

July 16, 2021: Advocacy Update spotlight on scope of practice—state legislative roundup

Scope of practice: State legislative roundup

As expected 2021 was filled with lots of legislation related to scope of practice. State medical associations, state osteopathic associations, national and state-level specialty societies, the American Osteopathic Association and AMA have all been extremely busy on scope this year—sometimes working out front and often behind the scenes.

The AMA worked with 35 state medical associations to help defeat scope legislation this year, including legislation related to Advanced Practice Registered Nurses (APRNs) (nurse practitioners, nurse anesthetists, nurse midwives, clinical nurse specialists), naturopaths, optometrists, pharmacists, physician assistants, psychologists and podiatrists. Due to the tremendous efforts of organized medicine at all levels and physician leaders across the country, there have been many wins but some tough losses as well. Following is a summary of some key bills:

APRNs

Key bills that would have significantly expanded APRN scope of practice were defeated in eight states this year, including Florida, Kansas, Kentucky, Louisiana, Maine, Mississippi, Tennessee and Texas. In addition, legislation enacted in Virginia, which would have allowed nurse practitioners (NP) to practice independently, was amended to retain the current transition to practice requirement but reduced the number of years required from five years to two years. This provision is only applicable until July 1, 2022, at which time the law reverts back to five years. The bill also retained the current oversight of NPs from the medical board and nursing board.

In response to the pandemic, Massachusetts' Governor Baker adopted an executive order expanding the scope of practice of NPs and other non-physicians. Legislators retained these expansions through legislation introduced in Dec. 2020 and signed into law by Governor Baker in early 2021. The new law creates a transition to independent practice process in which NPs, psychiatric nurse mental health clinical specialists and Certified Registered Nurse Anesthetists (CRNAs) can practice independently after two years of practice under a physician or nurse practitioner with independent practice authority and who meets other requirements (to be determined by regulatory process). Unfortunately, Delaware

and Utah also enacted legislation to allow independent practice of APRNs.

- Delaware’s legislature enacted two bills related to APRNs. One removes physician collaboration and the existing requirement that APRNs seeking independent practice must practice pursuant to a collaboration agreement for two years and a minimum of 4,000 full-time hours. A second bill adopts the new APRN compact. This makes Delaware the second state to adopt the APRN compact with North Dakota adopting earlier this year.
- Utah’s legislation removed the collaboration requirement for prescribing, thereby allowing NPs to diagnose, treat or prescribe without any physician involvement.

Unfortunately, several states enacted legislation specifically related to nurse anesthetists, one type of APRN, including Arkansas and Michigan. Arkansas enacted legislation replacing physician supervision of nurse anesthetists with “consultation.” In Michigan, the medical society and partner organizations were able to secure favorable amendments to a bill that would have allowed nurse anesthetists to practice independently (H.B. 4359). Based on amendments adopted in the Senate, nurse anesthetists must meet the following requirements to practice anesthesia care without supervision:

- Have a minimum of three years or more of experience practicing in the specialty field of nurse anesthesia along with a minimum of 4,000 hours practicing in a health care facility, or hold a doctor of nurse anesthesia practice degree or doctor of nursing practice degree.
- Collaboratively practice in a patient-centered care team which must include a licensed physician that is immediately available in-person or through telemedicine to address any urgent or emergent clinical concerns.

The amendments also prohibit nurse anesthetists from practicing pain management in a freestanding pain clinic without the supervision of a physician. The House accepted the Senate’s amendments on June 24. The bill was approved by Governor Whitmer on July 13.

Physician assistants (PAs)

Physician assistants (PAs) introduced the American Academy of PAs (AAPA) Optimal Team Practice Act, their model independent practice legislation, in multiple states this year. Such bills were defeated in Colorado, Indiana, South Dakota and Texas. Other states also had physician assistant legislation but state medical associations were able to secure favorable amendments. For example, Florida’s bill was amended to retain physician supervision but increased the number of physician assistants a physician can supervise. The bill in Tennessee was amended to create a semi-autonomous board requiring all rules relating to prescribing and collaboration to be jointly adopted by the PA Board and the Board of Medical Examiners.

Unfortunately, a concerning bill was enacted in Utah (S.B. 27), which replaces physician supervision of PAs with collaboration, requiring such collaboration with a physician only for the first 4,000 hours of practice. Between 4,000-10,000 hours of practice, a PA can collaborate with a physician or PA who has met the 10,000-hour requirement in the same specialty as the PA. If the PA changes specialties, the PA must engage in collaboration for a minimum of 4,000 hours with a physician who is trained and experienced in the specialty to which the PA is changing. While there are some guardrails, this type of transition to practice legislation is concerning and Utah now marks the fourth state to allow this type of path to independence for physician assistants. Oregon and Wyoming also enacted legislation replacing physician supervision of PAs with a weakened definition of collaboration with any member of the health care team. In Oregon, collaboration can occur with a physician, podiatric physician or employer. In Wyoming, collaboration can occur with any member of the health care team.

In addition to this legislative activity, AAPA adopted new policy at their annual House of Delegates to change the title of physician assistants or PAs to “physician associate.” The AMA stands in strong opposition to this title change, as outlined in AMA Immediate Past President Susan R. Bailey, MD’s, statement. The American Osteopathic Association (AOA) and several national specialty organizations have also issued strong statements opposing the title change. This title change is incompatible with laws and regulations at the state and federal levels, and the AMA is ready to work with interested partners to address this issue.

Optometrists

Legislation that would have allowed optometrists to perform eye surgery was defeated in Alabama and Florida, while favorable amendments were secured in Texas. Unfortunately, however, legislation expanding optometrist scope of practice passed in Mississippi and Wyoming. Mississippi’s H.B. 1302 allows optometrist to remove superficial foreign bodies from the eye, administer and prescribe pharmaceutical agents rational to the diagnosis and treatment of the eye and perform YAG laser procedures. Optometrists, however, are not permitted to perform cataract surgery or other procedures not specifically allowed. Wyoming’s legislation is much broader allowing optometrists to perform eye surgery.

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