

# OPTIMAL TEAM PRACTICE: THE WAY FORWARD

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## Abstract

Optimal team practice (OTP) represents an amendment to an existing American Academy of PAs policy, Guidelines for State Regulation of PAs (HP-3500.3.4), that advocates for expanded access to affordable, high-quality healthcare through modernization of PA–practice laws. OTP also calls for PAs to practice without a collaborative or supervisory agreement with a specific physician, enabling practice-level decisions about collaboration. However, OTP remains poorly understood and relatively under-researched. This article analyzes OTP and its potential implications on legislative efforts, training of PAs, and practice level changes.

The physician assistant (PA) profession is more than 50 years old and has earned substantial recognition from organized medicine and the public for its positive effect in expanding access to care, improving patient health outcomes, and improving patient quality of life<sup>1,2</sup>. A sizable body of health services research continues to demonstrate that care provided by PAs is comparable to that of primary care physicians in terms of patient outcomes and patients are well satisfied with the care delivered by PAs<sup>3-9</sup>. Moreover, research clearly demonstrates that PAs practicing in specialty areas, such as orthopedics and emergency medicine, provide safe and high-quality healthcare<sup>10,11</sup>. Additionally, PA and nurse practitioner (NP) malpractice and adverse actions are considerably less than physicians<sup>12</sup>. Despite these achievements, nearly all states require PAs to have signed written practice agreements with physicians in order to work in the medical setting. Removing anticompetitive barriers such as supervisory practice agreements may help increase access to affordable high-quality healthcare at a lower overall cost without eliminating or reducing collaboration between members of the healthcare team. In May 2017, the American Academy of PAs (AAPA) House of Delegates voted to adopt

optimal team practice (OTP) to meet evolving healthcare needs by enabling state chapters to seek changes to existing PA practice laws and policies. Yet little published analysis or debate exists on OTP. This article analyzes OTP and seeks to spur future discussion and examination of the concept.

## Origins of the OTP Movement

Clearly, a good deal of the impetus behind the OTP movement stems from the incremental gains obtained by advanced practice registered nurses (APRNs) in achieving full practice authority (FPA) in 22 states and in medical facilities run by the Department of Veterans Affairs. FPA grants NPs practice to the full extent of their education and training without the direct supervision of a physician or a collaborative agreement. PAs contend that this practice arrangement gives NPs an advantage in hiring decisions, particularly in primary care. PA proponents of OTP cite the results of a national survey of practicing PAs that “nearly half of the respondents (45%) said that they had personally experienced NPs being hired over PAs because NPs don’t need to identify and register a supervising or collaborating physician; 26% said they had not personally had that experience.”<sup>13</sup> However, the response rate of the survey was less than 10%, and the

results may have been influenced in part by nonresponse bias. Another study found preferential hiring practices favoring NPs over PAs at one institution; however, a close examination of that particular care model found that preferential hiring practices should be replaced by a more inclusive and analytical approach to employing PAs and NPs<sup>14</sup>.

Other studies have shown no preferential hiring of NPs over PAs. One of these, authored by 3 physicians, comprised 2 cross-sectional electronic surveys of councilors of the American College of Emergency Physicians and included questions about hiring practices<sup>15</sup>. Findings included:

- Most councilors' departments employ PAs and NPs (72.4% of 163 responses)
- Supervisory requirements varied greatly among respondents for the same emergency severity index level, regardless of experience level
- NPs used significantly more resources than PAs<sup>15</sup>.

Of particular interest, no statistically significant difference was found in the type of provider (PA or NP) hired between different emergency department (ED) settings<sup>15</sup>. Slightly more than 63% of councilors reported that their institutions hired less-experienced (less than 5 years' experience) PAs and 58.1% reported hiring less-experienced NPs<sup>15</sup>. Physicians who have direct experience in hiring PAs and NPs in the ED show no differences in hiring preferences between these 2 healthcare professionals. Yet PAs remain concerned that outdated and inconsistent state regulations overly restrict PA practice, although previous research seems to suggest a movement toward less-restrictive regulations and higher entry-to-practice requirements for both NPs and PAs<sup>16</sup>. Laws that require strict physician supervision tend to impair entry into professional practice and impede more attractive and innovative collaborative working arrangements. The principles of OTP emphasize a

continued commitment by PAs to team-based practice and the creation of autonomous PA boards to regulate PA scope of practice<sup>13</sup>. OTP advocates PAs to practice without a collaborative or supervisory practice agreement with a specific physician, enabling practice-level decisions about collaboration<sup>13</sup>. Some evidence supports that rigid supervision of PAs and NPs may not promote successful models of team-based care, which is a hallmark of OTP<sup>13,17</sup>. In addition, OTP advocates that PAs be directly reimbursed by all public and private insurers<sup>13</sup>. This step would improve billing transparency, enabling PA contributions to be fully visible in healthcare quality metrics. Enacting this element of OTP would require a change to Medicare payment regulations by Congress. A house resolution HR 1052 (sponsored by Sewell, D-AL and Smith, R-NE) if passed, would allow PAs to receive direct payment from the Medicare program. Addressing other anticompetitive barriers to practice for NPs and PAs may increase access to care, improve primary care capacity, and reduce healthcare costs<sup>17,18</sup>.

### **OTP Implementation**

AAPA developed and published model state legislation in February 2018, which details legislative best practices. These best practices are being used by state chapters to advance OTP initiatives. In addition, the PA profession can learn from the experiences of nursing regarding how to successfully navigate the legislative landscape. Nursing has a long and fruitful tradition of legislative and political advocacy and experience in removing anti-competitive barriers to practice. Nursing research has identified specific barriers associated with scope of practice reform, including a lack of physician support, inability to address all stakeholders, lack of a strong coalition, lack of clear vision, lack of consistent messaging, and a lack of recognition from other healthcare professionals about NP preparation and scope of practice<sup>19,20</sup>.

Nursing continues to march toward universal FPA. PAs in certain states are beginning to plan legislative efforts to attain OTP and may find it helpful to focus the conversation on how collaborative and supervisory agreements impede healthcare competition, raise healthcare costs, and deprive patients of choices<sup>17,21</sup>. In addition, one study found that on average, APRNs perceived physician oversight to have a negative effect on the safety and quality of care delivered by APRNs<sup>22</sup>. APRNs have used these key arguments successfully when campaigning for scope of practice reform.

The advantages of OTP appear to apply largely to PAs in primary care, given that vast majority of PAs work in specialties. Evidence suggests that PAs in primary care already display a good deal of practice autonomy<sup>23</sup>. Perhaps seeking a form of OTP in the primary care setting may be a more attainable first step for our profession, both from a training standpoint and as a realistic goal that could gain support in the medical community.

Given the size of the PA profession, in comparison with other disciplines, leveraging interdisciplinary synergies through formal alliances may increase visibility, trust, credibility, and political clout<sup>24</sup>. Other potential alliances include the National Governors Association, Bipartisan Policy Center, Josiah Macy Foundation, and American Association of Retired Persons, which have supported amending current scope of practice laws and regulations that restrict PAs and NPs from practicing to the full extent of their training and licenses. These types of alliances may help to offset the American Medical Association's (AMA's) opposition to the establishment of autonomous state boards that regulate PAs outside of the existing state medical licensing bodies' authority and purview (AMA resolution 233, A-17)<sup>25</sup>.

The AMA's policy against certain pillars of OTP heightens the importance of political campaigning and

compromise. Nursing's successful campaign to obtain FPA shows the value of political compromise in advancing OTP to law. For example, as a political concession to obtaining OTP, some states may consider imposing specific legal and regulatory requirements (as they do for APRNs) that PAs complete a structured transition-to-practice period. Under a transition-to-practice period, PAs would be required to work a set number of years and/or hours under physician supervision before being able to provide care without a supervisory practice agreement.

A transition-to-practice period may provide better support and expanded onboarding for newly graduated PAs entering the primary care workforce. However, no empirical evidence exists on whether a transition-to-practice period would result in better patient outcomes or more qualified clinicians.

Another legislative consideration is the importance of PA national certification. Historically, the medical community remains divided on the value of high-stake examinations and the need for continued recertification. But a synopsis of the literature tends to point to the value of maintenance of certification requirements<sup>26,27</sup>. For example, a recent narrative review of 39 studies by researchers found that in 37 studies, at least one positive outcome was reported as a result of a physician's participation in maintenance of certification<sup>26</sup>. Another study found that emergency physicians reported improved financial compensation, greater employment options, and improved professional recognition as benefits of maintenance of certification<sup>28</sup>. Additionally, evidence shows that the public highly values physicians with board credentials: respondents indicated they would change physicians if their current physician or specialist failed to maintain certification<sup>29</sup>. However, not all researchers are convinced that maintaining board or specialty certification is necessary or

leads to better patient outcomes. Two published studies found no correlation between maintenance of certification and better patient outcomes among internists participating in the maintenance of certification program compared with nonparticipants<sup>30,31</sup>. However, another large study found that passing a periodic assessment of medical knowledge is associated with reduced state medical board disciplinary actions among board-certified internists<sup>32</sup>. Although no research evidence exists on whether maintenance of certification for PAs improves patient outcomes, fulfilling maintenance of certification requirements may help allay concerns by physicians, lawmakers, healthcare plans, payers, and consumers about perceived patient safety issues associated with the elimination of supervisory agreements for PAs.

Although the role of specialty certification for PAs has not been well-established, the PA profession should critically examine the advantages and disadvantages of earning a specialty credential. The absence of a specialty credential may one day represent a significant barrier to practice. The nursing profession continues to campaign and endorse specialty certification for NPs<sup>33</sup>. For example, NPs can receive specialty certification through a wide variety of specialty certification boards<sup>33</sup>. As NPs continue to enter more specialties amid physician shortages, the standard for credentialing and privileging of NPs and PAs may one day require that newly minted PAs desiring to work in hospital specialties obtain a specialty credential or complete a postgraduate PA residency or fellowship. Specialty certification remains controversial in the PA profession because it could compromise the clinical flexibility that PAs have enjoyed for decades<sup>34</sup>.

### Educational Requirements

The Physician Assistant Education Association (PAEA), which represents PA programs initially objected to the findings of the AAPA Joint Task Force Report on OTP. The PAEA task force white paper articulated that OTP could increase tuition, impair diversity, increase didactic educational requirements, and exacerbate clinical site shortages<sup>35</sup>. Based on a program director survey administered by PAEA (N = 170) more than half (53%) of PA programs indicated that they would consider clinical doctorate degrees for PA students as a consequence of OTP<sup>35</sup>. No empirical evidence has been found that OTP would hurt diversity or increase the didactic and clinical requirements for PA students. Other professions, such as physical therapy and audiology, did not experience a significant decline in applicants, graduates, or diversity when transitioning from master's to doctoral entry-level degree<sup>36,37</sup>. Transitioning from a master's to a clinical doctorate as postulated by the PAEA task force may likely raise mixed feelings from a profession that has not historically been concerned with academic titles. Supporters suggest that PA clinical doctorates would be similar to nursing doctorates in preparing graduates for clinical faculty and leadership positions while maintaining parity with other disciplines<sup>38</sup>. Additionally, the role of postgraduate PA education remains to be determined under OTP but given that PA fellowships and residencies provide advanced didactic and clinical education and in some cases, a post-professional doctorate, such factors could give rise to greater PA practice autonomy<sup>39</sup>. More research is needed to fill in critical evidence gaps about the effect of postgraduate PA education on PA clinical practice and the profession<sup>40</sup>.

### OTP Implementation at the Practice Level

Although many PAs and NPs have their own patient panels and enjoy wide degrees of practice autonomy, the

overall responsibility and accountability for patient care has always been imputed to physicians<sup>41</sup>. Part of the intent of OTP is to correct this imbalance by having PAs be ultimately accountable for the care they provide. Some research suggests that physicians would welcome some elements of OTP, such as commitment to team-based practice with collaboration determined at the practice level<sup>42</sup>. However, few medical practices would relinquish complete control of patient care to PAs without some defined collaboration, for fear of increased malpractice liability. In hospitals, the medical staff policies, bylaws, and rules may supersede the implementation of certain elements of OTP at the practice level. Even if some the elements of OTP are passed, many hospitals likely would still require physician supervision of PAs, especially in sophisticated team-based models. Some healthcare facilities' organized medical staff have excluded PAs and NPs from membership and leadership positions. This leads to professional and political marginalization in the hospital hierarchy while reducing diversity in leadership. Without the support of the medical staff, OTP advocacy could fall on deaf ears. Also, research has shown that an increase in non-physician autonomy may negatively affect marketability; in one instance, increased NP practice autonomy and physician concern about insurance arrangements under which APRNs receive their compensation directly, rather than through a supervising physician, led to preferential hiring of PAs over NPs<sup>43</sup>. In states where NPs have higher levels of autonomy, physicians and NPs earned less, and PAs earned more<sup>43</sup>. Eliminating supervisory practice agreements may harm medical reimbursement opportunities and market dynamics for PAs after the initial rollout of OTP; for example, some payers and commercial healthcare plans could be resistant to credentialing and reimbursing PAs or NPs if they are not legally tied to a supervising physician<sup>44</sup>.

The PA profession will invariably run into challenges similar to those nursing experienced with the elimination of supervisory agreements in some areas of the country. Despite no measurable differences in patient outcomes, APRNs still struggle to negotiate and clarify professional identity among those in general practice<sup>45</sup>. Equally important is how PAs plan to redefine their professional identity under OTP to members of the healthcare team. A lack of professional identity has been linked to an underuse of certain healthcare professionals<sup>46,47</sup>. Moreover, the PA profession may have a difficult time convincing those in organized medicine about the legitimacy of OTP given that physician groups have characterized this newly approved resolution as a move toward independent practice, which will make this legislative campaign an uphill battle in many states.

### Conclusion

The PA profession has embarked on an ambitious policy that will take well over a decade to fully implement. OTP is designed to modernize PA practice laws and policies, enabling PAs to provide patients with greater access to healthcare. Although some in the profession have expressed enthusiasm and others trepidation about OTP, this new policy is but an evolutionary step in adapting to a changing healthcare marketplace. However, OTP remains poorly understood and relatively under-researched. The success of OTP largely depends on the PA profession's ability to coordinate efforts, as well as solicit support of other disciplines in removing anticompetitive barriers to practice. Given the impending primary care workforce shortage, growing number of aging patients, and rising healthcare costs, it is time we answered the call of researchers and others to practice medicine to the full extent of our education, training, and licensure. We can no longer sit idle knowing that a sea change is on the horizon.

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