National Rural Health Association Policy Position

# Workforce Series: Physician Assistants

*Recruitment and Retention of Quality Health Workforce in Rural Areas: A Series of Policy Papers on the Rural Health Careers Pipeline, Paper #12.*

## Introduction and Background

Health care shortages in the United States are well-documented and remain a barrier to access to care, particularly in rural areas. Physician assistants (PAs) are licensed to practice medicine with the supervision of licensed physicians. As extenders of physician services in the United States health care system, physician assistants are well-suited to improve access in health care shortage areas and rural locations.

PAs are educated in the medical model, like physicians, and complete a curriculum that includes clinical clerkships in the same specialties as physicians. PA educational programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). PAs must pass a national certifying exam similar to the licensing exam taken by physicians. All state licensing boards require graduation from an accredited PA program and passing the national certifying examination before a PA is authorized to practice in their jurisdiction. PAs receive a generalist, primary care education, but may specialize after graduation. To remain nationally certified, PAs must gain 100 hours of CME and pass a re-certification exam every six years. PAs can change specialties during their career usually by receiving additional training in the clinical setting and taking specialty continuing medical education courses. A substantial portion (38%) of PAs currently practice in primary care.[1]

While always practicing with physicians, PAs make autonomous medical decisions. PAs may practice in locations separate from their supervising physicians, but must be able to communicate with their supervising physicians while seeing patients. In some rural communities, PAs are the only source of medical care.. State regulations vary on the extent of supervision required. In all settings both the PA and the supervising physician are responsible for ensuring adequate PA supervision and for the care of the patients.

The PA profession began in the mid-1960s to extend physician care, especially in medically underserved areas. As the profession grows, incentives are needed to ensure that adequate numbers of PAs are available in areas that require more primary and specialty medical care, particularly in rural locations. The NRHA is committed to supporting legislation and policies to attract PAs to rural locations, especially medically needy areas.

## Workforce Issues

The primary issues for ensuring a sufficient number of health care professionals in rural areas are: 1) adequate supply, 2) appropriate distribution, and for PAs and 3) removal of barriers to providing care. Factors related to adequate supply include 1) the growing U.S. population size as well as age distribution and the current phenomenon of the “aging baby boomers” and 2) the number of available health care professionals, which is influenced by the number of new graduates as well as the retirement rate and withdrawal from active patient care of current practitioners.

Factors related to distribution include 1) distribution of persons needing health care and 2) factors that influence the location of health care professionals. The key issues in factor (2) include A) personal background and values of an individual professional, B) financial and other forms of compensation, C) medical facilities and resources in a particular location, D) economic, educational, and cultural resources in a particular location, and E) for professionals with a significant other, the preferences of that significant other. Studies have shown that the preferences of a significant other are often the primary influence on the location of a clinician.

Federal programs that encourage utilization of PAs in rural areas include the Rural Health Clinics Act passed in 1977 and

Medicare's critical access hospital program. Title VII education funding also was used to educate PAs for service in rural communities. One of the goals of the National Health Service Corps program was to place PAs in rural areas. However, some federal programs discourage PA utilization in rural areas by not covering physician services provided by PAs under the Federal Worker's Compensation Act and Medicare hospice, home health and skilled nursing care.

State regulations limit the contribution of the PA workforce by 1) overly restrictive supervision requirements, 2) lack of reimbursement for PAs provided physician services, 3) restrictive credentialing policies, especially in psychiatric services.

## Workforce Impact

Studies have documented that PAs offer high quality, cost-effective health care.[2] A large portion of PAs (38%) practice in primary care. [1] Despite barriers to PA medical care, some studies have found that PAs are more likely to locate in rural areas than other types of primary care clinicians.[3,4]

## Growing Profession

Due to demand, the number of accredited PA education programs has greatly increased since the early 1990s. There are over 140 PA programs graduating approximately 4,500 new PA clinicians each year[5]. As of 2008, there were over 70,000 PAs in the U.S. eligible to practice. The number has been growing steadily for the entire history of the profession. Today PAs are licensed to practice and prescribe medications as delegated by a supervising physician in all 50 states.

Of respondents to the 2006 AAPA census (20,000 PAs responding), 91% report being in clinical practice.[1] Sixteen percent reported working in counties that are classified as non-metropolitan. Of the 16%, 7.2% practice in nonmetropolitan areas with populations greater than 20,000, and 7.2% practice in nonmetropolitan areas with urban pop 2,500-20,000, and 1.7% practice in nonmetropolitan areas with urban pop < 2,500.[6] An approximation of the actual numbers would mean that 5,700 PAs work in areas with a population of less than 20,000. Studies in Iowa and Texas have shown that a higher proportion of PAs practice in rural areas than the percentage of other primary care providers.[3,4]

The mean age of PAs is 41 and the mean years since graduation is 11, indicating that the retirement rate will likely remain far less than the rate of production of new PAs for many years to come. The PA profession continues to be listed as one of the 5 most desirable professions in the U.S. and has the top rating for job market outlook[7] which attracts a large quantity of high quality program applicants.

## Improving Rural Deployment

Recruiting and retaining PA applicants from rural areas influences graduates to choose practice sites in rural areas. An example of this strategy is the PA Program at the University of Kentucky that has an extension campus 70 miles eastward in Morehead, Kentucky on the edge of the Appalachian Mountains in southeast Kentucky. Classroom lectures are conducted via interactive real-time video (T 1 line) with lectures originating from both sites. The fifteen students at the Morehead site receive admission preference if they are from any of 23 counties in southeast Kentucky. These students most often have all of their clinical training experiences in the rural areas and the vast majority return to rural settings to practice. Two new schools of osteopathic medicine have opened in the Appalachian area in the past five years, demonstrating this principle in physician training. Too often, students from rural areas that train in urban areas are pressured by debt and higher city salaries to seek employment in urban settings.

Educating rural primary and secondary school students about the need for additional health care personnel in rural areas and the benefits of the PA and other medical professions is a useful strategy. Some Area Health Education Centers make presentations at rural schools, even at the elementary level, to "sow early seeds" of information and stimulate interest. Coupling this with financial assistance for education can increase rural-based students, and, ultimately, graduating clinicians who locate in rural locations.

Financial incentives for new graduates to practice in rural settings are another way to improve rural distribution of health

care personnel. Loan forgiveness programs and the National Health Service Corps (NHSC) are examples of means to this end. The NHSC offers programs to communities or specific employers in underserved areas to solicit community support, a critical factor in success for recruiting and retaining rural clinicians. Federal funding provides partial loan forgiveness while the community provides partial financial support for the clinician's services for a specified period of time.

Employment opportunities that are appealing and competitive in salary and benefits, combined with a community environment that is supportive will also improve recruitment and retention. Certified Rural Health Clinics, an expanding network of Critical Access Hospitals, and appealing private practice employment positions can provide job security and incentives for longevity. Newer technology such as telemedicine can offer PAs links to specialty services as well as continuing education opportunities that are important aspects of clinical practice. Where feasible, outreach clinics from urban tertiary care center specialists into rural areas provide benefits to both patients and providers. PAs can play an integral role to increase a physician's efficiency in such settings.

## *Federal Policies and Programs*

Many efforts to improve health care in rural areas are dependent on institutions, insurance, and government policies and adequate funding.

Regulations for programs such as Medicare must take into account reimbursement levels and particularly differences in rural versus urban actual costs for services. The specific services covered and types of providers authorized to provide care are crucial to making health care delivery viable in rural areas. Examples include Medicare law that prevents physicians from delegating Medicare Home Health, Hospice and Skilled Nursing Facility certification duties to PAs. Additionally, PAs are not included as providers for the federal workers compensation program. Postmasters in small towns cannot go to a PA-staffed rural clinic for a work-related injury and have it covered by Federal workers comp. Bringing regulations and policies into closer alignment with patient needs by utilizing the abilities of existing providers more efficiently will make medical care more accessible.

Currently, the rules for rural health clinics are being revised by the Center for Medicare and Medicaid Services (CMS). There is a danger that the more restrictive regulation and additional requirements for rural health clinics proposed by CMS will lead to the closing of rural clinics in the future and seriously affect rural health care delivery.

Special population programs, such as SCHIP, need funding and regulations that allow qualified providers to deliver needed care in rural areas.

Funding for educational programs that impact rural health care is important. Funding for Title VII of the Public Health Service Act (health professions education) is chronically limited during federal budget proposals, which threatens needed medical training programs Funding cuts for Area Health Education Centers also threaten the education, recruitment, and training activities of this entity as well.

Loan forgiveness and programs such as the National Health Service Corps have been discussed above as a resource for solutions for appropriate distribution of health care providers. These programs are subject to federal regulation and funding as well and recognition of their importance during the budget planning season will enhance the potential increase of PAs in rural areas.

## *State Policies and Programs*

Many state programs, regulations, and policies are linked to their federal counterparts. Often federal funding for programs is dependent on state support as well, for the program to be carried out fully. Medicaid and the children's health programs (SCHIP) are typical examples. Often specific regulations and policies on programs are determined at the state level, and may vary among states, but cannot contradict any federal guidelines. Determination of reimbursement rates, and authorization of services by providers is made by individual states.

State regulation and credentialing of PAs varies by state and is overly restrictive in some, which can limit access to care in rural areas. PAs in states like Missouri, Ohio, Indiana, and Kentucky have encountered overly restrictive regulations such as arbitary limits on the distance of the satellite clinic from the home office and frequency of physician visits that discourage PA location in rural communities.

Overly restrictive practice requirements or lack of reimbursement by insurance companies for physician medical services provided by PAs is another barrier to rural access to care. For instance, some insurance companies require physician presence at the clinic before the PA provided medical services are fully covered. Another example is the refusal by mental health insurance payers to credential or cover PAs who provide psychiatric care. There is a significant shortage of psychiatrists in rural areas. The state of Iowa has funded two separate post graduate programs to educate physician assistants in psychiatric care so they can assist the limited number of psychiatrists in the state. Despite these programs, some insurers who cover mental health services do not reimburse those visits made to physician assistants providing psychiatric health care even though they are supervised by a psychiatrist.

## Summary

Providing adequate health care services in rural America is a complex issue. Since the physician/PA team is a key part of the rural health care system it should be included in any work force analysis and recommendations. Increased numbers and better distribution of PAs in rural areas can be achieved if adequate incentives and reimbursement are provided, and practice barriers to providing care by the physician/PA team are removed. Accomplishing this is dependent on many factors that will draw PAs to the rural areas. Facilities, regulations, practice parameters, financial incentives, and community amenities all must be considered. Health care is influenced by a multitude of other factors including regulatory bodies, professional provider organizations, funding policies, government programs, and patient demographics. The NRHA provides a setting where many different interest groups can be brought together to focus on solutions to the challenges of delivering appropriate health care services in rural settings. The NRHA goal is to ensure access to quality health care for all rural residents.

## Recommendations

1. Urge PA educators to recruit rural students and develop a rural track in their programs, and to introduce PA students to the values and rewards of providing health care to rural areas.
2. Secure federal and state funding for Title VII programs, to maintain and expand PA education programs and Area Health Education Center funding to include training of PAs in rural areas. Educate students in elementary school through college about the PA profession.
3. Advocate for government programs to increase incentives for PAs to practice in rural areas including:
    1. Loan forgiveness programs
    2. Promote and expand the National Health Service Corps program for PAs.
    3. Income tax credits
    4. Shortage area bonus programs
    5. Scholarships
4. Work with health organizations, CMS, and HRSA to ensure that any rules changes in the Rural Health Clinics Program or health professional shortage designations do not adversely affect access to health care in rural areas.
5. Eliminate barriers to care in federal law by covering PAs under the Federal Worker's Compensation and Medicare's hospice care, home health care and care in a skilled nursing facility programs.
6. Work with states to remove regulatory barriers to physician/PA care in rural areas, such as overly restrictive supervision requirements and unrealistic distance limits for satellite clinics staffed by PAs.
7. Work with health insurance companies to ensure that credentialing and reimbursement policies encourage physician/PA practice in rural areas. Ensure that health insurers allow psychiatrists to delegate psychiatric tasks to PAs working in rural communities.
8. Provide a platform for bringing together professional organizations (AAPA, AMA, AOA, and AAFP and others) to explore efforts to improve the physician/PA team approach to health care to increase access to

quality health care in rural communities.

9. Promote continued efforts within the NRHA, the AAPA, the PAEA (Physician Assistant Education Association) and other organizations to provide well-researched documentation of the needs for improved health care in rural areas and to continue to look for innovative solutions for providing quality health care by utilizing physician assistants in rural communities.

## References


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[4] Jones, PE, Physician and Physician Assistant Distribution in Rural and Frontier Texas Counties, University of Texas Southwestern Medical Center, Dallas, Texas, Poster presentation at AAPA Annual Conference May 27, 2008, San Antonio Texas.

[5] AAAP 2006 data Projected Number of People in Clinical Practice as PAs as of January 1, 2007, http://www.aapa.org/research/06number-clinpractice06.pdf

[6] AAPA Census Table 13.3 Number and Percent Distribution of Clinically Practicing Respondents by Metropolitan Status and Degree of Rurality of County of Primary Work Site, http://www.aapa.org/research/06census-content.html#3.13

[7] U.S. News and World Report, Sept., 10, 2007, http://www.usnews.com/usnews/biztech/best_careers_2007/careertable.htm


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