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PHYSICIAN ASSISTANT PROFESSIONAL ISSUES: OPTIMAL TEAM PRACTICE IN SOUTH DAKOTA

by

Michael Eggum

A Thesis Submitted in Partial Fulfillment

Of the Requirements for the

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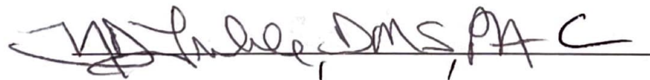

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ABSTRACT

Physician Assistant Professional Issues: Optimal Team Practice in South Dakota

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Optimal team practice (OTP) is a policy meant to modernize physician assistant (PA) practice laws, and one of the most controversial associated changes is removing the requirement for a PA to have a supervisory/collaborative agreement with a physician. In South Dakota (SD), there have been three OTP-related bills that failed to pass during their respective legislative sessions: House Bill 1163 from 2021, Senate Bill 134 from 2022, and Senate Bill 175 from 2023. This study was conducted as a survey consisting of 11 questions administered to SD PAs. The goal of this survey study was to determine PA understanding/disposition towards OTP-related changes in SD. The results suggest that SD PAs are generally supportive of OTP-related changes. Among the 51 respondents who completed the survey, 82.4% are moderately or completely agreeable to removing the requirement for an experienced PA to have a signed agreement and specific relationship with a physician. However, less than 30% of respondents advocated or were involved with OTP legislation at the state level, suggesting low engagement among SD PAs. Finding ways to increase involvement in the SD PA community, engaging nurse practitioner and physician colleagues, and proposing a strong OTP legislative bill while emphasizing the safety and benefits of OTP may be helpful in successfully modernizing SD PA practice laws.

Keywords: PA, OTP, autonomy, supervision, collaboration

TABLE OF CONTENTS

I. Introduction……………………………………………………………………………1

II. Background & Literature Review…………………………………………………..2

i. PA Profession: A Brief History

ii. Optimal Team Practice

iii. NP Autonomy: A Comparison

iv. SD OTP

v. OTP in Other States

vi. Review of OTP Research

III. Methods & Analysis……………………………………………………………………19

i. Methods

ii. Analysis

IV. Discussion……………………………………………………………………………30

i. Results

ii. Limitations

iii. OTP: Final Notes

iv. Conclusion

V. 2023 Update…………………………………………………………………………….36

VI. References……………………………………………………………………………39

LIST OF FIGURES

Figure 1. SD PA Work Setting Distribution……………………………………………...21

Figure 2. SD PA Medical Specialty Distribution………………………………………...22

Figure 3. PA Rating of Personal Autonomy…………………………………………..….23

Figure 4. PA Rating of Autonomy Satisfaction…………………………………………..24

Figure 5. SD OTP Bill Familiarity………………………………………………………..25

Figure 6. 9a: PA-Physician Relationship Terminology…………………………………..26

Figure 7. 9b: PA-Physician Practice Agreement…………………………………………27

Figure 8. 9c: PA Professional/Legal Responsibility……………………………………...28

Figure 9. PA Outlook on OTP Impact……………………………………………………29

I. Introduction

In the United States (US), physician assistants/physician associates (PAs) are licensed clinicians who practice medicine in every clinical setting and specialty, ranging from primary care in rural clinics to surgical subspecialties in large hospital systems.[1] PAs work alongside physicians and provide many of the same services, such as taking medical histories, performing physical exams, ordering/interpreting laboratory tests, diagnosing/treating illness and disease, and assisting in surgery.[2] To be qualified to practice, PAs must graduate from an accredited PA educational program (at the master's degree level) and pass a certification exam administered by the National Commission on Certification of Physician Assistants (NCCPA).[1-2] The NCCPA is one of four primary organizations associated with the PA profession, the others being the American Academy of Physician Associates (AAPA), PA Education Association (PAEA), and the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).[3] The AAPA is the national professional society for PAs, and the AAPA advocates for the PA profession and the patients that PAs serve. The PAEA is the national organization representing PA education programs, and it provides services for PA faculty, applicants, students, and other stakeholders. The ARC-PA is the accreditation agency that defines PA education standards and evaluates PA education programs in the US.[3] In the US as of 2023, there are more than 168,300 PAs practicing in all 50 states, the District of Columbia, and most of the US territories.[1-3]

II. Background & Literature Review

The sections that follow will explore a brief history of the PA profession, Optimal Team Practice (OTP), nurse practitioner (NP) autonomy as a comparison, South Dakota (SD) specific OTP legislation, OTP-related legislation in states adjacent to SD, and the final section will review existing literature regarding how PAs perceive OTP.

PA Profession: A Brief History

One of the first official milestones of the PA profession in the US occurred in 1965 when Dr. Eugene Stead developed an academic program at Duke University; at this program, students would be provided an education and orientation similar to that of physician training – a PA program.[4-6] However, there were instances of physician helpers and ideas of advanced, non-physician training in the US before the official start of PA education at Duke University. For example, a 1961 article written by Dr. Charles L. Hudson and published by the *Journal of the American Medical Association* (*JAMA)* discussed the need for an intermediate medical person who could carry out technical procedures and handle a certain degree of medical responsibility.[6] In an earlier example of a physician helper that Dr. Stead was familiar with, Dr. Amos Johnson utilized an unofficially trained assistant in his rural North Carolina general practice.[7] This assistant, Henry Lee "Buddy" Treadwell, began working in Dr. Johnson's clinic in 1940 with tasks such as patient escort, cleaning, and stocking. Gradually, Dr. Johnson taught Treadwell medical skills including how to perform laboratory procedures, make/develop X-ray films, take blood pressures, differentiate lung sounds through chest auscultation, and place/remove sutures. By 1960, Treadwell was accompanying patients to Duke University Medical Center for referrals and treatments, and his work and role were known in the Duke Medical Community and by Dr. Stead.[7]

In 1967, the first group of students enrolled in the 2-year Duke PA program graduated and began practicing medicine.[5-6] The first students at the Duke program were all former Navy medical corpsmen, a selection based partially on their extensive prior medical experience in the military and the abundance of corpsmen returning to civilian life.[4,6] Around the same time that the Duke PA program started graduating cohorts, another PA model was being developed in the opposite corner of the US at the University of Washington in Seattle.[4,8-9] Dr. Richard Smith was at the forefront of the PA program in Washington, and the first class was established in 1969. The program's title – MEDEX – was condensed verbiage of "medical extension" which referenced one of Dr. Smith's goals in creating the program: to expand medical care in the face of physician shortages in medically underserved areas.[4,8-9] Programs continued to develop, and by 1993 there were 57 accredited programs[6]; as of 2022, there were 300 accredited PA programs.[1]

The PA profession in the US is unique in that it was the first profession to officially share the knowledge base of physicians.[4] The professional organization representing physicians, the American Medical Association (AMA), first recognized the PA profession in 1971 and began working on national certification and practice characteristics that same year.[5-6] A few years earlier in 1968, the American Association of Physician Assistants (precursor to the AAPA) was established. The PA profession continued its professionalization and development in the late twentieth century, with the Association of Physician Assistant Programs (precursor to PAEA) being founded in 1972, the NCCPA being established in 1975, and the first issue of the *Journal of the American Academy of PAs* (*JAAPA*) being published in 1988. By 1990, PAs had prescriptive authority in 30 states and the District of Columbia, and by 1992, PAs were commissioned officers in every branch of the US military. The year 2000 saw Mississippi pass

legislation authorizing PA practice, which marked all 50 states authorizing PA practice. The following year in 2001, the ARC-PA officially became a freestanding agency. PAs obtained prescriptive authority in all 50 states in 2007 when Indiana passed legislation allowing PAs to prescribe.[5-6]

In 2008, the AAPA identified "Six Key Elements of a Modern PA Practice Act."[5] The AAPA stated that when a PA practice act includes the six elements, the resulting environment would allow PAs to practice fully and efficiently while also protecting public health and safety.[10] The first element is utilizing "licensure" as the regulatory term, as that denotes the highest level of scrutiny of professional qualification. This also ensures PAs are included in generic state laws that refer to "licensed health professionals." The second element is full prescriptive authority, or allowing PAs to prescribe all legal medications including controlled medications Schedules II-V and noncontrolled medication and devices. Element three is having the PA scope of practice be determined at the practice level. This means having a PA's scope of practice be determined by the PA, collaborating physicians, and the healthcare team, as opposed to having state laws define specific services PAs may provide. The fourth element is incorporating adaptable collaboration requirements between PAs and physicians. The AAPA elaborates that laws should define PA/physician relationships in a way that works well in all practice settings. Element five is having co-signature requirements be determined at the practice level, as opposed to having state law co-signature requirements. The sixth and last element states that the number of PAs a physician may collaborate with should be determined at the practice level. The AAPA explains that different specialties have different factors that relate to how PAs work with physicians (such as primary care collaboration compared to the collaboration in surgical specialties) and state laws defining PA-to-physician ratios will not account for these differences.[10] In 2016, the first of the

AAPA's six key elements was adopted in all 50 states when Ohio adopted the use of the term "licensure" in reference to PA regulation.[5]

Optimal Team Practice

In 2017, the AAPA House of Delegates passed a resolution that included a new policy allowing state chapters of the AAPA to pursue changes in how the PA profession operates: OTP.[5,11] According to the AAPA, OTP occurs when PAs, physicians, and other healthcare professionals work together to provide quality patient care without administrative constraints.[12-13] The AAPA elaborates by providing three items that state chapters should aim to achieve in supporting OTP. The first of these items is removing the legal requirement for a PA to have a specific relationship with a physician or other healthcare professional. The AAPA asserts that this would allow PAs to practice to the full extent of their education, training, and experience. The second item involves states creating a separate majority-PA board to regulate PAs. Alternatively, states may choose to add PAs and physicians who work with PAs to the existing medical board overseeing PA regulation. The last item is authorizing PAs to be eligible for direct payment by all public and private insurers.[12-13]

In response to the AAPA's announcement and position on OTP, the PAEA created a task force to collect data and consider the PAEA's position on OTP; in April 2017, the PAEA released its OTP Task Force paper.[11] The paper, titled "Optimal Team Practice: The Right Prescription for all PAs?" provides the PAEA's position regarding OTP at that time.[11,14] The PAEA supported the team practice, majority-PA state regulatory boards, and direct PA payment components of OTP. In the paper, the PAEA did not support the element of OTP which would remove the legal requirement for a PA to have a specific relationship with a physician or other healthcare professional (supervision). The PAEA argued that there had not been enough research

and consideration for how OTP (specifically removing the supervision requirement) would impact PA education and new PA graduates. To explore that impact and the implications of OTP, the PAEA recommended creating a joint task force consisting of the AAPA, PAEA, ARC-PA, and NCCPA.[11,14] In October 2017, the PAEA membership developed a task force to explore how OTP would impact PA education and new graduates, and in October 2019 this task force delivered its final report to the PAEA membership.[11] In response, the PAEA membership passed a position policy formally supporting OTP and its goal to reduce administrative burdens.[11]

There has been dissent around OTP from other organizations as well, namely the AMA.[15-16] More specifically, the AMA holds the position that PAs should only be allowed to practice under the direction and supervision of a physician or group of physicians, and the AMA opposes the creation of autonomous PA regulatory boards outside the existing medical licensing and regulatory boards.[15] These two positions held by the AMA directly oppose two elements of OTP: removing the legal requirement for PA supervision and the creation of separate PA-majority regulatory boards. The AMA also discusses these changes in the context of PA scope of practice expansions,[15-16] even though the core elements of OTP and the AAPA's description of OTP do not include any descriptions of expansions to the PA scope of practice.[12-13] In discussing OTP in terms of PAs practicing without physician supervision, the AAPA states that PAs would continue to practice as part of a team with physicians and that the PA scope of practice would be determined at the practice level.[12] In addition to opposing PA supervision changes, the AMA more generally opposes removing supervision requirements for any nonphysician professional, such as the different types of advanced practice registered nurses (APRNs).[15-16]

NP Autonomy: A Comparison

APRNs are nurses educated at the master's degree level or higher. There are four different types of APRNs each with specific roles: the NP (or certified nurse practitioner, CNP), clinical nurse specialist (CNS), certified nurse-midwife (CNM), and certified registered nurse anesthetist (CRNA).[17] The roles of the CNS, CNM, and CRNA are more specialized than the role of the NP, and the NP profession shares considerable similarities with the PA profession. NPs work autonomously and in collaboration with other healthcare professionals to provide medical services such as ordering/interpreting laboratory tests; diagnosing/treating acute and chronic medical conditions; prescribing medications and other treatments; and educating patients on disease prevention and positive lifestyle choices.[18] While PAs and NPs provide many of the same services, there are several differences between the two professions. The PA education curriculum is based on the medical school model, while NPs are trained in the advanced practice of nursing.[19] PAs are trained as medical generalists, whereby they are provided skills in all areas of medicine and for all patients. NPs are trained in one of the following health population focus areas: family, adult/gerontology, neonatal, pediatrics, women's health, or psychiatric/mental health. PAs and NPs are also regulated differently, where PAs are largely still regulated by state medical boards, and NPs are largely regulated by state nursing boards. Another difference between the professions relates to how they frame their practice: the PA profession is pursuing OTP, and the NP profession is pursuing full practice authority (FPA).[19]

The American Association of Nurse Practitioners (AANP) defines FPA as the authorization of NPs to evaluate patients, diagnose, order/interpret diagnostic tests, and initiate/manage treatments (including medications) under the exclusive licensure authority of the state board of nursing.[20-21] The AANP elaborates that in states with FPA, NP licensure is not dependent on unnecessary contracts, relationships with a physician, or oversight by the state

medical board.[20] NPs in states with FPA are still required to meet educational requirements for licensure, maintain national certification, and consult/refer to other healthcare providers when necessary. The AANP also argues that there are several positive impacts resulting from FPA including improved access to care (especially in rural and underserved areas); streamlining care and making delivery of care more efficient; decreasing costs associated with physician oversight of NP practice; and protecting the choice of the patients to see their preferred healthcare provider.[20] FPA licensure laws are currently in over half of US territories and states, including the western and midwestern states of South Dakota, North Dakota, Montana, Wyoming, Nebraska, Iowa, and Minnesota.[20-21]

SD contains all the components of FPA that the AANP lists, including the practice specifics, licensure authority by the state nursing board, and licensure that is independent of physicians and the state medical board. In SD, NPs are licensed and regulated by the SD Board of Nursing.[22] SD law defines the NP scope of practice as including the following: conducting advanced assessment; ordering and interpreting diagnostic procedures; establishing primary and differential diagnoses; prescribing, ordering, administering, and furnishing therapeutic measures (including medications); performing a physical examination; completing and signing official documents (e.g., birth/death certificates); and delegating and assigning therapeutic measures to assistive personnel. Regarding collaboration, SD law states that NPs will collaborate with other healthcare providers and refer or transfer patients as necessary. SD law also specifies that NPs with less than 1,040 practice hours must have a collaborative agreement (i.e., written mutual agreement) with a licensed physician or licensed and qualified NP with over 1,040 practice hours. After meeting the required 1,040 practice hours, NPs in SD are not required to have a collaborative agreement or any other contract/relationship with a physician.[22]

SD OTP

Unlike NP FPA, SD law does not contain all of the components of OTP for PAs. In SD, PAs are licensed and regulated by the SD State Board of Medical and Osteopathic Examiners.[23] The medical board does appoint a PA advisory committee which consists of three PAs. The advisory committee is tasked with assisting the board in regulating SD PAs and making recommendations to the medical board regarding rules pertaining to PA regulation. PAs in SD must have a practice agreement filed and approved by the medical board in order to practice. SD law defines a practice agreement as a written agreement authorized and signed by a PA and supervising physician. The law elaborates that a practice agreement describes the delegated activities a PA may perform, the PA's level of competence, and the supervision provided by the physician. SD law states that PAs are considered an agent of the supervising physician in the performance of any medical practice. PAs may provide services delegated by the supervising physician in the practice agreement if the service is within the PA's skill set, is included in the physician's scope of practice, and is provided with supervision. Such services that PAs may provide include initial medical diagnosis and implementation of a therapy or referral plan; prescribing drug samples or a limited supply of medications; instituting emergency treatment measures including ordering chemical or physical restraint; completing and signing official documents such as birth and death certificates; taking X-rays and performing radiologic procedures; and performing physical examinations. Regarding supervision, a physician may apply for medical board permission to supervise up to four PAs. The supervision may be direct personal contact or a combination of direct and telecommunication contact. If the PA's office is separate from the supervising physician's main office, there must be some form of on-site

personal supervision. The supervising physician is initially and continually responsible (professionally and legally) for the patient care and treatment provided by the supervised PA.[23]

During SD's 96th legislative session in 2021, Representative Chris Johnson introduced House Bill 1163 – an act that revised the law defining PA practice and included several components of OTP.[24] One of these revisions was changing the verbiage and relationship between a physician and PA from supervision to collaboration. With this change, a PA would not be supervised by a physician, rather the PA would collaborate by communicating pertinent information or consulting with a physician or other healthcare provider. Another major revision was replacing the practice agreement with a collaborative agreement, which would only be required for PAs who have not met 520 practice hours. The collaborative agreement would set the terms and conditions of the collaboration and it would be between the PA with less than 520 practice hours and a physician or another PA. Along with the removal of supervision, the PA scope of practice was amended to allow PAs to provide medical services for which they are competent to perform and have been prepared for by education, training, and experience. In addition to the services mentioned in the previous paragraph, PAs would be able to delegate and assign therapeutic measures to assistive personnel. An additional amendment in the scope of practice section stated that PAs would collaborate with other healthcare providers and refer/transfer patients as necessary. House Bill 1163 also removed physician responsibility for the specific care and treatment that a PA provides. Lastly, House Bill 1163 included a new section stating a PA may bill for and receive direct payment for any medically necessary service delivered.[24]

House Bill 1163 included two of the three components of OTP: removing the legal requirement for a PA to have a specific relationship with a physician or other healthcare

professional and authorizing PAs to be eligible for direct payment. During the 2021 legislative session, a revised form of House Bill 1163 changed the required number of practice hours a PA must have from 520 to 1,040 hours, after which a PA would not be required to have a collaborative agreement.[25] House Bill 1163 ultimately did not pass after being considered by the SD House Health and Human Services Committee, with a 7-6 vote to move the bill's consideration to the day after the end of the legislative session (killing the bill).[26] In early March of 2021, the AMA published a news article that discussed House Bill 1163 and reinforced the AMA's stance against the bill and their stance against removing supervision requirements.[26]

During SD's 97th legislative session in 2022, Senator Erin Tobin introduced Senate Bill 134 – an act similar to House Bill 1163 with many of the same revisions to the SD PA practice law.[27] Senate Bill 134 was identical to the revised version of House Bill 1163 regarding the collaborative agreement and the number of practice hours a PA must have. That is, a PA with less than 1,040 practice hours would need to have a collaborative agreement with a physician or another PA. One additional change with Senate Bill 134 was that for a PA with less than 1,040 practice hours to have a collaborative agreement with another PA, the latter PA would need at least 4,000 practice hours. Another revision included in Senate Bill 134 stated that a PA moving to a specialty in which the PA had less than 1,040 practice hours must have a collaborative agreement meeting the same conditions as previously listed. The rest of Senate Bill 134 included largely the same revisions as House Bill 1163, including the removal of supervision in favor of collaboration, the edits to the scope of practice section, removing physician responsibility for the specific care and treatment a PA provides, and adding PA billing and direct payment.[27]

Two amendments to Senate Bill 134 were made. The first amendment, Senate Bill 134A, included several changes mostly relating to the collaborative agreement.[28] With 134A, a PA

would need a collaborative agreement if the PA had less than 2,080 practice hours (double that of the original 1,040 hours). For a PA with less than 2,080 practice hours to have a collaborative agreement with another PA, the latter PA would need at least 10,000 practice hours (over double that of the original 4,000 hours) in the specialty the former PA would be entering. The revised Senate Bill 134A also listed the specialties a PA could work in without a collaborative agreement once meeting the required 2,080 practice hours. These specialties included a rural health emergency department or the primary care areas of family medicine, general internal medicine, general pediatrics, geriatrics, and acute care. Furthermore, the revision stated that a PA working outside of those specialties must enter a collaborative agreement with the employing healthcare facility rather than with a physician or another PA. The degree of collaboration would then be determined at the practice level by the employing facility. Another revision was a statement at the end of the scope of practice section that stated a PA may not engage in independent surgical services. Lastly, the section describing changes in specialty was updated to reflect the required 2,080 practice hours for a PA entering a new specialty, and that if the collaborative agreement was with another PA, the latter PA would need at least 10,000 practice hours in that specialty.[28]

The second amendment to Senate Bill 134 – Senate Bill 134B – further changed the collaborative agreement.[29] Senate Bill 134B removed the terms supervision and collaboration altogether and simply used the term practice agreement. The practice agreement would be required for PAs with less than 6,240 practice hours (six times that of the original 1,040 hours in Senate Bill 134) and would be between a PA and a physician who practices in the same specialty. The revised Senate Bill 134B removed the option for a PA to have a practice (collaborative) agreement with another PA or the employing healthcare facility. 134B also removed all the content describing the specialties a PA could work in without a practice

agreement, and stated that upon meeting 6,240 practice hours, a PA could practice without a practice agreement in accordance with standards developed by the medical board. Lastly, the comment stating PAs cannot engage in independent surgical services was amended to allow PAs to perform routine clinical office surgical procedures such as skin biopsy, mole/wart removal, or incision and drainage of abscesses.[29]

As with House Bill 1163, Senate Bill 134 also did not pass after failing in the Senate with a close vote of 16 to 19.[30-31] Senate Bill 134 did pass through the SD Senate Health and Human Services committee on February 9, 2022, with a vote of 4 to 3.[30] Jennifer M. Orozco, President of the AAPA, testified in support of Senate Bill 134 during the Senate Health and Human Services committee hearing on February 9.[31-32] Orozco expressed the AAPA's strong support of Senate Bill 134, and how the bill would eliminate outdated administrative burdens and allow PAs to practice at the full extent of their education, training, and experience.[32] Orozco made several points in support of the bill, including how it would align SD PA practice requirements with that of NPs in SD and provide employers with more flexibility in structuring healthcare teams. Orozco emphasized that PAs would not practice independently with the bill – they would still be required to collaborate with other clinicians and refer/transfer patients as necessary. Additionally, Orozco stated that Senate Bill 134 would improve access to the high-quality patient care that SD PAs already provide. Before concluding her testimony, Orozco pointed out how the South Dakota State Medical Association (SDSMA) had perpetuated misleading statements regarding the PAEA's position on OTP. Orozco explained that during testimony on House Bill 1163 the year prior in 2021, the SDSMA falsely testified that the PAEA opposed the underlying OTP policy despite the SDSMA being informed twice by the PAEA that the latter supported the policy. Orozco also mentioned that as of February 7, 2022 (two days before Orozco's testimony

on February 9), the SDSMA's website continued to perpetuate the false opposition of the PAEA.[32] On the SDSMA's website under its 2022 Legislative Accomplishments page, Senate Bill 134 is described as allowing the independent practice of PAs, and the page states that the SDSMA strongly opposed the legislation.[33]

During AAPA President Orozco's testimony before the SD Senate Health and Human Services committee, she mentioned how Senate Bill 134 is similar to an Executive Order passed by SD Governor Kristi Noem in early 2020.[32] On April 15, 2020, in response to the COVID-19 pandemic, Governor Noem signed Executive Order 2020-16.[34] Among the sections in this Executive Order, Section 14 specifically pertained to PAs. Section 14 temporarily suspended the provisions which require the supervision of PAs and advanced life support personnel when caring for or treating COVID-19 patients during the duration of the state of emergency.[34] SD was not the only state that suspended PA supervision requirements during the COVID-19 pandemic; at least ten other states waived or suspended PA supervision requirements, and many other states waived or suspended select practice requirements.[35] In 2022, AAPA President Orozco concluded her testimony in SD by stating that the two years prior during the pandemic demonstrated the need for more flexible laws that allow highly qualified clinicians to respond to patient needs, and that the AAPA supports Senate Bill 134.[32]

OTP in Other States

While SD has been unsuccessful with OTP legislation in 2021 and 2022, several surrounding states have had success. In April 2019, North Dakota (ND) became the first state to pass legislation enacting components of OTP.[36] ND's 2019 House Bill 1175 included several changes to PA practice, including the removal of the term supervision from the practice law. House Bill 1175 removed the requirement for ND PAs to have a written agreement with a

physician if the PA works at a licensed facility such as a hospital, and PAs with more than 4,000 practice hours are allowed to own their own practice with the approval of the ND Board of Medicine. PAs owning their own practice with less than 4,000 hours must have a collaborative agreement with a physician. Another change included in the bill was removing physician responsibility for the care PAs provide. Discussions with the ND Board of Medicine resulted in contributions from the board to the drafting of the bill and eventual support of the final bill. House Bill 1175 received unanimous approval in both the ND House and Senate and took effect on August 1, 2019.[36]

While not as extensive as ND's House Bill 1175, Iowa passed Senate File 2357 in March 2020, which was an act pertaining to PA practice regulations.[37] Iowa's 2020 Senate File 2357 was partially enacted in response to the growing COVID-19 pandemic and included several changes to the PA practice law. A few changes included authorizing PAs to prescribe all Schedule II controlled medications and removing chart co-signature requirements. The act also removed the requirement that remote locations staffed by a PA must be visited by a physician at least once every six months, and it allowed the PA scope of practice to be determined at the practice site. PAs are also authorized as rendering providers under Medicaid with the act's passage.[37]

On May 27, 2020, Minnesota signed into law Senate File 13, a bill that included several changes to PA practice.[38] Under the bill, PAs with less than 2,080 practice hours must have a collaborative agreement with a physician in a similar medical specialty. After completing 2,080 hours, PAs may enter a practice agreement with the PA's employer. PAs with a practice agreement must have an annual review with a physician in the same practice or facility, but no

further oversight is necessary. The Minnesota bill also removed delegated prescriptive authority, which allows PAs to prescribe based on their own qualifications.[38]

To the southwest of SD in Wyoming, Senate File 0033 took effect on January 1, 2022, and included a key component of OTP.[39] Wyoming's Senate File 0033 removed the requirements for supervision and for a PA to have a specific relationship with a physician or other medical provider. With the bill, collaboration is determined at the practice level and PAs will collaborate with or refer to another member of the healthcare team as necessary. Additionally, the bill requires a PA majority on Wyoming's PA advisory committee – the committee makes recommendations to the state's medical board on PA-related matters. The Wyoming Association of PAs attributed part of their success with the bill to effective teamwork with the Wyoming Board of Medicine and Wyoming Medical Society.[39]

Review of OTP Research

To date, there has been little research conducted on how PAs understand and perceive the changes associated with OTP and OTP-related legislation. In reviewing the existing literature, only three primary sources were found to contain research conducted on PA perceptions of OTP at the time of this study.[40-42]

In late 2016, the AAPA's Joint Task Force on the Future of PA Practice Authority created a PA full practice authority and responsibility (FPAR) proposal, which would eventually be renamed and passed by the AAPA's House of Delegates as OTP in May 2017.[11,43] Earlier in 2017, the AAPA Research Department conducted a survey on behalf of the Joint Task Force; the survey, titled the "2017 Full Practice Authority and Responsibility Survey," was sent to a total of 102,101 PAs, PA students, and retired PAs in all 50 states and the District of Columbia.[40,43] The survey consisted of over 30 questions focusing on respondents' perceptions and

agreement/disagreement with FPAR and its core components (team-based practice, removal of specific physician-PA relationships, autonomous state boards, and direct reimbursement).[40] Of the 102,101 PAs who were sent the survey, 12,485 PAs responded. In SD, there were 42 respondents[40] – there were 575 certified PAs in SD during 2017 according to the NCCPA's "2017 Statistical Profile of Certified Physician Assistants by State."[44] That would correlate to a response rate in SD of about 7.3%.

Pages 294-300 of the AAPA Research Department's "2017 Full Practice Authority and Responsibility State-Level Survey Report" lists the data from the 42 SD respondents.[40] In general, SD PA respondents were supportive of FPAR and its elements: 73.8% responded that they support FPAR, 95.2% supported a commitment to team-based practice, 76.2% supported autonomous state boards, 95.1% supported direct reimbursement, and 69% supported the elimination of laws and regulations requiring PAs to have a specific relationship with a physician. Among SD PA respondents, 61% were familiar with PA practice laws and regulations, and 38.1% responded that they were satisfied with those laws (33.3% responded that they were dissatisfied, and the rest responded with a neutral or no opinion rating). The survey also asked about respondents' willingness to participate in PA advocacy efforts: less than 5 respondents were already advocating at the state level for FPAR-related changes (no percent given), 33.3% responded that they were willing to spend some time advocating, 35.7% responded that they did not have the time to advocate, and 19% responded that they were not willing to spend time advocating.[40]

The response percentages found among SD PA respondents in the FPAR survey were generally consistent with the national trends regarding the core components of FPAR.[43] Nationally, 72% of respondents supported FPAR, 96% supported team-based practice, about

80% supported autonomous state boards, 93% supported direct reimbursement, and 63% supported the elimination of laws and regulations requiring supervisory agreements.[43]

Aside from the FPAR survey, the only other research found pertaining to PA perceptions of OTP were two AAPA Poster Session Abstracts published in *JAAPA*.[41-42] The first abstract, titled "Perceptions on full practice authority and responsibility/optimal team practice," was from 2018 and consisted of a study focusing on ND PA perceptions of FPAR/OTP.[41] The study was conducted via a survey that was sent to 214 ND PAs, and 73 replied for a 34% response rate. Overall, the study found that respondents were in favor of FPAR changes with an average response score of 4.3/6 on a scale system.[41] The second abstract, titled "PA alumni practice models, knowledge, and perceptions of optimal team practice," was from 2020 and consisted of a study focusing on a PA alumni network's perceptions of OTP, PA practice environments, and marketplace events.[42] This study was also conducted as a survey, which was sent to around 2,000 PA alumni from one institution. 420 PA alumni responded to the survey, which corresponds to a 22% response rate. Most of the respondents either supported or strongly supported the elements of OTP: 93% supported a commitment to team practice, 87% supported direct reimbursement, 71% supported regulatory board changes, and 61% supported practice without an agreement with a specific physician. This study also found that about 33% of PA respondents reported being told by a potential employer that the employer was only accepting applications from NPs; and that the majority of new PA graduates (96%) and experienced PAs (81%) consult at least daily with their collaborating physician.[42]

III. Methods & Analysis

Methods

To study PA understanding and disposition towards OTP-related changes and legislation in SD, a survey study was conducted. The survey consisted of eleven total questions and was created using Qualtrics survey software. The following questions were asked:

i. Are you a Physician Assistant currently licensed and working in South Dakota? [yes/no options; survey ended if "no" was selected]

1. How many years have you worked as a PA? [text entry type question]
2. What type of employment setting describes your current work? [multiple choice type question; options of: Hospital System, Clinic, Private Practice, Research, Education, Other; more than one option could be selected]
3. What area/specialty do you currently work in (if you work in a clinical setting)? [text entry type question]
4. Do you have a membership to SD Academy of PAs? [yes/no options]
5. How would you describe your current level of clinical autonomy on a scale of 1-5? [multiple choice; options of: 1-very restrictive, 2, 3, 4, 5-completely autonomous]
6. How would you describe your current satisfaction with your current level of clinical autonomy on a scale of 1-5? [multiple choice; options of: 1-very dissatisfied, 2, 3, 4, 5-completely satisfied]
7. How familiar are you with Optimal Team Practice (OTP)? [multiple choice; options of: Not familiar, Somewhat familiar, Very familiar]

8. Are you familiar with SD House Bill 1163 (from 2021) and/or SD Senate Bill 134 (from 2022)? Both are legislation that did not pass that looked to modernize SD PA practice laws. [multiple choice; options of: Not familiar, Somewhat Familiar, Very familiar, I advocated for or was involved with the bill]
9. For each of the following legislative measures to modernize PA practice laws, please rate your level of agreement: [the following three sub-questions were multiple choice; for each, the options were: 1-completely disagree, 2, 3-neutral, 4, 5-completely agree]
    a. Updating the PA-physician relationship terminology from supervisory to collaborative for a PA who has less than a specified number of practice hours
    b. Removing the requirement for an experienced PA to have a signed agreement and specific relationship with a physician
    c. PAs should be professionally/legally responsible for the care they provide (not physicians)
10. How do you foresee SD Optimal Team Practice / PA autonomy legislation impacting patient care and healthcare access in SD (if it were to pass)? [multiple choice; options of: Negative impact, No impact, Unsure, Positive impact]

The survey was originally distributed to a SD PA email list used by the SD Academy of PAs (SDAPA), with the assumption that only SD PAs would receive the email and survey link. The email was accompanied by a consent statement, a URL to the survey, and a QR code that was also linked to the survey. Prior to distribution, the survey was granted Institutional Review Board (IRB) approval through the University of South Dakota. This initial survey did not include question "i," "Are you a Physician Assistant currently licensed…" The survey was also

distributed to the SDAPA Facebook page with an updated consent statement and question "i" was added to the survey. An IRB amendment was approved for the Facebook post.

The survey link was live from mid-March through mid-June 2022, for a total of about 3 months. There were a total of 54 survey respondents, 51 of whom completed the survey. After data collection was complete, the IRB submission for the survey was closed. The data collected through Qualtrics was downloaded to Microsoft Excel for analysis (no identifiable information was collected). Frequency distribution histograms were created for each question, and percentage values were calculated based on the outcomes and response frequencies for each question.

Analysis

Survey questions 1-4 looked at demographic information pertaining to SD PAs. The mean years of experience for PAs in SD was 12.5 years, with a range of 1–42 years. 85.4% of respondents were in their first 20 years of practice. For a work setting, 87.3% of SD PAs worked in a hospital system or clinic setting; 30 respondents worked in a hospital; 25 worked in a clinic; and 8 worked in either education, a private practice, or some other setting (**Figure 1**).

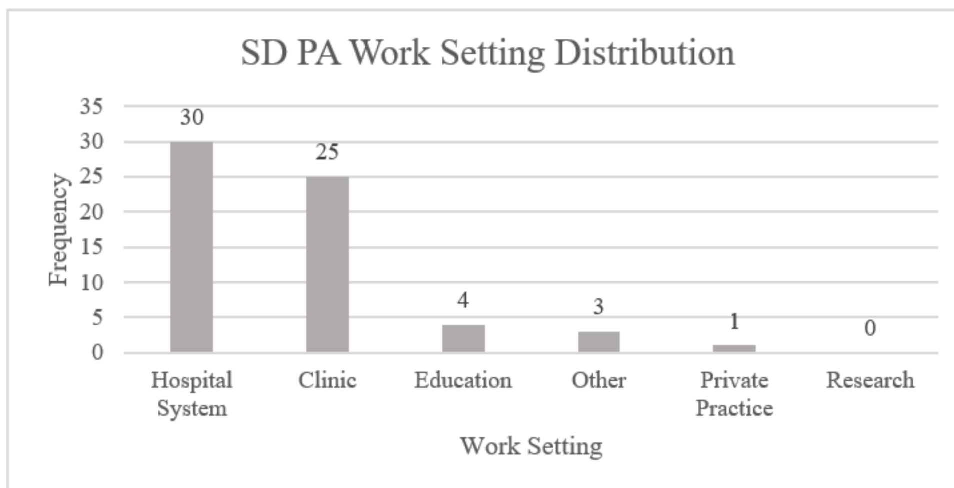

Figure 1. Work setting distribution among SD PAs. Settings were provided as answers to respondents.

Respondents provided a range of medical specialties, including primary care, urgent care, emergency medicine, internal medicine, infectious diseases, orthopedics, sports medicine, urogynecology, critical access, long-term care, hospitalist, allergy/asthma, urology, psychiatry, pediatrics/pediatric intensive care, and research. The most common specialty was primary care with 24 respondents, followed by emergency medicine or urgent care with 14 respondents. 78.9% of respondents worked in some form of primary care, emergency medicine, or internal medicine (**Figure 2**). Question 4 asked if respondents had a SDAPA membership, and 80.4% (41 individuals) did hold a membership.

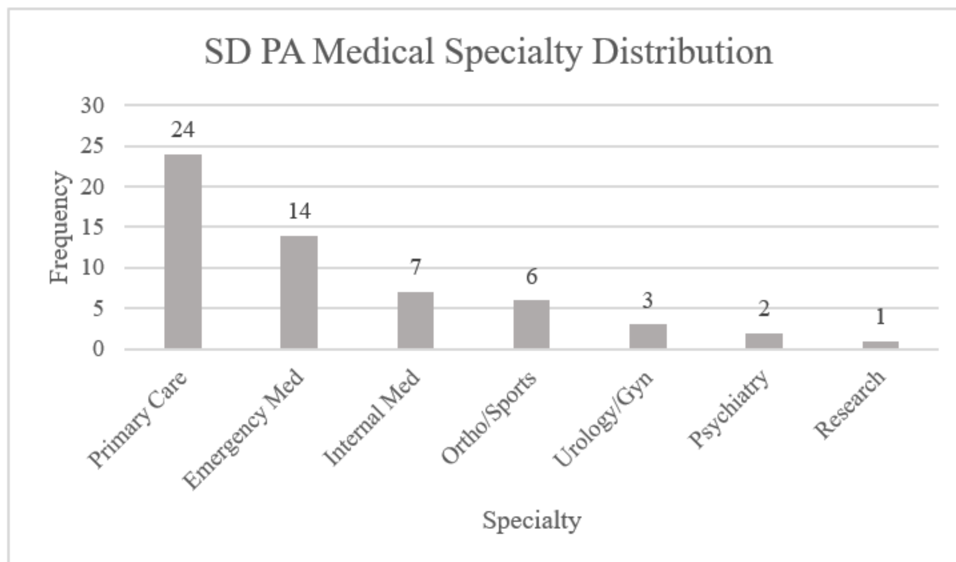

Figure 2. Medical specialty distribution among SD PAs. Specialty groupings were created based on the specialties given by respondents.

Questions 5-6 asked about respondents' perceptions regarding their own clinical autonomy. Respondents were first asked to rate their current level of clinical autonomy: 72.5% rated their autonomy as moderately to completely autonomous (survey responses 4-5). None of the respondents rated their autonomy as "1-very restrictive" and 3 respondents rated their autonomy as moderately restrictive (survey response 2). 11 total respondents gave a neutral rating (survey response 3) for their level of autonomy (**Figure 3**).

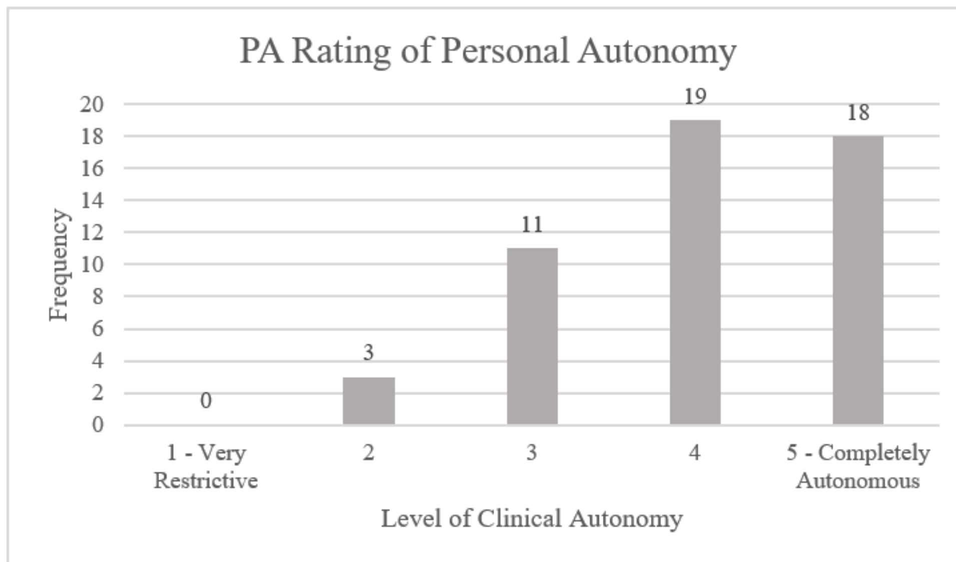

Figure 3. Ratings given by SD PAs on their perceived level of clinical autonomy, with a 1 being very restrictive and 5 being completely autonomous.

Respondents were then asked to rate their satisfaction with their current level of clinical autonomy (**Figure 4**). 68.6% responded that they were moderately to completely satisfied with their current autonomy (survey response 4-5). 2 respondents gave a rating of “1-very dissatisfied” and 4 gave a rating of moderate dissatisfaction (survey response 2). 10 respondents gave a neutral satisfaction rating (survey response 3).

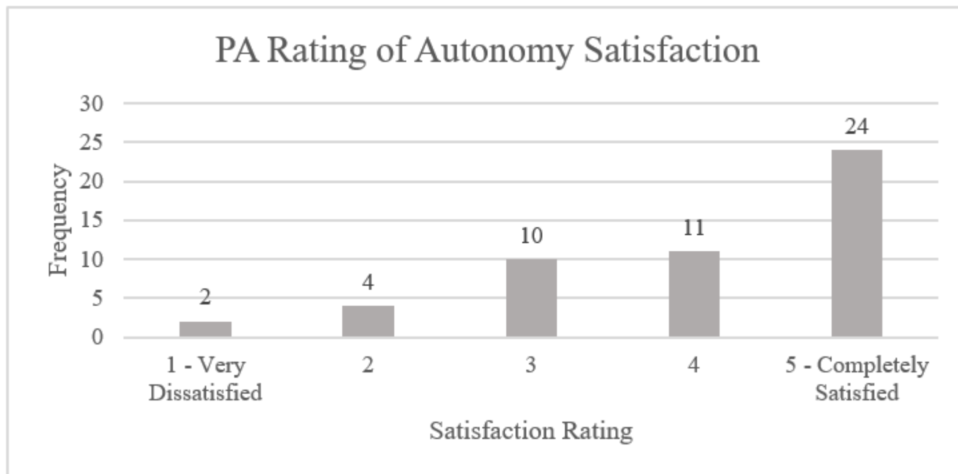

Figure 4. Satisfaction ratings given by SD PAs regarding their level of clinical autonomy, with a 1 being very dissatisfied and 5 being completely satisfied.

Questions 7-10 asked about familiarity and opinions on OTP and related legislation. Most SD PAs had at least heard of OTP, with 84.3% being “Somewhat Familiar” or “Very Familiar” with OTP. The other 15.7% were “Not Familiar” with OTP. Regarding SD-specific OTP legislation, the most common response was “Somewhat Familiar” with 19 responses. 2 respondents were “Not Familiar” with SD OTP, and the “Very Familiar” and “I advocated for or was involved with the bill” options each received 15 responses (**Figure 5**). In total, 29.4% of respondents advocated for SD OTP legislation, while 69.4% were at least somewhat familiar yet did not advocate for the legislation. 96.1% of respondents were at least minimally familiar with SD OTP legislation.

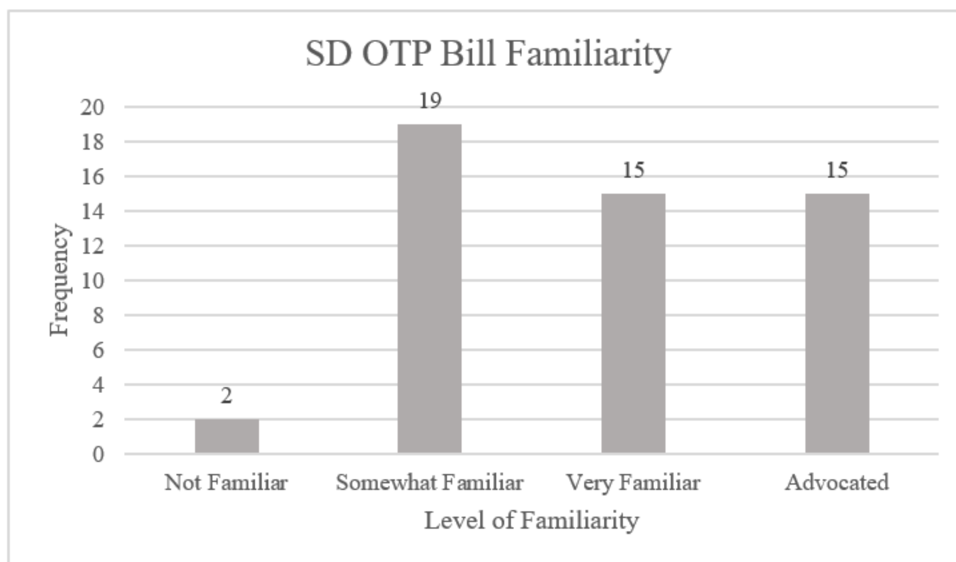

Figure 5. SD PA familiarity ratings with SD OTP legislation, including SD House Bill 1163 (from 2021) and SD Senate Bill 134 (from 2022).

Question 9 included three sub-questions, each asking respondents to rate their agreement with a proposed legislative measure pertaining to the modernization of PA practice laws. Question 9a pertained to a PA-physician relationship terminology change from supervisory to collaborative for a PA with less than a specified number of practice hours, and 82.4% of respondents were either moderately or completely agreeable with such a change (survey responses 4-5). 8 respondents gave a neutral rating (survey response 3), and 1 gave a "1-completely disagree" rating (**Figure 6**).

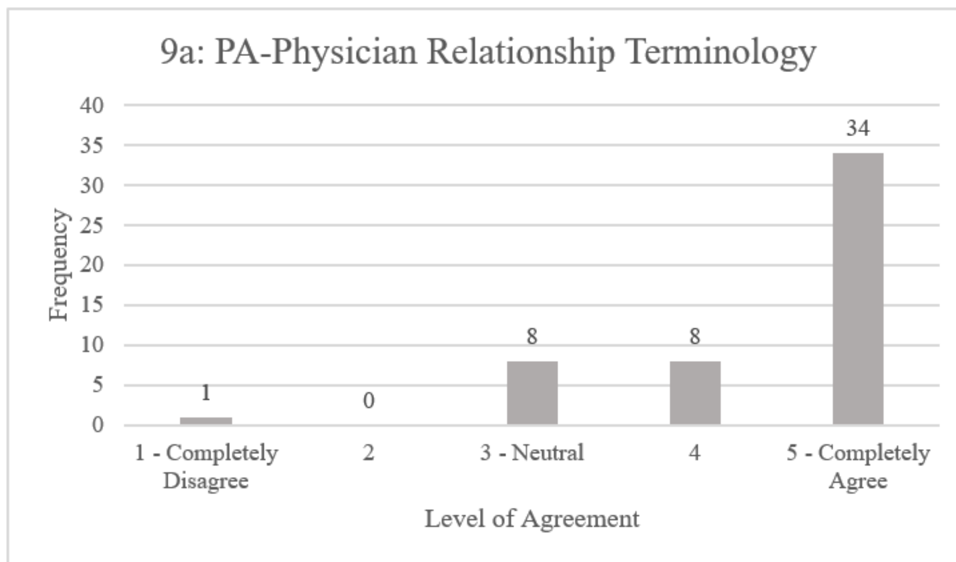

Figure 6. Agreement ratings given by SD PAs regarding a proposed legislative change in PA practice laws: changing PA-physician relationship terminology from supervisory to collaborative for PAs with less than a specified number of practice hours.

Question 9b pertained to removing the requirement for a PA to have an agreement or specific relationship with a physician (**Figure 7**). As with question 9a, 82.4% of respondents were either moderately or completely agreeable with such a change (survey responses 4-5). 5 respondents gave a neutral rating (survey response 3), and 4 respondents gave a moderately disagree rating (survey response 2).

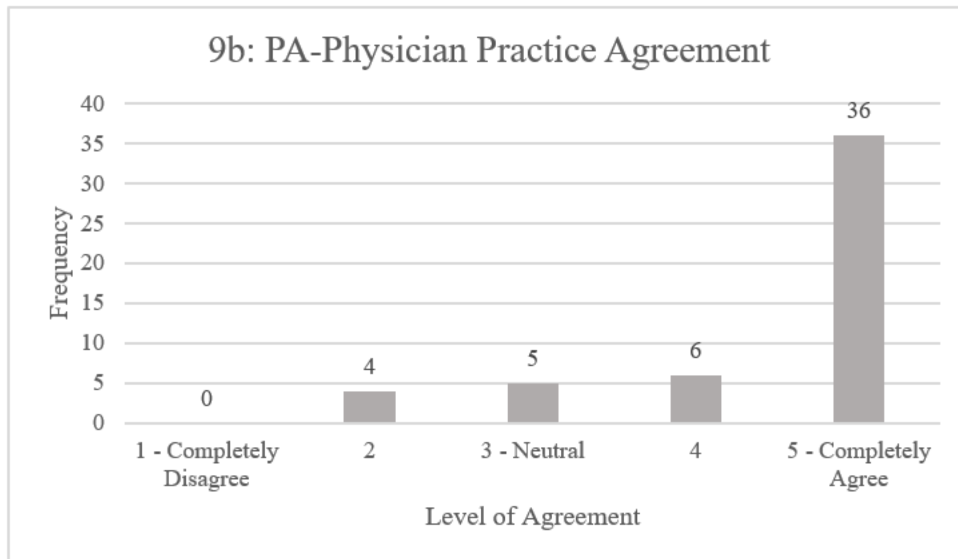

Figure 7. Agreement ratings given by SD PAs regarding a proposed legislative change in PA practice laws: removing the requirement for an experienced PA to have a signed agreement and specific relationship with a physician.

Question 9c pertained to a measure that would ensure PAs are professionally and legally responsible for the care they provide. 92.2% of respondents were either moderately or completely agreeable with such a change (survey responses 4-5), which is higher than either 9a or 9b. 4 respondents were neutral (survey response 3), and no respondents chose options "1-Comletely Disagree" or "2" (**Figure 8**).

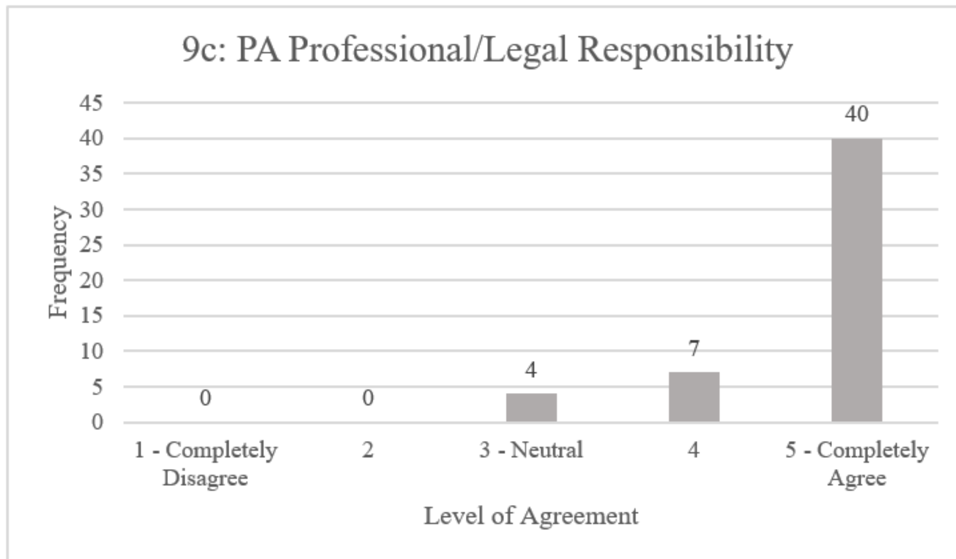

Figure 8. Agreement ratings given by SD PAs regarding a proposed legislative change in PA practice laws: PAs should be professionally/legally responsible for the care they provide (not physicians).

The last survey question asked how SD PAs foresee OTP-related legislation impacting healthcare should such legislation eventually pass (**Figure 9**). No respondents chose the "Negative Impact" option, 4 chose "No Impact" and 5 chose "Unsure." 42 respondents thought OTP legislation would have a "Positive Impact" which correlates to 82.4%.

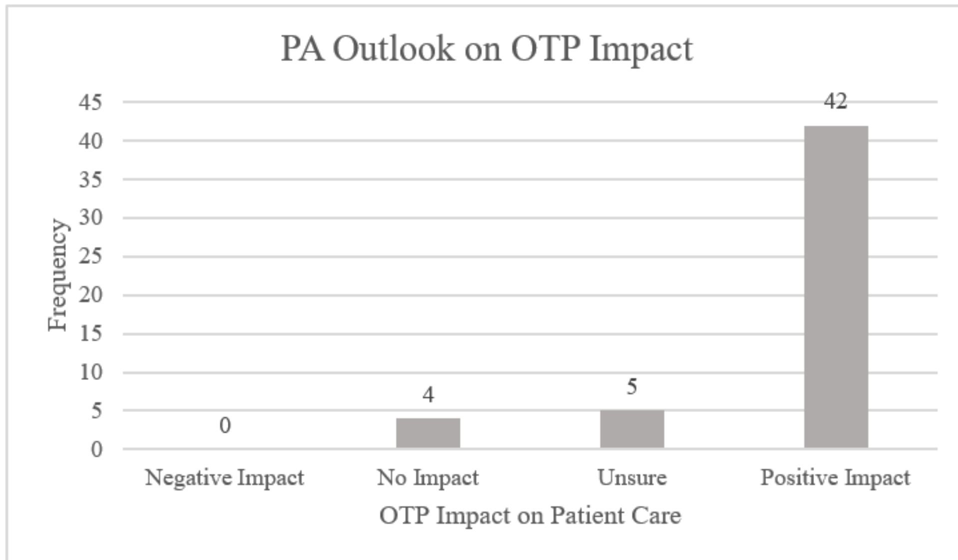

Figure 9. SD PA input on how OTP-related legislation would impact patient care and healthcare access in SD should such legislation pass.

IV. Discussion

Results

Based on the data collected from the 51 respondents in this survey study, the average SD PA is within his or her first 13 years of practice; and most work in clinic or hospital settings (87.3%) and in some form of primary care, emergency medicine, or internal medicine (78.9%). The majority (80.4%) of SD PA respondents have a SDAPA membership. Most SD PAs do not find their current clinical autonomy to be overly restrictive (72.5% rank autonomy as moderately to completely autonomous), and about 67% are satisfied with their current autonomy. Most SD PAs have at least heard of OTP (84.3%) and SD-specific OTP legislation (96.1%), but less than 30% actually advocated for the SD OTP bills. A majority of respondents (82.4%) think OTP legislation would have a positive impact on patient care and healthcare access in SD.

SD PA respondents are generally supportive of OTP-related changes. 82.4% of respondents are either moderately or completely agreeable to changing the PA-physician relationship terminology from supervisory to collaborative for PAs with less than a specified number of practice hours. 82.4% of respondents are also moderately or completely agreeable to removing the requirement for an experienced PA to have a signed agreement and specific relationship with a physician. Lastly, 92.2% of respondents are moderately or completely agreeable with changes that would ensure PAs are professionally and legally responsible for the care they provide (not physicians).

The findings from this survey study are consistent with prior research.[40-42] The AAPA Research Department's 2017 survey on FPAR found that nationally, PAs are generally supportive of FPAR (OTP) and its components.[40,43] The FPAR survey results from SD found that 73.8% of respondents supported FPAR as a whole and 69% supported the removal of

supervision/collaborative requirements.[40] A 2018 survey study of ND PAs had similar results with respondents being in favor of FPAR changes; respondents averaged a response score of 4.3/6 on a scale system.[41] Another 2020 study surveyed an institution's PA alumni network and found that 93% of respondents supported a commitment to team practice, 87% supported direct reimbursement, 71% supported regulatory board changes, and 61% supported practice without an agreement with a specific physician.[42] One interesting parallel with the AAPA's FPAR 2017 survey was how it found that only 33.3% of SD PA respondents said they were willing to spend some time advocating at the state level for FPAR changes,[40] and this 2022 survey study found that less than 30% of SD PAs actually advocated for or were involved with SD OTP legislation (House Bill 1163 from 2021 and/or Senate Bill 134 from 2022).

Limitations

There are several limitations to this survey study that should be considered. There were 54 total survey respondents, 51 of whom completed the survey and were analyzable. The most recent NCCPA report detailing the number of certified PAs by state was from 2020 data, and there were 644 PAs in SD according to the report.[45] 51 respondents out of 644 PAs corresponds to a response rate of 7.9%. However, it is probable that the actual response rate is lower than 7.9% as there were likely more than 644 PAs in SD at the time of the survey's distribution in 2022. Regardless, the modest sample size may not be generalizable for the entire population of SD PAs.

Another factor that should be considered is the characteristics of the respondents. Those who took the time to fill out the survey may be more likely to be involved in PA professional issues at the local, state, or national level. This could introduce error in the accuracy of several

components of the survey, including the questions which asked about having a membership with the SDAPA and one's knowledge about OTP/SD OTP.

In addition to gathering a larger sample size, there are several improvements that could be made to this survey study. To gather a better understanding of how SD PAs perceive OTP as a whole, the survey should include additional questions asking about the other components of OTP. Such questions might ask about one's understanding, perception, or agreement with continued team-based practice; changes to state regulatory boards (creating a separate majority-PA board to regulate PAs); and authorizing PAs to be eligible for direct payment by all public and private insurers. Other questions might ask about one's familiarity with the existing state PA practice law and one's willingness to advocate for OTP-related changes. Adding these questions would also allow for a better comparison with the AAPA's 2017 FPAR survey results.

OTP: Final Notes

The AAPA associates several benefits with the implementation of OTP legislation, including benefits to patients, PAs, physicians, and healthcare employers.[12-13] In an infographic describing how OTP can improve healthcare, the AAPA states that OTP will: strengthen healthcare teams by reducing administrative constraints and enabling practice-level decision-making; expand access to care by removing the requirement for PAs to have a specific relationship with a physician, which better enables PAs to practice in rural and medically underserved areas; reduce healthcare spending by increasing practice flexibility; and help employers meet patient needs through the increased flexibility in creating healthcare teams and in expanding the number of providers through which insurers can make direct payments.[13]

In 2019, the AAPA President at the time – Jonathan Sobel – commented in *JAAPA* about what the AAPA considered to be the facts about OTP.[46] Sobel first stated that OTP is meant to

reduce unnecessary administrative constraints on PA practice and ensure PAs are responsible for the care they provide. Sobel argued that OTP will not change the PA scope of practice; a PA's scope is determined by factors such as education, what the law allows, and clinical experience. Requiring an agreement with a specific physician does not impact what a PA is competent to do, and eliminating that requirement will not expand or reduce a PA's competence in what he or she can do. In creating autonomous state boards or including PAs on the medical board, Sobel stated that OTP would make PAs responsible for their own profession, just as physicians regulate physicians on medical boards and nurses regulate nurses on nursing boards. Another point Sobel made was how new PA graduates do not need special rules, as they are obliged to stay within their scope of practice limitations based on their education and experience like all other new and experienced clinicians.[46]

The last point Sobel made was that the federal government already expressed support for the key elements of OTP in a 2018 report prepared by the Department of Health and Human Services in collaboration with the Departments of the Treasury and Labor, the Federal Trade Commission, and several offices within the White House.[46-47] Within the report, titled "Reforming America's Healthcare System Through Choice and Competition," the aforementioned US Departments compiled a list of recommendations that they suggested the states and the federal government should consider carrying out.[47] On page 108 of the report and among the first of these recommendations are two of the key components of OTP. The US Departments recommend that the federal government and states should consider legislative and administrative proposals allowing non-physician providers to be paid directly for their services when evidence supports that the provider can safely and effectively provide that care. The following recommendation in the report is that states should consider eliminating requirements

for rigid collaborative/supervisory agreements between physicians and care extenders (such as PAs) when the agreements are not justified by legitimate health and safety concerns.[47]

A growing amount of evidence supports that PAs and NPs provide health services at levels consistent with that of physicians.[48-54] For example, studies have explored how the care provided by PAs, NPs, and physicians compare in areas such as primary care,[48] emergency medicine,[49] pediatrics,[50] and with human immunodeficiency virus care,[51] cardiovascular disease care,[52] and diabetes care.[52-54] All the studies cited here found that the care provided by PAs (and PAs/NPs in general) was consistent, comparable, similar, and/or had statistically or clinically insignificant differences with that of physician care.[48-54] That is, peer-reviewed research suggests that PAs provide a quality of care consistent with that of physician care, and arguing against OTP in concerns of patient safety is not factually based when considering the available studies.

Conclusion

The results from this 2022 survey study suggest that overall, SD PAs support OTP-related changes. These results are consistent with what was found in several prior studies relating to PA perceptions of OTP (and its precursor, FPAR).[40-42] One interesting finding was that less than 30% of respondents actually advocated for or were involved with SD-specific OTP legislation, while 69.4% were at least somewhat familiar with the legislation yet did not advocate for it. This finding is consistent with a 2017 AAPA survey study which found that 33.3% of SD PA respondents were willing to spend some time advocating at the state level for FPAR changes.[40] Strong engagement in the PA community is likely a necessity for successful OTP changes at the state level, and the low involvement among SD PAs found in this study may have contributed to House Bill 1163 (from 2021) and Senate Bill 134 (from 2022) failing in their respective legislative sessions. Future studies may explore why there is a general lack of

involvement among SD PAs, and whether this low engagement is specific to SD or indicative of a more regional or national trend. It may also be useful to survey NPs in SD regarding their perceptions of OTP, as well as if they see FPA benefiting their practice. As the AMA and SDSMA are both against OTP-related changes,[15-16,26,33] surveying SD physicians with regard to their understanding of and stance on OTP and FPA might be another beneficial measure. Specifically asking why SD physicians disagree with OTP changes (if they do disagree) would be interesting as well as useful in addressing any dissent. A growing number of states have successfully enacted OTP legislation or legislation improving/modernizing PA practice, including several states bordering SD.[36-39] Finding ways to engage the majority of the SD PA community, engaging SD NP colleagues, finding common ground with SD physicians, and proposing a strong OTP legislative bill while emphasizing the safety and benefits of OTP may all be helpful in successfully modernizing SD PA practice laws.

V. 2023 Update

During SD's 98th legislative session in 2023, Senator Erin Tobin introduced Senate Bill 175 – an act with similar revisions to the SD PA practice law as seen in House Bill 1163 from 2021 and Senate Bill 134 from the 2022 legislative session.[55] According to the bill, PAs with less than 2,080 practice hours would need to have a collaborative agreement with a physician or another PA with at least 4,000 practice hours. After meeting the 2,080 practice hours, PAs would be able to practice without a collaborative agreement in the emergency department at a rural healthcare facility or in the primary care areas of acute care, family medicine, general internal medicine, general pediatrics, and geriatrics. Senate Bill 175 stated that if a PA enters an area of practice outside those listed, the PA will need to obtain an additional 2,080 practice hours while under the terms of a collaborative agreement with the employing healthcare facility. A subsequent section of the bill states that in order for a PA to enter a specialty in which the PA has less than 2,080 practice hours, the PA would need to have a collaborative agreement with a physician or another PA with at least 4,000 practice hours. This change in specialty section is somewhat contradictory and overlaps with the previous section describing the collaborative agreement needed to practice in areas outside the listed primary care areas and rural emergency department. Other changes in Senate Bill 175 included removing supervision in favor of collaboration, removing physician responsibility for the specific care and treatment a PA provides, and adding PA billing and direct payment. There were also edits to the scope of practice section similar to those made in the bills from previous years, such as: authorizing PAs to delegate patient care measures to assistive personnel; explicitly stating that PAs will collaborate with other healthcare providers or transfer patients as necessary; and stating that PAs will not engage in independent surgical services aside from routine office procedures.[55]

Senate Bill 175 passed through the SD Senate Health and Human Services Committee with a vote of 5 to 2, but failed to pass through the Senate with a 14 to 20 vote.[56] The bill passed through the Health and Human Service Committee on February 8, and on February 13, 2023, the bill failed to pass through the Senate.[56] On February 10, 2023, the PAEA addressed a letter to Senator Tobin expressing the PAEA's strong support of SD Senate Bill 175 and OTP.[57] In the letter, the PAEA argued that Senate Bill 175 would expand access to high-quality care by eliminating outdated administrative barriers that restrict PA practice. The PAEA stated their main reason in writing the letter was to reiterate their strong support of OTP in response to mischaracterizations by external stakeholders – specifically the SDSMA. According to the PAEA, the SDSMA communicated to their membership (regarding Senate Bill 175) that the PAEA criticized the national effort to remove PA supervision and collaboration requirements. The letter to Senator Tobin goes on to say that the PAEA communicated several times – including during the 2022 SD legislative session – that the SDSMA's characterization of the PAEA's stance on OTP is not accurate. The PAEA stated their main concern originally was with regard to new PA graduates, and that the adopted OTP policy from 2017 addressed the PAEA's concern.[57]

AAPA President Orozco made similar claims regarding the SDSMA's mischaracterizations of the PAEA's stance on OTP in her testimony before the SD Senate Health and Human Service Committee during the 2022 legislative session.[32] According to Orozco, the SDSMA falsely perpetuated the PAEA's opposition of OTP in 2021 during debate over House Bill 1163 and during the 2022 legislative session.[32] Together, Orozco's testimony and the PAEA's letter suggest that the SDSMA made false claims about the PAEA's stance on OTP in 2021, 2022, and 2023 – three consecutive legislative sessions – despite the SDSMA being

informed multiple times that the PAEA supports OTP.[32, 57] AAPA President Orozco and the PAEA ended their respective communications with similar themes: that OTP legislation in SD would reduce administrative burdens, ensure better outcomes with continued PA collaboration, and benefit the people of SD.

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