

Frequently Asked Questions Optimal Team Practice

The 2017 [AAPA House of Delegates](#) (HOD) approved a new policy, often referred to as Optimal Team Practice, as updates to [AAPA Guidelines for State Regulation of PAs](#) (Guidelines). The Physician Assistant Education Association (PAEA) presented testimony during the House of Delegates, and the Guidelines as adopted include revisions based on those proposed by PAEA.

What changes have been made to the Guidelines?

The [new policy](#) calls for laws and regulations that:

- Emphasize PAs' commitment to team practice;
- Replace obsolete supervisory agreement laws with practice-level decision-making about collaboration;
- Create separate majority-PA boards to regulate PAs, or give that authority to healing arts or medical boards that have as members both PAs and physicians who practice with PAs; and
- Authorize PAs to be directly reimbursed by all public and private insurers.

Does this change the rules governing how PAs practice today?

It does not. State laws determine PA practice, not AAPA's HOD. Each state PA chapter will decide how and when to advocate for adoption of the various components in the Guidelines through legislative and regulatory changes in their respective state.

Why did AAPA decide to pursue these changes?

Research has consistently proven that [PAs provide high-quality care](#). Many of the oversight provisions included in early PA state laws to assure quality are no longer necessary, if indeed they ever were.

In addition, PAs are facing new obstacles in the [changing healthcare marketplace](#) and must adapt in order to ensure the future of the PA profession and meet the needs of patients. Increasingly, physicians are more likely to be employees rather than practice owners. As employees, they no longer see a financial benefit from entering into a supervisory agreement with a PA. In addition, 22 states and the District of Columbia allow nurse practitioners (NPs) to practice without a supervising or collaborating physician, which makes NPs easier to hire and manage. Even in states where NPs do not have full practice authority, there is often the perception that hiring an NP is less burdensome than hiring a PA. These conditions put PAs at a disadvantage relative to NPs, resulting in lost opportunities for employment and advancement. Forty-five percent of PAs and PA students surveyed in January 2017 reported that they had personally experienced NPs being hired over PAs due to PA supervisory agreement requirements.

The recommendation to eliminate the requirement that a PA have a supervisory agreement with a specific physician is a further evolution of the direction many state laws and regulations are already heading. In 2016, Michigan passed legislation removing physician supervision and delegation, and repealing the requirement that a physician assume responsibility for PA-provided care. Michigan PAs now practice with a "participating physician." In the 2017 legislative session, Illinois, New Mexico, and West Virginia each adopted legislation to refer to how physicians and PAs practice together as "collaboration," joining Alaska, which has used "collaboration" since the 1980s.

As more physicians and PAs are practicing in groups, the requirement for PAs to have “supervisory agreements” is increasingly difficult to manage and puts all providers involved at risk of disciplinary action for administrative infractions that are unrelated to patient care or outcomes.

Will the new Guidelines require a change in PA education?

The new Guidelines do not dictate a specific change to PA education. However, changing demographics in the applicant pool and realities in the healthcare marketplace will drive changes to PA education, just as marketplace and practice realities drove the need to change AAPA policy. PA education must continually evolve to meet marketplace needs and practice realities, which was recognized at PAEA’s Stakeholder Summit in 2016.

Under the new policy, new graduates and early career PAs, as well as PAs who are changing specialties, would continue to practice in teams with physicians, and 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 and will continue to be 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 care.

Rather than requiring a specific relationship with a physician, under the new Guidelines a new graduate PA would be able to report to or be supervised by a physician, a senior PA, or a chief PA. Being supervised by a PA would have many benefits to new graduate PAs, who would also be mentored in the PA role. New graduate PAs and PA employers are always responsible for assuring that there is adequate access to consultation and back-up. Removing a state law requirement for PAs to have a specific relationship with a physician does not diminish those responsibilities.

Were PA educators involved in development of this policy?

Yes. The draft policy was developed by the Joint Task Force on the Future of PA Practice Authority, a group convened to address a resolution submitted to the 2016 House of Delegates by the Association of Family Practice PAs. Of the 11 members of the Joint Task Force, two were full-time PA program faculty. During preparation of the resolution, the Joint Task Force held conference calls with key stakeholder groups, including a call with PA program directors. In addition, Joint Task Force leaders met with the PAEA Board prior to drafting the resolution that became the updated Guidelines.

PAEA representatives were present at the AAPA House of Delegates meeting. Although they initially withheld support for OTP, PAEA ultimately supported the OTP proposal with changes that were made on the House floor (collaboration being defined at the practice level). Optimal Team Practice, as passed by the House and supported by PAEA, is now codified in policy for the PA profession.

Of note, an eight-member PA task force is now drafting a revision to AAPA’s Model State Legislation to incorporate the changes to the Guidelines. Two of the task force members are full time PA program faculty.

Is Optimal Team Practice the same as independent practice?

Optimal Team Practice is about team practice – not independent practice. PAs are not seeking to practice independently. The new policy simply seeks to eliminate the legal requirement that a PA enter into a supervisory agreement with a physician in order to practice. In fact, Optimal Team Practice includes two important points that distinguish it from independent practice:

1. It reinforces PAs' commitment to team practice with physicians and explicitly states the PA/physician team model continues to be relevant, applicable and patient-centered; and,
2. Calls for a decision about the degree of collaboration between PAs and physicians to be made at the practice level, in accordance with the practice type and the education and experience of the practicing PA.

Currently PAs are held to professional and ethical standards by state regulatory authorities. Under the Optimal Team Practice framework, PAs will still be legally and ethically obligated to consult with and refer patients to physicians based on the patient's condition, the standard of care, and the PA's education and experience. If they don't, that PA will be subject to disciplinary action by the state medical board, just as any other medical provider would be.

Is this new AAPA policy the same as the full practice authority pursued by NPs?

No, it's not the same – it's better. The PA profession's commitment to team practice is powerful. The PA and physician who work together get to keep all the benefits of the team without the legal risks and administrative burdens. Everyone wins.

If implemented, do these changes allow PAs to open their own practices?

PAs can own practices in many states today. AAPA policy has long supported a PA's ability to participate in practice ownership, just like other health professions. Under the Optimal Team Practice framework, PAs who are practice owners will still be legally and ethically obligated to consult with and refer patients to physicians when indicated.

Are PAs ready for this change?

The PA profession is now in its 50th year. PA practice has been extensively studied and evaluated, and found to produce high-quality patient outcomes. State laws and regulations have simply not kept pace. In a survey conducted by the Joint Task Force in January 2017, 71 percent of PAs and PA students responding expressed overall support for the proposal.

How will this new policy benefit patients?

Numerous studies have shown that PAs provide high-quality patient care and are medical providers who bring value to patients and healthcare systems. When these new policies are incorporated in state laws, access to care will be expanded, especially for medically underserved populations and patients in rural areas, where the sudden death, disability, or retirement of a physician "supervisor" can mean that the PA can no longer practice. We also expect PA licensing to be expedited, and that PAs will have increased ability to provide volunteer medical services and respond to disasters and emergencies. In addition, the elimination of the requirement to have a supervisory agreement with a physician will enable physicians to focus on meeting patient needs, rather than filling out unnecessary paperwork.

Will this change how PAs work with physicians?

It won't change how PAs and physicians practice together, but it will enable them to care for patients without the unnecessary administrative burdens, and without a physician being responsible for PA-provided care. The PA role is well established – no change is required or anticipated. PAs will continue to consult, collaborate with, and refer patients to physicians just as they do now.

How will physicians respond to the updated Guidelines?

Prior to the adoption of this policy, we reached out to a number of physician organizations. Over the course of the many months of Task Forces deliberations, changes were made to address concerns raised by physicians and other groups. Although we have seen some hesitation from organized medicine, individual physicians who practice with PAs should appreciate the benefits.

What should PAs share with physicians they practice with about the policy changes?

PAs can share with physicians that these changes are good for physicians, good for patients, and good for PAs. More physician and PA time will be spent on activities that enhance patient care. Physicians can enjoy the benefits of team practice without being responsible for PA-provided care.

Why does the policy include a recommendation regarding the state board that regulates PAs?

The agency or board charged with regulating PA practice varies from state-to-state, with the most common model being PA regulation by a medical board.

Physicians and nurses are assured that their regulatory boards have current knowledge of their profession, but PAs have no such assurance. The typical state medical board that regulates PAs is made up of a majority of physicians, who may not have current knowledge of PA practice.

PAs should be regulated by PA boards, or by medical or healing arts boards that have PAs and physicians who practice with PAs as full voting members.

Why is it important for PAs to have the option to receive direct payment?

PAs are the only health professionals who bill Medicare that are not entitled to direct reimbursement. Medicare allows physicians, advanced practice registered nurses (APRNs), and other health professionals who bill Medicare to receive payment directly. Nearly all third-party payers reimburse for medical services and procedures provided by PAs. However, most payers require that payment be made to the PA's employer, which can unintentionally limit PA employment opportunities with staffing companies and certain practice arrangements.

Because PAs can't receive reimbursement directly, they can't re-assign their reimbursement in the same manner as physicians and APRNs. Even with direct reimbursement, most PAs will have their reimbursement assigned to their employer. As the healthcare system continues its rapid transformation toward more innovative care models, PAs must have the same reimbursement flexibility as other health professionals in order to maximize PA practice.

Will Medicare reimbursement be an issue if states use a term other than “supervision” to define the PA-physician relationship?

Medicare policy says that “State law or regulation governing a PA’s scope of practice in the State where the services are performed applies.” However, the current Medicare statute uses the word “supervision” to define a PA’s professional relationship with a physician. As PA state laws describing that professional relationship continue to evolve, moving away from the word and concept of “supervision,” Medicare rules must also change. AAPA is advocating for these changes and encouraging the Centers for Medicare and Medicaid Services to embrace state law changes that reflect a new, more efficient model.

What are the next steps?

Each state PA chapter will decide whether and when to pursue these changes – at their own pace and as the situation in each state allows. AAPA will work with state chapters to provide resources, guidance, and support as they work to have these policies adopted into law. At the same time, AAPA will lay the groundwork and advocate for changes to Medicare to authorize direct PA reimbursement and eliminate physician supervision language in the definition of PA services.

Whom can I contact for questions about the updated Guidelines?

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