



# Transforming Primary Care

**PAs and Patient-centered  
Medical Homes**

BY LESLIE KOLE, PA-C

## Transformative health system innovations. Re-engineering primary care.

### Transitioning from volume-based to value-based systems of care.

**T**HESE ARE JUST A FEW OF THE FANCY PHRASES flying around these days that pertain to fixing our fragmented, overburdened, primary-care delivery system. But in the post-Affordable Care Act (ACA) world we now live, the most popular model is transforming primary care practices into the Patient-centered Medical Homes (PCMH).

With PCMH, the emphasis is on long-term relationships between primary care providers—physicians, physician assistants, and nurse practitioners—and collaborative team care that is comprehensive, coordinated and enhanced by information technology. The patient is an integral part of the team and centrally involved in decision making.

Several provisions in ACA further promote the model, including increasing reimbursement to practices designated as homes for Medicaid patients with chronic conditions, funding PCMH demonstration pilot projects in nearly 40 states and creating the Center for Medicare & Medicaid Innovation (CMS Innovation Center) that is testing different payment and delivery system models.

In theory, primary-care redesign requires that practices address the health of individual patients—increased access and patient-provider assignment, coordinated care across time—and the health of “populations” by identifying groups of patients

with certain chronic conditions, such as diabetes, using clinical practice guidelines, collaborating closely with others providing care to that population group, improving patient self-management and measuring outcomes.

The belief is that by improving the health of populations that strain the delivery system, there will be improved individual health, better quality of care, increased efficiency and lower costs.

Accountable Care Organizations (ACOs) are developing, organizing and experimenting with different ways to adjust reimbursement in primary care and to reward improvements in quality, efficiency and care coordination. Many successful ACO models are embracing a shift from volume-based reimbursement to value-based reimbursement and the formation of population health management hubs.

The PA profession has been firmly rooted in providing primary care since its inception. The movement toward redesigning and strengthening primary care delivery systems gives PAs tremendous opportunities to be leaders in innovation. While the PCMH model is showing promising results in terms of patient and provider satisfaction, improvement in quality of care, and reducing costs, many challenges lie ahead. The viability of primary care delivery reform may be threatened by the impending primary care provider shortage, the aging of the population and the addition of millions of new patients coming from the ranks of the currently uninsured. To gain a better understanding of the role PAs are playing in transforming their practices to the PCMH model, and to estimate the additional skills they may need to adapt to change, PAs from several different primary care sites were interviewed, as well as a PA leader who has advised numerous practices on how to become PCMHs.

#### Team-based care

There are many different variants of PCMH but one commonality is that they all use a team-approach to delivering medical care. “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 a finely tuned understanding of the skills required to create and sustain an effective PCMH practice,” according to an AAPA issue brief on PAs and PCMHs.

Jeffrey Welsch, PA-C, was involved in transitioning the internal medicine department of Dean Clinic-East to a PCMH. Based in Madison, Wis., Dean

PA Wendy Hladick  
treats a patient in  
rural Alaska.



PA Margaret Allen with a patient in medically-underserved East Palo Alto, Calif.

Health System is one of the largest integrated healthcare delivery services in the country. PAs, NPs and physicians operate in pods based on the physical layout of the clinic. Pods typically consist of one or two physicians, a PA or NP, a nurse, a certified nurse assistant or medical assistant and receptionist. Welsch attributes the relatively smooth transition in his internal medicine practice to the strong partnership he already had with Albert Musa, MD. Musa had a challenging elderly patient population, with complex chronic diseases. When Welsch was initially hired, he was introduced at the outset as Musa's partner and they often saw patients together.

Looking back on Dean's pre-PCMH days Welsch remembers an internist colleague commenting that "practicing medicine felt like you were constantly running around with your hair on fire." With the transformation to team-based care Dean clinicians are taking much less work home and are not in the clinic as late. Nurses complete some of the never-ending paperwork and handle a good share of the phone calls, streamlining communication so the primary care providers can maximize their time seeing patients. "Now there is truth in scheduling, and you don't have to see a patient every 15 minutes," Welsch said. "I can spend more time on one visit and get to things like lifestyle change counseling. We've moved past the 'hair on fire' model of health care delivery."

TransforMED's Diane Cardwell, MPA, ARNP, PA-C, has done extensive coaching for team-building as family practices worked to become medical homes. TransforMED is a non-profit consulting program created by the American Academy

of Family Physicians to promote and assist practices to implement the PCMH model. Early research from TransforMED showed that when they taught teams to communicate more effectively and when providers were taught to utilize their team in a more meaningful way, their quality of life went up.

"My mantra is that we have to develop teams around what the patient needs," Cardwell said. "If we truly do patient-centered care, then the best model has to be what does the patient need and what does the patient want?"

In Danville, Pa., 20-year Geisinger Medical Center veteran Ron Byerly, PA-C, practices general internal medicine and serves as the Advance Practice Council representing PAs and NPs system wide. Geisinger is a physician-led integrated health services organization that acts as provider, employer and payer, and was one of the early adopters of the PCMH model. Byerly notes that effective collaboration and higher-level use of staff has gone a long way toward improving patient and provider satisfaction. For example, embedding RN case managers within the team has been a valuable improvement. The RN case managers monitor hemoglobin a1c values (HgbA1C) in diabetics and weights in patients with decompensating heart failure. "When there are variations of concern then the case managers come and search us out," he said. "We're working much more collaboratively with these RNs."

The care teams also benefit from regular monthly meetings where they discuss issues including planned prevention and reduction of hospital readmission rates or ER utilization. "But we also do case presentations of the more difficult cases, the

PA Morgan Nowak, right,  
with an audiology colleague  
in northern Virginia.



patients with multiple medical problems who have socioeconomic issues.” Everyone contributes to discussions. “It’s rewarding to be part of such a team,” Byerly said.

Diane Littlewood, RN, Director of Population Management with Geisinger Health Plan, has been involved in transitioning Geisinger’s many practice sites into PCMHs. “We’re really growing, we still have a lot to learn but its opened doors and we’re not in silos, we sit around tables, we talk about opportunities, we have experiences that we want to share with other sites and systems,” she said. “It has been a really good experience.”

The team approach is well established across the country in Washington state at Group Health Cooperative, another large, integrated system that is both provider and payer. PA Jon Lowe is medical chief of the Redmond Medical Center, where he practices medicine with nine physicians and a PA. PAs do not have their own panels but help to manage the physicians’ panels. Lowe manages a lot of geriatric patients, many who have complex medical problems.

“We developed a fairly rich support service with nurses and medical assistants,” he said. “The model is really one on one, so there is one medical assistant for each clinician; and then one RN for every five clinicians.” Group Health was well suited to implement the model because their providers are salaried and their compensation is not tied to the volume of patients seen. Since 2006, their primary care clinics underwent medical home redesign that relied on existing EHR technology.

### Comprehensive care

One of the criteria for becoming a PCMH is the ability to provide a comprehensive breadth of services. A

PCMH must be able to coordinate care across all settings, practices, hospitals, nursing homes and consultants in an increasingly complex health care network. Integrated multi-specialty centers, such as Geisinger and Group Health Cooperative, can more readily adapt to this requirement than many smaller sites. Despite the challenges The Health Center in Plainfield, Vt., proves that small practices can provide “umbrella care.” With some upfront funding from Vermont’s Blueprint for Health, a primary-care collaborative, the center has four physicians and four PAs, and is now a fully accredited PCMH.

Jessica Fisch, PA-C, has practiced at The Health Center, a rural, federally-qualified health center for 34 years. She said the transition to becoming a PCMH wasn’t so difficult because the center had always emphasized collaborative team care. In addition to the physicians and PAs, there are nurses, dental services, onsite pharmacy, mental health services, including counseling, PTSD treatment and substance abuse rehabilitation, physical therapy, social services, and health education. The clinic even reached out into the community, termed increasingly in health policy circles as “the medical neighborhood,” and contracted with a local bus company to arrange regular transportation for patients who otherwise could not get to the facility.

She notes, “This model comes from progressive thinking that hopefully can continue with healthcare reform and be implemented on a larger scale.”

Don Grabowski, The Health Center practice manager, relied heavily on the PAs as the facility implemented the medical home model. “PAs were always my ‘go to people’ for advice on guidelines—what’s the best way we can get patients to do this? They played critical advisory/clin-

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Diane Cardwell,  
MPA, ARNP, PA-C



PA Phoumy Bounkeva with a patient at Seattle's International District Clinic.

cal roles," he said. "PAs are really in touch with patients, they have a huge caseload here. PAs were like the incubator of new practices. One thing that makes that team work and allows us to provide such comprehensive care is that there are no hierarchies here, no egos getting in the way of figuring out what works best."

Amanda Johnson, PA-C, also of Dean Clinic-East, one of 14 internal medicine providers in her pod, agrees that the medical home approach is a better way to practice medicine. The clinic now has a social worker several days a week, a pharmacist who advises on medication management, a nutritionist, a mental health professional and a diabetes educator on-site. She says that patients are much happier to get everything done in one visit and more likely to be adherent if a provider can say, "Hey, our nutritionist or our pharmacist is right down the hall."

### Expanding access/open scheduling

Another criterion for becoming a medical home is timely access to care, including availability of appointments after regular office hours, especially evenings and weekends. PAs have been instrumental in expanding that access. Some practices are even open Sundays. Geisinger's Ron Byerly notes that a portion of his practice is dedicated to providing access to medical home patients. "That means the willingness to add patients on and the willingness to see somebody who would otherwise end up going to the emergency room."

Similarly, W. Scott Monks, PA-C, MPAS, joined Johns Hopkins Community Physicians (JHCP) in 2008 to help implement that PCMH pilot at the Water's Edge clinic in Belcamp, Md., to expand availability of same day appointments. With background in emergency medicine and urgent care, he was a good fit for the clinic's needs.

"My big task is to handle acute care, urgent care, same day visits and walk-ins," Monks says. "Above and beyond that, I do research and development to expand the services that the practice provided. I had the time to do that, approaches that

worked were farmed out to the rest of the practices at JHCP." Water's Edge is one of five Johns Hopkins Community Physicians facilities that have received the highest level of PCMH recognition from the National Committee for Quality Assurance (NCQA). Open access scheduling at Monk's practice has translated into increasing

patient satisfaction scores.

### Patient-centeredness

PCMH pilots have discovered that engaging patients and their families in their care leads to better outcomes, particularly for those with chronic illnesses. Research has shown that patients want to be partners with their clinicians in making decisions about testing, treatment options and lifestyle changes. Patient-centeredness is about the whole person not just the signs, symptoms and differential diagnoses. One of the goals of team-based care in a medical home setting is that the clinician has time to get to know about the patient's life circumstances, their home and work environment, and their personal problems, all of which can influence health.

As effective communicators and patient educators, PAs are perfectly positioned to bring about a better balance to the clinician-patient relationship. Beth Grivett, PA-C, with Premier Physicians Medical Group in South Orange County, Calif., is involved in transforming her practice into a PCMH. She has also been on the lecture circuit in the state promoting to physicians the value of PAs as change drivers and "quality improvement conduits." She advises that PAs can take on discreet projects that will add significant value to the practice. One example from her practice is educating providers about the value of understanding all required elements and specific coding in the recently enacted Medicare Annual Wellness Visits for seniors, which provides revenue to the practice and better health for seniors. She has done almost a hundred of such encounters with patients, allotting 40 minutes for each visit. "These visits help the patient understand how our practice is changing to become more patient-centered," she says. "They already think their physicians and PAs are wonderful, but they like the idea of spending some time discussing their desires and coordinating their care."

Advances in information technology such as patient portals and access to virtual personal health records may heighten patients' involvement in managing their health care. Use of

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e-mail and telephone communication should further enhance access to primary care and improve communication between the patient and the medical home.

At Group Health interactions with patients are called “touches.” New telephone technology enables patients to connect directly to their personal primary care providers by simply entering their medical history number. “We’ve kind of turned the pecking order or hierarchy of the phone answering upside down—so we have the highest most capable person answering the phone when you call,” says PA Jon Lowe. “We do a lot of patient touches through secured messaging with email and telephone; we’ve actually increased our touches over 100 percent in the last few years with the medical home.”

### Information technology

Essential to most PCMHs, electronic medical records (EMR) link systems of care and facilitates care coordination and information transfer between providers. EMR also enables sharing of best practices through evidence-based guidelines, decision-support tools and care reminders that are embedded in work flows so that they are effective aids to providers and patients. Lowe explains that EPIC (Epic Systems Corporation) EMR, provides a single patient record system across Group Health Cooperative in Seattle that allows seamless access to patient data across the continuum of care. “We have very real time information on all of our patients throughout the entire system,” he says. “We have partnered well with our specialist and our hospitalists and we’ve built systems to make sure that when our patients end up in the emergency room or urgent care and don’t get admitted, they get back to primary care the following week or following day for a check-up, and we’re really following their condition and making sure that they’re not getting in trouble.”

Robust EMR systems take some getting used to by providers, Lowe says. “Managing virtual work or electronic medical records work makes his day very busy. We do a lot more than we have in the past [now that] the electronic medical record makes everything visible. It improves the ability to pull [information] together but it does require a huge amount of work or time from the entire team.”

Accessing other providers’ information technology can also assist with care coordination. PA Scott Monks, of Johns Hopkins Community Physicians, used information technology to develop and implement a protocol for enhancing the quality of care and cost effectiveness when medical home patients are seen in the ER, get admitted to the hospital and for transitions of care upon discharge. “We developed a relationship with [local hospitals] to help track our patients when they are

admitted,” he says. “We have real access to their medical records system, so we can actively go in daily and look for patients who are admitted from just our practice—then we go right to their medical records and find out what’s going on... look at their labs, any consult notes. As a reciprocal task, because we do not have privileges at [the local] hospitals we do outreach to the hospital attending physician to give them a heads up on what’s been done so far, what’s going on [or] that something needs to be done.... we send chart summaries and office visits...in an effort to try to reduce unnecessary testing and we’re another resource for them if they have questions about the patient.”

Paying attention to transitions of care has reduced hospital readmissions substantially. JHCP PCMH also created preventive care templates for its EHR system that notifies the team to document certain measures or to ask specific questions of the patient at the next visit.

Enabled by the EMR, Amanda Johnson was a leader at Dean Clinic-East in developing the quality metrics using a patient registry and she devised processes for proactive patient management as a part of the PCMH. Soon after joining Dean in 2009, Johnson was placed on bed rest for pregnancy, giving her plenty of time to work on the metrics of how primary-care teams could do better surveillance of patients’ health maintenance such as blood pressure control, low density lipoprotein levels in coronary artery disease patients, colonoscopies and PAP smears. “I was able to concentrate on working out the kinks--no one else had the time to devote to this in a busy day of seeing patients.”

Johnson started initially with lists generated from the EMR of patients who were overdue for tests or procedures, such as microalbumin and HgbA1C in diabetics. Chart review tested the validity of the lists and patients were prompted to get the recommended care. A few months later, she re-analyzed that data to see how many patients remained who were overdue for health maintenance tests or procedures. Johnson developed a streamlined work flow allowing unit clerks to run all the metrics, freeing up time for the nurses and clinicians to handle other matters. “Our data shows that we have achieved better outcomes by keeping track of all the metrics that need to be kept up to date on a regular basis,” she said. “Building the EMR is a lot of work up front, especially when you’re seeing 20 patients a day. But [eventually with refinements] it allows you to practice more efficiently and give better care and not be in the office until late at night documenting everything,” she noted.



PA Rachel Farrell with a patient in her clinic in rural Northern California.

### Chronic care management

One goal of the PCMH is a paradigm shift from fragmented, uncoordinated, episodic care to a proactive planned approach to prevention and health promotion, particularly among patients with chronic diseases. The NCQA predicts that by 2015 there will be 150 million Americans living with at least one chronic disease. PAs are perfect candidates for executing the essentials of this model, because they understand how to incorporate the clinical information systems, decision support, delivery system design, and self-management support for patients with diseases such as diabetes, heart disease, asthma, COPD and depression.

Many PCMHs have found pre-visit planning to be efficient for patients with chronic diseases. In advance of an appointment, nurses review and update medication lists, find consultation reports of visits to specialists, and alert providers to lapses in preventive care. Without an EMR, The Health Center in Vermont employs a “data-mining” nurse who peruses the charts of patients with chronic diseases in advance of office visits. “Otherwise I’d be flipping through the chart myself to see if an HgbA1C was done or if a foot exam is needed,” says PA Jessica Fisch, “that’s a lot of time wasted.”

At JHCP Water’s Edge, PA Scott Monks developed and implemented a depression follow-up program and a diabetes education program for which he has quantifiable metrics showing that patients who attend his class have improvements in their HgbA1C level compared to those who don’t attend.

Steve Crawford, MD, a physician at the University of Oklahoma, commented that the PCMH model has forced a focus on quality of care measures and the efforts to improve them. “Everybody thinks, oh you’re doing a good job here and there, but if you look at a population-based analysis, there are particular gaps that occur that you’re not cognizant of. When you become cognizant of them, you attempt to address those gaps in care and in general that helps improve the overall quality provided to the group of patients that are part of your medical home.” In addition to improving health, there are financial incentives for providers for improved quality of care metrics at many PCMHs.

### Future challenges

Data from early demonstration projects and from larger integrated health care systems, such as Geisinger and Group Health Cooperative, appear generally favorable. However transformation to the PCMH model is time consuming and expensive. Transitioning from a volume-driven to a value-driven system requires years of effort. Even after the transformation is complete, it can cost thousands of dollars and take months of staff time just to apply for recognition as a medical home from one of the accrediting bodies. More than half of primary care practices are small and lack EMR capability. Without upfront funding, transformation for these practices may be out of reach. Further, primary care delivery cannot be revitalized without payment reform.

PAs must be willing to take leadership roles when their practices are undergoing systematic change. Become familiar with the wealth of resources that exist to help practices make the changes necessary to become a PMCH. PAs can find future roles in training health professionals in the fine points of team practice, as PA Diane Cardwell did for TransforMED. Moving from provider/physician-focused autonomous systems to collaborative team arrangements requires skills that many providers lack and will need if the PCMH model is to take hold on a nationwide scale. Information technology, quality-of-care measurement, or quality improvement projects are all ripe areas for PA involvement.

AAPA is committed to supporting PAs in the PMCH and welcomes those involved in medical home transformation to share experiences and advice via the online PCMH community. Contact [ellen@aapa.org](mailto:ellen@aapa.org) to join the online group. Read the AAPA issue Brief: PAs and the Patient-Centered Medical Home at <http://bit.ly/UCajos>. Log on to [www.aapa.org/pcmh](http://www.aapa.org/pcmh) to find more profiles of PAs in PCMH practices and OCMH resources. Check out PAs in Action at [www.pasconnect.org/pas-in-action/](http://www.pasconnect.org/pas-in-action/) to find out more about PAs’ accomplishments. **PA**

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