THE University of Vermont MEDICAL GROUP

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Dear Chair Houghton and the House Health Care Committee,

I am sorry I am not able to join you for your hearing on legislation making modest changes to the oversight of Radiologist Assistants (RAs) in Vermont. I am very appreciative of the Committee's willingness to take this issue up and allowing my colleague, Vermont's only licensed RA Mary Streeter, to testify in support of this bill.

I am the Chair of the Department of Radiology at the Larner College of Medicine at the University of Vermont and the Health Care Service Chief at the University of Vermont Health Network's Department of Radiology. I have been a practicing radiologist for 28 years, and have worked at the UVM Health Network for 22 years.

In short, there are a myriad of reasons we could cite for our request for this legislative change: the pressing need for access to necessary and timely health care services; the national workforce challenge facing all levels of recruitment and retention – of which our state and our Network are most certainly not immune; the cost of relying on the most expensive resource to deliver care, highly specialized physicians, and more. Our request for this legislation is grounded in something more fundamental, though. We have a decade's worth of excellent results with the practice of RAs in our state, and must now recognize that the rules governing their practice need a modest level of modernization. We do not see this request as radical or as an expansion of scope, but rather a recognition of the modern clinical environment and the reasonable expectation that our rules adapt to these changes while remaining firmly grounded in our unwavering commitment to safe patient care.

We support the legislation before your Committee and see it as straightforward:

- RAs should be able to receive the required, appropriate level of direct supervision through synchronous audio and/or visual means, and
- RAs should be able to communicate physician findings directly to patients as well as their own observations regarding the technical performance of a procedure or exam – not clinical findings – in real time during or immediately after a procedure or exam.

These changes will save time, be more efficient and improve patient care. By increasing access to necessary testing with remote supervision of the RA by a radiologist, we will reduce delays in diagnosis, for example, for shoulder injuries or gastroesophageal reflux, and get patients to the right treatment faster. Better communication at the point-of-care will give patients the reassurance they need that an exam or procedure were technically successful, while they wait for a diagnosis or clinical observation from the physician radiologists. This level of professional engagement between a highly-skilled clinician (the RA) and the patient they are treating is entirely missing in today's regulatory and practice construct.

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10 years ago, we worked with the Legislature and the Vermont Board of Medical Practice to create our state's first licensure program for RAs. We knew then that there was a highly-skilled group of clinicians who could be providing excellent patient care, but we needed a regulatory structure to support their practice. We are now in a situation where, without some modest changes to this structure, it does not make sense to hire RAs. The current supervision requirements essentially create complete redundancy between our physicians and RAs. This is particularly challenging as the recruitment for physician radiologists has become increasingly difficult. In fact, without some change, we may lose access to all radiology services at Porter Medical Center in Middlebury, as the current group of physicians working there look to retirement or scaled-back practice schedules. It should be in all of our best interests to ensure patients across our state have access to these clinical services.

I urge you to advance this legislation and thank you for your time and attention.

Sincerely,

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