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The Veterinary Professional Associate (VPA) Concept: Suggested Roles, Responsibilities, Skills, Knowledge, and Competencies

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Abstract

Capacity in the veterinary medical profession is currently insufficient to meet demand for veterinary services in the U.S.^{1,2,3,4} Although expansion of educational programs to train more veterinarians and veterinary nurses/technicians is well underway,⁴ it has been suggested that creating a new class of professional, a non-veterinarian clinician, should be considered.¹ A group of thought leaders in academic veterinary medicine convened to consider this concept as one method to help address inadequate capacity in the veterinary medical profession. By consensus, the group agreed the Veterinary Professional Associate (VPA) would be a new professional position in veterinary medicine that would bolster healthcare access and outcomes, while enhancing operations of healthcare teams. The VPA should work under supervision of a licensed veterinarian and would be distinguished from a Credentialed Veterinary Nurse/Technician (CrVN/T) in that their education would emphasize competencies in front-line assessments, including obtaining a history and identification of abnormal findings on physical examination and diagnostic tests. In addition to education and training in the performance of basic medical and surgical skills, VPA training should also emphasize competencies in client communications, which will bolster the paradigms of contextual, incremental, narrative, adaptive, culturally competent, and spectrum-of-care delivery. The VPA would improve health care delivery through progressive team leadership and advanced care coordination/management, along with advanced case management, relieving the supervising veterinarian of these responsibilities. The VPA's capability to serve in a front-line capacity and perform a variety of downstream medical and surgical tasks would enhance the efficiencies and proficiencies of the veterinary healthcare team.

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Introduction and Background

Capacity in the veterinary medical profession is currently insufficient to meet demand for veterinary services in the U.S.^{1,2,3,4} This gap is most frequently experienced as inadequate access to care in the companion animal, food animal, and equine practice sectors, and has been a key factor in the rapidly rising costs of veterinary healthcare – which have further compounded access-to-care challenges. In addition to private practice, other sectors of the veterinary profession are negatively impacted by the inadequate capacity, including public practice, corporate practice, government, and academia. Although seemingly acute, the shortage is not new,⁵ and expansion of educational programs to train more veterinarians and veterinary nurses/technicians is well underway.⁴ As a complement, it has been suggested that creating a new class of professional, a non-veterinarian clinician, should be considered.¹

Non-physician clinicians in human medicine, such as nurse practitioners (NPs) and physician assistants (PAs), were created in response to demand for greater health care access, especially for the nation's poorer citizens.⁶ These professionals have consistently been shown to increase productivity and improve patient outcomes. According to a report by Medical Economics, non-physician clinicians can substantially increase capacity in a primary care practice.⁷ Their deployment can positively impact a medical practice by enhancing patient care and expanding appointment availability and practice hours. This, in turn, helps lower fixed costs per patient and boosts profitability for the physician owner. Data analyzed by the Medical Group Management Association reveals that financial performance improves when human medical practices employ non-physician providers.⁸

The benefits of deploying non-physician providers extend beyond improving the bottom line. Reviewing seventeen years of data from emergency department visits in the United States, a study published in the International Journal of Emergency Medicine found that, when working alongside emergency care physicians, non-physician providers can reduce wait times and improve physicians' efficiency.⁹ Non-physician clinicians can manage lower acuity visits and fill gaps in areas such as telehealth and routine care, freeing up physicians to oversee more complex cases. The evidence for these benefits is substantial. In a systematic review of thirteen randomized controlled trials across numerous countries, researchers concluded nurse practitioners enhance patient care, service cost-effectiveness, efficiency, and general patient satisfaction with the overall quality of care provided.⁹

Proper planning must take place to derive benefits from the deployment of mid-level health providers in human medicine. Based on the strongly positive impact, the World Health Organization has advanced the deployment of non-physician clinicians to expand access and affordability to healthcare worldwide. However, it notes that they need to be well-embedded in the system and receive adequate training, support, recognition, and pay.¹⁰ To fully leverage their benefits, non-physician clinicians should be included in the overall planning of the health practice, whether general or specialty.¹¹

There are also discernible costs to employing a non-physician clinician within a medical practice setting. Beyond salary and benefits, there is an increase in communication and coordination

costs as non-physician clinicians work hand-in-hand with physicians. In solo physician practices, these costs may be particularly salient, potentially offsetting the benefits of a non-physician provider.¹² Thus, proper planning and deployment in smaller practices are likely to be especially important to realize the gains achieved.

Other reservations have been expressed regarding the benefits of employing NPs and PAs, including recent concerns cited by VPA opponents from within the veterinary profession. A sampling of talking points includes:

- NP training, certification requirements, and competency to practice independently were found to be widely variable in one published study, leading to a recommendation to restrict independent, unsupervised practice by NPs until the variability is resolved.¹³
- NPs, on average, utilized more resources and achieved less favorable patient outcomes than physicians in another study, although this difference was found to be quite variable based on case complexity.¹⁴ In fact, even larger variability was found within each respective profession, and NPs actually outperformed physicians in 38% of cases.
- In yet another study, malpractice allegations against NPs and PAs were more likely to be diagnosis-related than those against physicians.¹⁵ However, the same study documented that malpractice payment reports were approximately 10x more common in physicians than with NPs and PAs, and these payments ranged from 1.3 to 2.3 times higher with physicians than with non-physician clinicians.
- And finally, analysis of a multi-year data set from one specific private multispecialty human healthcare clinic with over 300 physicians indicated that per-month spending

was substantially higher for patients whose primary health professional was a nonphysician instead of a doctor.¹⁶ These differences were largely attributed to a combination of several factors that included more ordering of tests, more referrals to specialists, and more emergency department utilization. Although costs were sometimes a bit higher, the authors clearly “praised NPs and PAs as invaluable members of the Hattiesburg care team without whom thousands of patients would go without care.”

Of course, these studies were all conducted to scrutinize the marked expansion of access to healthcare that NPs and PAs provide. Results stand to offer invaluable insights and guidance if a new class of professional, a non-veterinarian clinician, is ultimately created.

First recommended in 2009 by faculty at the College of Veterinary Medicine and Biomedical Sciences at Colorado State University,¹⁷ it was proposed that a non-veterinarian clinical service provider (or veterinary professional associate – VPA) could bridge the gap between veterinary nurses/technicians and veterinarians. Similar in concept to the physician’s assistant from human medicine, a non-veterinarian clinician has since been recommended by several additional authors.^{18,19,20,21,22} In a survey of credentialed veterinary technicians and both credentialed and non-credentialed veterinary assistants, more than 80% of 703 respondents were interested in the possibility of a veterinary nursing graduate program toward a new credential and career path in advanced practice veterinary nursing.^{19,20} Top reasons generating interest were 1) personal/professional satisfaction, 2) career advancement, 3) possibilities of greater financial outlook, and 4) career opportunities.

More recently, in a survey conducted by the American Association of Veterinary State Boards (AAVSB), the majority of respondents who had an opinion agreed that the need exists for an advanced animal healthcare provider (AAHP).²³ In this study, the AAHP was framed as a non-veterinarian with additional training beyond an associate or bachelor degree program. In fact, 77% of all respondents agreed that veterinary technicians could take on additional responsibilities with additional training and education.

With a similar concept in mind, the Lincoln Memorial University-College of Veterinary Medicine launched its Master of Veterinary Clinical Care (MVCC) program in 2022 with a focus on providing advanced training for licensed veterinary technicians who hold a baccalaureate degree.²⁴ An MVCC program is also under development at the Colorado State University-College of Veterinary Medicine and Biomedical Sciences, with intended launch in fall 2025.²⁵ Using these programs as a starting point, this project was designed to identify and recommend potential VPA roles, responsibilities, skills, knowledge, and competencies.

Methods

Over the course of 2022 and 2023, a group of thought leaders (deans, directors, and a department head) representing 5 US colleges of veterinary medicine was convened both virtually and in-person (approximately 10 times in total) to discuss the concept of a non-veterinarian clinician, or VPA, in veterinary medicine. The authors of this report were included in the group.

Discussions focused on:

- What is the problem that needs to be addressed?
- What roles and responsibilities, if entrusted to a VPA, could effectively address the problem, i.e., what tasks would they perform?
- What knowledge, skills, and competencies would be critical for the VPA to possess?

Participants shared their own perspectives along with thoughts and ideas garnered from their respective professional networks. This report contains a summary of the group members' consideration of these questions.

Results

It was agreed the primary driver for this discussion is the problem of limited access to healthcare in veterinary medicine. Although veterinary workforce capacity and the related ability to access veterinary services were recognized as generally inadequate across all sectors of the veterinary profession, the group's focus emerged as a call to address long-standing shortage sectors, including companion animal (including shelter medicine), livestock, and equine practice.

Ultimately, development of a competency-based VPA education (CBVPAE) framework similar and complementary to the competency-based veterinary education (CBVE) framework²⁶ was discussed as the preferred outcome. In this regard, it was agreed that the competency-based framework would ideally be derived from a narrowly defined set of roles and responsibilities for the VPA. Understanding that developing robust, industry-wide consensus on this topic would

likely entail a multi-year, complex, inclusive, and iterative process, the group agreed to start the ball rolling by considering desirable roles, responsibilities, and a list of potential skills/tasks that, if performed by the VPA, would enable veterinarians to deliver healthcare services more efficiently and effectively. As a pilot, these roles, responsibilities, and skills/tasks provide a useful preliminary foundation for developing a CBVPAE framework, which can then inform creation of appropriate curricula leading to a master's degree in veterinary clinical care.

Recognizing the regulatory challenges inherent in creating an entirely new professional classification, it was conceded that VPA roles and responsibilities in the end would be specifically defined state-by-state (jurisdiction-by-jurisdiction) by individual practice acts. In that context, participants in this project agreed unanimously that the VPA should work only under the appropriate level of supervision by a veterinarian, who ultimately bears responsibility for patient care. In this context, the suggested VPA model is more similar to the PA, who is restricted to practicing under supervision of a physician in human medicine, than the NP, who is able to practice independently. In the case of the VPA, appropriate veterinarian supervision would include any preliminary diagnoses, suggested therapies/prescriptions, and surgeries to be performed.

Agreed-upon general categories of knowledge and skills for the VPA included:

- Basic sciences, including anatomy, physiology, microbiology, immunology, nutrition, pathology, pharmacology, toxicology, and behavior;

- Clinical sciences, including physical examination, laboratory diagnostics, medicine, anesthesia, minor surgery, dentistry, and diagnostic imaging; and
- Professional skills, including communications, practice management, team leadership, and advanced case management and care coordination.

A more complete list of suggested skills/tasks for the VPA is included in Appendix A. It should be noted that this list is intended as a starting point for further discussion and refinement. Tasks for which there was not unanimous agreement within the group included establishment of the veterinarian-client-patient relationship (VCPR) and spays.

As a general precept, it was agreed that the VPA should be competent to identify normal vs. abnormal through an appropriate combination of physical examination and diagnostic testing. Abnormal cases would then be triaged by the VPA into uncomplicated cases that could be managed by the VPA (under the supervision of a veterinarian) and more complex cases that would be referred (in-house) for diagnosis and decision on course of action by a veterinarian. In turn, the ensuing course of treatment planning and associated treatment, including medicine and/or surgery, would be completed by either the veterinarian or the VPA, or both working together, as dictated by specific case details.

Throughout this process, the VPA would be expected to lead communications with the client, fully understanding the client and case context, thereby enabling effective and efficient problem definition and resolution. In particular, the paradigms of contextual, incremental, narrative, culturally competent, and spectrum of care delivery would be successfully employed.

Discussion

Following are key points from the group's discussions:

- Fully understanding client and case context would stand to enhance client satisfaction.
- Progressive team leadership and the associated quality assurance should help decrease medical errors and enhance patient outcomes.
- The accompanying task list and core skills (see Appendix A) provide initial structure (similar to entrustable professional activities – or EPAs) from which a CBVPAE framework can be built and should provide a foundation for course objectives and curriculum development.
- To maximize effectiveness, it was agreed that the VPA's clinical skills should include the ability to conduct minor surgeries (as defined in Appendix A) and write routine prescriptions (limited to on-label use of drugs per FDA restrictions).
- In effect, the VPA adds a potential rung to the career ladder for credentialed veterinary nurses/technicians (CrVN/Ts) in that the VPA education would add to the strengths of a CrVN/T by emphasizing competencies in front-line assessments. These would include obtaining a history and identification of abnormal findings on physical examination and diagnostic tests that could be used to initiate treatment under the supervision of a veterinarian.
- Along with the VPA, veterinary technician specialists (VTSs) can be considered as non-veterinarian clinicians within their specialty. Like the VPA, specialty training provides an additional rung on CrVN/T career ladders. In contrast, the VPA training would be distinct from that of the various VTS programs in two ways:

- VPA education would be provided in a structured, academic setting leading to a master's degree, and
- Initially, VPA education would be designed to create a generalist, in contrast to the specialists who receive VTS certification. At some future point, however, specialty training options may also be developed for the VPA, as is the case for non-physician providers in human medicine.

Ideally, the VPA and the VTS will serve complementary roles in veterinary practice.

Although strong support for the VPA concept was defined within this study group, reservations have been expressed and questions raised from various sectors of the veterinary profession.

These include the following list derived from 101 respondents to a recent polling of a specific veterinarian group on Facebook:

- Patient safety concerns exist.
- Why not raise the level of veterinary technician training first?
 - Need to pay and utilize them better first.
- DVMs will be liable for VPA oversight.
 - Lack of protection from litigation compared to human medicine.
 - VPAs should have their own liability insurance.
- VPAs will flood the market and put veterinarians out of a job.
- Corporates will hire one vet and multiple VPAs to increase profits.
- Can't find enough people to fill veterinary technician or veterinary assistant roles. How will VPA positions be filled?

- VPAs could take away bread-and-butter/mentally relaxing cases (e.g. vaccines) from DVMs.
- The DVM degree is perceived by some as already devalued, and adding a VPA could devalue further.

Many of these concerns and questions have been encountered by leadership at Colorado State University – College of Veterinary Medicine and Biomedical Sciences as they develop and launch their new MVCC program. In response, they have developed the FAQ document contained in Appendix B. The Coalition for the Veterinary Professional Associate (www.cvpa.vet) has responded in similar fashion.²⁷

Recommended next steps start with active engagement with the CVPA. This organization is currently leading several important initiatives related to the VPA, including development of a competency-based framework, options for accreditation, methods of outcomes assessment, and pathways to licensure. To complement the CVPA endeavors, it would be useful to consider an industry-wide summit to discuss the VPA, including human health, academic, and regulatory perspectives. Importantly, the summit could launch a regular forum for those who are creating an MVCC program to exchange ideas and share best practices. At the core of these activities, inclusion of AAVMC member institutions will be critical.

Summary

The introduction of non-veterinarian clinicians, or VPAs, into veterinary practice settings presents a promising potential solution to help address the longstanding capacity issues within the profession. Drawing parallels with successful implementations in human medicine, the potential benefits of VPAs include increased practice capacity (and client satisfaction), improved patient outcomes (and animal welfare), and enhanced practice profitability. This study highlights suggested VPA roles, responsibilities, skills, knowledge, and competencies.

VPA inclusion in veterinary practice is not envisioned as universally applicable or beneficial, rather it is likely to be situation-specific within emerging practice models that emphasize opportunities for career advancement, specialization, spectrum of care, out of hours services, improved operational efficiencies, and wellbeing of the team. Ultimately, including a VPA will be a decision to fill a complementary role that cannot be best served or supplied by addition of another licensed veterinarian or another veterinary technician. And similar to ongoing evaluation of non-physician clinicians in human medicine, it will be critical to devise and carry out rigorous assessments of VPA competencies and effectiveness in the practice environment to substantiate that VPAs are value-added and do not lower the quality of the veterinarian-client-patient relationship or delivery of care.

The decision to include advanced animal care professionals, such as the VPA in a health care team, will be driven by unique contextual factors that have the potential to empower veterinary practices to better adapt and serve the business, employees, patients and clients from the

community. Without a mosaic of team-based options to consider, the profession will continue to suffer workforce shortages, a decline in wellbeing, inefficiencies, and failure to adapt to new and evolving practice models such as spectrum of care, urgent care, shelter medicine, emerging specialization, telemedicine, and ambulatory practice.

The perspectives included in this project contribute valuable insights into the possible VPA impacts on practice workflow and efficiency. In leading the healthcare team toward these outcomes, the VPA might well offer an attractive, entirely new opportunity for credentialed veterinary nurses/technicians to advance in their careers.

Regulatory environments and potential restraints notwithstanding, and fully embracing the need to work under appropriate supervision of a licensed veterinarian as defined by existing practice acts, introducing a VPA could offer an important element of a broad-based solution to the capacity challenges in the veterinary profession. In that regard, accredited colleges/schools of veterinary medicine should continue to pursue development of MVCC degree programs informed by the results of this project and guided in the long run by the impact and success of their graduates.

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Appendix A – Suggested VPA Skills/Tasks

Note: Skills/tasks with majority, but not unanimous, support are identified with an asterisk ()*

Non-Clinical

- Leadership, professionalism & ethics
- Communications
- Client and patient care coordination
- Critical thinking
- Knowledge of comparative medicine/one health, public health & zoonotic disease
- Knowledge of biosecurity and sanitation
- Knowledge of VPA roles in small animal, large animal, shelter, exotics, wildlife, research, etc.
- Knowledge of industry issues and animal welfare & practice act legislation
- Business acumen (profit and loss, fixed vs variable costs, etc.)
- Cultural competency/DEI awareness
- Co-worker training
- Healthcare team management (including health & wellbeing)

Clinical

General

- Establish veterinarian-client-patient relationship (VCPR)*
- Perform comprehensive physical exam (including oral, orthopedic, neuro)
- Acquire history
- Develop diagnostic & treatment plans
- Knowledge of and proficiency in providing a continuum of acceptable care (i.e., spectrum of care)
- Recognize case complexity for appropriate referral to DVM
- Charting/documentation/medical records
- Basic imaging interpretation (including dental radiography & FAST scan US)
- Write routine prescriptions and authorize prescription refills

Advanced nursing practices

- Hospitalized patient assessment & treatment
- Blood transfusions and fluid therapy
- Advanced anesthesia
- Pain management
- Hospice/palliative case management
- Euthanasia

Preventive care

Behavior, socialization & training
Develop vaccine protocol based on risk assessment
Heartworm testing and prevention
Internal parasite testing and prevention
External parasite testing and prevention
Interpretation of routine diagnostic tests
Nutritional management

Diagnosis and Treatment of common/uncomplicated medical conditions

Cardiac disease
Ear infections
Eye infections/ulcers
Gastroenteritis (vomiting/diarrhea)
Lameness
Obesity
Oral/periodontal disease
Respiratory disease
Skin infections/allergies
Urinary tract disease

Diagnosis and Treatment of common/uncomplicated surgical conditions

Laceration repair/surgical closure
Abscess/wound management
Superficial mass removal (after FNA and cytology)
Dental extractions
Castrations
Spays*
Aural hematomas
Surgical & dental rechecks

Shelter medicine

Disease outbreak response
Population rounds
Parvovirus, distemper, panleukopenia & URI treatment
Intake assessments – health and behavioral
Behavior support medications
Animal welfare audits
Infection control/Biological risk management
Rabies sampling
Zoonoses

Livestock & poultry medicine

Vaccine application & program management

Body condition assessment & monitoring

Calving management

Milk sampling & mastitis diagnosis and management

Neonatal care

Mortality assessment (necropsy)

Pregnancy diagnosis & reproduction management

Metabolic disease monitoring

Lameness diagnosis & hoof trimming

Infectious disease monitoring

Animal welfare audits

Reportable disease assessment & monitoring

Livestock worker training

Appendix B – Frequently Asked Questions: Veterinary Professional Associate (VPA) and Master’s in Veterinary Clinical Care (MVCC)

Wayne A. Jensen, DVM, PhD, MBA
College of Veterinary Medicine and Biomedical Sciences, Colorado State University

How do you envision a non-veterinarian clinician addressing the workforce shortage?

VPAs would help address the shortage of veterinarians by assuming responsibility for much of the routine care that is currently provided by veterinarians. This would allow veterinarians to focus their time on more complex patients. The VPA’s capability to serve in a front-line capacity and perform a variety of downstream medical and surgical tasks will complement and enhance the efficiencies and proficiencies of the veterinary healthcare team.

What specific areas or roles do you see non-veterinarian clinicians filling?

VPAs will work under supervision of a licensed veterinarian so their roles will be defined by the supervising veterinarian. Their education and training will emphasize competencies in front-line assessments including identification of abnormal findings on physical examination and diagnostic tests. In addition to education and training in the performance of basic medical and surgical skills, VPA training will also emphasize competencies in client communications which will bolster the paradigms of contextual, incremental, narrative, and spectrum of care delivery.

What are the potential impacts of introducing a non-veterinarian clinician on veterinary technicians and their career paths?

The MVCC leading to the VPA will provide credentialed veterinary technicians a promotion path to a position with greater responsibility and compensation.

How might non-veterinarian clinicians affect the cost and accessibility of veterinary care?

The cost of veterinary care has been identified as a primary factor preventing owners from accessing veterinary care. VPA graduates will have lower student debt so they won’t require the same salary as veterinarians, and thus will enable practices to offer quality care at reduced costs.

How might the financial models of veterinary practices change with the introduction of non-veterinarian clinicians?

Employing VPAs would increase the practice’s ability to see more patients thereby generating more revenue for the practice. Providing the opportunity for veterinarians to focus their time on more complex patients would also result in increased practice revenue. In addition, the supervising veterinarian should expect to earn a portion (e.g., 5%) of the VPA’s production. Overall, this business model has the capability of generating more revenue for the practice, resulting in higher salaries for all practice employees and greater work-life balance for veterinarians and staff.

Should VPAs come from a veterinary technician background?

Some of the best veterinarians were veterinary technicians prior to being admitted to veterinary school. However, being a veterinary technician is not essential to become a successful veterinarian and the same is true for VPAs. In addition, the key to solving the veterinary workforce issue is attracting more people to our profession.

What are your thoughts on offering part of the non-veterinarian clinician education online (how can we ensure hands-on skills are adequately developed)?

Using accessible and interactive technologies and models, students will be able to experience and demonstrate hands-on learning techniques throughout the entire program, including the online portion.

How do you respond to concerns about non-veterinarian clinicians being inadequately trained?

The MVCC that is being created at Colorado State University is focused only on the management of routine health conditions in dogs and cats (eventually there will be a separate VPA program to manage routine health conditions in large animals). By limiting the scope of training, (i.e., not including complex disease conditions and the approximately 1/3 of material focused on large animals), the MVCC will ensure VPAs are competent in the management of routine conditions in dogs and cats including routine surgery (e.g., the core contact hours for preclinical surgical training in the VPA program is equivalent to the core contact hours for preclinical surgical training in the current small animal DVM track, 108 and 105 hours respectively).

How would liability and supervision work for non-veterinarian clinicians?

This relationship of supervision is similar to the veterinarian-veterinary technician relationship that has been in place for decades.

What changes to state practice acts would be necessary to implement non-veterinarian clinicians broadly?

Creation of a new professional position in veterinary medicine will require changes to each state's veterinary practice act. This can be done by either the legislative process or by citizen initiatives that place proposed statutes or constitutional amendments on the ballot for voters to approve.

How do you justify creating this new role when the veterinary profession hasn't fully utilized existing veterinary technicians?

Veterinary technicians are not trained to diagnose and develop treatment plans for routine medical and surgical conditions. VPA graduates will be competent in providing these services.

What alternative solutions exist to address the veterinary workforce shortage?

Several DVM programs are increasing their class size, and 12-15 new DVM programs have been proposed. However, the projected increase in DVMs is insufficient to fully address the access to care, cost of care, and burnout issues in our profession. Additionally, the cost of training DVMs (i.e., the debt burden associated with obtaining a DVM degree) is prohibitive for exclusively providing only routine veterinary care to less affluent clients.

Will there be a national licensing exam?

Eventually, but this will require a sufficient number of programs to support interest by a national testing organization (e.g., AAVSB, ICVA). Until a national licensing exam is available, the comprehensive final exam required of Plan B Master's programs at CSU will be used to ensure the competency of MVCC graduates.

Will there be a national organization to accredit VPA training programs?

The Coalition for the Veterinary Professional Associate (www.cvpa.vet) recently became an Associate Member of the Commission on Accreditation of Allied Health Education Programs (www.caahep.org) and intends to establish a new health science discipline and Accreditation Committee for the VPA profession. CAAHEP requires the existence of three programs before the accreditation process can be implemented.