2014 Advancing Primary Care Conference
Review Article

With a call of “all hands on deck,” Andrew Morris-Singer, President of Primary Care Progress, challenged the attendees at the 2014 Advancing Rural Primary Care Conference to be “game-changers” in directing the future of patient care under health care reform.

With federal reform expanding Medicaid and other insurance avenues, a glut of 20 million newly covered patients needing primary care is expected. However, Thomas Morris, Associate Administrator of the Federal Office of Rural Health Policy, reported that the majority of rural residents live in a state without plans to increase Medicaid. There is a wider rural-urban disparity in insurance coverage than existed before the Affordable Care Act.

Answers to this dilemma may be found by bringing more Physician Assistants (PAs) to rural areas. Since 1977 under the federal Rural Health Clinics Act, PAs and nurse practitioners (NPs) have been supported to address the inadequate supply of physicians in rural areas by managing Rural Health Clinics and Federally Qualified Health Centers. Among federal provisions, PAs leading such clinics are eligible for incentive payments (tied to using electronic health records) when they meet the needy threshold criteria and achieve Meaningful Use. “PA-led” means the PA is the primary care provider, the clinical or medical director, or the owner.

Bill Finerfrock, Executive Director of the National Association of Rural Health Clinics, reminded the audience that in 1970 America met the first model of a rural PA, Chipper Wallet, in the daily comic strip, Gasoline Alley. Since that time the number of Rural Health Clinics, which to be certified must employ a PA or NP, number over 4,000 clinics across the country. Finerfrock reported that Missouri, Texas and California lead the country with the highest number of Rural Health Clinics, with the Midwest states of Illinois, Kansas, Michigan and Iowa also on the top-ten list.

A new study profiling the PA profession in the US was presented by Mark Christiansen, PhD, PA-C, National Commission on Certification of Physician Assistants, Inc. Almost 45% of the profession is under the age of 35; reassuring news in that the graying of the physician supply seen in many studies is not realized among PAs. With 190 PA programs graduating over 6000 PAs each year, the top practice area is family medicine/general practice (24.3%). Next is surgery subspecialties (19.3%) and emergency medicine (15.3%). Forty percent of PAs report practicing in two or more areas and over a third (35.4%) of PAs take call each week.

The challenge of maintaining rural health systems was recognized by Alan Morgan, Chief Executive Officer of the National Rural Health Association. He shared that in recent years there have been 11-15 rural hospital closures a year, with 9 more added in 2014. From his agency’s resources, he cited that
compared to urban counties, rural counties are more likely to report poor health (19.5% vs. 15.6%), obesity (27.4% vs 23.9%), and more chronic disease (9.6% vs 8.4%).

Thomas Tape, Chair of the American College of Physicians Health and Public Policy, and Chief of the Division of Internal Medicine at the University of Nebraska Medical Center, reported that the US ranks last among 19 developed countries in terms of preventable mortality and ranked highest in per capita health expenditures among 11 developed countries. Acknowledging that current health care costs are unsustainable, Dr. Tape reported that the future of health care must focus on quality and value. Measures to illustrate this included information from the Commonwealth Fund showing that currently the US average for percent of insured adults was 83% (Massachusetts was highest at 95% and Texas was lowest at 64%). The US average of adults who went without needed care because of cost in the past year was 17% (Hawaii reported the lowest at 9% and Mississippi was highest at 22%).

Katharine Witgert, Director of the National Academy of State Health Policy, spoke of the PA role in the rural workforce as one allowing autonomy as the PA is often the principle provider while maintaining physician oversight. Creative opportunities for small practices to engage in local resources by telehealth access is directed by PAs who are well-suited for the coordination of the rural care. She called PAs to take a “seat at the table,” noting that there remained many chairs to fill, such as working with state rural health offices, Medicaid agencies, health insurers, the local governance, as well as the primary care office.

Robert Wergin, MD, President of the American Academy of Family Practice, reminded the audience that of 70,000 PAs in 2010, 43.2% were in primary care (citing data from the Agency for Healthcare Research and Quality). Twenty percent of the US population live in rural or frontier areas of the country, and 16% of PAs work in these rural areas compared to 9% of physicians.

Patient Centered Medical Homes were modeled as primary care practices that offer around-the-clock access to coordinated care and a team of providers that values patients’ needs. Of 502 practices over 7 regions, Dr. Wergin reported that 53% have NPs/PAs and 36% with registered nurses (RNs).

He challenged the audience to recognize that the future of rural health must be team-based, integrated with public, community and behavioral health. Addressing concerns of quality care, Dr. Wergin cite studies such as the equivalent outcomes of diabetic care when PAs are part of the team, and how patient continuity of care is similar between NP/PA and physicians.

Bob McNellis, with the federal Agency for Healthcare Research and Quality, shared that primary health care must be comprehensive, continuous and coordinated, offering first contact in patient access to health care systems and be whole-person oriented (not oriented to organ systems). New processes of care coordination will offer ongoing quality and safety improvement, and he recommended linking clinical care to community resources to better support population health management. Primary care in this way is not simply a location, but it serves then as a model of health care delivery that is patient-centered and continuously improved through a broad-based approach to quality and safety.
A progressive model of the physician-PA team was described by Steve Wengel, Chair of the Department of Psychiatry at UNMC, Howard Liu, Director of Behavioral Health Education Center of Nebraska, and Michelle Williams, PA in the Department of Psychiatry. They presented a medical home model with an integrated mental health component that offered easy access and continuity of care by supporting a mental health professional working alongside the primary care providers. Citing that when mental health is disconnected from primary care, poor communication, long wait times and eventually lost access to care occurs, Ms. Williams suggested that a shared patient approach is functional and the role of a psychiatric PA offers an aided-independent practice approach with physician availability for consultation.

Jeffrey Katz, PA-C, president-elect of the American Academy of Physician Assistants, and Ben Taylor, PhD, PA-C, President of the Association of Family Practice Physician Assistants, both brought research data and their own personal experience as clinically active PAs to demonstrate the role of PAs in reforming primary care.

Rethinking cultural competency, Amy Drassen Ham, PhD, MA, MPH, proposed that in light of the greater diversity found in the growing primary care patient population, the current approach to cultural competency may not be effective. She recommended that culturally-informed care maintains a professional responsibility without requiring a high level of expertise, and more emphasizes an awareness of socioeconomic barriers, personal living situations, and varying worldviews, beyond limitations of race/ethnic stereotypes.

“The need is apparent for a system redesign,” said Keith Mueller, Professor and Head, Department of Health Management and Policy at the University of Iowa. He suggested that health care delivery as we’ve known it may be on “the eve of destruction” unless our thinking transitions from valuing volume to valuing care across the continuum. Early signs that ruin may be avoided include the reward mechanisms being initiated for quality and efficiency, the fledging interoperable use of information technology, and the occasional collaboration among stakeholders in health care. If these new directions take hold with success, a value-based high performance system of health care may succeed.

Conference attendees consistently remarked that the speakers were insightful and the information was highly useful in gaining the effective utilization of PAs in primary care. Conference evaluations report that those attending believe they are positioned to lead better health care for rural America, and that team care will be enhanced to allow for better patient outcomes.