

UTILIZATION OF PHYSICIAN ASSISTANTS (PA)

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) provides policy for the utilization of Physician Assistants (PAs) in VHA.

2. SUMMARY OF CHANGES:

a. Amendment dated June 24, 2024 removes the language found in paragraph 4.e.(1) that require a local VA medical facility policy on the utilization of physician assistants. This amendment is required by VHA Notice 2024-08, Suspension of Local Policy Mandates in Overdue VHA National Policies, dated June 24, 2024, which suspends implementation of this local policy mandate.

b. Amendment dated May 17, 2022 includes the following changes:

(1) Paragraphs 2.a. and Appendix A removes ongoing and current National Commission on Certification of Physician Assistants (NCCPA) Physician Assistant National Recertifying Examination (PANRE) requirements in order to align with VA Handbook 5005, Staffing, Part II, Appendix II-G38, dated September 27, 2020.

(2) Paragraphs 2.c. and 2.e. removes references to the Supremacy Clause reference and physician liability.

(3) Paragraph 4.f adds Podiatrist as a discipline considered as a collaborating physician.

(4) Appendix A removes requirements for chart reviews.

(5) Appendix A paragraph 3.b.(1).includes newly appointed PAs who have not yet received their State license but have passed the NCCPA Physician Assistant National Certifying Examination (PANRE) and are required to have limited autonomy.

c. Updates the descriptions in the responsibilities section to provide greater clarification.

d. Establishes Core PA Scope of Practice and Expanded Scope of Practice elements.

e. Establishes specific levels of PA practice autonomy.

f. Updates requirements for physician oversight of PA practice.

g. Establishes the requirement for the use of Focused Professional Practice Evaluations (FPPE) and Ongoing Professional Practice Evaluations (OPPE) for physician assistants.

3. RELATED ISSUES: VA Handbook 5005; VHA Handbooks 1100.19, and 1100.17.

- 4. RESPONSIBLE OFFICE:** The Executive Director of Physician Assistant Services (12PAS) is responsible for the contents of this Directive. Questions concerning this Directive may be directed to the office of Patient Care Services at VHA12PCSAction@va.gov.
- 5. RESCISSIONS:** VHA Directive 2004-029, dated July 2, 2004, is rescinded.
- 6. RECERTIFICATION:** This VHA Directive is scheduled for recertification on or before the last working day of December 2018.

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UTILIZATION OF PHYSICIAN ASSISTANTS (PAs)

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy and guidelines for utilization of Physician Assistants (PA) in VHA. **AUTHORITY:** 38 U.S.C. § 7301(b) and 7402(b).

2. BACKGROUND:

a. A PA is a health care professional trained at the graduate level and credentialed to provide medical services to patients within a defined Scope of Practice. PAs receive over 2,000 hours of didactic training in the medical sciences and over 2,000 hours of supervised clinical training. PA training programs are nationally accredited by the Accreditation Review Commission on Education of the Physician Assistant (ARC-PA). PAs must receive a passing score on the Physician Assistant National Certifying Examination (PANCE) for initial board certification by the National Commission on Certification of Physician Assistants (NCCPA).

b. VA is authorized by 38 CFR § 17.419(b) to establish a national standard of practice for a PA irrespective of state law limitations. The established qualification standards and credentialing requirements for employment for PAs are addressed in VA Handbook 5005, Staffing, Part II, Appendix G38, dated September 27, 2020, and VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021.

3. POLICY: It is VHA policy to credential and utilize PAs throughout the full spectrum of patient care activities based upon an individualized Scope of Practice as described in this Directive.

4. RESPONSIBILITIES:

a. **Director of Physician Assistant Services.** The Director of Physician Assistant Services is responsible for providing guidance and policy clarification on the credentialing, establishment of scopes of practice, and appropriate utilization of PAs.

b. **Veterans Integrated Service Network Director.** The Veterans Integrated Service Network (VISN) Director is responsible for ensuring that medical facilities within their jurisdiction are in compliance with all VA and VHA Directives pertaining to PA credentialing and utilization.

c. **VISN Chief Medical Officer.** The VISN Chief Medical Officer is responsible for establishing a network of support and communication that promotes value added models of care in order to integrate PAs utilization within the VISN. This support may be in the form of designating a VISN Lead PA or the appointment of a VISN-wide PA Committee.

d. **VISN Lead PA or PA Committee.** The VISN Lead PA or PA Committee is charged with the selection and utilization of appropriate metrics to measure and monitor the effectiveness of PA utilization and quality outcomes and the identification of additional areas where utilization

of PAs would bring enhanced value. The results of these metric measurements are reported to the VHA Director of Physician Assistant Services on a quarterly basis.

e. **Medical Facility Director.** The medical facility Director is responsible for approving all PA Scopes of Practice upon recommendation by the facility Executive Committee of the Medical Staff. The medical facility Director may appoint a facility Lead PA from the PA staff to facilitate the coordination and appropriate utilization of PAs.

f. **Facility Chief of Staff.** The facility Chief of Staff or designee is responsible for:

(1) Appointing a member of the physician staff (allopathic, osteopathic, or podiatric physician) to serve as the primary collaborating physician for each physician assistant. **NOTE:** *A physician contracted by VA to provide clinical services at VA medical facilities may be appointed as a PA's collaborating physician.*

(2) Designating an alternate collaborating physician when the primary collaborating physician is unavailable, such as extended leave.

(3) Providing notification to the affected physician and PA of any change in the designated collaborating physician.

(4) Ensuring the number of PAs assigned to each physician is consistent with the physician's ability to be effective in the role of a collaborating physician, while maintaining productivity expectations.

(5) Ensuring that appropriate periodic evaluations and reviews of the PA's performance are conducted by the Chief of the Service to which the PA is assigned.

g. **Chief of Service.** The Chief of Service is responsible for:

(1) Ensuring completion of appropriate Focused Professional Practice Evaluations (FPPE) and Ongoing Professional Practice Evaluations (OPPE) for PAs in accordance with the established medical staff processes used at the VA medical facility for other practitioners. **NOTE:** *For further information, see VHA Directive 1190, Peer Review for Quality Management, dated November 21, 2018.*

(2) Taking action to correct any discovered deficiencies in the PAs clinical practice.

(3) Reviewing and acting on requests by the PA to transfer primary patient care responsibility from the PA to a physician, when the complexity of a patient's medical condition exceeds the ability of the PA to safely and effectively manage the patient's care and requires the consistent and ongoing expertise of a physician.

h. **Collaborating Physician.** The collaborating physician is responsible for:

(1) Providing appropriate clinical oversight, consultation, and patient care management assistance to a PA who PA that has passed NCCPA – PANCE, but has not yet obtained their license (Graduate PA).

(2) The level of physician consultation and collaboration is to be determined at the facility level.

(3) Providing opportunity and support, upon request from the PA, for the PA to obtain additional clinical skills. *NOTE: Collaborating physicians may also act in the role of instructor and proctor when PAs are undergoing in-service training in therapeutic or diagnostic procedures.*

(4) Supporting recommendations for modifications to the PA’s Scope of Practice when new clinical competencies are acquired.

(5) Monitoring the PA’s clinical activities to ensure they are within their authorized Scope of Practice and are medically appropriate. The collaborating physician must provide timely notification to the Chief of Service of any deficiencies in relationship to the PA’s established Scope of Practice for corrective action.

(6) Providing input into periodic assessments of the PA such as FPPE, OPPE, and annual proficiency reports, as well as making recommendations for renewal or changes to the PA’s Scope of Practice.

i. **Facility Lead Physician Assistant.** The Facility Lead PA is responsible for carrying out duties as assigned by the VA medical facility Director which may include, but are not limited to:

(1) Providing knowledge and expertise on issues pertaining to the employment, credentialing, clinical practice, and appropriate utilization of PAs to senior management and staff.

(2) Providing clinically and occupationally focused orientation to new PA appointees and mentoring other PA staff members.

(3) Facilitating the performance of PAs FPPE and OPPE, and monitoring PA performance.

(4) Identifying PAs educational needs and facilitating availability of necessary training.

j. **Physician Assistant.** A Physician Assistant (PA) is responsible for:

(1) Adhering to all applicable Federal, VA, VHA, and facility policies or regulations.

(2) Ensuring that their clinical activities are within their Scope of Practice and are medically and ethically appropriate.

(3) Ensuring that no patient care activities are engaged in without a collaborating physician available for appropriate clinical oversight, consultation, and patient care management assistance.

(4) Engaging with their collaborating physician when consultation and guidance is needed.

(5) Deferring to the collaborating physician when there is a difference in opinion with the collaborating physician regarding patient care management.

5. REFERENCES:

- a. 38 U.S.C. § 7402.
- b. VA Handbook 5005. Staffing, Part II, Appendix G38, dated September 27, 2020.
- c. VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021.
- d. VHA Directive 1190, Peer Review for Quality Management, dated November 21, 2018.
- e. VHA Directive 1400.01, Resident Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019
- f. VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012.
- g. VHA Handbook 1100.17, National Practitioner Data Bank (NPDB) Reports, dated December 28, 2009.

6. DEFINITIONS:

a. **Physician Assistant.** A PA is a credentialed health care professional who provides patient centered medical care to assigned patients as a member of a health care team and who is authorized to practice with defined levels of autonomy and to exercise independent medical decision making within their scope of practice. PA's practice with clinical oversight, consultation, and input by a designated collaborating physician.

b. **Scope of Practice.** The patient care activities for which the individual PA is privileged are defined by a Scope of Practice. The Scope of Practice defines the degree of consultation and input required by the collaborating physician for specific patient care activities and is based on the PA's education and training, experience, demonstrated clinical skill and competency, and area of assignment. The PA's Scope of Practice must identify a designated collaborating physician.

c. **Collaborating Physician.** The role and responsibility of the collaborating physician is defined at the facility level.

d. **Lead Physician Assistant.** The lead PA is a senior member of the PA staff who has been appointed as the Lead PA at the facility or VISN level.

**PHYSICIAN ASSISTANT (PA)
SCOPE OF PRACTICE AND COMPETENCY ASSESSMENTS**

1. PA SCOPE OF PRACTICE: PAs are privileged through a Scope of Practice process. An individualized Scope of Practice will be developed by the collaborating physician in consultation with the PA. Factors to be considered when specifying patient care activities and levels of autonomy in the Scope of Practice are: the PA's training, experience clinical competency, the nature and degree of complexity of the patient care duties, the role of the PA in the healthcare team, and the associated degree of liability risk. The Scope of Practice may be one that includes the basic Core Elements of PA practice or an Expanded Scope of Practice for more advanced practice. Initial, renewal, and modification of Scopes of Practice must be approved by the Executive Committee of the Medical Staff and the medical facility Director, using the Medical Staff process. PAs must not function in a patient care role without an approved Scope of Practice.

a. **Scope of Practice Core Elements.** The core PA Scope of Practice elements are based on nationally standardized training by PA training programs accredited by the Accreditation Review Commission on the Education of Physician Assistants (ARC-PA) and the ongoing medical knowledge and clinical skills assessment performed by the National Commission on Certification of Physician Assistants (NCCPA). The core elements for a PA Scope of Practice may include, but are not limited to:

- (1) Obtaining medical histories and performing physical examinations.
- (2) Providing and coordinating medical care for assigned patients in any care setting, including establishing diagnoses, formulating and implementing care plans, and providing follow-up care.
- (3) Evaluating outpatients to determine the need for further health care.
- (4) Ordering diagnostic studies and other special tests, such as Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) scans, etc.
- (5) Carrying out health promotion, disease prevention, and patient education activities.
- (6) Ordering or obtaining laboratory specimens.
- (7) Ordering ancillary services, such as, pharmacy, social services, physical medicine and rehabilitation therapies, prosthetic services, etc.
- (8) Ordering VA specialty service consults and initiating requests for non-VA medical care and consults in accordance with VHA and local facility policy and procedures.
- (9) Ordering patient care supplies.
- (10) Writing orders for or prescribing medications (see paragraph c. of this Appendix).

(11) Admitting and discharging patients in consultation with, and on behalf of, the collaborating physician, obtaining admission history and performing physical examinations, conducting patient rounds, documenting progress notes and summaries in the patient record, and writing patient orders on assigned patients. PAs may be delegated the responsibility of documenting operative notes if the PA was present for the procedure, but the operative surgeon must review and co-sign the note. The PA may also be delegated the task of documenting the discharge summary, but the collaborating physician must write a discharge note, or co-sign the discharge summary written by the PA in accordance with The Joint Commission standards that are applicable.

(12) Other patient record entries by PAs, including medical histories, physical examinations, progress notes, service consults, Compensation and Pension evaluations, and patient orders do not require physician co-signature unless specifically required by Federal law, VA policy, or the standards of applicable external accrediting bodies.

(13) Obtaining and documenting informed consent for treatments and procedures for which the PA is responsible. If the PA is a member of a health care team, the PA may not be obtaining informed consent but rather may be responsible for other elements of the informed consent process. The PA's Scope of Practice must authorize obtaining informed consent for the treatment or procedure being performed. In addition, the Scope of Practice must authorize the PA to perform the procedure or provide the treatment for which the consent is being obtained or to actively participate as an integral member of the treatment team performing the procedure such as assisting the primary surgeon. *NOTE: The PA need not participate in the particular procedure the patient is scheduled to undergo but the PA must be authorized to perform or participate in the procedure by their Scope of Practice and must have sufficient knowledge and training in the treatment or procedure, its indications, risk and benefits, complications, and alternative treatments, to effectively counsel the patient.*

(14) Providing education and counseling of patients and families in preventive care, medical conditions, and the use of prescribed treatments and drugs.

b. **Expanded Scopes of Practice.** An expanded Scope of Practice may be approved when the PA has undergone additional training, competence has been verified, and is appropriate to the area of assignment (see paragraph 4 of this Appendix). Examples of elements included in an expanded Scope of Practice include, but are not limited to:

(1) Performing certain surgical and therapeutic procedures including, but not limited to, suturing of lacerations, obtaining biopsies, intra-articular injections, and intravascular catheter placement.

(2) Performing certain procedures in the operating room, such as vein harvesting, closing or assisting the primary surgeon in operative procedures.

(3) Performing specialized therapeutic or diagnostic procedures in specialty care settings.

(a) Performing therapeutic or diagnostic procedures in a radiology setting with limited autonomy (see paragraph 3.b. of this Appendix) when the procedure is within a general radiologist's scope of clinical privileges; and

(b) Assisting in the performance of therapeutic or diagnostic procedures that require the expertise of an interventional radiology specialist with direct supervision (see paragraph 3.c. of this Appendix).

(4) Prescribing or providing treatment for mental health patients with serious mental illness in mental health specialty settings when:

(a) The PA has received specialized training in current mental health treatment modalities; or

(b) The PA has received specialized pharmacology training specific to treatment of psychiatric and other mental health conditions.

(5) Administering intravenous fluids, medications or contrast agents.

(6) Interpreting EKG studies and providing preliminary reports.

c. **Writing of Medication Orders or Prescriptions.** All medication orders or prescriptions written by PAs must be consistent with the PAs Scope of Practice.

(1) PAs may prescribe or order all medications listed in the VA National Formulary consistent with the PA's level of prescribing authority and practice setting. Exceptions include medications restricted to specific clinical services outside of the PA's practice setting and those specifically restricted by VHA or local VA medical facility policy. An individual medication formulary included in the Scope of Practice is not required.

(2) PAs may prescribe non-formulary medications when established non-formulary drug request policy and procedure is followed.

(3) PA prescriptions or orders for medications when included in their Scope of Practice do not require a physician co-signature.

(4) **Controlled Substances.** Authorization for medication prescribing or inpatient ordering of controlled substances can only be granted in accordance with the Federal Controlled Substances Act and applicable regulations contained in Title 21 of the Code of Federal Regulations (CFR) Chapter II, Part 1306. PAs may be authorized to prescribe or order controlled substances utilizing the PA's individual Drug Enforcement Administration (DEA) registration when:

(a) Holds a current, active, full, and unrestricted license or registration from a state that authorizes PAs to prescribe controlled substances; and

(b) The schedules of drugs the PA is authorized to prescribe by their Scope of Practice is consistent with the schedules established by the PA's State licensure or those included on the PA's individual DEA registration certificate, whichever is more restrictive.

d. **Emergency Duties.** Emergency duties are those carried out for patients in life-threatening situations. The PA activates appropriate emergency procedures and initiates appropriate clinical intervention until appropriately trained staff arrive.

e. **Restrictions.** The following restrictions apply to PAs Scopes of Practice:

(1) PAs may not produce final electrocardiogram (ECG) reports for entry into the patient's record.

(2) PAs may not produce final reports for imaging studies (X-rays, CT, MRI) for entry into the patient record

2. ADDITIONAL DUTIES: PAs may be assigned additional duties which include, but are not limited to:

a. Administrative duties such as Patient Aligned Care Teams (PACT) Teamlet Leaders, clinic or program managers, or other administrative or management duties.

b. Education of health profession trainees and students.

c. Clinical research.

d. Preventive Medicine programs and related duties.

e. Emergency Preparedness (i.e., duties that may arise as a result of national health disasters).

3. PHYSICIAN ASSISTANT PRACTICE AUTONOMY: PAs function as health care providers with varying levels of autonomy and exercise independent decision making within their Scopes of Practice. The level of autonomy and degree of involvement of the collaborating physician in the PA's clinical activities varies depending on the PA's practice setting, clinical competence, complexity of the patients treated, and the nature of the assigned duties. Changes in the level of autonomy in the PA's Scope of Practice will be upon recommendation from the collaborating physician or the Chief of Service. Such recommendations should be based on the PA's level of competency and clinical proficiency. Methods for assessing the PA's competency may include the collaborating physician's direct observations, discussions with the PA during consultation sessions, , Focused Professional Practice Evaluations (FPPE) and Ongoing Professional Practice Evaluations (OPPE) evaluative data, or other structured performance reviews. The categories below describe levels of PA practice autonomy that may be authorized and the degree of physician oversight required for each.

a. **Full.** Full autonomy is appropriate for an experienced PA in Primary Care, other outpatient, or inpatient settings where sufficient clinical competence has been demonstrated in carrying out assigned patient care responsibilities. This level may also be used when the PA performs lower risk outpatient therapeutic and diagnostic procedures common to the area of the PA's practice. The PA at this level practices with a high level of autonomy on a day-to-day basis and requires infrequent consultation with the collaborating physician. When consultation with the physician does occur, it must be documented in the patient record by the PA. The physical presence of the collaborating physician at the site of PA practice is not required. The collaborating physician will concur with continuing this level of autonomy or recommend changes when the PA's Scope of Practice is renewed or interim changes are requested. This level of autonomy is appropriate for the majority of PA practice settings (e.g. inpatient, outpatient, Community Based Outpatient Clinics (CBOC), Community Living Centers (CLC), Long Term Care, Home Based Primary Care (HBPC), Telemedicine, or remote sites).

b. **Limited.**

(1) **Newly Appointed PA.** Limited autonomy is to be used for a newly appointed entry level PA, i.e., a PA who has passed NCCPA – PANCE, but has not yet obtained their license (Graduate PA), until such time as the collaborating physician can determine that the PA is sufficiently competent to function with lesser degree of oversight. PAs functioning at this level require more frequent oversight, consultation, and assistance from the collaborating physician. The collaborating physician for a PA at this level should be available for frequent consultations with the goal of a graduated progression towards less frequent oversight and greater autonomy.

(2) **Higher Risk Procedures or Patient Care.** Limited autonomy is appropriate for PAs authorized to perform higher risk procedures in critical care areas or in highly specialized areas. Examples of PA activities appropriate for this level of autonomy include, but are not limited to, performing procedures or providing patient care in endoscopy, general radiology or intensive care areas. A designated physician with appropriate clinical privileges must be in close proximity to the site of care and be able to intervene or assist the PA in a short period of time should significant complications or medical emergencies arise. PAs authorized to perform procedures or provide inpatient care described above have demonstrated clinical competence as well as procedural technical proficiency. Other monitoring methods used may include direct observation, review of procedure logs, and review of FPPE, OPPE, and other evaluative data. This level of autonomy may be used for a PA who has been delegated responsibility for instructing and proctoring other PAs learning new procedures (See par. 4. of this Appendix).

c. **Supervised.** Supervised autonomy requires that a collaborating physician with appropriate clinical privileges to perform a procedure be in immediate proximity (in the same room) to the procedure being performed by the PA and is able to intervene immediately if necessary. Examples of PA activities at this level include assisting in high risk operative procedures performed by a physician led team assisting in procedures performed by an interventional radiology specialist or when a PA is undergoing training for specialized procedures.

4. TRAINING:

a. PAs undergoing training to perform specialized therapeutic or diagnostic procedures must do so under direct observation and guidance. The guidance may be provided by a physician or a PA depending on the nature of the procedure and local policy. The clinician providing the supervised training must be authorized to perform the procedure by their clinical privileges or Scope of Practice. When a PA has been delegated the responsibility for instructing and proctoring another PA, authorization to do so must be included in their Scope of Practice.

b. Guidelines for the training of PAs in specialized procedures and determinants of technical and clinical competency will be established by the local facility. The training content or curriculum and the criteria used to determine technical competence will be documented and included in the PA's credentialing folder. The documentation should include:

(1) Any necessary didactic training or course study required by VHA Directive, Federal Regulation or local facility policy (e.g., an appropriate radiation safety course prior to the use of fluoroscopy).

(2) The minimum number of proctored procedures to be performed satisfactorily before competency can be determined.

c. Documentation of training and procedural competency from a former employer, a non-VA procedure specific training program or course or a Post Graduate Physician Assistant Residency may be accepted as meeting all or part of the local facility's training content or curriculum and criteria for technical competence determination. Documentation must include:

(1) Description of the training or curriculum.

(2) A detailed procedure log.

(3) An attestation of procedural competence from the clinician who provided the training or who has closely observed the PA performing the procedure.

d. A PA with sufficient training and demonstrated competence in a specialized therapeutic or diagnostic procedure may perform the procedures when included in the PA's approved Scope of Practice. All training records and proctored procedure logs must be maintained in the PA's Credentialing and Privileging Record. With the accretion of responsibility documented in the Scope of Practice, a FPPE for the new areas of practice will be initiated at the time practice is expanded. The FPPE will be documented with the results reported to the Executive Committee of the Medical Staff in accordance with local facility policy.

5. PROFICIENCY AND COMPETENCY ASSESSMENTS:

a. The Chief of Staff will ensure that clinical activities of PAs are periodically reviewed and evaluated. The Chief of Staff is responsible for ensuring that reviews are conducted and action is taken to correct any discovered deficiencies.

b. OPPE and FPPE will be performed on all PAs at required intervals in accordance with local facility policy and documented appropriately.

c. The PA's collaborating physician will provide input into the assigned PA's FPPE or OPPE.

d. PA Scopes of Practice will be reviewed and renewed biennially.

e. The collaborating physician is responsible for providing input to the PA's annual proficiency report or completing the report when designated by the rating official. Non-physician administrative supervisors may also provide input to the report when applicable.