FAQ on PA and APRN Practice and Team-Based Care

What does the current law state about physician supervision of PAs/NPs/CNMs/CRNAs?

Physician Assistants (PA)

Current statutory and regulatory supervisory requirements include having a written supervisory agreement between a supervising physician and the PA that outlines the PA's scope of practice, accessing the supervising physician(s), and a process for evaluating the PA's performance. "Supervise" or "Supervision" is defined in rule as the physician's function of overseeing the medical acts performed by a physician assistant. While supervision is considered continuous, it also does NOT require the physical presence of the supervising physician at the time and place that the services are rendered. Written prescribing instructions must be maintained at each site.

For the first six months of a new practice arrangement, the PA and supervising physician are required to meet once a month, and after the initial 6-month period, they are required to meet once every six months. The purpose of these meetings is to discuss practice relevant clinical issues and quality improvement measures. NC Medical Practice Act, 21 NCAC Section .0200. See also NCMB Position Statement Physician Supervision of other Licensed Health Care Practitioners.

Other practice limiting factors:

For employed or contracted PAs, these functions can be accomplished based on the employee/employer relationship or through independent contractor agreements. In addition, all practitioners are expected to refer or consult when needed, and the referral or consultation is not necessarily limited to the supervising physician.

Health care facilities where PAs practice also may impose limitations on what services can be performed by PAs. Similarly, insurers and health plans also may limit what and how services can be paid.

Advanced Practice Registered Nurses:

- **Nurse Practitioners (NP)**

  Current statutory and regulatory supervisory requirements include having a written collaborative practice agreement between a supervising physician and the NP that outlines the NP's scope of practice, accessing the supervising physicians, and a process for evaluating the NP's performance. "Supervision" is defined in rule as the physician's function of overseeing the medical acts performed by the NP. For the first six months of a new practice arrangement, the NP and supervising physician are required to meet once a month, and after the initial 6-month period, they are required to meet once every six months. The purpose of these meetings is to identify clinical problems discussed, including progress toward improving outcomes. Written instructions about ordering medications, tests and treatments also must be provided.

  NP scope includes but is not restricted to:

  1. promotion and maintenance of health;
  2. prevention of illness and disability;

3. diagnosing, treating and managing acute and chronic illnesses;
4. guidance and counseling for both individuals and families;
5. prescribing, administering and dispensing therapeutic measures, tests, procedures and drugs;
6. planning for situations beyond the NP's expertise, and consulting with and referring to other health care providers as appropriate; and
7. evaluating health outcomes.

Link to relevant statutes and rules.

Other practice limiting factors:

For employed or contracted NPs, these functions can be accomplished based on the employee/employer relationship or through independent contractor agreements. In addition, all practitioners are expected to refer or consult when needed and the referral or consultation is not necessarily limited to the supervising physician.

Health care facilities where NPs practice also may impose limitations on what services can be performed by NPs. Similarly, insurers and health plans may limit what and how services can be paid.

- **Certified Nurse Midwives (CNM)**

  Current statutory and regulatory supervisory requirements include having site-specific written clinical practice guidelines outlining individual and shared responsibilities between the CNM and supervising physician, ongoing communication and consultation, and periodic and joint evaluation of services rendered.

  CNM scope includes the provision of prenatal, intrapartum, postpartum, newborn and inter-conceptional care as outlined in N.C. Gen. Stat. 90-178.2.

  Link to relevant statutes and rules.

  Other practice limiting factors:

  For employed or contracted CNMs, these functions can be accomplished based on the employee/employer relationship or through independent contractor agreements. In addition, all practitioners are expected to refer or consult when needed and the referral or consultation is not necessarily limited to the supervising physician.

  Health care facilities where CNMs practice also may impose limitations on what services can be performed by CNMs. Similarly, insurers and health plans may limit what and how services can be paid.

- **Certified Registered Nurse Anesthetists (CRNA)**

  CRNAs perform nurse anesthesia activities in collaboration with a physician, dentist, podiatrist or other lawfully qualified health care provider. Nurse Anesthesia practices include pre-anesthesia preparation and evaluation, anesthesia induction, maintenance and emergence, post-anesthesia care and other clinical activities as outlined in 21 NCAC 36 .0226.

CRNAs are not required to have a written collaborative practice agreement or guidelines. Physician supervision of CRNA practice is required in situations where a CRNA prescribes a medical treatment regimen or makes a medical diagnosis.

Link to rule.

Other practice limiting factors:

For employed or contracted CRNAs, these functions can be accomplished based on the employee/employer relationship or through independent contractor agreements. In addition, all practitioners are expected to refer or consult when needed and the referral or consultation is not necessarily limited to the supervising physician.

Health care facilities where CRNAs practice also may impose limitations on and require physician supervision of services performed by CRNAs. Similarly, insurers and health plans may limit what and how services can be paid.

- **Certified Nurse Specialists (CNS)**

CNS are not subject to statutory or regulatory requirements for physician supervision. CNS practice, which does not include pharmacologic prescriptive authority, includes:

1. assessing clients' health status, synthesizing and analyzing multiple sources of data, and identifying alternative possibilities as to the nature of a health care problem;
2. diagnosing and managing clients' acute and chronic health problems within an advanced practice nursing framework;
3. assessing for and monitoring the usage and effect of pharmacologic agents within an advanced practice nursing framework;
4. formulating strategies to promote wellness and prevent illness;
5. prescribing and implementing therapeutic and corrective non-pharmacologic nursing interventions;
6. planning for situations beyond the clinical nurse specialist's expertise and consulting with or referring clients to other health care providers as appropriate;
7. promoting and practicing in collegial and collaborative relationships with clients, families, other health care professionals, and individuals whose decisions influence the health of individual clients, families, and communities;
8. initiating, establishing, and using measures to evaluate health care outcomes and modify nursing practice decisions;
9. assuming leadership for the application of research findings for the improvement of health care outcomes; and
10. integrating education, consultation, management, leadership and research into the clinical nurse specialist role.

Link to CNS rule.

Other practice limiting factors:

For employed or contracted CNS, these functions can be accomplished based on the employee/employer relationship or through independent contractor agreements. In addition, all

practitioners are expected to refer or consult when needed and the referral or consultation is not necessarily limited to the supervising physician.

Health care facilities where CRNAs practice also may impose limitations on what services can be performed by CRNAs. Similarly, insurers and health plans may limit what and how services can be paid.

See also NCMB Position Statement Physician Supervision of other Licensed Health Care Practitioners.

What is the NCMS' current policy on 'scope of practice'?

Existing NCMS policy on what historically has been referred to as 'scope of practice' is set out in at least seven current NCMS policies, as follows:

Physician Relationship with Non-Physician Practitioners

RESOLVED, That the North Carolina Medical Society supports the following guidelines for supervising physicians and non-physician practitioners who perform medical acts, tasks and functions:

1. Each professional is responsible for meeting practice standards of her/his professional group and regulatory board.
2. Each professional is responsible for maintaining a working environment in which there is mutual trust and respect, and open, active communication, promoting the optimum contribution of skills and knowledge to the services offered to patients.
3. A clear understanding of the circumstances requiring consultation with the supervising physician as documented.
4. Geographic separation is not a barrier when consultation can be accomplished in a reasonable time frame by telephone or other means of communication.
5. Professional credentials of each are communicated by signage, name tags, etc.
6. Practice arrangements include a negotiated method for addressing ongoing quality assurance.
7. Each professional is aware of limitations of knowledge or skills, and willing to refer for appropriate consultation and care as necessary; and be it further

RESOLVED, That the North Carolina Medical Society supports the requirement of physician supervision of health care providers who perform medical acts, tasks, and functions.

(Report DD-1996, adopted 11/17/96)(revised as amended, Report H-2003, Item 3 #31, adopted as 23 amended 11/16/03)(revised, Report N-2008, Item 3-46, adopted 10/19/2008)(revised, Report G-2013, 24 Item 1-6, adopted 10/26/2013)

Supervision of Physician Assistants and Advanced Nurse Practitioners

RESOLVED, That the North Carolina Medical Society supports a requirement that the name, address, physical location, contact information and supervisory role of any physician that supervises an advanced nurse practitioner or physician assistant be available in a prominent location accessible to patients.

(Resolution 4-2006, adopted as amended, 10/29/2006)(reaffirmed, Report H-2011, Item 3-33, adopted 31 10/23/2011)(reaffirmed, Board Report-2018, Item 14, adopted 11/3/2018)

Physician Assistants as Part of the Patient-Centered Medical Home

RESOLVED, That the North Carolina Medical Society supports and endorses the use of Physician Assistants as part of a physician-led team, including within the Patient-Centered Medical Home model.

(*Resolution 10-2012, adopted as amended 10/27/2012*)

Regulation of Medical Acts by Nurses

RESOLVED, That the North Carolina Medical Society supports joint adoption of regulations governing nurse practitioners by the North Carolina Board of Nursing and the North Carolina Medical Board; and be it further

RESOLVED That the North Carolina Medical Society supports the use of a joint subcommittee comprised of representatives from the North Carolina Medical Board and the North Carolina Board of Nursing as the entity to formulate regulatory proposals for nurse practitioners; and be it further

RESOLVED, That the North Carolina Medical Society supports a professional regulatory system whereby nurse practitioners obtain their nursing license from the North Carolina Board of Nursing and their authorization to perform medical acts from the North Carolina Medical Board.

(Resolution 5-1972, adopted 5/24/72)(Report S-1984, Item 8, adopted 5/5/84)(reaffirmed, Report CC16 1994, Item 13, adopted 11/6/94)(revised, Report L3-2004, Item 3, adopted 11/14/2004)(reaffirmed, 17 Report I-2009, Item 2-66, adopted 11/01/2009)(reaffirmed, Reaffirmation Report-2014, Item 47, adopted 18 10/25/2014)

Prescription Privileges

RESOLVED, That the North Carolina Medical Society supports the prescription of medications for the treatment of mental illnesses be limited to allopathic physicians, osteopathic physicians and physician assistants, and nurse practitioners under the supervision of a physician.

(Substitute Resolution 17-2002, adopted 11/17/02)(revised, Report N-2008, Item 3-35, adopted 25 10/19/2008)(revised, Report G-2013, Item 1-7, adopted 10/26/2013)

Physician Supervision of Nurse Anesthetists

RESOLVED, That the North Carolina Medical Society supports physician supervision of nurse anesthesia activities that involve prescribing a medical treatment regimen or making a medical diagnosis.

(Report B-1998, adopted 11/15/98)(revised, Report L3-2004, Item 37, adopted 11/14/2004)(reaffirmed, 30 Report I-2009, Item 2-55, adopted 11/01/2009)(reaffirmed, Reaffirmation Report-2014, Item 50, adopted 31 10/25/2014)

Credentials Disclosure

RESOLVED, That the North Carolina Medical Society supports the practice of advising patients at the time an appointment is made whether they will be evaluated by a physician or a non-physician practitioner.

(Resolution 5-2008, adopted as amended, 10/19/2008)(revised, Report G-2013, Item 1-10, adopted 5 10/26/2013)(reaffirmed, Board Report-2018, Item 15, adopted 11/3/2018)

Why did the NCMS create the Medical Team Task Force (MTTF)?

In 2016, NCMS leadership sought to examine the effectiveness of current North Carolina laws regarding physician supervision of advanced practice nurses and PAs. Nursing groups were – and continue -- pursuing legislative changes that would allow full practice authority upon graduation, certification and licensure without physician oversight. In light of our evolving health care system and practice, the MTTF was formed to review the existing requirements for physician supervision and to determine if a modernization of those requirements was warranted.

Who serves on the MTTF?

Representatives from a cross-section of North Carolina medical specialty organizations and NCMS leadership and staff. The Medical Team Task Force is chaired by NCMS Past President **Robert 'Charlie' Monteiro, MD**, an internist practicing in the Triangle.

What is the charge of the MTTF?

As originally adopted in 2017, the Task Force is charged with

a) reviewing the different forms, effectiveness and status of physician supervision of advanced practice nurses, and
b) determining whether changes occurring in health care delivery and payment systems warrant a modernization of the current regulatory scheme. If changes are appropriate, the Task Force should make recommendations to the North Carolina Medical Society Board of Directors.

What recommendations has the MTTF made to date?

In March 2019, after two years of robust discussion, the MTTF recommendation to the NCMS Board of Directors is as follows:

RESOLVED, that the NCMS seek changes in the regulation of Physician Assistants in North Carolina to establish a career entry interval of 4,000 clinical hours to be required upon entry into practice, and a specialty training interval of 1,000 hours to be required whenever the PA changes specialty; and be it further

RESOLVED, that the NCMS seek changes in the regulation of Physician Assistants in North Carolina to define the heightened requirements of a career entry interval and specialty training interval to be that a Physician Assistant:

1) Work in team-based setting in collaboration with a physician,

2) Maintain a collaborative practice agreement on site, which includes clinical oversight, quality measures, scope of practice, onboarding/orientation process, and process/plan for expansion of scope throughout interval, and

3) Permit the NC Medical Board to inspect the collaborative practice agreement within 72 hours; and be it further

RESOLVED, that the NCMS seek changes in the regulation of Physician Assistants in North Carolina to define a team-based setting for PAs that includes physician-owned medical practices, and licensed health facilities with active credentialing and quality programs, where physicians have consistent and

meaningful participation in the design and implementation of health services to patients; and be it further

RESOLVED, that the NCMS seek changes in the regulation of Physician Assistants in North Carolina to repeal statutory physician supervision of Physician Assistants practicing in team-based settings, and to implement statutory collaboration with a physician in all non-team settings, and during career entry and specialty training intervals; and be it further

RESOLVED, that the NCMS seek changes in the regulation of Physician Assistants in North Carolina to require, in all settings requiring collaboration, that the Physician Assistant:

1) collaborate with, consult with or refer to the appropriate member of the health care team as indicated by the condition of the patient, the education, experience and competence of the Physician Assistant, and the applicable standard of care;
2) determine the degree of collaboration at the practice level, which may include decisions made by the employer, group, hospital service, and the credentialing and privileging systems of a licensed facility; and
3) accept responsibility for the care they provide.

The NCMS Board of Directors adopted this recommendation at its March 2019 meeting and reaffirmed its adoption at its March 2021 meeting.

Is the MTTF still functioning and if so, has its composition/charge changed at all?

Yes, at its March 2021 meeting, the Board of Directors endorsed the continuation of the Task Force's work. Efforts are underway to update the roster of task force members to include a variety of medical specialty viewpoints and NCMS membership.

How does the proposed legislation (SB345 – PA Team Based Practice) change current regulations on PA supervision?

The current legislation improves the transition from graduate school to practice by requiring 4,000 hours of post-graduate competency and practice-based training (career entry hours) under the supervision of a physician. Thereafter, if the PA changes medical specialty, it requires an additional 1,000 supervised hours. The changes also promote team-based practice by moving away from regulatorily mandated check-in meetings (once a month for the first six months, and once every six months thereafter) in favor of encouraging person-centered, team-based care in settings where physicians and other providers are part of the care team.

For PAs who have completed the career entry hours, who are not practicing in a team-based setting, the PA is still required to have a written or electronic supervisory arrangement with a physician. Consistent with current practice, PAs are expected to collaborate and consult with or refer to the appropriate members of the health care team as required by the patient's condition and as indicated by the education, experience and competencies of the PA and the standard of care.

Has the NCMS changed its position on physician supervision of PAs and advanced practice nurses? Why or why not?

Yes, but the change is nuanced and is designed to promote better quality of care. With changes to the health care system well underway, the NCMS convened the Medical Team Task Force in 2016 to look at improving the existing regulatory requirements for APPs to ensure they are consistent with providing high quality, person-centered, team-based care.

Since PAs (and APPs generally) do not have residency programs, a 4,000-hour career entry/transition to practice requirement was proposed to ensure post-graduate competency- and practice-based training. In addition, if a PA changes medical specialty after the initial 4,000 career entry hours, an additional 1,000 hours of supervised practice is required. Once the 4,000 career entry hours are satisfied, PAs who practice in a team-based setting are not required to have a supervisory agreement because of the availability of physicians and other providers in those settings. Practice policies and protocols can further define PAs' practice in those team-based settings. Team-based settings are defined as:

- Medical practices organized as professional corporations formed between a physician and a physician assistant.
- Physician-owned medical practices where the physician owners have consistent and meaningful participation in the design and implementation of health services to patients.
- Licensed health facilities with active credentialing and quality programs where physicians have consistent and meaningful participation in the design and implementation of health services to patients.

Career Entry—the existing regulations focus more on monthly meetings in the first six months and thereafter one meeting every six months. There are no requirements for meaningful post-graduate competency- and practice-based training (career entry) hours. The legislation changes this and requires 4,000 supervised clinical career entry hours with a supervising physician and includes specific requirements to ensure post-graduate competency- and practice-based training.

Medical Specialty Changes—currently PAs are able to change medical specialties without receiving any specialty-specific training and are subject only to the monthly check in meeting for the first six months if there is a new supervising physician and thereafter one meeting every six months. The legislation, however, would require an additional 1,000 hours of supervised practice with a supervising physician, assuming the PA has already fulfilled the initial 4,000 clinical career entry hours.

PAs practicing in Team-based Settings—after the 4,000 career entry hours under the supervision of a physician, a specific supervisory agreement is not required in a team-based setting; however, practice policies and protocols "…protocols can address elements of PA practice and the functioning of the medical team that are not explicitly required or addressed in the law and rules. This is consistent with the way the Medical Practice Act, including provisions related to PA practice, works today.

PAs practicing outside of Team-based Settings—A supervisory arrangement with a physician is still required.

How does SB345 – PA Team Based Practice differ from SB249/HB277 – the SAVE Act?

Although both SB 345, Physician Assistant Team-Based Practice, and SB 249/HB 277, The Save Act, concern regulations related to advance practice providers, the bills are significantly distinguishable.

Stated broadly, the most important differences between these bills include SB 345's (1) career entry requirement of 4,000 hours of supervised practice, (2) additional 1,000 hours of supervised practice if there is a medical specialty change, and (3) focus on the promotion of team-based settings and enhanced supervisory arrangements versus SB 249/HB 277's complete removal of required supervision in all circumstances regardless of practice setting and/or clinical experience. The following chart includes a high-level overview of additional differences.

SB 345	SB 249/HB 277
Applies to physician assistants.	Applies to nurse practitioners, certified nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists.
	Provides expanded statutory definitions for practice for all categories of referenced APRNs.
Requires physician assistants to have a supervisory arrangement with a physician unless (1) the physician assistant practices in a team-based setting and (2) has more than 4,000 hours of practice experience as a licensed physician assistant and more than 1,000 hours of practice within the specific medical specialty of practice with a physician in that specialty. Requires a physician assistant practicing in a perioperative setting, including the provision of surgical or anesthesia-related services, to be supervised by a physician.	Removes required supervision/supervisory arrangements in all circumstances.
Requires supervisory arrangements to describe a minimum of the following: 1. The terms of clinical oversight. 2. An onboarding or orientation process. 3. Quality measures to be achieved. 4. Scope of delegate duties. 5. Plan for interval expansion.	Does not include statutory requirements related to onboarding, clinical oversight, or quality measures to be achieved for newly licensed APRNs.
Requires an additional 1,000 hours of practice experience as a licensed physician assistant within the specific medical specialty of practice with a physician in that specialty if the physician assistant changes specialty area.	Does not include statutory requirements related to hours of practice-based training needed should the APRN choose to switch specialty area.
Prohibits physician assistants from performing final interpretations of diagnostic imaging studies	Permits APRNs to interpret diagnostic studies.
	Makes the NC Board of Nursing the sole regulatory agency for all four categories of APRNs.
Defines "team-based setting" as inclusive of any of the following practice settings:	Offers no definition for team-based setting.

SB 345	SB 249/HB 277
1. Medical practices organized as professional corporations formed between a physician and a physician assistant. 2. Physician-owned medical practices where the physician owners have consistent and meaningful participation in the design and implementation of health services to patients. 3. Licensed health facilities with active credentialing and quality programs where physicians have consistent and meaningful participation in the design and implementation of health services to patients. Specifically excludes medical practices that specialize in pain management from the definition of a team-based setting.	
Adds new statutory language requiring all physician assistants, regardless of whether a supervisory arrangement is in place, to "collaborate and consult with or refer to the appropriate members of the health care team as required by the patient's condition and as indicated by the education, experience, and competencies of the physician assistant and the standard of care." The bill also notes that the "degree of collaboration must be determined by the practice which may include decisions by the employer, group, hospital service and the credentialing and privileging systems of a licensed facility."	Includes language requiring CNMs, CNSs, and NPs to consult with or refer to "other health care providers as warranted by the needs of the patient.
Allows physician assistants to prescribe medications and to plan and initiate a therapeutic regimen that includes ordering and prescribing non-pharmacological interventions provided the physician assistant complies with statutory language requiring collaboration and consultation within the health care team.	Permits CNMs, CNSs, and NPs, to prescribe pharmacologic and nonpharmacologic therapies without a supervising arrangement or required collaboration.

What is team-based care?

Team-based care is

- Deliberate, intentional integration, and the collaboration of health professionals to deliver care.
- Integration, collaboration, and facilitation of care across individual team members and providers.
- Purposeful inclusion of patients and families in the team**.**

The National Academy of Medicine (NAM) defines team-based care as: *The provision of health services to individuals, families, and/or communities by at least two health care providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated high-quality care.*

Why is team-based care important?

In 2011, the Institute of Medicine (IOM) (now the NAM) challenged health care systems across the nation to think beyond siloed health care professionals of medicine, nursing, social work, pharmacy and public health, and to work collaboratively to develop strategies to ensure optimal patient outcomes using interprofessional teams.

According to the IOM/NAM, the benefits of effective teamwork include:

- Improved patient satisfaction
- Decreased medical errors
- Improved workforce retention
- Greater provider satisfaction
- Cost efficiencies for systems as well as patients
- Enhanced community engagement

According to a study published in *Health Affairs* in March 2021, "provider teams outperformed solo providers, irrespective of team composition. Among solo providers, physicians and nonphysicians exhibited little meaningful difference in performance. As policy makers contemplate scope-of-practice changes, they should consider the effects of not only provider type but also team-based care on outcomes. Interventions that may encourage provider team formation, including scope-of-practice reforms, may improve the value of care."[1]

What is Interprofessional Education (IPE)?

The Inter-professional Education Collaborative (IPEC) outlines core competencies each member of the health care team should have in common:

- Shared values and ethics
- Respect for professional roles and responsibilities

[1] Provider Teams Outperform Solo Providers In Managing Chronic Diseases And Could Improve The Value Of Care
Maximilian J. Pany, Lucy Chen, Bethany Sheridan, and Robert S. Huckman
Health Affairs 2021 40:3, 435-444

- Clear inter-professional communication
- Development of effective teams
- Demonstrated teamwork

IPE is now a standard part of medical school curriculum.

Where can I find more information on team-based care?

KIPL Power Hour on Team-Based Care

Sara Heath, How to Use Team-Based Care to Improve the Patient Experience.

NCIOM Team-based Care in North Carolina