State of New Hampshire

GENERAL COURT

CONCORD

MEMORANDUM

DATE:	**November 1, 2024**
TO:	**Honorable Sherman Packard, Speaker of the House** **Honorable Jeb Bradley, President of the Senate** **Honorable Paul C. Smith, House Clerk** **Honorable Tammy L. Wright, Senate Clerk** **Honorable Chris Sununu, Governor** **Michael York, State Librarian**
FROM:	**Representative Sherry Gould, Chairman**
SUBJECT:	**Final Report of the Committee to Research Physician Assistant Scope of Practice** **HB 1222, Chapter 264, Laws of 2024**

Pursuant to HB 1222, Chapter 264, Laws of 2024, enclosed please find the Final Report of the Committee to Research Physician Assistant Scope of Practice.

If you have any questions or comments regarding this report, please do not hesitate to contact me.

I would like to thank those members of the committee who were instrumental in this study. I would also like to acknowledge all those who testified before the committee and assisted the committee in our study.

Enclosures

cc: Members of the Committee

FINAL REPORT

Committee to Research Physician Assistant Scope of Practice

HB 1222, Chapter 264, Laws of 2024

November 1, 2024

Rep. Sherry Gould, Chair
Rep. Karen Calabro, Clerk
Rep. Peter Schmidt
Rep. Erica Layon
Sen. Suzanne Prentiss

Committee Charge and Study Purpose:

The study committee shall:

I. Research revisions to statutes and regulations governing the scope of practice of physician assistants to identify differences between advanced practice provider scopes of practice, especially collaboration agreements with physicians, that should be changed to bring physician assistants more in line with advanced practice nurse practitioners and increase access to care.

II. Research other state laws that govern physician assistant scope of practice, educational requirements, and the level of supervision and collaboration with physicians, with the intent to make New Hampshire's practice environment attractive to physician assistants. In doing the research described in this paragraph, the committee shall compare these areas between the 2 advanced practice provider professions.

III. Research patient safety in states where collaboration agreements between physicians and physician assistants have been relaxed or eliminated.

IV. Research billing by advanced practice providers and reimbursement by health insurance companies for provided services. Special attention shall be paid to the barriers faced by physician assistants seeking reimbursement by health insurance companies as primary care providers.

V. Identify and correct, for the benefit of the public and legislators, misconceptions of a physician assistant's role in the health care system, including misconceptions regarding physician assistant education, training, experience, qualifications for advanced practice provider positions in all health care settings, and how physician assistants practice medicine within health care teams.

Process and Procedures:

The committee organized on September 18th 2024 and elected Representative Sherry Gould as Chair. The Chair appointed Representative Karen Calabro clerk. The committee met three times throughout the study period.

Findings:

Physician associates (PAs) are rigorously educated, trained, and licensed healthcare clinicians who practice medicine in every specialty and setting. They have completed a robust and unique educational training program. As healthcare providers they play a critical role in New Hampshire's healthcare system. PAs provide high quality, cost-effective, and safe care in all healthcare settings across the state. PAs and Nurse Practitioners (NPs) are equivalently qualified for advanced practice positions across the healthcare system. With HB 1222 becoming law, PA licensing, scope of practice laws and regulations will soon put them on par with those of NPs; to work in collaboration with all the other members of the team, including physicians. However, until PAs are able to be reimbursed as primary care providers (PCPs) and permitted to have their own panel of patients, they will not be fully utilized in the healthcare system. This will hinder patient access to care, especially primary care. The committee recognizes the importance of the insurance providers working with the PA's to ensure this vital step is accomplished.

The committee finds that common misconceptions about how PAs function in modern healthcare teams and misconceptions regarding PA education, training and qualifications further hinder them from fully practicing to their capabilities. A big step in correcting this misperception is changing the word "assistant" in their profession's name to "associate". The local and national PA associations, the New Hampshire Society of Physician Associates, and the American Academy of Physician Associates, respectively, have formally and legally changed their names, which will go a long way to addressing misconceptions about the PA profession.

The committee was informed that the two schools offering PA master programs in New Hampshire – one at Franklin Pierce University (FPU) in Lebanon, and the other at Mass College of Pharmacy and Health Sciences (MCPHS) in Manchester - have both stated that with the language changed in state law, they will rename the degree at their institutions to match the evolving field of study. It was noted that as the field is evolving it is expected that curriculum and training will evolve and input from physicians will be helpful to ensure a seamless provision of care across the healthcare system.

Summary of Committee Considerations

The committee heard oral and/or written comments from, and asked questions of, the following stakeholders, legislators, and members of the public:

- New Hampshire Society of Physician Associates
- New Hampshire Board of Medicine
- New Hampshire Board of Nursing
- New Hampshire Nurse Practitioners Association
- New Hampshire Medical Society
- New Hampshire Department of Insurance
- America's Health Insurance Plans
- Representative Jess Edwards
- Representative David Nagel, MD
- Dr. Todd Morrell MD, Dartmouth Health

The committee learned that PAs have always been at a disadvantage when competing for employment or advancement opportunities compared to their NP colleagues because PAs need a signed collaboration agreement with a physician to practice medicine, and NPs do not. SB 228 in 2022 attempted to address this disparity, but the employment challenges faced by PAs only got worse. The committee learned that last year, PAs began losing their jobs or were no longer being hired by major healthcare employers because of the need for these written collaboration agreements. PAs across the state, especially in rural areas, who own their own primary care practice or find themselves without their collaborating physician are forced to pay a physician over $12,000 a year to sign a collaboration agreement or else they lose their practice, and hundreds of patients lose their primary care provider.

HB 1222 removed the written collaboration agreement requirement for PAs employed in a setting with a physician on staff. For PAs with less than 8,000 post-graduate clinical practice hours who are practicing in a setting without a physician on staff, the new law requires they have a written collaboration agreement with a physician. PAs with more than 8,000 post-graduate clinical practice hours, who will be practicing in a setting without a physician on staff, will need a waiver from the collaboration agreement requirement from the Board of Medicine through 2026. After 2026, these PAs with more then 8,000 post-graduate clinical practice hours will no longer need a collaboration agreement to practice medicine. The committee notes that the Board of Medicine is currently adopting rules for the waiver process. The committee also notes that this action puts them on par with other advanced care providers, NPs, who never need a collaboration agreement to practice medicine, regardless of post-graduate clinical practice experience. It is important to note that nothing in law or regulation prohibits a healthcare employer from requiring internal collaborative or mentoring relationships between physicians and PAs as part of their internal credentialing and privileging processes.

The New Hampshire Medical Society and two physicians expressed opposition to PAs practicing without a collaboration agreement in any setting, citing patient safety concerns. However, the committee did not receive any information indicating an increase in adverse outcomes for patients receiving care from PAs practicing without collaboration agreements. In fact, the committee received a 2023 study that shows there have been no upticks in malpractice cases against PAs in states where collaboration agreements are relaxed or eliminated. Moreover, there are no indications that patient safety has been compromised in the three-plus decades that NPs have been practicing without collaboration agreements in New Hampshire.

More specifically we heard concerns over PAs opening their own specialty care practices and engaging in specialty care. Our findings are that these concerns are unfounded. Such a path would be outside of a PAs scope of practice and contrary to their training. PAs attempting specialty care practices are unable to be reimbursed for services by health insurers, let alone carry malpractice insurance as required by law. Under current NH law PAs can only practice specialty care under a qualified physician and nothing in HB 1222 changes that. This differs from NPs who have their own different credentialing capabilities. PA's simply can not open their own specialty care practice.

The Board of Medicine is charged with keeping the public safe by regulating physicians and physician assistants/associates. The Board took no position on HB 1222, but noted the employment challenges collaboration agreements caused for PAs. The Board has not indicated

any concerns with HB 1222 now that it has become law and is working quickly to implement rules associated with the new law. Board of Medicine member Daniel Frazee, PA-C, told the committee that PAs do not practice independently even if a PA practices in a setting without a physician on staff. He noted that training, laws, and regulations require PAs to collaborate with physicians and all other appropriate members of the healthcare team and prohibits PAs from practicing without the ability to consult with a member of the healthcare team.

Josh Dion, APRN, spoke on behalf of the Board of Nursing, which regulates nurses and NPs in the state. Mr. Dion emphasized that the Board sees no need for any changes to law or regulations. He further noted that PAs and NPs are not trained in their unique style of practice, and both are equivalently qualified for advanced practice positions throughout our healthcare system. Kim Mohan, APRN and President of the New Hampshire Nurse Practitioners Association, echoed Mr. Dion's comments. She expressed her concern with the education, training, licensure, and scope of practice comparisons between PAs and NPs, as they can lack appropriate context. The issue of PAs being reimbursed as a primary care providers, and being allowed to carry their own patient panels received a significant amount of attention during committee proceedings.

With HB 1222 now law, the issue of PAs being reimbursed as PCPs is currently the most significant barrier to PAs being able to practice medicine to the fullest extent of their education, training, and experience. This barrier is why the majority of PAs work on physician-led specialty care teams. This barrier led to many of the adverse PA employment actions discussed before the committee. The state Department of Insurance informed the committee that there are no state laws or regulations preventing PAs from being credentialed by health insurance carriers as PCPs carrying their own patient panels. A representative for the health insurance association noted there are many factors that go into credentialing decisions. The removal of the collaboration agreement requirement for most PAs will help advance the process of PAs being credentialed as primary care providers. NPs are able to be reimbursed as PCPs with their own panels. The committee is pleased to know that discussions on this issue between PA associations and carriers at the national and state level have begun. It remains to be seen if that process will take several months or even a year or more, for PAs to begin to be able to practice as PCPs with their own panels, and be reimbursed accordingly. The committee's hope is that this process proceeds as quickly as prudently possible, as this will greatly address the issue of a lack of PCPs. This lack of PCPs directly leads to a delay in accessing primary care statewide, and a lack of access to care in many areas, especially in rural locations.

The committee was tasked with identifying and correcting misconceptions about PAs and their education, training, and qualifications. The PA profession started when PAs functioned more as assistants to physicians. Over the succeeding decades, the profession has evolved so that PAs are highly skilled, highly trained, highly qualified healthcare providers practicing in every medical setting. Despite this, PAs are still known as Physician Assistants. As a result, many still do not realize that PAs are skilled providers. According to the American Academy of Physician Associates (AAPA), lack of understanding of the education and training of PAs, and their roles on healthcare teams are a factor in PAs not yet being credentialed as PCPs. As noted previously in this report, the AAPA and NHSPA have changed their names to replace the term "assistant(s)" with "associate(s). To help address misconceptions about the PA profession, the committee believes legislation should be introduced and passed in 2025 to change the name of the

profession everywhere in state law and regulations to "Physician Associate(s)." The committee understands that once such a bill becomes law, the state's two PA schools will change their names accordingly.

Recommendations:

The committee is pleased to submit this report to guide legislators and other stakeholders when considering legislation related to PA practice during the next legislature and into the future.

Specifically, the committee finds the following:

1) There is no need for legislation changing PA licensing or scope of practice laws or regulations. When HB 1222 is fully enacted at the beginning of 2027, PAs and NPs will have similar licensing and scope of practice laws and regulations, which is appropriate based on the education, training, and experience of both professions.

2) According to information obtained by the committee, there has been no decline in safety or quality of care in states where collaboration agreements between physicians and PAs have been relaxed or eliminated.

3) There are no state laws or regulations preventing health insurance carriers from credentialing and reimbursing PAs as primary care providers or allowing PAs to have their own patient panels. However, carriers typically either do not credential PAs as Primary Care Providers or do not allow PAs to have their own panels.
    - The Department of Insurance should address this issue as appropriate when reviewing network adequacy rules in the coming months.

4) Legislation is needed in 2025 to change the name of the PA profession in all state statutes and regulations from physician "assistant(s)" to physician "associate(s)" in order to come in line with changes already implemented by local and national PA associations, the New Hampshire Society of Physician Associates, and the American Academy of Physician Associates.

Respectfully Submitted,

Representative Sherry Gould, Chairman

Appendix

HB 1222 Study Committee
Room 306-308 LOB
September 18, 2024

- Good Morning, colleagues, staff, and members of the public. As the first named House member, I'd like to call this meeting of the HB 1222 study committee to order

- For the record, my name is Sherry Gould and I represent Merrimack District 8 which includes the towns of Bradford, Henniker and Warner

- This study committee was created when HB 1222 was signed into law by the Governor in late July. We are here by statute, appointed to focus on how to retain, grow and fully leverage our advanced practice provider workforce to increase access to care in our state, especially primary care.

- Our charge is to look at the laws and regulations governing advanced practice providers – namely, Physician Assistants (AKA Physician Associates) and Nurse Practitioners, to identify any barriers to these providers being fully utilized in our healthcare systems as their education, training and experience allows.

- Committee members have CHAPTER 264, HB 1222 - FINAL VERSION before you and on page 4, line 17, you will see the 5 specific areas we are asked to examine

- We will specifically focus on PAs, the hurdles they've recently removed and identify any that may still remain. I want to be clear, the discussion and work of this committee will remain focused on those five areas outlined in our statutory duties, and will not

include any rehashing of HB 1222, which passed the House and Senate and was signed by the Governor.

- I've set aside next Thursday, September 26th at 10 am in this room for another meeting if needed.

- Finally, we'll meet again. discuss our findings for a report that includes what (if any) changes to statute we recommend for legislative action in the next session of the general court

- Let me remind you that we would like to stay concise with our meeting times, so if you have written comments to leave us, please do not read them, but summarize so we may ask questions

- Now, I'll ask any legislators present if they'd like to speak.

- Next I'll invite the stakeholders named in the bill to come up, in the order they are listed in the bill, to provide comments to the committee, if they so choose.

- And finally, if there are any members of the public or any of the stakeholder groups named in the bill wishing to provide any further comments, we'll hear from those folks before wrapping up for the day.

- Chairman position elected- Representative Layon nominates Representative Sherry Gould, Representative Calabro 2nd
- Vice-Chair position elected: Chairman Gould nominates Representative Karen Calabro, Representative Schmidt 2nds
- Review of the required information of the final version Ch 264.1222

- Senator Prentiss was asked to be on this committee, but was unable to attend this meeting today, as told by Chairman Gould.
- Formally started recording at this time. 10:07am
- Chairman Gould describes that description of the Collaborative is on page 4.

- Introductions: Representative Erica Layon, Derry Vice-Chair HHS Representative Schmidt HHS, Representative Karen Calabro Transportation, Hills 45

- LEGISLATORS PRESENT are formally invited to talk: Representative Edwards is asked to speak as cosponsor of the original bill. He describes a long-standing experience, and describes how his father established the 4th PA program in Nebraska, and watched the political and economic turf wars and barriers to entry for decades. He doesn't think it will disappear entirely, but encourages our committee to keep in mind an objective we all share: recognizing we have severe workforce shortages in healthcare and we need to improve their access to safe medicine with attention to costs. Right to healthcare access and safety issues will need to be a priority. As a general POV, this profession is every bit as capable as NPs as was seen (by himself) while on Active Duty in Afghanistan, and entire facilities led by PA's without doctors on site, and he recognizes embedded in their training, that they work as a collaborative team and to learn what they do not know or maintain access to others whose expertise is more in line (with their deficits). (Notes he will be gone 1st/2nd week of Oct.)

- STAKEHOLDERS ARE INVITED TO SPEAK:

- Discussion with Sarah LEslie VP and Cochair NHSPA's Dave Cuzzi from Prospect Hill in Concord, representing New Hampshire's Physician Associates.
  - 71% PA's are women. Franklin Pierce Lebanon and MCPHS University remain the only two institutions that have Physician Associate Programs, and we do not see any more need to have legislative and offer a side by side of PA's and NP's practice laws, and they lack parity. New England States and all states governing PAs shows NH has a more hospitable atmosphere, than was previously due to this law. They are not ensured to have increased safety, however. They should be able to have their own panels. (PA fact sheet is provided.)
  - PAand NP are Advanced Practice providers, equally eligible, and PAs are at a competitive disadvantage, and we do not need a collaborative agreement, and until this law was signed, it hurt PAs. It also exposed MD's who signed (collaborative agreements) to law suits.
  - In 2022 The PA bill did 3 things. Removed "Supervision" and changed to "collaboration." It made doctors clear that they could not be sued without direct access/care. And not requiring insurance. Through the fault of no one, it actually got worse with hiring practices. Family practices fired a dozen PA's due to not wanting to have the extra red tape. At DH several PAs were passed over for new positions due to the requirement and (subpar) PA reimbursement rate issues. The new bill became a priority to the PAs in NH and we aimed to reduce the requirement and the root of our many barriers to employment. Scope of practice laws, which lack equity with NPs are still required for PAs with fewer than 8000 clinical hours.

They can apply for the waiver after that required limit. (We aim to provide) Incremental steps for experienced PAs to operate, and discuss the reimbursement rates, and permit their acting as PCPs. However, they can't have their own panels, and have to see the panel of the MDs. Naturopaths are included (in this reimbursement permission), but PAs are not yet included. Insurance is open to these discussion, and NHSPA has no issues with this.

- We ask that there be a name change to Physician Associates as title changes in statute would address the common misconception of our role.

- Representative Schmidt questions these stakeholders: "This paints a sad picture of "re-regulating" healthcare laws. Some of the issues raised suggested that there may have been some lawsuits to undo these unintended effects. Answer by Representative Calabro PA: "Most of us, including myself did not know this was a systemic issue until HB1222 came to light in the House in General Session." She describes how she could not find work for 18 months as a PA in community health centers across Southern New Hampshire despite being Quality Assurance Medical Lead and the same of Mobile Crisis at Harbor Care. Answer also by David Cuzzi: There is no history of PA lawsuits or nefarious dealings that would create the need for this tether; only the risks of it existing. The physician assistants and MD could be sued together in a case, and as such, doctors stopped wanting that liability, and let them go. (As a result, and to continue working, the costs of hiring an MD to cosign, is expensive for PAs. The reduction of HB228 of the lawsuit factor from risks for Doctors signing the agreements, still did not mitigate the risks to PAs, and as such would make insurance for their PAs

prohibitively expensive. Is this situation unique? HB1222 has only been law for 2 months, and we knew it wouldn't be an overnight scenario of improvement. In larger healthcare settings, there might be a quicker positive impact, and administrative changes implemented, but the real issue is in primary care, and why the legislation focused primarily on this. Shares of reimbursement rates (to increase) will take time with insurance. Once we get to that point, this will be more stable for PAs as they can have their own panels, and access would improve in rural settings.

- Representative Schmidt asks a Follow up: where did the PAs go? Answer David Cuzzi: There was a diversion to surgical subspecialities, largely in the larger clinics/hospital settings, but many left the state.
- Representative Layon, looking at this, "We made some great changes, and it sounds like you're hoping we change the name in addition? The name is going to need to be changed within our legislation, so we can keep this in mind and not confuse people about them being a Provider (with the name Assistant). Answer David Cuzzi: "We found that a title change is helpful."
- Chairman Gould: question on behalf of the House: "One path appears to be if a PA wants to work in a hospital, and the other is for PAs who go into private practice without an MD. Provisions are needed in each setting. In DH, is there anything in the bill or statute that prevents a hospital to change or create any rules that they want to implement, and can't collaboration agreements be part of that, should they wish to? Answer David Cuzzi: That is a confusion out there amongst providers, and nothing in the statute prevents any entity from setting their own rules. Chairman Gould: We discussed this at length in committee, and there are rules in

place for safety/credentialing, and scope of practice discussions. Answer by Cuzzi- “Page 3 of the bill on line 28 requires them (All employed Physician Associates) to comply with their workplace rules. Their rules might include a collaborative agreement.”

- Representative Schmidt: Is there a bill that addresses the issues that you are speaking to and that continue to be a problem, and is this bill well-done? David Cuzzi: No. It addressed most of the issues, but not all. They (NHSPA) would love to work with folks about having their own panels in future, a title change, and licensing compacts which do not exist in NH. We feel it has largely addressed the concerns regarding barriers, and we would like to have conversations about bringing that in for next year. A “Compact” bill was presented this year, but ED&A did not move forward with it because it was not “live” and now the 7th/13th state has already signed on (to include one). ED&A issues are going to take 1-2 years for the compact to be fully up and running. Representative Schmidt: Compacts before ED&A are a nasty term in the POV of many Committee members. David Cuzzi: We have been to the rodeo.
  Chairman Gould- we will attend to this in time to come and address its implementation.
- NHBOM’s Cassandra Brown, Board Council from OPLC; Dan Frazey PA on the NHBOM. HB1222 at the moment the board is in the process of editing the final review, which was sent to OLS within the deadline, and because it was rushed in 90d, we do not take a position. We are not available to come next Thursday, as the BOM is meeting at that time, and so we may not be able to attend. Chairman Gould to Dan Frazey PAC: Might we understand how you are present, as the board did not authorize you to speak on their behalf? Answer: They

will discuss it as a board and provide a unified voice. The BOM recognizes what they (PA's) do for our communities, and their relationship with us is helpful. We have two functions: regulatory and protective of the public. We have two jobs as protectors of the public and of providers. Question by Representative Schmidt: The rule-making process is where within your board? Answer: Our edits are being drafted at present, and we hope to get it back by Oct1st. JOCAR is still operating tomorrow, and Representatives Layon and Schmidt are attending. Because it's in that process, you are sympathetic to the predicament we are discussing this morning. Regular rule-making process (will take place) thereafter. The Board wrote a letter to you regarding this, and discussed that the BOM recognizes the barriers for PAs, and is sympathetic to their issues. Representative Calabro asks "Specifically, which barriers?" Answer: It was brought to my attention that with these restrictions, we were no longer being hired, were leaving the state, and I personally saw this, and the questionable issue about a lack of (healthcare) access up North, and not retaining highly trained PAs across the state. NHBOM states again that while they are not able to be present next week- lawyers from the BOM can pass any committee comments to us next Thursday.

- Stakeholders: Nurse Practitioner's Association: Chairman Gould reports her daughter is an NP and established palliative care with concentration in pediatrics and she is now doing critical care. She (her daughter) has helped us immensely in understanding the situation. She has a collaborative agreement in SC. Dupont Group's Brendan Flaherty: "We were not prepared to present, and glad to bring folks to the next meeting or provide resources, but did not

weigh in on the bill." He is an Associate at DG (Flaherty), and is offering any resources needed. They convene a large workforce stakeholders group and meet every Thursday morning, which covers all areas of healthcare, and at present, there are no PAs in this group, but they are welcome to join their organization.

- Representative Schmidt Question: There are allegations that there was some misinformation regarding a side by side presented by the NHSPAs group that we had issues with, and it has since been corrected, and they are asked to present this, and it is in included in the package. David Cuzzi did explain that it lacked an appropriate context and he did not include it in the package. It was regarding the PAs education that was part of the issue. and it can be resent via email. David Cuzzi: Reminds us that it lacks context and we have an updated worksheet before us.
- Chairman Gould apologizes for fast tracking this process, and feels that NPs had good lobbyists and advocated appropriately, and branded themselves better. We need to improve public education here, with regards to PA's.
- NHMS: Ava Hawks, Director of Advocacy for NHMS: Our issues are similar to those representing NPs. We thought Organizational meetings are for electing officers, and not material, so we are not prepared to talk. Offers resources.
- American Health Insurance Companies: Heidi Kroll, (Gallagher), a AHIP representative, which includes most carriers in NH. They do not take a position, and did not with regards to the bill, but monitored it, as other stakeholders, and feel they cannot speak for any other carriers. "My experience is in working with government relations, and internal teams with issues that stakeholders may want to discuss with them." They can work through issues,

welcomes them, and offers a path forward. Issues, as seen, are credentialing to provide primary care services, and reimbursement, not exactly at the same rate, but reimbursed for those services, not previously being reimbursed. The carriers are concerned about (increasing) rates, and so providers' payment models vary, QA, access, adequacy requirements, and so there is no set formula about negotiating the rates.

- Representative Edwards wishes to speak: Follow up on a couple of legislative matters upcoming. One has been parity issues of reimbursement, and the legislature weighs in on this, but there doesn't seem to be a good time to do that, and insurance companies should review their own policies so they can have a positive influence on these issues. We are ahead of where medicaid is in reimbursement, and (with regards to Insurance) he has worked with them on RX cost issues, and found them to be very helpful. In a year, we may be concerned about the parity issue, but not presently. The name change was considered and he was asked to be the prime sponsor, but he felt that its going to be a very busy session, and feels premature as the national trend moves, and we can watch how other states resolve this issue. Representative Calabro offers to help, citing that there is no need to delay (a housekeeping matter like a name change).
- Gould invites others to speak at this time, but there are no more speakers.
- Chairman Gould moves to adjourn. We are to meet next Thursday at 10am. LOB 306-8.

PA practice laws, regulatory reforms, and medical malpractice rates: A summary of findings

Executive Summary

- Ten years (2010-2019) of medical malpractice payment report (MMPR) data for physician associates/assistants (PAs) and physicians from the National Practitioner Data Bank were compared to the PA laws and regulations of states for the same period.
- States with permissive practice environments (with four or more permissive scope of practice reforms) compared to restrictive states (with three or fewer scope of practice reforms) had no increased risk of PA MMPR occurrences.
- Certain scope of practice (SOP) elements had a significant effect on the number of MMPRs for PAs and physicians – with five of six practice reforms decreasing or having no significant effect on PA and physician MMPR occurrences.
- Creating a more permissive PA practice environment led to a reduction in MMPRs for PAs and physicians.
- Changing from restrictive to permissive PA practice laws and regulations does not result in harmful or low-quality care.
- Removing barriers to PA practice improves access to high-quality, cost-effective care while maintaining patient safety.

Background

All states have an obligation to protect patients within their borders by regulating the practice of medicine. By including the PA profession in laws and regulations and by designating a state agency to regulate PA practice, states both protect the public and define the PA role within the U.S. healthcare system. However, few studies demonstrate the impact of these provisions on patient safety. This is important because some PA regulations and physician collaboration/supervision requirements have been noted to be unnecessary, unjustified, costly, and potentially detrimental.[1-4] Despite the growing body of evidence demonstrating the safety and high-quality care PAs provide and the benefits of

removing unnecessarily restrictive PA practice laws and regulations, opposition to improving the PA practice environment has been expressed by some individuals, primarily based on an unfounded assertion that a permissive PA regulatory environment threatens patient safety.

Authorizing PAs to provide care to patients and removing restrictive laws and regulations without sacrificing patient safety is essential to meet the needs of patients and the U.S. healthcare system. A system which continues to face significant challenges with an aging population, limited access to care, increasing health inequities, and workforce shortages. PAs are highly educated, licensed clinicians who practice medicine in every specialty and setting and, if given the opportunity to do so, are a major solution to some of the most pressing healthcare challenges.

To explore the interaction between regulatory changes and patient safety, researchers at AAPA developed an observational study examining ten years (2010-2019) of MMPR data from the National Practitioner Data Bank (NPDB) compared to the laws and regulations of states* governing PA practice during the same period. The goal was to determine if states with permissive compared to restrictive PA regulatory environments had higher instances of MMPRs. Reported malpractice payments can serve as an approximation of the acts or omissions constituting medical errors or negligence, and prior studies have demonstrated MMPRs are highly correlated with adverse patient outcomes and have been used as a surrogate measure of serious adverse medical events.[5-6]

* For purposes of this research, "state" includes all 50 states and the District of Columbia.

Methods and Results

Six factors of ideal PA practice laws and regulations that allow for optimal practice were identified based on recognized standards, industry experts, and regulatory agencies.[1-3,7] Negative binomial regressions indicated no statistically significant differences in MMPR rates between states with permissive versus restrictive PA practice laws and regulations. Additionally, permissive states were no more likely than restrictive states to have PAs committing MMPRs resulting in temporary injury, permanent injury, or death. Five of six practice reforms decreased or had no significant effect on PA and physician MMPR occurrences. One reform, physician cosignature, was associated with a weak but statistically significant increased risk of MMPRs for PAs and a trend toward a decreased risk for physicians; however, these findings may represent a more accurate attribution of care and accountability rather than an overall increased risk to patients.

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State Elements and Their Associated Risk with MMPRs for PAs and Physicians
A highly significant decrease in MMPRs for both PAs and Physicians
Allowing PAs to practice consistent with their training and experience (and not limiting PA SOP to that of a collaborating physician)
A significant decrease in MMPRs for physicians with no effect on MMPRs for PAs
Allowing PAs to practice in collaboration with physicians or have no formal statutory relationship with a physician
Authorizing physicians to collaborate with an unlimited number of PAs
No significant effect on MMPRs for PAs or physicians
Allowing PA SOP to be determined at the practice site
Not requiring a physician to be onsite or in proximity to a practicing PA

Conclusion

This study demonstrates no evidence that states with permissive compared to restrictive PA practice laws and regulations had higher instances of MMPRs or patient harm. The findings of this study suggest unnecessary and restrictive PA practice elements can be eliminated from state laws and regulations without adversely affecting MMPRs or patient safety. Removing barriers to PA SOP improves access to high-quality, cost-effective care while maintaining patient safety. Almost all the regulatory factors included within these statistical models illustrate that creating a more permissive PA practice environment leads to a reduction in MMPRs for PAs and physicians. Less restrictive state laws and regulations will allow PAs to meet the medical needs of patients and the healthcare system.

For additional information, please refer to the following article:

DePalma SM, DePalma M, Kolhoff S, Smith NE. Medical malpractice payment reports of physician assistants/associates related to state practice laws and regulations. *J Med Regul*. 2023; 109(4): 27-37. doi: 10.30770/2572-1852-109.4.27. https://meridian.allenpress.com/jmr/article/109/4/27/498933/Medical-Malpractice-Payment-Reports-of-Physician

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5. Kravitz RL, Rolph JE, McGuigan K. Malpractice claims data as a quality improvement tool. *JAMA.* 1991; 266(15): 2087-2092.29.
6. Bishop TF, Ryan AM, Casalino LP. Paid malpractice claims for adverse events in inpatient and outpatient settings. 2011; 305(23): 2427-2431.
7. American Academy of Physician Associates. *Optimal team practice*. Accessed November, 22, 2002. https://www.aapa.org/advocacy-central/optimal-team-practice/

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PAs as Primary Care Providers: Insurance Credentialling/Reimbursement

People who have access to high-quality primary care are more likely to receive preventive health services and screenings and to experience improved health outcomes related to mortality, disease progression, and chronic condition management.[1] PCPs help patients navigate the complex healthcare system by delivering primary care services and coordinating care with other specialists, and making referrals, as necessary. Experienced PAs are trained and qualified to provide high-quality primary care. Though progress is being made as AAPA engages with payers, there are still some payers that don't recognize PAs as PCPs. This means PAs cannot serve as PCPs, limiting access to care, increasing healthcare costs, and hurting PA employment opportunities and career advancement.

There is no direct relationship between eliminating collaboration requirements and payers authorizing PAs to be PCPs. However, AAPA, in its discussions with large payers, has found payers are more likely to grant PCP status when PAs have increased practice autonomy.

- HealthCare.gov and the federal Medicare program authorize and include PAs in the official definition of primary care provider.
- PAs, through rigorous education and clinical training, are well-qualified to serve as a patient's primary care provider (PCP) and to serve as a PCP for a panel of patients. Personnel at commercial insurers benefit by gaining a better understanding of PA education and scope of practice to demonstrate comparable clinical skills and treatment outcomes to other providers.
- While not necessarily formal policy, commercial insurers are more likely to include PAs as PCPs based on their perception of PAs being able to make independent, autonomous diagnostic assessments and medical treatment decisions.
- There is an acknowledged shortage of primary care providers in the US.[1] As insurance companies and accountable care organizations seek to meet network adequacy requirements, especially in medically underserved communities, PAs are increasingly one of the solutions utilized to meet primary care and PCP staffing requirements.
- Patients often pay a lower co-pay and/or have reduced out-of-pocket expenses when being treated by their PCP. Increasingly, commercial insurers are incentivized to designate PAs as PCPs in order to lower the cost of healthcare for patients and the healthcare system.

For additional information contact Michael Powe, AAPA's Vice President, Reimbursement & Professional Advocacy, at michael@aapa.org

April 2024

[1] https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model
1 https://www.air.org/resource/blog-post/how-address-shortage-primary-care-providers-united-states

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Key Provisions in State PA Laws – New England Region

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Connecticut	Yes - supervision	Yes – delegation agreement on file at practice.	No requirement	No requirement	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication.
Maine	Yes - collaboration	Yes – for those with less than 4,000 clinical hours there is a board-approved collaboration agreement. PAs with more than 4,000 hours who are the principal provider in a practice that does not include a physician partner must have a board-approved practice agreement. All other PAs must simply have a physician available for consultation.	No requirement	No requirement	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication.
Massachusetts	Yes - supervision	Yes – supervising physician approved by board. Written delegation agreement with specific protocols required for major invasive procedures.	No requirement	No requirement	No requirement	Prescriptions or orders for Schedule II controlled substances must be reviewed by physician within 96 hours.	No restriction	Schedule II-V; all non-controlled medication. See review provision for Schedule II.

New Hampshire	Yes – collaboration with physician or appropriate member of healthcare team as dictated by patient condition, standard of care, and PA training and experience	For PAs employed in a setting with at least one physician on staff, no collaboration agreement is required. PAs with less than 8,000 post-graduate clinical hours practicing in a setting without a physician on staff shall enter into a written collaboration agreement with a licensed New Hampshire physician. PAs with more than 8,000 post-graduate clinical practice hours seeking to practice in a setting without a physician on staff must receive a waiver from the collaboration agreement requirement from the Board of Medicine. This waiver requirement sunsets on December 31, 2026. At that time, PAs with more than 8000 post-graduate clinical practice hours may practice in any setting without a collaboration agreement.	No requirement	No requirement	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication.

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Rhode Island	Yes - collaboration	No requirement	No requirement	No requirement	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication.
Vermont	Yes - collaboration	Yes – practice agreement filed with board and kept at practice site.	No requirement	No requirement	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication.

The information contained in this summary is condensed and accurate as of August 2024. This document is intended for background purposes only. For a complete and current version of statutes and regulations, AAPA encourages you to visit the state's legislative and regulatory websites. Many states are currently working on improvements to existing PA statutes and regulations. For information on pending improvements please contact AAPA.

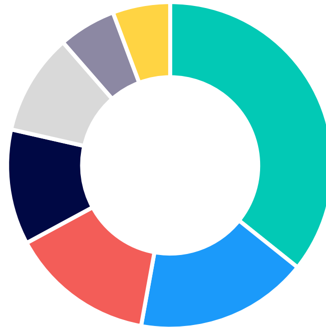
Last Updated: August 2024

NEW HAMPSHIRE
PA PRACTICE PROFILE

Number of PAs **in New Hampshire:**
1,100+

Number of PAs **in the United States:**
178,700

Percent of PAs by Specialty in New Hampshire



- 33.8% Surgical subspecialties
- 16.2% IM subspecialties
- 13.5% Family medicine
- 10.8% Urgent care
- 9.5% All other specialties
- 5.4% General peds, general IM
- 5.4% Emergency medicine

Percent of PAs by Setting in New Hampshire

- 42.9% Hospital Settings
- 41.4% Physician office or clinic
- 8.6% Urgent care center
- 7.1% Other settings

In New Hampshire:

- 40.6% of New Hampshire PAs serve in rural areas
- A typical PA completes 58 patient visits per week
- A typical PA is on call 51 hours per month

Two PA Programs in New Hampshire:

- Franklin Pierce University
- MCPHS University (Manchester/Worcester)

18.9% of PAs **specialize in Primary Care**

18.4% of PAs **are employed by a Physician Group or Solo Practice**

Source: AAPA 2024 Salary Survey

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The Facts About PAs

PAs (physician associates/physician assistants) are licensed clinicians who practice medicine in every specialty and setting. Trusted, rigorously educated and trained healthcare professionals, PAs are dedicated to expanding access to care and transforming health and wellness through patient-centered, team-based medical practice. A PA's specific duties depend on the settings in which they work, their level of experience, and state law. There are more than 150,000 PAs in the United States, who engage in more than 400 million patient interactions each year.

PAs are licensed and regulated at the state level. To become licensed, a PA must have graduated from an accredited PA program and passed the Physician Assistant National Certifying Examination.

PAs are educated at a master's degree level and complete approximately 27 months or three academic years of instruction. The PA school curriculum is modeled on the medical school curriculum, which includes both didactic and clinical training. In the didactic phase, students take courses in basic medical sciences, behavioral sciences, and behavioral ethics. In the clinical phase, PA students complete more than 2,000 hours of clinical rotations in medical and surgical disciplines, including family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry.

Myths and Facts

Myth: Patient safety will be compromised if PAs work without direct physician oversight.
Fact: PAs practice within the scope of their education, training, and experience, and they have been found to provide the same safe, high-quality care with similar outcomes as other healthcare providers. When PAs were compared with other medical staff, there was little or no negative effect on health outcomes or cost. PAs worked as additions, as well as substitutes, in complex systems where the work is organized in teams, which creates challenges for identifying cause and effect. [1] PA employment was also often part of wider service redesign or staffing changes in response to other changes, for example, availability of medical staff. The evidence here suggests that PAs make a positive contribution to medical care and medical teams. Like all healthcare professionals, PAs have a legal and ethical obligation to consult, refer, or transfer patients when their healthcare needs are outside the PA's level of expertise.

Additionally, patients have been found to prefer seeing a PA for certain specialty services, such as minor procedures, long-term appointments, follow-ups, and preoperative teaching in orthopedic clinics. [2]

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[1] Halter M, Wheeler C, Pelone F, et al.. Contribution of physician assistants/associates to secondary care: a systematic review. BMJ Open. 2018;8(6):e019573. doi:10.1136/bmjopen-2017-019573.
[2] Manning, B.T., Bohl, D.D., Redondo, M.L., et al. Midlevel providers in orthopaedic surgery: the patient's perspective. Iowa Orthopaedic Journal.

Myth: PAs jeopardize patient safety by overprescribing controlled substances.
Fact: Several studies show PAs have similar prescribing patterns to physicians and other providers and are less – not more – likely to overprescribe than other types of health care providers. Stanford University researchers found that the specialties representing the largest number of prescriptions for Schedule II opioid medications to Medicare beneficiaries in 2013 were family practice physicians (15.3 million), internal medicine physicians (12.8 million), nurse practitioners (4.1 million), and PAs (3.1 million).[3] Another team found that PAs and NPs had a similar increase in the proportion of opioid prescriptions they wrote between 2005 and 2015. PAs and NPs prescribed less hydromorphone and morphine when compared to physicians.[4]

Myth: PA utilization increases healthcare costs.
Fact: PAs are an extremely cost-effective provider. One study on the cost-effectiveness of PAs found that when the cost of a PA's salary and education are considered alongside the services they provide, PAs are "one of the most cost-effective health care clinicians to employ."[5] Another study found that greater use of PAs in primary care visits was not associated with higher specialty referrals, advanced imaging, ED visits, or inpatient stays.[6] Additionally, expanded use of NPs and PAs in the primary care provider role for some patients may be associated with notable cost savings.[7] Across a large multi-state healthcare system, there was no direct relationship between having more physicians on a family medicine team compared to PAs and NPs and the number of emergency department visits, hospital utilization, or readmission rates.[8] In a large review of the data, researchers found that 29 out of 39 studies showed that costs were lower for PA-delivered care compared to physician delivered-care.[9]

Myth: The quality of care provided by PAs is lower than that of physicians.
Fact: PAs have been found to provide routine patient care that is similar in quality to physicians and NPs.[10] In studies of the Veterans Administration, there was no clinically significant variation among the physician, NP, and PA primary care providers with regards to diabetes outcomes. The studies suggest that similar chronic

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[3] Chen, J.H., Humphreys, K., Shah, N.H. (2015). Distribution of opioids by different types of Medicare prescribers. *Journal of the American Medical Association Internal Medicine.*
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[9] van den Brink GTWJ, Hooker RS, Van Vught AJ, Vermeulen H, Laurant MGH. The cost-effectiveness of physician assistants/associates: A systematic review of international evidence. *PLoS One*.
[10] Sarzynski, E. Barry, H. (2019) Current evidence and controversies: advanced practice providers in healthcare. *American Journal of Managed Care.*

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illness outcomes may be achieved by these providers. [11] [12] Looking at patients with cirrhosis, patients with PA and NP led care had lower rate of 30-day readmission, among several positive outcomes. When PAs, NPs, and gastroenterologists and hepatologists collaborated, the best patient outcomes were achieved. [13] In a multi-site study of pediatric intensive care units (PICU), PAs and NPs had more complex patients upon admission compared to physician-only PICUs. There was no difference in mortality nor length of stay in the two types of teams, and patients seen by PA and NP led PICU teams had lower odds of some infections. Finally, in a recent review of the literature, research showed PAs have comparable quality of care to physicians (15/39 studies) and/or higher quality of care than that of physicians (18/39).

Myth: PAs are seeking "independent practice."
Fact: The PA profession thrives in team-based practice. Numerous studies have shown that team-based care increases access and satisfaction for patients. A recent study found that PAs helped physicians increase patient panels and provide broader care. PAs were found to perform more "substitutive" services than "supplemental," which enabled physicians to increase patients seen and provide more services. [14] In a study in the Academic Emergency Medicine Journal, it was found that there were no adverse effects from PAs and NPs managing emergency department visits on workflow, safety, or patient satisfaction - which indicates there is little/no risk from increased coverage in emergency departments. [15] In a study looking at Press Ganey scores provided by over 44,000 patients receiving outpatient services, there was no difference in patient satisfaction scores based on the provider seen. [16] A review of the literature found that across studies, patients are satisfied with the care provided by PAs. [17]

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[11] Jackson GL, Smith VA, Edelman D, et al. Intermediate Diabetes Outcomes in Patients Managed by Physicians, Nurse Practitioners, or Physician Assistants: A Cohort Study. Ann Intern Med. 2018;169(12):825-835. doi:10.7326/M17-1987
[12] Jackson GL, Smith VA, Edelman D, et al. (2018) Intermediate Diabetes Outcomes in Patients Managed by Physicians, Nurse Practitioners, or Physician Assistants: A Cohort Study. *Ann Intern Med.*
[13] Tapper EB, Hao S, Lin M, et al. (2020). The Quality and Outcomes of Care Provided to Patients with Cirrhosis by Advanced Practice Providers. *Hepatology*.
[14] Dai M., Ingham R.C., Peterson, L.E. (2019). Scope of practice and patient panel size of family physicians who work with nurse practitioners or physician assistants. *Family Medicine.*
[15] Pines JM, Zocchi MS, Ritsema T, et al. (2020). The Impact of Advanced Practice Provider Staffing on Emergency Department Care: Productivity, Flow, Safety, and Experience. *Acad Emerg Med*.
[16] Stephens AR, Presson AP, Chen D, Tyser AR, Kazmers NH. (2021). Inter-specialty variation of the Press Ganey Outpatient Medical Practice Survey. *Medicine (Baltimore).*
[17] Hooker RS, Moloney-Johns AJ, McFarland MM. (201) Patient satisfaction with physician assistant/associate care: an international scoping review. *Hum Resour Health*.

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Key Provisions in State PA Laws

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Alabama	Yes – supervision	Yes – written job description/ registration approved by the board	No requirement	At least quarterly	In OR or immediately available to OR when PA is involved in care of patient. Unless otherwise approved by board, must be present in OR when PA performs/assists in invasive procedures deeper than complete dermis. At least 10% of the time a PA is present in a remote site if: (i) PA has less than 2 years/4,000 hours in a registration agreement (ii) PA enters a new registration w/ a new supervising physician having a dissimilar primary specialty than previous supervising physician.	Determined by facility/practice; co-signature required any time PA enters a verbal order from a physician for controlled substances or other medications which the PA is not authorized to prescribe.	360 hours per week cumulative time for all PAs supervised (no more than equal to 9 full-time equivalents); physician may request transitional allowance NTE 45 days increasing total weekly hours for orientation of incoming PA.	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
					If PA has at least 2 years/4,000 hours in a registration agreement, physician shall visit remote site no less than twice/year & meet with PA no less than quarterly.			
Alaska	Yes - collaboration	Yes – collaborative plan filed with department	No requirement	Annual direct contact. Monthly telephone, radio, electronic, or direct personal contact. Collaborative plans in effect for less than two years must include at least one direct personal contact visit with the collaborating physician per calendar quarter for at least four hours' duration; twice yearly subsequently.	PAs practicing remotely (more than 30 miles from collaborating physician) with less than 2 years of experience: on-site supervision for first 160 hours, or 40 hours if changing collaborating physicians.	No requirement	No restriction	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Arizona	No - unless PA has fewer than 8,000 hours of practice experience (in which case, collaboration is required).	Yes – written collaborative agreements are required for PAs with less than 8,000 hours of practice experience.	No requirement	PAs with less than 8,000 hours of practice experience must meet in person or via telecommunication once a week if PA works in separate location.	No requirement but board may require for certain procedures.	No requirement	No restriction	Schedule II-V; all non-controlled medication. Schedule II-III opioids and benzodiazepines limited to a 30-day supply. 90-day supply limit for all other II-V.
Arkansas	Yes - supervision	Yes – board must approve delegation agreement	No requirement (subject to board discretion)	No requirement (subject to board discretion)	No requirement (subject to board discretion)	No requirement (subject to board discretion)	No restriction	Schedule II-V, and all non-controlled medication
California	Yes - supervision	Yes – practice agreement kept on file at practice	No requirement	No requirement	Only for surgical procedures requiring other than local anesthesia	No requirement	Up to 4 PAs at one time	Schedule II-V; all non-controlled medication
Colorado	Yes – collaboration is required for PAs with more than 5,000 practice hours. Supervision is required for PAs with less than 5,000 practice hours and for PAs changing specialty (who have less than 3,000 practice hours in new area).	Yes – collaborative agreements are required for PAs with more than 5,000 practice hours. Supervision agreements are required for PAs with less than 5,000 practice hours and for PAs changing specialty.	No requirement	In-person meeting with a physician required at least once every 12 months (quarterly for first year of practice, twice yearly for first year in new specialty).	On-site supervision of newly-graduated PAs for the first 160 hours.	Physician assessment of PA competence to include chart review.	Up to 8 PAs at one time, board may approve more.	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Connecticut	Yes - supervision	Yes – delegation agreement on file at practice	No requirement	No requirement	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication
Delaware	Yes - collaboration	Yes – written agreement kept on file at primary location where PA provides care	No requirement	No requirement	If a physician practice has multiple offices, physician must visit each office at least once per month. Physician not required to visit or be onsite while PA is practicing.	No requirement	Up to 4 at a time; does not apply to physicians and PAs who practice in the same building as long as there is active physician coverage.	Schedule II-V; all non-controlled medication
District of Columbia	Yes – collaboration (used interchangeably with “supervision” in some cases)	Yes – delegation agreement sent to board and kept on file at practice	No requirement	Quarterly review	No requirement	No requirement	Up to 4 at a time	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Florida	Yes - supervision	No agreement required	Dermatology practices only	No requirement	No requirement	No requirement	Up to 10 at a time	Schedule II-V; all non-controlled medication. Schedule II limited to a 7-day supply. Subject to formulary of prohibited drugs. PAs may not prescribe general anesthetics and radiographic contrast materials. PAs practicing with psychiatrists, pediatricians, family practice, or internal medicine physicians may prescribe a 14-day supply of psychiatric mental health controlled substances for children younger than 18 years of age.

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Georgia	Yes - supervision	Yes – board approves written job description	No requirement	No requirement	No requirement	Supervising physician shall periodically review.	Up to 4 at a time	Schedule II-V; all non-controlled medication. Subject to formulary.
Hawaii	Yes - supervision	No requirement	No requirement	No requirement	No requirement	Regular review of a sample of records; PAs with less than 1 year of experience 50% for first 6 months and 25% for second six months within 30 days. If controlled substance prescribed, reviewed and initialed within 7 working days.	Up to 4 at a time	Schedule II-V; all non-controlled medication
Idaho	Yes - supervision	Yes – collaborative practice agreement kept on file at practice and sent to board on request. No written agreement required in practices with a credentialing/privileging system.	No requirement	Regularly scheduled conferences required	Onsite visit required at least monthly	Periodic review of a representative sample of records required	Up to 4 at a time, board may approve up to 6	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Illinois	Yes - collaboration	Yes – written agreement required to be available to the board upon request. Collaborating physician must file a notice of employment and collaboration within 60 days prior to practice. Written agreement not required for PAs practicing in a hospital, hospital affiliate, or licensed ambulatory surgical center.	No requirement	Supervision and consultation required at least once/month, may be done via telecommunication.	No requirement	Periodic review of orders/care provided	Up to 7 full-time equivalent PAs. Ratio limits do not apply to PAs in hospitals, hospital affiliates, HPSAs, or ambulatory surgical centers.	Schedule II-V; all non-controlled medication. Schedule II limited to a 30-day supply of oral, transdermal, or topical medication only.
Indiana	Yes - collaboration	Yes – collaborative agreement submitted to board.	No requirement	No requirement	No requirement	For first year of employment 10% chart review within 10 business days. Subsequent review determined at practice level. No Rx co-signature requirement.	Up to 4 at a time	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Iowa	No, unless a PA in their first two years of independent practice has not previously practiced under a supervising physician or in collaboration with the appropriate physician or other health care professional for a period of at least two years (in which case, supervision is required).	No requirement. The rules shall determine the terms of collaboration for a PA engaged in independent practice after the conclusion of two years of practice under a supervising physician.	No requirement	No requirement	No requirement	No requirement	Up to 5 at one time	Schedule II-V; all non-controlled medication.
Kansas	Yes - supervision	Yes – active practice request form filed with the board. The form includes a description of the PA's scope of practice and methods of supervision.	"Indirect supervision" requires physician to be within 15 minutes of where PA is practicing. This is a	No requirement	Onsite direct supervision for first 80 hours a PA practices at a remote site; at least once every 30 days thereafter.	100% review within 7 days for first 30 days of a supervisory relationship. After 30 days, periodic review and evaluation of the PA's performance is required, which may	Up to 3 PAs who practice at a different location without board approval (not to exceed 5 total PAs at	Schedule II-V; all non-controlled medication

			different standard than “offsite supervision” which allows PAs to practice remotely and has no proximity requirement.			include the review of patient records.	remote locations). No restriction at same site.	
Kentucky	Yes - supervision	Yes – physician applies for approval to supervise PA. Practice description required.	May be required by board.	No requirement	Levels of supervision must be listed on application and in practice agreement in accordance with board policy documents.	Physician must review/countersign a sufficient number of medical notes written by PA to ensure quality of care, to be determined by the physician, practice, or institution.	Up to 4 agreements or total PAs supervised. Board may approve an additional PA for a 30-day period in emergency situation requiring additional professional resources.	Schedule III-V; all non-controlled substances; Schedule III limited to 30-day supply w/o refill; Schedule IV or V ltd. to original prescription and refills not to exceed 6-month supply. Prescriptions for benzodiazepines or Carisoprodol limited to a 30-day supply without refill.

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Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Louisiana	Yes - supervision	Yes - PA/physician must maintain a written practice agreement which is kept on file at the practice location and available to the board upon request.	No requirement	No requirement	No requirement	No requirement	Up to 8 PAs	Schedule II-V; all non-controlled substances
Maine	Yes - collaboration	Yes – for those with less than 4,000 clinical hours there is a board-approved collaboration agreement. PAs with more than 4,000 hours who are the principal provider in a practice that does not include a physician partner must have a board-approved practice agreement. All other PAs must simply have a physician available for consultation.	No requirement	No requirement	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Maryland	Yes – supervision *Effective 10/1/2024 - Collaboration	Yes – delegation agreement must be filed with the board. Board approval is required for certain advanced procedures. *Effective 10/1/24 – Collaboration agreement required	Board may require only for certain advanced duties.	No requirement	Board may require only for certain advanced duties.	No requirement	Up to 4 at a time, except in hospitals, correctional facilities, detention centers or public health facilities.	Schedule II-V; all non-controlled medication
Massachusetts	Yes - supervision	Yes – supervising physician approved by board. Written delegation agreement with specific protocols required for major invasive procedures.	No requirement	No requirement	No requirement	Prescriptions or orders for Schedule II controlled substances must be reviewed by physician within 96 hours.	No restriction	Schedule II-V; all non-controlled medication. See review provision for Schedule II.
Michigan	Yes - consultation	Yes – practice agreement required	No requirement	No requirement	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Minnesota	Yes – PAs with fewer than 2,080 hours must collaborate. All other PAs must have an annual review with a physician, but no collaboration required.	Yes – PA with less than 2,080 practice hours must have collaborative agreement with a physician. PAs with over 2,080 hours work under a practice agreement with the employer that must be on file at practice.	No requirement	Annual review of practice agreement by a physician within the same clinic, facility, or system and has knowledge of the PA's practice.	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication
Mississippi	Yes - supervision	Yes – protocol must be approved by board before PA can practice.	PA must practice within 75 miles of the primary office in which the supervising physician holds privileges. Board may make exceptions in some cases.	No requirement	Newly licensed PAs require onsite supervision for 120 days or 960 hours.	Monthly review of random sample of charts that represent 10% or 20 charts, whichever is less.	No restriction	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Missouri	Yes - collaboration	Yes – PA and collaborating physician shall enter into a collaborative practice arrangement.	Proximity to be determined by the board of registration of healing arts.	As defined in practice agreement, must include annual review.	Physician shall determine the time during which PA shall practice with physician before practicing at site where physician is not continuously present. Removes onsite requirement for supervision.	Review of 10% of charts every two weeks.	Up to a combined total of 6 PAs, NPs, and assistant physicians.	Schedule III-V, Schedule II containing hydrocodone and all non-controlled medication. (Schedule III limited to 5-day supply with no refill, except buprenorphine, which may be prescribed for 30 days).
Montana	No, unless PA has fewer than 8,000 hours of practice experience (in which case, collaboration is required).	Yes – collaboration agreement required for PAs with less than 8,000 hours, kept on file at practice site and available to board upon request.	No requirement	Monthly meeting for PAs with less than 8,000 hours.	No requirement	For PAs with less than one year of practice experience, 20% chart review for first six months, then 10% each month for next six months. After 12 months, chart review must occur, but the amount is to be determined at the practice level.	No restriction	Schedule II-V; all non-controlled medication. Schedule II limited to 34-day supply.

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Nebraska	Yes - supervision	Yes – written agreement must be kept on file at practice site and available to board upon request.	No requirement	No requirement	PAs with less than 2 years experience: if less than 3 months of permanent license, onsite required for 20% of the time. If greater than 3 months, 10% onsite required. Board may waive in some cases.	For PA with less than 2 years' experience: review of 20 records per month. If PA cares for fewer than 20 patients per month, 100% of records must be reviewed.	Up to 4 PAs at one time. Board may grant waiver.	Schedule II-V; all non-controlled medication
Nevada	Yes - supervision	Yes – medical board requires PA (before starting practice) to submit name and location of the practice and supervising physician information. Osteopathic board requires PA to submit copy of collaborating agreement to the board within 10 days.	No requirement	Physician is required to spend part of a day once per month at any location where a PA provides medical services.	Medical board requires monthly onsite presence. Osteopathic board requires monthly onsite presence. Onsite supervision for the first 30 days of an agreement is also required except when PA is employed at a federally qualified health center.	Medical board requires review and initial on selected charts. Osteopathic board requires review and initial on at least 10% of patient charts at least 4 times/year.	3 PAs, or a combination of three PAs/APRNs. Board may make exceptions.	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
New Hampshire	Yes – collaboration with physician or appropriate member of healthcare team as dictated by patient condition, standard of care, and PA training and experience	For PAs employed by an entity with at least one physician on staff, no such agreements are required. For PAs with w/less than 8K clinical practice hours not employed by an entity that also employs a physician, a collaboration agreement is required. For PAs w/more than 8K clinical practice hours not employed by an entity that also employs a physician, the PA may apply to Board of Medicine for waiver of collaboration agreement requirement from the Board of Medicine. After Jan. 1, 2027, PAs with more than 8K	No requirement	No requirement	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication

		clinical practice hours may practice in any setting without a collaboration agreement. requirement from the Board of Medicine. This waiver requirement sunsets on December 31, 2026. At that time, PAs with more than 8000 post-graduate clinical practice hours may practice in any setting without a collaboration agreement.						
New Jersey	Yes - supervision	Optional. If a PA/Physician choose to have a delegation agreement, it must be provided to committee and kept on file at practice. If PA/Physician choose not to have a delegation agreement, specific list of what a PA may do can be found in statute.	No requirement	No requirement	No requirement	No requirement	Up to 4 at a time, board may grant exceptions.	Schedule II-V; all non-controlled medication (certain conditions apply)

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
New Mexico	Yes – collaboration for PAs with 3+ years of practice experience who practice primary care. All other PAs are supervised.	Yes – medical and osteopathic boards require a written supervision plan, and boards must approve supervising physician before beginning practice. Medical board allows PAs with 3+ years to collaborate if practicing primary care – no agreement or approval of physician required as long as board approves change in license status from “supervised” to “collaborating.”	No requirement	No requirement	No requirement	No requirement	Medical Board: no restriction. Osteopathic Board: Up to 3, board may approve additional PAs.	Schedule II-V; all non-controlled medication. Subject to formulary.
New York	Yes - supervision	No requirement	No requirement	No requirement	No requirement	No requirement	Up to 6 in private practice. Up to 8 in correctional facilities.	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
North Carolina	Yes - supervision	Yes – PA submits information on supervising physician before beginning practice. PA must keep supervisory arrangements and prescribing instructions at each practice site.	No requirement	Monthly meetings for the first 6 months, then once every 6 months. May be done via telecommunication.	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication. PAs in pain management clinics must personally consult supervising physician prior to issuing a targeted controlled substance if the Rx will or is expected to exceed 30 days; if Rx is continually prescribed PA must consult supervising physician at least every 90 days. All prescribers in the state are prohibited from: prescribing more than a 5-day supply of targeted controlled substance upon initial consultation & treatment of a patient for acute pain, prescribing more than a 7-day supply of targeted controlled substances for post-operative acute pain relief.

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
North Dakota	No, unless PA has fewer than 4,000 hours of practice experience and owns their own practice (in which case, collaboration is required).	Yes – collaboration agreement required for PAs with fewer than 4,000 of practice. The agreement must be provided to the board upon request.	No requirement	No requirement	No requirement	For PAs owning their own practice, chart reviews at periodic intervals as required by the board.	No restriction	Schedule II-V; all non-controlled medication
Ohio	Yes - supervision	Yes – supervision agreement required, must be kept on file by physician.	No requirement	No requirement	Required during first 500 hours of a PA's provisional period of physician-delegated prescriptive authority, for practice in a healthcare facility's emergency department, and at the discretion of a healthcare facility or supervising physician.	No requirement	Up to 5 PAs at one time.	Schedule II-V; all non-controlled medication (special conditions for urgent care centers). Certain conditions apply to Schedule II. Subject to formulary.

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Oklahoma	Yes - delegation	Yes – practice agreement determined at practice level and filed with Board.	No requirement	No requirement	No requirement	No requirement	Up to 4 at once, board may grant waivers. Ratio requirement does not apply to state institutions, correctional facilities, or hospitals.	Schedule II-V; all non-controlled medication. Schedule II immediate or ongoing administration onsite. 30-day supply limit for all controlled medications. Subject to formulary.
Oregon	Yes - collaboration	Yes – PA with less than 2,000 hours of practice experience must enter into collaborative agreement with physician. Other PAs may enter into a collaborative agreement with a physician or the PA's employer. Agreement kept on file at practice.	No requirement	No requirement	At least 8 hours per month, subject to board discretion.	Chart review required; number or percentage of charts to be reviewed determined by PA-physician team.	No requirement	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Pennsylvania	Yes - supervision	Yes – submission of written practice agreement and registration form.	No requirement	Osteopathic Board: monthly (at least) education and review sessions held by the supervising physician to discuss specific conditions, protocols, procedures, and patients. (Rules have not been updated to reflect statutory changes).	No requirement	100% of all charts within 10 days for PAs with less than 1 year experience or in a new specialty.	Up to 6 PAs at a time; board may grant waiver.	Schedule II-V; all non-controlled medication (Schedule II limited to 72 hours for initial therapy, 30 days for ongoing therapy).
Rhode Island	Yes – collaboration	No requirement	No requirement	No requirement	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
South Carolina	Yes - supervision	Yes – board approves scope of practice guidelines (or proposed changes). Approved written scope of practice guidelines must be provided to the board by the supervising physician within 72 hours.	Supervising physician must be actively practicing w/in the geographic boundaries of South Carolina.	No requirement	PA with less than 2 years continuous practice or changing specialties may not practice at a location offsite from the supervising physician until the PA has 60 days clinical experience. This may be waived by supervising physician in writing on a form approved by and submitted to the board.	Physician must review, initial, and date an off-site PA's charts as specified in the scope of practice guidelines.	A supervising physician may sign scope of practice guidelines for up to 6 FTE PAs, APRNs, or a combination. Physician may only supervise a total of 6 PAs, APRNs, or a combination of both in clinical practice at once. Board may approve exceptions.	Schedule II-V; all non-controlled medication. Schedule II limited to initial prescription not to exceed a 31-day supply. Prescriptions for controlled substances in schedule III through V must not exceed a 90-day supply.
South Dakota	Yes - supervision	Yes – PA and supervising physician must keep a jointly written and signed practice agreement. Must be filed/approved by the board prior to practice.	No requirement	"The supervising physician and physician assistant shall meet to discuss patient care and review the physician assistant practice."	No requirement	No requirement	Up to 4 at a time.	Schedule II-V; all non-controlled medication. Schedule II limited to a 30-day supply.

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Tennessee	Yes - collaboration	Yes – PA and physician develop written protocol to be kept on file at the practice site.	No requirement	No requirement	Onsite collaboration required only for certain invasive procedures. Physician must visit remote sites every 30 days.	Review of 20% of chart notes written by PA every 30 days; review and sign all charts of patients receiving controlled drug prescription within 10 days.	No restriction	Schedule II-V; all non-controlled medication. Schedule II or III opioid listed on the formulary limited to a maximum of a nonrefillable, 30-day course of treatment, unless specifically approved after consultation with the collaborating physician before the initial issuance of the prescription or dispensing of the medication. This limitation shall not apply to prescriptions issued in a hospital, nursing home, or inpatient facilities.

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Texas	Yes - supervision	Yes – PA/physician must file notice of intent to practice with the board before beginning practice.	No requirement	No requirement	No requirement	No requirement	Physician may enter into a prescriptive authority agreement with 7 PAs/APRNs (total) or their FTE. Restriction does not apply if the PA is in a practice serving a medically-underserved population or a facility-based practice in a hospital.	Schedule III-V; all non-controlled medication (Schedule III-V limited to a 90-day supply; Schedule II may be prescribed/ordered in hospital or hospice settings).

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Utah	Yes – collaboration required for PAs with fewer than 10,000 hours of practice experience. Collaboration not required thereafter.	Yes – PAs with less than 10,000 hours of practice experience must have a written agreement with a physician (or a PA with more than 10,000 hours, for PAs with more than 4,000 hours). The agreement must be kept at the practice site and provided to the board upon request.	No requirement	No requirement	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication
Vermont	Yes - collaboration	Yes – practice agreement filed with board and kept at practice site.	No requirement	No requirement	No requirement	No requirement	No restriction	Schedule II-V; all non-controlled medication

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Virginia	Yes - collaboration	Yes - must be available to the board upon request. PAs employed by a hospital can practice without a separate practice agreement if the credentialing and privileging requirements of the facility include a practice arrangement.	No requirement	No requirement	No requirement	Practice agreement must include evaluation process for the PA's performance, including a requirement specifying the time period, proportionate to the acuity of care and practice setting, within which the physician or podiatrist shall review the record of services rendered by the PA.	No more than 6 on a patient care team at any time.	Schedule II-V; all non-controlled medication. Prohibited from prescribing amphetamine, Schedule II, for the purpose of weight reduction or control. May not prescribe controlled substances, Schedules III through VI, for the purpose of weight reduction or control in the treatment of obesity, unless certain conditions are met. May not prescribe or administer anabolic steroids to any patient for other than accepted therapeutic purposes.

Jurisdiction	Collaboration with or Supervision by Physician Required	Practice Agreement & Process	Physician Proximity	Physician Meetings Required	On-Site/In Person Physician Oversight Required	Minimum Chart Review or Countersignature Requirement	Number of PAs with whom a Physician May Practice	Prescriptive Authority
Washington	Yes - supervision	Yes – practice agreement kept at PA's practice site and must be provided to the board upon request.	No requirement	No requirement	No requirement	No requirement	Up to 10 PAs per physician. Board may waive this limit.	Schedule II-V; all non-controlled medication
West Virginia	Yes - collaboration	No requirement – a PA must file a practice notification with the board.	No requirement	No requirement	On-site collaboration may be required by the board for certain medical acts for a specified period of time so the physician may assess the PA's ability to perform the task safely.	No requirement – "…as necessary for appropriate and meaningful collaboration."	No requirement	Schedule II-V; all non-controlled medication (up to a three-day supply of Schedule II narcotic).
Wisconsin	Yes – collaboration	Yes- available upon request to the board	No requirement	No requirement	No requirement	No requirement	No requirement	Schedule II-V; all non-controlled medication
Wyoming	No requirement	No requirement	No requirement	No requirement	No requirement	No requirement	No requirement	Schedule II-V; all non-controlled medication

The information contained in this summary is condensed and accurate as of August 2024. This document is intended for background purposes only. For a complete and current version of statutes and regulations, AAPA encourages you to visit the state's legislative and regulatory websites. Many states are currently working on improvements to existing PA statutes and regulations. For information on pending improvements please contact AAPA.

Last Updated: August 2024

Readopt with amendments Med 601.02, eff. 8-6-21 (doc. #13249), to read as follows:

Med 601.02 “Approved program” means a program for the education and training of physician assistants that is accredited by the ~~American Medical Association's Committee on Allied Health Education and Accreditation, or the Commission on Accreditation of Allied Health Education Programs or by~~ ***Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or*** its successor.

Readopt with amendments Med 601.03, eff. 12-31-23 (doc. #13803), to read as follows:

Med 601.03 “Collaboration” means “collaboration” as defined in RSA 328-D:1, II-a~~.~~, namely “a physician assistant’s consultation with or referral to ~~an appropriate~~ ***a*** physician or ~~other health care professional~~ ***to the appropriate member of the health care team*** as indicated based on the patient’s condition, the physician assistant’s education, training, and experience, and the applicable standards of care.”

Readopt with amendments Med 601.05, eff. 12-31-23 (doc. #13803), to read as follows:

Med 601.05 “Participating ~~P~~***p***hysician” means “participating physician” as defined in RSA 328-D:1, II-c~~.~~, namely, “a physician practicing as a sole practitioner, a physician designated by a group of physicians to represent their physician group, or a physician designated by a health care facility to represent that facility, who ***collaborates with a physician assistant or who*** enters into a collaboration agreement with a physician assistant in accordance with this chapter***.***”~~.~~

Readopt with amendments Med 601.06, eff. 8-6-21 (doc. #13249), to read as follows:

Med 601.06 “Physician assistant (PA)” means “***‘***physician assistant ***or P.A.’***” as defined in RSA 328-D:1, III***, namely “a person qualified both by academic and practical training to provide patient services and licensed under this chapter***.***”***

Readopt with amendments Med 602, eff. 12-31-23 (doc. #13803), to read as follows:

PART Med 602 ~~SUPERVISION OF A~~ PHYSICIAN ASSISTANT ***RESPONSIBILITIES; COLLABORATION AGREEMENTS***

Med 602.01 Responsibility of the Physician Assistant.

(a) A***s stated in RSA 328-D:12, “***A physician assistant is responsible for their own medical decision making. A participating physician included in a collaboration agreement with a physician assistant shall not, by the existence of the collaboration agreement alone, be legally liable for the actions or inactions of the physician assistant~~.~~***; provided, however, that t***~~T~~his shall not otherwise limit the liability of the participating physician.***”***

(b) ***As required by RSA 328-D:18,*** ~~The~~ ***each*** physician assistant shall have current valid professional liability coverage ***while actively engaged in providing medical care***.

Med 602.02 Collaboration Agreement ***for PAs Having Fewer Than 8,000 Hours of Post-Graduate Clinical Practice Hours***.

(a) Except as provided in RSA 328-D:15, III and RSA 328-D:16, II, a physician assistant ***with fewer than 8,000 hours of post-graduate clinical practice hours who is practicing in a group, practice, or health system that does not have at least one licensed New Hampshire physician*** shall engage in practice as a physician assistant in this state only if the physician assistant has entered into a written collaboration agreement with a sole practice physician or a physician representing a group or health system s~~o long as the sole practitioner or at least one physician in the group or health system~~ ***who*** practices in a similar area of medicine as the physician assistant, and is a licensed New Hampshire physician.

(b) A collaboration agreement shall include all of the following:

(1) Processes for collaboration and consultation with the appropriate physician and other health care professional as indicated based on the patient's condition and the physician assistant's education, training, and experience, and the applicable standards of care;

(2) An acknowledgment that the physician assistant's scope of practice shall be limited to medical care that is within the physician assistant's education, training, and experience as outlined in RSA 328-D:3-b, VII-XIII;

(3) A statement that although collaboration occurs between the physician assistant and physicians and other health care professionals, a physician shall be accessible for consultation in person, by telephone, or electronic means at all times when a physician assistant is practicing; and

(4) The signatures of the physician assistant and the participating physician. No other signatures shall be required.

(c) The collaboration agreement shall be updated as necessary.

(d) In the event of the unanticipated unavailability of a participating physician practicing as a sole practitioner due to serious illness or death, a physician assistant may continue to practice for not more than a 30-day period without entering into a new collaboration agreement with another participating physician.

(e) The collaboration agreement shall be kept on file at the practice and made available to the board upon request.

Med 602.03 Waiver of Collaboration Agreement Available for PAs Having More Than 8,000 Hours of Post-Graduate Clinical Practice Hours.

(a) Until January 1, 2027, a New Hampshire licensed physician assistant with more than 8,000 post-graduate clinical practice hours who intends to practice in a setting that does not have at least one licensed New Hampshire physician in the group, practice, or health system may request the board of medicine to waive the collaboration agreement requirement.

(b) The waiver request shall:

(1) Include the information specified in (c), below;

(2) Be accompanied by the documentation specified in (d), below; and

(3) Be signed by the physician assistant who is requesting the waiver.

(c) The information required by (b)(1), above, shall be:

(1) The physician assistant's name and license number;

(2) The physical location, mailing address, and telephone number of the practice; and

(3) The practice's primary area of medical practice.

(d) The documentation required by (b)(2), above, shall be:

(1) Proof of malpractice insurance, in the form of a copy of ????; and

(2) Proof of the required post-graduate clinical practice hours, in the form of either:

a. A letter signed by the manager of the physician assistant's medical office, hospital administration, department chair, or collaborating physician that the physician assistant has accrued the requisite hours; or

b. A notarized affidavit affirming, under penalty of law, that the physician assistant has accrued the requisite hours and that shows the hours earned by practice name, dates of service, employment status, and total clinical hours earned.

(e) The physician assistant may include information regarding additional training and qualifications or other relevant evidence to support the waiver request.

(f) Upon receipt of a waiver request, the board's administrator shall:

(1) Review the requestor's file to determine whether the requestor is in good standing and whether the requestor is the subject of a pending investigation or disciplinary action; and

(2) Provide the information to the board.

(g) The board shall review a waiver request at the first board meeting that is 10 business days or more after the waiver request is received, provided that the board may review a waiver request received within 10 business days prior to the board meeting if:

(1) The board administrator confirms that the requestor is in good standing and is not the subject of a pending investigation or disciplinary action; and

(2) There is sufficient time in the agenda to do so.

(g) The board shall approve the request and grant the waiver if the requestor:

(1) Has submitted a complete request that demonstrates the requestor's qualifications;

(2) Is in good standing; and

(3) Is not the subject of a pending investigation or disciplinary action.

(h) If the board is unable to determine that the criteria for approval in (g), above, are met, the board shall request further information from the requestor.

(i) The board shall notify the requestor of its decision. If the requested waiver is denied, the notification shall:

(1) Identify each reason why the request was denied; and

(2) Inform the requestor that a rehearing request may be filed within 30 days in accordance with Plc 206.31.

(j) A physician assistant whose waiver request is denied may re-apply for a waiver after the reason(s) for the denial have been addressed.

Adopt Med 613 to read as follows:

PART Med 613 CONTINUING MEDICAL EDUCATION

Med 613.01 Continuing Medical Education.

(a) Each physician assistant shall engage in continuing medical education to maintain requisite knowledge and skills, either by:

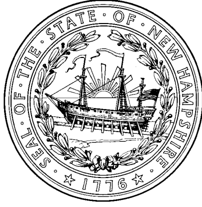
(1) Maintaining national certification through the National Commission on Certification of Physician Assistants (NCCPA) or its successor organization; or

(2) Obtaining not less than 100 credit hours of approved continuing medical education activity, as defined in RSA 328-D:1, I-a, in each renewal period, of which 50 credit hours shall be category 1 CME.

(b) Each physician assistant shall demonstrate compliance with this section by submitting proof of national certification or CME credit hours with the renewal application

APPENDIX I: STATE STATUTES IMPLEMENTED

Rule	State Statute(s) Implemented
Med 601.02, Med 601.03	RSA 328-D:1
Med 601.05, Med 601.06	RSA 328-D:1
Med 602.01(a)	RSA 328-D:12
Med 602.01(b)	RSA 328-D:18
Med 602.02, Med 602.03	RSA 328-D:3-b, I



STATE OF NEW HAMPSHIRE

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

BOARD OF MEDICINE

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STATEMENT REGARDING HB 1222

The New Hampshire Board of Medicine considered House Bill 1222 as amended at its meeting on April 3, 2024. The Board of Medicine does not take a position on HB 1222.

The Board recognizes the challenges faced by physician assistants in New Hampshire relative to collaboration agreements restricting employment opportunities. The Board, as a general matter, supports changes in statute for physician assistants which would ensure appropriate education, collaboration with medical teams, and limits on scope of practice based on training, experience, and team support.

Original Research Article

Medical Malpractice Payment Reports of Physician Assistants/Associates Related to State Practice Laws and Regulations

Sondra M. DePalma, DHSc, PA-C, CLS, CHC, FNLA, AACC; Michael DePalma, DMSc, PA-C; Sean Kolhoff, PhD; Noël E. Smith, MA

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ABSTRACT:

Purpose: Authorizing physician assistants/associates (PAs) to provide care to patients and removing restrictive laws and regulations without sacrificing patient safety is essential to meet the needs of patients and the US healthcare system. The aim of this observational study was to determine if states with permissive compared to restrictive PA scope of practice laws and regulations had higher instances of medical malpractice payment reports (MMPR), a proxy of patient harm.

Design: This observational study examined 10 years (2010-2019) of medical malpractice payment reports data from the National Practitioner Data Bank (NPDB) compared to the laws and regulations of states for the same period.

Results: Negative binomial regressions indicated no statistically significant differences in MMPR rates between states with permissive versus restrictive PA practice laws and regulations. Five of six practice reforms decreased or had no significant effect on PA and physician MMPR occurrences. One reform was associated with a weak but statistically significant increased risk of MMPRs for PAs and a trend toward a decreased risk for physicians.

Conclusion: This study suggests that removing restrictive laws and regulations to PA practice does not increase overall risks to patients or increase rates of malpractice within US healthcare.

Introduction

The US healthcare system is one of the most complex and high-cost health systems globally. Despite spending nearly twice on healthcare as a share of the economy as other countries, the US has the highest rate of avoidable deaths, one of the lowest life expectancies, higher chronic disease burdens, and other health disadvantages in comparison with comparable nations.[1] In addition, physician and provider shortages, a rising number of natural and health emergencies, increasing numbers and ages of healthcare beneficiaries, greater complexity of conditions and comorbidities, ongoing disparities in health outcomes, and other factors threaten US healthcare.[2-6]

The high per capita cost of care, low value per cost, and other factors have caused policy experts (eg, The National Academies of Sciences, Engineering, and Medicine and The Hamilton Project), regulatory agencies (eg, US Department of Health and Human Services, US Department of Treasury, and US Department of Labor), and other stakeholders to recommend changes to the US health system. The recommended changes include authorizing qualified healthcare practitioners, such as physician assistants/associates (PAs), to practice to the full extent of their training and qualifications without restrictive state laws and regulations that limit their scope of practice (SOP) or impose requirements on physician collaboration.[7-11]

State laws and regulations have been imposed on the PA profession in part to address health and safety concerns, yet there is a lack of evidence that these laws and regulations affect patient safety. Some PA practice laws and regulations and physician collaboration requirements have been noted to be unnecessary, unjustified, costly, and potentially detrimental.[8-11] Proponents of permissive PA practice laws and regulations note the demonstrated quality, cost-effective care provided by PAs, care that has been shown in many ways to be comparable to that of physicians.[8-15] The available evidence demonstrates favorable PA practice laws

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and regulations increase patient access, lower healthcare costs, positively affect quality of care, and reduce preventable healthcare amenable deaths.[8-10, 16-18] Past research has noted that PAs have lower rates of malpractice and lower malpractice payments when compared to physicians.[19-20] In addition, the comparable and sometimes complementary services PAs provide compared to physicians are associated with high levels of patient satisfaction, and patients report that PAs are trusted, valued practitioners who provide safe and effective healthcare and improve health outcomes.[11, 21-23]

Despite the evidence supporting the benefits of PAs and the removal of restrictive SOP laws and regulations, there is opposition from some physicians, physician groups, and regulators primarily based on an unfounded assertion that permissive PA practice laws and regulations threaten patient safety and should be opposed.[24-25] Other opponents are concerned permissive laws and regulations will result in increased malpractice payments and premiums.[26-27]

If, as suggested by opponents, permissive PA practice laws represent a threat to patient safety and an increased risk of malpractice, there should be a greater number of malpractice payments against PAs in states with permissive compared to restrictive PA practice laws and regulations. Reported malpractice payments serve as an approximation of the acts or omissions constituting medical errors or negligence, are highly correlated with adverse patient outcomes, and have been used as a surrogate measure of serious adverse medical events.[28-30] It is also important in an assessment of risk, and consistent with other research, to analyze potential transference of risk from one group of practitioners (ie, PAs) to another (ie, physicians) with changes in collaborative practices.[31] Therefore, this study evaluated if PA practice laws and regulations affect the number of medical malpractice payment reports (MMPR) for PAs and physicians within the US, including Washington, DC.

Methods

Data for the number of MMPRs against PAs and physicians (allopathic and osteopathic physicians combined) between 2010 and 2019 were obtained from the National Practitioner Data Bank (NPDB) Public Use Data File[32] as of March 31, 2023. Data from the NPDB were used because the database is the most comprehensive national source of information about practitioners' malpractice and medical discipline records.[33]

This 10-year span of data was selected for analysis as it was the most recent period prior to temporary regulatory waivers enacted due to COVID-19 and to allow for expected delays in reporting of aggregated judgements,[19] both of which would have confounded the analysis. The number of MMPRs for PAs and allopathic and osteopathic physicians that occurred in each state and year of the 10-year data period were extracted and used to develop a variable reflecting the number of MMPRs for each practitioner type used in subsequent data analysis.

Additional control variables from the Agency for Healthcare Research and Quality's (AHRQ) Social Determinants of Health dataset were included in the analyses.[34] From this dataset, the number of employed PAs and physicians per state and Washington, DC, population of each state and Washington, DC, county-level unemployment rate,

IF, AS SUGGESTED BY OPPONENTS, PERMISSIVE PA PRACTICE LAWS REPRESENT A THREAT TO PATIENT SAFETY AND AN INCREASED RISK OF MALPRACTICE, THERE SHOULD BE A GREATER NUMBER OF MALPRACTICE PAYMENTS AGAINST PAs IN STATES WITH PERMISSIVE COMPARED TO RESTRICTIVE PA PRACTICE LAWS AND REGULATIONS.

and county-level income per capita were derived for each data year. Consistent with prior research on SOP reform and MMPR events, data relating to the presence of joint and several liability reforms, limits on punitive and non-economic damages, and apology laws were included.[31]

Six elements of an ideal PA SOP that allow for optimal practice were identified based on recognized standards, industry experts, and regulatory agencies (Table 1).[8-9,35] These ideal factors eliminate physician supervisory requirements and allow collaborative practices, if needed, to be determined at the practice level based on institutional polices and the training, experience, and competency of the individual PAs. The state laws and regulations for all 50 states and Washington, DC, as published in the annual *PA State Laws and Regulations* from 2010 through 2019 and confirmed with legislative and regulatory tracking software,[36-45] were independently reviewed by 2 researchers to ensure data accuracy. Any discrepancies in analysis, for which there were

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few, were reviewed by a policy expert and consensus was obtained.

Each of the SOP elements were assigned a code to perform statistical analysis for each year in which they were in effect (Table 1). A restrictive component identified in either a state's laws or regulations for an element was assigned a "0". The express exclusion of a restrictive component or the absence of restrictive language in laws or regulations for an element was assigned a "1". State laws were used to determine the nominal assignment in instances where there was a discrepancy between the laws and regulations due to a delay in regulatory updates. A change in an SOP element was then assigned to the year following a legislative amendment or a revision of a regulation. This was done to

Table 1
PA scope of practice elements analyzed

Elements, definitions in state laws and regulations, and assignments	
PAs practice in collaboration or have no formal statutory relationship with a physician.	
• **Permissive:** The working relationship between a physician and a PA is described as collaboration and/or there is the absence of the term "supervision" or "supervising physician."	• **Restrictive:** The working relationship a physician has with a PA is defined as supervision or there are terms like "supervising physician" or "physician supervision."
Physicians may collaborate with an unlimited number of PAs.	
• **Permissive:** There is an absence of a limit or a specific number of PAs with whom a physician may collaborate or supervise.	• **Restrictive:** There is a maximum number of PAs, either total or at one time, with whom a physician may collaborate or supervise.
No physician co-signature or specific mandated review is required on medical record documentation or orders. **Did not review or include any requirements, if present, for co-signature of prescriptions.*	
• **Permissive:** There is no requirement (explicit or implied) for physician co-signature of medical record documentation or orders made by a PA. Any review of medical records or orders, if required, can be performed on a sample of records, periodically, or 'in accordance with accepted standards.'	• **Restrictive:** There is a requirement for physician co-signature on all or some portion of medical record documentation and/or orders made by a PA or for some duration of time (eg, co-signature required for new PAs or PAs new to a practice or specialty).
Scope of practice determined at the practice site.	
• **Permissive:** There is no requirement that a regulatory body approve a PA's scope of practice or the services they may perform.	• **Restrictive:** Some or all PAs must have their scope of practice or a list of services they perform approved by a regulatory body.
PAs practice without the need for the physical presence or proximity of a physician.	
• **Permissive:** There are no requirements for a physician to be within proximity of a PA (either by time or distance), have an in-person meeting with a PA, or ever be present at the practice site. Any quality review, if required, does not specify it must be done in-person or face-to-face.	• **Restrictive:** There are requirements that a physician have a periodic on-site presence at a facility in which a PA practices, proximity requirements (defined by time or distance) to a PA during the PA's practice, or in-person meeting requirements.
Scope of practice is determined by the training and competency of the PA; not limited to the scope of a collaborating physician.	
• **Permissive:** There is no language limiting a PA's scope of practice to a component of a collaborating/supervising physician's scope of practice or specialty.	• **Restrictive:** There is language limiting a PA's scope of practice to a component of a collaborating/supervising physician's scope of practice or specialty.

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control for interstate variations in legislative and regulatory schedules and is consistent with the methodology of citations in the *PA State Laws and Regulations* books. It also accounts for some inevitable delay for regulatory or legislative changes to be incorporated into practice. Summary statistics for the variables used in this study can be viewed in Table 2.

Negative Binomial Regression Analysis

A series of multilevel regression analyses were calculated to explore the predictive relationship

Table 2
Summary statistics

Variable	Mean	Std Dev	Min	Max
Physician Associate (PA) Counts				
Medical Malpractice Payment Records (MMPRs)	3.75	5.63	0	36
MMPR severity: Temporary injury	0.85	1.52	0	11
MMPR severity: Permanent injury	2.07	3.68	0	28
MMPR severity: Death	1.23	2.09	0	16
Physician (MD & DO) Counts				
Medical Malpractice Payment Records (MMPRs)	130.77	194.97	0	1398
MMPR severity: Temporary injury	29.57	51.65	0	500
MMPR severity: Permanent injury	74.12	112.40	0	726
MMPR severity: Death	40.23	58.21	0	327
Scope of Practice (SOP) Factors				
Relationship with physician not defined as supervisory	0.05	0.22	0	1
No physician collaboration/supervision ratio restrictions	0.22	0.41	0	1
No physician co-signature requirements	0.59	0.49	0	1
No physician on-site/proximity or in-person/meeting requirements	0.34	0.47	0	1
SOP determined at practice site	0.63	0.48	0	1
PA SOP not limited by collaborating/supervising physician SOP	0.10	0.31	0	1
Permissiveness of SOP regulations in Practice State	0.13	0.34	0	1
Control Factors				
State population (millions)	6.17	6.95	0.55	39.28
Total PAs	2089	2420	103	14943
Total MDs	13015	23887	1193	140148
Total DOs	1466	1727	64	6909
Joint and several liability reform	0.82	0.38	0	1
Punitive damages cap	0.62	0.49	0	1
Non-economic damages cap	0.46	0.50	0	1
Apology law	0.76	0.43	0	1
Average county percentage in poverty	15.11	3.85	8.32	25.72
Averaged county unemployment rate	6.31	2.41	2.48	13.97
Averaged county real income per capita (thousand $)	26.82	5.77	17.62	56.15

Note: The number of observations for all variables is 510. For scope of practice factors and tort reforms, mean values reflect the proportion of state-years within the sample frame where the regulatory changes were in effect. Practitioner counts reflect PAs, MDs, and DOs who were not employed by the federal government.

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between SOP elements and MMPR occurrences for PAs and allopathic and osteopathic physicians (combined) within each state across the data years. After examining the data, negative binomial regressions were selected due to the presence of overdispersion. A significant empty negative binomial model was found, indicating MMPRs varied between states(s) across the years(t) included in the analysis ($\sigma^2_{\mu st} = 0.365$ $p < 0.001$).

Subsequent log-linked negative binomial regression analyses were calculated to identify how the overall regulatory environment in a state during the data period impacted the occurrences of MMPRs. The basic estimating equation took the following form: $MMPR_{st} = exp(\beta_0 + \beta_1 SOP_{st} + \beta_2 Torts_{st} + \beta_3 X_{st} + Y_s + \tau_t + ln(pop_{st}) + \varepsilon_{st})$ where MMPR represents the number of malpractice counts, or the severity of an incident of malpractice, against practitioners in state *s* in year *t*. Due to insufficient counts to analyze more granular cases of MMPRs, MMPRs coded in the NPDB as minor temporary injury and major temporary injury were categorized in this study as *temporary injury* and four categories of permanent injuries were classified as *permanent injury.* MMPRs coded as death were also included in the analysis, but insignificant injuries and emotional injuries were not due to insufficient PA data.

The presence of the SOP elements in state *s* at time *t* are represented in the equation by *SOP* indicator variables. An additional indicator code was created to classify states with 4 or more permissive SOP elements as *permissive states*

A SERIES OF MULTILEVEL REGRESSION ANALYSES WERE CALCULATED TO EXPLORE THE PREDICTIVE RELATIONSHIP BETWEEN SOP ELEMENTS AND MMPR OCCURRENCES FOR PAs AND ALLOPATHIC AND OSTEOPATHIC PHYSICIANS (COMBINED) WITHIN EACH STATE ACROSS THE DATA YEARS.

and those with three or fewer permissive SOP elements as *restrictive states*. *Torts* represents the litigiousness of states based on their passage of the previously mentioned tort reforms; *X* represents the state level control factors of unemployment, percent of the population in poverty, and income per capita. To account for variance across years, variables used within the model were within-state cluster centered. Indicator variables for each state (Y) and year (τ) were included. The natural log of the annual state population was used as an offset variable, as opposed to the number of PAs or physicians, due to the conflating influence of the regulatory environment on the population of practitioners within a state. Regressions were analyzed using IBS SPSS version 29.

Results

There were no significant interactions between states having permissive practice environments (with 4 or more permissive SOP elements) compared to restrictive states (with 3 or fewer SOP elements) and the number of MMPR occurrences (Table 3).

There were also no statistically significant interactions between instances of overall PA MMPRs and a state having joint and several liability reforms, limits on punitive and non-economic damages, or apology laws (Table 4). However, certain SOP elements had a significant effect on the number and severity of MMPRs for PAs and physicians (Table 5). The results for each series of models are detailed in the following sections.

MMPR Occurrences. A significant regression equation was found predicting the relationship between the number of MMPRs in a state and the regulatory environment within a state ($p < 0.001$, $\beta = -14.41$), indicating the passage of PA SOP elements may influence the occurrence of MMPRs within a state. Two SOP elements were found to have a significant impact on the number of PA MMPRs. States enacting legislation allowing PAs to practice outside the scope of practice of their collaborating/supervising physician had a statistically significant 58.3% reduction in PA MMPRs ($IRR = 0.417$, 95% CI 0.309-0.592 [$\beta = -0.875$, $p < 0.001$]). Conversely, removing physician co-signature requirements lead to a 16.2% increase in PA MMPRs ($IRR = 1.162$, 95% CI 1.001 – 1.349 [$\beta = 0.150$ $p < 0.05$]; Table 3). Physician MMPRs were also significantly affected by changes to PA SOP ($p < 0.001$, $\beta = -10.76$). When relationships with physicians were not defined as supervisory ($p < 0.05$, $\beta = -0.29$ [$IRR = 0.745$, 95% CI 0.586 – 0.948]), there were no physician supervision/collaboration ratio restrictions ($p < 0.05$, $\beta = -0.16$ [$IRR = 0.853$, 95% CI 0.735 – 0.990]), and PAs could practice outside the scope of practice of their supervising/collaborating physician ($p < 0.01$, $\beta = -0.25$ [$IRR = 0.782$, 95% CI 0.671 – 0.910]; Table 3) physician MMPRs decreased.

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MMPR Severity. Permissive states were no more likely than restrictive states to have PAs committing MMPRs resulting in temporary injury, permanent injury, or death. However, some SOP elements were related to MMPR severity. PA MMPRs resulting in temporary injury occurred less frequently when relationships were not defined as supervisory ($p < 0.05$, $\beta = -2.02$) and when PA SOP was not limited by the SOP of their supervising or collaborating physician ($p < 0.001$, $\beta = -0.90$). However, PA MMPRs resulting in temporary injury increased in instances when there were no physician on-site/proximity or in-person/meeting requirements ($p < 0.05$, $\beta = 0.24$). PA SOP not being limited by the SOP of their supervising or collaborating physician related to a reduction in the number of PA MMPRs whose outcome was permanent injury ($p < 0.001$, $\beta = -1.13$). Additionally, PA SOP not being limited by the SOP of their supervising or collaborating physician also predicted fewer death related PA MMPRs ($p < 0.01$, $\beta = -0.69$; Table 5).

Discussion

While there were statistically significant interactions between some elements of PA practice reforms and PA and physician MMPRs, having a more permissive regulatory environment for PAs was not associated

Table 3

Interaction between MMPRs (PAs/Physicians) and Scope of Practice (SOP) regulatory factors

SOP Factor	IRR(SE)	95% Confidence Interval		p
		Lower Bound	Upper Bound	
Physician Assistant/Associates (PAs)				
Relationship with physician not defined as supervisory	0.663 (0.259)	0.399	1.101	0.112
No physician collaboration/supervision ratio restrictions	0.946 (0.126)	0.738	1.211	0.659
No physician co-signature requirements	1.162 (0.076)	1.001	1.349	0.048*
No physician on-site/proximity or in-person/meeting requirements	1.006 (0.087)	0.847	1.194	0.949
SOP determined at practice site	1.062 (0.082)	0.904	1.247	0.463
PA SOP not limited by collaborating/supervising physician SOP	0.417 (0.152)	0.309	0.592	0.000***
Permissive State	1.100 (0.175)	0.780	1.551	0.588
Physicians (MDs & DOs)				
Relationship with physician not defined as supervisory	0.745 (0.122)	0.586	0.948	0.017*
No physician collaboration/supervision ratio restrictions	0.853 (0.076)	0.735	0.990	0.036*
No physician co-signature requirements	0.910 (0.050	0.826	1.003	0.058
No physician on-site/proximity or in-person/meeting requirements	1.016 (0.058)	0.907	1.138	0.783
SOP determined at practice site	0.967 (0.052)	0.873	1.071	0.520
PA SOP not limited by collaborating/supervising physician SOP	0.782 (0.078)	0.671	0.910	0.002**
Permissive State	1.160 (0.104)	0.945	1.424	0.154

N=510. Values reflect incident rate ratios. Standard errors in parentheses. State population used as offset variable. Models also include tort-related laws, averaged county unemployment rates, averaged county-level real income per capita, and the averaged percent of the county living in poverty.
*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

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with an increase in PA MMPRs between 2010 and 2019. Therefore, this study finds no evidence that creating a permissive practice environment will lead to an increase in MMPRs. In fact, almost all the PA SOP elements included within these statistical models illustrate that creating a more permissive PA practice environment leads to a reduction in MMPRs for PAs and physicians. The exact cause of the decreased overall MMPRs is unknown, but allowing PAs and physicians to have flexible collaboration determined at the practice site may result in more meaningful collaboration, optimized practice, and efficiency of care that improves healthcare and reduces risk.

Allowing PAs to practice consistent with their training and experience, and not limiting their SOP to that of a collaborating/supervising physician, was associated with a highly significant decrease in MMPRs for both PAs and physicians. Allowing PAs to practice in collaboration with physicians or have no formal statutory relationship with a physician and authorizing physicians to collaborate with an unlimited number of PAs significantly decreased the risk of MMPRs for physicians without affecting the occurrence of MMPRs for PAs. Allowing PA SOP to be determined at the practice site and not requiring a physician to be onsite or in proximity to a practicing PA had no significant effect on PA or physician MMPR occurrences.

Not requiring physician co-signature was associated with a relatively weak ($\beta = 0.150$), but statistically significant ($p = 0.048$) increased risk of MMPRs for PAs while a trend toward a decreased risk for physicians was approaching significance ($p = 0.058$). These findings may represent a more accurate attribution of care and accountability rather than an overall increased risk to patients.

ALLOWING PAs TO PRACTICE CONSISTENT WITH THEIR TRAINING AND EXPERIENCE, AND NOT LIMITING THEIR SOP TO THAT OF A COLLABORATING/SUPERVISING PHYSICIAN, WAS ASSOCIATED WITH A HIGHLY SIGNIFICANT DECREASE IN MMPRS FOR BOTH PAS AND PHYSICIANS.

Furthermore, an interpretation of these findings is limited by the fact that there was considerable interstate variability in laws and regulations related to co-signature, with some states mandating co-signature of all medical records of a PA and other states only requiring a physician signature for a limited number of PAs, certain percentage of medical records, or specified time. Conversely, physicians may have been required to co-sign medical records in the absence of state laws or regulations requiring it due to billing mechanisms like "incident to" or split (or shared) billing. Therefore, this element may be influenced by confounding factors to a greater

Table 4

Malpractice events and severity by state permissiveness and tort reforms

Measure	Malpractice	Temporary Injury	Permanent Injury	Death
Physician Associates (PAs)				
Permissive state	-0.078 (0.176)	-0.440 (0.299)	-0.077 (0.279)	0.226 (0.264)
Joint and several liability reform	0.218 (0.119)	0.332 (0.207)	0.173 (0.180)	0.271 (0.190)
Punitive damages cap	-0.047 (0.090)	-0.177 (0.148)	0.019 (0.137)	0.139 (0.146)
Noneconomic damages cap	0.072 (0.078)	0.178 (0.127)	-0.011 (0.118)	0.164 (0.123)
Apology law	0.055 (0.091	-0.013 (0.148)	0.025 (0.137)	0.070 (0.146)

N=510. Values reflect incident rate ratios. Standard errors in parentheses. State population used as offset variable. Models also include individual scope of practice regulations, averaged county unemployment rates, averaged county-level real income per capita, and the averaged percent of the county living in poverty.
Note: Due to limited instances of PA MMPRs, categories in the NPDB dataset were combined based on categorization as "temporary" or "permanent" injury. Emotional and insignificant injuries were not included in the analysis. States with 4 or more SOP reforms were classified as permissive states.
$^{*}p < 0.05$, $^{**}p < 0.01$, $^{***}p < 0.001$ (no values in this table were statistically significant).

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extent than other SOP elements. Given that and the relatively weak association between the independent (physician co-signature) and dependent (PA MMPRs) variables, further research is needed prior to assuming the correlation implies causation.

This research, supporting similar findings that relaxing state laws and regulations does not result in harmful or low-quality care[11-18], should assuage fears that eliminating restrictive PA practice elements will lead to an increase in PAs' patients having serious adverse medical events. It should also alleviate concerns that rates of malpractice would increase.

Limitations

There were several limitations to the study. Although the NPDB is the largest national database of MMPRs, there may be some, although limited, non-compliance in reporting by entities and claims against corporations or hospitals may not identify individual practitioners.[46] There is also variability in elapsed time between a negligent act or omission and a malpractice report to the NPDB; however, there are fewer elapsed years for aggregated judgements for PAs than physicians and the timeframe of the data analyzed should allow for delayed reporting.[19] In addition, data in the

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Table 5
SOP factors and reported severity of malpractice events

SOP Factor	Malpractice	Temporary Injury	Permanent Injury	Death
Physician Associates (PAs)				
Relationship with physician not defined as supervisory	-0.412 (0.259)	-2.021* (0.964)	-0.198 (0.360)	-0.596 (0.444)
No physician collaboration/ supervision ratio restrictions	-0.056 (0.126)	0.129 (0.193)	-0.167 (0.197)	0.004 (0.192)
No physician co-signature requirements	0.150* (0.076)	0.161 (0.112)	0.121 (0.115)	0.229 (0.118)
No physician on-site/proximity or in-person/meeting requirements	0.006 (0.087)	0.241* (0.122)	-0.075 (0.134)	-0.026 (0.135
SOP determined at practice site	0.060 (0.082)	0.050 (0.130)	0.164 (0.124)	-0.048 (0.126)
PA SOP not limited by collaborating/ supervising physician SOP	-0.875*** (0.152)	-0.896*** (0.269)	-1.133*** (0.247)	-0.689** (0.223)
Permissive state	0.095 (0.175)	-0.470 (0.299)	-0.046 (0.276)	0.324 (0.261)
Physicians (MDs & DOs)				
Relationship with physician not defined as supervisory	-0.294* (0.122)	-0.285 (0.162)	-0.208 (0.135)	-0.455** (0.170)
No physician collaboration/ supervision ratio restrictions	-0.159* (0.076)	-0.035 (0.086)	-0.257** (0.086)	-0.277** (0.095)
No physician co-signature requirements	-0.094 (0.050)	-0.042 (0.055)	-0.124* (0.054)	-0.096 (0.061)
No physician on-site/proximity or in-person/meeting requirements	0.016 (0.058)	0.168** (0.064)	0.002 (0.064)	0.035 (0.071)
SOP determined at practice site	-0.033 (0.052)	-0.011 (0.059)	0.019 (0.057)	-0.149* (0.064)
PA SOP not limited by collaborating/ supervising physician SOP	-0.246*** (0.078)	-0.246** (0.090)	-0.264** (0.086)	-0.313*** (0.098)
Permissive state	0.149 (0.104)	-0.021 (0.120)	0.244* (0.176)	0.300* (0.131)

N=510. Values reflect incident rate ratios. Standard errors in parentheses. State population used as offset variable. Models also include tort-related laws, averaged county unemployment rates, averaged county-level real income per capita, and the averaged percent of the county living in poverty.
Note: Due to limited instances of PA MMPRs, categories in the NPDB dataset were combined based on categorization as "temporary" or "permanent" injury. Emotional and insignificant injuries were not included in the analysis.
$*p < 0.05$, $**p < 0.01$, $***p < 0.001$.

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NPDB may not comprehensively and definitively correspond with unsafe practice or patient harm.

Another limitation unrelated to the NPBD is that some acts or omissions of PAs may have been attributed to a physician or employer under the doctrine of respondent superior and not reported as an MMPR of a PA; however, a review of case law

THIS RESEARCH, SUPPORTING SIMILAR FINDINGS THAT RELAXING STATE LAWS AND REGULATIONS DOES NOT RESULT IN HARMFUL OR LOW-QUALITY CARE, SHOULD ASSUAGE FEARS THAT ELIMINATING RESTRICTIVE PA PRACTICE ELEMENTS WILL LEAD TO AN INCREASE IN PAs' PATIENTS HAVING SERIOUS ADVERSE MEDICAL EVENTS.

demonstrated that liability for the acts or omissions of a PA are generally assigned to a PA, even when a physician has explicit or implied liability as a collaborating physician.[47]

This study could not account for some state, practice, and PA factors that may affect MMPRs. While the statistical model controlled for some economic factors like unemployment and income per capita, other economic characteristics of a state and individual attitudes toward litigation could affect the findings. Additionally, practice characteristics were unable to be assessed but may be relevant. These characteristics include but are not limited to PA utilization, patient complexity, workplace culture, the extent to which laws and regulations were followed, and how quickly changes in laws and regulations were adapted into practice. The individual characteristics of PAs (eg, experience, specialty, etc.) that may affect clinical outcomes are not available within the NPDB or AHRQ data and therefore could not be included in this model.

Another limitation is in the interpretation of state laws and regulations and the categorization of the SOP elements. A restrictive designation was given regardless of whether an element applied in all or only limited circumstances. Additionally, although most elements could be easily delineated as permissive or restrictive, some state laws and regulations used vague language that had to be interpreted, and Board directives related to laws and regulations at the time could not be ascertained. However, any random error in interpretation, with over- and under-interpretation equally probable, was likely minimized by the large number of data points. Additionally, by assessing the risk of malpractice against the overall leniency or restrictiveness of a state, the effects of variations in individual components were minimized.

The findings of physician MMPRs have limited extrapolation beyond their intent to ensure there was no overall increase in the rates of MMPRs among PAs and physicians or a transference of risk from one group of practitioners to another with changes to collaboration requirements. The various PA practice laws and regulations may affect physician practice differently, and changes in PA laws and regulations are not likely to influence the rates of MMPRs among physicians who do not collaborate with PAs.

Despite the limitations, the NPDB represents the most comprehensive source of practitioners' malpractice and medical discipline records. This is the first study to examine PA practice laws and regulations and their relationship to PA and physician MMPRs, and it demonstrates no evidence that states with permissive compared to restrictive PA practice laws and regulations had higher instances of MMPRs or patient harm.

Conclusion

The findings of this study provide evidence that restrictive PA SOP elements can be eliminated from state laws and regulations without adversely affecting MMPRs or patient safety. Removing barriers to optimal practice environments for PAs improves access to high-quality, cost-effective care while maintaining patient safety. Less restrictive state PA laws and regulations will allow PAs to meet the medical needs of patients while increasing benefits for patients and the US healthcare system.

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Funding/support: None

Other disclosures: None

Author contributions: Study concept and design (all); acquisition of data (all); analysis and interpretation of data (all); drafting of manuscript (SMD, MD, SK); revision of manuscript (all)

Keywords: physician assistant, physician associate, regulations, scope of practice, malpractice

Received: January 24, 2023; **revision received**: October 16, 2023; **accepted:** November 2, 2023

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September 18, 2024

HB 1222 Study Committee
New Hampshire General Court
Legislative Office Building, Room 306
33 North State Street
Concord, New Hampshire 03301

Dear Committee Member:

The New Hampshire Society of Physician Assistants (NHSPA) represents 1100 New Hampshire PAs who work in every medical setting and practice type across the state, 71% of whom are women. We also represent the students in our state's two PA schools at Franklin Pierce University in Lebanon, and at Mass College of Pharmacy and Health Sciences in Manchester.

We have prepared this binder for you with information that speaks specifically to the issues on which HB 1222 asked the study committee to focus. We hope the committee will agree with NHSPA on three points:

1) There is no need for further legislation regarding licensing or scope of practice for PAs or any New Hampshire healthcare provider.
2) Legislation changing the name of the PA profession from "Physician Assistant" to Physician <u>Associate</u>" anywhere in state statute and regulation would help address some of the common misconceptions hindering PAs from practicing to the full extent of the education, training and experience.
3) PAs and insurance carriers at the state and national level should continue to work together to make sure PAs are reimbursed as primary care providers.

In your binder, you'll find the following documents:

- Side-by-side comparing key NH PA and Nurse Practitioner (NP) licensing and scope of practice requirements and laws and regulations
- Side-by-side comparing key PA practice laws/regs in the New England States
- Side-by-side comparing key PA practice laws/regs in all 50 states
- A general "PA Myths and Facts" document from AAPA
- A "PA Myths and Facts" document specific to NH and HB 1222 from AAPA and NHPSA
- A side-by-side on what HB 1222 does and doesn't do now that it is law
- Board of Medicine statement on HB 1222
- Draft Board of Medicine rules implementing the waiver process called for in HB 1222
- Fact Sheets:
  - A side-by-side on what HB 1222 does and doesn't do now that it is law
  - PA Education
  - PA Scope of Practice

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    - PAs and specialty care
    - PAs and reimbursement by insurance as a Primary Care Provider (PCP)
- December 2023 Journal of Medical Regulation Research article comparing malpractice settlements for PAs in states with relaxed collaboration requirements
    - Also attached is an AAPA ExSum of this research article

If you have any questions or would like additional information, please contact me, NHSPA VP and Legislative Co-Chair Sarah Leslie, or our lobbyist, David Cuzzi of Prospect Hill Strategies.

Sincerely,

Malcolm Hauthaway
President

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PA Practice Requirement	Law Prior to HB 1222 Signing	Current Law after HB 1222 SIgning
Collaboration Agreement signed by a NH Licensed Physician and PA	Yes	Yes, only for PAs w/less than 8000 clinical practice hours practicing in setting w/o physician on staff. PAs w/more than 8,000 clinical practice hours practicing in a setting w/o physician on staff, see below.
PAs can own their own practice	Yes. Must have a signed collaboration agreement with a licensed NH physician	Yes. PAs w/less than 8,000 clinical practice hours must have collaboration agreement w/licensed NH physician. PA's w/more than 8,000 clinical practice hours must apply to Board of Med. for waiver. Waiver process sunsets in 2027.
Scope of Practice: Physician assistants may provide any legal medical service for which they have been prepared by their education, training, and experience and are competent to perform.	Yes	Yes/no change for current law
Physician assistants shall collaborate with, consult with, and/or refer to a physician or appropriate member of health care team as indicated by patient's condition, the education, experience, and competencies of the physician assistant, and standard of care.	Yes	Yes/no change from current law
Can only practice when physician or appropriate member of healthcare team is available in person or electronically	Yes	Yes/no change from current law
PAs shall follow all internal scope of practice, privileging, credentialling & other policies required by employers	No	Yes
Healthcare employers require internal collaboration agreements between PAs & physicians as condition of employment	Yes	Yes/no change from current law
PAs can own their own specialty practice	No	No/no change from current law
PAs must carry valid malpractice insurance to practice medicine in NH	Yes	Yes/no change from current law

NH PA and NP License Requirements & Scope of Practice

Physician Assistants (PAs) and Nurse Practitioners (NPs) are similarly trained and educated. Both play an increasingly vital role as front-line healthcare providers. Both are equally qualified to fill these advanced practice provider positions statewide. Although most licensing and scope of practice regulations for the two professions are similar, some disparities exist, especially in the area of collaboration agreements for PAs practicing ina setting without a physician on staff. What is important for policy-makers and patients to know is that, regardless of whether they see a PA or a NP, they are being treated by a highly educated, well-trained healthcare provider who places the patient at the center of their care. The following compares the licensing and scope of practice laws and regs governing PA and NP practice in New Hampshire.

License Requirements	**NH Physician Assistant**	**NH Nurse Practitioner**
Licensing Body	Board of Medicine	Board of Nursing
Certifying Organization	National Commission on Certification of Physician Assistants (NCCPA)	American Nurses Credentialing Center (ANCC) & American Academy of Nurse Practitioners (AANP)
Pass Initial Certification Exam	Yes	Yes
Re-Certification	Recertify every 10 years with exam.	Recertify every 5 years, no exam required.
Continuing Medical Education (CME/CE) Requirements	100 CME hours every 2 years.	30 CE hours every 2 years.
Graduate from Accredited Program	Yes	Yes
Hold Graduate Degree or Higher	Yes	Yes
Have Two Letters of Reference from a Physician	Yes	No
Official Letter of Verification from Each State the Provider is Licensed Showing Good Standing and Disciplinary History	Yes	No
Copy of Curriculum Vitae	Yes	No
Licensure Compact	No	Yes
Next Page, please		

Scope of Practice		
Full Prescriptive Authority (Schedule II-V)	Yes	Yes
Signed Collaboration or Supervising Agreement with licensed NH Physician	For PAs employed by an entity with at least one physician on staff, no such agreements are required. For PAs with w/less than 8K clinical practice hours not employed by an entity that also employs a physician, a collaboration agreement is required. For PAs w/more than 8K clinical practice hours not employed by an entity that also employs a physician, the PA may apply to Board of Medicine for waiver of collaboration agreement requirement from the Board. After Jan. 1, 2027, PAs with more than 8K clinical practice hours may practice in any setting without a collaboration agreement.	No
Obtain and Perform Comprehensive Health Histories and Physical Exams	Yes	Yes
Evaluate, Diagnose, Manage, and Provide Medical Treatment	Yes	Yes
Order, Perform, and Interpret Diagnostic Studies and Therapeutic Procedures	Yes	Yes
Educate Patients on Health Promotion and Disease Prevention	Yes	Yes

Write Medical Orders and Provide Consults Upon Request	Yes	Yes
Obtain Informed Consents	Yes	Yes
May Supervise, Delegate or Assign Therapeutic or Diagnostic Measures to Licensed or Unlicensed Personnel	Yes	Yes
Can Sign any Form that is Signed by a Physician (ex: POLST, DNR, Death Certificates, & Local, State, or Federal Forms)	Yes	Yes
Required by Law to Consult or Refer to Appropriate Member of Healthcare Team	Yes	Yes
Required by Law to Recognize Limits of Knowledge & Expertise	Yes	Yes
Must Practice When a Physician or Appropriate Member of Healthcare Team is Available In Person or By Electronic Means	Yes	No
Can Be Assigned as a Primary Care Provider	Yes However, most insurance companies do not yet reimburse PAs as PCPs	Yes
Required by Law to Have Malpractice Insurance	Yes	No
Can Volunteer at a Camp or Event without a Collaboration Agreement	Yes	Yes

FACTS ON PHYSICIAN ASSISTANT EDUCATION

Physician assistants (PAs) are rigorously educated, trained and licensed healthcare clinicians who practice medicine in every specialty and setting. PAs are licensed and regulated at the state level. To become licensed, a PA must have graduated from an accredited PA program and passed the Physician Assistant National Certifying Examination. PAs are educated at a master's degree level and complete approximately 27 months of ***full-time*, in-person** instruction. ***This is equivalent to three academic years of instruction***.

The PA school curriculum is modeled on the medical school curriculum, which includes both didactic and clinical training. In the didactic phase, students take courses in basic medical sciences, behavioral sciences, and behavioral ethics. In the clinical phase, PA students complete more than 2,000 hours of clinical rotations in medical and surgical disciplines, including family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry.

Admission to PA masters program is very selective and very competitive. NH has two PA schools – one at Franklin Pierce University (FPU) in Lebanon, and the other at Mass College of Pharmacy and Health Sciences (MCPHS) in Manchester. Below are some, but not all, prerequisites for admission into the FPU PA master's program, which are very similar to those for MCPHS.

- 500 hours of patient care experience (hands-on direct care of a patient that is not for academic credit such as employment or volunteer experiences as a nurse, EMT, paramedic, CNA, phlebotomist, respiratory therapist
- Shadow a PA for at least 20 hours
- All prerequisite courses must be passed with a grade of "C" or better and be completed prior to matriculation.
- Applicants must possess a minimum cumulative GPA of 3.0 and a science GPA of 3.0 on a 4.0 scale. Applicants may apply with up to two outstanding prerequisites.
- Anatomy & Physiology I (4 credits with lab)
- Anatomy & Physiology 11 (4 credits with lab)
- Biology (4 credits with lab)
- Chemistry I (4 credits with lab)
- Chemistry II (4 credits with lab)
- Microbiology (4 credits with lab)
- Statistics (3 credits)
- Organic Chemistry or Biochemistry (4 credits with lab)

FACTS ON PA SCOPE OF PRACTICE AUTHORITY

HB 1222 in no way changes how a PA's scope of practice is defined in statute or regulation.

Physician Assistants (PAs) in New Hampshire are governed statutorily by RSA 328-D, and regulated by rules promulgated by the Board of Medicine in MED 600. Some believe that a PA's scope of practice is included in the collaboration agreement they must sign with a NH licensed physician. However, this is not accurate. Per statute and regulation, a PA's scope of practice must be acknowledged in a collaboration agreement. But the scope of practice itself is specifically *defined* by statute and regulation outside of the context of a collaboration agreement.

RSA 328-D:3-b defines PA scope of practice. Specifically, paragraphs I, II, and III of RSA 328-D:3-b defines what must be included in a collaboration agreement, with paragraph II requiring in the agreement "An acknowledgment that the physician assistant's scope of practice shall be limited to medical care that is within the physician assistant's education, training, and experience as outlined in paragraphs VII-XVIII." MED 602.03 essentially restates the collaboration agreement's requirements in RSA 328-D:3-b I-III, using, in MED 602.03 (b)(2), the identical acknowledgement requirement in RSA 328-D:3-b paragraph II as previously stated.

PA scope of practice is specifically defined in RSA 328-D:3-b paragraphs VII-XVIII and MED 603.01. RSA 328-D:3-b VII and Med 603.01 state the following:

> "Scope of Practice.
> (a) Physician assistants may provide any legal medical service for which they have been prepared by their education, training, and experience and are competent to perform.
> (b) Medical and surgical services provided by physician assistants include, but are not limited to:
>> (1) Obtaining and performing comprehensive health histories and physical examinations;
>> (2) Evaluating, diagnosing, managing, and providing medical treatment;
>> (3) Ordering, performing, and interpreting diagnostic studies and therapeutic procedures;
>> (4) Educating patients on health promotion and disease prevention;
>> (5) Providing consultation upon request; and
>> (6) Writing medical orders."

Moreover, RSA 328-D:3-b paragraph XVIII states:

> "The scope of practice of a physician assistant shall be determined at the practice level based on the education, training, and experience of the physician assistant. Practice settings may include, but are not limited to, a physician employer setting, group practice setting, independent private practice setting, or in a health care facility setting governed by a system of credentialing and/or granting of privileges."

FACTS ON PHYSICIAN ASSISTANTS AND SPECIALTY CARE

Physician Assistants (PAs) in New Hampshire work in all specialties of medicine. However, PAs are not allowed to independently provide specialty care (e.g. urology, cardiology). HB 1222 WOULD NOT change this. Some have said passage of HB 1222 would allow PAs to open specialty care practices and be the practice's sole practitioner. This is not true. HB 1222 would not change the legal, regulatory, and practical reasons PAs cannot own a "solo" specialty care practice, with or without a collaboration agreement.

- A PA's scope of practice, defined by law (RSA 328-D:3-b VII) and predicated on the PA's education, training, and experience, would not allow a PA to practice specialties of medicine independently.
- A PA practicing in this manner would be subject to discipline by the Board of Medicine and likely loss of their license to practice
- A PA would be unable to obtain malpractice insurance for specialty care provided in an independent practice
    - NH law requires PAs to carry malpractice insurance to practice medicine
- Insurance companies would not credential PAs is this setting and would not recognize treatment as reimbursable
- Nurse Practitioners (NPs) have practiced without collaboration agreements in New Hampshire for decades, and there is no evidence any NP has attempted to start a specialty care practice

PAs working for a healthcare employer (health systems, large group practices etc.) in specialty care do not practice medicine outside of their scope of practice as defined by law. Additionally, employers' internal credentialing processes provide even more scope of practice guardrails in these settings as well as the framework for insurance reimbursement and malpractice coverage. Moreover, PAs employed in a specialty care setting work on interdisciplinary healthcare teams, and constantly collaborate with team members, including physicians, nurses, etc. None of this would change under HB 1222.

- HB 1222 would put in statute the requirement that PAs must collaborate with a physician or appropriate member of the healthcare team as dictated by the PA's education, training, experience, patient condition, and standard of care
- HB 1222 would require that a physician or appropriate member of the healthcare team be available in person or by electronic means when practicing medicine
- HB 1222 would put in law that PAs must comply with all scope of practice or similar internal policies as required by their employer
- Any PA practicing outside of their scope of practice would be subject to discipline by the Board of Medicine and likely lose their job and their license to practice

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Sarah Leslie, PA-C
NHSPA VP & Legislative C-Chair
Talking Points
HB 1222 Study Committee
LOB Room 306-308
September 18, 2024

- Good morning, members of the Committee

- For the record, my name is Sarah Leslie, and I am the VP of the NH Society of PAs – NHSPA – and the co-chair of NHSPA's advocacy committee

- I am a licensed PA in NH and I live in Deerfield

- NHSPA represents the over 1100 NH PAs who work in every medical setting and practice type across the state, 71% of whom are women

- We also represent the PA students here in NH

- NH has two PA schools – one at Franklin Pierce University in Lebanon, and the other at Mass College of Pharmacy and Health Sciences in Manchester

- Our "Bottom Line Up Front" is that, with HB 1222 now law, NHSPA does not see any need for legislation to address licensing or scope of practice laws for PAs or any provider group.

- We have provided the committee a binder of information that will help you research the specific areas of focus of this panel as laid out in HB 1222, specifically;
  - A side-by-side of PA and NP licensing and scope of practice laws which show that with passage of HB 1222, there are still differences, but they are more similar now than prior to its passage.
  - Documents showing how New England states, and another showing how all states, govern physician assistants, which show New Hampshire now has a more attractive environment for PAs
  - A study showing that patient safety has not been diminished in states that have eliminated or relaxed collaboration agreements, and other fact sheet addressing PA care and patient safety

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  - Information on the status of efforts to have insurance companies recognize PAs as primary care providers so they may be reimbursed as PCPs by payors and be able to carry their own panels.
  - PA "myths and facts" documents to help the committee identify and correct common misconceptions about PAs that can lead to PAs not being fully deployed and utilized in the healthcare workforce

- I'd like to provide a brief history of PA employment challenges and recent legislative efforts to address these challenges

- PAs and NPs are advanced practice providers – formerly referred to as "mid level" – providers who are similarly educated and equally qualified for all positions for which advanced practice providers are eligible

- However, for years, PAs have been at a competitive disadvantage when competing with NPs for jobs, including advancement opportunities with current employers.

- NPs do not need a signed collaboration agreement with a licensed NH physician regardless of their practice environment and regardless of how long they have practiced.

- However, until HB 1222 became law, all PA's needed a collaboration agreement, regardless of how long a PA had been practicing medicine

- This hurt PAs because it raised administrative and malpractice costs for physicians, employers, and individual PAs

- It also exposed physicians signing these agreements to more lawsuits

- This legal tether was one factor in PAs not being considered PCPs in the eyes of health insurance companies

- So in 2022 SB 228, which passed the legislature on voice votes, did three things in hopes of addressing these barriers to PA employment;
  - Removed the term "supervision" of a PA by a physician and changed it to "collaboration" in all statutes and regulations
  - It made clear in law that physicians couldn't be sued simply because they signed a collaboration agreement unless the physician was actually involved in the care of a patient

- Required PAs carry malpractice insurance, making PAs the only provider required by statute to do so
- Included language designed to make PAs able to be reimbursed by health insurance companies as PCPs

- Unfortunately, through the fault of no one, SB 228 did not solve the PA employment challenge

- In fact, the situation became worse for PAs

- Physicians could still be sued even when they had no involvement in a case

- At Southern NH Medical, their physician group laid off 12 PAs in the family practice office because the new physicians wouldn't sign the collaboration agreements

- At Core Physician Group in Exeter, they stopped hiring PAs and recently let some of their PAs go because they were told they could not be reimbursed as PCPs and carry panels

- At Dartmouth-Hitchcock, several PAs contacted NHSPA to share stories of being told they were passed over for new positions or promotions because of either the collaboration agreement requirement or the PCP reimbursement issue – or both.

- At the same time, Rep. Rochefort brought in HB 1222

- NHSPA did not know he'd be doing so

- But by the time the bill was heard in House ED&A, the issues at Southern, Exeter, and Dartmouth Hitchcock became known to NHSPA which made it clear that we needed to do what we could to get some version of HB 1222 into law to make sure PAs wouldn't keep losing their jobs or losing out on new opportunities.

- Generally speaking, HB 1222 aimed to eliminate the requirement that all PAs have a signed collaboration agreement with a NH licensed physician to practice medicine, as this requirement was the root of many barriers PAs face in our employment.

- And this requirement kept PAs from sharing similar licensing and scope of practice laws and regs with our NP colleagues

- The final version of HB 1222 removed the collaboration agreement requirement for any PA working where a physician is on staff

- For PA's with fewer than 8000 post-grad clinical practice hours working for an entity without a physician on staff, HB 1222 still requires they have a collaboration agreement.

- For PAs with more than 8000 post-grad clinical practice hours working for an entity without a physician on staff looking to remove the collaboration agreement requirement, HB 1222 will require them to get a waiver from the Board of Medicine

- The Board of Medicine is drafting the rules for that waiver process now.

- This waiver process sunsets at the end of 2026

- At that point, a PA with more than 8000 post-grad clinical practice hours will be able to practice for an entity that does not employ a physician without requiring a collaboration agreement.

- I'd also note that the bill includes language explicitly noting that no part of this bill prohibits healthcare employers from requiring internal collaborative or mentoring relationships for PAs for internal credentialling and privileging.

- The waiver application process was added in the Senate to provide an incremental step for more experienced PAs and beginning in 2027, they may enjoy the same practice freedoms that have been enjoyed by all NH NPs for decades

- Regarding the issue of insurance companies reimbursing PAs as PCPs, I would like to note that the 2021 NH Medicaid survey and Medicaid indicated that PAs are authorized to act as PCPs in NH.

- However, payors such as Anthem have in their policy that PAs can act as a PCP, only to cover for a physician or NP, but cannot carry their own panel.

- The NH HealthCost website also lists physicians, NPs, and naturopaths as being able to be PCPs but PAs were not on the list.

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- I want to make clear that NHSPA and our national organization – the American Academy of Physician Associates – are working with carriers at the national level and beginning to do so at the local level, to address this issue

- The insurers have been open to these discussions and NHSPA sees no reason for legislative intervention at this time as this is an issue that will take time to address

- I would note that in an effort to address some of the myths of PAs being "assistants to physicians", our national organization changed its name to the American Academy of Physician Associates in 2021.

- NHSPA is currently in the process of changing its name from "assistants" to "associates"

- We do think legislation changing our profession's title from "Physician Assistant" to "Physician Associate" everywhere in statute and regulation would help address a common misconception hindering the PA profession. In essence, have our title more accurately reflect the role we play in the healthcare team.

- With that, I appreciate the committee's attention and am happy to take any questions

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