising physician whenever it will safeguard or advance the welfare of the patient. This includes seeking assistance in situations of conflict with a patient or another health care professional.
Value of PAs
Among the unique attributes of PAs are the focus, content, and length of their education, their socialization, and their adaptability in the delivery of medical services previously provided only by physicians. PAs are also distinguished by their commitment to practice as part of physician-PA teams.

PA Education
PA educational programs provide a broad-based, generalist medical education with a focus on primary care. As are trained to think like physicians and to be life-long learners. The educational process frequently draws upon the prior experience of students, adds intense didactic and clinical instruction, and produces individuals who know how to practice medicine as part of a team and value their role in the system. Their generalist training prepares PAs to work with physicians in any specialty.

PA Practice
By functioning as part of physician-directed teams, PAs have flexibility in practice. A supervising physician is authorized within the boundaries of state law or federal regulations, to delegate to the PA any portion of the physician’s practice that are within the PA’s ability to perform. New tasks and responsibilities can be taught and delegated as the PA’s expertise expands and as the team members’ understanding of one another grows. … The synergy of physician-PA team practice benefits patients both individually and collectively.

Physicians have a depth and breadth of training that is unmatched by other medical professionals. PAs embrace the notion that physicians should lead the health care team. PAs do not seek to compete with physicians, but rather endorse their role and support the concept of physician-directed care. The current system that consists of education, national certification, state licensure, federal regulations, and the team practice concept has made this success possible. AAPA believes that changes to the system should be made only if they are improvements that have benefits for the public as well as for PAs and their physician colleagues.

Quality Incentive Programs [Adopted 2005, reaffirmed 2010, 2015]
Impact on PAs
Providing culturally effective care and employing strategies to increase patient adherence will improve patient outcomes. Education in transition management may be necessary to help PAs gently persuade some supervising physicians to make the necessary changes in practice.

Competencies for the PA Profession [Adopted 2005, reaffirmed 2010, amended 2013]
Introduction
This document serves as a map for the individual PA, the physician-PA team, and organizations committed to promoting the development and maintenance of professional competencies among PAs.

Patient-centered, PA practice reflects a number of overarching themes. These include an unwavering commitment to patient safety, cultural competence, quality health care, lifelong learning, and professional growth. Furthermore, the profession’s dedication to the physician-PA team benefits patients and the larger community.

Professionalism
PAs are expected to demonstrate:
- understanding of legal and regulatory requirements, as well as the appropriate role of the PA
- professional relationships with physician supervisors and other health care providers

Systems-based Practice
PAs should work to improve the health care system of which their practices are a part. PAs are expected to:
- effectively interact with different types of medical practice and delivery systems
- understand the funding sources and payment systems that provide coverage for patient care and use the systems effectively
- practice cost-effective health care and resource allocation that does not compromise quality of care
- advocate for quality patient care and assist patients in dealing with system complexities
- partner with supervising physicians, health care managers, and other health care providers to assess, coordinate, and improve the delivery and effectiveness of health care and patient outcomes

The Role of In-Store or Retail Health Clinics (Adopted 2007 and reaffirmed 2012)

Executive Summary
PAs have worked hard to overcome misconceptions about their abilities and the medical marketplace has demonstrated that physician-PA teams are capable of a wide range of services, including highly complicated specialty practice.

There are several principles that AMA, AAFP, and AAP believe should be followed by store-based clinics. The principles that the three organizations have in common are referrals of patients to physician practices in the community; use of evidence-based medical protocols; and compliance with relevant state laws regarding physician supervision or collaboration with PAs and NPs or some form of physician-directed team practice.
AAPA adopted a policy related to retail clinics in 2003 that says:

“AAPA supports expanded health care access for all people. AAPA encourages innovation in health care delivery, but remains committed to the model of physician-directed team care. AAPA maintains that continuity of care is a high priority; therefore, communication between the episodic care provider and the primary provider should be maximized within the constraints of regulation, patient confidentiality, and patient preference.”

As a complement to this policy, AAPA proposes that retail clinics:

- Seek to establish arrangements by which their health care providers have ongoing access to and supervision by physicians (MDs and DOs), consistent with state laws
- Seek to establish referral systems with physician practices or other facilities for appropriate treatment if the patient’s condition is beyond the scope of services provided by the clinic
- Seek to establish formal connections with physician practices in the community to provide continuity of care and encourage a medical home for patients.