Missouri Assistant Physician Legislation

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Objectives

• Discuss scope of practice issues for mid-level providers.
• Review how the Missouri Assistant Physician became a reality.
• Identify concerns and implications of an Assistant Physician.
• Discuss implications of physicians licensed to practice without residency training.
Background

• Concern regarding shortage of PCP’s in rural and urban underserved areas of MO.
• Perception that there is an excess of quality medical school graduates that do not match into residency.
• Assumption that those unmatched graduates can help fill need for primary care services.
• Assistant Physician (AP) proposed as a means to ease PCP shortage in rural MO.
Legislation

- Introduced in 2014 by Rep from Rolla, MO who is an orthopedic surgeon.
- Part of omnibus bill that passed without much discussion or input from GME org.
- Final rules published by MO-DHSS/BOHA in August of 2016.
- First applications for licensure opened in January 2017.
- Originally time limited, now unlimited, with grandfather period for USMLE thanks to updated legislation (Rep from Nixa, MO who is pharmacist).
Rules for AP licensure

• Must be medical school graduate (IMG ok)
• Must have passed USMLE/COMLEX step 2 within some time restrictions (3 yrs – unless applied before 2016, grace period).
• Must practice within 50 mile radius of collaborating physician.
• Must complete 50 hrs of CME per year.
• Only one month required to practice with the collaborating physician present.
Scope of Practice for AP’s

• “Provide care for the diagnosis and treatment of acute or chronically ill or injured persons” as defined by collaborative agreement “consistent with skill, training, education and competence”

• This includes prescribing, performing procedures, and limited controlled substance dispensing.

• Only 10% of charts must be reviewed by supervising physician (20% if controlled rx’d)
Concerns of GME Community

• Establishes a new category of practicing physician, creating a two-tiered system.
• Supervision requirements are far less stringent than for residents in training.
• No duty hour restrictions, limited chart review, limited CME requirements.
• Applicant pool likely comprised of those not deemed quality residency candidates.
Implications of Collaboration

• Allowing physicians without complete training to provide patient care under limited supervision risks quality and safety.
• Promoting care to underserved as a “fallback option” devalues primary care.
• Establishes an inappropriate standard for the care of rural or urban underserved.
• Creates confusion for patients around PA’s, NP’s and AP’s and their roles.
Questions for organized FM to consider:

• Do we have primary care needs that cannot be met without AP’s?
• Legislation was opposed by PA and to lesser degree, NP organizations.
• Push for independent scope of practice for NP’s and other mid-levels is tough to reconcile with opposition to those with similar training.
Questions for organized FM to consider:

• Is this a standard of care that the public wishes to endorse?

• Preliminary data suggest that the bulk of applicants and licensees are off-shore grads with significantly higher USMLE failure rates than national averages.

• A significant percentage of those in collaborative practice agreements are in urban regions, some not underserved.
Questions for organized FM to consider:

• Will CMMS recognize and reimburse services provided by AP’s?

• MO legislation states that for purposes of payment the AP shall be considered the same as a PA.

• CMMS officials were unaware of this stipulation and have not made a determination on payment (personal communication).
Questions for organized FM to consider:

- Similar legislation has been enacted in UT, AR and KS, how will others respond?
- Legislation in these states is limited to either graduates from state medical schools or resident citizens.
- So far legislation has been blocked in VA and WA through efforts in part by FP org.
- State academies need to be aware of efforts in their states.
Are residency programs and rural practices “islands” of comprehensiveness in sea of “Generic PCP styled” practice models?
Is anybody doing PC better than nobody?
So what’s the Bottom line?

- Comprehensiveness is a core tenant of FM.
- Scope of practice is a key driver in student interest for FM.
- Both internal and external forces have led to a decline in scope of services offered by FM docs.
- However, a broad scope of practice has a positive impact on patient health and physician certification performance.
- Scope of practice does distinguish physician training from other primary care providers.
THANK YOU!

Questions?