Breaking Down Barriers to PA Practice in Oklahoma

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Overview

• Overview of PA Practice in Oklahoma
• Six Key Elements, Licensure Procedures, and Successes in the States
• Optimal Team Practice
• ...So How Do We Get There??
PA Practice in Oklahoma

Number of PA Licensees in Oklahoma: 1,650
Number of PAs in the U.S.: 123,000+

- 22.5% Family medicine
- 22.5% Surgical subspecialties
- 16.3% Urgent care
- 11.3% Internal medicine subspecialties
- 6.3% Emergency medicine
- 6.3% General pediatrics
- 17.5% All other specialty areas

**26.3% of PAs practice primary care: family medicine, general internal medicine, general pediatrics**
PA Practice in Oklahoma

Number of PA Licensees in Oklahoma: 1,650
Number of PAs in the U.S.: 123,000+

- 46.8% Physician office or clinic
- 24.7% Hospital settings
- 14.3% Urgent care center
- 14.3% All other settings

**19.5% of PAs practice in rural areas
**A typical PA completes 104 patient visits each week
Six Key Elements of a Modern PA Practice Act

1. “Licensure” as the regulatory term (50 states + D.C.)
   - Oklahoma has this element
2. Full prescriptive authority (43 states + D.C.)
3. Scope of practice determined at the practice level (37 states + D.C.)
4. Adaptable collaboration requirements (30 states + D.C.)
   - Oklahoma has this element
5. No chart co-signature requirement (31 states + D.C.)
   - Oklahoma has this element
6. No PA-physician ratio limitation (14 states)
States typically require:
• Application
• Official transcripts
• Proof of national certification
• Background check
• Fees

Additional requirements may include: personal interviews for each applicant, physician identified prior to licensure, letter(s) of recommendation or other forms, practice agreement approved by board prior to licensure, jurisprudence exam, board action for licensure
PA Licensure Procedures

Oklahoma requirements:
- Core items (application, transcripts, fees)
- Jurisprudence examination
- Licensure requires board approval of each applicant

Average Oklahoma licensure turnaround time: 6-8 weeks

States with no “extra” requirements: average 2-5 weeks

**Oklahoma is the flagship state for the Uniform Application for PAs**
AAPA National Update

Illinois, Michigan, New Mexico, Tennessee, and West Virginia
Removed “supervision,” replaced with “collaboration” or “participation”

Washington, D.C and Texas
Improved flexibility for PAs and physicians related to in-person meetings
AAPA National Update

Arizona, Louisiana, and Wisconsin
Improved prescriptive authority

Kansas, North Dakota, and Maryland
Expanded ability to use telemedicine
AAPA National Update

Kentucky, Missouri, and Oregon
Added PAs to provisions related to psychiatric care

Kentucky, Utah, and Wyoming
Enabled PAs to sign forms/certify health status
AAPA National Update

Oklahoma
Added PAs to loan repayment/scholarship programs

Connecticut, Louisiana, and Missouri
Improved or eliminated PA to physician ratio requirement
Incentives for physicians to enter into supervisory agreements with PAs have diminished

- Physicians more likely to be employees rather than employers
- No personal financial advantage for physicians to have an agreement with a PA
Marketplace Realities Driving Need for Change

**NPs** don’t require an agreement with a specific physician

Number of States where NPs Have Full Practice Authority

- **1990**: 4 (+D.C.)
- **1998**: 8 (+D.C.)
- **2012**: 16 (+D.C.)
- **2014**: 19 (+D.C.)
- **2017/2018**: 22 (+D.C.)
45% of PAs say they have personally experienced NPs being hired over PAs due to supervision requirements

AAPA FPAR Survey, 2017
“Removing unnecessary restrictions on PA practice, such as eliminating the requirement for PAs to have an agreement with a specific physician in order to practice, would help alleviate healthcare shortages and improve efficiency with no adverse effects on patient outcomes.”

- Authors E. Kathleen Adams and Sara Markowitz
Research Recognizes Quality of PA Care

AAPA Tools for State Advocates:
https://bit.ly/2n1rdnN
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<tr>
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<th>About Optimal Team Practice</th>
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<tr>
<td>1</td>
<td>Emphasize PAs’ commitment to team practice</td>
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<td>2</td>
<td>Authorize PAs to practice without an agreement with a specific physician—enabling practice-level decisions about collaboration</td>
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<td>3</td>
<td>Create autonomous majority-PA boards to regulate PAs, or give authority to healing arts or medical boards that have PAs as members</td>
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<td>4</td>
<td>Authorize PAs to be eligible for direct payment by all public and private payers</td>
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OTP is Not Independent Practice

1. It reinforces PAs’ commitment to team practice with physicians and explicitly states the PA-physician team model continues to be relevant, applicable and patient-centered.

2. It also calls for a decision about the degree of collaboration between PAs and physicians to be made at the practice level, in accordance with the practice type and the education and experience of the PA.
Case for Separate PA Boards

- PAs are most commonly regulated by state medical boards
- Physicians and nurses are assured their regulatory boards have current knowledge of their profession
  - PAs have no such assurance
- Medical boards are primarily comprised of physicians
Making PAs Eligible for Direct Payment

- Practices, hospitals and health systems are limited in how they employ and work with PAs due to outdated regulations.
- Rural Health clinics (RHC) may not be paid for PA delivery of a variety of services the federal government requires them to provide.
- RHCs have a disincentive to hire PAs; and PAs have a disincentive to own RHCs, which reduces patient access to care.
Nationwide Look at OTP Activity

25 states are active on OTP. That includes:

- Formed task forces
- Surveyed members
- Reached out to stakeholders
- Educated members
- Published articles

Some are actively planning legislation
Identifying the “WHY” in OTP

- Add value to health systems
- Expand patient access to care
- Increase volunteer medical services
- Focus on patient-centered care
Why Physicians Should Support OTP

- Reduces administrative burdens and increases flexibility
- Eliminates physician liability for care provided by a PA
- Allows team practice and design to be determined at the practice level
- Eliminates the threat of disciplinary action for “paperwork infractions”
- Ensures accuracy of data related to the quality and value of care
Outreach Strategy for Stakeholders

- Conducting Research
- Using Personal Relationships
- Linking Organizations
- Engaging Medical Liaisons
- Capitalizing on Opportunities
Advancing PA Awareness and Understanding

Expectant mother. Unexpected test results.

YOUR PA CAN HANDLE IT.
yourPAcan.org
Communication Tools for Constituent Organizations

www.aapa.org/what-is-a-pa/
Communication Tools for Constituent Organizations

Optimal Team Practice: https://bit.ly/2GNYfbk


What is a PA: www.aapa.org/what-is-a-pa/
Supporting State OTP Activity

AAPA’s Board approved funding to support state advocacy and communication strategies:

- **FY18**
  - $200K for OTP states

- **FY19**
  - +$200K for targeted ad placements
  - +$300K for OTP states

- +$100K for states pursuing other targeted changes
Breaking Down Barriers: Tips & Tricks

• Building relationships with the medical board
• Strengthening alliances with other provider groups
• Making friends with legislators
• Harnessing local media
• Partnering with neighboring states’ chapters
• Creating opportunities for change
• Increasing member engagement
• Teaming up with AAPA
Building Relationships with the Medical Board

• Send a regular OAPA observer to medical board meetings
• Request time to do a presentation on PA practice
• Offer to be a resource
Strengthening Alliances

- Make new friends: reach out to groups you know – and groups you don’t know
- Do your research: what goals overlap?
- Get involved
Making Friends with Legislators

• Look for connections
• Offer invitations for site visits or other events
• Attend fundraisers/town halls
Harnessing Local Media

- Outreach
- Op-eds
- Letters to the editor
Partnering with Neighboring State Chapters

- Connect via social media
- Invite to CME and other events
- Meet up at AAPA events
- Share notes and ideas
- “Comparison is the thief of joy” – not here!
Creating Opportunities for Change

- Licensure
- Buprenorphine
- Responding to local challenges – pro and con
Increasing Member Engagement

• Outreach to PA programs
• Social events
• Volunteer opportunities – internal and external
Team up with AAPA

- Legislative resources
  - Research, memos, drafting/markups, info on other states
  - E-mail blasts
- Media resources
  - Op-eds, letters to the editor, press contacts, infographics, advertising
- Membership resources
  - Membership statistics and information
- Research resources
  - AAPA salary report, PA practice profiles
Case Study: Texas

2017 legislative session wins

• S.B. 919, allows PAs to sign death certificates in certain cases

• S.B. 1565, includes PAs in the definition of “primary care provider” for the purposes of ordering medical services for individuals admitted (voluntarily/involuntarily) to certain state facilities

• H.B. 2546, allows PAs to sign workers’ compensation forms
Case Study: Texas

2017 legislative session wins (continued)

• H.B. 1978, allows PAs to provide volunteer healthcare outside of the normal delegation/supervisory agreement

• S.B. 1625, removes the requirement that PAs with Rx authority have monthly face-to-face meetings with a physician, allowing this meeting to occur via telecommunication and strengthens PA board authority

• S.B. 11A, includes PAs in the list of healthcare providers who may place a DNR order in a patient’s medical record in certain facilities
Case Study: Texas

How’d They Do It?

• Medical board relationship
• Alliance with Texas Medical Association
• Legislator friends
• Making the most of local issues -> opportunity
• Chapter engagement
• Partnership with AAPA
Case Study: Illinois

2017 legislative session wins

- Replaced “supervision” with “collaboration”
- Got PAs listed as healthcare providers under Medicaid
- Improved ratio language: from 5 PAs per physician to 5 FTE PAs per physician
Case Study: Illinois

How’d They Do It?

• Engaged medical board and medical society
• Made friends in the legislature
• Leveraging neighboring states’ experiences
• Using an impending deadline as a reason to advocate for change
• HUGE member engagement
• Partnership with AAPA
Case Study: Louisiana

2017-2018 legislative session wins

• S.B. 216, allows PAs to sign an emergency certificate to admit individuals who are experiencing a mental or behavioral health crisis (2017)

• S.B. 528, increased PA to physician ratio from 4 to 8 and removed outdated requirements for prescriptive authority (2018)
Case Study: Louisiana

How’d They Do It?

• Made friends with a legislator

• Increased member engagement

• Partnership with AAPA
Case Study: Indiana

2016 Policy Change

• Update of the Indiana High School Athletic Association policy related to sports physical forms, which previously had to be signed by a physician

• New policy allows forms to be signed by physician, PA, and NP
Case Study: Indiana

How’d They Do It?

- Built a coalition including physician, nursing, and other groups
- Used current events (FTC action) as an opportunity for change
- Member engagement
- Partnership with AAPA
Case Studies: Takeaways

Major Lessons:

• Goals or agenda don’t have to be big or bold
• Small wins lead to bigger wins
• Education helps – legislature, medical board, other stakeholders
• Know the climate – and be prepared to refute misconceptions
• These things take time
• Ask for help