Incorporating Mid-level Staff

Chapter FastFACTS

1. Your practice schedule and needs will determine how to best add mid-level practitioners.
2. The abilities of mid-level practitioners depend on their training and experience.
3. To best incorporate a mid-level practitioner into your practice, you may need to cede territory in areas where he or she has had extensive training and experience.
4. A “welcome to the practice” marketing campaign will help introduce your new mid-level staff member to your patients.
5. Having a “script” prepared—in order to answer patients’ questions about mid-level practitioners in general and your new hire in particular—helps your practice deliver a consistent message.

Adding one or more mid-level practitioners to your practice can—and probably should—lead to dramatic changes in the way your practice delivers care. If properly integrated, these new hires will spend most of their time practicing up to the limits of their license while allowing you more time to spend practicing up to the limits of yours.

Family physician Glen Stream, MD, president-elect of the AAFP, works at the Rockwood Clinic, a multi-specialty group in Spokane, Wash. He is one of more than 200 providers, of whom about 40% are non-physicians. While that number
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includes physical therapists, dietitians, and others, most are NPs and PAs. The practice uses a medical home-style team model, which allows all providers to practice as much as possible at the top of their licenses. “There’s always a physician available to answer questions if the NP or PA comes up with anything that’s outside his or her range of training,” Dr. Stream says. “We always want them to have physician backup, but we give them a fair amount of autonomy.”

Dr. Freelove in Salina, Kan., advises physicians to be open-minded when they’re considering how to incorporate a mid-level practitioner into their practice. (See “Ways Mid-level Practitioners Can Help Your Practice.”) Especially if you’re used to handling everything yourself, you need to think about which tasks you can hand off to increase your practice’s efficiency and your own satisfaction, he says. “You have to be a good team player, and [that may mean rethinking] how you deliver care,” he explains. “You have to be ready and willing to work in a more collaborative fashion than most private practices are used to.”

Finding the Biggest Wins

How a practice incorporates mid-level practitioners depends on their individual aptitudes, what kind of schedule they want to have, and where the practice has the greatest need. “Within the scope of their training they can do anything that the physician can do,” Mr. Hunt says. “You won’t have a mid-level [practi-
tioner] doing open-heart surgery, but you could have him see patients with multiple chronic illnesses, manage their medication lists, and come up with a plan for them to manage their illnesses at home—pretty complex stuff.”

Southern Indiana Pediatrics in Bloomington, Ind., uses its five NPs on both wellness care and acute visits. By doing so efficiently, the practice profits—literally—from having them, Dr. Laughlin says. In addition, because the NPs allow the practice to expand the number of patients it can see and the amount of time spent on each patient, the practice has a lower-than-average utilization of hospital admissions and emergency department visits, which pleases insurers and employers.

Dr. Goertz works in a federally qualified health center that employs more than a dozen mid-level practitioners, mostly NPs. Each is paired with a physician, and the two share a patient panel. Dr. Goertz says each team works a little differently. “They learn each other’s abilities,” he says. “The NP knows
whom to contact for help, and the [family practitioner] knows what kinds of patients the NP can handle.” He says it’s impossible to generalize about the abilities of mid-level practitioners since these abilities depend not only on the training program, but also on what type of experience the individual acquired before starting advanced practice training. The mid-level practitioners at the center don’t see as many patients—about 60 per week compared with the physician’s 85, Dr. Goertz estimates. The practice uses its electronic medical record system to compile statistics on its patients’ overall health status; those reports show significantly better results among patients whose care team is working together effectively, he notes.

Reorganizing Your Practice

Incorporating a mid-level practitioner into your practice may involve rethinking your own role, particularly if your new hire is an NP and you haven’t worked with an NP previously, says Denise Henning, a certified nurse-midwife who works as clinical director of women’s health services in a rural Florida clinic. “Some docs are used to thinking of themselves as captain of the ship, and they’re used to the way they direct RNs on a hospital floor,” she says. “Then they get out to private practice, hire an NP, and treat her as if she’s just another registered nurse. RNs that self-select to become NPs are more independent and very smart. They have respect for physicians and their training, but they expect to be respected in return and not treated condescendingly. You need to treat them like a colleague rather than an employee—that’s the key to a happy life with a nurse practitioner.”

“I’ve had clients say they won’t hire [a mid-level practitioner] because patients won’t see one, but that’s a belief of the physician, not the patient.”

David Zetter
Consultant
Zetter HealthCare
Mechanicsburg, Pa.
Effectively incorporating a mid-level practitioner may mean ceding territory in areas where he or she may have more extensive training and experience than you have. (See “Specialized Mid-level Practitioners.”) For example, managing the chronically ill can be a sweet spot for either a PA or an NP, both of whom are trained to spend time doing health education and

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**Specialized Mid-level Practitioners**

Training programs for both NPs and PAs emphasize primary care, and the basic certification for both is sufficient for most primary care duties. However, members of both professions sometimes have specialty credentialing based on additional training and experience.

- The National Commission of Certification of Physician Assistants offers Certificates of Added Qualifications in the following areas:
  - Cardiovascular and thoracic medicine
  - Emergency medicine
  - Nephrology
  - Orthopedic surgery
  - Psychiatry
  - Surgery

- The American Academy of Nurse Practitioners Certification Program certifies NPs as adult, family, or gerontologic nurse practitioners.

- The American Nurses Credentialing Center credentials nurse practitioners in the following specialized areas:
  - Acute Care NP
  - Adult NP
  - Adult Psychiatric and Mental Health NP
  - Diabetes Management—Advanced
  - Family NP
  - Family Psychiatric and Mental Health NP
  - Gerontological NP
  - Pediatric NP
  - School NP
working closely with patients to make sure they understand their often complicated regimens. While an RN can draw blood, a mid-level practitioner is also able to interpret test results and adjust medications.

“Medicine has been a rigid triangle where everyone [physician, mid-level practitioner, and registered nurse] has turf,” Ms. Lord says. “If we’re going to evolve medicine to be effective at prevention, we have to be more like a rubber band circle that stretches so that the person leading is the one who has the most expertise for that particular thing.” For example, the physician might be the appropriate person to conduct an initial exam on a recovering stroke patient; but then a physical therapist or occupational ther-

What Is “Supervision”?

You may feel that having a mid-level practitioner isn’t worth the time you’ll spend supervising, but it may not take as much time as you think. State regulations vary (see Chapter 5), and your physical presence on the premises—or lack of it—may affect how the mid-level practitioner’s services are billed (see Chapter 4). However, the most significant demand on your time will be lending the benefit of your training in cases that turn out to go beyond the limits of your mid-level practitioner’s license—which is time you’d be spending on that patient whether or not you employed the mid-level practitioner.

“Most state laws call for supervision [of PAs], a term I try to stay away from because it sounds like you’re looking over their shoulder all the time,” says Ellen Rathfon, senior director of professional advocacy for the AAPA. For the employee’s first few months on the job, you’ll probably want to stop in at some point during all of your mid-level practitioner’s appointments, Ms. Rathfon says, to make sure you’re on the same page with diagnosis and treatment. This time demand will level off as you become more comfortable with each other’s practice style. You may also meet regularly at the beginning or end of the day. State law may require you to review and sign a certain percentage of charts for the patients seen by the mid-level practitioner.

Beyond that, the amount that you supervise depends entirely on your working relationship. Often, being a phone call away should be adequate. “[The mid-level practitioner] needs to be able to trust that the physician is available, and needs to know when to consult,” Ms. Rathfon says. “Effective team practice boils down to communication.”

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apist might take the lead in subsequent weeks. Group education for diabetics or a clinic specifically for monitoring patients on blood thinners could be handled by an NP or PA.

Others in your practice, including front and back office staff, nurses, and medical assistants, may need to be re-educated as well. Front desk personnel, for example, should be trained to recognize when it would be appropriate to offer patients the opportunity to meet with an NP or PA, says Karen Schechter, director of healthcare services for St. Louis consulting firm Stone Carlie. The billing staff should review the rules for how different payers treat services provided by mid-level practitioners. (See Chapter 4.)

Ensuring Patient Acceptance

Worried that your patients will want to see a “real doctor” rather than your mid-level practitioner? Here are a few tactics you can use to get him or her off on the right foot with your patients.

Make introductions: Especially if you’ve just hired your first mid-level practitioner, Mr. Hunt suggests mailing an announcement about the new hire and enclosing an explanatory brochure from the new provider’s professional association. (Both the AAPA and the AANP sell such brochures in bulk quantities, and the AANP’s version can be personalized with your practice’s information for an additional fee.) Explain how the mid-level practitioner’s scope of practice differs from that of a nurse so patients don’t feel they’re about to see someone who can’t fully handle their issues.

Ms. Capko recommends doing a “welcome to the practice” marketing campaign, including these components:

- Adding the mid-level practitioner’s biographical information to the practice Website
- Including a feature about the mid-level practitioner in the practice’s newsletter to patients
- Putting up a "bio board" in the waiting room with the mid-level practitioner's photo and his or her professional background, hobbies, and personal information

Eliminate surprises: If you book patients to see a PA or NP rather than the physician, they should be told when they make their appointment rather than being surprised when they arrive
Redesigning Healthcare
Geisinger Health System, Danville, Pa.

Geisinger Health System, an integrated delivery network that includes its own health insurance arm, has been a pioneer in using mid-level practitioners in caring for chronic illness. Thomas Graf, MD, chair of Geisinger’s community practice, estimates that the 200-physician practice, spread over 40 sites, has one NP or PA for every four physicians. His own practice site has three to four physicians and two PAs.

The organization has explored many ways to use advanced practitioners effectively, Dr. Graf says. Some are “mini-doctors,” acting as a patient’s primary care provider for patients who prefer them; but most have more specific roles. In nursing homes, for example, a mid-level practitioner will see new patients within 24 hours of admission, tracking their conditions and managing any exacerbations. “That has a big impact on productivity for the office physician because he’s not getting ten thousand faxes and phone calls,” Dr. Graf says. “They still have to supervise; but a lot of daily interruptions go away, and the patient gets much more complete care.”

Mid-level practitioners also perform focused follow-up care for chronically ill patients, such as blood sugar monitoring for diabetics. These providers meet every six weeks with the patient to conduct education, answer questions, increase medication if necessary, and make sure that follow-up screenings are complete. Seventy percent of patients in the diabetic monitoring program reached their blood sugar targets, some after failing to do so for years or even decades.

The diabetes campaign has worked out so well that the organization is rolling out mid-level practitioner-run clinics for blood pressure and lipid

Tales From the Field: Two Case Studies

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Thomas Graf, MD
Chair of Community Practice
Geisinger Health System
Danville, Pa.
control, and is considering adding them for osteoarthritis, kidney disease, and other chronic conditions that have minimal symptoms and wide variation in the patient’s response to treatment.

Dr. Graf recommends conducting a careful analysis of your practice to see where an advanced practitioner can add the most value. Geisinger has an electronic health record system that automatically flags abnormal lab values, and one function of the mid-level practitioners is to review those values to determine which ones can be taken care of by a medication adjustment or other minor intervention and which ones need physician management. But tasks like calling patients with normal test results should be handled by the front desk, or even via computer.

**Physician Extenders**

*Albany Internal Medicine, Albany, Ga.*

Joseph Stubbs, MD, past president of the ACP, hired one of the first PAs in Georgia back in the 1970s. In those days his group’s practice included hospital visits, and the physicians used the PA to monitor emergency room patients and keep them up to date on their condition. Today the practice has nine physicians, two PAs, an NP, and a clinical nurse educator specializing in diabetes education. “We couldn’t practice without them,” Dr. Stubbs says. “They perform an invaluable service in managing patients with chronic illnesses and seeing people on the same day.”

He believes that mid-level practitioners are best used as physician extenders, teamed up with a physician to monitor a common patient panel. Dr. Stubbs prefers to hire NPs or PAs who have previous experience with the team approach used at his practice. He says NPs have the edge when it comes to patient education; but otherwise, the two are equally useful. “They can spend more time and see patients more frequently for follow-up management of medication changes, especially for patients with multiple chronic diseases that need to be closely monitored,” he says. “If the doc does that, it really clogs up the schedule; but the collaboration cuts down on unnecessary referrals and tests.” The mid-level practitioners at his practice tend to be divided up consistently among the physicians so that they’re familiar with certain patient panels.

Although it may be tempting to load up their schedules, Dr. Stubbs advises allowing mid-level practitioners to see patients at 20- to 30-minute intervals to allow time for physician consultations during the visit. He also suggests physicians have a new mid-level practitioner shadow them for some period in order to become familiar with how they prefer to treat patients, and to meet with the staffer monthly to discuss the care of chronically ill patients.
at the office, Ms. Schechter says. “It’s disconcerting to the patient if they think they have an appointment with the doctor and an NP comes in,” she says. “But most people, once they develop a relationship with the NP or PA, are totally happy.”

Create a first-visit strategy: Mr. Peltz recommends the physician introduce each patient to the mid-level practitioner. “We have the physician introduce the mid-level practitioner to the patient at the beginning of the exam, and that transfers their good will to the mid-level practitioner in front of the patient,” he says. The physician can also use that time to reinforce with the mid-level practitioner the practice’s way of treating particular types of patients. Then either the physician or the mid-level practitioner goes on to handle the rest of the appointment, depending on which one the patient was scheduled to see.

Have a “script” ready: Mr. Zetter recommends having a “script” prepared in order to answer patients’ questions about mid-level practitioners in general and your new hire in particular, and making sure everyone in the practice uses it in order to deliver a consistent message. “I’ve had clients say they won’t hire [a mid-level practitioner] because patients won’t see one, but that’s a belief of the physician, not the patient,” he says.

Demonstrate the advantages: Like a new physician, a mid-level practitioner will have a wide-open schedule when he or she first starts at a practice, making it easy for patients to get an immediate appointment. The mid-level practitioner’s greater availability will often help speed patients’ acceptance, says Ms. Moghadas. “They can wait three weeks to see the doc, or see the PA today,” she says. The mid-level practitioner may also seem like a more appealing option if the physician has had a history of running behind and keeping people waiting, although the hiring of the new staff member in itself should help ease that situation. Ms. Moghadas and other experts advise coaching the front-desk staff to offer an appointment with the mid-level practitioner whenever appropriate, using language that conveys the provider’s equality with the doctor in caring for the patient’s current need.

Some communities resist accepting mid-level providers, but even they can be brought around. One of Ms. Coult’s clients is a rural pediatric clinic that lost two physicians and has only one
left, assisted by several NPs. The patients were used to seeing physicians most of the time and hesitated to accept an appointment with a mid-level practitioner. The practice found the following strategies helped lead to patient acceptance:

- The physician does all well-child check ups and has the nurse practitioners handle acute care—the reverse of the pattern used in many practices.
- The front desk offers immediate appointments with an NP (as opposed to a longer wait to see the physician) and promotes the NPs’ training and competence in order to ward off fears of seeing someone other than the doctor.
- The physician actively marketed his most recent hire, a male NP with significant experience, by sending him out to schools and local health fairs to conduct community education.