The Six Key Elements of a Modern PA Practice Act

All states have an obligation to protect those within their borders by regulating the practice of medicine within the state. By including the PA profession in state law 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 information demonstrating the safety and high quality of PA practice and the need to better utilize their healthcare workforce. AAPA has identified six specific components that the Academy believes all state PA practice acts should contain. Together these components create 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 the AAPA Model State Legislation for PAs[1] and in AAPA's Guidelines for State Regulation of PAs.[2]

1. "LICENSURE" AS THE REGULATORY TERM

While some early state laws referred to PAs as "certified" or "registered," all states and the District of Columbia now use the preferred term, "licensed." Licensure is the preferred regulatory term because 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 state laws that refer broadly to "licensed health professionals," such as laws that require all licensed health professionals to report certain injuries to law enforcement and governors' emergency executive orders allowing "licensed health professionals" from other states 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 PA education. State laws should authorize PAs to prescribe all legal medications, including controlled medications in the Drug Enforcement Administration's Schedules II-V and noncontrolled medications and devices. Laws that restrict PA prescriptive authority have the potential to cause interruptions in the delivery of care. If a patient seen by a PA requires medication that state laws prohibit the PA 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 is based on the PA's education and experience, state law, policies of employers and facilities, and the needs of the patients at the practice. To a large extent, PA scope of practice is determined by the PA,

collaborating physicians and the healthcare team. This allows for flexible and customized team function. 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.

State 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 state regulatory agency restrict the ability of healthcare teams to customize practices, leading to inefficiencies and limiting access to care.

4. ADAPTABLE COLLABORATION REQUIREMENTS

If PAs are to practice in the most efficient and effective way possible, state laws and regulations must define the relationship between PAs and physicians in a way that works well in all practice settings. Restrictions that impose a proximity requirement or require a physician to be on site with a PA at specified intervals are cumbersome and inefficient. A more adaptable approach allows teams to provide better care to more patients.

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 services in a rural primary care setting, 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 physicians and PAs. Requiring physicians and PAs to practice within a specific proximity limit 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.

Several medical organizations, including the American College of Physicians,[3] the American Academy of Family Physicians,[4] and the American Osteopathic Association,[5] have policy supporting adaptable collaboration requirements.

5. COSIGNATURE REQUIREMENTS DETERMINED AT THE PRACTICE LEVEL

The ideal system for collaboration is the 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 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. State law 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 by definition 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 collaborating physician and ask the physician to review the note. Or physicians new to a collaborating team may choose to review a portion of chart entries as a method of acquainting themselves with the team of providers.

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

State 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.

The principle that physicians and PAs at the practice level should determine the number of PAs with whom a physician may practice is supported by several national medical organizations, including the American Medical Association,[6] the American College of Emergency Physicians[7] and the Society of Hospital Medicine.[8]

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 115,500 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

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Last updated: January 2017