

The Role of Physician Assistants in Outpatient Mental Health Care

A Report to the Minnesota Legislature
pursuant to Laws of Minnesota 2012, Chapter 247, Article 1, Section 25

**CHILDREN'S MENTAL HEALTH DIVISION
ADULT MENTAL HEALTH DIVISION**

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Minnesota Department of **Human Services**

Legislative Report

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Executive Summary

The Department of Human Services and a majority of Mental Health Stakeholders find that:

1. Advanced specialty training in mental health care would qualify Physician assistants to deliver a limited set of mental health services to persons with mental illness in supervised multi-disciplinary practice settings.
2. Access to mental health care could improve with the advent of advanced-practice physician assistants serving as medication prescribers, under remote psychiatric supervision, thereby fulfilling a hard-to-fill role in a multi-disciplinary care team. The potential for better access lies particularly in under-served rural areas and urban minority communities.
3. Physician assistants who meet current licensure standards are under-qualified by lack of clinical training and supervised experience to serve Medical Assistance recipients with severe mental illnesses. The gap is stark in the clinical qualifications required of the six Mental Health Professional disciplines when compared to that required of Physicians Assistants. To allow MA coverage of treatmentservices delivered by generalist physician assistants wouldrisk the safety of severely mentally ill individuals and waste public resources on less than effective healthcare interventions.
4. The *Delegation Agreement* between a psychiatrist and a physician assistant does not guarantee competent treatment for persons with complex, severe mental illnesses, the stakeholder majority concluded. The agreement specifieswhat procedures a psychiatrist permits the PA to do, where procedures may be performed, and terms of supervision. But the judgment of the psychiatrist and psychiatrist's liability for any harm cannot substitute for specialized training and years of supervised practice.

Recommendations

The Department of Human Services and the stakeholder majority recommend that the Legislature:

1. Establish *Certified Psychiatric Physician Assistant* as a new category of advanced-level mental health specialty provider under Minnesota Health Care Programs, as defined in "Certification Requirementsfor Advanced-Practice Psychiatric PA" in Sections 1 through 10, below, and
2. Authorize DHS to convene representatives of Minnesota's physician assistant training programs to develop curricula for preparation of physician assistants to achieve psychiatric certification, and
3. Establish state certification under these advanced-level specialty standards as the minimum provider-eligibility requirement for Medical Assistance payment to Minnesota-licensed physician assistants providing mental health services to Minnesota Health Care Programs recipients in outpatient settings. Certification should be administered by the Minnesota Board of Medical Practice, or other appropriate licensing board, according to these recommended standards and other standards deemed appropriate by the board.

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Introduction: the Scope of this Report

This report regards payment policy for the publicly-financed Minnesota Health Care Programs, including Medical Assistance (MA) and MinnesotaCare. The report makes no recommendation with regard to physician assistants' scope of practice, nor does it comment on what procedures a physician assistant (PA) should be permitted to perform in Minnesota. These are distinct issues. This report discusses what the State should pay for; under what conditions the State should pay for a service; and for which publicly-insured consumers a service should be paid. Minnesota law and community standard practice permit PAs to perform mental health services that may be covered by some private/commercial insurers, but not others. Each insurer establishes its own payment policies and they vary. Additionally, the federal Medicaid partner of the State's MA program has its own payment policies; in this instance, federal Medicaid permits reimbursement for a wider range of mental health service provision by PAs; but it allows states to set more restrictive policies. This report makes recommendations for Minnesota Health Care Program payment policy for Physician assistants.

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Legislation and background

During the 2012 Legislative Session, the Minnesota Academy of Physician Assistants sought designation for its members as *mental health professionals* under Minnesota law with the specific purpose of gaining authority to receive Medical Assistance payment for mental health services.

Mental health stakeholders—including representatives of the six mental health professional disciplines, consumer advocates, mental health service providers, and the Department of Human Services mental health policy divisions—opposed the designation on the grounds that licensure standards in Minnesota do not provide physician assistants with the crucial specialty training and experience to safely and effectively provide mental health services to the disproportionately vulnerable and severely ill Medical Assistance population. The scope of clinical activities granted to a licensed mental health professional, stakeholders agreed, is well beyond the capability of a physician assistant, even though performing under the delegated authority of a supervising psychiatrist. The positive judgment of the delegating psychiatrist cannot transfer to the physician assistant the expertise to perform comprehensive diagnostic assessments, clinical supervision of other mental health professionals, psychotherapy, mental health rehabilitation, or treatment planning for persons with severe and complex conditions and multiple diagnoses such as are common among the Medical Assistance population.

At the behest of the extant chairman of the House Health and Human Services Committee, stakeholders agreed to a compromise in the form of two measures: The first permitted physician assistants under the supervision of a psychiatrist or neurologist to bill Medication Management and the Evaluation and Management Services provided to Medical Assistance recipients when being treated in an inpatient hospital only. Coverage for other mental health services was prohibited. The second measure would require mental health stakeholders to consider a potential role for physician assistants in a mental health outpatient context, as follows:

Minnesota Laws 2012, Chapter 247, Article 1:

Sec. 25. PHYSICIAN ASSISTANTS AND OUTPATIENT MENTAL HEALTH.

The commissioner of human services shall convene a group of interested stakeholders to assist the commissioner in developing recommendations on how to improve access to, and the quality of, outpatient mental health services for medical assistance enrollees through the use of physician assistants. The commissioner shall report these recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and financing by January 15, 2013.

The Department of Human Services (DHS) convened a broad base of the mental health stakeholder community in Fall 2012. (See names and represented organizations in Appendix B.) In addition to invited representatives, other interested parties attended the meetings, all of which were open to the public. All sessions were well attended and participants were representative of the key sectors of the mental health stakeholder community. Skilled spokespersons for the physician assistant community participated actively in all sessions.

DHS facilitated all sessions and outlined a basic discussion proposal, which was designed to satisfy intent of the law. Ensuing sessions engaged participants in defining the various stakeholder interests and in developing the findings and recommendations that follow in this report. It is the view of DHS staff facilitating the discussions that all pertinent interests were clearly and successfully articulated.

Findings and recommendations represent the positions of DHS and the majority of participating mental health stakeholders. The representatives of the physician assistant community influenced the development of the specialty training model recommended in this report and DHS believes that physician assistant participants are in general agreement with the recommended model insofar as they see a need for specialty training. DHS acknowledges, however, that physician assistant representatives do not concur with the majority's asserted need for specialization and do not support the key recommendation. On the other side, DHS notes that a majority of advocacy and provider community representatives oppose any role for generalist physician assistants as mental health service providers; they point out that mental health is a healthcare specialty area where each professional makes a years-long commitment to developing his or her clinical competency.

Purpose of the Recommendations

The mandate given to DHS is to determine an appropriate and beneficial role for physician assistants in outpatient mental health service delivery. Compliance with the law does not permit DHS to dismiss PAs as mental health providers. Nor does the law allow DHS to permit activities that threaten recipients' safety or to pay for ineffective services by under-qualified providers. The purpose given to DHS and mental health stakeholders is to determine mental health service activities that can be performed by physician assistants; define the qualifications necessary to perform those services; and, finally, to identify a physician assistant role that will improve access to care and improve the quality of that care—all to the benefit and protection of Minnesotans whose health care is insured by the public healthcare system.

Findings

The Minnesota Department of Human Services expresses its gratitude to the mental health stakeholder community for its assistance in reaching these conclusions:

1. Advanced specialty training in mental health care would qualify Physician assistants to deliver a limited set of services to persons with mental illness in supervised multi-disciplinary practice settings.
2. Access to mental health care would improve with the advent of advanced-practice physician assistants serving as medication prescribers, under remote psychiatric supervision, thereby fulfilling a hard-to-fill role in a multi-disciplinary care team. The potential for better access lies particularly in under-served rural areas and urban minority communities.
3. Physician assistants, under current licensure requirements, are under-qualified by lack of clinical training and supervised experience to serve Minnesota's severely mentally-ill Medical Assistance population. Allowing coverage of mental health services delivered to vulnerable Medical Assistance populations when provided by generalist physician assistants without advanced specialty mental health training would risk the safety of severely mentally ill children and adults and waste public resources on ineffective healthcare interventions. For the care of persons with complex and severe mental illnesses, the *delegation agreement*, under which the physician assistant derives authority and direction to deliver care from a supervising psychiatrist, depends too much on the judgment of an individual, often over-worked, psychiatrist, and his concern over liability.
4. Specialty training runs counter to tradition among physician assistants (PAs), who view themselves and their field as *generalists*, capable of assisting a physician in any field of medicine if so judged by the individual supervising physician. Resistance to specialization is not a disregard for the advantages of advanced mental health expertise (which some PAs have attained) but, rather, to the imposition of a mandate for advanced training and a delay in their authority to bill the State for serving MA patients.
5. Licensed mental health professionals and consumer advocates counter that mental illness is a complex health care specialty that demands advanced clinical training and long experience practicing under the scrutiny of qualified clinical supervisor. The adults and children, covered by the state's public healthcare programs, tend to be the sickest of Minnesotans with a mental illness and those with the most complex conditions and intensive service needs.
6. Current mental health specialty training and experience requirements for physician assistant licensure are minimal compared to the years of training and experience of the state's top-level *Mental Health Professionals*. Policymakers have considered the minimum competency appropriate for serving the MA population and published Common Licensing Standards in 2007 as a baseline standard of clinical competency. PA licensure requirements do not reach this baseline standard. Moreover, PA requirements are well below the specialty training and experience requirements for the "second-tier" mental health workforce—*Mental Health Practitioners*.

Recommendations

The Department of Human Services and the stakeholder majority recommend to the Minnesota Legislature that it:

4. Establish *Certified Psychiatric Physician Assistant* as a new category of advanced-level mental health specialty provider under Minnesota Health Care Programs, as defined in “Certification Requirements for Advanced-Practice Psychiatric PA” in Sections 1 through 10, below, and
5. Authorize DHS to convene representatives of Minnesota’s physician assistant training programs to develop curricula for preparation of physician assistants to achieve psychiatric certification, and
6. Establish state certification under these advanced-level specialty standards as the minimum provider-eligibility requirement for Medical Assistance payment to Minnesota-licensed physician assistants providing mental health services to Minnesota Health Care Programs recipients in outpatient settings. Certification should be administered by the Minnesota Board of Medical Practice, or other appropriate licensing board, according to these recommended standards and other standards deemed appropriate by the board.

Comparing the professions

Concern about physician assistants practicing in the mental health arena is focused on comparative depth of training; roughly speaking, the number of hours, weeks, and years in the classrooms and in the clinics. No concern was expressed in the stakeholder meetings about the quality of instruction.

Comparisons are stark. Classroom preparation in mental health/psychiatry education compares at a semester credit ratio of roughly 1:12 for the generalist PA-C versus a master’s prepared, non-prescribing mental health professional, such as a Licensed Independent Clinical Social Worker (LICSW). The contrast is even greater for time spent in supervised clinical practice, with a ratio of 1:16; and this comparison only includes the mental health professionals post-graduate clinical work—not the in-school practicum requirements.

The typical mental health concentration for a generalist PA program requires a 2 semester-credit (classroom) course in mental health/psychiatry plus a 4 or 6 week clinical rotation. A clinical rotation involves readings, exams, patient contact, and performance evaluation.

By contrast, the master’s-trained mental health professional will complete 24 semester credits in the classroom on clinical mental health topics, followed by equal or greater number of hours of clinical practicum. (The practicum is a required part of the course and comprises supervised hands-on clinical work.) Following graduation, but before licensure, the clinical trainee completes 4,000 hours (two years) of supervised clinical work. The master’s-level professions in Minnesota are: clinical social work; marriage and family therapy; and clinical professional counseling.

Advanced practice psychiatric nursing programs tend to be master’s programs and are comparable to the above in the requirements. [Note, however, that Advanced-Practice Registered Nursing

(APRN) programs already are moving toward more-advanced specialization with introduction of doctoral-degree requirements. It won't be long before the typical "Psych nurse" will be a Ph.D.]Clinical psychology in Minnesota already requires a doctoral degree; while psychiatry is a medical specialty, requiring, first, the completion of generalist medical school and then an internship and residency in the psychiatry specialty.

In lieu of training and supervised experience, physician assistants point to the *Delegation Agreement* as their guarantor of performance. To assure a physician assistant's competency in the chosen area of practice, much reliance is placed on the *Physician—Physician Assistant Delegation Agreement*, a four-page form that identifies very specifically what a psychiatrist is permitting the PA to do, where the practice may be performed, and the terms of supervision. The professional judgment of the psychiatrist, knowledge of the PA, along with psychiatrist's knowledge that her/his license is at risk for any harm caused by the PA, are frequently touted by PAs in the stakeholder group as the guarantee of safe and effective work. The other Stakeholders, however, were unconvinced. "With all due respect to the psychiatrists in the room..." their comments would begin. A psychiatrist's judgment is not infallible. There is no guarantee that every psychiatrist is imbued with good character. There is no promise that an overworked physician will not be distracted from his supervisory duty. In the end, there should be qualification requirements for all mental health professions, according to the advocates, providers, and clinicians. Said one: "A physician's comfort level is not a practice standard."

Enactment of these recommendations will be the beginning of a practice standard for physician assistants in the care and treatment of persons with mental illness. PAs told Stakeholders that they do not wish to be mental health professionals. They do not want to be independent practitioners, as they value their relationships with their physicians as members of a team. They do not desire to provide all the services performed by a mental health professional; nor to supervise other clinicians; nor to engage in the complexities of a mental health diagnostic assessment (as defined in Rules, Part 9505.0372, subpart 1). What physician assistants said they desire is the opportunity to work in a wider variety of teams, in new outpatient settings, and to serve MA clients.

In one final comparison, DHS and mental health stakeholders, recommend a physician assistant credential that is suitable to the practice the PAs intend. For the services they want to deliver; for the settings in which they want to work; and for the supervision and team practices they wish to expand, Stakeholders determined that physician assistants' mental health-specific education and pre-licensure clinical experience should be one-half that of the master's-trained mental health professional. See below.

Purpose of certification requirements

The purpose of these Certification Requirements is to establish a state credential suitable for physician assistant outpatient mental health practice that will:

- Improve the quality of mental health care,
- Improve access to qualified mental health care, and
- Protect the safety of the public and, in particular, adults and children with mental illnesses

The new credential is for application to services covered by Minnesota Health Care Programs (MHCP) and other payers as may choose to institute it.

CERTIFICATION REQUIREMENTS FOR ADVANCED-PRACTICE PSYCHIATRIC PA

The specialty standards recommended here are based on a national model arising from the physician assistant field, the *Psychiatry Certificate of Advanced Qualifications, or Psychiatry CAQ*. Published by the National Commission on the Certification of Physician Assistants (NCCA) in 2012, it is one of several CAQ's aimed toward developing physician assistants' advanced competence in a variety of medical specialty fields. CAQ's, as a means for physician assistants (PAs) to demonstrate qualifications in a specialty field, have not been universally adopted and remain controversial among PAs who support the generalist tradition in the field.

Due to the lack of universal acceptance among PAs, Stakeholders chose not to recommend adoption of the CAQ by name; nor in its entirety. However, all Stakeholders participating in the group's first meeting agreed to use the Psychiatry CAQ as the basis for future discussion. This early decision had the further effect of granting Stakeholders leeway to consider variations that would better fit the Minnesota's unique context of professional standards, consumer expectations, and regulatory environment. Perhaps the single most significant deviation from the CAQ is the Stakeholders' recommendation to build clinical knowledge on a foundation of enrolled graduate-program coursework—as occurs in all of Minnesota's mental health professional fields—and to rely less on the CAQ's exclusive use of continuing education events.

This was one of several discussion topics that focused on contrasts between how physician assistants are trained and how the six mental health professional disciplines are trained. Another such topic engendered around DHS staff's commitment to acknowledge distinct training and supervised-experience traditions between the medical disciplines of psychiatry and advanced practice psychiatric nursing—the tradition of which PAs are a part—and the non-prescribing disciplines of clinical psychology, clinical social work, marriage and family therapy, and professional counseling. In the end, while recognizing that approaches to clinical competence development do, indeed, differ between the medical disciplines and the non-prescribing disciplines, their common commitment to in-depth focus on specialized clinical expertise stands out against the relatively minimal clinical mental health preparation gained from even the most advanced physician assistant training programs. (See Appendix A for a more detailed comparison.)

1. Certification by population

A physician assistant is certified for advanced psychiatric practice with an age-defined population focus. The PA chooses to focus on either the:

- Child/Adolescent population (under age 26) or
- Adult population (age 18 and over)

The PAs education, supervised practice, and certification must be congruent with regard to population focus.

The age overlap (18 to 26) is intended to encourage PAs serving individuals on either end of the crucial transitional age range to develop expertise in the common problems of the transition age group and expertise in guiding individuals from the child system into the adult system.

2. Prerequisites for certification

- a. Current Certified Physician Assistant (PA-C) status¹ and
- b. Possession of a valid, unrestricted license to practice as a physician assistant in Minnesota.

3. Certification Process

A candidate for advanced practice psychiatric physician assistant certification may satisfy certification requirements in one of the following ways, in addition to complying with such additional requirements as may be established by the state licensing board:

- a. Complete the Education and Supervised Practice requirements defined below;
- b. Complete an accredited 12-month inpatient or outpatient psychiatric fellowship in the PAs focus population; or
- c. Complete six prior years of outpatient or inpatient psychiatric practice within the previous 10 years, as certified to the state licensing board.

4. Education Requirements

Education requirements for psychiatric physician assistant certification must be successfully completed, as defined in this section, prior to certification.

Minimum education in psychiatry specialty practice, including coursework and corresponding clinical experience, must be completed as follows:

- a. 12 semester credits of accredited Master's-level coursework (didactics) and corresponding clinical practicum in specified *Psychiatry practice knowledge areas* (see below);
- b. Up to 25% of the total education requirement may be completed by Category I Continuing Medical Education² credits focused on psychiatry practice in specified psychiatry practice knowledge areas in the PAs population focus, as attested by a supervising psychiatrist who (i) practices in the area of the PAs population focus and (ii) is familiar with the PAs practice and experience;
- c. Category I Continuing Medical Education credits are substituted for Master's-level Semester credits at the rate of 1 semester credit = 15 CME credits, up to a maximum of 45 CME credits, in accordance with (b). Only CME credits that require a passing score on a posttest may be counted toward the education requirement;
- d. Qualifying psychiatry coursework credits may be completed as part of a master's-level physician assistant certification (PA-C) program or as part of a post-graduate residency or psychiatric specialty program.

Psychiatry practice knowledge areas must include the following:

- a. 50 percent of credits in ***psychiatric service delivery and patient care*** specific to the PAs population focus in these topics:
 - Psychiatric interview and assessment—age-specific for population focus

Differential diagnosis using DSM, current version—age-specific for population focus
Psychopharmacology and prescriptive decision-making—age specific for population focus
Monitoring psychopharmacology and interpreting results
Management of psychiatric disorders—age-specific for population focus
Treatment planning with measurable goals
Evidence-based interventions (non-pharmacological)—age-specific for population focus
Care coordination across service systems: primary care, school, employer, social services, corrections, acute care, and emergency departments, Veterans Administration
Family role in treatment—age-specific for population focus
Psychotherapy—common therapies; when to refer

b. 50 percent of credits in ***psychiatric disorders*** as applicable to the PAs population focus:

Psychopathology—age-specific for population focus
Anxiety disorders
Mood/Affective disorders
Attention deficit disorders
Psychotic disorders
Personality disorders
Dissociative disorders
Adjustment disorders
Impulse control and addiction disorders
Adverse childhood effects of trauma—age-specific for population focus
Co-occurring substance use and mental illness
Autism Spectrum Disorders
Eating disorders

c. **Elective psychiatric topics** as appropriate to PAs practice setting and population focus:

Normative development
Crisis recognition, intervention, and stabilization—age-specific for population focus
Advanced topics in major categories of psychiatric disorders, per PAs intended practice
Trauma-Informed Care—age-specific for population focus
Abuse and Violence / Acute and delayed reaction to stress
Substance use disorders
Sexual and gender disorders
Dementia
Childhood disorders that persist into adolescence and adulthood
Sleep disorders
Somatoform disorders

5. Supervised Clinical Practice Requirements

2,000 hours of post-master's degree supervised clinical psychiatry practice working as a PA in the PAs population focus. Supervised practice:

- a. Must be completed within six years prior to the PAs attestation that the experience requirement has been satisfied.
- b. Must be attested to by a psychiatrist who is familiar with the PAs practice and experience of the performance of patient management relevant to the practice setting and/or understands how and when the appropriate techniques and methods should be applied.

Clinical supervision:

- a. Must be based on a written delegation agreement or supervision plan;
- b. Must be provided at the rate of two hours of supervision for every 40 hours of patient contact; and
- c. Must promote the PAs knowledge, skills, and values development.

6. Continuing Education Requirements

To maintain certification as a psychiatric physician assistant, continuing medical education (CME) requirements must be completed as follows:

100 credits of Category I CMEs in psychiatry must be earned and logged during a two-year cycle (or pro-rated according to an alternative cycle, as determined by the Board of Medical Practice). 60% of CME credits must be earned in the *psychiatry practice knowledge areas* defined in Section 4.

7. Eligible settings

Minnesota Health Care Programs covers certified psychiatric physician assistant services, as defined in Section 8, when delivered in a setting where:

- a. the physician assistant is under the direct supervision of a psychiatrist with whom the PA has a delegation agreement; and
- b. a defined multidisciplinary team peer review process is utilized for quality assurance; or
- c. a primary care clinic has an established protocol to utilize the State's Psychiatric Consultation Service in the administration of psychotropic medications.

Discussion. Supervision of a physician assistant, as defined in state law, permits a supervising physician to be immediately available by telephone or other telecommunication device.³ Thus a certified psychiatric physician assistant could serve the role of prescriber for a multidisciplinary team in a community that lacks a resident psychiatrist; wherein supervision is provided by a remotely-located psychiatrist.

Immediate, off-site supervision be permitted where the supervising psychiatrist has the capability to virtually and securely view the patient's electronic medical record in consultation with the physician assistant.

8. Services eligible for Certified Psychiatric Physician Assistant delivery

The following mental health services are covered by Minnesota Health Care Programs when provided by a Certified Psychiatric Physician Assistant (CPPA), but not when provided by a physician assistant licensed under Minnesota Statutes, Section 147A.02; or a Physician Assistant-Certified (PA-C):

1. Evaluation and Management for established patients⁴, provided under direct supervision of a psychiatrist, except when the outpatient visit requires a *comprehensive examination*⁵, *medical decision making of high complexity*⁶, or the patient's presenting problems are of *moderate-to-high severity*⁷.
2. Prescribing of psychotropic medications for established patients, provided under direct supervision of a psychiatrist, except when the prescribing requires a *comprehensive examination*, *medical decision making of high complexity*, or the patient's presenting problems are of *moderate-to-high severity*.
3. Management of psychotropic medications for established patients, under direct supervision of a psychiatrist, except when the medication management requires a *comprehensive examination*, *medical decision making of high complexity*, or the patient's presenting problems are of *moderate-to-high severity*.
4. Outpatient Consultations for established patients requested or referred by a physician, school-linked mental health professional or practitioner, a child's Individual Education Program (IEP) team, or other appropriate professional.
5. Emergency psychiatric services, under direct supervision of a psychiatrist.
6. Mobile crisis intervention services, when the CPPA is additionally-qualified by having completed required mental health crisis training and when accompanied by a licensed mental health professional.

Discussion. In the first three of the six eligible service categories, DHS and Stakeholders are prohibiting a physician assistant from delivering the service to patients with the most complex conditions and most severe diagnoses; this is due to the conviction among the stakeholder majority that a PA, even a CPPA, is not prepared for the most difficult patients.

Criteria with which to delineate the most-difficult patients from less-difficult patients can be unclear. DHS proposed descriptors from the Physicians' Current Procedural Terminology (CPT) Manual that are used to distinguish between levels of procedure and billing codes; wherein a low level procedure is billed as a lower-value code; a high level procedure is billed as a higher-value code. (CPT codes are arranged by categories and subcategories of medical procedure. For a particular category, codes are arranged in tiers or levels of intensity or skill-level required or time required to perform.) Physicians are familiar with CPT codes. These Eligible Services recommendations use terms such as "medical decision making of **high** complexity," which physicians will recognize as distinct from decision making of "moderate" complexity or the lowest tier, "straightforward medical decision making". Additionally the report uses the term "presenting problem of moderate-to-high severity," which physicians and physician assistants will recognize as a more severe mental illness than a patient with a presenting problem of "low-to-moderate" severity or "presenting problems that are self-limited or minor".

The prohibited-level term “comprehensive examination” is used where a medical practitioner should recognize its distinction from “a detailed examination” or the lowest tier “problem-focused examination”.

Physician assistants agreed that it was appropriate to limit their decision-making to less severe and less complex conditions and lower risk patients. The challenge, all Stakeholders agreed, was how to make the distinction before an appointment is set or the patient enters the room. What is to be done if a PA begins a session with a patient whose condition was thought to be stable and controlled with medication; only to find that the patient has stopped taking his meds and has just stepped over the edge of decompensation? Here is the risk of a mental health practice utilizing a clinician not prepared to respond to a full range of presenting conditions. The present solution? Make use of the “immediately-available” supervisor.

In practice, these distinctions may be difficult to make. In day-to-day practice, decisions about which level of CPT code to use are often based on additive distinctions; that is, how many diagnoses does a patient have? Or how long did it take to complete the procedure? The more diagnoses or the more minutes required, the higher the code billed, according psychiatrists participating in stakeholder discussion.

Despite the potential for impracticable delineators, Stakeholders said an attempt should be made to set the most complex or severely ill patients off-limits to PAs. The prohibition applied to the six eligible service, they concluded, should be against only the most severe and complex conditions and the highest risk patients.

Dilemma of the “established patient” limitation. Limiting psychiatric physician assistants’ contact only to established patients inherently forces a break in the continuity of the therapeutic relationship opened by the initial clinician, at the point that the patient is “handed off” to a PA. While acknowledged as a legitimate concern, Stakeholders said the harm of broken continuity must be weighed against the potential impact of the PA’s lesser clinical qualifications. Several participants favored the “established patient” limitation out of a conviction that PAs—even a CPPA with the recommended specialty training and supervised experience—would lack the clinical expertise to conduct the crucial first assessment, as errors or misjudgments here could endanger the patient or others and set in motion an ineffective course of treatment. (This “waste of time” is especially detrimental for a young child whose developmental clock is ticking.) PA representatives defended their abilities to know when they encounter a condition beyond their level of expertise or outside their scope of practice and, then, to make a referral to an appropriate clinician. Advocates were unconvinced that PAs could know what they don’t know. The final resolution, though satisfactory to no one, was that the risk of an inadequate assessment and the time squandered with ineffective treatment is a greater danger to patients than breaking therapeutic continuity.

9. Non-covered services

Notwithstanding any physician-physician assistant delegation agreement, diagnostic order, or therapeutic order to the contrary, the following mental health services are not covered by Minnesota Health Care Programs when provided by a physician assistant licensed under Minnesota Statutes, Section 147A.02, or a Physician Assistant-Certified (PA-C) or a Certified Psychiatric Physician Assistant (CPPA):

1. Mental Health Diagnostic Assessments, defined in Minnesota Rules, Part 9505.0372, Subpart 1.
Only a Diagnostic Assessment performed by a licensed mental health professional, as defined in Rules, Part 9505.0371, Subpart 5, Item A, or performed by a clinical trainee, as defined in Rules, Part 9505.0371, Subpart 5, Item C, establishes medical necessity for provision of mental health clinical, rehabilitative, or crisis intervention services, including outpatient mental health services except as permitted in Section 8.
2. Psychotherapy
3. Psychosocial Skills Training
4. Mental health rehabilitation services, except as a member of a multi-disciplinary adult or youth Assertive Community Treatment team and under the direct supervision of a psychiatrist or advanced practice mental health/psychiatric nurse.
5. Mental Health Crisis Intervention Services, unless accompanied by a licensed Mental Health Professional.
6. Evaluation and Management of a new psychiatric patient.
7. Evaluation and Management of an established psychiatric patient when the outpatient visit requires (a) a *comprehensive examination*, (b) *medical decision making of high complexity*, or (c) the patient's presenting problems are of *moderate-to-high severity*.
8. Psychiatric outpatient or office consultation of a new or established patient when the consultation requires (a) a *comprehensive examination*, (b) *medical decision making of high complexity*, or (c) the patient's presenting problems are of *moderate-to-high severity*.

Develop psychiatric specialty Physician Assistant training

Where will physician assistants obtain the specialized training in Psychiatry that would be necessary under this proposal? DHS proposes to convene physician assistant educators from Minnesota's professional training programs to develop curricula designed to meet the requirements of this proposal. Development is expected to require approximately one year.

Minnesota has a history of demanding a high-quality mental health workforce. The Legislature and the Governor have long upheld quality mental health, even as other states have welcomed less educated and less experienced clinicians. From 1992⁸ when the mental health workforce began to expand to new professional disciplines, the state's mental health professional educators have responded to quality demands with new curricula—new training programs, new instructors, and new ideas.

DHS anticipates the same positive response from the educational institutions that train physician assistants. Already, physician assistant education is on a strong growth curve—with the number of Minnesota training programs to double by 2016. Moreover, all programs under development offer,

or plan to offer, Master's-level education with clinical practicum requirements. With the new market demand resulting from certification requirements, DHS expects that the professional training programs will be able to develop the capacity necessary for the Certified Psychiatric Physician Assistant.

Minnesota's Physician Assistant training programs

Following is a brief summary of Minnesota's physician assistant education programs—those currently accredited and training PAs, as well as those that have applied for accreditation for new programs. The summary shows the psychiatry-specific requirements in these PA-C generalist programs and thus indicates the depth of psychiatric training expected of graduates.

Accrediting agency. All Minnesota PA programs have been accredited by, or have applied for accreditation from, the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA)

Augsburg College, Master of Science in Physician Assistant Studies, began 1995

Six week rotation in Psychiatry Clinical Practicum; 1/6 of an "Integrative Health Care" course = MH
Overall program: 31 month master's: 18 mo. didactic (classroom); 13 mo. clinical phase. <http://www.augsburg.edu/pa/details/>

Mayo School of Health Sciences, Master of Science in Physician Assistant Studies, began 2004

In conjunction with the University of Wisconsin-La Crosse. Didactics at UW, LaCrosse, w. clinical experience in Mayo facilities in Southern Minnesota, Southwest Wisconsin, and Northeast Iowa

Four week rotation in Psychiatry

Overall program: a 12-month preclinical phase (classroom and laboratory); 12-month clinical phase incl. 44 weeks of in clinical rotations (35--40 hrs. of practice experience/wk.)
http://www.uwlax.edu/pastudies/Program_Info.htm

St. Catherine University, Master of Physician Assistant Studies, first enrolled Sept. 2012

2 semester credits in Mental Health required + 10 credit clinical "clerkship" (over one semester)
Overall program: 110 credits and over 2,000 clinical hours.

The program provides 14 months of [classroom-based learning](#) followed by 14 months of [clinical education](#), concluding with a senior seminar.

Bethel University, Master of Science in Physician Assistant Studies, to begin summer 2013

4 credit hours in a Mental/Behavioral Health rotation

1 credit hour in Behavioral Medicine coursework

Overall program: Didactics 80 credit hours; Clinical Rotations 69 credit hours
http://www.bethelu.edu/admission/graduate_admission/mspas/about_the_program

College of St. Scholastica, Physician Assistant Master's Program— pending accreditation, 2016
Requirements in mental health/psychiatry not yet determined

Overall program: 28 months, half didactic (course work), half clinical rotation
<http://www.css.edu/Academics/Health-Sciences/Graduate-Areas-of-Study/Physician-Assistant.html>

¹ A PA-C must earn and log a minimum of 100 credits of CME during every two-year period. By the end of the sixth year of the certification maintenance cycle, PA-C designees must have also passed a recertification exam. See: <http://www.nccpa.net/CertificationProcess.aspx> and <http://www.aapa.org/cme/requirements.aspx>

² A **Category I** CME must be classified by AAPA as Category I (Preapproved) CME by one of the following sponsors: AAPA, AMA (providers accredited by ACCME), AOA or AAFP. Some ways Category I CME credits can be earned include seminars, conferences and online. The CME program provider will issue you a certificate or letter of completion, indicating the number of CME credits you've earned during each program. Upon fulfillment of CME requirements, candidates attest to their completion, which is subject to audit. **Category II CME** is any medically related activity that enhances the role of a PA (including journal reading). Category II credits are earned on an hour-by-hour basis. There is no minimum requirement for Category II activities. The CME provider is the organization that offered the seminar, conducted the training, etc. Usually, providers are associations, hospitals, schools, pharmaceutical companies, or other health care organizations. The NCCPA does not audit Category II CME. (1 CME credit = 1 contact hour)

³ Minnesota Statutes, Section 147A.01, Subdivision 24, states in part: "The constant physical presence of the supervising physician is not required so long as the supervising physician and physician assistant are or can be in contact with one another by radio, telephone, or other telecommunication device."

⁴ The term **established patient**, as used in the *Physicians' Current Procedural Terminology* (CPT) manual, is presumed to mean a patient with whom a clinic or hospital has a prior patient relationship. As used in these recommendations, it additionally means that another clinician has initiated a prior diagnostic or therapeutic interaction and, when "handed off" to the PA, **the patient is one for whom the severity and complexity of the condition has been established.**

⁵ The term *comprehensive examination* is used in the *Physicians' Current Procedural Terminology* (CPT) manual to indicate the level of examination requiring the highest level of qualifications and the greatest amount of time to perform, in a taxonomy with five tiers of complexity.

⁶ The term *medical decision making of moderate-to-high complexity* is used in the CPT Manual to indicate the level of medical decision making requiring the highest level of qualifications and the greatest amount of time to perform, in a taxonomy with five tiers of complexity.

⁷ The term *presenting problem of high severity* is used in the CPT Manual to indicate the level of medical condition in which the potential risk to the patient is greatest and which requires the highest qualifications to treat, in a taxonomy with five tiers of complexity.

⁸ The 1992 Legislature enacted Licensed Marriage and Family Therapists (LMFT) as mental health professionals in the Adult Mental Health Act. Laws of Minnesota 1992, Chapter 526, section 1.

Appendix A

Comparing Standards for Mental Health Professional Practice in Minnesota

This table compares levels of specialty training and supervised clinical practice of two existing mental health professional groupings (master’s-level non-prescribing mental health professions, on the left, and master’s-level APRNs, which include Clinical Nurse Specialists and Nurse Practitioners with specialties in mental health, on the right, to nationally proposed but not-yet-adopted standards for a Physician Assistant specialty in Psychiatry. The Psychiatry CAQ, in the center column, serves as basis for this report’s recommendations. It should be noted that, while the CAQ has met resistance from the generalist tradition among physician assistants, nursing has moved to require doctoral-level training for the APRN designation. This move to even greater advanced specialization coincides with a bill before the Minnesota Legislature to remove the physician-supervision requirement and allow APRNs to practice independently. Such APRN independence would be a boon to mental health care access in areas of the state that lack psychiatrists. The ability of an Advanced-Practice Psychiatric Nurse to practice in any area of the state, without the need to maintain supervisory proximity to a psychiatrist would compete, it must be assumed, against the ability of a Certified Psychiatric Physician Assistant to serve the prescriber role on multidisciplinary mental health service teams in underserved rural areas and minority communities.

[as of December 2012]

<i>Common Licensing Standards for Master’s-level Mental Health Professionals in Minnesota⁹</i>	<i>Physician Assistants Psychiatry Certificate of Added Qualifications (CAQ)¹⁰</i>	<i>Advanced Practice Registered Nurses (APRNs)</i>
Prerequisites		
Master’s or Doctoral degree in one of the recognized mental health professional disciplines.	Current Certified Physician assistant (PA-C) certification. ¹¹	Bachelor’s: Registered Nurse w. national exam. Master’s in Specialty ¹² area w. national exam. APRNs may specialize but cannot be licensed solely within a specialty area.
Unrestricted license. (From licensing requirements, not Common Standards document.)	Possession of a valid, unrestricted license to practice as a PA in at least one jurisdiction or privilege to practice for a government agency.	Unrestricted license.
Supervised Clinical Practice Requirements		
4,000 hours	2,000 hours	500-540 hours
Defined as: supervised post-graduate professional clinical practice in the diagnosis and treatment of child and adult psychosocial function and mental, emotional, and behavioral illnesses and disorders	Defined as: supervised experience working as a PA in the psychiatry specialty. Must be completed within six years prior to the PA attestation that the experience requirement has been satisfied.	Defined as: supervised experience working with the specific population and in the chosen role; completed as part of certification training program
Including: Documentation in the applicant’s supervision record of: 1,800 hours of direct clinical client contact 200 post-degree hours direct clinical supervision, with: • a minimum 50% one-on-one supervision, of which at least half must be in-person supervision and up to half may be via eye-to-eye electronic media; • up to 50% group: eye-to-eye electronic media; group in-person; or telephone. (Max. group 6 supervisees)	Including: Attestation by a psychiatrist familiar with the PAs practice and experience of: • the performance of patient management relevant to the practice setting and/or understands how and when the appropriate techniques and methods should be applied. • Must be logged and are subject to audit by NCCPA. • Areas of supervised experience/knowledge are shown, below, under “Patient care” and “Disorders”.	Including each of these areas: • bio-psychopathology assessment • diagnosing • treatment • evaluation • referral Ongoing contractual agreement for <i>Collaborative Management</i> also is required.

Education Requirements

360 clock hours or 24 semester credit hours	150 credits of Category I Continuing Medical Education ¹³ (1 credit = 1 contact hour) ¹⁴	53-55 semester credits / 825 hours (1 credit = 15 hours) Master's program
Defined as: minimum education credits as part of a Master's or Doctoral degree, in specified clinical knowledge areas .	Defined as: CME's focused on psychiatry practice, as attested by a supervising psychiatrist who is familiar with the PAs practice and experience.	Defined as: Master's level coursework (didactic preparation) specific to the chosen population and role.
<p>Of these education requirements:</p> <ul style="list-style-type: none"> 30% Diagnostic assessment for child and/or adult mental disorders; normative development; psychopathology, incl. developmental psychopathology; 10% Clinical treatment planning, with measurable goals; 30% Clinical intervention methods informed by research evidence and community standards of practice; 10% Evaluation methodologies (intervention effectiveness) 20% Professional values / ethics, including cultural context and diversity. <p>May be satisfied by a combination of these methods:</p> <ul style="list-style-type: none"> • accredited Masters-level coursework • post-graduate coursework • continuing education units (with a post test and a program description with goals and objectives available for public review) may be used for up to 90 hours or 25% of total education in clinical knowledge areas 	<p>Knowledge/Experience requirements:</p> <p>The <i>Patient Case Requirement</i> means being involved in patient cases that are core to psychiatry practice, including patient care and disorders, as appropriate to the applicant's practice setting and area of focus:</p> <p>Psychiatric patient care:</p> <ul style="list-style-type: none"> Psychiatric interview, differential diagnosis, and treatment plan Psychiatric pharmacology Treatment implementation/intervention Crisis intervention/risk management Ethical & legal issues <p>Psychiatric disorders as appropriate given the applicant's practice setting and area of focus:</p> <ul style="list-style-type: none"> Mood disorders Psychotic disorders Substance-related disorders Anxiety disorders Personality disorders Delirium, dementia, and cognitive disorders Life cycle and adjustment disorders Childhood disorders that persist into adolescence and adulthood Somatoform and factitious disorders Eating disorders Sexual and gender identity disorders Dissociative disorders Impulse control disorders not elsewhere classified Sleep disorders Ethics and forensic issues 	<p>For prescriptive authority:</p> <ul style="list-style-type: none"> • 30 hours of coursework in the prescribing of psychotropic medications and medications to treat their side effects • written <i>Prescribing Agreement</i> with a collaborating physician that defines delegated responsibilities regarding prescribing drugs and therapeutic devices. <p>http://www.graduatenuisingedu.org/minnesota/#license</p> <p>Including coursework in:</p> <ul style="list-style-type: none"> • Health assessment • Psychotropic classifications • Psycho-pharmacology • Indications • Dosages • Contraindications • Side effects • Evidence of application <p>http://www.graduatenuisingedu.org/minnesota/#license</p>
Continuing Education Requirements		
40 hours 60% of these in <i>clinical knowledge areas</i> , as identified under Education Requirements	125 credits of Category I CME (1 credit = 1 contact hour = 50 minutes)	75 contact hours in Category I CE including 25 contact hours in pharmacology Other professional development activities chosen from these options: academic credits, presentations, publication/research, preceptor hours, professional services
Defined as: Minimum requirements for each licensure renewal period or continuing education reporting period	Defined as: Earned and logged during the ten-year CAQ cycle.	Certification renews every five years

Of which: a minimum of 60% must be in the clinical knowledge areas defined, under <i>Education Requirements</i>	Of which: all must be in the psychiatry specialty.	
	In addition: Before the expiration of the current CAQ, the PA again must take and pass the Psychiatry Specialty Exam.	
Other practice requirements		
		Must practice within a health care system that provides for consultation, collaborative management, and referral as indicated by the health status of the patient. <i>Collaborative Management</i> is a mutually-agreed upon plan between an APRN and one or more physicians that designates the scope of collaboration necessary to manage the care of patients.

⁹ Common licensing standards were recommended to the Legislature in January 2007 and were voluntarily adopted by the licensing boards of the master's-trained, non-prescribing mental health professional disciplines of Licensed Independent Clinical Social Workers (LICSW); Licensed Marriage and Family Therapists (LMFT); Licensed Professional Clinical Counselors (LPPC). Advanced Practice Psychiatric Nurses complete Master's or Doctoral-level training but, like other medical professions, their training and supervised experience approach differs sufficiently that their licensure requirements and training programs could not reasonably be adopted to the scheme of the Common Licensing Standards; it was clear, however, that APRNs' training and supervised experience were comparable. Licensed Psychologists (LP) are doctoral-prepared. Psychiatrists are specialist medical doctors (MD).

¹⁰ Certification standards are published by the National Commission on Certification of Physician Assistants (NCCA). See a full description of the **Psychiatry Certificate of Added Qualifications** requirements at <http://www.nccpa.net/Psychiatry.aspx>

¹¹ A PA-C must earn and log a minimum of 100 credits of CME during every two-year period. By the end of the sixth year of the certification maintenance cycle, PA-C designees must have also passed a recertification exam. See: <http://www.nccpa.net/CertificationProcess.aspx> and <http://www.aapa.org/cme/requirements.aspx>

¹² In Nursing, one first chooses between (a) Clinical Nurse Specialist (b) Nurse Practitioner. Under **Psychiatric/Mental Health Clinical Nurse Specialist**, chose *Child/Adolescent; Adult; or Geriatric* specialty. Under **Psychiatric/Mental Health Nurse Practitioner**, choose *Adult* specialty or *Family* specialty ("Family" includes children).

¹³ A **Category I CME** must be classified by AAPA as Category I (Preapproved) CME by one of the following sponsors: AAPA, AMA (providers accredited by ACCME), AOA or AAFP. Some ways Category I CME credits can be earned include seminars, conferences and online. The CME program provider will issue you a certificate or letter of completion, indicating the number of CME credits you've earned during each program. Upon fulfillment of CME requirements, candidates attest to their completion, which is subject to audit. **Category II CME** is any medically related activity that enhances the role of a PA (including journal reading). Category II credits are earned on an hour-by-hour basis. There is no minimum requirement for Category II activities. The CME provider is the organization that offered the seminar, conducted the training, etc. Usually, providers are associations, hospitals, schools, pharmaceutical companies, or other health care organizations. The NCCPA does not audit Category II CME.

¹⁴ Verified by (a) Mn Board of Medical Practice, Jeanne Hoffman, Licensure Unit Supervisor, 11/26/12, 11:56 p.m. (b) American Academy of Physician Assistants (AAPA), Chief Learning Officer, Mike Saxton, 571-319-4403 msaxton@aapa.org (11/26/12, 12:20 p.m. CT)

Appendix B

Roster of Participating Mental Health Stakeholders

Sue Abderholden, Executive Director
National Alliance on Mental Illness (NAMI-Mn)

Pam Berkwitz
Minnesota Coalition of Licensed Social Workers

Wallace Boeve, Program Director
Physician Assistant Program, Bethel University

Ron Brand, Executive Director
Mn Assoc. of Community Mental Health Programs

Darrel Cotch, PA-C
Minnesota Academy of Physician Assistants

Ed Eide, Executive Director
Mental Health Association of Minnesota

Valerie Fitzgerald – President
Minnesota Counseling Association

Charlotte Guest, M.D.
Minnesota Academy of Physician Assistants

Ed Eide, Executive Director
Mental Health Association of Minnesota

Shawntera Hardy
Health Partners

Erin Huppert,
Director, Health Policy & Gov't Affairs
Allina Health

Tracy Keizer, President of the Board
Minnesota Academy of Physician Assistants

Peg Larsen, Lobbyist
Minnesota Counseling Association

Tom Lehman, Lobbyist
Minnesota Academy of Physician Assistants

Dawn Ludwig, Director and Dept Chair
Physician Assistant Studies Program
Augsburg College

Pam Luinenburg, Coordinator
Minnesota Coalition of Licensed Social Workers

Jennifer McNertney, Policy Analyst
Minnesota Hospital Association

Carrie Mortrude, Governmental Affairs
Minnesota Nursing Association

Beth Nelson, Legislative Chair
Mn. Association for Marriage and Family Therapy

Mary Regan, Executive Director
Mn. Council of Child Caring Agencies (MCCCA)

Trisha Stark, Ph.D., LP, Executive Director
Minnesota Psychological Association

Michael Trangle, MD
Regions Psychiatry PA/NP Fellowship Program

Peg Truax, President-elect
Minnesota Counseling Association

Jonathan Uecker, M.D.,
Legislative Committee Chair
Minnesota Psychiatric Society

Linda Vukelich, Executive Director
Minnesota Psychiatric Society

Facilitators—Department of Human Services
Gary Cox, Children's Mental Health Division
Julie Pearson, Adult Mental Health Division