



Background Information Statement
Submitted to
U.S. Senate Committee on Health, Education, Labor and Pensions
Regarding the Hearing on “Mental Health and Substance Use Disorders in America: Priorities, Challenges, and Opportunities”
October 29, 2015
On Behalf of the American Academy of Physician Assistants

On behalf of the more than 104,000 nationally-certified physician assistants (PAs), the American Academy of Physician Assistants (AAPA) appreciates the ability to share with members of the Senate Committee on Health, Education, Labor and Pensions our policy priorities relating to mental health and substance abuse. We are pleased that the Committee is addressing these important issues, and we believe that PAs can be a part of the solution to provider shortages in both mental health and addiction medicine.

Millions of Americans struggle with mental illnesses and addictive disorders, and many of them are unable to receive the treatment they need. This is especially true in rural and medically-underserved areas, where the U.S. Department of Health and Human Services recently estimated that more than 90 million people lack access to mental health and addiction medicine professionals. Given this outlook, as well as the historical use of PAs to alleviate healthcare provider shortages, AAPA believes that PAs should be – and are well-equipped to be – better utilized and integrated in the mental healthcare and addiction medicine fields.

PA Education and Practice

PAs receive a broad medical education over approximately three academic years which includes coursework in anatomy, physiology, biochemistry, pharmacology, physical diagnosis, behavioral sciences, and medical ethics, as well as more than 2,000 hours of clinical rotations. PA rotations include primary care, emergency medicine, family medicine, and psychiatry among other areas of specialty, and they often vary in practice setting and location. The majority of PA programs award a master’s degree to graduates, and PAs must pass the Physician Assistant National Certifying Examination and be licensed by their state to become certified to practice. Once practicing, PAs must complete 100 hours of continuing medical education (CME) every two years and pass a national recertification exam every ten years to maintain their certification.

PAs practice and prescribe medication in all 50 states, the District of Columbia, and all U.S. territories with the exception of Puerto Rico. They manage the full scope of patient care, often handling patients with multiple comorbidities. In their normal course of work, PAs conduct physical exams, assist in surgery, diagnose and treat illnesses, order and interpret tests, and counsel on preventative healthcare. The rigorous education and clinical training of PAs enables them to be fully qualified and equipped to manage the treatment of both patients with mental illnesses and those with opioid addiction.

PAs in Mental Healthcare

According to a survey conducted by the National Commission on Certification of Physician Assistants (NCCPA), in December of 2014, there were 740 PAs who specialized in psychiatry. At the same time, there were over 32,000 PAs who were working at hospitals, community health centers, rural health clinics, non-federally qualified public or



community health clinics, and free clinics in addition to those working at behavioral healthcare facilities. This means that a significant number of PAs are working on the “front lines” of caring for patients who are, in many cases, underserved and presenting with complex or comorbid conditions affecting both their physical and mental health. PA education and training provides PAs with the ability to assess and treat the whole patient at these facilities, whether they are in need of mental healthcare, emergency/primary care, or both. This type of integration has proven to be successful in a variety of settings, and AAPA recommends that this model be replicated in proposals to increase access to mental healthcare.

Many of the mental health reform bills before Congress include providers like psychiatric nurse practitioners, clinical social workers, and mental health peer-support specialists, but leave out PAs. This is an oversight which should be corrected. PAs have the training and experience to provide a full spectrum of patient care to individuals in need of mental healthcare, including conducting patient histories and examinations, performing psychiatric evaluations and assessments, ordering and interpreting diagnostic tests, establishing and managing treatment plans, prescribing medications, and ordering referrals as necessary. As such, AAPA recommends that PAs be included in any comprehensive mental health reform package which is ultimately considered by Congress. In so doing, they should be authorized to practice to the full extent allowed under state laws, a distinction which is particularly important in mental health shortage areas.

PAs in Addiction Medicine

While some PAs may choose to specialize in addiction medicine, the PAs who elect to work in high-need urban, rural, or medically-underserved locations may be just as likely to see patients who are experiencing an addiction to opioids. As a result, AAPA has been proactive in ensuring that PAs have access to continuing education and other coursework related to safely prescribing opioid medications, as well as recognizing and treating patients who are experiencing addiction to these substances. Thousands of PAs have participated in the CO*RE Risk Evaluation and Mitigation Strategy (REMS) educational activity on safely prescribing extended release and long-acting (ER/LA) opioid painkillers, and AAPA is pleased to be a partner among several other provider groups in continuing to provide opportunities for inter-professional education in this area. Additionally, AAPA has hosted multiple online and in-person CME courses addressing opioid abuse, pain management and safe prescribing, and plans to remain active in encouraging PAs to remain up to date on current best practices surrounding the responsible prescribing of opioid medications and comprehensive assistance for those who become dependent.

PA Prescribing Authority and Buprenorphine

PAs are currently permitted to prescribe in all 50 states and the District of Columbia; 41 states and D.C. also allow PAs to prescribe Schedule II medications. PAs are currently able to prescribe Schedule III buprenorphine to their patients for pain management, but the Drug Addiction Treatment Act of 2000 does not allow PAs to prescribe this medication for the treatment of opioid addiction. In light of the shortage of physicians specializing in mental health and addiction medicine, AAPA strongly believes that PAs must be able to treat their patients to the extent allowed under state laws. As such, they should be authorized to prescribe buprenorphine to treat opioid addiction in states where they are already permitted to prescribe similarly-scheduled medications.

Currently, both the Senate and the House are considering legislation to increase the number of providers who are eligible to prescribe buprenorphine. One particular bill, the TREAT Act (S. 1455/H.R. 2536), appears to have the

intention of allowing PAs to prescribe buprenorphine to patients who are experiencing addiction to opioid drugs as part of a comprehensive treatment plan, as appropriate. AAPA supports this idea in principle; however, the legislative language found in Section 4 of the bill covers PAs who are “supervised” by physicians, but it does not address PAs who “collaborate” with physicians, allowing only those who are “supervised” to prescribe buprenorphine. This is problematic because the state of Alaska, the District of Columbia, and the U.S. Department of Veterans Affairs use “collaborate” to define the relationship between PAs and physicians. As a result, the bill as currently drafted would arbitrarily leave out a number of PAs and potentially leave out many more as other states update PA practice laws to use the term “collaboration.”

Due to the nature of the PAs’ national certification process, there is no practical difference in education or experience between a PA practicing in a “supervision” state versus a PA practicing in a “collaboration” state. While the term used to describe how PAs interact with physicians is chosen at the discretion of each state, states have largely given PAs a wide scope of practice, with some states even allowing PAs to own their own practices. In many rural and medically-underserved areas, it is not uncommon for a PA to be the only healthcare practitioner for miles, meaning PAs are their patients’ primary medical provider. This is particularly true in Alaska – a state known for its remoteness and limited access to healthcare – but due to the state’s use of “collaboration” in its statute, under the TREAT Act, patients in the most rural parts of the state may not have access to all of the tools necessary to treat opioid addiction.

Many states are beginning to recognize that the term “collaboration” is a more accurate description of the relationship between PAs and the physicians with whom they work than “supervision,” and several are entertaining legislation to make a change to their statutes to reflect this shift in language and thinking. In 2014, 49 states and D.C. made changes to their laws and regulations with the goal of increasing PA scope of practice. Unfortunately, the TREAT Act as written would represent a step backwards for the PA profession, and most importantly, the patients.

Recommendations

PAs are versatile healthcare practitioners who are qualified to provide comprehensive patient care, and they are already serving as a valuable part of the healthcare team at behavioral health facilities, rural health clinics, and other settings. We are hopeful that the Committee will consider AAPA’s recommendations, which include:

- 1) **Replicating models which fully integrate PAs into mental healthcare teams, allowing PAs to practice to the extent authorized under state law;**
- 2) **Including PAs in any legislation meant to expand access to mental healthcare, as well as addiction medicine; and**
- 3) **Authorizing PAs to prescribe buprenorphine as part of a comprehensive opioid addiction treatment plan, in accordance with state law.**

We look forward to working with you as you move forward on these important issues. Should you have any questions, please do not hesitate to have your staff contact Sandy Harding, AAPA Senior Director of Federal Advocacy, at 571-319-4338 or sharding@aapa.org.