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Alaska State Medical Board Engagement

May 2021

Purpose

To engage members of the Alaska State Medical Board in a discussion of the status of PA practice in Alaska and opportunities for improvement that would expand patient access to care.

Executive Summary

With their expedited training, broad presence across multiple specialties, collaborative approach to patient care, and adaptable occupational model, PAs are a feasible part of the solution to expanding patient access to care in healthcare workforce shortages areas in Alaska. Certain statutes, administrative codes, and rules exist in the state of Alaska that inhibit employability and utilization of PAs in settings where their services are needed. These codes predominantly involve the collaborative plan, which dictates much of a PA's scope of practice in Alaska. Several states with similar healthcare delivery challenges and vulnerable patient populations as Alaska have recently enacted legislative changes addressing PA scope of practice. Leaders from the Alaska Academy of PAs hope to engage members of the Alaska State Medical Board in a discussion of the status of PA practice in Alaska. Together, AKAPA and the Alaska State Medical Board can explore opportunities for improvement that would expand patient access to care.

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White Paper

Issue

The collaborative and flexible nature of the PA occupational model allows PAs to expand patient access to care in a safe and adaptable manner.[1] Certain statutes, administrative codes, and rules exist in the state of Alaska that inhibit employability and utilization of PAs in settings where their services are needed.

Discussion

In 2020, Alaska had the highest number of PAs per capita in the US (84.5 PAs per 100,000 people), with 91.8% serving in areas designated as rural.[2] Over one-third (34.8%) of Alaska PAs specialize in primary care and more than half (52.2%) provide care from a physician office or clinic. In addition to primary care settings, 23.2% of Alaska PAs are employed in surgical specialties, 21.7% in internal medicine and other specialties, and 10.1% in emergency medicine.[2] Training to become a PA takes an average of 27 months and the didactic phase includes more than 75 hours in pharmacology, 175 hours in behavioral sciences, more than 400 hours in basic sciences, and nearly 580 hours of clinical medicine didactic education.[4] During the clinical phase, PA students complete at least 2,000 hours of supervised clinical practice in various settings and locations.[4] With their expedited training, broad presence across multiple specialties, collaborative approach to patient care, and adaptable occupational model,[3,1] PAs are a feasible part of the solution to expanding patient access to care in healthcare workforce shortage areas in Alaska.

To practice in the Alaska, PAs must adhere to the following regulations:

- Apply for a state license
- Submit a collaborative plan listing at least two physicians, one as the primary collaborator and one as the alternate, within 14 days of beginning employment
- Apply for an Alaska Drug Enforcement Agency (DEA) number
- Apply for the Physician Drug Monitoring Program (PDMP)

PAs practicing in remote sites must adhere to additional requirements:

- PAs with less than two years of experience who are working at a practice site that is greater than 30 miles by road from the physician's primary office must work 160 hours in direct patient care under the direct and immediate supervision of the primary collaborative physician or an alternate.

- PAs with more than two years of experience who are working at a practice site that is greater than 30 miles by road from the physician's primary office must submit a detailed curriculum vitae with the collaborative plan outlining their education, skills, and experience necessary to meet the needs and demands of the remote site practice.

Barriers related to these regulations:

- Collaborative Plan:
  - The collaborative plan is considered approved once signed, unless there are any clerical mistakes on the form. If mistakes are discovered 14-days after submission and the PA has been practicing, they are out of compliance with state law (AAC 12 40.410(b)).
  - A PA will not be granted an Alaska DEA until they have a collaborative plan on file. Some facilities do not allow PAs to practice until they have a DEA number.
  - A loss of collaborative physician eliminates a PA's ability to practice (AAC 12 40.450 (h)).
  - Requiring two collaborating physicians in the context of a healthcare workforce shortage exacerbates the lack of access to care for patients in certain specialties.
  - Current collaborative plan agreements for PAs working in remote sites (greater than 30 miles from the collaborative physician's primary site) require "direct personal contact" of at least 4 hours between PAs and collaborative physicians (AAC 12 40.430), regardless of the experience level of the PA. Direct and personal has been interpreted as in person, in spite of pervasive telemedicine practices and access to electronic health records.
- Prescriptive Authority:
  - PAs are granted prescriptive privileges in every state in the US, which is commensurate with their pharmacologic training.[4]
  - In Alaska, PAs may prescribe Schedule II-IV medications, but only if they are granted approval by the collaborative physician (AAC 12 40.450(c) and (d)). PA prescriptive authority may not exceed that of the collaborative physician. This can be problematic if PAs have completed additional pharmacologic training, such as those who qualify for a burprenorphine waiver, and their collaborative physicians have not. In these circumstances, PAs may not provide additional pharmacologic services to patients in spite of having completed required training.
  - Prescriptions are required to have the primary collaborative physician's name and DEA on every prescription written by a PA (AAC 12 40.450(i)). This allows for broad dissemination of a collaborative physician's DEA number, increasing the risk of fraudulent use. It also presumes responsibility for PA prescribing with patient's who may not have been seen by the collaborative physician.

An example of recent PA practice legislative changes in states with similar healthcare delivery challenges and vulnerable patient populations as Alaska (additional examples can be provided by request):

- Wyoming – in 2021, Senate File 0033 removed requirements for PAs to have a specific relationship with a physician or other provider in order to practice. The new law states that PAs may collaborate with or refer to the appropriate member of a health care team as indicated by the patient's condition; the current standard of care; and the PA's education, experience, and competence. Collaboration is determined at the practice level (https://wyoleg.gov/Legislation/2021/SF0033).
- Utah – in 2021, Senate Bill 27 was passed, removing the requirement for physician supervision and delegation of service agreements for PAs with less than 10,000 hours of practice experience. Various adaptable collaboration requirements filed at the practice level were created for PAs with less than 10,000 hours of practice experience (https://le.utah.gov/~2021/bills/static/SB0027.html).
- Maine – in 2020, LD 1660 was passed allowing PAs who are not the principal provider at a practice and have more than 4000 hour of practice experience to work without a collaborative agreement with a physician. A physician must be available for consultation. PAs with less than 4,000 hours of practice and those without a physician partner in a solo practice are still required to have a collaborative practice agreement with a physician. (https://mainelegislature.org/legis/bills/display_ps.asp?ld=1660&PID=1456&snum=129)
- North Dakota – in 2019, North Dakota enacted HB 1175, which removed the requirement that PAs have a written agreement with a physician if they practice at licensed facilities (e.g., hospitals and nursing homes), facilities or clinics with a credentialing and privileging process, or physician-owned facilities or practices. The law also removed references to physician responsibility for care provided by PAs and made PAs responsible for the care they provide to patients. (https://www.legis.nd.gov/assembly/66-2019/documents/19-0736-03000.pdf)

Recommendation

Leaders from the Alaska Academy of PAs hope to engage members of the Alaska State Medical Board in a discussion of the status of PA practice in Alaska. Together, AKAPA and the Alaska State Medical Board can explore opportunities for improvement that would expand patient access to care. For example, a portion of the rules that are inhibiting greater PA utilization are enacted by the State Medical Board and may be modified at that level in order to increase PA utilization.

References

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