PROFESSIONAL ISSUES

ISSUE BRIEF

Physician Assistants and the Patient-Centered Medical Home

Physician assistant practice is integrated, patient-focused and team-based—perfectly suited to the patient-centered medical home. PAs, as skilled medical providers, excellent communicators and consummate team players, embody qualities essential to an effective PCMH practice.

Physician-PA Teams: Ideal for the Medical Home

The PCMH model of care assumes team delivery of patient care, with the patient as a core member of the team. The lead clinician on a team may be a physician, PA or other primary care provider who works with a team of other professionals and staff.

In this model, clinicians work together to provide care that is comprehensive, ongoing and coordinated. Improved access includes short wait times, convenient hours for patients, use of electronic communication and responsiveness to patients' preferences. The clinical team provides primary, acute and preventive medical care and integrates specialty referrals and other services in the health system and community.[1]

Understanding team dynamics is one of the major challenges to creating a successful medical home. With their education, regulation and clinical style all based on a team approach to care, PAs bring to a practice a finely tuned understanding of the skills required to create and sustain an effective PCMH practice.

Physician Assistants are

- Educated as medical generalists
- Competent to diagnose, treat, manage and coordinate primary care for patients of all ages
- Qualified to lead a patient care team as the primary care provider
- Educated in a team-based model, ideal preparation for team-based care
- High achievers on patient satisfaction surveys
- At ease with team-based patient care and a flexible scope of practice
- Ideal for meeting evolving practice needs
- Skilled providers of primary care medicine who work in patient-centered teams with physician oversight

PA Scope of Practice Includes

- Obtaining medical histories
- Conducting physical assessments and examinations
- Diagnosing and treating illnesses and injuries
- Managing acute and chronic illnesses
- Performing and interpreting diagnostic and laboratory studies
- Prescribing medication
- Counseling and teaching health and nutrition
- Referring patients to specialists and other providers
- Performing minor surgical procedures

The System Needs PAs

The United States faces a looming shortage of primary care providers. A study from the University of Missouri reported in *Health Affairs* predicted a shortage of 35,000–44,000 adult primary care physicians by 2025.[2] The Association of American Medical Colleges predicts a shortage of 45,000 primary care physicians by 2020 and 65,800 too few by 2025.[3, 4] Workforce studies, recent experience with Massachusetts' mandated insurance coverage and years of experience in underserved areas all underscore the fact that physicians alone cannot provide the amount of coordinated, managed, primary care that will be needed in the next 20 years.[5, 6]

Physicians Endorse PAs

Both the American College of Physicians and the American Academy of Family Physicians recognize physicians and PAs working together as "a proven model for delivering high-quality, cost-effective patient care." Both organizations state that PAs should be recognized as primary care providers in the PCMH.[7,8]

Accreditors Recognize PAs

AAPA has worked closely with the National Committee for Quality Assurance and The Joint Commission to ensure that their medical home standards fully include PAs. In early 2010, NCQA expanded eligibility for three of its recognition programs to include PAs: patient centered medical home, diabetes and heart/stroke. Joint Commission standards for the Health Care Home identify primary care ***clinicians*** as the key to patient-centered care. URAC standards on the health care home are similarly broad.

Medical home accreditors recognize PAs. Standards from NCQA, The Joint Commission and URAC recognize PAs as primary care providers and as qualified to lead patient care teams.

States Recognize PAs

In many states, medical home regulations allows decisions about individual clinician roles to be made at the practice level.

Iowa law defines the medical home as "… a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider and other health care professionals …." The law includes PA in its definition of primary care provider and describes the medical home as a "provider-directed medical practice" in which each patient has "an ongoing relationship with a personal provider."[9]

Maine recognizes PAs as primary care providers in its state health programs, including its patient-centered medical home.[10]

Minnesota law includes PAs in its definition of "personal clinician." In Minnesota, "health care homes" must "emphasize, enhance and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses and PAs as personal clinicians."[11]

The **Vermont** Blueprint for Health recognizes physicians, PAs as primary care providers who can have panels of assigned patients. All payers in the state recognize PAs as primary care providers. Vermont law includes PAs in its definition of "health care professional" and defines primary care as "health services provided by health care professionals specifically trained for and skilled in first-contact and continuing care …."[12]

PAs Lead Patient-Centered Teams

From the heartland to the coasts, PAs are leading care patient teams. Examples of PA roles in medical home practices illustrate the flexibility of the team:

A PA-run family practice in rural New York has achieved NCQA's highest level of recognition as a PCMH. The PA who led the practice to level three recognition is the primary medical provider for the practice, which participates in the Adirondack Region Medical Home Pilot. A family physician in practice 15 miles away provides collegial and clinical support.

In a small family practice in Maine with one physician and one PA, each has his own panel of patients, and each manages urgent care and chronic disease patients. They cover for one another as needed to maintain their open access schedule.

In an internal medicine practice near Albany, N.Y., a PA spends half her day seeing her own panel of assigned patients and half her day on acute same-day patients. Dividing her time between her assigned patients and same-day appointments accomplishes three important goals: 1) patients can select the PA as their primary provider —one of only two female clinicians in the practice; 2) the PA is allowed the professional satisfaction of developing ongoing relationships with patients; and 3) by scheduling to cover some acute appointments, the PA facilitates patient flow and limits waiting time.

In a Colorado community health center with more than two dozen physicians, PAs and nurse practitioners, the physicians take hospital calls and deliver babies, so are not always in clinic. Each clinician has his or her own panel of 1,200 to 1,500 patients, enabling same-day access, dropping the no-show rate and increasing productivity.

Challenges to Full Utilization of PAs

Many PCMH practices utilize PAs effectively; however, regulatory and cultural challenges remain. Statutes, rules and policies that only recognize physicians or "independent" clinicians as primary care providers result in underutilization of PAs and limit patient access.

For example, a large private payer requires that practices participating in its PCMH program form panels of five to 20 "primary care physicians." In a rural area, practices were unable to muster enough primary care physicians, and the PAs in their practices did not "count" toward the minimum. The practices eventually abandoned their efforts to participate. As a result, the patients, the physicians, the PAs and the health care system in that community are deprived of the benefits that the PCMH model offers.

Even where PCMH policy language clearly allows PA leadership, planners sometimes misunderstand the nuances of PA practice. Leading a PCMH and receiving clincial guidance from a physician are not mutually exclusive

concepts. Delegated autonomy characterizes much of a PA's work, and the style and level of physician oversight is tailored to the needs of an individual practice and its patients.

To fully utilize PAs in the PCMH model:

- **Allow patients to choose a PA as their primary provider.** This maximizes access, while still allowing physician oversight of the PA's work.
- **Allow a PA to lead the transformation of a practice,** if the PA is the best person for the job. This does not usurp physician oversight of the PA's clinical work.
- **Assign PAs patient panels,** rather than having them see only same-day, acute patients. This enables PAs to develop the kind of clinician-patient relationships that are essential to the medical home. Primary care practices that only utilize PAs for overflow and schedule relief may soon find professionally dissatisfied clinicians who will leave for more clinically fulfilling positions.

Further Information

Additional information about PAs and the patient-centered medical home is available by contacting Ellen Rathfon, Senior Director, Professional Advocacy, at ellen@aapa.org or 571-319-4347.

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9 2011 Iowa Code Annotated, Title IV Public Health; Subtitle 2, Health-Related Activities; Chapter 135, Department of Public Health; Division XXII, Medical Home; 135.157, Definitions; and 135.158, Medical home purposes – characteristics.

10 Code of Main Rules, 10-144, Department of Health and Human Services, Chapter 101, MaineCare Benefits Manual, Chapter VI, 1.08-1(c) and 1.09-1 and 1.09-2.

11 Minnesota Statutes Annotated, Public Welfare and Related Activities, Chapter 256B.0751(e).

12 Vermont Administrative Code; Title 4; Subtitle 5; Rule 13. Rule H-2008-05; 4-5-13:2 and Vermont Statutes, Title 8, Chapter 107; 8 V.S.A. § 4080f.

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