Autonomy Now!

Why PAs, Like NPs, Need Full Practice Authority

Brian Sady, PA-C, MMSc

Across the nation, states are dealing with shortages of health care providers.[1] The situation is expected to worsen as the physician population ages and many retire from the workforce.[2] Meanwhile, the number of medical schools—and graduates from them—continue to stagnate. Even when additional residency spots are created, relatively small percentages of MDs/DOs choose to practice in primary care. Combine these circumstances with the fact that the Affordable Care Act has injected a significant number of new patients into an already overburdened health care system and you realize that new innovations are desperately needed to increase access to care for patients.

Utilizing PAs and NPs to the full extent of their training will not only help alleviate the shortages but also increase the quality and accessibility of care. NP and PA programs are proliferating across the country and producing steadily increasing numbers of graduates.[3] Many of these newly minted NPs and PAs choose to enter primary care settings to practice, where they help to lower health care costs, decrease malpractice rates, and yield excellent patient outcomes and satisfaction rates.[4,5]

> *"Experienced PAs and NPs are held hostage and unable to practice without collaborative agreements."*

Yet physician organizations and state legislators continue to resist efforts to give these experienced and well-trained providers expanded scopes of practice and full practice authority. In many cases, physician interest groups continue to lobby for restrictive laws that are not backed with any data.[6]

Patients continue to suffer from a lack of access to health care because of legislative battles between groups of providers over practice territory, money, and egos. Many patients have to wait extended periods to see a provider; in some rural areas, there may be no care available at all.

In these situations, experienced PAs and NPs are held hostage and unable to practice without collaborative agreements. Often, physicians demand monthly stipends (sometimes thousands of dollars) to act as a collaborator under such an agreement. In many cases, these "collaborating" physicians provide almost no oversight. Burdensome legislation stipulating supervisory or collaborative requirements—for which there is little to no supportive evidence—keeps health care costs higher than necessary, decreases access to care, and stifles any flexibility or innovation in health care.

NPs presently have full practice authority in 21 states and the District of Columbia and are recognized for their education and clinical training.[7] They must, and will,

Brian Sady has been a practicing PA in Las Vegas for 17 years, specializing in emergency medicine and family practice.

continue to lobby and fight for full practice authority in the rest of the country. PAs must join in this effort by continuing to lobby for full practice authority for experienced PAs in primary care. It's time PAs were also recognized by state legislators for their education, clinical training, and dedication to quality patient outcomes.

PAs are graduate-level educated providers with a wealth of knowledge and experience. PAs, like our NP counterparts, have 50 years of patient outcomes data and studies that prove we are effective and safe providers. Organizations such as the VA, the FTC, and other citizen advocacy groups support PAs.[8-10] These organizations have supported NP independence and will support the push for PA practice autonomy as well.

> *"The time has come to remove punitive legislation and supervisory burdens from hard-working providers."*

The time has come to start the movement for full practice authority for PAs on a national and state level. Experienced PAs in primary care are ready for this challenge and should lobby for legislation that would allow them the option to practice without collaborative agreements. In states that have granted independence to NPs, the wording "practice alone or in collaboration with a physician" has been used, allowing flexibility in practice environments; PAs could use the same language in their lobbying efforts.

The criteria for PA autonomy will undoubtedly be debated extensively. For our NP colleagues, many states require a specific number of hours practicing with a collaborative agreement in place before independent practice is allowed. Since very little data exist that can direct the PA profession on the number of years a PA should practice before gaining autonomy, relevant NP legislative requirements could be used as a precedent.

For example, Nevada gives NPs the ability to practice without a collaborative agreement as new graduates. Connecticut gives NPs the ability to practice independently after three years of collaboration with a physician. There is little doubt that these are arbitrary numbers that were agreed upon at the state level—but PAs will face the same negotiations when lobbying for their right to practice autonomously.

I propose several criteria as a starting point for PA autonomy discussions.[11] PAs should

- Be NCCPA board-certified and eligible for state licensure
- Have three years full-time, or 6,000 hours, of practice in a primary care setting
- Have practiced at least one of the three required years within the previous two calendar years.

As I see it, PAs in a state that has passed full practice authority legislation, and met the above criteria, could start practicing without collaboration as soon as the law takes effect. Out-of-state PAs applying for licensure in a state with autonomy legislation should be permitted to use their practice experience in another state to meet the minimum requirements for autonomy.

The time has come to remove punitive legislation and supervisory burdens from hard-working, well-intentioned, quality providers. Many physicians practicing on the front lines of medicine with PAs and NPs are choosing to hire NPs who are independent, because it's easier for them to do so. Independent NPs do not come burdened with a state-mandated list of supervisory requirements (which may create a perception of increased legal liability for the physician).

Many PAs may fear backlash from physicians over the issue of autonomy. The reality is that, yes, there will be some resistance from organized medicine. But when PA autonomy legislation is passed, organizations and physicians will continue to hire PAs—just as they continue to hire NPs. PAs who gain autonomy will be studied just as independent NPs are being studied. And, as is the case with our NP colleagues, PAs' patient outcome data will continue to be positive.

Laws are not what make good providers. Accredited education programs, quality CME, access to technology, best practices, and team health care make good providers. America doesn't have 20 years to wait for PAs and NPs to creep forward with baby steps in legislative sessions that last years. Our patients need us now! They need PAs and NPs to fight for their care, to be their advocates, and to be their providers.[11] They need us to stand up and own our professions so we can be more effec-

tive—not for us, but for them. I hope you agree. Feel free to send your thoughts to PAEditor@frontlinemedcom.com. **CR**

REFERENCES

1. United Health Foundation. America's Health Rankings: a Call to Action for Individuals and Their Communities (2014). http://cdnfiles.americashealthrankings.org/SiteFiles/PressReleases/Americas%20Health%20Rankings%202014%20Edition.pdf. Accessed September 9, 2015.
2. Association of American Medical Colleges Center for Workforce Studies. *2013 State Physician Workforce Data Book*. https://members.aamc.org/eweb/upload/State%20Physician%20Workforce%20Data%20Book%202013%20(PDF).pdf. Accessed September 9, 2015.
3. Physician Assistant Education Association. *PAEA 28th Annual Report: Physician Assistant Educational Programs in the United States, 2011-2012*. www.paeaonline.org/index.php?ht=a/GetDocumentAction/i/156969. Accessed September 9, 2015.
4. Hooker RS, Nicholson JG, Le T. Does the employment of physician assistants and nurse practitioners increase liability? *J Med Licensure Discipline*. 2009;95(2):6-15.
5. Hooker RS, Muchow AN. Modifying state laws for NPs and PAs can reduce cost of medical services. *Nurs Econ*. 2015;33(2):88-94.
6. Isaacs S, Jellinek P. *Accept No Substitute: A Report on Scope of Practice*. The Physicians Foundation. November 2012: 14-15. www.sc.edu/study/colleges_schools/nursing/centers_institutes/center_nursing_leadership/sc_onevoice_oneplan/a_report_on_scope_of_practice.pdf. Accessed September 9, 2015.
7. American Association of Nurse Practitioners. State Practice Environment. www.aanp.org/legislation-regulation/state-legislation/state-practice-environment. Accessed September 9, 2015.
8. LeBuhn R, Swankin DA. *Reforming Scopes of Practice: A White Paper*. Citizen Advocacy Center. July 2010. www.cacenter.org/files/ReformingScopesofPractice-WhitePaper.pdf. Accessed September 9, 2015.
9. Department of Veteran's Affairs, Veteran's Health Administration. VHA DIRECTIVE 1063: Utilization of Physician Assistants, Appendix A-5. www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2958. Accessed September 9, 2015.
10. Federal Trade Commission Office of Policy Planning, Bureau of Economics, and Bureau of Competition. Letter to Representative Kirkton, April 21, 2015. www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-representative-jeanne-kirkton-missouri-house-representatives-regarding-competitive/150422missourihouse.pdf. Accessed September 9, 2015.
11. Sady B. *Optional Autonomy for PAs in Nevada: A White Paper*. June 2015. https://app.box.com/s/6f6567b1fobkvvo1g7egfd2gq6ir1jx7. Accessed September 10, 2015.