VA National Standards of Practice (NSP) Listening Session 4: Transcript

September 14, 2023

0:10

Moderator: Good afternoon and thank you for joining the Veterans Affairs National Standards of Practice Listening Session number 4. Today's session will run from 2:00 to 4:30 p.m. Eastern Daylight Time. My name is Elizabeth, and I will be your moderator for this session. I will now go over a few housekeeping items to keep in mind during the session. The session will be recorded and closed captioning is available on the bottom left corner of your webinar platform. The session, recording and transcript of the recording will be made available on the Veterans Affairs National Standards of Practice website, at a later date upon completion of all five listening sessions. If you experience any technical difficulties at any time during the session, you may notify our technical team using the Q and A function located at the bottom right-hand corner of the webinar platform. Speaking time will be allocated based on the number of people who requested to comment. During this session, all attendees will be placed on mute. If you indicated upon registration your intent to present, a VA representative will turn the mic over to you during your allotted time to provide comment. You will be unmuted during your period of comment and muted upon completion. Each speaker will be allocated 10 minutes to present. Allocation time is based on the number of people who requested to present. If you sent any materials to us ahead of this listening session to support your comments, they will be displayed on the webinar platform. If you are scheduled to present and use a phone to join today's session, we will call your name during your allocated speaking time and request you to raise your hand by dialing star 3 to identify yourself on the line. I will then give you the capability to unmute your phone line and you will hear a prompt to press star 6 to unmute your mic. Please announce your name and affiliation upon being unmuted. We will mute your microphone upon completion of your allocated time. If you did not indicate you're interested to share a comment upon registration, but are still interested in doing so today, please write it in the Q and A function

located at the bottom right-hand corner of the webinar platform. Time will be allotted as available at the end of the session. Any participants unable to speak during today's session may submit written comments after the session to VA.NSP@va.gov. Participants have until October 5, 2023, to submit comments. We ask everyone to please be respectful during your period of comment and while others are speaking.

3:24

Moderator: I will now turn it over to Ms. Sallie Massarsky to begin our session. Ms. Massarsky, the floor is yours.

3:36

Sallie Massarsky: Thank you, Elizabeth. I will now- excuse me. Good afternoon. My name is Sallie Massarsky, Director of the Veterans Health Administration Office of Regulations, Appeals and Policy. Thank you for joining the fourth VA National Standards of Practice Listening Session focused on physician assistants, physicians, emergency medical technicians, and paramedics. We greatly appreciate your input today on variance between State licenses for these health care occupations and your recommendations on what should be included in their VA national standard of practice. Your comments today will inform and guide our decisions moving forward. We would like to note that during these sessions VA will not directly respond to your presentations, but we are actively listening. The proposed national standard for each of the occupations will be posted on the Federal Register once ready for a 60-day public comment period. We have several VHA clinical representatives on the line who may ask clarifying questions. I'd like to welcome Dr. Marsden McGuire, who's the Director for Continuum of Care and General Mental Health for the Office of Mental Health and Suicide Prevention, Mr. Scott Burrough, Executive Director of Physician Assistant

Services, and finally Dr. Kevin Patel, Chief of the Ambulance Service Program. If anyone I just mentioned would like to introduce others from their office, please feel free to do so at this time.

5:19

Sallie Massarsky: All right. Hearing nothing. Thank you once again for attending today's Listening Session. Your participation and attendance demonstrates your commitment and enabling VA health care professionals to provide the best care for our nation's Veterans. I will now hand it back over to our moderator.

5:41

Moderator: Thank you so much. As a reminder, if you indicated upon registration your intent to present, we will turn the mic over to you during your allotted time to provide comment. You will be unmuted during your period of comment and muted upon completion. Please note there may be a delay during this unmute mute process and your patience is appreciated. Each speaker will be allocated 10 minutes to present. Allocation time is based on the number of people who requested to present. If you send any materials to us ahead of this listening session to support your comments, they will be displayed on the webinar platform. If you're scheduled to present and use a phone to join today's session, we will call your name during your allocated speaking time and request you to raise your hand by dialing star three to identify yourself on the line. I will then give you the capability to unmute your phone line and you'll hear a prompt to press star 6 to unmute your mic, please announce your name and affiliation. Upon being unmuted, we will mute your microphone upon completion of your allocated time. If you did not indicate your interest to share a comment upon registration, but are still interested in doing so today, please write it in the Q and A function located at the bottom right-hand corner of the webinar platform. Time will- time will be allotted as available at the end of the session. Any participants unable to speak during today's session may submit

written comments after the session to VA.NSP@va.gov. Participants have until October 5th, 2023, to submit comments. We ask everyone to please be respectful during your period of comment and while others are speaking. Speakers should fully be fully aware that you may experience delays during the unmuting mute process.

7:53

Moderator: We will begin with physician. I will now call upon Alexis Pierce from the American Medical Association to present their comment.

8:11

Alexis Pierce: And I am an attorney advisor with the American Medical Association. Thank you for giving me a chance to speak today. Our main concern with the Federal Supremacy project is that it will allow non-physician providers to practice independently and potentially undermine the physician led team-based care approach to care delivery, ultimately leading to a lower standard of care. Scope of practice for any healthcare professional should be based on standardized adequate training and demonstrated competence in patient care. The well proven pathways of education and training for physicians include medical school and residency and years of caring for patients under the expert guidance of medical faculty. Physicians complete four years of medical school plus three to seven-year residency programs, including 12,000 to 16,000 hours of clinical training. As resident physicians gain experience and demonstrate growth and their ability to care for patients, they are giving greater responsibility and independence. No other healthcare profession comes close to this level of training, which is necessary to develop the acumen and clinical judgment required for the independent practice of medicine. For example, physician assistant programs are two years in length, require about 2,000 hours of clinical care, and have no residency requirement. Similarly,

nurse anesthetists complete only two to three years of graduate level education and have no residency requirement. Students of optometry rarely complete postgraduate education. They're trained in primary eye care. They're not exposed to standard surgical procedure aseptic surgical technique or medical response to adverse surgical events. For these reasons, physicians and non-physicians are not interchangeable on a care team. But it is more than just the vast difference in hours of education and training. It is also the difference in rigor, standardization and comprehensiveness of medical school and residency programs compared to other non-physician programs. During medical school, students receive a science driven education in the classroom and in laboratories. This period of intense study is supplemented by two years of patient care rotations through different specialties during which medical students gain experience managing patients in all aspects of medicine and begin developing clinical judgments. After passing a series of examinations to assess a physician's readiness for licensure, medical students then match into a three to seven-year residency program. Residency is crucial. During residency, physicians provide care in a select surgical or medical specialty under the supervision of experienced physician faculty. As a resident, physicians gain experience and demonstrate growth in their ability to care for patients. They're given greater responsibility and independence. Altogether, the medical education ensures that physicians are exposed to a broad range of patients, illnesses, conditions, and procedures. Physicians emerge from residency well equipped to handle even the most complex clinical scenario. This level of education and training is necessary to develop the acumen required for the independent practice of medicine, including diagnosing, and treating patients, performing eye surgery, and administering anesthesia. In developing the national standards of practice, patient sentiment should also be considered and support for physician-led teams should be enhanced. Based on a series of nationwide surveys, patients overwhelmingly want physicians to lead their healthcare team. Four out of five patients want a physician leading their healthcare team and 95% believe it is important for physicians to be involved in their medical diagnosis and treatment decisions. Moreover, only 3%

of U.S. voters said it was not important to have physicians involved in specific treatments such as anesthesia, surgery, and other invasive procedures. Moreover, due to the physician's unique role as head of the care team, it is important that physician input is received and implemented within the project as early as possible. Importantly, physician representation on all of the work groups, not just the physician work group, should be mandatory since it could help to counter internal and external resistance when the national standards of practice are published in the Federal Register for comment and help to ensure that these standards appropriately support team-based care. As the veteran population ages and their health care needs become more complex, highly trained physicians capable of leading health care teams at the VA will be crucial to the provision of high quality and cost-effective healthcare to our nation's Veterans. Every healthcare professional has an important role to play in the high stakes field of medicine, but these high stakes demand education, experience, acumen coordination, and the robust management of care found only with physician-led teams. Our nation's Veterans should be provided with physician led team care that considers important scope of practice limitations and makes the most of the respective education and training of physicians and non-physician practitioners. Therefore, instead of implementing the Supremacy Project as it's currently laid out, additional investments in physician and physician led team-based care should be made to ensure that Veterans receive the care they deserve. At the very least, we urge you to ensure that physician led team-based care is maintained and that physician representation and all the work groups, not just the physician work group be mandatory. Thank you so much for your time.

13:35

Moderator: Thank you so much for your comment. I would like to give a quick reminder that there is a slight delay in the mute/unmute process so if any presenter will just pause quickly before they begin speaking so their name is not cut off.

13:50

Moderator: I did want to open the mic to Dr. Marsden McGuire, who I think has a clarifying question.

14:01

Dr. Marsden McGuire: Yes, thank you and thank you for the presentation, Ms. Pierce. The very last thing you said, I believe ended was a sentence ending with the word mandatory. Would you please repeat that as I'm not sure I got it fully. Thank you.

14:22

Alexis Pierce: Thanks. I was just saying that all of the workgroups, not just the physician workgroup, should have physicians on that workgroup, and it should be mandatory that they are able to participate in that process from the workgroup level.

14:40

Dr. Marsden McGuire: Thank you for the clarification.

Alexis Pierce: Thank you.

14:50

Moderator: Thank you so much. We will now move on to the next individual. I will now call upon Cyndi Yag Howard from the American Academy of Dermatology Association.

15:18

Cyndi Yag Howard: …of practice for physician assistants. My name is Dr. Cyndi Yag Howard, and I am a board-certified dermatologist from Naples, Florida, and I'm also the vice president-elect of the American Academy of Dermatology Association, which is comprised of over 17,000 US physician members. The best and most effective care occurs when a team of healthcare professionals with complementary and not interchangeable skills work together. Dermatologists and physician assistants have long worked together to meet their patients' needs. The optimal way to provide dermatologic care is under the direction of a board-certified dermatologist who retains ultimate responsibility for patient care and tasks delegates- and the tasks that are delegated to the care team members. The dermatologist also remains responsible for ensuring that all delegated activities are within the scope of each care team members training and level of expertise. So why is this important? Because the vast difference in the level of training and experience between the board-certified dermatologists and non-physician providers matters. Before board-certified dermatologists are allowed to practice independently, they must complete a minimum of eight years of comprehensive post collegiate medical education and training. That includes four years of medical school, one year of internship, at least three years of comprehensive dermatology residency training in an accredited dermatology residency program, 12,000-6,000 hours of direct patient care during training, several national standards examinations assessing their medical knowledge and one comprehensive specialty specific two-day examination assessing the expertise in dermatology and that leads to the final ultimate certification by the American Board of Dermatology. In stark contrast, physician assistants complete a 26 month, not eight-year, 26-month physician assistant program, followed by 2,000 hours, not 16,000 hours of clinical rotations. And their rotations emphasize only primary care, not dermatology in ambulatory clinics, physician offices, and acute or long-term care facilities. Unlike physicians, physician assistants are not required to complete a residency program. Physician assistants who elect to practice in dermatology are trained by dermatologists or other

non-physician providers in an apprentice-style fashion. There are absolutely no standardized training requirements for non-physician providers who choose to specialize in any particular field. They're subject to no formal assessment of diagnostic skills, no minimum number of procedures performed and no minimum time in training. A 2015 study from the University of Wisconsin comparing data on biopsies performed by dermatologists versus non-physicians suggests that non-physicians have less accurate diagnostic skills and perform more biopsies with a lower rate of detecting malignancy per biopsy performed, thus increasing patient morbidity and the cost of care. The authors found the number of biopsies performed per malignant neoplasms identified was double for non-physicians versus physicians. I would also like to note that after the Hattiesburg Clinic expanded its use of non-physicians to address its primary care shortage, it concluded that nurse practitioners and physician assistants should not practice independently. The findings are based on 10 years of data from more than 33,000 Medicare patients and 208,000 patient survey responses. The Hattiesburg clinic failed to meet its expectations regarding utilization, cost, quality, or patient satisfaction. Costs increased by $43 per patient per month and $119 if adjusted for patient complexity, totaling more than $10.3 million per year. As members of the health care delivery system, it is a common goal that both physicians and physician assistants have, to ensure that patients receive the highest quality care. We believe this goal is achieved when health care is delivered by a physician-led team, a model that is also supported by the public, as physicians are number one priority is the health and welfare of our patients. We appreciate the opportunity to provide feedback on this important public health issue and we'll submit written comments for your review, and I would be happy to answer any questions you might have.

20:36

Moderator: Thank you so much for your comment. We will move on to the next individual. And as a reminder, if you are scheduled to present and use a phone to join today's session, we will call your

name and we request that you raise your hand by dialing star three to identify yourself on the line. Next, I will call upon Kristin McCabe-Kline from the American College of Emergency Physicians. As a reminder, if you dialed in to today's webinar and used a phone, please raise your hand by dialing star three to identify yourself on the line.

21:51

Moderator: In the interest of time, we will move to the next individual. I will now call upon Brooke Trainum from the American Psychiatric Association.

22:16

Brooke Trainum: Hi, good afternoon. My name is Brooke Trainum, and I'm the Director of Practice Policy at the American Psychiatric Association. Thank you for the opportunity to speak today. The American Psychiatric Association represents over 38,000 psychiatric physicians and their patients, many of which are part of the VA system. APA appreciates the ongoing efforts of the VA to address persistent challenges our nation's Veterans face in accessing quality mental health care and suicide prevention services. As physicians, psychiatrists want to ensure that our nation's Veterans receive the best medical care possible, including care from physician-led multidisciplinary teams, which research has shown to result in the highest quality of care for patients. Psychiatrists are just one of the 40 physician specialties and account for many of the 87 subspecialties for physicians, many of which spend years in residency learning a chosen field of expertise. This level of knowledge enhances care teams and ultimately leads to better patient outcomes. We encourage the VA as you research and develop the national standards for physicians, as well as for other health care professions to take that into account, the different requirements for each specialty and subspecialty to set the standards accordingly, and in developing any national standard. The entire practice team in their roles must be considered rather than a siloed approach to care. As we heard from a previous

presenter, APA also encourages the VA to consider patient sentiment for the support of physician-led team. Based on a series of nationwide surveys, patients overwhelmingly want physicians leading their health care team. Four out of five patients want physicians leading their health care team and 95% believe it is important for physicians to be involved in their medical diagnoses and treatment decisions. Superseding State practice laws may have unintended consequences of decreasing patient confidence within the VA system. APA is also concerned that if implemented, non-physician health care providers may lack the oversight that is required, leading to a lack of accountability for Veterans' care that has already been documented in reports by the VA Office of the Inspector General. The reports have shown multiple cases of quality and safety concerns regarding VA providers, again potentially leading to a decreased confidence in the VA system. For others on the care team, not physicians do not have uniform training requirements. There's no official required residencies for nurse practitioner physician assistants before they call themselves specialists. Additionally, there are no uniform requirements for these clinicians when they transfer from one specialty to another. Removing current patient safety requirements for non-physician providers will not increase access to care. It is inappropriate to address actual perceived workforce shortages in the medical profession by exposing patients to health care providers whose education and training does not support the caregiving role they seek. Non-physician providers do not have extensive training in pharmacology, differential diagnoses or the years of education and training regarding the human body and systems that physicians have. Further, it is unequitable to Veterans to remove physician involvement from non-physician providers practicing within the system. It would give Veterans a lower standard of care compared to care civilians receive. In a majority of States, State law requires physician involvement in care, meaning that civilians would have a higher standard of care than Veterans would have in those same States. In reviewing national standards for physicians, APA does encourage the VA to consider how it plans to address the need for subspecialty skills for psychiatrists within the broader physician category and how this new national standard will affect

the distribution of these skills within a facility and a region. APA also encourages the VA to consider how national standards for psychiatrists and others providing mental health services will align with the mental health staffing model developed by the Office of Mental Health and Suicide Prevention to set staffing expectations moving forward. Veterans deserve the highest standard of care, which includes physician involvement, and the highest uniform training requirements. If the VA wants to standardize this requirement, it should choose the strongest and most rigorous training required as its standard. Thank you for your time today. Thank you so much.

26:45

Moderator: At this time, I will call upon the individuals who may have experienced technical difficulty earlier when called upon. As a reminder, if you are using your phone, please press star 3 to raise your hand to identify yourself when your name is called. Once we identify you, press star 6 to be unmuted. I will now call upon Kristin McCabe- Kline with the American College of Emergency Physicians.

27:55 [MATERIALS: American College of Emergency Physicians]

Moderator: Seems as though Ms. McCabe-Kline is unable to attend but has an individual taking her place, so I will call on Laura Wooster from the American College of Emergency Physicians.

28:15

Laura Wooster: Hi, this is Laura Wooster, Senior Vice President of Advocacy and Practice Affairs for the American College of Emergency Physicians. Thank you for having us today. Just wanted to talk about the unique needs of emergency care when it comes to physician-led care as all patients who present to emergency departments deserve to have access to high quality patient centric care delivered by emergency physician-led care teams. This is particularly true for our Veterans who

include some of the most medically vulnerable patients often suffering from multiple chronic conditions or other complex medical needs. Most patients who come into the ED with acute, undifferentiated, and often undiagnosed conditions, and determining correct diagnosis and treatment with little to no information when seconds count requires a depth of training acquired only through medical school in years of additional rigorous training. Mid-level providers such as physician assistants serve integral roles as members of the emergency care team, but they do not replace the medical expertise provided by emergency physicians. So, the standard must be onsite supervision by an emergency physician who has real time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP. Just as an aside, when it comes to the roles of EMT's and paramedics, ACEP feels strongly that EMS care should also be overseen by a medical director, physician, ideally board certified in emergency medicine and EMS. Next slide. One thing to realize though is that in most other specialties mid-level providers may be designated to oversee care for patients in a very focused area such as hypertension, cardiac rehab, post-surgical care or well children for example. But in emergency care, we can't control or predict what type of patients will present coming through the doors at any moment, and that makes it much more difficult to designate only a certain set of patients for care overseen by midlevel providers. In terms of training, emergency physicians complete at least 11 years of formal education, while NP's complete five to eight years and PAs seven years. As well, emergency physicians must complete over 12,000 hours of hands-on training with patients. NPs generally complete over 500 hours and PAs around 2,000 hours. Last year Stanford University study that was published by the National Bureau of Economic Research examined 44 VHA emergency departments in time period of 2017 to 2020. The study found that in these VHA EDs, NPs used more resources but achieved worse outcomes relative to physicians. Specifically compared to physicians, NPs were found to have increased ED length of stay by 11%, resulted in 20% more 30-day preventable hospitalizations increase the cost of ED care by 7%, or $74 million annually. It's actually less costly to employ

physicians than to employ independent NPs, even accounting for difference in salary, as shown by these results. So, should the PA similarly expand PA roles to allow for practice without physician supervision, as was done with NP's? We can expect similar outcomes and metrics, which are, I think, for the worst for our nation's Veterans. And the public actually share similar concerns. A 2022 Morning Consult public poll found that 79% prefer a physician to lead their care while in the ED, versus only 5% who would prefer a PA. Actually, over seven in 10 would be concerned if a physician was unavailable to oversee their diagnosing and treatment in medical emergency. Lastly, just to close, while many advocate for expanding the roles of midlevel providers and reviewing to especially to help address shortages and especially rural and underserved areas, and reviewing actual practice locations of PAs and physicians, it's clear that they tend to work in the same large urban areas as physicians do. There remains significant shortages of PAs in rural areas, just as there are physicians, and expanding the scope expansion really won't solve that issue. And this occurs regardless of the level of autonomy granted to PAs at the State level. Thank you again for your time.

32:32

Moderator: Thank you so much for your comments. We will move on to physician assistant. I will now call upon Jennifer Orozco from the American Academy of Physician Associates to present their comment.

32:54

Jennifer Orozco: Thank you so much and good afternoon. My name is Jennifer Orozco, and I am the Chief Medical Officer for the American Academy of PAs, which is a national membership organization for all PAs. And on behalf of the more than 168,000 PAs across the nation and as a PA, I thank the VA for hosting this Listening Session and the opportunity to speak to you today. The PA profession probably maintains a close connection to the VA, as the very first PA students in 1965

were Veterans. These first PA students were former Navy hospital corpsmen and Army combat medics who returned from the Vietnam War with considerable medical training from their military service. The VA was the first employer of PAs in 1967 and today is the largest single employer of PAs in the nation. 11% of all practicing PAs and 24% of PAs employed by the VA are Veterans, active-duty military, or served in the National Guard and Reserves. PAs maintain a strong personal desire and dedication to serve Veterans. PAs practice in all medical and surgical specialties in all 50 States, the District of Columbia, U.S. Territories, as well as the uniformed services. PAs provide proven, high quality, cost effective medical care in virtually all health care settings. PAs undertake rigorous education and clinical training and are established as fully qualified and prepared to manage the treatment of patients who present with any physical and or mental illness. PAs are educated and equipped. PAs are educated and equipped as active members of a health care team, while managing the full scope of patient care autonomously and collaboratively. Further, PAs routinely treat patients with complex diagnoses or multiple comorbidities, including the unique health care situations that impact the nation's military and Veteran populations. The APA applauds the VA for their collaborate for their collaborative dedication to VA patient care and outcomes. We also encourage the VA to remove undue barriers that restrict the ability of PAs to practice within the fullest extent of their education and experience. And let me say this personally, that this is about the patients and in this case, our Veterans. And PAs do not provide midlevel care. Therefore, they are not midlevel providers. What they are are proven providers of safe, high-quality care. They are board certified clinicians who practice medicine, lead complex clinical teams, departments, and hospital systems. They are improving care for all Americans, including the 99 million Americans without access to primary care and the more than 155 million Americans without access to mental health care, and that's just to name a few. For decades, PAs employed by the VA have practiced medicine under federally established guidelines. The current PA Utilization Directive, which was issued in 2013 and was scheduled to be updated in 2018. In 2020, the VA adopted the authority of VA professionals to

practice healthcare role after the ongoing COVID-19 pandemic demonstrated the critical need to ensure that PAs as well as other healthcare providers can practice to the fullest extent of their education and training. During the COVID-19 pandemic, PAs have played a major role in providing essential services, including setting up emergency response centers which streamline care and increase access to health care for patients. The APA has urged the VA to make use of the authority granted by rule to adopt national standards of practice that grant full practice authority and license independent practitioner status to PAs within the VA healthcare system. The APA urges the VA to create strong national standards of practice for the PA profession that will improve access to high quality health care for Americans Veterans. In 2019, the Medicare Payment Advisory Commission concluded in a report to Congress that “PAs provide care that is substantially similar to physicians in terms of clinical quality, outcomes, and patient experience.” PAs have also been shown to increase access to care, improve care coordination and decrease healthcare costs. The PA profession thrives in team-based practice and like all other healthcare professionals, PAs have a legal and ethical obligation to consult, refer, or transfer patients when their healthcare needs are outside the PAs level of expertise. Moreover, team-based care increases access for patients. Batson et. al., or what is being referred to in the previous speakers as the Hattiesburg study, is a non-peer reviewed limited review of a singular clinic in Mississippi that does not differentiate between PAs and other providers. The authors themselves classify their work as really “an observational experience and not a scientific study.” Data is important in ensuring that PAs receive the best care possible, but the miscalculation and manipulation of poorly extrapolated findings to fit a political narrative is an indolent attempt to undercut patient care. The Anber studies referenced also are papers that intentionally excluded PAs. However, the paper references studies that PAs as primary care providers are not correlated with worse outcomes than our physician colleagues. Peer reviewed data is critical for patient care out for patient care outcomes. PAs are dedicated to the team-based practice of medicine and APA is committed to ensuring that what is best for patients remains at the forefront of our work with the

VA and our nation's military and veteran populations. The APA supports the VA's ongoing efforts to develop national practice standards that ensure our nation's Veterans receive the highest quality care available. Former VA Secretary Robert Wilkie wrote to Congress in 2021 that, “the VA fully supports the idea of giving PAs full practice authority that would enable Veterans Health Administration PAs to practice medicine as licensed, independent practitioners and increase Veterans access to care.” APA supports and encourages the VA to authorize PAs to practice to the full extent of their education, training, and experience and in a manner that standardizes the professions practiced in all VA's medical facilities. Full practice authority for PAs would ensure that our nation's Veterans continue to receive the high-quality care that they deserve while also reducing burdens across the VA health system**.** I thank you so much for your time and I am now open to any questions.

40:18

Moderator: Thank you so much for your comments. I will now call upon Thomas Zampieri to present their comment.

40:54

Thomas Zampieri: Thank you for this opportunity to present. I've been, I practiced both as a civilian and VA-employed physician assistant and graduated from one of the first original physician assistant programs in 1978 during the time that I was in the VA, I served on various national committees on looking at the clinical guidelines for physicians’ assistants and appreciate the opportunity to discuss the national standards of practice today. Physician assistants in the VA have been used in multiple specialties, primary care emergency departments. And for decades, the PAs have worked with physicians in collaboration, successfully improving access to care and providing cost-effective, high-quality care. The physician's assistant occupation is master’s level. They take the national

certification exam for physician's assistants. The PA Education Association works on ensuring that PA graduates are well trained and meet clinical hours of experience. The VA has, however, struggled with as a veteran's service organization representative with large numbers of workforce vacancies. And ironically, what I've observed is that without the national standards of practice for physician assistants, PAs have been actually excluded from being employed in different types of physicians and especially in VA mental health, which is one of the areas where there's the highest vacancy rates for any occupation with over 4,000 vacancies and one of the reasons they have not hired PAs ironically is the VA is said they have to be considered core mental health providers, that they have to be licensed independent providers, which is interesting to me because of my 30 years of experience and working with the VA and then testifying in front of Congress, that on one hand you have a situation where you need to recruit providers, physicians' assistants have worked with psychiatry and psychologists across the system again for decades, but they've been excluded from employment, even when they apply for vacancies and told that we can only hire LIPs rather than recruiting them, putting them into practice and having standardized clinical scopes of practice for them with physician collaboration. Instead, they literally will not hire them. So, we have a discrepancy here. Furthermore, I also served while I was employed in the VA for two years with the National Academy of Sciences Institute of Medicine from 1990 to 1992. I was on their panel for non-physician providers, and they surveyed and did extensive research on 34 VA Medical Centers. They went and visited them. They surveyed chiefs of staffs. They surveyed supervising physicians. And the IOM Final Report 1992 recommended that the VA establish clear national standards of practice. Again, 1992, not me, not any of the other speakers today, the Institute of Medicine tells the VA you need to make it so that you don't have to follow 50 different State laws regarding licensure and all the other aspects of those and fully optimally use physicians' assistants with their training and experience. The VA also has just recently released VHA priorities: hire faster and be more competitive, connect Veterans with the best care possible, accelerate the experience of an high

reliability of care, support Veterans and reduce Veterans' suicides. Well, those seem to all correlate well with hiring and utilizing physicians' assistants. Again, as someone who spent 10 years working with Congress and testifying about VHA&VBA issues, and yet again, PAs are not part of the core mental health occupation. Someone needs to carefully explain that and especially with again the high vacancy rate and the high suicide rate that was mentioned before. 28% of all VA physician assistants are Veterans. I have myself as a Vietnam veteran. Many, many colleagues, they understand what it's like and the unique situation that Veterans have experienced. They certainly understand the PTSD problems, traumatic brain injuries. They have the capacity to treat these patients and work with their physician colleagues and in a collaborative way to reduce suicides. So, it's extremely frustrating again as a VSO, not just, you know, as someone who used to be a physician assistant, that arbitrary barriers have been put up. Oh, sorry, we won't hire you because we don't consider you a LIP. Not well, we need to hire providers that have experience, training, licensure, national certification, and let them be utilized. So, we seem to, 30 years now, be back in the same circle of let me read briefly what the IOM's report was: to the extent possible, the VA should unambiguously develop its own non-physician provider practice policies under guidance from VA's Central Office. Once the principal is ruled upon, the VA will be in a stronger position to propagate its own positions on advanced use of these types of providers currently forbidden to practice because of a variety of different State licensure. This is pretty remarkable. And so, to summarize the things that I think are important here today, is that the VA should practice at the top of their license, education and training; include PAs as core mental health occupation. The VA actually has psychiatry residencies for physician assistants, and yet they won't hire them when they apply. Dual postings for all vacancies, but especially in primary care and CBOCs and include the full you know standardization of practice for physician assistants. I thank you for this opportunity to present today and look forward to the VA working on solutions to these problems. Thank you.

51:40

Moderator: Thank you so much for your comments. I will now call upon Jason Scull with the American Medical Association.

52:15

Jason Scull: Can you hear me? Good afternoon.

Moderator: We can hear you. You may proceed.

52:37

Moderator: I believe, Mr. Scull, you may have muted yourself. We will work to unmute you at this time.

52:40

Jason Scull: Can you hear me now?

Moderator: Yes, we can hear you.

52:42

Jason Scull: Sorry about that. Thank you for the opportunity to weigh in on the national standard of practice for physician assistants. Our main concern with the Federal Supremacy Project has been that it may allow physician assistants and other non-physician providers to provide services and perform procedures independently that are outside the scope of their education, training and licensure. This will undermine physician-led teams and ultimately lead to a lower standard of care for Veterans. According to numerous studies, expanding the scope of practice of physician assistants

will increase the cost of care due to inappropriate prescribing, unnecessary referrals to specialists, unnecessary orders for diagnostic imaging studies such as X-rays, and more biopsies performed compared to physicians. Hattiesburg Clinic, a multispecialty clinic and an accountable care organization in Hattiesburg, MS, found a care provided by non-physicians working on their own patient panels to higher cost, more referrals, higher emergency department use, and lower patient satisfaction and care provided by physicians. Another study using Medicare data from 2005 through 2020 found that the presence of non-physician providers, including physician assistants in emergency in emergency departments, resulted in 5.3% more imaging studies per ED visit. Notably, this is consistent with the November 2022 study by the National Bureau of Economic Research that found the nurse practitioner practicing independently in the VA emergency department respond to lower skill in their care in their clinical decision making by ordering more tests and consults in order to gather information from other sources compared to physicians. The conclusions from these studies should be evident. Physician assistants are valued members of physician-led teams, but they are not physicians and should not function independently. Physicians go to medical school for four years. PAs go for 2.5 years. Physicians must complete three to seven years of additional residency training. PAs have no residency training requirements. Physicians must complete 12,000 to 16,000 hours of advanced clinical training. PAs must complete 2,000 hours of clinical training. The importance of physician-led care is also understood by State legislatures. More than 45 States require physicians' supervision or collaboration of physician assistants, with the majority of those States requiring physician supervision. This includes ensuring that physician assistants have a written agreement with the physician in place. Finally, the VA should listen to patients. 91% say a physician's education and training are vital for optimal care. Three of four patients would wait longer and pay more to be treated by a physician. And 95% say it's important for a physician to be involved in their diagnosis and treatment. A balanced NSP development process designed to get the best results for VA beneficiaries that include relevant physicians best to be representatives on NSP workgroups that

consult with a more diverse group of internal and external stakeholders before they are published in the Federal Register. The AMA looks forward to working with the VA as it moves through the NSP development process. And thank you again for the opportunity to comment.

56:30

Moderator: Thank you so much for your comment. We will now move on to Emergency Medical Technicians and Paramedic as a reminder. If you are scheduled to present and used a phone to join today's session, we will call your name during your allocated speaking time and request that you raise your hand by dialing star 3 to identify yourself on the line. I will now call upon Cassandra Williamson with the Transgender and Diverse Veterans of America who will comment on Emergency Medical Technician and Paramedic, Physician and Physician Assistant.

57:35

Moderator: As a reminder, if you are scheduled to present during today's session and use a phone to dial in, please press star three so we can identify you. It seems as though Ms. Williamson is not on the line.

58:03

Moderator: So, at this time I would like to pause and give the VHA representatives on the line an opportunity to ask any clarifying questions to our presenters. If you have any questions, please use your raise your hand at this time. Hearing none, we will now open the mic again to any individual who indicated their interest to present using the Q and A function of the chat.

58:41

Moderator: You may also raise your hand now using the WebEx platform at the bottom of your screen. If you've dialed in on your phone, you may press star three on your phone to raise your hand to indicate your interest to present. Once identified, you press star 6 to be unmuted.

59:27

Moderator: Once again, if you would like to present during this call, you may use the Q and A function of the chat or you may raise your hand now using the WebEx platform at the bottom of your screen. If you dialed in on your phone, you may press star three on your phone to raise your hand to indicate your interest to present.

1:00:00

Moderator: We will now conclude the open comment section during this listening session, but the line will remain open until 4:30 p.m. We commend each of you for your steadfast dedication and continued support in enabling VA healthcare professionals to provide the best, best care to our nation's Veterans. As a reminder, all suggestions made through these listening sessions will be used to improve and inform the content included in VA's proposed national standards of practice across all 51 occupations. All VA proposals for each occupations VA national standards of practice will still occur through the Federal Register during the 60-day open comment period. For more information on VA's national standards of practice, visit the VA National Standards of Practice website & sign up for our newsletter at https://www.va.gov/standardsofpractice/.

1:01:17

Moderator: Thank you again for attending the Veterans Affairs National Standards of Practice Listening Session number four. A recording and transcript of this listening session will be available on

the VA National Standards of Practice website upon conclusion of all scheduled listening sessions. Have a wonderful day. Goodbye.

NOTE: *All listening sessions conducted ran 2.5 hours in duration—audio recordings have been edited to remove pauses. Please contact presenters directly to request presented materials referenced in each session.*