MdAPA Issue Talking Points

Scope of Practice Determined at the Practice Site

- Unlike Maryland, 41 states and the District of Columbia allow a PA's scope of practice to be determined at the practice level.

- Almost the entire country has abandoned the concept that the medical board or other regulatory agency should make decisions about scope of practice details for individual PAs.

- Licensed healthcare facilities (hospitals, nursing homes, surgical centers and others) have a role in determining the scope of practice for PAs in their institutions. Within an institution, PAs request clinical privileges, which must be approved by the medical staff, and ultimately, the institution's governing body. This process defines a scope of practice that each individual is qualified to provide within that organization. Institutions assess PA requests for privileges, including verification of professional credentials (graduation, licensure, and certification) and documentation of additional relevant training, previous privileges and/or procedure logs, CME, or skills assessment under direct observation.

- In practices that are not part of a system or institution, an individual PA's scope of practice is best determined by the PA and their clinical team. This allows for flexible and customized teams. Individual clinical roles are shaped by the needs of patients and the education, experience, and preferences of the team members.

- As states recognize the potential of PAs to ease workforce burdens, they are broadening laws and regulations, enabling PAs to practice without having to submit detailed practice descriptions to regulators. This model allows PAs and their practice teams to adapt quickly and efficiently to changes in workforce needs, medical knowledge, technological advances, payment systems, and standards of care[1,2,3,4].

Collaboration

- Unlike Maryland, almost half the country (19 states and DC) uses a term other than supervision to describe how PAs practice. More states are in the pipeline to make this change in 2022 and beyond.

- Despite early laws that defined physicians and PAs in an employer-employee or supervisor-worker relationship, the most effective teams always have been collaborative and collegial. The model works best when PAs and physicians decide how they will practice together, it is not dictated by laws and regulations, and when PAs are appropriately treated as competent and skilled professionals.

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[1] Reed DO, Hooker RS. PAs in orthopedics in the VHA's community-based outpatient clinics. JAAPA. 2017;30(4): 38-42.

[2] Davis A, Radix S, Cawley JF, Hooker RS, Walker C. Access and Innovation in a time of rapid change: PA scope of practice. Ann Health Law. 2015;24(1):286-336.

[3] 1 Paydarfar JA, Benoit JG, Tietz AM. Improving access to head and neck cancer surgical services through the incorporation of associate providers. Otolaryngol Head Neck Surg. 2016;155(5):723-28.

[4] Kurtzman ET, Barnow BS. A comparison of nurse practitioners, physician assistants, and primary care physicians' patterns of practice and quality of care in health centers. Med Care. 2017;55(6):615-22.

- When practicing most effectively and efficiently, PAs make autonomous decisions about patient care. If they reach the limits of their expertise, like any other medical provider, they consult someone who has the necessary expertise. This is a core tenet of team practice.

- Collaboration reflects a more modern approach and accurate description, which is better for patients, better for PAs and better for their physician colleagues.

- It is in the best interests of patients and the system to recognize that PA practice is collaborative and team-based. The PA profession is no longer an experiment, but a proven provider of high-quality, cost-effective medical care.

<u>Differentiation Between "Core" versus "Advanced" Duties</u>

- West Virginia eliminated the distinction between "core" versus "advanced" duties in 2021 with the enactment of SB 714 in favor of scope being determined at the practice level. No matter the setting, PAs in West Virginia practice pursuant to a practice notification that is filed with the medical or osteopathic board stating that a PA will practice in collaboration with one or more physicians.

- Unlike Maryland, 41 states and the District of Columbia allow a PA's scope of practice to be determined at the practice level. Therefore, almost the entire country has abandoned the concept that the medical board or other regulatory agency should make decisions about scope of practice details for individual PAs.

- If asked about the other 8 states in addition to Maryland, below is what you should know. There are nuanced differences. Except for West Virginia, none of them replicated Maryland's process regarding "advanced"/ "core" duties.

    1. **Alabama**—Regardless of the procedures or medical acts PAs provide, the state has an outmoded, ***blanket requirement for all agreements to be filed with and approved by the medical board before a PA may practice***. PAs must be registered to a physician; this authorizes the physician to supervise the PA. The medical board must approve the registration agreement between a physician and PA. Registration agreements contain a detailed job description setting forth the PA's functions and activities. PA scope of practice includes core duties and skills. "Additional duties" must also be approved by the board which is excessive since the board has to approve every aspect of the PA's scope.

    2. **Georgia**—Regardless of the procedures or medical acts PAs provide, the state has an antiquated, ***blanket requirement for all agreements***, referred to as the Utilization Application, and Basic Job Description, ***to be filed with and approved by the medical board before a PA may practice.*** Official notification must be received in writing from the board of approval and PAs cannot begin working until they have received this notification. Acts not covered in the Job Description must be requested and approved via an "Additional Duty" application, particularly if they involve the delivery of general, spinal, or

epidural anesthesia. Again, this is excessive since the board approves all aspects of PA practice before they can provide patient care.

3. **Kentucky**—Regardless of the procedures or medical acts PAs provide, the state has an archaic, ***blanket requirement for all PA scope of practice to be approved by the medical board before a PA may provide patient care***. The supervising physician must also apply and be approved to supervise the PA.

4. **Maine**—agreement (when required) is approved by the medical board. PAs with less than 4,000 hours of documented clinical practice are required to practice in a collaborative agreement with a physician except that PAs working in a physician group practice setting or a health care facility setting under a system of credentialing and granting of privileges and scope of practice agreement may use that system of credentialing and granting of privileges and scope of practice agreement in lieu of a collaborative agreement. Allows PAs with more than 4,000 hours to practice without a written agreement. A physician must simply be available for consultation. (PAs who are the principal provider in a practice that does not include a physician partner must have a practice agreement with a physician).

5. **Mississippi**— Regardless of the procedures or medical acts PAs provide, the medical board enforces a ***dated, absolute requirement in which all PAs must have their protocol approved by the board in advance of any practice or change of practice***.

6. **Pennsylvania**—PAs provide medical services according to a written agreement filed with the medical or osteopathic board. Regardless of the procedures or services a PA will provide, ***both boards have the authority to randomly audit and approve up to 10% of all agreement submissions.*** If deficiencies are noted, a revised written agreement will need to be resubmitted within 2 weeks of notification that the written agreement came under review.

7. **South Carolina**—No matter the PA's scope, all PAs submit a scope of practice guideline to the medical board. ***A PA may begin practice 10 days after submittal and until the board makes a final determination.*** At any time, if the medical board disapproves the scope of practice guidelines (or proposed changes), it must provide a written explanation of its determination and a suggested remedy, if possible. Once the medical board issues a final determination, the PA and supervising physician must practice in accordance with the medical board's determination.

8. **Washington**—A new law passed in 2020 to replace delegation agreements with practice agreements. Under the new law, practice agreements will be valid as soon as all parties sign them and will no longer require approval from the medical commission. In addition, PAs can practice at remote sites without requiring approval from the medical commission. However, PAs were regulated

by both the osteopathic and medical board. While the laws and licensure governing PAs under the medical board became effective July 1, 2021, ***the repeal of the relevant osteopathic laws will not occur until July 1, 2022.*** As a result, Washington is on this list due to a technicality--the implementation delay.

Legislation Does Not Implement Independent Practice

- Independent practice suggests PAs would provide care in a silo, disconnected from other professionals and that is not a facet of this bill.

- Independent practice is expressly prohibited in lines 782-785. The tether to physicians remains by virtue of the collaboration registration.

- PAs will continue to work as part of a healthcare team like other providers, will consult, collaborate, and refer for patient care when clinically appropriate as provided on Page 20, lines 876-888.

- PAs have a strong commitment to patient-centered, team-based practice and this legislation would not alter that commitment. The bill allows providers to retain all the benefits of working as a team while eliminating the administrative burdens that come from a mandated relationship.