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OPTIMAL TEAM PRACTICE: THE RIGHT PRESCRIPTION FOR ALL PAS?

Physician Assistant Education Association
OTP Task Force

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EXECUTIVE SUMMARY

As the national organization representing PA education programs in the United States, the Physician Assistant Education Association (PAEA) is professionally and ethically obligated to respond to policy proposals that affect the clinical practice environment and therefore the educational content of the programs that prepare PAs for practice. The Association represents 226 PA programs and more than 1,600 primary faculty, and its member programs graduate approximately 8,600 new graduates each year.

PAEA has concerns about the implications of resolution 2017-A-07-HO, concerning “optimal team practice (OTP),” which is on the docket for the 2017 House of Delegates (HOD) meeting. The resolution translates into policy language the recommendations of AAPA’s Joint Task Force (JTF) on the Future of PA Practice Authority, including a recommendation to “eliminate legal provisions that require a PA to have and/or report a supervisory, collaborating or other specific relationship with a physician.” The resolution proposes this and other changes to policy HP-3500.3.4, “Guidelines for State Regulation of PAs.”

PAEA supports three of the four elements of the OTP resolution: team practice, autonomous state boards, and direct reimbursement for PAs. However, we do not support the elimination of legal provisions that require a collaborating physician for PAs, because of the potentially far-reaching implications for PA education and for new PA graduates.

Accordingly, PAEA cannot support the optimal team practice provisions (lines 122-163) of resolution 2017-A-07-HO, which would eliminate a legal relationship between PAs and physicians. We ask the HOD to strike this language and retain the Collaboration section (lines 94-121) until a greater understanding of the benefits and challenges for PA education are fully explored by AAPA, PAEA, ARC-PA, and NCCPA as part of an inclusive joint task force. This task force should also be charged to delineate the potential effects of OTP on new graduates, in order to facilitate successful transition to a new model of practice.

The JTF process has been flawed by a lack of inclusion of key PA organizations, an AAPA opinion survey limited by participation bias and a low response rate, and a too hastily developed OTP proposal and resolution. We also believe that the nearly 600 pages of comments gathered by AAPA as part of its survey indicate that many more PAs share PAEA’s concerns about the effect of OTP on new graduates than is apparent from the formal survey results.

The JTF was initially charged with answering the following question: “Should the American Academy of Physician Assistants (AAPA) go beyond its current position that: PAs should be

able to practice autonomously; and individual state COs may pursue full practice authority/full practice responsibility/independent practice for PAs?” Although the language of the discussion has evolved from full practice authority and responsibility (FPAR) to “optimal team practice”, (OTP) and the word “independent” has been removed from the resulting resolution language, the intent remains the same.

Findings from PAEA surveys administered to program directors, medical directors, and past PAEA presidents are unambiguous. The consequences of OTP for PA programs may include increased content, length, and costs; reduced student diversity; and increased experience requirements for applicants. The already critical shortages of clinical training sites would make it problematic, if not impossible, for many programs to accommodate expansion of their clinical curricula. And finally, implementation of OTP may cause PA programs to explore awarding a clinical doctorate, with uncertain implications for the professional practice environment of all PAs.

A truly inclusive task force to address the implications of OTP for PA education and for new graduates is a critical component of a transparent process that brings together all the key PA stakeholders. Examples of recent successful joint activities include the Clinical Competencies Summits of 2005 and 2012, the Clinical Doctorate Summit of 2009, and the 2015 Stakeholder Summit. These experiences can provide a model for a thoughtful and complete discussion about the full implications of OTP.

INTRODUCTION

The aim of this report is to fulfill the charge of the Physician Assistant Education Association (PAEA) Board of Directors to:

- Identify the implications of “optimal team practice” (as defined by AAPA) for PA education
- Prepare a formal response to AAPA’s Joint Task Force on the Future of PA Practice Authority (JTF) detailing these implications

As the national organization representing the 226 accredited PA programs in the United States, as well as the more than 1,600 principal PA faculty educators at those programs,¹ PAEA is professionally and ethically obligated to respond to the AAPA’s proposal for optimal team practice (OTP) in support of PA students, graduates, and the patients they care for. Changes in professional practice policy that affect the PA clinical environment have significant implications for PA programs.

A note on terminology: In consideration of the decision made by the JTF to use the terminology “optimal team practice (OTP)” instead of the original “full practice authority and responsibility (FPAR),” we have used the term OTP in this paper. However, the key factor in the definition as it is understood in this paper is that OTP implies the absence of a specific legal relationship between a new graduate PA and a collaborating physician or group of physicians who are obligated to support the PA. In some contexts, we have retained the term “full practice authority,” particularly in discussion of the results of survey questions that were asked using this original terminology.

THE ORIGINS OF OTP: AAPA JOINT TASK FORCE

In July 2016, the AAPA’s Joint Task Force on the Future of PA Practice Authority (JTF) was charged with answering the following question: “Should AAPA go beyond its current position that PAs should be able to practice autonomously; and should individual state COs be allowed to pursue full practice authority/full practice responsibility/independent practice for PAs?”²

Additional charges to the JTF included (*emphasis added*):

- Understand and document the current federal, state, and employer context of the practice authority of PAs, APRNs, and other relevant health care providers.
- *Obtain input and/or feedback from PA stakeholders.*

- *Develop or select appropriate terms and definitions for different types of PA practice authority.*
- *Consider and describe what, if any, limitations or requirements should be established for PAs under the Task Force’s recommended PA practice authority (i.e., differences for primary care PAs vs. surgical PAs, contingent upon number of years practicing or number of years practicing in a specialty, etc.).*
- Consider and describe the potential benefits of its recommendations for PAs, patients, PA employers, *as well as any potential risks and obstacles* that should be taken into account (i.e., malpractice insurance). If so, what should that practice authority be called, and how should it be defined and described?

Joint Task Force Findings

After nine months of data gathering and stakeholder engagement, including a survey sent to 102,101 PAs (with 12,485 respondents — a 12.6% response rate, including 1,827 students), the JTF completed its report and submitted a resolution to the AAPA House of Delegates (HOD) for consideration at its 2017 meeting.³ The resolution has four key elements:

1. Emphasize the PA profession’s continued commitment to team-based practice.
2. Support the elimination of provisions in laws and regulations that require a PA to have and/or report a supervisory, collaborating, or other specific relationship with a physician in order to practice.
3. Advocate for the establishment of autonomous state boards, with a voting membership comprised of a majority of PAs, to license, regulate, and discipline PAs.
4. Ensure that PAs are eligible to be reimbursed directly by public and private insurance.

The JTF report also introduced the new term “OTP,” replacing the original FPAR.

CONCERNS ABOUT THE JTF PROPOSAL

PAEA supports three of the four key elements in HOD resolution 2017-A-07-HO:

1. Team practice — as an accreditation standard, team practice is integrated throughout the curriculum of PA programs and is modeled by PA faculty, most of whom are also clinically practicing PAs.
2. Establishment of autonomous state boards, where PAs can elevate the credibility of the profession and hold themselves accountable.
3. Direct reimbursement for PAs, as it is essential that PA billing and reimbursement data are easily tracked and available. These data provide critical workforce information that can clearly establish the impact PAs have on patient care.

However, PAEA does not support eliminating a specific relationship between PAs and physicians for new graduates, as would occur under the recommended Guidelines for State Regulation of PAs as revised by resolution 2017-A-07-HO.⁴ This element has major implications for the overarching responsibility of PA educators to design, deliver, and assess curricula that currently prepare new PA graduates to practice medicine with physician collaboration.

CONCERNS ABOUT ELIMINATION OF PHYSICIAN SUPERVISION OF NEW GRADUATES

PAEA has significant concerns about the section of 2017-A-07-HO that states (on page 5, lines 152-157):

“Optimal Team Practice is applicable to all PAs, regardless of specialty or experience. Whether a PA is early career, changing specialty or simply encountering a condition with which they are unfamiliar, the PA is responsible for seeking consultation as necessary to assure that the patient’s treatment is consistent with the standard of care.”

PAEA has three issues with this approach:

- New graduates are now educated and trained under a model aimed at readiness for practice with physician collaboration.
- Many current students choose to join the profession on the assumption that physician collaboration would be present to a high degree early in their careers, then lessening over time as they gain experience and more autonomous practice.
- Patients have come to expect a PA/physician team partnership predicated on collaboration.

OTP changes all three of these dynamics without accounting for how the PA education model would have to adapt to the elimination of requirements for a PA to have a supervisory, collaborating, or other specific relationship with a physician.

PAEA recognizes that the current practice environment has changed since the early days of our profession, and the solo physician/PA model is far less ubiquitous than it used to be. Many PAs now work in health systems with a cadre of physicians and other clinicians. However, even in these environments, new PA graduates still require a formal relationship with a collaborating physician.

Every PA has shared the practice experience of being an “early career” new graduate. Current students joined this profession with the expectation of practicing with physicians who share responsibility for patients. Unpublished data from the 2016 PAEA Matriculating Student Survey (to be published by August 2017) of newly enrolled students show that 91% of respondents (N = 4,237) describe the supervising physician relationship as “essential” or “very important” to their considerations regarding their career path after PA school.⁵ Table 1 shows the detailed results. PAEA is concerned that OTP will create an unsupportive environment for new graduates that could compromise their success and, in some settings, patient safety. This is particularly true for new graduates who have an incomplete understanding of their own limitations and knowledge and/or are practicing in settings where there are geographic or other barriers to consultation.

TABLE 1. IMPORTANCE OF CONSIDERATIONS FOR CAREER PATH AFTER PA SCHOOL⁵

	Essential		Very Important		Somewhat Important		Not Important		Total
	n	%	n	%	n	%	n	%	
Supervising physician relationship	2,280	54	1,588	38	355	8	34	1	4,237

CONCERNS ABOUT THE JTF PROCESS

Although the JTF was charged to “obtain input and/or feedback from PA stakeholders,” PAEA was not formally or informally involved in the process until the Association extended an invitation to AAPA Vice President of Constituent Organization Outreach and Advocacy Ann Davis, the lead AAPA staff to the task force, to attend the January 2017 PAEA Board meeting. JTF Chair Jeffrey Katz also attended the meeting. This late involvement of PAEA suggests that AAPA underestimated the impact that changing one of the foundations of the PA profession — practice with physician collaboration — would have on PA programs, current students, and recent graduates. The omission of PAEA input is unfortunate as the journey of all PAs begins with PAEA member programs.

These concerns have also been expressed by others. At the AAPA Leadership and Advocacy Summit in Arlington, Virginia, on March 4, 2017, the following comments were representative of those captured in the summary document:

- How do we ensure training for new graduates under this new freedom?
- There is no system in place to maintain quality, especially with new grads.

- Regarding new grads . . . need thought on oversight, logistics, and infrastructure in monitoring onset of increased practice authority.
- Need for new graduates to have three years of supervised practice before moving to collaboration.⁶

In a letter otherwise fully supportive of FPA, the group “PAs for Tomorrow” viewed the role of new graduates with appropriate care and concern:

While a newly graduated and certified PA should certainly receive more training, whether it be via a formal residency or on-the-job, PAs know PA education better than any other profession, including MD/DO; PAs should have the responsibility for overseeing the members of their profession and determining when any oversight should no longer be formally or legally required.⁷

These concerns about the impact on new graduates — and their patients — have been marginalized by the speed of the OTP process. Recent recognition of this impact on new graduates is evidenced in a naming convention change that bestows on new graduates the title of “early career PAs.” This euphemism for new graduates would be less troublesome if the OTP proposal addressed the risks of OTP for new graduates in a meaningful way. Unfortunately, the only recognition of this oversight is found in the final paragraphs of the JTF report:

We understand that Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), Physician Assistant Education Association (PAEA), and individual PA programs may be concerned that there is a need for additional restrictions on early-career PAs . . . *[T]o address this concern, AAPA should work closely with ARC-PA and PAEA to ensure that PA programs, preceptors, PA students and new graduates, and employers understand the expectation that early-career PAs will need to work closely with physicians and experienced PAs to gain the clinical experience that is critical to success (emphasis added).*⁸

It is not clear from the JTF proposal exactly what “working closely” means and how AAPA, ARC-PA, and PAEA will engage with employers to explain something that is left undefined in the JTF proposal. Furthermore, it is worth noting that three of the four PA organizations (NCCPA, PAEA, and ARC-PA) are, by default, being compelled to collaborate on a proposal on which they had no upfront involvement.

Concerns About the JTF Survey

The results of AAPA’s 2017 Full Practice Authority and Responsibility Survey are problematic in several regards. First, the survey had a response rate of only 12% (12,485 out of a total PA population of 102,101), and 14% of the respondents were students. More than 5% (680) of respondents reported an “unknown” PA role. A survey with a low response rate is more likely to suffer from potentially significant participation bias — those with extreme opinions, or those who are naturally more likely to participate in group activities (“joiners”), are given a disproportionate voice. The short survey time frame — 21 days — likely contributed to the low response rate. These data are a shaky foundation on which to base significant legislative and regulatory changes for the discipline.

Second, all messaging around FPAR was overwhelmingly positive, both in vehicles pushed out from AAPA and in the online Huddle forum. The Huddle became a sounding board for a relatively small number of PAs with strong opinions about improving PA marketability in comparison to nurse practitioners, while rarely addressing unintended consequences and potential costs. Positive messaging⁹⁻¹⁰ may have influenced and biased participation for those who supported the proposal.

Third, the survey design included question sequencing that built a case for assenting to the elimination of physician collaboration as responders worked through the survey, which introduced an additional source of bias. Notably, no questions addressed how new graduates might fare in a practice environment without a collaborating physician. Only two survey response statements addressed potential negative outcomes of the proposal:

- *I am concerned that the proposal will negatively impact the relationships I have with physicians, and*
- *Even if FPAR creates conflict with physician organizations, I think we should still pursue it.*

Unreported Data in the Comments

In terms of the survey analysis, perhaps most troublesome is the lack of attention to the 586 pages of responder comments, some of which provide an important counterpoint to the carefully crafted Likert scale questions. Exploration of the survey comments reveals important elements and themes not addressed at all in the report.

PAEA staff performed a *post hoc* word find of the 2017 Full Practice Authority and Responsibility Survey Report Compilation of Respondent Comments¹¹ for “new grad,” “new grads,” or “new graduates.” This search revealed that responders used these terms *498 times*.

Although hand-searching documents can be problematic, our analysis found that only two of the 498 identified instances supported the elimination of formal physician collaboration for new PA graduates entering practice. Fifteen comments referred to unprepared new graduate nurse practitioners or were unrelated to new graduate OTP. Table 2 shows the complete breakdown of comments.

A consistent sentiment emerged during a thematic analysis of the open-ended comments: *PAs are gravely concerned about the effects of OTP on new graduates*. More than 96% of the instances (481/498) that addressed new graduates expressed concern about or advised against full practice authority for new PA graduates. Many commenters went so far as to recommend lengthening PA education, expanding postgraduate residencies, or establishing graduated degrees of autonomy whereby new graduates may, over time, earn full practice authority status.

TABLE 2. BREAKDOWN OF RESPONDENT COMMENTS THAT INCLUDE TERMS FOR NEW PA GRADUATES IN THE 2017 FULL PRACTICE AUTHORITY AND RESPONSIBILITY SURVEY REPORT ¹¹

Total instances of the term "new grad," "new grads," or "new graduates" n	Express concern, skepticism, or lack of support about awarding OTP to new graduates n (%)	Mention unprepared new grad nurse practitioners or are unrelated to new grad OTP practice n (%)	Express overt support of OTP for new graduates n (%)
498	481 (96.5)	15 (3.0)	2 (0.4)

Although 71% of respondents to the AAPA survey expressed overall support for removing the legal relationships and required physician collaboration for all PAs, many survey commenters remarked on the need for measured consideration in the case of new graduates. PAEA finds it concerning that no mention of these concerns found its way into the final JTF report. It is unclear what may have motivated AAPA to omit discussion and analysis of these repeatedly expressed sentiments.

PAEA SURVEY DATA: PROGRAM DIRECTORS, PAST PRESIDENTS, AND MEDICAL DIRECTORS

To gauge PA educators' opinions about the potential impact of OTP on their curricula, students, and graduates, PAEA developed and administered surveys to all program directors (N = 218), past presidents (N = 28), and medical directors (N = 218), from January through April 2017. Response rates were generally high: 78% (n = 170) for program directors, 61% (n = 17) for past presidents, and 34% (n = 77) for medical directors. The questions were similar

but adapted to each population's role. For example, questions concerning the effects of OTP on budgeting were asked of program directors, but not of medical directors.

PA Program Director Survey

All respondents were asked the question, "Does your program's current curriculum already prepare your graduates to practice without 'a supervisory, collaborating, or other specific relationship with a physician' in order to practice?"

Those who responded "Yes" were asked no additional questions. The large majority (86%) responded "No." This majority was then asked a series of questions on the implications of FPAR (as it was then called), to which responses were as follows:

- More than two-thirds (68%) predicted a need to increase the duration or content of their programs. And these respondents predicted a median increase of two semesters or three quarters.
- Two-thirds (67%) predicted a need to expand the clinical portion of training, with a median predicted increase of two semesters or two quarters.
- Nearly three-quarters (74%) indicated that current clinical sites would be inadequate to meet the projected increased clinical training needs.
- Student tuition to cover the costs for program expansion was predicted to rise by 25%.
- More than half (53%) would consider awarding a clinical doctorate because of FPAR (3% of programs are exploring the clinical doctorate in any case).
- Nearly three-quarters (74%) indicated that increases in tuition and program duration would lead to a decrease in applicant diversity.
- 63% predicted that FPAR would lead to a need to increase direct patient care experience hour requirements for admission to their programs, and 62% predicted that this increased requirement would decrease applicant diversity.

Complete results of the program director survey can be found in Appendix A.

PAEA Past President Survey

All respondents were asked the question, "In your experience, do PA programs currently prepare your graduates to practice without 'a supervisory, collaborating, or other specific relationship with a physician' in order to practice?"

Fully 100% of respondents indicated that PA programs do not prepare graduates to practice without a supervisory, collaborating, or other specific relationship with a physician. They were then asked a series of questions on the implications of FPAR (as it was then called), to which responses were as follows:

- Three-quarters (75%) predicted a need to increase the duration or content of programs, with a median predicted increase of one semester.
- A large majority (81%) predicted a need to expand the clinical portion of training, with a predicted necessary median increase of one semester.
- The same percentage of respondents (81%) also indicated that current clinical sites would be inadequate to meet projected increased clinical training needs.
- More than three-quarters (77%) predicted that FPAR’s impact on program length and/or content would cause programs to consider awarding a clinical doctorate.
- 60% predicted that FPAR adoption would cause programs to increase direct patient experience requirements for admission, and 89% predicted that this would decrease applicant diversity.
- 69% predicted that the willingness of clinical preceptors to accept PA students would moderately or significantly decrease under FPAR.

Complete results of the past president survey can be found in Appendix B.

Medical Director Survey

All respondents were asked the question, “Does your program’s current curriculum already prepare your graduates to practice without ‘a supervisory, collaborating, or other specific relationship with a physician’ in order to practice?”

Those who responded “Yes” were asked no additional questions. The large majority (89%) responded “No.” This majority was then asked a series of questions on the implications of FPAR (as it was then called), to which responses were as follows:

- 85% predicted a need to increase the duration or content of their programs, with a median predicted increase of two semesters or 3.5 quarters.
- 89% predicted a need to expand the clinical portion of training, with a median predicted increase of two semesters or three quarters.
- 85% indicated that current clinical sites would be inadequate to meet the projected increased clinical training needs.
- More than half (56%) indicated that FPAR would cause their programs to consider awarding a clinical doctorate.
- 41% predicted that FPAR would lead to a change in direct patient care experience requirements.
- More than half (58%) predicted that the willingness of clinical preceptors would moderately or significantly decrease under FPAR.

Complete results of the medical director survey can be found in Appendix C.

UNINTENDED CONSEQUENCES OF OTP

If OTP is adopted as written, the prevailing model of PA education will have to adapt to ensure practice-ready graduates. As the aim of OTP is to remove legal provisions requiring a supervisory relationship between PAs and physicians, including for new graduates, the professional performance bar will have to be raised to enhance the knowledge, attitudes, and skills that new graduates bring to their first day of practice. There are several likely consequences of this action:

Programs Move to a Clinical Doctorate

Curriculum content aimed at honing clinical problem-solving skills and decision making for new graduates will need to expand as practice support from physicians may shrink in the absence of legislated collaborative responsibility. Because one primary driver of the OTP proposal is competition with nurse practitioners, who have succeeded in gaining full practice authority under nursing practice acts in at least 20 states (with legislation pending in 15 more),¹² it is likely that the PA profession will seek to match NPs' academic credentials with a clinical doctorate. In addition, the shortage of doctoral-prepared PA faculty may affect the education of students in programs that award a clinical doctorate.

Among the many unknowns about the potential move to a PA clinical doctorate is the response of insurers and health systems to a change in terminal degree. Will OTP be linked to a clinical doctorate by insurers and employers? And, if OTP initiates and accelerates the move to a clinical doctorate as an entry-level degree, will states allow “grandfathering” for PAs without doctorates, as occurred when the master’s degree became the standard, but the relationship with physicians did not change?

Increased Length of Program

The results of the program director survey indicate that the duration of PA education in an OTP practice environment would likely increase by a median of two semesters or three quarters, and by more than 500 additional hours of clinical training. The past president and medical director surveys also support these positions. With the past two decades as a guide, these predictions are reasonable — PA education has lengthened with the adoption of the master’s degree credential. As of 2017, only 26% of programs retain the 24-month model that was the predominant curriculum length before the move to the master’s degree.^{13,14,15}

Increased Costs

Costs for a PA education under OTP are predicted by program directors to increase by 25%, which would likely: (1) increase average student debt load, (2) create additional barriers for

many minority candidates and reduce the diversity of the PA applicant pool, and (3) further decrease incentives for graduates to go into less well-compensated primary care specialties.¹⁶ Increased tuition and program duration will also inevitably increase pressure to develop the clinical doctorate as the entry-level degree for PAs.

Additional Pressure on Clinical Sites

Many PA programs are now facing a critical shortage of clinical sites for curricula that require 2,000 hours of clinical training. Some program directors indicated that an additional 500 hours of training may be needed and would be impossible for programs to accomplish without limiting enrollment. It is also unclear how physician and PA preceptors would respond to training PA students under the heightened performance expectations of OTP, and whether the increased demand for clinical sites would solidify the trend toward paying for clinical sites.

Postgraduate Residencies

An additional unknown is the role postgraduate residencies may play for PA graduates entering practice under OTP. There are 82 postgraduate programs listed by the Association of Postgraduate PA Programs.¹⁷ If PAEA member programs are unable to expand their curricula and clinical training to meet the expectations of OTP, it may fall to existing and new postgraduate PA programs to provide the necessary skills and training for new graduates to qualify to practice without a formal relationship with a physician. It is unclear how these postgraduate experiences would affect the discussion of requirements for clinical doctorates.

OTHER POSSIBLE EFFECTS OF OTP

Accreditation: History as Prologue

Ultimately, it is the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) that will decide the impact of the elimination of physician supervision on education standards and the possible emergence of a clinical doctorate as the entry-level degree. The mission of the ARC-PA is to “[protect] the interests of the public, including current and prospective PA students, and the PA profession by defining the standards for PA education and evaluating PA educational programs within the territorial United States to ensure their compliance with those standards.” As such, the ARC-PA will need to evaluate any changes to PA training and degrees awarded, much as it did in response to programs awarding entry-level master’s degrees. As the *Accreditation Standards for Physician Assistant Education, Fourth edition* (Clarifications 10/2011) noted:

The PA profession has evolved over time to one requiring a high level of academic rigor. Institutions that sponsor PA programs are expected to incorporate this higher level of academic rigor into their programs and award an appropriate master's degree.

Programs accredited prior to 2013 that do not currently offer a graduate degree must transition to conferring a graduate degree, which should be awarded by the sponsoring institution, upon all PA students who matriculate into the program after 2020.

Certification

It is unknown whether the National Commission on Certification of Physician Assistants (NCCPA) will find it necessary to change how it certifies new graduates should OTP be adopted and eventually codified in state laws. However, it seems likely that the organization recognized as the certifying body for our profession would consider whether the certification process might need to include a higher passing standard or additional testing components when new graduates are no longer practicing with formal physician collaboration.

Four-Org Collaboration

The Competencies for the Physician Assistant Profession, initially defined in collaboration among the four PA organizations, are a model for how the four PA organizations can work together. Given the success of this model in defining professional competencies that impact clinical practice, it is imperative that a similar model be used to address other potential changes to clinical practice, such as those proposed in the AAPA resolution on optimal team practice.

CONCLUSION

PAEA recognizes the hard work of AAPA's JTF, especially the recent efforts to reshape the resolution in response to feedback from multiple stakeholders. PAEA further recognizes the opportunities and challenges for the PA profession that are at the foundation of the resolution. The PA profession has grown significantly over the last 50 years, and it is incumbent upon us to do whatever is needed to ensure continued growth and progress for current and future generations of PAs.

PAEA supports three of the four elements of the HOD resolution on OTP: commitment to team practice; autonomous state boards, where PAs can elevate the credibility of the profession and hold themselves accountable; and direct reimbursement for PAs, as it is

essential that PA billing and reimbursement data are easy to track and can be used to clearly establish the impact and quality of PA patient care.

However, the JTF process has been flawed by a lack of inclusion of key PA professional organizations. The OTP proposal and resulting HOD resolution have been developed too quickly, with not enough time allowed for full consideration of the potential consequences for PA education, specifically the preparation of new graduates to practice without a supervisory, collaborating, or other specific relationship with a physician. The OTP resolution forces this issue prematurely and offers only the vague suggestion that AAPA should “work closely” with ARC-PA and PAEA to create a solution to the new graduate issue.

The results of PAEA’s program director, past president, and medical director surveys are unambiguous. PA programs *do not* currently train students for OTP. This new practice model proposed by the JTF would require essentially a new paradigm for PA education. Unintended consequences of OTP for PA programs could include increased program content, length, and costs; and increased health care experience requirements for applicants to PA programs, which would likely reduce applicant and student diversity. The already critical shortage of clinical training sites in many parts of the country would make it problematic — if not impossible — for many programs to accommodate expansion of their clinical curricula. And finally, PA programs may need to explore awarding a clinical doctorate, with uncertain implications for the professional practice environment of all PAs.

Accordingly, PAEA cannot support the optimal team practice provisions (lines 122-163) of resolution 2017-A-07-HO, eliminating a legal relationship between PAs and physicians. We ask the HOD to strike this language and retain the Collaboration section (lines 94-121) until a greater understanding of the benefits and challenges for PA education, and for new graduates, are fully explored by AAPA, PAEA, ARC-PA, and NCCPA as part of an inclusive joint task force.

A truly inclusive task force would facilitate a transparent process that brings together all the key PA stakeholders. Examples of recent successful joint activities include the Clinical Competencies Summits of 2005 and 2012, the Clinical Doctorate Summit of 2009, and the 2015 Stakeholder Summit. These experiences can inform a thoughtful and comprehensive discussion about the impact of OTP on PA education and its implications for new graduates.

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APPENDIX A

Program Director Survey

PROGRAM DIRECTOR SURVEY EMAIL

We need PA program directors to respond to this important 8-question survey about how AAPA's FPA Proposal may impact PA education. Because programs now educate graduates to practice with physician supervision, we need to consider the potential effect FPA may have on applicant pool experience, diversity, program content and length, and costs. Your perspective is extremely important as PAEA leadership enters discussions with stakeholders. The AAPA's Full Practice Authority (FPA) task force is formulating a proposal to do four things:

1. Emphasize our profession's continued commitment to team-based practice.
2. Support the elimination of provisions in laws and regulations that require a PA to have a supervisory, collaborating, or other specific relationship with a physician in order to practice.
3. Advocate for the establishment of autonomous state boards, with a voting membership comprised of a majority of PAs, to license, regulate, and discipline PAs.
4. Ensure that PAs are eligible to be reimbursed directly by public and private insurance.

Your survey responses about this issue will inform PAEA leadership as we participate in the FPA discussion.

PROGRAM DIRECTOR QUESTIONS

- Does your program's current curriculum already prepare your graduates to practice without "a supervisory, collaborating, or other specific relationship with a physician in order to practice?"
- Would you predict a need to increase the number of semesters, quarters or expanded content in the DIDACTIC portion of your curriculum to meet the expectations of Full Practice Authority?
- Would you predict a need to increase the number of semesters or quarters in the CLINICAL portion of your curriculum to meet the expectations of Full Practice Authority?
- Would your current clinical site supply be adequate to absorb the increase in clinical training time for Full Practice Authority?
- Would the increase in the length of your program lead you to explore awarding a clinical doctorate?

- Would changes to tuition and duration of the program affect the diversity of your student applicant pool?
- Would FPA adoption cause you to change your admission criteria to increase applicant direct patient care experience requirements for admission?
- Would changes to direct patient care experience requirements of the program affect the diversity of your student applicant pool?

Methodology and Sample Information

Population: All PAEA member program directors (218)

Reminders: Two reminder emails were sent to program directors

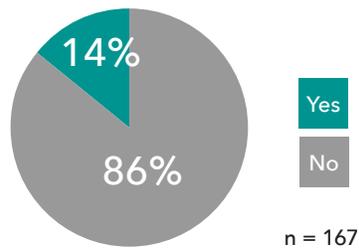
Response: N=170

Response rate: 78% (170/218)

Results

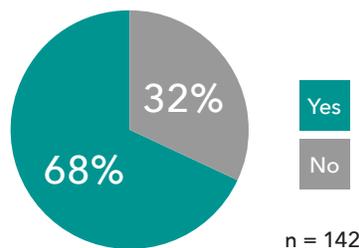
QUESTION 1.

Does your program’s current curriculum already prepare your graduates to practice without “. . . a supervisory, collaborating, or other specific relationship with a physician in order to practice?”



QUESTION 2.

Would you predict a need to increase the number of semesters, quarters, or expanded content in the **DIDACTIC** portion of your curriculum to meet the expectations of Full Practice Authority?



QUESTION 2B.

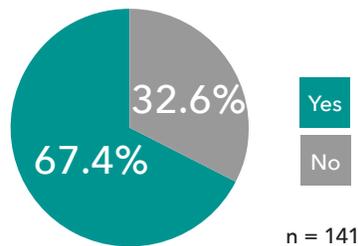
Please enter the number of additional semesters, quarters, or expanded content you predict would need to be added to the **DIDACTIC** portion of your program to achieve the expectations of Full Practice Authority at graduation.*

	n	Mean	Med	Min	Max	SD
Semesters	69	1.83	2	1	5	0.99
Quarters	9	3	3	1	8	2.12
No additional semester/quarters but expanded courses	12	3.33	3	1	6	1.69
No additional semester/quarters but # of additional hours	3	10	10	8	12	2
Total	93	-	-	-	-	-

*Any responses given as ranges were translated into the median of the given range for running averages and other descriptive statistics.

QUESTION 3.

Would you predict a need to increase the number of semesters or quarters in the **CLINICAL** portion of your curriculum to meet the expectations of Full Practice Authority?



QUESTION 3B.

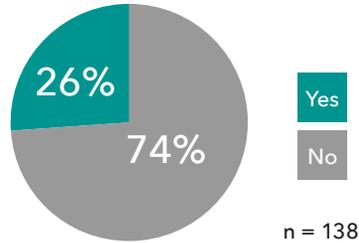
Please enter the number of additional semesters, quarters, or expanded content you predict would need to be added to the **CLINICAL** portion of your program to achieve the expectations of Full Practice Authority at graduation.

	n	Mean	Med	Min	Max	SD
Semesters	72	1.76	2	1	5	0.99
Quarters	10	2.45	3	1	8	2.12
No additional semester/quarters but expanded courses	4	4.75	3	1	6	1.69
No additional semester/quarters but # of additional hours	3	600	560	240	1000	381.58
Total	89	-	-	-	-	-

*Any responses given as ranges were translated into the median of the given range for running averages and other descriptive statistics.

QUESTION 3C.

Would your current clinical site supply be adequate to absorb the increase in clinical training time for Full Practice Authority?



QUESTION 3D.

By way of estimate, how much would **STUDENT TUITION** increase, if you needed to increase the length of the didactic or clinical portions of your curriculum to meet the expectations of Full Practice Authority?

n	Mean (%)	Med (%)	Min (%)	Max (%)	P10 (%)	P25 (%)	P75 (%)	P90 (%)
96	34.35	25	0	100	10	20	40	86

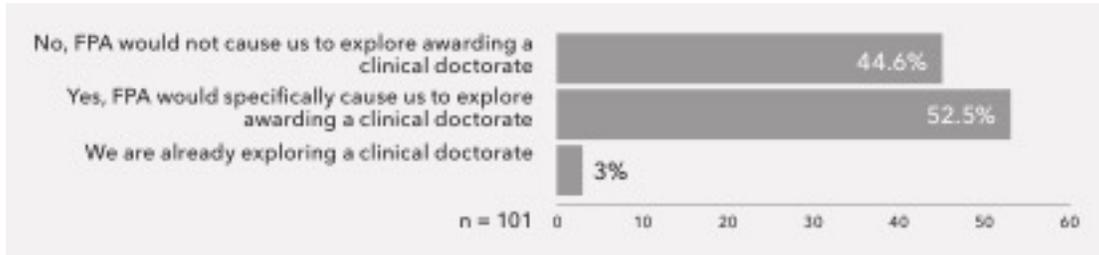
QUESTION 3E.

By way of estimate, how much would your **PROGRAM** budget (including faculty pay or overhead costs) increase, if you needed to increase the length of the didactic or clinical portions of your curriculum to meet the expectations of Full Practice Authority?

n	Mean (%)	Med (%)	Min (%)	Max (%)	P10 (%)	P25 (%)	P75 (%)	P90 (%)
97	32.25	25	0	120	10	15	40	71

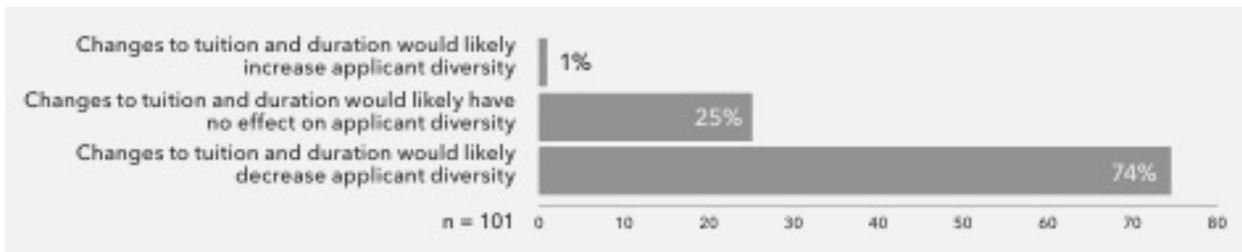
QUESTION 4.

Would the increase in the length of your program lead you to explore awarding a clinical doctorate?



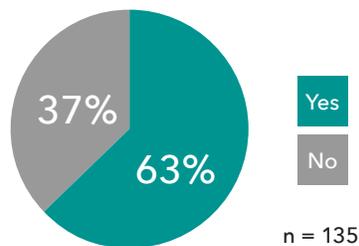
QUESTION 5.

Would changes to tuition and duration of the program affect the diversity of your student applicant pool?



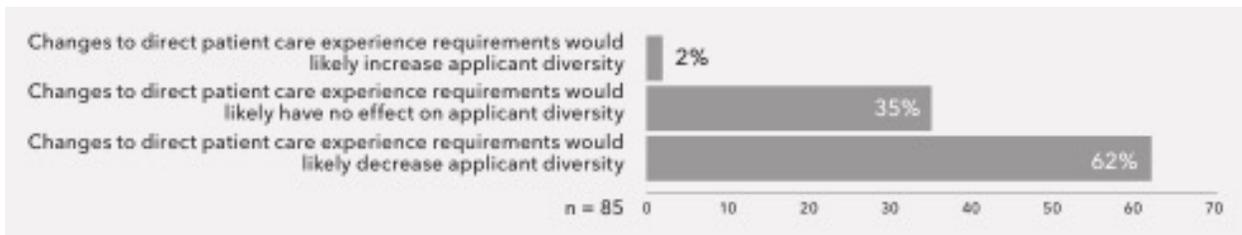
QUESTION 6.

Would FPA adoption cause you to change your admission criteria to increase applicant direct patient care experience requirements for admission?



QUESTION 6A.

Would changes to direct patient care experience requirements of the program affect the diversity of your student applicant pool?



APPENDIX B

Past President Survey

PAST PRESIDENT SURVEY EMAIL

We need past APAP/PAEA presidents to respond to this important 10-question survey about how AAPA's FPA Proposal may impact PA education. Because programs now educate graduates to practice with physician supervision, we must consider the potential effect FPA may have on applicant pool experience, diversity, and program content and length. Your perspective is extremely important as PAEA leadership enters discussions with stakeholders. The AAPA's Full Practice Authority (FPA) task force is formulating a proposal to do four things:

1. Emphasize our profession's continued commitment to team-based practice.
2. Support the elimination of provisions in laws and regulations that require a PA to have a supervisory, collaborating, or other specific relationship with a physician in order to practice.
3. Advocate for the establishment of autonomous state boards, with a voting membership comprised of a majority of PAs, to license, regulate, and discipline PAs.
4. Ensure that PAs are eligible to be reimbursed directly by public and private insurance.

Your survey responses about this issue will inform PAEA leadership as we participate in the FPA discussion.

PAST PRESIDENT QUESTIONS

- In your experience, do PA programs currently prepare graduates to practice without “a supervisory, collaborating, or other specific relationship with a physician in order to practice?”
- Would you predict that programs need to increase the number of semesters or quarters in the DIDACTIC year to meet the expectations of Full Practice Authority?
- Please enter the number of additional semesters, quarters, or expanded content you predict would need to be added to the DIDACTIC portion of programs to achieve the expectations of Full Practice Authority at graduation.
- Would you predict a need to increase the number of semesters or quarters in the CLINICAL portion of programs' curriculums to meet the expectations of Full Practice Authority?
- Please enter the number of additional semesters, quarters, or expanded content you predict would need to be added to the CLINICAL portion of programs' curriculums to achieve the expectations of Full Practice Authority at graduation.

- In your experience, would programs' current clinical site supply be adequate to absorb the increase in clinical training time for Full Practice Authority?
- In your experience, would the increase in the length of programs' curriculums lead them to explore awarding a clinical doctorate?
- Would FPA adoption cause programs to change admission criteria to increase applicant direct patient care experience requirements?
- Would changes to direct patient care experience requirements affect the diversity of programs' student applicant pool?
- If AAPA adopted the FPAR proposal, would the willingness of clinical preceptors to accept PA students for clinical rotations be affected?

Methodology and Sample Information

Population: All living PAEA past presidents (28)

Reminders: Two reminder emails were sent

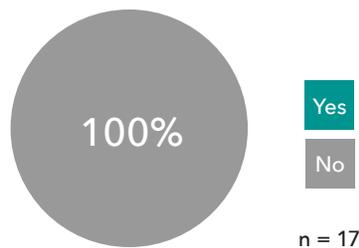
Response: N=17

Response rate: 60.71% (17/28)

Results

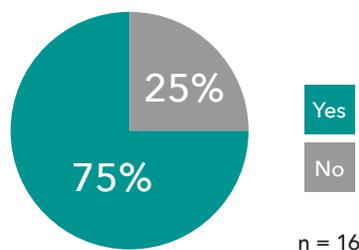
QUESTION 1.

In your experience, do PA programs currently prepare their graduates to practice without “. . . a supervisory, collaborating, or other specific relationship with a physician in order to practice?”



QUESTION 2.

Would you predict that programs need to increase the number of semesters or quarters in the **DIDACTIC** year to meet the expectations of Full Practice Authority?



QUESTION 2B.

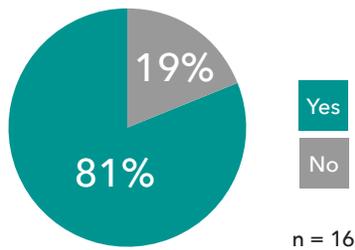
Please enter the number of additional semesters, quarters, or expanded content you predict would need to be added to the **DIDACTIC** portion of programs to achieve the expectations of Full Practice Authority at graduation.*

	n	Mean	Med	Min	Max	SD
Semesters	8	1.19	1	1	3	0.53
Quarters	1	4	4	4	4	NA
No additional semester/quarters but expanded courses	2	3	3	1	5	2.83
No additional semester/quarters but # of additional hours	1	1	1	1	1	NA

**Any responses given as ranges were translated into the median of the given range for the purpose of running averages and other descriptive statistics.*

QUESTION 3.

Would you predict a need to increase the number of semesters or quarters in the **CLINICAL** portion of programs' curriculums to meet the expectations of Full Practice Authority?



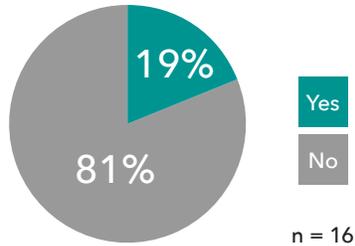
QUESTION 3B.

Please enter the number of additional semesters, quarters, or expanded content you predict would need to be added to the **CLINICAL** portion of programs to achieve the expectations of Full Practice Authority at graduation.

	n	Mean	Med	Min	Max	SD
Semesters	9	1.4	1	1	2	0.49
Quarters	2	2.5	2.5	1	4	2.12

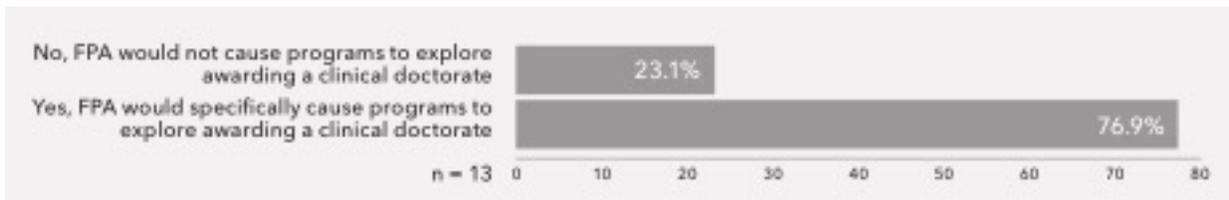
QUESTION 3C.

In your experience, would programs' current clinical site supply be adequate to absorb the increase in clinical training time for Full Practice Authority?



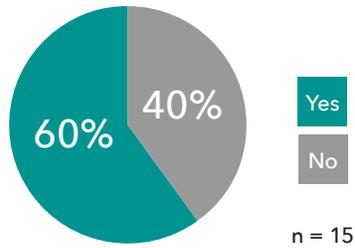
QUESTION 4.

In your experience, would the increase in the length of programs' curriculums lead them to explore awarding a clinical doctorate?



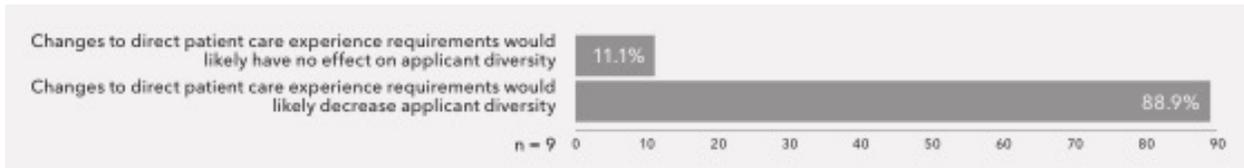
QUESTION 5.

In your opinion, would FPA adoption cause programs to change admission criteria to increase applicant direct patient care experience requirements?



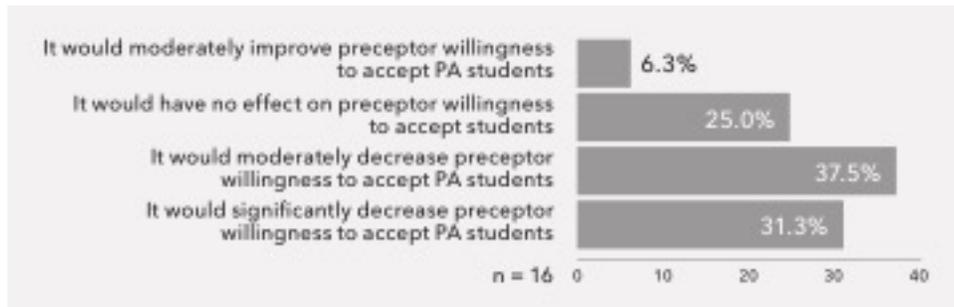
QUESTION 5A.

Would changes to direct patient care experience requirements affect the diversity of programs' student applicant pool?



QUESTION 6.

If AAPA adopted the FPA proposal, would the willingness of clinical preceptors to accept PA students for clinical rotations be affected?



APPENDIX C

Medical Director Survey

MEDICAL DIRECTOR SURVEY EMAIL

We need PA medical directors to respond to this important 10-question survey about how AAPA's FPA Proposal may impact PA education. Because programs now educate graduates to practice with physician supervision, we must consider the potential effect FPA may have on applicant pool experience, diversity, and program content and length. Your perspective is extremely important as PAEA leadership enters discussions with stakeholders. The AAPA's Full Practice Authority (FPA) task force is formulating a proposal to do four things:

1. Emphasize our profession's continued commitment to team-based practice.
2. Support the elimination of provisions in laws and regulations that require a PA to have a supervisory, collaborating, or other specific relationship with a physician in order to practice.
3. Advocate for the establishment of autonomous state boards, with a voting membership comprised of a majority of PAs, to license, regulate, and discipline PAs.
4. Ensure that PAs are eligible to be reimbursed directly by public and private insurance.

Your survey responses about this issue will inform PAEA leadership as we participate in the FPA discussion.

MEDICAL DIRECTOR QUESTIONS

- Does your program's current curriculum already prepare your graduates to practice without ". . . a supervisory, collaborating, or other specific relationship with a physician in order to practice?"
- Would you predict a need to increase the number of semesters or quarters in the DIDACTIC portion of your curriculum to meet the expectations of Full Practice Authority?
- Please enter the number of additional semesters, quarters, or expanded content you predict would need to be added to the DIDACTIC portion of your program to achieve the expectations of Full Practice Authority at graduation.
- Would you predict a need to increase the number of semesters or quarters in the CLINICAL portion of your curriculum to meet the expectations of Full Practice Authority?

- Please enter the number of additional semesters, quarters, or expanded content you predict would need to be added to the CLINICAL portion of your program to achieve the expectations of Full Practice Authority at graduation.
- Would your current clinical site supply be adequate to absorb the increase in clinical training time for Full Practice Authority?
- Would the increase in the length of your program lead you to explore awarding a clinical doctorate?
- Would FPA adoption cause you to change your admission criteria to increase applicant direct patient care experience requirements for admission?
- Would changes to direct patient care experience requirements of the program affect the diversity of your student applicant pool?
- If AAPA adopted the FPA proposal, would the willingness of clinical preceptors to accept PA students for clinical rotations be affected?

Methodology and Sample Information

Population: Medical directors (227; some programs have more than one medical director) at all PAEA member programs (218)

Reminders: Two reminder emails were sent

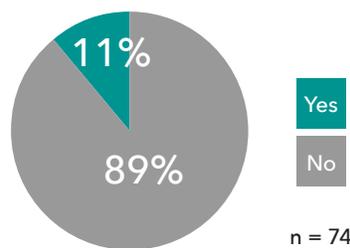
Response: 78 medical directors representing 77 PA programs

Response rate = 34.36% of all medical directors, 35.32% of PA programs

Results

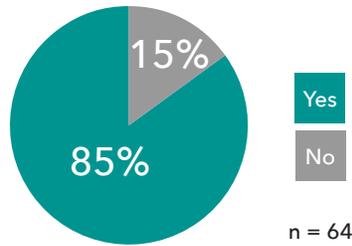
QUESTION 1.

Does your program's current curriculum already prepare your graduates to practice without "... a supervisory, collaborating, or other specific relationship with a physician in order to practice?"



QUESTION 2.

Would you predict a need to increase the number of semesters, quarters, or expanded content in the **DIDACTIC** portion of your curriculum to meet the expectations of Full Practice Authority?



QUESTION 2B.

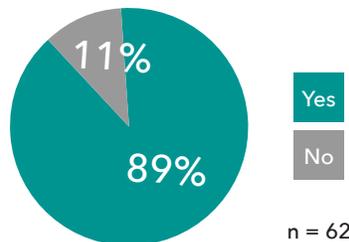
Please enter the number of additional semesters, quarters, or expanded content you predict would need to be added to the **DIDACTIC** portion of your program to achieve the expectations of Full Practice Authority at graduation.*

	n	Mean	Med	Min	Max	SD
Semesters	38	2.1	2	1	6	1.15
Quarters	8	3.1	3.5	1	4	1.13
No additional semester/quarters but expanded courses	1	6	6	6	6	NA
No additional semester/quarters but # of additional hours	2	30	30	20	40	14.14

**Any responses given as ranges were translated into the median of the given range for running averages and other descriptive statistics.*

QUESTION 3.

Would you predict a need to increase the number of semesters or quarters in the **CLINICAL** portion of your curriculum to meet the expectations of Full Practice Authority?



QUESTION 3B.

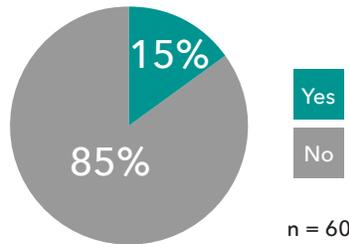
Please enter the number of additional semesters, quarters, or expanded content you predict would need to be added to the **CLINICAL** portion of your program to achieve the expectations of Full Practice Authority at graduation.

	n	Mean	Med	Min	Max	SD
Semesters	43	2.3	2	1	8	1.37
Quarters	9	2.7	3	1	4	1.41
No additional semester/quarters but expanded courses	0	NA	NA	NA	NA	NA
No additional semester/quarters but # of additional hours	0	NA	NA	NA	NA	NA

**Any responses given as ranges were translated into the median of the given range for running averages and other descriptive statistics.*

QUESTION 3C.

Would your current clinical site supply be adequate to absorb the increase in clinical training time for Full Practice Authority?



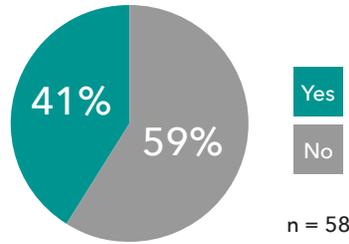
QUESTION 4.

Would the increase in the length of your program lead you to explore awarding a clinical doctorate?



QUESTION 5.

Would FPA adoption cause you to change your admission criteria to increase applicant direct patient care experience requirements for admission?



QUESTION 5A.

Would changes to direct patient care experience requirements of the program affect the diversity of your student applicant pool?



QUESTION 6.

If AAPA adopted the FPAR proposal, would the willingness of clinical preceptors to accept PA students for clinical rotations be affected?

