FAQ ABOUT PHYSICIAN ASSISTANT SUPERVISION

We’ve compiled some questions that have been submitted to the Board regarding different aspects of physician assistant supervision and the related documentation. Most of the standards relating to supervision requirements are found in Board Rules 26.0 and 27.0.

WHO IS AN APPROPRIATE SUPERVISOR?

In answering a recent question on this topic, we included some general guidance. Feedback on the guidance was positive, so we’re including it as a preface to the questions about who qualifies as an appropriate physician to supervise a given physician assistant.

When deciding who is an appropriate physician to supervise a physician assistant, it may help for you to keep in mind the two primary goals for supervision. One is to provide a physician who is qualified to assess the quality of care provided by the PA. The other primary goal is to have a physician who is committed to be a resource for consultation with the PA. While it is not a requirement for everyone who a PA consults with to be a documented supervisor, and a PA is free to consult with any appropriately qualified health care professional, it is a requirement for a PA to have at least one documented physician (MD or DO) supervisor available (even if only electronically) whenever practicing. A decision about who is an appropriate supervisor may be easier if you think about those goals.

MUST A SUPERVISING PHYSICIAN BE BOARD CERTIFIED IN A SPECIALTY FIELD TO SUPERVISE A PHYSICIAN ASSISTANT WHO PRACTICES IN THAT SPECIALTY FIELD OF PRACTICE?

Answer: No, it is not necessary for a physician to be board certified to supervise a PA. The requirement for supervision is found in Vermont law at 26 V.S.A. § 1735a(c), which states:

The physician assistant's scope of practice shall be limited to medical care which is delegated to the physician assistant by the supervising physician and performed with the supervision of the supervising physician. The medical care shall be within the supervising physician's scope of practice and shall be care which the supervising physician has determined that the physician assistant is qualified by education, training, and experience to provide.

The Board’s Rules also include provisions that address qualification to supervise. Whether a primary or secondary supervisor, the requirement is to: Supervise PAs only in the field(s) of medicine in which the physician is qualified and actively practices. Rule Sections 27.2.2.1 & 27.2.4. The Rules also specify that the tasks and duties delegated to the PA shall include only activities within the supervising physician’s scope of practice. Rule Section 27.3.4.

Example: may a psychiatrist who treats patients in an in-patient facility supervise a PA who provides non-psychiatric medical care to patients in the facility?

Answer: It depends. If the psychiatrist in this example stays current and provides general medical care often enough for those services to be considered within the psychiatrist’s scope, and a field in which the psychiatrist actively practices, then it would be fine. If the psychiatrist focuses only on psychiatry and does not provide care
outside of psychiatric treatment, then it would not be appropriate for the MD to act as the PA’s supervisor. Looking back to the guidance at the beginning of this section, it would seem self-evident that the psychiatrist who does not stay current on other fields of practice would not be in a position to assess, for instance, the PA’s management of hypertension in those patients, nor would the psychiatrist be able to provide consultation if the PA had questions about those aspects of care.

Example: a PA who works at a satellite site screening patients for referral to a subspecialist, such as an orthopedic office with orthopedic generalist physicians, but who focuses on seeing patients who are potential candidates for referral to a spine specialist, should the supervising physician be an orthopedist who is in the office most days with the PA, or the spine specialist who works in a remote location seeing patients who are first screened by the PA?

Answer: Assuming this is all within one department, orthopedics, it sounds like either physician could be the primary supervisor. In one sense the PA could be said to be acting as an orthopedic generalist when screening patients and making referrals to the spine specialist. Or, it could be said that the care being provided by the PA is comparable to a first visit with a spine specialist. There are likely many other examples where there is more than one physician could fill the role of supervising physician and the hospital may choose based on what works best for the organization. Keep in mind that whoever is chosen to be the primary supervisor, that physician will need to have access to charts in order to perform chart review.

HOW SPECIFIC IS THE REQUIREMENT FOR THE TASKS AND DUTIES DELEGATED TO A PA BY THE SUPERVISING PHYSICIAN TO BE WITHIN THE SUPERVISOR’S SCOPE OF PRACTICE? IN OTHER WORDS, WHAT IF IT’S A TASK THAT THE MD HAS NOT DONE, BUT THAT IS WITHIN THE MD’S FIELD?

Answer: There are multiple parts to this answer.

**Controlled Substance Prescribing and MAT**

There are specific requirements for prescribing of controlled substances and for Medication-Assisted Treatment (MAT) for opioid use disorder. As stated in the Board Rule 27.3.5, a PA may prescribe only those drugs that are within the scope of practice of both the PA and the primary supervising physician as documented in the Delegation Agreement. Also, when PAs became eligible to obtain a waiver to prescribe buprenorphine, the Board issued guidance that the supervisor must prescribe for MAT in order to supervise a PA prescribing for MAT. Do those requirements mean that the supervising MD must prescribe every specific drug prescribed by the PA? Certainly, for a PA to be able to prescribe drugs within a DEA schedule, the supervisor would have to prescribe drugs in that schedule.

But does that mean that a PA can prescribe any drug within a DEA schedule if the supervising physician prescribes drugs from that schedule? As this discussion becomes more specific, we get beyond answers that are clear and directly supported by the language of statutes, regulations, or other Board guidance. Questions of this nature would be decided by the Board if a case were to arise in which it became necessary to rule about whether care delegated to a PA was within the supervising MD’s scope of practice. For instance, a case could arise in which an MD who prescribed all schedules of controlled substances delegated prescribing of all DEA schedules of controlled substances to a PA. If the MD never
treated ADHD, treatment of ADHD could be found outside the scope of practice of the MD, and it would thus be improper for the MD to delegate treatment of ADHD and improper for the PA to engage in such practice. However, that does not necessarily mean that a PA can prescribe a certain drug only if the MD also prescribes it? In the ADHD example, if the MD treats patients for ADHD, but it is not the practice of the MD to prescribe a certain drug, the MD still might have sufficient knowledge to assess the care provided by the PA and consult with the PA about the treatment. The decision demands exercise of professional judgment by the supervising MD and the PA, and ultimately would be evaluated by the Board under all the facts and circumstances if it were to come up in a case.

What about care that is not prescribing controlled substances or MAT?

The answers to questions about scope of practice and delegation to a PA will often turn on all the facts and circumstances. Another question recently posed to the Board was about whether a PA could do a procedure in the office to insert an implanted birth control medication delivery device in patients, if the supervising MD does not use that device for her patients. If the MD were experienced in providing birth control and with using implants, it might be reasonable for the MD to supervise the PA even thought it’s not a device used by the MD in her practice. In that case, another fact was that the manufacturer requires healthcare professionals to have a 2-hour training before the medication device is sold to be implanted by them. That fact is one that would suggest it’s not within the scope of practice of the MD, but more facts would need to be examined. What if the MD had the training with the intent of supervising the PA’s use of the device, but still did not employ the device in practice? That would tend to support a finding that it would acceptable for the MD to supervise the PA in using the device, still assuming that the MD generally prescribes birth control and is generally knowledgeable about implanting devices. Once again, it might be helpful for MDs who are considering questions such as this to consider whether they would feel capable of assessing the PA’s use of the device and able to consult with the PA if questions arose about an issue related to the device.

SUPERVISION DOCUMENTATION

DOES A PA WHO HAS MULTIPLE PRACTICE SITES WITHIN A HOSPITAL SYSTEM NEED MORE THAN ONE SET OF SUPERVISION DOCUMENTS, OR CAN ONE SET COVER MORE THAN ONE PRACTICE SITE?

It depends. So long as the sites are within the same department of the organization and the PA’s scope of practice and primary supervisor will be the same for each practice site, then only one set of paperwork is needed. Secondary supervisors must be listed, too. If opting for one primary supervisor/one set of documents, it is important to remember that the primary supervisor needs to take all of the PA’s practice sites that are under her supervision into account in providing supervision, and should include some records of care from all sites being supervised when doing chart review.

HOW MUCH SUPERVISION IS ENOUGH? HOW MANY CHARTS MUST BE REVIEWED BY A PRIMARY SUPERVISOR? HOW OFTEN MUST DOCUMENTED DISCUSSION TAKE PLACE BETWEEN THE PRIMARY SUPERVISOR AND PA?

Answer: Again, it depends.
Rule 27.1 requires two elements of supervision, in addition to having a documented supervisor available for consultation. One is regular, documented review of PA charts by the primary supervisor. The other is regular, documented discussion of cases, which must include cases chosen by the primary supervisor and may include cases chosen by the PA. How many charts must be reviewed and how often structured case discussions must occur depends on the situation, as described in detail in Rule 27.7:

If the question of adequacy of supervision is presented in a case before the Board, the Board will consider:

27.7.1.1 Whether the documented plan for supervision was followed;

27.7.1.2 The PA’s experience level in terms of time and quality;

27.7.1.3 The physician’s familiarity with the PA’s capabilities based upon the length of time the two have worked together and the degree to which the physician has had the opportunity to observe the PA’s performance;

27.7.1.4 The complexity, difficulty, and seriousness of the medical procedures that the PA is allowed to undertake pursuant to the Delegation Agreement;

27.7.1.5 The degree to which the supervisor or other physicians are readily available to immediately consult or take over care in the event of difficulty;

27.7.1.6 Any adverse information that the physician supervisor knows about or reasonably should know about regarding specific risks, such as a history of discipline of the PA or indications of impairments that may impact quality of care.

Obviously, there is quite a broad range for what is an appropriate level of supervision and the physician must exercise some professional judgment to create an effective plan.

We often get questions about how to express the plan for chart review, especially whether it should be in terms of a percentage or number of charts. The rule allows for either. Some may prefer using a number of charts as opposed to a percentage, as that will avoid having to keep track of how many encounters the PA has had in order to know how many chart reviews must be done. On the other hand, using a number instead of a percentage forces the supervisor to rely on an estimate of how many patients might be seen in a given period. Regardless, either is equally acceptable so long as it reflects an appropriate quantum of supervision based upon the factors quoted above.

Please remember you may always contact the board to speak with the Licensing Specialist, Tracy Hayes, to discuss your questions about supervision of physician assistants.

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