

Collaborative Statement Quenches Fire Over NP Participation in PCMH, Ensures All Participants Meet Same Standards

By Jim King, M.D.

4/29/2009

During the past couple of months, there has been a lot of discussion about where nurse practitioners, or NPs, fit into the patient-centered medical home, or PCMH, model, particularly in light of planned and ongoing PCMH demonstration projects.

Although the AAFP continues to push for PCMH demonstration projects that are led by physician-directed medical practices, members of Congress, employers and consumers often don't understand why the PCMH model cannot rely on NPs in states where these practitioners have authority under state law to practice independently.

Congressional leaders, in particular, strongly believe there are not enough physicians willing to locate to rural areas, whereas NPs are willing to work there. These leaders argue that if NP practices in rural areas are not allowed to participate in PCMH demonstration projects, individuals (i.e., voters) in these otherwise underserved areas will not have access to the benefits of a medical home.

In response, the AAFP, along with its primary care colleagues in the American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, looked at possibly adding an addendum regarding NPs and the PCMH to the Joint Principles of the Patient-Centered Medical Home (3-page PDF; About PDFs).

We received an overwhelming response from members about this possible addendum. Many were adamant in their objection to NPs taking on any kind of a leading role in the PCMH. "There is nothing to gain by promoting less-trained individuals to act as a primary care base," said one member. "A PCMH should be comprehensive and only be provided by someone who has the capability to provide comprehensive care, not someone who only is trained to provide limited care," said another.

Other members took a more pragmatic tack. "I think this is an excellent example of focusing on the needs of the patient and not on the desires of the practitioner," said a member. Another noted, "I see no reason why, where independence is already a done deal, that (NPs) should not have the opportunity to run a medical home. The relative outcomes can never be measured and compared if it's never allowed to happen."

JOINT STATEMENT ON NPS

In the end, the four primary care organizations decided that an addendum to the joint principles would not serve our needs as well as would a separate joint statement (see below) that we could use to brief congressional leaders on where we stand relative to NP practice participation in PCMH demonstration projects.

Let's be clear here, however. The existence of this statement *does not* mean that any of the primary care physician organizations involved believe that NPs can lead PCMH practices as well as physicians. All of our organizations continue to believe that the best expression of a PCMH is via a physician-directed medical practice.

We've heard from the Senate Finance Committee that we need to figure out the place for NPs in the

medical home if we want them to fight the subspecialists on payment reform for primary care. In addition, the Patient-Centered Primary Care Collaborative, which has been an aggressive advocate on our behalf in pushing for increased payment for primary care, also indicated that it was important that the primary care physician organizations come to terms with the NP issue.

Having this statement in hand as we discuss the PCMH on Capitol Hill, at the state level, or even at the local level, allows us to get our issues on the table during health care reform discussions. It also serves as our demand that all participants in PCMH demonstration projects be held to the same standards and be evaluated in the same way.

WHAT THE STATEMENT SAYS

The statement recognizes that primary care physicians and NPs have common goals of providing high-quality, patient-centered and team-based care, as well as improving patients' overall health status, but the focus is on three areas that must be addressed in any PCMH demonstration project, whether physician practice-led or not.

First, the statement points out that education and training levels between physicians and NPs are not equivalent. The statement suggests that patients with complex problems, multiple diagnoses, or undiagnosed conditions, or who are difficult management challenges, would be best served by physicians working with a team of health care professionals, which may include NPs. In addition, patients must be informed about the credentials of the person providing their care so they are not confused about what type of health care professional they are seeing.

Also, research funding should be available to evaluate PCMH practice organizations, including how effective the consultation process is among primary care physicians, subspecialists, NPs and other care team members.

Second, the statement reinforces that all practices participating in PCMH demonstration projects -- whether led by physicians or NPs -- must meet the same eligibility requirements and recognition standards. All clinicians must be subject to the same standards of evaluation and assessment and must operate under current state practice statutes and regulations.

In addition, evaluation measurements for all PCMH practices must take into account differences in the complexity of patients seen by the practice, the business model the practice operates under, and the compensation model used in the practice.

Third, workforce policies must ensure that there are adequate supplies of primary care physicians, NPs and physician assistants, or PAs, to improve access to quality care and avert anticipated shortages of primary care clinicians. Workforce policies and payment systems also must recognize that training more NPs and PAs does not eliminate the need to increase the number of primary care physicians in the United States.

The AAFP Board and the leaders of our primary care colleagues believe that this statement is important to furthering our advocacy agenda. With this statement, we now have something to present in response to the debate on the PCMH and health care reform when we are asked where NPs fit into the puzzle. This document is about supporting the respective roles of physicians and NPs equivalent with their individual training and experience.

**Joint Statement on Nurse Practitioners in Patient-Centered Medical Home Demonstration
Projects**

**American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)**

April 15, 2009

The principles of the Patient Centered Medical Home (PCMH) were designed by the AAFP, AAP, ACP, and the AOA with comprehensive and coordinated primary care as core elements of its design. This model is congruent with the extensive, multinational evidence supporting primary care as the basis for improving the quality and cost efficiency of care.

The AAFP, AAP, ACP and AOA recognize that physicians and nurse practitioners (NPs) have common goals of providing high-quality, patient-centered, team-based care and improving the health status of those they serve. However, there are substantial differences in the nature and extent of education and training of physicians as compared with that of NPs. Further, states vary in the scope of practice that is granted to non-physician providers and in some states NPs have been granted independent practice authority by legislation. Therefore, our organizations offer the following position statements regarding the potential inclusion of nurse practitioner practices in patient-centered medical home demonstration projects:

1) Physicians and NPs complete their education and training with different types and levels of knowledge, skills, and abilities that are not equivalent but may be complementary. As trained health care professionals, physicians and NPs share a commitment to ensuring coordinated, comprehensive care for our patients that is driven by improved patient outcomes.

A. Patients with complex problems, multiple diagnoses, undiagnosed conditions, or difficult management challenges are best served by physicians working with a team of health care professionals that may include NPs, physician assistants, and other clinical team members (e.g., nurses, pharmacists, medical assistants, educators).

B. Patients must be informed of the credentials of the person providing their care to allow them to understand the background, orientation, and qualifications of the health care professionals providing their care and to better enable them to distinguish among different health care professionals.

C. Research funding is needed for the evaluation of PCMH practice organization and team based care including effective consultation between primary care physicians, subspecialists, NPs and other members of the care team as clinically indicated. Page 2 of 2

2) In the PCMH model, care for patients is best served by a multidisciplinary team where the clinical team is led by a physician. If it is necessary to test different models of the PCMH, our organizations agree that PCMH demonstration projects that include evaluation of physician-led PCMHs may also test and evaluate the effectiveness of nurse practitioner practices seeking designation as a PCMH consistent with the following:

A. In PCMH demonstration projects, all practices must meet the same eligibility requirements and

recognition standards.

B. All practices involved in PCMH demonstrations must be subject to the same standards of evaluation and assessment, especially those related to quality improvement, outcomes, cost effectiveness, and patient experience.

C. All clinicians within the PCMH must operate within current state practice acts.

D. Evaluation metrics for all PCMH practices must take into account differences in the complexity of the patients seen by the practice, the business model under which the practice operates (e.g., independent private practice, practice affiliated and supported by an academic health center or grant funding, satellite practice of integrated delivery system), and the compensation model in effect for clinicians (e.g., salaried, volume-based fee-for-service, capitation, mixed).

3) Workforce policies must ensure adequate supplies of primary care physicians, nurse practitioners, and physician assistants to improve access to quality care and to avert anticipated shortages of primary care clinicians. Workforce policies and payment systems must recognize that training more nurse practitioners and physician assistants does not eliminate the need nor substitute for increasing the numbers of physicians trained to provide primary care.