



Guidelines for State Regulation of PAs

(Adopted 1988, amended 1993, 1998, 2001, 2005, 2006, 2009, 2011, 2013, 2016)

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 collaborating 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, 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 is 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.

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. 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 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 requirements. 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 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 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 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.