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**S.128, An Act Relating to Physician Assistant Licensure  
Testimony of Christine O'Neill on behalf of the Physician Assistant Academy of Vermont  
Senate Health and Welfare Committee  
March 21, 2019**

**Introduction**

Good morning. My name is Christine O'Neill and I am a physician assistant (PA). I graduated from the Yale University School of Medicine's PA program in 2002 and have been a practicing PA in Vermont for the past 16 years. For the past 2.5 years, I also served as the Director of Advanced Practice Providers at the University of Vermont Medical Center, overseeing the services provided by over 200 PAs, advanced practice nurses (APRNs--nurse practitioners, certified nurse midwives, certified registered nurse anesthetists) and anesthesiology assistants. In this role, I was responsible for advising the organization on advanced practice provider compliance, helping to ensure that our PAs and advanced practice nurses met all Federal, State, regulator, payor and hospital bylaw practice requirements.

Thank you for the opportunity to testify on behalf of the Physician Assistant Academy of Vermont in support of S.128, An Act Relating to Physician Assistant Licensure. The goal of S.128 is to remove barriers to PA employment and practice in Vermont.

**What is a PA?**

PAs are state-licensed, nationally certified professionals who practice medicine in collaboration with physicians and other providers. PAs obtain patient histories, perform physical examinations, diagnose illness and develop treatment strategies, order and interpret lab tests, counsel patients on preventative health, perform various medical procedures, assist in surgical operations, and write prescriptions. The PA profession was founded over 50 years ago on the concept of collaborative practice with physicians, and there are now over 131,000 PAs practicing in the US. Across all medical and surgical specialties and in all clinical settings, PAs provide medical care, enhance care coordination, increase patient access, and contribute to improved quality.

PA scope of practice and degree of autonomy is determined by the PA's education, training and experience, the specialty and the type of practice. In some practices a PA may care for a panel of



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their own patients; in others physicians and PAs may manage some patients on their own and others together. Healthcare teams are strongest when practice-level decision making is enabled.

### **Education**

PAs receive a broad, generalist medical education that makes the profession uniquely flexible and able to adapt to the evolving needs of Vermont's healthcare system. The intensive PA curriculum is modeled on that used in medical schools and PA students often take classes and have clinical rotations alongside medical students and residents.

PA programs are very selective and require premedical coursework. Applicants have an average of 3 years of direct patient care experience in areas such as EMT/paramedic, medical assistant and nursing.

- All PA programs follow the same curricular blueprint based on the medical school model and all adhere to the same accreditation standards.
- The typical PA program extends over about 27 continuous months--approximately three academic years--compared to about 38 months for medical school. Programs are full-time, graduate-level, and include over 1000 didactic hours and 2000 hours of supervised clinical rotations in: family practice, internal medicine, pediatrics, OB/GYN, psychiatry/mental health, emergency medicine, surgery and more.

### **Certification**

In order to practice, PAs must:

- 1) graduate from an accredited PA program,
- 2) pass the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants, and,
- 3) be licensed by a state.

To maintain their national certification, PAs must complete 100 hours of continuing medical education (CME) every two years (50 hours must be AMA PRA Category 1 credit) and take a recertification exam in general medicine every 10 years.



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## **PAs Ensure Vermonters Have Timely Access to Primary Care, Specialty Care, Mental Health and Addiction Treatment**

There are currently over 360 licensed PAs in Vermont, practicing in primary care and all medical and surgical specialties. Sixty five percent of PAs serve in rural areas. Fifteen percent specialize in primary care. Along with physicians and nurse practitioners, PAs are one of the three primary care providers recognized by the federal government.

PAs expand access to primary care in Vermont by offsetting the decreasing supply of physicians and closure of existing practices to new patients. Rural areas in Vermont are particularly hard hit. A 2016 Vermont AHEC (Area Health Education Centers) report (the most recent year for which there is data) indicated that there was a primary care physician shortage of 46 physicians statewide. It is reasonable to conclude that the physician shortage will persist given the aging physician population, increasing national physician shortage projections through 2030, and the increasing proportion of Vermonters over age 65. The AHEC report indicated that the impact of the physician shortage is somewhat counterbalanced by an increase in PAs and NPs providing primary care.

There are also significant access issues in specialty care in Vermont, with wait times exceeding 6 months in some specialties. PA's work in all medical and surgical specialties in Vermont. PAs can significantly reduce wait times by serving as an entry point to the practice, providing initial evaluations, and decreasing time to diagnosis and treatment.

PAs also expand access to mental health and addiction treatment, both in inpatient and outpatient settings. A growing number of PAs are now certified by the DEA to provide medication assisted treatment (MAT) for opioid use disorder, strengthening Vermont's unique "hub and spoke" treatment model. In a new partnership with UVM's Addiction Treatment Program, PAs and physicians at the University of Vermont's Emergency Department are in the process of becoming certified to initiate Suboxone therapy in the Emergency Department. By eliminating the time gap between patient request for treatment--when a patient is most motivated to succeed--and an appointment in the treatment program, the odds of successful addiction treatment increase significantly.

As we shift to a population health delivery model, PAs can become even more valuable, ensuring that patients have their chronic and acute care needs met at a lower cost and freeing physicians to focus on more complex patients. You'll next hear from Sarah Bushweller, who will share her experience piloting a novel Electronic Visit program in her primary care practice.



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## **S.128 Will Remove Barriers to PA Practice in Vermont**

Over the past decade, physicians in Vermont have moved away from private and small group practice to employment by larger health care organizations. PAs often practice in large teams of practitioners and with numerous physicians. This shift in employment has resulted in a significant administrative burden in licensing PAs, especially in hospital/facility departments employing large numbers of physicians and PAs, where in some instances hundreds of Delegation Agreements, Primary and Secondary Physician Agreements signed by PAs and physicians must be submitted to the Board of Medical Practice. This requires a large time investment on the part of physicians, PAs and administrators, and often results in the attitude that PAs may be becoming too burdensome to employ. Additionally, physicians often raise concerns about their legal liability for the PAs on their service, since, in contrast and by statute, they are not liable for the nurse practitioners they collaborate with.

From my perspective as a hospital administrator overseeing the practice of both advanced practice nurses and PAs, I can say that the differences between APRN and PA licensure make it much more difficult to employ PAs. Current barriers such as physician liability for PA practice, the volume of licensure paperwork needing to be submitted to the licensure board, and state-mandated retrospective chart review resulted in several physicians and administrators asking if we should move away from employing PAs.

S.128 proposes four key changes to address these barriers and ensure a strong contingent of PAs are available to provide critical health care services in Vermont. PAAV reached out to the Vermont Medical Society, the Board of Medical Practice, and many other groups seeking their input, as we developed these recommendations. These recommendations reflect how PAs and physicians are practicing in Vermont today. The bill:

- 1. Removes physician liability for PA practice making each member of physician-PA teams responsible for their own practice and clinical decision making** - Vermont law currently makes a “supervising physician” legally liable for all PA activities. Some physicians are concerned about assuming legal liability for PAs because, in contrast, they are not liable for the nurse practitioners they collaborate with.
- 2. Reduces administrative burden and streamlines the licensure process** - The bill proposes that the relationship between physicians and PAs be changed from supervisory to collaborative, reflecting the removal of physician legal liability for PA practice. It replaces a



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“delegation agreement” between a PA and a physician with a simplified “practice agreement.” A key component of the practice agreement is that in determining PA scope and collaboration requirements it considers the PA’s education, training and experience and requires periodic joint review of the PA’s performance, the specifics of which are determined at the practice level. The PA and one representative of the practice sign the practice agreement and do not need to file it with the Board of Medical Practice. The board may request a copy at any time. PAs employed by Vermont hospitals or FQHCs that grant privileges would practice in accordance with the privileges granted by the hospital or FQHC and not require a practice agreement, though the facility may still choose to utilize one.

- 3. Allows PAs to be named PCP of record, increasing access to primary care services and reducing potentially duplicative services.**
- 4. Allows PAs to receive direct reimbursement for their services under Medicaid and private health insurance plans -** PAs are the only billing healthcare providers that cannot receive direct reimbursement. With the bill’s proposal to remove the “supervising physician” and the “delegation agreement,” it no longer makes sense that reimbursement for a PA’s work is made directly to a PA’s collaborating physician or employer. Typically, employed PAs and physicians reassign their insurance reimbursement to their employer, but direct PA billing and reimbursement will increase transparency and accountability for patients, payers and the health care system.

Finally, I’d like to bring to your attention three recent publications that support removal of barriers to PA licensure and practice:

- *Physician Assistants: Modernize Laws to Improve Rural Access*, July 2017 National Rural Health Association policy brief that recommends modernizing state PA practice laws in order to improve rural access to care.
- *Reforming America’s Healthcare System Through Choice and Competition*, December 2018 joint report by the U.S. Departments of Health and Human Services, Labor and Treasury suggesting that states: “consider changes to their scope-of-practice statutes to allow all healthcare providers to practice to the top of their license, utilizing their full skill set.” Specifically, the report urges states to give consideration to “eliminating requirements for rigid collaborative practice and supervision agreements” between physicians and PAs. The report also recommends that the federal and state governments consider allowing PAs and similar providers “to be paid directly for their services.”



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- *Improving Efficiency in the Health Care System: Removing Anticompetitive Barriers for Advanced Practice Registered Nurses and Physician Assistants*, June 2018 policy proposal from The Hamilton Project (Brookings Institution) suggesting that reforming burdensome PA and NP practice laws increases both provider supply and care delivery efficiency.

PAAV urges the committee to support S.128. Thank you for considering this information. I'd be happy to answer questions.

### Resources

*2018 Update: The Complexities of Physician Supply and Demand: Projections from 2016 to 2030*, Final Report Prepared for: Association of American Medical Colleges. [https://aamc-black.global.ssl.fastly.net/production/media/filer\\_public/85/d7/85d7b689-f417-4ef0-97fb-ecc129836829/aamc\\_2018\\_workforce\\_projections\\_update\\_april\\_11\\_2018.pdf](https://aamc-black.global.ssl.fastly.net/production/media/filer_public/85/d7/85d7b689-f417-4ef0-97fb-ecc129836829/aamc_2018_workforce_projections_update_april_11_2018.pdf)

*“The report aggregates the shortages in four broad categories: primary care, medical specialties, surgical specialties, and other specialties. By 2030, the study estimates a shortfall of between 14,800 and 49,300 primary care physicians. At the same time, there will be a shortage in non-primary care specialties of between 33,800 and 72,700 physicians. These findings are consistent with previous reports and persist despite modeling that takes into account the use of other health professions and changes in care delivery.”* AAMC News: New research shows increasing physician shortages in both primary and specialty care, April 11, 2018. [https://news.aamc.org/press-releases/article/workforce\\_report\\_shortage\\_04112018/](https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/)

*Physician Assistants: Modernize Laws to Improve Rural Access*, National Rural Health Association Policy Brief, July 2017.

[https://www.ruralhealthweb.org/NRHA/media/Emerge\\_NRHA/Advocacy/Policy%20documents/04-09-18-NRHA-Policy-Physician-Assistants-Modernize-Laws-to-Improve-Rural-Access.pdf](https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/04-09-18-NRHA-Policy-Physician-Assistants-Modernize-Laws-to-Improve-Rural-Access.pdf)

*Reforming America's Healthcare System Through Choice and Competition*, U.S. Departments of Health and Human Services, Labor and Treasury, December 2018.

<https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf>



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*Removing Anticompetitive Barriers for Advanced Practice Registered Nurses and Physician Assistants, The Hamilton Project (Brookings Institution), December 2018.*

[http://www.hamiltonproject.org/assets/files/AM\\_Web\\_20190122.pdf](http://www.hamiltonproject.org/assets/files/AM_Web_20190122.pdf)

*The Vermont Primary Care Practitioner Workforce 2016 Snapshot, Vermont AHEC.*

[http://contentmanager.med.uvm.edu/docs/vermont\\_primary\\_care\\_practitioner\\_workforce\\_2016\\_snapshot/ahec-documents/vermont\\_primary\\_care\\_practitioner\\_workforce\\_2016\\_snapshot.pdf?sfvrsn=2](http://contentmanager.med.uvm.edu/docs/vermont_primary_care_practitioner_workforce_2016_snapshot/ahec-documents/vermont_primary_care_practitioner_workforce_2016_snapshot.pdf?sfvrsn=2)