



Scope of Practice Kit: What is a Physician?

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When you go to see your doctor, you may or may not be aware that different health care practitioners are responsible for different parts of your care. The United States is adopting a new model of primary care delivery that is built around patients called the Patient Centered Medical Home (PCMH). A PCMH calls on family physicians to lead health care teams towards a standard of care that increases quality as well as affordability.

- In order to effectively lead a health care team in patient care, a medical doctor must complete a long and rigorous primary care training program. Medical doctors are required to complete 4 years of graduate-level education and 3 to 7 years of residency training in which they log between 12,000 and 16,000 hours of clinical patient care.
- During this training period, physicians are taught to provide thorough exams in order to be able to make complex diagnoses. These diagnoses move beyond just symptom management, to develop comprehensive treatment plans for the whole patient.
- By seeing a board-certified primary care physician, patients encounter fewer emergency room visits, fewer hospital admissions and readmissions, and shorter hospital stays.
- One out of every four patients in the United States is treated by a family physician, and more than 215 million office visits are made to family physicians each year.
- More than 43% of family physicians are also available to patients through extended evening and weekend office hours. Physician availability and flexibility are part of the core principles of the patient centered medical home model.
- Family physicians are the main source of primary health care for Medicare recipients. Sixty percent of people aged 65 and older identify a family doctor as their usual source of care. Rural and Hispanic seniors are more likely to identify a family physician as their main source of health care.
- As the landscape of health care continues to change, family physicians remain firmly positioned to treat all people with a focus on prevention, wellness, and overall care coordination.



Scope of Practice Kit: Primary Care Is...

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- ... care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern – not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.
- ...includes the primary care physicians, other physicians who include some primary care services in their practices, and some non-physician providers. However, the most important person in the definition of primary care is the **Patient**.
- ... includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.).
- ... performed and managed by a **personal physician** often collaborating with other health professionals, and utilizing consultation or referral as appropriate.
- ... provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services.
- ... promotes effective communication with patients and encourages the role of the patient as a partner in health care.

A Primary Care Physician...

- ... is a generalist physician who provides definitive care to the undifferentiated patient at the point of first contact and takes continuing responsibility for providing the patient's care. Such a physician must be specifically trained to provide primary care services.
- ... devotes the majority of his or her practice to providing primary care services to a defined population of patients.
- ... serves as the entry point for substantially all of the patient's medical and health care needs - not limited by problem origin, organ system, or diagnosis.
- ...is an advocate for the patient in coordinating the use of the entire health care system to benefit the patient.

Most importantly, a Primary Care Physician refers ONLY to a doctor of medicine (M.D.) or osteopathy (D.O).

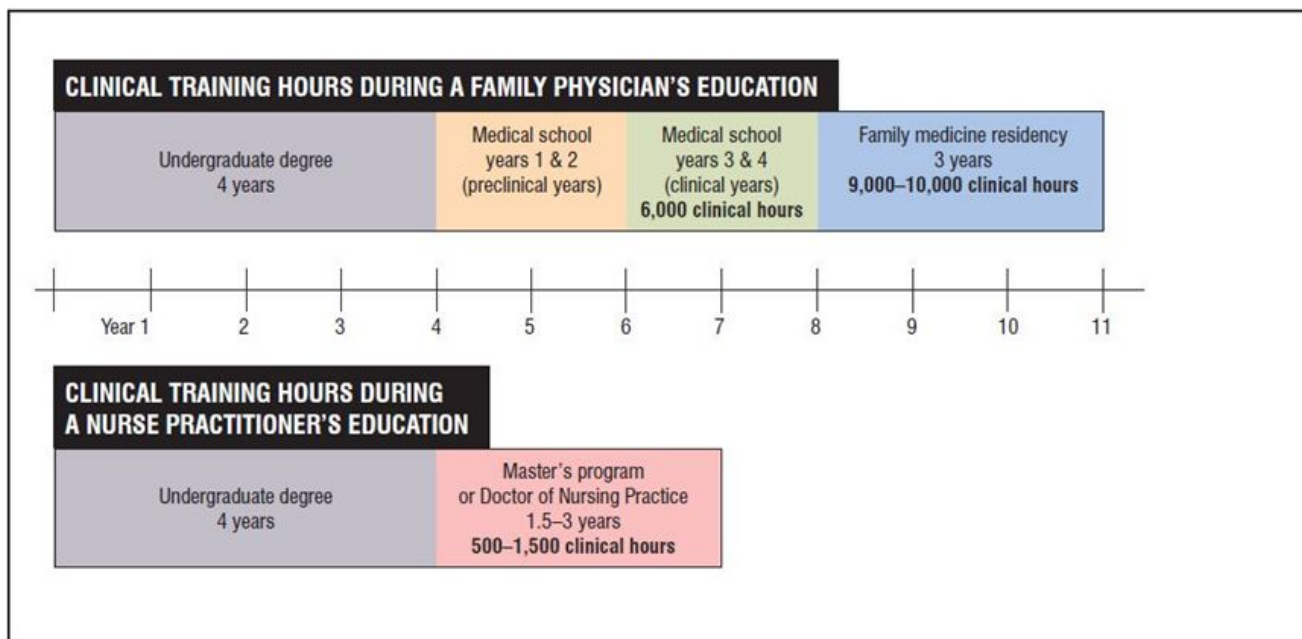


Scope of Practice Kit: What is a Nurse Practitioner?

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The United States is adopting a new model of primary care built around patients, and nurse practitioners are an integral part of physician-led care teams that increase the quality and affordability of health care.

- Nurse Practitioners are required to complete 2 to 4 years of graduate-level education which includes between 500 and 1,500 clinical hours.



- Nurse practitioner training focuses on symptom identification, immunization, medication administration, and patient progress in recuperation or rehabilitation plans. Their knowledge and expert management in these areas makes them valuable members of physician-led health care teams.
- While nurse practitioners offer important primary care services, they are not necessarily a cost-effective solution for primary care shortages. Nurse practitioners handling more diagnosis will lead to medical malpractice cases against nurses and could result in more misdiagnoses. These costs will be passed on to consumers through higher insurance premiums and the need for redundant follow-up care.
- Adding more nurses will not guarantee better care. Primary care service areas with a ratio closest to one nurse practitioner for each family physician have the lowest costs, lowest hospitalizations, and the lowest avoidable hospitalizations. In service areas with more than one nurse practitioner for each family physician, data shows significantly higher costs and utilization of health care services.
- Primary care is a team effort, and adding more nurse practitioners to physician-led teams can contribute to the elimination of the primary care shortage.



Scope of Practice Kit: What Do Patients Say?

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The United States is adopting a new model of primary care built around patients, and their perspectives on health care providers offer valuable insight into increasing the quality and affordability of care.

- Patients highly value the additional education and training that physicians receive. According to two consecutive surveys, **90% of patient respondents stated that a physician's additional years of medical education and training are vital to optimal patient care**, especially in the event of a complication or medical emergency.
- **Quality** and **safety** are top concerns for patients. **Three out of 4** patients stated that **they prefer to be treated by a physician** even if it takes longer to get an appointment and even if it costs more.
- Confusion about health care provider qualifications abounds among patients. In a 2010 patient survey:
 - 26% of patients thought that nurse practitioners were medical doctors
 - 35% of respondents thought that a doctor of nursing practice (DNP) was a physician.
 - 90% of respondents stated that they would support legislation to require all health care providers to clearly designate their level of education, skills, and training in their offices and promotional materials.
- The physician-patient relationship remains central to the whole person health care experience. A Colorado study found that:
 - 68% of patients felt that family physicians were most likely to understand their entire health background, while only 11% felt the same about nurse practitioners.
 - 72% of patients indicated that physicians were their most trusted source for health care information; 6% of patients identified nurse practitioners as their most trusted source.
- Effective chronic disease management is a top priority for patients. In patient surveys from 2008 and 2010:
 - 86% of respondents indicated that patients with one or more chronic diseases benefitted when a physician leads the primary health care team.
 - 83% of patients indicated that they preferred a physician to have primary responsibility for the diagnosis and management of their health care.
- Patients are concerned about prescription drugs. According to a series of patient surveys:
 - 78% of patients stated that only medical doctors should treat chronic pain by prescribing prescription drugs or other substances that have a high potential for addiction or abuse.
 - 77% of patients stated that only medical doctors should write prescriptions for medication to treat mental health conditions.
- Patients want access to the highest quality care at an affordable price. Solutions to the primary care shortage must consider patient perspectives and the high value they place on physician-led care.



Scope of Practice Kit: The Issue & The Solution

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What are the issues?

- There is a shortage of primary care physicians throughout much of the country
 - To rectify this, legislatures & interest groups are pushing for independent practice for nurse practitioners
 - Problem – primary care physicians and nurse practitioners **do not** share the same levels of expertise, training, or knowledge.
 - Problem – health professionals' training has a direct impact on the depth and quality of patient care.
 - Problem - this expands nurse practitioner practices **beyond** their training and appropriate scope.
 - Problem - this establishes a two-tiered health care system.
 - Problem - this is a public health / public safety concern.

What are the Solutions?

- Family physicians complete more than 20,000 hours in medical training, while nurse practitioners complete 2,800 to 5,350 hours of nursing training.
 - Family physicians complete and experience at least **four times** more clinical training.
 - Family physicians have the knowledge and training to order and interpret tests within the context of the patient's overall health condition.
 - Family physicians assess patients presenting with undifferentiated symptoms and signs, and make a diagnosis that can range from very simple to very complex.
 - Family physicians can develop and implement medical treatment plans that address multiple organ systems and that integrate medication.
- A physician-led team based approach – The Patient Centered Medical Home
 - This model ensures that patients have access to the expertise of all health professionals.
 - Only through this model will patients be ensured the best care from the appropriate health care professional at the proper time.
- Training more primary care physicians will increase access and strengthen primary care.
 - Students and residents need stronger incentives to choose the primary care specialty.
 - Scholarships & loan forgiveness programs are critical for primary care physicians.
- Patients and physicians benefit from appropriately trained nurse practitioners and physician assistants.
 - These health care providers are part of the solution, but are NOT a substitute for doctors.
 - Nurse practitioners can develop and implement a nursing care plan that is built on the medical treatment plan written by a doctor.



Scope of Practice Kit: The Bottom Line

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There is no comparison between Doctors & Nurses

Provider	Post-graduate training	Residency Training	Total time before independence	Patient encounters before independence	Total training before independence
Family Physician (MD, DO)	4 years, doctoral program	<u>REQUIRED</u> 3 years minimum	11 years	1,650 patients <u>minimum</u>	20,700 – 21,700 hours
Advanced Practice Nurse (NP, CRNA, CNM)	1.5 to 3 years, master's program (MSN)	NOT REQUIRED	5.5 – 7 years	NOT REQUIRED	2,800 – 5,350 hours

“Current evidence is insufficient to support substitution of physicians by nurses in primary care in any comprehensive fashion, particularly in a modern American practice setting...substitution of physicians by independent nurses providing comprehensive primary care is not an approach supported by the literature.”

-“Substitution of Physicians by Nurses in Primary Care: An Update and Reanalysis of the Evidence.” University of Missouri report, July 21, 2011.

Who would you rather have care for you & your family?



Scope of Practice Kit: Addendum A

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The Institute of Medicine (IOM) report, *Future of Nursing: Leading Change, Advancing Health* calls for improving the education of nurses and enabling them to work to the full extent of their training and expertise. The nursing workforce is critical to effective primary care and community health, but their training and expertise is not equal to that of a primary care physician.

- The IOM focuses a disproportionate amount of the report on expanding the scope of practice for Advanced Practice Registered Nurses (APRN). Physicians and nurses are not interchangeable, and optimal patient care is achieved when physicians, nurses, and other health professionals work together as a team in roles that do not exceed the full level of their training and experience.
- While nurses provide important primary care services, the curriculum of doctor of nursing programs require only 30 to 40 additional credit hours beyond a master's degree. This requirement does not equate the 12,000 to 16,000 hours of primary care physician clinical training and the professions should not be considered equal or interchangeable.
- By focusing much of the report on the APRN workforce, the IOM misses an opportunity to make valuable recommendations that address the physician and nursing workforces that care for most Americans in primary care settings. Our health care system needs more primary care physicians and more nurses, but the report fails to address these shortages.
- The report recommends that scope of practice barriers be removed, which would allow nurses to practice medicine with no limitations or parameters for safeguarding the public. The IOM does not offer a required minimum number of supervised clinical hours, or documented favorable performance appraisals that must be achieved in order for a nurse to practice as this report recommends.
- The act of caring for people is too important to use a political process to increase scope of practice. Scope of practice should be based on training and competency, and public policies should promote the recruitment, training, and retention of more primary care physicians, nurses, and physician assistants.



Primary Care *for the* 21st Century

*Ensuring a Quality,
Physician-led Team
for Every Patient*

September 18, 2012



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Executive Summary



The United States is adopting a new model of primary care built around patients and delivered by teams. As a key element of this approach, primary care medical practices are being called upon to do more, and to do it better, while managing resources ever more wisely. This approach is generally known as the patient-centered medical home (PCMH).¹ It has proven to increase quality of care for the patient and cost-effectiveness for the health care system.²

Within a medical home, each patient has an ongoing relationship with a personal physician trained to provide first contact, complex diagnosis, and continuous, comprehensive care. The personal physician leads a team of professionals at the practice level who are collectively responsible for the ongoing care of patients—many of whom are living with one or more chronic conditions. This reorganization puts primary care at the center of the patient's team and better enables doctors, nurse practitioners (NPs), physician assistants, nurses, and other health care professionals to work side by side in caring for patients.



Yet even as the role and complexity of primary care practice expands, there has been a significant amount of discussion within the health care and public policy communities about advanced practice nurses directing primary care practices on their own, without a physician on staff. This effort to have nurses practice

independent of physicians comes at the very same moment that medical practice itself is changing to an integrated, team-based approach that includes physicians and other health professionals. These two approaches take the country and our health care system in opposite and conflicting directions.

The rationale behind most proposals to allow nurse practitioners to practice independently is that the nation is facing a primary care physician shortage. This is true. But substituting NPs for doctors cannot be the answer. Nurse practitioners are not doctors, and responsible leaders of nursing acknowledge this fact. Dr. Kathleen Potempa, the dean of the University of Michigan School of Nursing and president of the American Association of Colleges of Nursing told the *New York Times* that, “Nurses are very proud of the fact that they’re nurses, and if nurses had wanted to be doctors, they would have gone to medical school.”³ Dr. Potempa is right—nurse practitioners do not have the substance of doctor training or the length of clinical experience required to be doctors.⁴ For example, for licensure, NPs receive only 5.5-7 years of education compared with 11 years for a physician.⁵ The clinical experience that NPs receive within that education is only one-fifth of the clinical experience a physician receives.⁶

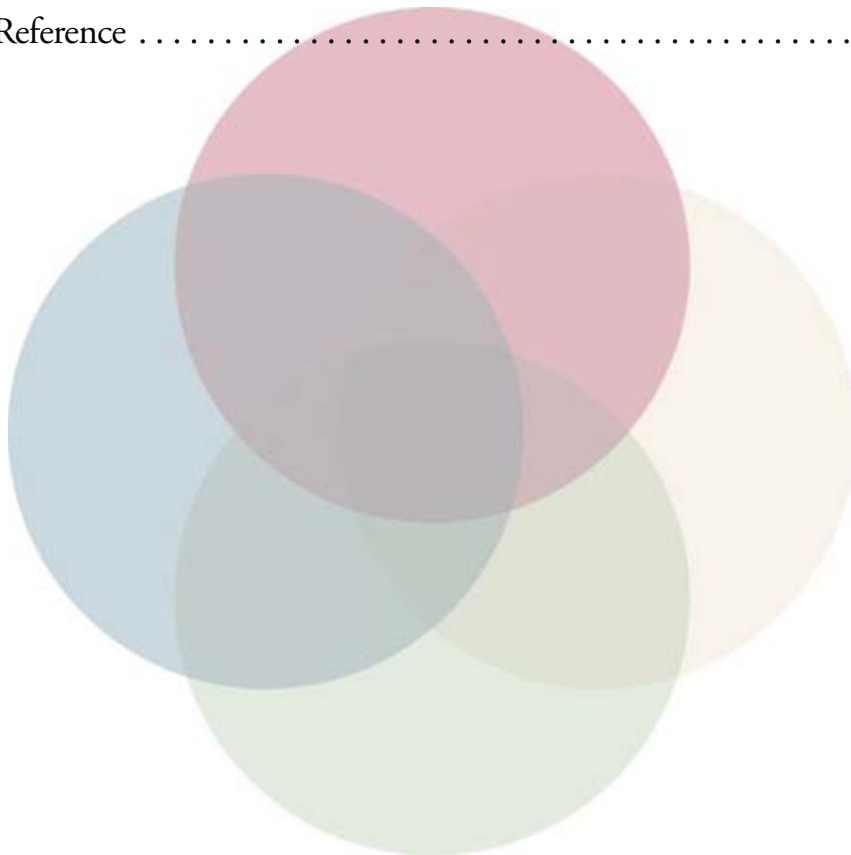


Patient-Centered Medical Home

The nation can fill the primary care gap through the continuing transition to team-based care in medical homes, with all health professionals playing valuable and appropriate roles. Studies show the ideal practice ratio of NPs to physicians is approximately 4-to-1.⁷ With PCMHs built around that ratio, everyone can have a primary care doctor and receive the benefits of team-based care. The American Academy of Family Physicians believes it is axiomatic that every American *should* have a primary care physician and benefit from care provided in a PCMH where team-based care leads to improved quality and cost efficiency.

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Our Primary Care System is Changing



Health care as Americans know it is undergoing fundamental change. This change is not just in public policy, in covering more of the uninsured, in technology, or in the health care profession—it is in the *delivery* of care and in the role of the patient. The United States is moving toward a patient-centered model of care, which is proven to increase quality and cost-effectiveness.⁸ This model is anchored by the patient-centered medical home (PCMH), in which patients have a relationship with a primary care physician-led team who manages their care. Through this approach, an integrated team of professionals and support staff provides care in a practice organized around the patient.⁹ In turn, patients have access to personalized, coordinated, and comprehensive primary care when they need it, when it's convenient for them, and from the right professional—be it a doctor, nurse, physician assistant, physical therapist, dietitian, or other clinician.

Why now? As Dorrie Fontaine, dean of the University of Virginia's School of Nursing, recently put it: "nothing in health care is getting less complex."¹⁰ For frustrated patients, members of the medical community, and payers, the change to a PCMH model is long overdue. Although the term *medical home* had been used initially by the American Academy of Pediatrics in 1967, the model of care had not been practiced broadly.¹¹ The term *medical home* was used to describe a partnership approach with families who had children with special health care needs to provide primary care that was accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective. Although this idea posed a promising concept, the partnership approach did not take root broadly in primary care practices in the United States for several decades.

A breakthrough for the PCMH came in 2002 when the leadership of seven national family medicine organizations, including the American Academy of Family Physicians (AAFP), recognized "growing frustration among family physicians, confusion among the public about the role of family physicians, and continuing inequities and inefficiencies in the U.S. health care system."¹² They

channeled this frustration into an opportunity to improve the situation and to “shape their own destinies by redesigning their model of practice.”¹³ Together, the organizations initiated the Future of Family Medicine project, “to transform and renew the specialty of family medicine to meet the needs of people and society in a changing environment. The Future of Family Medicine project identified core values, a new model of practice, and a process for development, research, education, partnership, and change with great potential to transform the ability of family medicine to improve the health and health care of the nation.”¹⁴ The proposed new model of practice had characteristics very similar to a PCMH.¹⁵

Today, the PCMH has become a fast-growing model that is remaking health care across the country.¹⁶ Successfully piloted in several locations, the PCMH model facilitates improved primary care and will likely become a reality for most Americans in some form in the next decade.

Today, the PCMH has become a fast-growing model that is redesigning primary care across the country. Successfully piloted in several locations, the PCMH model facilitates improved primary care and will likely become a reality for most Americans in some form in the next decade. The Institute of Medicine (IOM) has developed a commonly accepted definition of primary care: “Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (IOM, 1996). The term “integrated” in the IOM definition encompasses “the provision of comprehensive, coordinated, and continuous services that provide a seamless process of care.”

For the PCMH to become a reality, primary care practices must provide and perform as the strong foundation where medical homes reside. Not surprisingly, many U.S. primary care practices several years ago were not immediately able to perform as a medical home. However, organizations such as the AAFP and others have spent roughly eight years working to help physicians and their teams make the change. In 2005, the AAFP created TransforMED to provide best practices, educational seminars, guidelines,

launch tips, principles, research, online courses, step-by-step explanations, training programs, and webinars. The AAFP offers family physicians and their teams the tools they need to transform their practices into medical homes. The mission of TransforMED is nothing less than the transformation of health care delivery to achieve optimal patient care, professional satisfaction, and the success of 21st century primary care practices.

About the PCMH



A medical home is characterized by every patient/family having a personal physician who provides first-contact care, understands the health care needs of the patient/family, facilitates planned co-management across the lifespan, and has the resources and capacity to meet the patient/family needs.¹⁷ As TransformMED CEO Dr. Terry McGeeney described it, “everything that goes on in a practice is for the benefit of the patient, and the patient is central to all activities and decisions. However, the concept goes much further than this. It implies trust, respect, shared decision making, cultural sensitivity, mindful communication in the exam room, whole-person orientation, and a continuous relationship over time. These are the strengths—the core values of family medicine.”¹⁸

Patient-centered care offers a full array of health care services using a team-based approach. This includes delivering care for all stages and ages of life, acute care, chronic care, behavioral and mental health care, preventive services, and end-of-life care. It also includes coordinating and/or integrating care for services not provided by the PCMH across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient community (e.g., family, public, and private community-based services).¹⁹



In short, the PCMH model is a win-win for the patient because it:

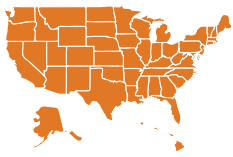
- Implements patient- and family-centered care based on the needs and preferences of patients, families, and caregivers;
- Incorporates shared decision making;
- Encourages and supports self-management and self-care techniques;
- Facilitates complete and accurate information sharing and effective communication;
- Encourages active collaboration of patients/families in the design and implementation of care delivery;
- Ensures cultural and linguistic competency among clinicians and staff; and
- Collects and acts upon patient, family, and caregiver experience and satisfaction data.²⁰

Bringing down the cost of care. The cost of health care continues to be a major hurdle for our nation. While there is no silver bullet, there is growing evidence that the PCMH model—which emphasizes improved access to more robust primary care teams—can reduce total costs. A recent report by the Patient-Centered Primary Care Collaborative provides 34 examples of private insurance companies, and state and federal entities implementing the PCMH model and finding that “outcomes of better health, better care and lower costs are being achieved.”²¹ It also found that, “major insurers are driving primary care transformation through payments for patient-centered services nationwide as a means to increase access to care, control costs, improve patient satisfaction and make Americans healthier.”²² BlueCross BlueShield has tested the cost savings of the PCMH model and their first-year results showed “nearly 60 percent of eligible PCMH groups recorded lower than expected health care costs.”²³ The CareFirst BlueCross BlueShield president and CEO, Chet Burrell, said, “The program demonstrates to primary care providers that we recognize the critical role they can play in improving care and meaningfully reducing costs over the long term.”²⁴ In regions across the United States, outcomes from the PCMH model have shown reductions in emergency room visits, decreases in hospital admissions, and fewer total hospital inpatient days.²⁵

The PCMH Team. Health professionals share a common goal of providing high-quality, patient-centered, and team-based care that improves the health status of those they serve. The reorganization of care to a PCMH model puts primary care in the center of the health care system with doctors, nurse practitioners, physician assistants, nurses, and other health care professionals working side by side to care for patients. It draws on a team and uses the specific training and strengths of each member. For example, family physicians are trained to make complex diagnoses, often when a patient presents confusing symptoms. Nurse practitioners, on the other hand, are specifically trained to follow through on the treatment of a patient after a diagnosis and to implement protocols for chronic disease management.

Leadership is required in a medical home just as it is required in businesses, governments, schools, athletics, and other organizations. Just as every American should have a primary care doctor, every medical home must have a physician serving as a leader who brings the highest level of training and preparation to guide the integrated, multi-disciplinary team. Delivering on this promise of a PCMH means it will be increasingly difficult for a health care professional to work alone. With each professional playing his or her specific role, the interdisciplinary PCMH team can deliver the highest quality care with the greatest cost-effectiveness. But a patient-centered team approach is the key.

Meeting the Country's Need for Primary Care Physicians



There is ample evidence supporting primary care physicians as the foundation for a more efficient and effective health care system, but physician shortages are a reality. According to the Association of American Medical Colleges' projections reported in 2010, "America will face a shortage of more than 90,000 doctors in 10 years" and "there will be 45,000 too few primary care physicians" by 2020.²⁶ The shortage must be overcome with the right incentives for doctors so patients receive the quality care they deserve. Physicians are far from being the only health providers who are in high demand. Our country also needs more nurses, physician assistants, and other health care professionals. According to the American Association of Colleges of Nursing, "the U.S. nursing shortage is projected to grow to 260,000 registered nurses by 2025."²⁷

There has been a significant amount of discussion among the health care and policy communities about expanding the roles of nurse practitioners to practice independently and direct medical homes without a physician on staff. The rationale is to cover health care needs resulting from the primary care physician shortage. The movement for nurses to treat patients without a physician comes at the same time as the medical practice itself is changing to a team-based approach. These two approaches take this country in opposite and conflicting directions. Granting independent practice to nurse practitioners would be creating two classes of care: one run by a physician-led team and one run by less-qualified health professionals. Americans should not be forced into this two-tier scenario. Everyone deserves to be under the care of a doctor.

Substituting nurses—even advanced practice nurses—for licensed physicians cannot be the answer in a system built around medical homes.

Nurse practitioners are a vital part of the health care team, but they cannot fulfill the need for a fully trained physician. A physician brings a broader and deeper expertise to the diagnosis and treatment of all health problems, ranging from strep throat to chronic obstructive pulmonary disease, from unsightly moles to cancer, from stress headaches to refractory multiple sclerosis. The family physician is trained to provide a complex differential diagnosis, develop a treatment plan that addresses multiple organ systems, and order and interpret tests within the context of the patient's overall health condition.²⁸

Today, 22 states and the District of Columbia allow nurse practitioners autonomy in diagnosis and treatment. About half of those, however, require involvement of a physician for prescribing all or certain drugs.²⁹ Some have called for removing scope-of-practice barriers for advanced practice registered nurses, or APRNs, in all states. The reality, however, is that the education and training of physicians and APRNs are substantially different, and physicians and nurses are not interchangeable. Dr. Bruce Bagley described this scenario well, saying that “with four years of medical school and three years of residency training, the physician’s depth of understanding of complex medical problems cannot be equaled by lesser-trained professionals. It’s in the patient’s best interest for family physicians and nurse practitioners to work together.”³⁰

Research shows that the best care is achieved when the ratio of nurse practitioners to physicians is about 4-to-1.³¹ At this ratio, we can provide everyone a physician-led team, and fill the primary care shortage.

Education & Training



Physicians and nurse practitioners complete their education and training with different types and levels of knowledge, skills, and abilities that are not equivalent but are complementary. Primary care physicians receive far more education, clinical training, and continuing medical education to ensure they are well-equipped to diagnose and manage patient care.

Many family physician practices have embraced nurse practitioners and physician assistants as physician extenders in their offices.

Most nurse practitioners—also known as APRNs and advanced registered nurse practitioners—typically receive their education through a one-and-a-half to three-year degree program that confers a Master of Science in Nursing (MSN), depending on the prior education of the student. Approximately 77 percent of nurse practitioners hold an MSN degree. Many of the remainder used alternate pathways available in their states to achieve nurse practitioner licensure without an advanced degree.³² Typically, for entry into master's level nursing programs, students are required to at least have passed the National Council Licensure Examination for Registered Nurses and to have satisfactorily completed the Graduate Record Examination.³³ Eleven states and the District of Columbia do not require that nurse practitioners hold a master's degree.

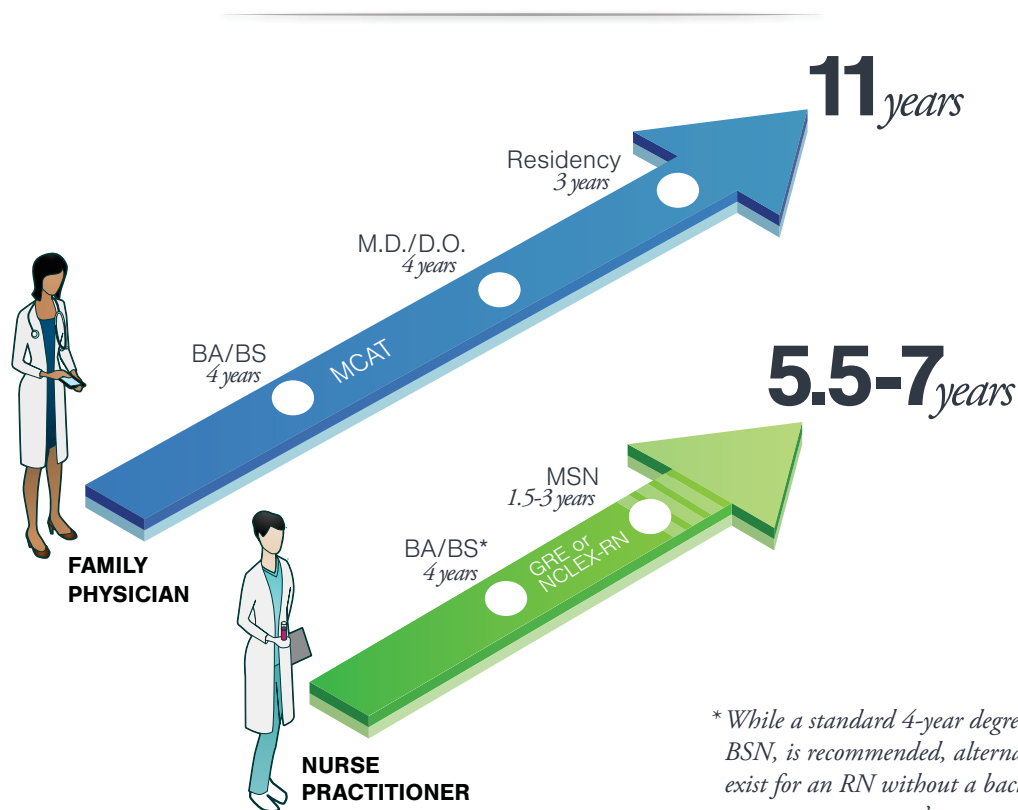
The training and certification nurse practitioners receive is appropriate for dealing with patients who need basic preventive care or treatment of straightforward acute illnesses and previously diagnosed, uncomplicated chronic conditions. But patients with complex problems, multiple diagnoses, or difficult management challenges require the expertise of primary care physicians working with a team of health care professionals.

Family physicians typically receive their education through a four-year graduate degree program at one of the 130 accredited medical schools in the United States and an additional three-year program of clinical residency. Students must pass the Medical College Admissions Test for entrance into medical school. Medical students spend nearly 9,000 hours in lectures, clinical study, laboratories, and direct patient care. The overall training process begins with medical school and continues through residency. During their time in

medical school, students take two “step” examinations, called the United States Medical Licensing Examination, and must take core clerkships, or periods of clinical instruction. Passing both examinations and the clerkships grants students the Medical Doctor (MD) degree, which entitles them to start full clinical training in a residency program.³⁴ Physicians can also earn a doctor of osteopathic medicine (DO) degree through colleges of osteopathic medicine.³⁵ The residency program, as defined by the American Medical Association, “is three to seven years or more of professional training under the supervision of senior physician educators. The length of residency training varies depending on the medical specialty chosen: family practice [medicine], internal medicine, and pediatrics, for example, require three years of training.”

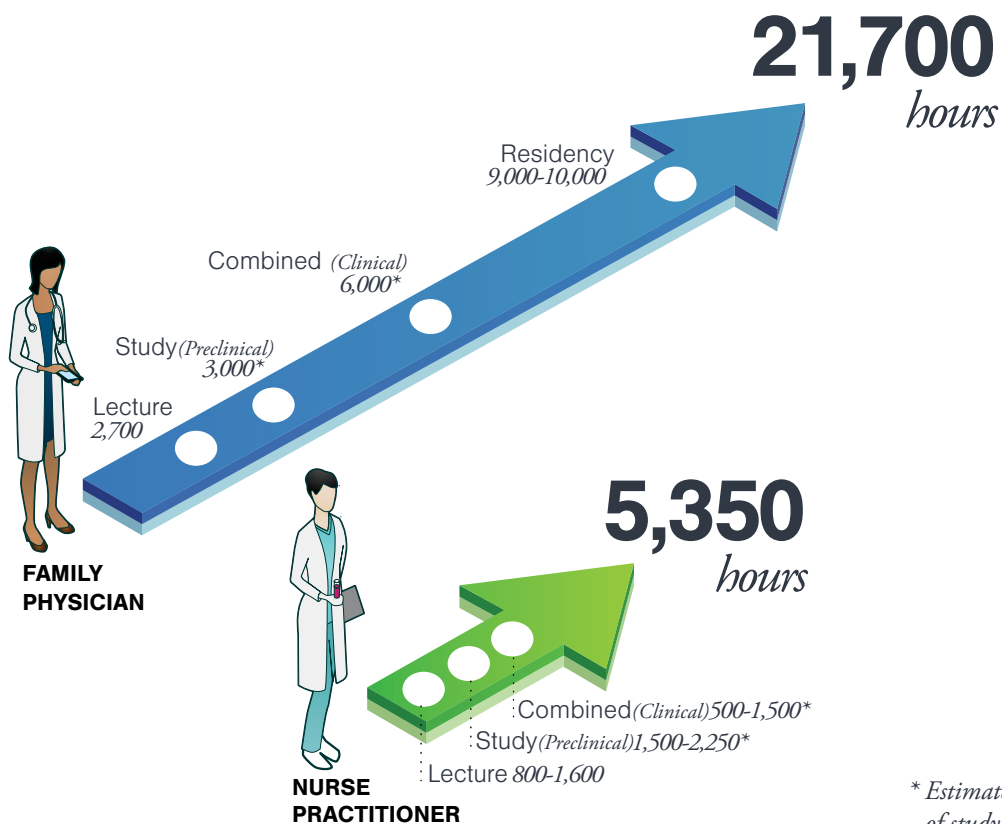
Degrees Required & Time to Completion.

The graphic below offers a side-by-side comparison of the education required to become a family physician versus the requirements to become a nurse practitioner.



Training & Clinical Hours Required.

The graphic below offers a side-by-side comparison of the training involved in becoming a family physician versus the requirements for becoming a nurse practitioner.



** Estimate based on 750 hours of study dedicated by a student per year.*

When it comes to costs associated with replacing physicians with nurse practitioners or nonphysicians in health care practices, a recent study titled *The Impact of Nonphysician Clinicians. Do They Improve the Quality and Cost-Effectiveness of Health Care Services?* found that “the evidence that role revision increases health care efficiency or lowers costs is weak and contradictory. Health care planners need to be alert to the possibility that, while nonphysicians cost less to employ than physicians, savings on salaries may be offset by lower productivity and less efficient use of non-staff resources.”³⁷ Utilizing all health professionals in a team approach will work for the patient and the practice. It is important to recognize that “involving nurse practitioners in a practice team and exerting their full capabilities is a promising way to expand primary care workforce.”³⁸

“The primary-care doctor — a category that includes family physicians, general internists and general pediatricians — has been held up as the gatekeeper in keeping people out of emergency rooms and controlling health care costs.”³⁶

—*USA Today*

The Future of Care



Nurse practitioners and primary care physicians have plenty of demand for their skills. And when they join together to provide care for patients in a team setting, those skills are put to the best use.

The team approach gives the patient access to the full range of health care services without sacrificing the medical expertise that ensures the most accurate diagnoses and the most appropriate treatments in the timeliest manner. In the end, patients want to see and have access to a physician. In fact, three in five Americans say they receive the best medical care from their primary care physician.³⁹

The interests of patients are best served when their care is provided by a physician or through an integrated practice supervised directly by a physician.⁴⁰
We must not compromise quality for any American, and we don't have to.

The AAFP encourages health professionals to work together as clinically integrated teams in the best interest of patients. Integrated practice arrangements should include a licensed physician supervising one or more nonphysician health care providers (physician assistants, advanced registered nurse practitioners, certified nurse midwives, various levels of nursing personnel, and other nonphysician providers), and possibly other physicians working as an interdependent team. The central goal of an integrated health care practice is to provide the most effective, accessible, and efficient care to the patient, based upon clinical and patient-focused outcome measures or assessments. The team member assuming lead responsibility for various aspects of patient care will ultimately be determined by matching team members' clinical competencies and skills with patient needs.⁴¹ A nurse practitioner, for example, may take the lead to manage care for a patient with stable diabetes.

The PCMH represents an example of an integrated practice arrangement in which a licensed physician (MD/DO) works jointly with other health care

personnel to manage the care of an individual patient and a population of patients using an integrated approach to health care. The arrangement should support an interdependent, team-based approach to care. It should address patient needs for high-quality, accessible health care and reflect the skills, training, and abilities of each health care team member to the full extent of his or her license. The characteristics of the highest-quality PCMH include:

Personal physician—Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.

Physician-directed medical practice—The personal physician leads a team of individuals at the practice level who all take responsibility for the ongoing care of patients.

Whole-person orientation—The personal physician provides for all the patient's health care needs or takes responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, and end-of-life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public, and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to ensure that patients get the indicated care when and where they need/want it, in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Medical practices advocate for their patients to help them attain optimal, patient-centered outcomes defined by a care-planning process that is driven by a compassionate, robust partnership between physicians, patients, and patients' families.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

- Patients actively participate in decision making, and feedback is sought to ensure patients' expectations are met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate nongovernmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model. Patients and families participate in quality-improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physicians, and practice staff.

What It Takes to Get There



National workforce policies should ensure adequate supplies of family physicians and other health care professionals in primary care to improve access to quality care and avert anticipated shortages of primary care clinicians. Workforce policies and payment systems must recognize that *training more nurse practitioners and physician assistants neither eliminates the need nor substitutes for increasing the numbers of physicians trained to provide primary care*. Flexibility in federal and state regulation is essential to ensuring that each medical practice can determine—within a defined spectrum—the appropriate physician ratios, supervision processes, and clinical roles within the medical team.

Americans must have access to the primary care physicians who have the medical expertise to treat 80 percent of the health care problems that people have.⁴²

Since 2006, the AAFP has called for physician workforce policies that can reverse this alarming physician shortage trend.⁴³ Critical investment in training and education will not only help guide health system change to achieve optimal, cost-efficient health for everyone, but it will support “the most rapidly growing sector in terms of employment through 2020.” Federal investment must support efforts to train and place the necessary primary care workforce, especially in rural and underserved areas. To meet any and all of our health care needs, the United States must:

- Increase the number of family physicians by increasing support for primary care physician education;
- Increase support for programs that help medical students pay back or defray the burden of their medical school debt so the option of a primary care medical career is truly available; and
- Improve primary care physician payment to encourage these students to consider family medicine and primary care for their careers.⁴⁴

Family physicians and other primary care doctors provide the front door to our health care system. They are the physicians to whom patients turn for diagnosis of sometimes complex and confusing symptoms and for help navigating our health care system. We need primary care doctors in PCMHs leading teams that deliver high-quality, cost-effective 21st century primary care. Physicians offer an unmatched service to patients and without their skills, patients would receive second-tier care. We must not downgrade Americans' care by offering them nurses instead of doctors. We can fill the need by having all health professionals on the team in the right roles.

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Primary Care for the 21st Century

Ensuring a Quality, Physician-led Team for Every Patient

The U.S. is moving to a new primary care model built around patients and delivered by teams, known as the **Patient-Centered Medical Home (PCMH)**.



What is it?

- Each person has an ongoing relationship with a **personal physician** who provides continuous, comprehensive care
- **Physician leads a team** of professionals to care for patients



- Personal physician **coordinates with other health care providers within the PCMH** and across the complex health care system



- **Quality and safety** are hallmarks, and patients and their families actively participate in decision making



- **Enhanced access to care** through open and same-day scheduling, expanded clinical hours, and new options for communication

Can a nurse lead the team?

Nurses are vital members of the team, but
nurse
≠
doctor

Years of Education and Training¹



Doctors bring broader and deeper expertise to the diagnosis and treatment of all health problems. Doctors are trained to provide complex diagnoses and develop comprehensive plans to treat them.

3 out of 4

patients prefer to be treated by a physician even if it takes longer to get an appointment and even if it costs more.²

Why do we need it?



- **Fewer** emergency room visits
- **Fewer** hospital admissions and readmissions
- **Shorter** hospital stays³

How do we make the PCMH a reality for everyone?

- 1** We have to fix the primary care workforce shortage.

45,000 too few primary care physicians by 2020⁴

AND

260,000 too few registered nurses by 2025⁵

- 2** We need more doctors, and we need more nurses, and we need them working together in teams.



Studies show the ideal practice ratio of nurse practitioners to physicians is approximately **4 to 1**.⁶ At this ratio, everyone can have a physician-led team, and the primary care shortage can be eliminated.

- 3** How can we train more primary care doctors?



- Increase federal funding for primary care physician education.



- Help medical students pay back or defray medical school debt.



- Improve primary care physician payment so students will consider primary care careers.

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