OTP: Pipe Dream, Smoke Screen, or the Right Thing?

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We live in a world of acronyms. OMG, GOAT, and the like are ubiquitous on social media and increasingly sprinkled into more traditional journalistic formats. But if you're a PA, the most important acronym for at least the past two years has been OTP—optimal team practice.

In my February 2017 editorial, I opined on the related concept of *full practice authority* (FPA), discussing the hurdles the NP and PA professions face to achieve this goal (*Clinician Reviews*. 2017;27[2]:12-14). Both professions, now more than a half-century old, assert that they have demonstrated, through practice and research, a commitment to competent, quality health care. In recent years, these assertions have been increasingly centered around acquiring more autonomy and responsibility—what NPs refer to as the ability to practice to the fullest extent of their education and training. As a profession, the NPs have done an excellent job of breaking down unnecessary barriers to their practice.

PAs, however, continue to have challenges with this concept. To address this, a mere three months after my FPA editorial, the House of Delegates of the American Academy of PAs (AAPA) adopted OTP as a policy. The Academy says OTP is designed to increase access to care and help align the PA profession with modern societal health care needs.[1] While the AAPA's Guidelines for State Regulation of PAs continue to emphasize a commitment to team-based care, the OTP policy calls for changes in statutes and regulations that will

- Allow PAs to practice without a formal agreement with a particular physician
- Create separate majority-PA regulatory boards (or give authority to boards comprised of PAs and physicians who practice with PAs), and
- Allow PAs to be directly reimbursed by all public and private insurers. (PAs continue to be the only health care professionals who bill Medicare but are not entitled to direct reimbursement.)

These changes encourage PAs to practice to the full extent of their training and remove restrictions that currently obstruct delivery of care.[1,2] Yet there are unintended consequences as the profession pursues this path.

The Physician Assistant Education Association (PAEA), while supporting most of the OTP policy, has raised concerns about changing curricula to reflect increased autonomy, which would require longer educational programs and incur higher costs for students.[3] A significant part of PA education for the past half-century has been the social integration into the health care realm with physicians. There is also concern that changes to accommodate OTP might ultimately lead to a requirement for PAs to have a doctorate degree in order to practice—although not everyone sees that as a drawback!

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Proponents of OTP, on the other hand, insist that times have changed and the profession must change with them—or at least, the rules governing the profession must be amended to reflect practical realities. AAPA leaders believe that physician oversight provisions are no longer necessary, and that PAs must acclimate to the changing health care marketplace to solidify the future of the profession and meet the needs of patients.

Barriers to PA recruitment continue to exist as a result of statutory requirements. In today's health care system, physicians are more likely to be employed by a large in-

stitution. Because of this, they may no longer see a financial benefit to entering into a formal agreement with a PA, which is currently required by statute for PAs to practice. Furthermore, as PAs and physicians increasingly practice in groups, the requirement for PAs to have an agreement with a specific physician is challenging to manage and places all providers involved at risk for disciplinary action for administrative infractions unrelated to patient care or outcomes.

Advocates for OTP also emphasize the perception that our NP colleagues are preferentially hired over PAs. In 22 states and the District of Columbia, NPs are allowed to practice without a collaborative agreement with a specific physician, anecdotally making them easier to hire.[4] Even in states where NPs do not have FPA, the perception that hiring an NP is less burdensome than hiring a PA often exists. If accurate, these reports suggest PAs are at a disadvantage relative to NPs, resulting in lost opportunities for employment and advancement. (At least one study—based on a survey of members of the American College of Emergency Physicians council, who have direct experience in hiring NPs and PAs—demonstrated no differences in hiring preferences between the two professions. The same survey also revealed wide variability in supervisory requirements, however.[5])

My concern: Are we on the right track, with the right strategic plan for achieving OTP?

By recommending the elimination of the requirement for PAs to have an agreement with a specific physician in order to practice, AAPA is in effect broadening an evolution already occurring at the state level. In 2016, Michigan removed the supervisory requirement and repealed the stipulation of physician responsibility for PA-provided care; PAs in Michigan now practice with a "participating physician." In 2017, New Mexico amended its Medical Practice Act to allow PAs who practice primary care to collaborate with a physician, while PAs who practice specialty care must be supervised by a physician.[6] Illinois recently signed a 10-year extension of the state's PA Practice Act that also better reflects the relationship between PAs and physicians, substituting "collaborating physician" for "supervising physician."[7] West Virginia has also adopted legislation referring to the physician/PA relationship as a "collaboration" (terminology Alaska has used since the 1980s).

In supporting the recent changes in Illinois, Dr. Nestor Ramirez, President of the Illinois State Medical Society, noted that "Patients are best served by physician-led teams of professionals practicing within the scope of their licensure, and physicians work collaboratively with PAs and other allied healthcare professionals to ensure that the care provided is of the highest quality." Changing the terminology to *collaboration,* he added, simply "brings the language of the Physician Assistant Practice Act in line with that of other licensure acts."[7]

Perhaps the larger challenge in implementing OTP will be achieving this level of support from all our physician colleagues. In a small survey on this topic conducted by researchers at the Hofstra Northwell School of Graduate Nursing and Physician Assistant Studies, nearly 80% of physician respondents had no previous knowledge of OTP. The majority (62.8%) agreed with the notion that PAs are committed to team practice (first component of OTP); however, less than half of the respondents (47.3%) said they would support OTP policy. The authors concluded that OTP advocacy efforts should target physician awareness and support.[8]

One thing is clear: the OTP train has left the proverbial station. My concern is: Are we on the right track, with the right strategic plan, and with the right people on board? In my opinion, we need to turn to our professional organizational leaders and ask them to carefully evaluate all the unintended consequences of OTP and outline a carefully thought-out plan for the next decade of PA practice. While state efforts are thus far focused on amending supervisory requirements, I think we would be best served focusing on the development of PA-

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specific regulatory boards (currently, only five states have one). In the long term, this would make the profession responsible for its own practice regulations.

There is no doubt that we must find appropriate responses to the changing practice environment. As we work toward professional solutions, we must take into consideration the needs of all stakeholders, including our physician colleagues, PA educators, PA regulators, current and future students, and patients. How do we best partner with them—and with our NP colleagues—for the sake of continuity of patient care? Send your ideas to me at **PAeditor@mdedge.com.** **CR**

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