



PAAs in Emergency Medicine

Emergency medicine is among the top three specialties chosen by PAs — following behind only family medicine and orthopedics. PAs in emergency medicine serve in settings from the smallest rural emergency departments (EDs) in Critical Access Hospitals to the largest Level 1 trauma centers. In rural settings, a PA may be the only provider on call for the ED, and on an urban trauma team, they may be found in the thick of responses to multi-casualty events. PAs often are the backbone of fast-track care and observation units within EDs. Employers of PAs in emergency medicine range from small hospitals to the largest emergency medicine staffing companies.

EDUCATION AND CERTIFICATION

Comprehensive master's degree programs provide PAs with a generalist medical education. Programs typically last 27 months¹ and employ a curriculum modeled on medical school. A classroom phase covers basic medical sciences, including anatomy, physiology, pharmacology, physical diagnosis, behavioral sciences, and ethics. PA students take more than 75 hours in pharmacology, 175 hours in behavioral sciences, more than 400 hours in basic sciences and nearly 580 hours of clinical medicine. This is followed by rotations in emergency medicine, family medicine, internal medicine, general surgery, pediatrics, obgyn, and psychiatry. PA students complete at least 2,000 hours of supervised clinical practice by graduation.^{2,3}

PA EDUCATION BY THE NUMBERS

27 months
75 hours of pharmacology
175 hours in behavioral sciences
400+ basic sciences
580 hours clinical medicine
2,000+ hours in clinical rotations

After graduation, PAs must pass a national certifying exam and obtain a state license. To maintain certification, PAs complete 100 hours of continuing medical education (CME) every two years and pass a national recertification exam every 10 years.⁴

To provide patient care in the hospital, PAs must be credentialed and privileged through the hospital credentialing process. For more information, see AAPA's [Practice Resources](#) webpage.

While postgraduate education is not required, the Society of Emergency Medicine PAs (SEMPA) identifies more than 40 postgraduate emergency medicine training programs for PAs.^{5,6}

PA WORKFORCE

Data show that 10 percent (14,000 PAs) of the PA workforce practices emergency medicine, and PAs account for one in every eight ED visits.^{7,8}

According to the National Center for Health Statistics, in 2017 (the most recent available numbers) PAs conducted 17,775,000 patient visits in EDs, up 2 million visits from 2013, five years prior. In 2013, 29 percent (4.5 million) of those PA visits did not involve a physician. By 2017, 40 percent (7 million) were PA-only. In the remaining PA cases, the patient saw the PA and a physician. In most years from 2009-2017, PAs saw on average 13 percent of all ED visits, according to NCHS findings.⁹

PA SCOPE OF PRACTICE IN EMERGENCY MEDICINE

PAs are found practicing every aspect of emergency medicine – from fast tracks to trauma. They examine and evaluate patients, order and interpret lab tests, and diagnose and treat. PAs perform procedures in the ED — using point of care ultrasound, as needed.

Services provided by PAs in emergency medicine	Provided 'for most patients'
Perform physical exams and obtain medical histories	97.0%
Diagnose, treat, and manage acute illnesses	96.6%
Order, perform, and interpret diagnostic studies	94.4%
Prescribe medications for acute and chronic illnesses	92.9%
Counsel and educate patients and families	82.0%
Make referrals	49.0%
Provide care coordination	40.7%
Perform procedures	38.5%
Diagnose, treat, and manage chronic illnesses	35.0%
Provide preventive care	20.3%
<i>Source: 2019 Statistical Profile of Certified PAs by Specialty. NCCPA.</i>	

When COVID-19 took the world by storm in 2020, the flexibility of the PA profession enabled facilities to move PAs to areas of greatest need. At Brigham and Women's Hospital in Boston the senior director of PA services and the ED's lead PA organized the hospital's 350 PAs into teams, deploying them to units hardest hit. With few elective surgeries, PAs from surgical departments shifted to the ED, COVID-19 testing sites, specialized respiratory clinics, and telehealth call centers.¹⁰

In March 2020, as the crush of critically ill COVID-19 patients hit New York City, Mount Sinai Hospital in one week converted its ED-based observation unit into a COVID-19 14-bed step-down and a 13-bed ED-ICU. Medical staffing was provided 24/7 by teams of experienced residents or senior PAs/NPs. All departments rapidly modified workflow and staffing, enabling the new unit to achieve optimal function, effectiveness, and safety for patients and staff.¹¹

MedStar Emergency Physicians, an employed group of 160 physicians and 90 PAs, care for 420,000 patients per year in seven MedStar EDs. Their structured ED onboarding allows for hiring of new graduates and experienced PAs. New hires work in tandem with established PAs for three to six months, completing their structured learning in 12 months. After five years of increasing autonomy and successful evaluations, PAs reach the level of greatest autonomy, seeing high acuity patients and shouldering additional professional challenges.¹²

PAs often provide medical staffing for ED observation units (OUs). When Long Island Jewish Medical Center transitioned its 12-bed OU coverage from 12-hour physician/24-hour PA to 3-hour physician/24-hour PA, they examined the impact on length of stay (LOS), acceptance rate to the OU (AROU), and admission rates from the OU. The change led to slightly longer LOS and temporarily decreased AROU. However, unit volume and evaluation and management coding remained stable, and the hospital is satisfied with the model.¹³ PAs supplied by US Acute Care Solutions have enabled Northwest Hospital (LifeBridge Health) in Randallstown, Maryland, to make its OU as efficient as possible. By increasing staff, the hospital exceeded national benchmarks for LOS, conversion rate to inpatient status, and 30-day readmission¹⁴

In Washington State, 18 of 39 Critical Access Hospitals staffed their EDs with PAs and NPs. The ED census ranged widely by hospital — from 200 to 25,000 per year. All sites were level IV or V trauma centers and managed cardiac events, significant injuries, and some obstetrics. A survey found half of the PAs/NPs saw an

ECG ST-elevated myocardial infarction within the two weeks prior to the survey. Six had attended births within the previous 12 months. Half the sites provide clinical rotations for PA and NP students.¹⁵

SEMPA reports on procedures performed by PAs in EDs. Multiple layer laceration repair was most frequently performed (at least once a week by 55.38% of respondents). Only 0.73 percent of respondents never perform multiple layer laceration repair. Slit lamp exams were frequent (at least once a week by 51.9%). At least one-fourth of respondents frequently performed reduction of major joint dislocations, closed fracture reductions, procedural sedation, arthrocentesis and lumbar puncture.^{16,17}

EMTALA

The Emergency Medical Treatment and Labor Act (EMTALA) touches on PA practice in four areas: performing medical screening examinations (MSEs), certifying false labor, authorizing patient transfers, and taking call in EDs.¹⁸

- The EMTALA law and regulations allow PAs to conduct MSEs. Written hospital policies must specify that PAs are qualified to conduct them. Individual PAs must have privileges to perform the exams.
- Under EMTALA, PAs can certify false labor if they are acting within their scope of practice as defined by the hospital and their individual privileges.
- EMTALA allows “qualified medical personnel” other than physicians to sign certifications of transfer of emergency patients. If a PA certifies transfer of an unstable patient to another ED, they must consult with a physician prior to transfer and the physician must co-sign the order within a timeframe specified in hospital policy.
- EMTALA allows PAs to provide “further assessment or stabilizing treatment” in an ED. The on-call physician must determine whether to direct the PA to provide the care for the patient in the ED or to provide the care themselves.

THIRD-PARTY REIMBURSEMENT

Medical and surgical services delivered by PAs are covered by Medicare, Medicaid, TRICARE, and nearly all commercial payers.

The Medicare program covers services provided by PAs in all practice settings at a uniform rate of 85 percent of the physician fee. Generally, all services for which Medicare would pay if provided by a physician are covered when performed by a PA, in accordance with state law. Those include services provided in an office or clinic, any department of a hospital including the ED, a skilled nursing facility, an ambulatory surgical center, and a patient’s home. Under Medicaid, all 50 states and the District of Columbia cover medical services provided by PAs.

Nearly all commercial payers reimburse for services provided by PAs, however, they do not necessarily follow Medicare guidelines. Because of variation in claims submission, it is important to verify each payer’s specific coverage policies for PAs.

For more information about third-party coverage, visit <https://www.aapa.org/reimbursement/>.

CONCLUSION

Many studies attest to the high quality of care PAs provide, favorably comparing it to physician care.¹⁹⁻²¹ In addition, patient satisfaction with PAs is very high. With PAs on staff, access to the care team improves, wait times decrease, and patient satisfaction rises.^{22,23}

Meeting the nation's need for emergency care will require utilization of all medical providers, including PAs. As providers trained in medicine, PAs possess the skills, education, and necessary training to diagnose and treat the vast majority of people in need of healthcare and to refer patients elsewhere, as needed. PAs work in collaboration with other clinicians to ensure the best possible outcomes for their patients.

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