American Academy of PAs

The Six Key Elements of a Modern PA Practice Act

All jurisdictions (states) have an obligation to protect those within their borders by regulating the practice of medicine. By including the PA profession in laws and designating a state agency to regulate PA practice, states both protect the public and define the role of PAs.

States have modified their approach to PA regulation over the years in response to a growing body of evidence demonstrating the safety and high-quality care PAs provide coupled with the need to better utilize their healthcare workforce. AAPA has identified six specific components that the Academy believes all PA practice acts should contain. Together, these components are the backbone to creating an ideal PA practice act that allows PAs to practice fully and efficiently while protecting public health and safety. The Six Key Elements of a Modern PA Practice Act, outlined below, are reflected in AAPA's Model State Legislation[i] and in AAPA's Guidelines for State Regulation .[ii]

1. "LICENSURE" AS THE REGULATORY TERM

Historically, when the profession started, laws frequently referred to PAs as "certified" or "registered." Today, all states, the District of Columbia, and U.S. territories use "licensed," which is the preferred regulatory term as it denotes the highest level of scrutiny of professional qualifications and means that authorizing PAs to practice is a direct responsibility of the state. In addition, this term ensures PAs are included in laws and regulations that refer broadly to "licensed health professionals," such as those that require all licensed health professionals to report certain injuries to law enforcement and governors' emergency executive orders allowing "licensed health professionals" from other jurisdictions to help provide emergency care.

2. FULL PRESCRIPTIVE AUTHORITY

Prescribing medications, including Schedule II-V controlled medications, is integral to the practice of medicine. All PAs are required to complete extensive training in pharmacology as a part of their education. Laws should authorize PAs to prescribe all legal medications, including controlled medications in the Drug Enforcement Administration's Schedules II-V, non-controlled medications, and devices. Laws that restrict PA prescriptive authority may cause interruptions in patient care. If a patient seen by a PA requires medication that PAs are prohibited from prescribing, then both patient and clinician are forced to take extra steps to ensure the patient receives the medication, which can result in additional costs to the system.

3. SCOPE OF PRACTICE DETERMINED AT THE PRACTICE LEVEL

PAs practice medicine as part of healthcare teams. PA scope of practice should be based on the PA's medical education, training, experience, and competencies. To a large extent, PA scope of practice is determined by the PA, the healthcare team, policies of employers and facilities, and patients' needs. This allows for flexible and customized care. As teams decide on clinical roles in a practice, the needs of patients and the education, experience and preferences of the team members shape these roles.

Laws that include a specific list of services that PAs can provide or require the scope of practice of each individual PA to be approved by the regulatory agency restrict the ability of healthcare teams to customize practices, leading to inefficiencies and limiting access to care.

4. ADAPTABLE PROXIMITY REQUIREMENTS

If PAs are to practice in the most efficient and effective way possible, laws and regulations must define the relationship between PAs and physicians in a way that works well in all practice settings. Restrictions that impose proximity requirements — such as limits on the time or distance a physician may be from a practicing PA or specific physician on-site requirements — are cumbersome and inefficient. An adaptable approach allows teams to provide better care to more patients and to utilize all clinicians' capacity effectively and efficiently.

For instance, in some situations, such as assisting at surgery, the PA and physician will be in very close proximity. If, however, a PA is providing care in a rural setting, or via telemedicine, mandating the physician to be constantly or even intermittently on site creates an inefficient use of the physician's time and limits the team's ability to expand access to care.

Similarly, mandated limitations on the distance a physician can be from a PA also affect efficiency and access. Telecommunication allows for nearly instantaneous communication between healthcare providers. Requiring physicians and PAs to practice within a specific distance inhibits creativity in workforce planning and fails to acknowledge the ability to consult using telecommunication. If a specific distance is included in law, it is likely to be too great for some settings and unnecessarily restrictive for others.

5. COSIGNATURE REQUIREMENTS DETERMINED AT THE PRACTICE LEVEL

The ideal system for collaboration is one designed at the practice or facility level. In the early years of the PA profession, cosigning PA chart entries was a way for physicians to demonstrate they were closely overseeing PA practice. But more than 50 years of collaboration between physicians and PAs has shown that decisions about patient care and chart review are best tailored to the needs of individual practices or institutions. Requirements for physician cosignature remove a clinical team's discretion to decide what works best for their practice, impose an unnecessary burden, and hinder the efficiency of the care delivered.

Healthcare facilities, institutions and group practices should establish collaboration policies that best suit the needs of the patients they serve. Chart review is only one method of communication between providers, and it is retrospective. Ongoing communication between providers caring for a group of patients enhances coordination of care and patient outcomes. Reviewing medical record entries may be part of this communication, but it should be at the discretion of the providers and not required in law. For instance, a PA seeing a complex patient may elect to discuss the patient with a colleague or ask a physician to review a note.

6. NUMBER OF PAS A PHYSICIAN MAY COLLABORATE WITH DETERMINED AT THE PRACTICE LEVEL

Laws and regulations should not include a specific numerical limit on the number of PAs that one physician may collaborate with, nor should they stipulate that a physician can collaborate only with specific, named PAs. The number of PAs that a particular physician works with should be determined by several factors that may vary widely across practice settings. In primary care settings, for example, a physician might collaborate with multiple PAs, while in a complex surgical setting, a team of one PA and one surgeon might be appropriate. Any physician-to-PA ratio in statute or rule cannot account for these differences.

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FOR MORE INFORMATION

The AAPA website contains a wealth of additional information about PA practice and state laws and regulations. A map of the number of key elements included in each practice act can be found here.

ABOUT AAPA

AAPA is the national organization that advocates for all PAs and provides tools to improve PA practice and patient care. Founded in 1968, AAPA represents a profession of more than 150,000 certified PAs across all medical and surgical specialties in all 50 states, the District of Columbia, the U.S. territories and the uniformed services. Visit AAPA.org to learn more.

REFERENCES

[i] American Academy of PAs. Model state legislation for PAs. https://www.aapa.org/download/29354/. Accessed January 4, 2022.

[ii] American Academy of PAs. Guidelines for state regulation of PAs. https://www.aapa.org/download/35030/.