

# MANAGED CARE

## OUTLOOK

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### **As Health Care Continues to Evolve, So Does the Role of the Physician Assistant**

On January 8, 2014, the State Health Care Cost Containment Commission, in conjunction with the University of Virginia's Miller Center, published a report examining the role of governors and other key leaders in the transformation of the health care system from its current state to one that is more integrated, patient-centered, and cost-effective. The report, "Cracking the Code on Health Care Costs," offers a number of recommendations aimed at helping states develop solutions unique to their health care markets and cultures.<sup>1</sup>

Within the context of that discussion, the report highlights the importance of nonphysician providers at a time when the industry is suffering from a significant shortage of primary care physicians. According to the report, "Experience has shown that nonphysician providers, such as nurses, nurse practitioners, and physician assistants (PAs), can provide much of the routine and primary care frequently provided by physicians at the same level competency. Moreover, the cost of care delivered is frequently lower."

The first step to better understanding how to more fully integrate certified PAs into the health care system is to understand the scope and market penetration of how many PAs are out there right now, says James Cannon, DHA, MBA, PA-C, chief operating officer (COO) of a major health care organization, and Chairman of the Board for the National Commission on Certification of Physician

Assistants (NCCPA). "With 95,000+ certified PAs working in every specialty and every state across the country, clearly they are a critical part of the health care delivery system. As we all know, the Affordable Care Act focuses on getting the right care at the right time at the right place — and at the right cost. PAs are an excellent resource for meeting each and every one of those criteria."

It is important to note that PAs are initially trained as primary care general practice providers, explains Cannon. As a result, even if they later turn their attention to a specialty area, their "first language," so to speak, is primary care. Also, PAs can be quite autonomous in many respects. Yes, they work on a physician-led team, but in some instances, the physician is miles away at another facility. More often than not, the PA takes the patient's history, examines and diagnoses the patient, interprets diagnostic tests and studies, and prescribes medications and other courses of treatment. In most partnerships the physician is there to consult with on an as needed basis, not to get involved in every case. PAs also have a very strong penetration in the surgical specialties — in particular cardiothoracic, vascular, and orthopaedic. As a result, they are very much a part of the day-to-day delivery of the full range of health care, he adds.

Nevertheless, barriers exist that prevent PAs from being fully utilized, acknowledges Cannon. For example, the rules and regulations governing PAs are inconsistent from one state

to another. “When you’ve seen one PA state practice act, you’ve seen one PA state practice act,” he jokes.

While it is true that there are only two states left in the nation that do not allow PAs to prescribe controlled substances or narcotics, there remains quite a bit of variation with respect to whether a PA can practice without onsite physician oversight. Roughly two-thirds of the states allow for remote practice of PAs, but with varying degrees of connectedness between the PA and supervising physician.

“There must be consistency across state lines when it comes to rules and regulations,” urges Cannon. “It won’t make sense to have exchanges that can cross state lines but inconsistency in the rules and regulations. We must find a way for PAs to work at the peak of their ability, skills, and education without being impeded by inconsistent laws and regulations. In most insurance plans under ACA, wellness and prevention are the focus as this can reduce unnecessary emergency department visits and hospitalizations, which leads to real savings. PAs are educated as generalists and trained in patient education, so insurers and ACOs understand they are an important part of the staffing equation.”

From a holistic perspective, there is a “Triple Play” effect, says Cannon, that relates to access, quality of care, and cost. “First, we are going to have to increase capacity in some way to provide access to care for a growing patient population, but what does that look like? Do we increase the number of patients that a provider sees? Obviously, if we increase the panel size of a provider, that provider won’t be able to spend as much time with each patient. So the second factor is, how will this impact the quality of the patient-provider interaction? How will it impact patient outcomes? And finally, you have to find something that bends the cost curve and lowers cost without sacrificing access to care and quality. The traditional fee-for-service payment model promotes fragmentation and higher spending. PAs address this challenge by

delivering and coordinating care while billing at 85 percent of the physician’s rate for the same service, at least to Medicare and some commercial insurers.”

A number of organizations have already begun to more fully integrate PAs into their systems, notes Cannon. “Kaiser Permanente and the Cleveland Clinic are excellent examples on the private side. They have figured out the recipe. They have fantastic electronic health records; they have excellent evidence-based clinical guidelines; they use PAs extensively throughout their facilities; and they know they cannot achieve their financial or economic targets without these resources. On the federal side, the nation’s largest employer of PAs is the Veterans Administration (VA). Just recently, the VA said that it wants to have an even more collaborative relationship between PAs and physicians. They recognize that PAs are a vital part of the health care team, and they’ve done a great job of integrating them into their system.”

NCCPA is the only certifying organization for PAs in the United States. The PA-C credential is awarded by NCCPA to PAs who fulfill certification, certification maintenance, and recertification requirements. In 2011, NCCPA launched its Certificate of Added Qualifications (CAQ) program for certified PAs practicing in cardiovascular and thoracic surgery, emergency medicine, nephrology, orthopaedic surgery, and psychiatry; CAQs in pediatrics and hospital medicine are being added in 2014. Ensuring qualified PAs are equipped with the credentials they need to function effectively and seamlessly in an evolving health care system is critically important, says Cannon.

For additional information about NCCPA, go to [www.NCCPA.net](http://www.NCCPA.net) ■

#### **Endnote:**

1. For additional information about the State Health Care Cost Containment Commission report, including the list of recommendations, refer to the sidebar below.

## Report Examines How Key Leaders Can Transform the Current Health Care System

Earlier this year, the State Health Care Cost Containment Commission, organized by the University of Virginia's Miller Center, released a report that examines how the nation's governors and other state leaders can transform the current health care system into one that is more coordinated, patient-centered, of higher quality, and less costly. The report, "Cracking the Code on Health Care Costs," also emphasizes the importance of tailoring solutions to the unique health care markets and cultures of individual states and offers a short list of recommendations at the state level for doing so. That list includes the following:

1. **Create an Alliance of Stakeholders to Transform the Health Care System:** To move toward a more cost-effective health care system, state government must form an alliance with purchasers, the medical community, and other stakeholders to create a consensus and commitment for change.
2. **Define and Collect Data to Create a Profile of Health Care in the State:** Working with their stakeholder alliance, states should establish a common definition of health care spending, identify quality-tracking measures, create a process for collecting cost and quality data, and conduct an initial analysis of where health care spending is above national norms.
3. **Establish Statewide Baselines and Goals for Health Care Spending, Quality, and Other Measures as Appropriate:** The state and its alliance should establish appropriate targets for limiting cost growth and quality improvements in the health care system.
4. **Leverage Payment Reforms to Accelerate the Trend toward Coordinated, Risk-Based Care:** States should use health spending programs they administer to encourage the formation of high-performing coordinated care organizations that accept risk-based, global payments. Programs that states can use for leverage include Medicaid, the state employee health program (which can be combined with local government employees for increased influence), and health insurance exchanges.
5. **Encourage Consumer Selection of High-Value Care Based on Cost and Quality Data, and Promote Market Competition:** States can help ensure that consumers are given the cost and quality information they need to make informed health care decisions and that adequate competition exists in the health care marketplace. States can make the cost and quality of health care services more transparent by reporting such information on a statewide basis and requiring plans and providers to publish such information.
6. **Reform Health Care Regulations to Promote System Efficiency:** State health care regulations affecting insurance, benefits, scope of practice, and medical malpractice can influence health care costs. States should review these policies to ensure they promote efficiency and do not present obstacles to expanding the availability of risk-based, coordinated care.
7. **Promote Better Population Health and Personal Responsibility in Health Care:** States can use education and the bully pulpit, wellness programs for state employees, and public health initiatives to promote population health and encourage individuals to take more personal responsibility for their health care decisions.

The State Health Care Cost Containment Commission is co-chaired by Mike Leavitt, former U.S. Secretary of Health and Human Services and Governor of Utah, and Bill Ritter, former Governor of Colorado. Its members represent all key sectors of the health care community and include health insurance, hospital, and physician group chief executive officers (CEOs) as well as representatives of the major purchasers of health care, such as Medicare, Medicaid, the private sector, and consumers. The Commission's efforts are funded by Kaiser Permanente and The Robert Wood Johnson Foundation.

To access the full report, go to [millercenter.org/policy/commissions/healthcare](http://millercenter.org/policy/commissions/healthcare).

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