Canadian Association of Physician Assistants
Association canadienne des adjoints au médecin

Canadian Physician Assistant Profession

The Potential Impact on the Ontario Health Care System

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Introduction

The Canadian Association of Physician Assistants (CAPA) would like to thank the Ministry of Health and Long-Term Care (MOHLTC) as well as physicians in Ontario for their ongoing support of the Physician Assistant profession in Ontario. CAPA would also like to take this opportunity to submit information for consideration by the MOHLTC under the Ontario Seniors Care Strategy which demonstrates the effectiveness of PAs in Ontario and identifies why the further integration of Physician Assistants (PAs) into both the provincial and Canadian public health care system is so crucial for improving access to patient care. In the MOHLTC 's Action Plan on Health Care the government highlights the need for a plan that is efficient, yet still patient-centered and focused on access to quality care. Of specific interest is the ageing population: "with the number of seniors doubling over the next 20 years"[1] there will be a need for increased resources allocated to the care of Ontario's seniors. The government is in the process of designing a Seniors Strategy focuses that will have an intense focus on supporting seniors to stay healthy and stay at home longer, reducing strain on hospitals and long-term care homes. CAPA fully supports this strategy and believes that PAs, as part of the Physician/PA Model of care, can improve access to timely and quality care for Ontario seniors and provide community care in a safe and cost effective manner.

CAPA has created the following report which includes: a thorough literature review of Canadian, US and international studies, as well as examples of PAs who have had a positive impact on patient care in the Canadian health care system and around the world.

CAPA's mission is to improve access to quality care through the Physician/Physician Assistant Model of patient-centered health care. The following points attempt to describe the Physician Assistant role and the impact that this profession can have on the health care system:

- Physician Assistants function in a collaborative semi-autonomous role which extends medical care to more patients in a cost effective and efficient manner.

- Physician Assistants make a significant contribution to patient care through their flexible and dynamic scope of practice with an ability to extend physician services across specialties and program services including long-term care, community care, and geriatrics.

[1] The Ministry of Health and Long-Term Care. (2012). *Ontario's Action Plan for Health Care. Retrieved from: http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/*

- Physician Assistant utilization is efficient and economical and does not result in increased resource allocation; Physician Assistants are designed to improve the health system and enhance efficiencies. [2]

- Physician Assistants provide the capacity of meeting the needs of the population in a safe, competent and cost effective manner. This is supported by successful integration and use of Physician Assistants in primary care settings in the United States ,the Canadian Forces and globally.

In today's environment, health care delivery is increasingly challenging: new funding frameworks and resource allocation issues call for increased efficiency at all levels of public service. Canadians require improved access to quality medical care that provides them with acute care, preventative health care, and chronic disease management through the use of primary care networks and collaborative teams. These teams will become increasingly challenged to meet the needs of the growing population and will need to use efficient and innovative methods. Canadian national and provincial commissions have highlighted the need for primary care reform and an increased level of care for seniors, while international surveys of primary care physicians in seven countries show the current inadequate status of Canada's primary care system in comparison to other nations. Evidence suggests a lean and perhaps inadequate supply of primary care providers.[3] Calls for improved collaboration have been included in the National Forum on Health in 1997, The Mazankowski Health Report 2001, The Romanow Commission on Health Care in Canada 2001-2002 and many others. Many of these reports support a team-based collaborative model. The College of Family Physicians of Canada supports the use of Physicians Assistants[4] in collaborative practices as part of the solution. Today approximately 4.5 million Canadians, including many seniors, do not have access to a primary care provider.[5] CAPA believes that the integration and support of Physician Assistants in Ontario and throughout the rest of Canada would be a positive step in addressing this need.

As the Physician Assistant profession is relatively new to the public health care system in Canada, it was felt beneficial to present both Canadian data and US material in this submission. In the United States,

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[2] Morgan, Shah, Kaufman and Albanese. (2008). *Impact of Physician Assistant Care on Office Visit Resource Use in the United States. Health Research and Educational Trust*. Vol. 43, No. 5, p.p. 1906 – 1919

[3] Moores, Wilson, Cave, Woodhead, and Donoff; *Improving the Quality and Capacity of Canada's Health Services: Primary Care Physician Perspectives.* Healthcare Policy, 3(2) 2007: 0-0

[4] College of Family Physicians of Canada (2011). *Position Statement on Physician Assistants.* Retrieved from: http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/Health_Professionals/CFPC%20Position%20Statement_Physician%20Assistants_FINAL%20ENGLISH.pdf .

[5] Statistics Canada. (2012). *Canadian Community Health Survey*. Retrieved from: http://www.statcan.gc.ca/daily-quotidien/110621/dq110621b-eng.htm

the profession has been in existence for over forty years and is currently one of the fastest growing segments of the health care workforce, with almost 84,250 PAs practicing primary care and virtually every medical specialty[6]. There is a predicted growth rate of 6,500 new PAs a year in the U.S., with a forecast of 20 new education programs starting in the next 5 years. Our analysis also includes research from Australia, New Zealand, the Netherlands, and the United Kingdom as these countries have health care delivery systems and resource issues similar to Canada's.

The inclusion of PAs in the public health care system is a safe, economical and high quality alternative to some of the challenges that we are facing with health care delivery in Ontario and throughout Canada.

Physician Assistants are part of the solution to providing better access and optimizing patient-centered care for Canadians in a safe, competent and efficient manner.

Global Impact of the Profession

Physician Assistants (PAs) currently practice in Australia, Canada, England, Ghana, Kenya, New Zealand, Nicaragua, Scotland, South Africa, United States, the Netherlands, Taiwan and Thailand.[7] The common principal shared in all these countries is the need to provide primary health care and medical services traditionally delivered by physicians. The fact is, not all medical services require the extensive and comprehensive knowledge of a physician and can be delegated to qualified health care professionals.

The primary reason cited for the development of a global and common PA curriculum was the discrepancy between the supply and the demand for health care providers. There is a growing understanding that a rearrangement of work tasks among health care professions is necessary. Delegation of tasks from highly educated and relatively expensive physicians to other health care workers should help prevent lengthy waiting lists for patients and make health care more efficient.[8]

In Canada the PA profession originated with the Canadian Forces (CF). Senior military medics (medical assistants, medics, and navy corpsman) were trained to provide advanced care on navy ships as well as on the front lines during the Second World War. This was an operational necessity due to the shortage of medical doctors within the scale of operations and geographic reality. Often physicians were stationed to larger geographic areas where the majority of the military personnel were located. Military medics were deployed to the front lines as part of a team and, working under the direction of a

[6] The American Academy of Physician Assistants. (2011). *House Passes Bill to Expand Ways PAs Treat Federal Employees.* para 4 . Retrieved from: http://www.aapa.org/news_and_publications/news/item.aspx?id=3281&terms=fastest%20growing%20profession

[7] Hooker R., Hogan K. and Leeker E. (2007). *The Globalization of the Physician Assistant Profession*. The Journal of Physician Assistant Education, Vol 18, No 3, p.p. 76-77. Retrieved from: http://www.paeaonline.org/index.php?ht=action/GetDocumentAction/i/25227

[8] Geesje; Olle. ten; Helianthe and Kort (2008). *Training the Physician Assistant in the Netherlands.* University Medical Center, Utrecht, Netherlands. The Journal of Physician Assistant Education,Vol 19, No 4

physician, provided care to military personnel and sometimes, civilians. If physicians were not available, the education, training, and experience of these providers allowed quality medical care beyond first aid measures to continue. With time it was observed that quality care did not always require a physician's or surgeon's intervention. This model of care evolved in the military and Physician Assistants became more prevalent, not only for deployment on missions abroad, but also on ships and at various Canadian Forces Bases.

PAs first entered the public health care system in Manitoba in 1999. Since then PAs have been integrated in Ontario, New Brunswick and will soon be adopted in Alberta. There are currently upwards of 300 PAs working in the public health care system, the majority of which are employed in Ontario. The profession is regulated in Manitoba and New Brunswick by the provincial colleges of physicians and surgeons and regulation is pending in Ontario. In October 2011, CAPA was asked by the Health Professions Regulatory Advisory Council to submit an application for regulation of the PA profession. CAPA submitted the application in January 2012 and is currently awaiting the Ontario Minister of Health and Long-Term Care's decision. In Alberta a voluntary registry exists under the College of Physicians and Surgeons of Alberta and planning is underway to launch a pilot project by Alberta Health Services to integrate PAs into the health care system.

The Physician Assistant profession began formally in the United States in 1961 when Dr. Charles Hudson spoke to the American Medical Association, calling for a profession to work alongside doctors performing skilled medical tasks requiring advanced knowledge. It was foreseen that the nature of technology and the complexity of care had created a shortage and misdistribution of physicians. Dr. Eugene Stead of Duke University proposed the Physician Assistant solution and the first graduates began to practice in 1967[9]. The Physician Assistant Educational Association reports on their website in-excess of 160 accredited programs as of May 2012.

Canadian Physician Assistants are academically prepared and highly skilled health care professionals, educated in the medical model, that practice medicine under the supervision of a licensed physician, within a patient-centered health care team.

Canadian Medical Association recognized Physician Assistants as a health care profession in 2003 with a unique body of knowledge and competency profile

Scope of Practice

The Physician Assistant scope of practice mirrors that of their supervising physician. PAs possess a defined body of knowledge building on the medical sciences and clinical medicine that includes clinical and procedural skills, and a professional philosophy to support effective patient care. PAs apply these

[9] Physician Assistant History Society. (2012). *Stead Jr. Eugene*. Retrieved from : http://pahx.org/stead-jr-eugene.

competencies to collect data and interpret information, develop and further investigate differential diagnoses, make appropriate clinical decisions, and carry out required diagnostic, procedural, and therapeutic interventions[10]. They practice medicine within a formalized physician/PA relationship. PAs supplement, not supplant, the work of physicians as both a philosophy of the profession, and reality of clinical practice with tasks varying based on the PAs level of experience and expertise. PAs practice in all clinical settings including specialty areas such as surgery, internal medicine or family practice, emergency, long-term care, geriatrics, rehabilitation, orthopaedics, obstetrics and oncology. PAs provide care in any area with traditional physician practice.

Physician Assistants provide nine general clusters of activity that serve the patient population seen in primary care environments[11].

- Gathering data
- Seeing common problems and diseases
- Conducting laboratory and diagnostic studies
- Performing management activities
- Performing surgical procedures
- Managing emergency situations
- Conducting health promotion and disease prevention activities
- Prescribing medications
- Using interpersonal skills

Physician Assistant Education

Canada has four Physician Assistant academic programs, which are accredited by the Canadian Medical Association (CMA) Conjoint Accreditation Services, they include:

- McMaster University Physician Assistants Education Program, Bachelor of Health Sciences Degree (Physician Assistant);
- Canadian Forces Health Services Training Centre Physician Assistant Program, Physician Assistant Baccalaureate in an Allied Health Program;
- The Consortium of Physician Assistant Education (which includes: the University of Toronto; The Northern Ontario School of Medicine and the Michener Institute for Applied Health Sciences) Bachelor of Science Physician Assistant Degree; and
- University of Manitoba Master of Physician Assistant Studies program.

[10] Canadian Association of Physician Assistants. (2012). *Scope of Practice and National Competency Profile*. Retrieved from: http://capa-acam.ca/en/Scope_Of_Practice__National_Competency_Profile_55
[11] Hooker, Cawley, and Asprey . (2010). *Physician Assistant Policy and Practice 3rd ed*. F.A. Davis Philadelphia.

The educational curriculums are modeled after the CanMEDS Physician Competency Framework and mirror that of a physician's education. Physician Assistants are educated as generalist medical practitioners in the medical model. They develop clinical expertise through experiences and mentoring over time while on clinical rotation and in practice. The Physician Assistant profession's philosophy is to approach the provision of medical care in collaboration with a physician but as critically-thinking, problem-solving medical professionals in their own right.

A single national standard is ensured through the Physician Assistant Certification Council of Canada (PACCC), an independent Council of the Canadian Association of Physician Assistants (CAPA) that administers and maintains the PA certification process. This includes the PA Entry to Practice Certification Examination (PA Cert Exam), written upon the successful completion of a Canadian Medical Association (CMA) accredited PA program. The PA Cert Exam is administered independently of any training facility to ensure that the PA meets the standard set out in the National Competency Profile (NCP) for the Physician Assistant profession. PACCC aims to reassure the public that there is a national standard of care from PA providers who successfully complete the PA Cert Exam. Those who are successful carry the designation of Canadian Certified Physician Assistant (CCPA).

PAs contribute to health system and physicians' effectiveness.

The principal utilization of PAs focuses on clinical situations where duties normally performed by the physician can be delegated to a qualified medical professional. PAs are permitted to practice by way of delegation of the supervising physician. Under the provincial *Medical Acts,* physicians have the ability to delegate controlled acts to a health professional. PAs are not autonomous professionals. A relationship with a supervising physician is essential to their ability to practice. The delegation of these duties frees up the physician's time to address complex issues that require the extensive and unique knowledge of a physician while potentially expanding the physician's practice and improving the overall quality of care provided. Research demonstrates that PAs in primary care settings can be used for 75 percent of all visits without referral to physician level care.[12] Furthermore, a study conducted by the Australasian College of Emergency Medicine and Australasian Society for Emergency Medicine suggests that PAs can manage up to 62 percent of all patients in emergency care environments.[13]. This study also found that in the emergency department setting, PAs appeared equally capable of performing procedures if adequately trained and supervised and the quality of care provided by PAs was comparable with that of

[12] Schweitzer, S.O. & Record, J.C. (1981). *Staffing primary care in 1990: physician replacement and cost saving*. Springer Publication Co., New York.
[13] The Australasian College of Emergency Medicine and Australasian Society for Emergency Medicine. (2011). *Roles and Task Assignments.* para 3, p.p. 9.

emergency specialists (attending) physicians and senior residents. This resulted in shorter wait times for patients.[14]

In both of these situations, PAs have been shown to enhance the delivery of care and improve access for patients. In preparation of this document, CAPA conducted a thorough literature review. A total of 28 studies were reviewed from Canada and abroad. The literature suggests that PAs can potentially increase the number of patients seen, decrease wait times, reduce doctors' working hours, enhance productivity and are a safe, qualified and economical alternative to other health care options.

One of the first Canadian studies to be conducted on the utilization of PAs attempted to measure the impact of the integration of the new roles of primary health care nurse practitioners and PAs on patient flow, wait times and proportions of patients who left without being seen in six Ontario emergency departments (EDs). The study demonstrated that PAs were able to improve wait times, patient flow and diminish the rates of those who left without being seen in the ED. Specifically when a PA was on duty, the odds of a patient being assessed within the wait time benchmark were 1.9 times higher than when a PA was not on duty. Further, when a PA was on duty, the likelihood that a patient left without being seen was less than half than when a PA was not on duty.[15]

A report on Orthopaedic Physician Assistants in Manitoba published in the Journal of Canadian Surgery, found that PAs were able to free their supervising orthopaedic surgeon the equivalent of four 50 hour work weeks per year, which in turn was used for activities such as administrative work, research and other clinical activities. Furthermore, surgical throughput was greatly enhanced: PAs allowed for use of the double room model, which increased the group's surgical throughput of primary joint replacements by 42 percent over the preceding year and a reduction in median wait times from 44 weeks to 30 weeks. The study also suggests that the use of PAs as first assistants in the operating room instead of general practitioners freed up the equivalent of 1.5 general practitioners working 40 hours per week for 44 weeks per year based on a surgical volume of 1400 joint replacements per year. In this team, PAs were regarded as important members of the health care team by surgeons, nurses, orthopaedic residents and patients, and were found to be essentially cost neutral. This Canadian study on orthopaedic hip and knee joint replacement conducted a cost analysis on the use of PAs and found that of the 402 procedures performed in 2006, PAs were present for 279 (69.4%) of them and the total forgone general

[14] The Australasian College of Emergency Medicine and Australasian Society for Emergency Medicine. (2011). *Roles and Task Assignments*. *Quality of Care*. para 3, p.p. 13.

[15] Ducharme, Adler, Pelletier, Murray and Tepper. (2009). *Impact on patient flow after the integration of nurse practitioners and physician assistants in Ontario emergency departments.* The Canadian Journal of Emergency Medicine, Vol. 5, p.p. 458. Retrieved from: http://www.cjem-online.ca/v11/n5/p455

practitioner assist fees were $56,113 for the 402 procedures, which resulted in an average cost saving of $139.58 per procedure.[16]

A literary analysis conducted by a team consisting of a PA candidates from the Faculty of Health Sciences, McMaster University and a physician from the Faculty of Medicine, University of Toronto, looked at various Canadian and US research studies regarding PAs and the efficiency of their use.[17] Of specific relevance was data obtained from two hospitals in Halifax, Nova Scotia for the purpose of conducting a business case analysis on the effectiveness of the introduction of a PA in a plastic surgery clinic. The presented research found that, depending on the type of surgery, a PA conducts over 50 percent of the surgeon's tasks. Additionally, the PA could increase overall surgical productivity by 37 percent and was cost neutral when using a single operating room. If two operating rooms are available simultaneously, the potential for improved productivity and cost effectiveness is greater.[18] This reinforces the flexibility and the adaptability of the PA role, while at the same time supporting the efficiency of the role. The MOHLTC is looking to shift procedures into the community: routine procedures that are traditionally performed by physicians in hospitals would be shifted to not-for-profit community-based clinics. The PA, under the supervision of a physician would be ideal for this situation given their broad level of knowledge and their advanced medical skills.

A study was conducted at Seven Oaks General Hospital in Winnipeg, Manitoba with a team comprised of physicians, PAs and NPs providing care to a patient population that had increased 30 percent since 2008. The team approach with both PAs and NPs found wait times, length of stay, and "left, not seen" rates declined to "enviable" levels without a significant increase in baseline physician staffing. Nurse practitioners staffed the minor treatment area seeing triage levels 3, 4, and 5 during day shifts while PAs provided treatment in the emergency department with levels 2, 3, 4, and 5. With assistance from PAs seeing significant numbers of patients, emergency physicians are able to focus on patients with the most acute needs, and have more time for consultation with team members.[19] The arrival of critical level 1 cases allowed a team approach with the medical doctor and the PA. The minor treatment area was used by the PAs to treat patients after the NP's shift.

A systematic review conducted by Kleinpell included 31 studies examining the use of both nurse practitioners (NPs) and PAs in the intensive care unit (ICU). The review concluded that the integration of

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[16] Bohm, Dunbar, Pitman, Rhule and Araneta . (2009). *Experience with physician assistants in a Canadian arthroplasty program*. Can J Surg, Vol. 53, No. 2, p.p. 106 - 107. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845948/

[17] Sigurdson L. (2006). *Meeting Challenges in the Delivery of Surgical Care: A Financial Analysis of the Role of Physician Assistants*. Saint Mary's University. UTMJ, Vol 88, No.2

[18] Sigurdson, L. (2006). *Meeting Challenges in the Delivery of Surgical Care: A Financial Analysis of the Role of Physician Assistants*. Saint Mary's University. UTMJ, Vol 88, No.2, p.p. 90.

[19] Dunlop, K. (2011). *A team designed to meet patients' needs*. Canadian Nurse, 107(1), p.p. 36.

alternative health care providers into ICU health care teams positively impacted patient care and that patient flow was increased without altering patient outcomes or direct hospital costs.[20]

The balance between health care needs and available resources is a constant challenge in many countries around the globe. The Physician Assistant as a cost-effective alternative to training and retaining more physicians is a potential solution currently common to many countries. In New Zealand, PAs are a relatively new phenomenon. The Health Board undertook a trial to introduce the PA profession into the public health care system. The Counties of Manukou District Health Board in New Zealand conducted an evaluation of the Physician Assistant Trial. The report noted that PA teams improved the speed of treatment by taking a first responder role in emergencies and always being available on the ward.[21] In addition, evidence suggested that patient safety was enhanced by the presence of PAs. Teams with PAs made 24.5 percent fewer patient-at-risk calls (calls made by nurses requesting assistance with seriously ill patients) than teams without PAs. The fact that fewer patients "crashed" on teams with PAs suggests that PAs were improving patient safety, possibly by intervening earlier than would otherwise have occurred. Staff members who worked with PAs reported care was made safer by the PAs who were constantly available, knowledgeable, diligent and vigilant workers who took their time to focus on quality and safety. As a result of their inclusion into the New Zealand health care system, PAs improved patient satisfaction and team communications, fostered teamwork, organization, trust and enhanced patient safety and care. [22]

An Australian literature review conducted by Siggins-Miller Consultants, prepared for Health Workforce Australia, revealed that PAs can reduce escalating health care costs by providing a new workforce group which is qualified and can provide safe and effective services at a lower cost. Furthermore it is suggested that PAs can increase the productivity of other health professionals and doctors by releasing them from routine and repetitive tasks to allow them to work at the top of their license.[23] The Australian report cited American and Canadian studies, which reinforced the use of the Physician/PA model of care as an economic and resource-saving alternative in a variety of specialty settings. Further studies stated that "experiences with surgical PAs in rural practice settings resulted in significant time savings for general surgeons who could be freed up to concentrate on more acute and complex care needs." In family practice settings the use of PAs has been found to be cost effective, with a compensation to production

[20] Kleinpell, Elx and Grabenkort. (2008). *Nurse Practitioners and Physician Assistants in the Intensive Care Unit: An Evidence-Based review. Critical Care Med*. Vol 36 (10), p.p. 2888-97.
[21] Siggins Miller "prepared for Health Work Force New Zealand". (2012). *Evaluation of the Physician Assistant Trial, Final Report*. p.p. v.
[22] Siggins Miller "prepared for Health Work Force New Zealand". (2012). *Evaluation of the Physician Assistant Trial, Final Report*. p.p. v.
[23] Sigging Miller "prepared for Health Work Force Australia". (2011). *The potential role of Physician Assistants in the Australian context, Vol 1: Final Report*. p.p. iii

ratio of 0.36. The annual financial differential for the practice was $52,592. Similarly, PAs employed in dermatology practices have been shown to generate up to six times their salaries in billings.[24]

In the United States PAs have proved to be a less-expensive alternative to increased staffing. One rural ED staffed by both ED physicians and PAs found that the net cost of using ED physicians was higher with a net loss of $50.00 compared to a net gain of $260.00 in employing PAs[25]. A literature review titled: *Economic Basis of Physician Assistants Practice,* examined the cost-benefit projection and estimated that the employment cost of a PA was 53 percent less than a physician[26]. In an environment where it is difficult to recruit an adequate number of physicians to meet the Canadian population's needs, this is a viable and economical solution.

PAs and Long-Term Care

Ontario's Action Plan on Health Care highlights long-term and community care for seniors as one of the number one health priorities for the coming years. Given the increased number of seniors that will be requiring care, the MOHLTC has committed to placing more emphasis on seniors and helping them to live longer, healthier and more enjoyable lives. The government is attempting to accomplish this through its Ontario Seniors Care Strategy. [27] The new program includes the expansion of house calls, more access to home care through additional support worker hours, care coordinators that work closely with health care providers to make sure the right care is in place for seniors recovering after hospital stays to reduce readmissions, and giving LHIN's greater flexibility to shift resources where the need is greatest. PAs would be the perfect fit for this program and could significantly help improve access for seniors to medical care. A US study, which focused on the use of nurse practitioners and PAs in long-term care found that medical attention increases (defined as the number of visits and medical orders) to nursing home residents when primary care is provided by nurse practitioners and PAs in these facilities. [28] PAs can also have an important preventive role in the care of geriatric patients. [29] Most nursing homes and long-term care facilities do not have a full-time medical staff. Physicians typically visit such facilities on a weekly basis. Patients with acute problems are generally treated over the phone or sent to an

[24]. Sigurdson, L. (2006). *Meeting Challenges in the Delivery of Surgical Care: A Financial Analysis of the Role of Physician Assistants*. Saint Mary's University. UTMJ, Vol 88, No.2, p.p. 20.
[25] Ellis, GL, and Brandt, TE. (1997). *Use of Physician Extenders and Fast Tracks in the United States Emergency Departments*. AM. J. Emerg. Med. Vol 15, p.p. 229 -32
[26] Hooker, R. (2000). *The Economic Basis of Physician Assistants Practice. Physician Assistant*. Vol 24 (4), p.p. 51-71.
[27] The Ministry of Health and Long-Term Care. (2012). *Ontario's Action Plan For Health Care.* Retrieved from: http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/
[28] Caprio, Thomas, V., MD. *Physician Practice in the Nursing Home: Collaboration with Nurse Practitioners and Physician Assistants.* The Annals of Long-Term Care (2006). Vol. 14, No. 3. p.p. 21. Retrieved from: http://www.annalsoflongtermcare.com/attachments/5474.pdf
[29] Hooker, Cawley and Asprey. (2010). *Physician Assistant Specialization: Nonprimary care.* PA Specialty Care. Ch. 7. p.p. 235.

emergency department. An American study suggested that "having a full-time PA on staff at a nursing home or long-term care facility can translate into patients being evaluated sooner and can prevent transfer to the hospital in many cases. Further, PAs in long-term care settings have been shown to decrease the hospital admission rates for seniors." [30] It has been demonstrated that "PAs can reduce the annual hospital admission by 38% after a PA was introduced into a nursing home."[31] According to Ontario's Action Plan on Health Care, the elderly represent a large group of Canadians with unmet health care needs. Recruiting and training PAs to provide services to geriatric populations can be an avenue to address the currently unmet health care needs of this population.

Economic Impact

Question may arise about the validity of this data as it relates to Canada given that these statistics were measured in the US health care system where the majority of patients have third party health insurance or pay out of pocket for medical care. However, if we factor in billings from physicians to provincial Medicare and the salary incurred by the PA, the savings to the provincial government in Ontario would be comparable. Physician Assistant salaries are generally a third of those of primary care physicians[32] according to a comparison through several online salary portals.

Currently in Canada there are two different methods in which a PA is remunerated. The majority of PAs are funded by the provincial governments. Some governments have built PA funding into their budgets. For example, Manitoba has 80 positions dedicated for Physicians Assistants (or Clinical Assistant - a non-certified limited scope provider) in support of specialty services. Other provinces such as Ontario have established grant programs, which provide funding for PAs on a contractual basis, such as the Ontario Demonstration Projects or the Ontario PA Graduate Grant Program. Some physicians who have not been selected for either of these programs have decided to fund the PA from their operation budgets. They bill OHIP for services rendered by the PA to their patients. It is CAPA's desire to work with the Ontario Medical Association as well as other provincial medical associations to come up with a comprehensive funding model(s) to ensure that PAs are adequately compensated and that there is a consistent approach across the country for physicians wanting to employ PAs in their practices.

[30] Hooker, Cawley and Asprey. (2010). *Physician Assistant Specialization: Nonprimary care.* PA Specialty Care. Ch. 7. p.p. 235.
[31] Caprio, Thomas, V., MD. *Physician Practice in the Nursing Home: Collaboration with Nurse Practitioners and Physician Assistants.* The Annals of Long-Term Care (2006). Vol. 14, No. 3. p.p. 22. Retrieved from: http://www.annalsoflongtermcare.com/attachments/5474.pdf
[32] Physician Assistant. (2012). *Physician Assistant Salary, Expert Details Analysis of Physician Assistant Salary in the US.* Retrieved from: http://www.physicianassistant.cc/physician-assistant-salary/physician-assistant-salary and http://mdsalaries.blogspot.ca/

Summary

Physician Assistants have been part of the North American health workforce since 1965 and the concept has expanded globally.

Physician Assistants have a positive impact on the existing medical workforce. PAs are:

1. Formally educated and nationally certified as medical generalists with the ability of horizontal mobility between medical specialties;

2. Improving access to quality medical care and services by supplementing or supplying physician level care;

3. Allowing attending physicians, surgeons, and residents to spend more time in clinics or theatres to perform more other tasks and receive further education and training;

4. Allowing the physicians to concentrate on tasks and medical problems they are alone uniquely qualified to perform;

5. Playing a role in coordinating care across the health care system;

6. Improving access to treatment by providing the initial history and diagnostic services on the ward, clinics or units including the emergency or family medical units when volumes are high and physicians are not available;

7. Playing a preventive role in the care of geriatric patients and have been shown to reduce hospital admission rates for the elderly;

8. Improving continuity of care due to their presence in the clinic or on the ward addressing the service gap created when physician/house officers/residents are absent;

9. Increasing availability to allied staff, nurses, patients, and family throughout the day to assess patients or provide information;

10. Providing a reliable point of contact for consults when the residents or attending physician are not available;

11. Reducing communication issues occurring in handovers between the night-shift, week-end coverage, patient-at-risk team and the doctors; and

12. An economic alternative to support and supplement patient care.

Conclusion

A review of the literature on the utilization and benefits of the Physician Assistant profession demonstrates that PAs are a safe, efficient and cost-effective, patient-centered model of care that increases access to quality care for patients and appears to have a significant benefit to Canadians. Further, the integration of PAs as part of Ontario's Seniors Care Strategy could provide substantial advantage to the elderly community particularly from a preventative care standpoint.

Canada's health care environment is changing and provincial governments are being forced to do more with less. Cutbacks in health care resources are occurring just as the needs of a growing population are increasing. The Physician Assistant profession is a sustainable economic solution for health human resources and stressed resources required to deliver a high level of quality care that seniors deserve.

The Canadian Forces have been employing PAs for over 50 years and are very satisfied with the standard of care that these professionals provide. A number of provinces, including Ontario have already incorporated PAs into their public health care teams and are thriving. Our neighbours to the south provide an excellent example of how the profession can positively impact health care delivery. Australia and New Zealand are supportive of the role and are ready to take the next steps.

It is time to be innovative and move away from the traditional model of health care delivery in Ontario and throughout Canada.

On behalf of our PA members, the Canadian Association of Physician Assistants would like to thank the Ontario government and Dr. Samir Sinha for the opportunity to provide information in support of Ontario Seniors Care Strategy and would welcome the occasion to meet with the Dr. Sinha to discuss this analysis further. CAPA is optimistic for the future of health care in Ontario, provided that PAs are included as part of the solution.

References

Bohm, Dunbar, Pitman, Rhule and Araneta . (2009). *Experience with physician assistants in a Canadian arthroplasty program*. Can J Surg, Vol. 53, No. 2, p.p. 106 - 107. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845948/

Brugna, R. (2006). *The Physician Assistant Role in Geriatric Medicine and Rehabilitation.* Physical & Occupational Therapy in Geriatrics. Vol. 25, p.p. 67 -76

Canadian Association of Physician Assistants. (2012). *Scope of Practice and National Competency Profile*. Retrieved from: http://capa-acam.ca/en/Scope_Of_Practice__National_Competency_Profile_55

Caprio, Thomas, V., MD. *Physician Practice in the Nursing Home: Collaboration with Nurse Practitioners and Physician Assistants.* The Annals of Long-Term Care (2006). Vol. 14, No. 3. p.p. 21. Retrieved from: http://www.annalsoflongtermcare.com/attachments/5474.pdf

Drennan, Chattopadhyay, Halter, Brearley, Lusignan, Gabe and Gage. (2012). *Physician assistants in English primary care teams: A survey.* Journal of Interprofessional Care, early online: 1-3. Retrieved from: http://www.clininf.eu/resources/papers/doc_download/171-physician-assistants-in-english-primary-care-teams-a-survey.html

Ducharme, Adler, Pelletier, Murray and Tepper. (2009). *Impact on patient flow after the integration of nurse practitioners and physician assistants in Ontario emergency departments.* The Canadian Journal of Emergency Medicine, Vol. 5, p.p. 458. Retrieved from: http://www.cjem-online.ca/v11/n5/p455

Dunlop, K. (2011). *A team designed to meet patients' needs*. Canadian Nurse, 107(1), p.p. 36

Ellis, GL, and Brandt, TE. (1997). *Use of Physician Extenders and Fast Tracks in the United States Emergency Departments*. AM. J. Emerg. Med. Vol 15, p.p. 229 -32

Geesje; Olle. ten; Helianthe and Kort (2008). *Training the Physician Assistant in the Netherlands.* University Medical Center, Utrecht, Netherlands. The Journal of Physician Assistant Education, Vol 19, No 4

Grysybicki, Sullivan, Miller Oppy, Bethke and Raab. (2002). *The Economic Benefit for Family/General Medicine Practices Employing Physician Assistants*. AM. J. Manag Care, Vol. 8, No.7, p.p. 613-620

Hooker, R. (2000). *The Economic Basis of Physician Assistants Practice. Physician Assistant*. Vol 24 (4), p.p. 51-71

Hooker R., Hogan K. and Leeker E. (2007). *The Globalization of the Physician Assistant Profession*. The Journal of Physician Assistant Education, Vol 18, No 3, p.p. 76-77. Retrieved from: http://www.paeaonline.org/index.php?ht=action/GetDocumentAction/i/25227

Hooker, Cawley J, and Asprey. (2010). *Physician Assistant Policy and Practice 3rd ed*. F.A. Davis, Philadelphia

Hooker, Cawley and Asprey. (2010). *Physician Assistant Specialization: Nonprimary care.* PA Specialty Care. Ch. 7. p.p. 235 – 236

Kleinpell, Elx and Grabenkort. (2008). *Nurse Practitioners and Physician Assistants in the Intensive Care Unit: An Evidence-Based review. Critical Care Med*. Vol 36 (10), p.p. 2888-97

Moores, Wilson, Cave, Woodhead, and Donoff (2007). *Improving the Quality and Capacity of Canada's Health Services: Primary Care Physician Perspectives.* Healthcare Policy, Vol 3 No.2 p.p. 0-0 . Retrieved from: http://www.longwoods.com/content/19365

Moote, Nelson, Veltkamp, and Campbell. (2012). *Productivity Assessment of Physician Assistants and Nurse Practitioners in Oncology in an Academic Medical Center*. Journal of Oncology. Vol. 8, No. 3, p.p. 167-172

Morgan, Shah, Kaufman and Albanese. (2008). *Impact of Physician Assistant Care on Office Visit Resource Use in the United States. Health Research and Educational Trust*. Vol. 43, No. 5, p.p. 1906 – 1919

Page, L. (2008). *Midlevels: Boost or Burden? Long viewed as an unaffordable luxury, physician midlevels can improve patient care--and your practice's bottom line.* Medical Economics Magazine. p.p. 26 – 31. Retrieved from: http://business.highbeam.com/62468/article-1G1-187051488/midlevels-boost-burden-long-viewed-unaffordable-luxury

Physician Assistant. (2012). *Physician Assistant Salary, Expert Details Analysis of Physician Assistant Salary in the US*. Retrieved from: http://www.physicianassistant.cc/physician-assistant-salary/physician-assistant-salary and http://mdsalaries.blogspot.ca/

Physician Assistant History Society. (2012). *Stead Jr. Eugene*. Retrieved from: http://pahx.org/stead-jr-eugene

Statistics Canada. (2012). *Canadian Community Health Survey*. Retrieved from: http://www.statcan.gc.ca/daily-quotidien/110621/dq110621b-eng.htm

The American Academy of Physician Assistants. (2011). *House Passes Bill to Expand Ways PAs Treat Federal Employees.* para 4 . Retrieved from: http://www.aapa.org/news_and_publications/news/item.aspx?id=3281&terms=fastest%20growing%20profession

Schweitzer, S.O. & Record, J.C. (1981). *Staffing primary care in 1990: physician replacement and cost saving*. Springer Publication Co., New York

Siggins Miller "prepared for Health Work Force New Zealand". (2012). *Evaluation of the Physician Assistant Trial, Final Report*. p.p. iv – vii

Sigging Miller "prepared for Health Work Force Australia". (2011). *The potential role of Physician Assistants in the Australian context, Vol 1: Final Report*. p.p. iii

Sigurdson L. (2006). *Meeting Challenges in the Delivery of Surgical Care: A Financial Analysis of the Role of Physician Assistants*. Saint Mary's University. UTMJ, Vol 88, No.2, p.p. 20 – 90

The Australasian College of Emergency Medicine and Australasian Society for Emergency Medicine. (2011). *Roles and Task Assignments*. *Quality of Care*. para 3, p.p. 9-13