

Non-physician Providers in Your Office

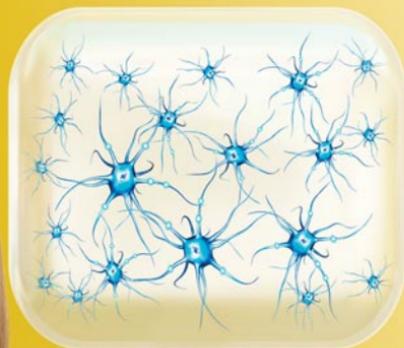
Chapter FastFACTS

- 1. Nurse practitioners, physician assistants, and registered nurses can help your office provide comprehensive, cost-effective care.**
- 2. Using an EHR to set up care pathways, clinical guidelines, and clinical protocols will help mid-level staff practice at the top of their license.**
- 3. Non-physician providers can perform triage, run group visits, see well babies, administer student physical exams, and coordinate care with consultants' offices.**
- 4. The AAFP states that non-physician providers should always be under the direction and supervision of a practicing, licensed physician.**
- 5. Advanced practice nurses are beginning to be awarded the degree of Doctor of Nursing Practice.**

Three years ago, Ali A. Mohammad, MD, says he discovered the key to practicing top-quality primary care: He had to forget part of his training. While conducting a practice improvement project to lower blood pressure among a small group of chronically ill patients in his Clinton, Okla., solo practice, he came to an important realization: Medicine's traditional view of the physician as the "captain of the ship" who gives orders but doesn't engage in give-and-take with the crew was serving neither him nor his patients well.

What emerging science says about Fibromyalgia pain:

It's the neurons talking.



Fibromyalgia is a chronic widespread pain condition¹

So, why are the neurons talking?

Scientific evidence suggests that Fibromyalgia may be the result of central sensitization. Central sensitization^{2,4}:

- Is believed to be an underlying cause of the amplified pain perception in the central nervous system
- Results from the excessive release of 2 important pain neurotransmitters, **substance P** and **glutamate**

Patients suffering from Fibromyalgia experience a range of symptoms including^{5,6}

- **Allodynia**: a heightened sense of pain in response to normal stimuli (eg, a hug or handshake)
- **Hyperalgesia**: an amplified response to painful stimuli (eg, when a small pinprick causes a sharp, stabbing pain)

When your patients present with chronic widespread pain consider that they may have Fibromyalgia, and help them find solutions for the pain.

To learn more about Fibromyalgia, visit www.FibroKnowledge.com

Listen to pain. Think Fibromyalgia.

References: 1. Wolfe F, Smythe HA, Yunus MB, et al. The American College of Rheumatology 1990 criteria for the classification of fibromyalgia: report of the Multicenter Criteria Committee. *Arthritis Rheum.* 1990;33(2):160-172. 2. Staud R. Biology and therapy of fibromyalgia: pain in fibromyalgia syndrome. *Arthritis Res Ther.* 2006;8(3):208-214. 3. Costigan M, Scholz J, Woolf CJ. Neuropathic pain: a maladaptive response of the nervous system to damage. *Annu Rev Neurosci.* 2009;32:1-52. 4. Costigan M, Scholz J, Samad T, Woolf CJ. Pain. In: Siegel GJ, Albers RW, Brady ST, Price DL, eds. *Basic Neurochemistry: Molecular, Cellular and Medical Aspects*. 7th ed. Burlington, MA: Elsevier Academic Press; 2006:927-938. 5. Dubinsky RM, Kalkan H, El Chami Z, Bouthwell C, Ali H. Practice parameter: treatment of postherpetic neuralgia. *Neurology.* 2004;63:959-965. 6. Goldenberg DL, Burckhardt C, Clifford L. Management of fibromyalgia syndrome. *JAMA.* 2004;292(19):2388-2395.

By listening to his two nurses during the project and giving them latitude to use their expertise, he was able to adapt his practice to provide complex, more effective primary care to those who needed it most. As a result, he developed new respect for his nurses' skills and ideas. For him, acknowledging the expertise of non-physician providers and embracing their place in the primary care office was an eye-opener, one that counters what most physicians learn in medical school and residency. "They trained us to be independent, to tell patients this is how you do it, to tell nurses what to do," he says. But "chronic diseases cannot be managed by one person."

Today any 5-star primary care practice should include nurse practitioners (NPs), physician assistants (PAs), and registered nurses (RNs) working alongside family doctors, internists, and pediatricians. Everyone needs to be working at the "top of his or her license" and to have the authority to act creatively in getting results, whether better access, outreach, or outcomes. (See "Why Hire a Mid-level Practitioner?," opposite.)

Some futurists go further speculating that a top primary care practice might be one where a smaller group of doctors oversees a larger cadre of non-physician providers. They envision that most face-to-face encounters will occur between patients and nurses, health educators, therapists, or other mid-level providers. This would free physicians to concentrate on managing, overseeing, reviewing data, planning quality improvements, making diagnoses, and handling the rarer complicated cases, medical mysteries, or other cases that require the services of a doctor.

"The physicians who may be leading this kind of future primary care practice may be reaching many more people than they can on a one-to-one basis," ACPE's Dr. Silbaugh says.

Leveraging Your Hard Work

The true effectiveness of primary care depends on what teams can provide, as opposed to a single person: ease of access, relationships sustained over time, comprehensive service, and coordination of care across the healthcare system, says Dr. Moore, a family physician in Washington state and founder of the Ideal Medical Practices movement. "It's not just about hard-working and caring doctors. That's nice, but it's not enough" to deliver

Why Hire a Mid-level Practitioner?

Even if a primary care group needing extra help can find a new physician, there are reasons to hire a non-physician provider instead.

It's cheaper. Several 2009 surveys have put the mean hourly rate paid to NPs at about \$45 per hour, and the mean total NP income for members practicing clinically more than 35 hours a week is about \$90,000. Moreover, malpractice insurance costs are significantly less than for physicians.

Mid-level providers will bring in less money than new physicians, but not as little as many physicians might think, says practice consultant Mr. Muschler. Studies of PAs in primary care have concluded that PAs perform “between 70% to 90% of services that their supervising physicians perform,” according to the American Academy of Physician Assistants.

Mr. Scroggins recommends filling the non-physician provider's schedule first to ensure that that person is as productive as possible. Not only will the doctor's schedule always fill, but part of the point of having midlevels on staff is to free up physicians to “do things that will promote the value of the practice,” he says, such as quality improvement projects and outreach to patients who need more of the doctor's time.

It's an alternative for physicians who worry that hiring a new doctor may create a future competitor, or that the new doctor would be difficult to fire if he or she becomes a partner. It's easier to let mid-levels go if they aren't working out, if they don't fit in with your practice's culture, or if adequate business doesn't materialize to support them.

An extender, according to Mr. Muschler, isn't there to build his or her own practice, but to enhance what the physician is doing. “They are there to help you, as the primary physician or owner of the practice, to have a greater influence over a larger number of patients. They allow you to increase patient access without working harder,” he says. “And they increase patient satisfaction because they create more access to a provider-level person—somebody they can talk to about their disease management and [who] can prescribe medication in many states.”

It expands the kind of work that can be done onsite. According to a 2009 study in the journal *Health Affairs* on “medical home runs,” top practices seemed able to accomplish so much because they had added “behavioral health specialists, social workers, and culturally savvy medical assistants to the care team” to increase contact with medically unstable patients.

top-quality medical care, he says. “It's working as a team that leverages that.”

Even the patient-centered medical home model, while based on a relationship between a patient and his or her personal physician who coordinates care, calls for a team-based approach. In fact, advocates maintain that the team-based approach is today as essential as information technology to promoting coordination of care; effective communication; and an efficient cost-effective practice.



“Inside the [EHR] you can set up care pathways, clinical guidelines, and clinical protocols so that mid-levels and nursing staff can practice at the top of their license.

Steven Waldren, MD
Director

AAFP’s Center for Health Information Technology

Dr. Mohammad saw proof during his ACP-sponsored “Closing the Gap” quality improvement project. By encouraging his nurses to do whatever they needed, to be as creative as they wished, and to reach out to whomever they chose, he empowered his staff to meet elusive blood pressure, lipid, and weight reduction goals in many study patients.

In the process he regained some of the joy that had been lost amid the day-to-day work struggles. “It reminded me that we can really be part of the solution, why we became doctors in the first place,” he says. Now a professor at the University of Oklahoma-Tulsa, Dr. Mohammad is passing that lesson on, teaching doctor trainees the advantages of working with non-physician providers.

Information Technology: The Great Enabler

As science improves and evidence-based clinical guidelines proliferate, many therapies now in the purview of physicians can be administered by mid-level providers. The key is training these providers to follow protocols and to know when to call for backup. Standardized orders can help. For example, an order that empowers nurses to fill out mammogram referral forms for women over 50 before they see the physician can be more effi-

cient than waiting for the doctor to remember them. The same applies to refilling most medications or calculating BMI for hypertensive patients before they enter the exam room. This ability to delegate can make the difference between a practice that meets quality-of-care targets and one that doesn't, experts say.

"Inside the [EHR] you can set up care pathways, clinical guidelines, and clinical protocols so that mid-levels and nursing staff can practice at the top of their license," explains Dr. Waldren, director of the AAFP's Center for Health Information Technology. Without this technology, physicians have to get involved earlier. "It goes back to a mindset of how can we, as a team—not just the physician—care for our patients in the most efficient ... way," he says.

Models That Work

Primary care offices tend to hire non-physician providers to fill one of two main roles:

- To **extend** their services—i.e., to provide comprehensive care to a panel of patients along with input from a supervising physician, or
- To **complement** their work—i.e., to provide work that would not otherwise get done adequately.

Exceptional practices use these workers appropriately. RNs, for example, are most effectively used in primary care offices to perform triage, give shots, or counsel patients, Ms. Hart says.

"A nurse doesn't go to four years of nursing school just to room patients and check blood pressures," Dr. McGeeney says. "Doctors don't go to medical school just to treat a sore throat when you already know the strep test is positive. That's where NPs and PAs come in."

Consultants and physicians told *Doctor's Digest* that ideal work for non-physician providers includes performing triage,

Get instant medication safety/hazard alerts and instant error reporting tools from the Institute for Safe Medication Practices (ISMP) and the latest expert practice management tips from **Doctor's Digest**. Just visit www.doctorsdigest.net to sign up for this free service.



running group visits, seeing well babies, administering student physical exams, answering nurse lines, and coordinating care with consultants' offices. They can work alongside physicians in teams in which the same physicians are always paired with certain non-physician providers; others work more independently. Various models can work, experts say.



“We have given some first-line authority to the nurse now to sign off on a normal mammogram and [relay] only the abnormal ones over to me.”

Grace E. Terrell, MD
 Cornerstone Internal Medicine
 President and CEO
 Cornerstone Health Care, High Point, N.C.

For example, Dr. Terrell says having the pod system in her office, in which every doctor works with a mid-level practitioner and two nurses, means that patients usually see someone who is a member of their assigned team. The result, she says, is expanded access to care even though the practice doesn't technically offer open access. “[Patients] can walk in, and we will see them,” Dr. Terrell says, “and we can collaborate in ways that just weren't possible a few years ago—because of electronic records.”

What has made their system work particularly well, she says, is the time spent creating protocols that allow nurses to do more than before. For example, Dr. Terrell says, “We have given some first-line authority to the nurse now to sign off on a normal mammogram and [relay] only the abnormal ones over to me.”

Fears of Misuse

Nonetheless, battles are still being waged over acceptable scope-of-practice, from the health reform debate in Washington, D.C., to debates about how to expand access in underserved rural parts of the country.

In several policy statements (reaffirmed as recently as last year), the AAFP has stressed that non-physician providers “should

always function under the ‘direction and responsible supervision’ of a practicing, licensed physician” even if state licensing gives them authority to practice independently. “The central principle underlying physician supervision of [non-physician providers] is that the physician retains ultimate responsibility of the patient care” and “means that the [non-physician provider] only performs medical acts and procedures that have been specifically authorized by the supervising physician,” AAFP policy states. “The increasing variety of situations in which [non-physician providers] practice, the emphasis on practice teams, and the growing tendency of health policy makers to identify [non-physician providers] as a means of improving the availability of healthcare services raise important issues regarding the appropriate relationship between NPPs and physicians.”

The situation may get murkier. Advanced practice nurses, including NPs, are beginning to be awarded the degree of Doctor of Nursing Practice (DNP). In addition, the nursing PhD will become the standard—replacing the current master’s degree—for all advanced nursing practice by 2015. When all schools affiliated with the American Association of Colleges of Nursing voted in 2004 to endorse the association’s “Position Statement on the Practice Doctorate in Nursing,” its members said that “nursing is moving in the direction of other health professions” in transitioning to doctorate degrees and is no different from “medicine (MD), dentistry (DDS), pharmacy (PharmD), psychology (PsyD), physical therapy (DPT), and audiology (AudD), [which] all offer practice doctorates.”

As of April 2009, according to the association, 92 DNP programs are currently enrolling students at schools of nursing nationwide, and an additional 102 DNP programs are in the planning stages.

“Now we will have nurses who are doctors. Can you foresee a confused public?” Dr. Ward says.

The Best Option?

Despite these concerns, more physicians are recognizing the value of having non-physician providers on their teams (see “Fastest-growing Occupations,” p.58). When asked about difficulties they encounter in practice, NPs responding to a survey by the

American Academy of Nurse Practitioners (AANP) reported fewer difficulties with “PCP (primary care physician) recognition.” In 2003, 41.2% of NPs stated they had difficulty with PCP recognition; in 2009, that figure had dropped to 33.3%.

The hard truth is that in many parts of the country, the short-

Fastest-growing Occupations

The U.S. Department of Labor projected in December 2009 that from 2008 to 2018, we will need 772,200 more professionals in physician offices—including 109,300 physicians, 106,500 nurses, 107,600 medical assistants, and 248,700 office and administrative support positions. Medical assistants and physician assistants rank among the 30 fastest-growing occupations. To provide context, listed below are others among the fastest-growing professions (in thousands):

| Occupation | Employment | | Change | |
|--|------------|-------|---------|--------|
| | 2008 | 2018 | Percent | Number |
| Biomedical engineers | 16 | 28 | 72.0 | 12 |
| Network systems and data communications analysts | 292 | 448 | 53.4 | 156 |
| Home health aides | 922 | 1,383 | 50.0 | 461 |
| Personal and home care aides | 817 | 1,193 | 46.0 | 376 |
| Medical scientists, except epidemiologists | 109 | 154 | 40.4 | 44 |
| Physician assistants | 75 | 104 | 39.0 | 29 |
| Skin care specialists | 39 | 54 | 37.9 | 15 |
| Biochemists and biophysicists | 23 | 32 | 37.4 | 9 |
| Physical therapist aides | 46 | 63 | 36.3 | 17 |
| Medical assistants | 484 | 648 | 33.9 | 164 |
| Physical therapist assistants | 64 | 85 | 33.3 | 21 |
| Occupational therapist aides | 8 | 10 | 30.7 | 2 |
| Pharmacy technicians | 326 | 426 | 0.6 | 100 |
| Physical therapists | 186 | 242 | 30.3 | 56 |

For more information go to <http://www.bls.gov/news.release/ecopro.nr0.htm>.

age of family physicians and general internists working in ambulatory care is so great that there is no other option than to find ways for others to provide primary care. According to the AAFP, the number of U.S. medical school graduates entering primary care residencies has dropped nearly 52% since 1997, and it predicts a shortage of 40,000 family physicians in 2020.

In addition, a new study in the Feb. 24, 2010, issue of the *Journal of the American Medical Association* found that the average number of hours non-resident physicians work has dropped 5.7% since 1996 (to 51 hours per week) after remaining stable for the two previous decades (at 55 hours per week). The largest drop was among younger physicians (under 45) working in ambulatory settings. That decrease, according to the authors, is “equivalent to a loss of approximately 36,000 physicians from the workforce” and has “many workforce analysts and professional organizations concerned about the adequacy of the size of the future physician workforce.” Will non-physician providers be the ones to take up the slack? Only time will tell.

Meanwhile, inroads are being made by non-physician providers; and for many physicians, like Drs. Mohammad and Morris, the impact on patients is generally positive. According to Dr. Morris, working with nurse practitioners and other non-physician providers means that her patients spend less time in the waiting room. “When I get hung up with something that I can’t get out of, at least my team member is getting the next patient started. They might not get out much sooner, but it’s the Disney concept—they feel they are being advanced along with something more than just reading a book to occupy their time while they wait.”

In addition, she says, she has come to believe that when patients are engaged with a number of different people, “they realize that the quality of their healthcare experience isn’t always based on how much time you spend with the doctor. Sometimes it comes from education from a nurse . . . or the diet and exercise that you do at home,” she says. “Sometimes, seeing a doctor may not be the most important thing” in primary care.