Your Primary Care Team: New Options

Chapter FastFACTS

1. **Studies say mid-level practitioners ease pressure on physicians by providing routine care and monitoring chronic illness.**
2. **The number of mid-level practitioners is growing in response to the physician shortage and increasing patient demand for primary care.**
3. **There are currently 140,000 NPs, up from about 100,000 five years ago, and an estimated 74,469 PAs, up from 63,000 in 2005.**
4. **Benchmarking your practice against national averages can help determine whether adding a mid-level practitioner would be a good option for you.**
5. **Practices that use mid-level practitioners will be well-positioned to take part in ACOs and other coordinated care efforts.**

Mid-level practitioners—mostly physician assistants (PAs) and nurse practitioners (NPs)—are changing the face of primary care and, potentially, your own practice. They're playing key roles in easing access to primary care and monitoring the chronically ill. New models of coordinated care depend on them to round out the care team. Their professional organizations are pressing for changes in state laws to standardize the treatment of mid-level practitioners nationally, including such issues as scope of practice, ability to prescribe, and oversight of licensing.

Last year *Money* magazine ranked "physician assistant" the fifth best job in America, based on high pay, satisfying work, and growth potential. NPs were ranked as 65th in the top 100. ("Primary care physician" was ranked 34th on the same list although its ranking would have been higher if the job hadn't earned a "D" for amount of stress.)

The mid-level numbers are growing for good reason: There are potential economic advantages for practices that use them, and they can reduce stress for time-pressed physicians. A joint position paper issued last year by the American College of Physicians (ACP) and the American Academy of Physician Assistants (AAPA) cited numerous studies showing that mid-level practitioners eased pressure on physicians by providing routine care and monitoring chronic illness. "When PAs assist with patients with lower acuity, the practice is able to see more patients faster, reducing wait times and increasing patient satisfaction," said the paper, which advocates more extensive use of PAs to facilitate team-based care.

Is it time to add a mid-level practitioner to your practice or to expand the roles of those you may already employ? In this issue of *Doctor's Digest*, we'll help you determine your next step. We discuss how to analyze your practice to see if it would benefit from adding one or more mid-level practitioners, describe how some practices are using these providers, and give you information on hiring mid-level practitioners and fitting them into the work flow of your practice. The last two chapters go into detail on reimbursement for mid-level services and pertinent legal issues.

Dramatic Growth

Projected physician shortages explain why using mid-level practitioners is becoming more common. Start with a look at pri-

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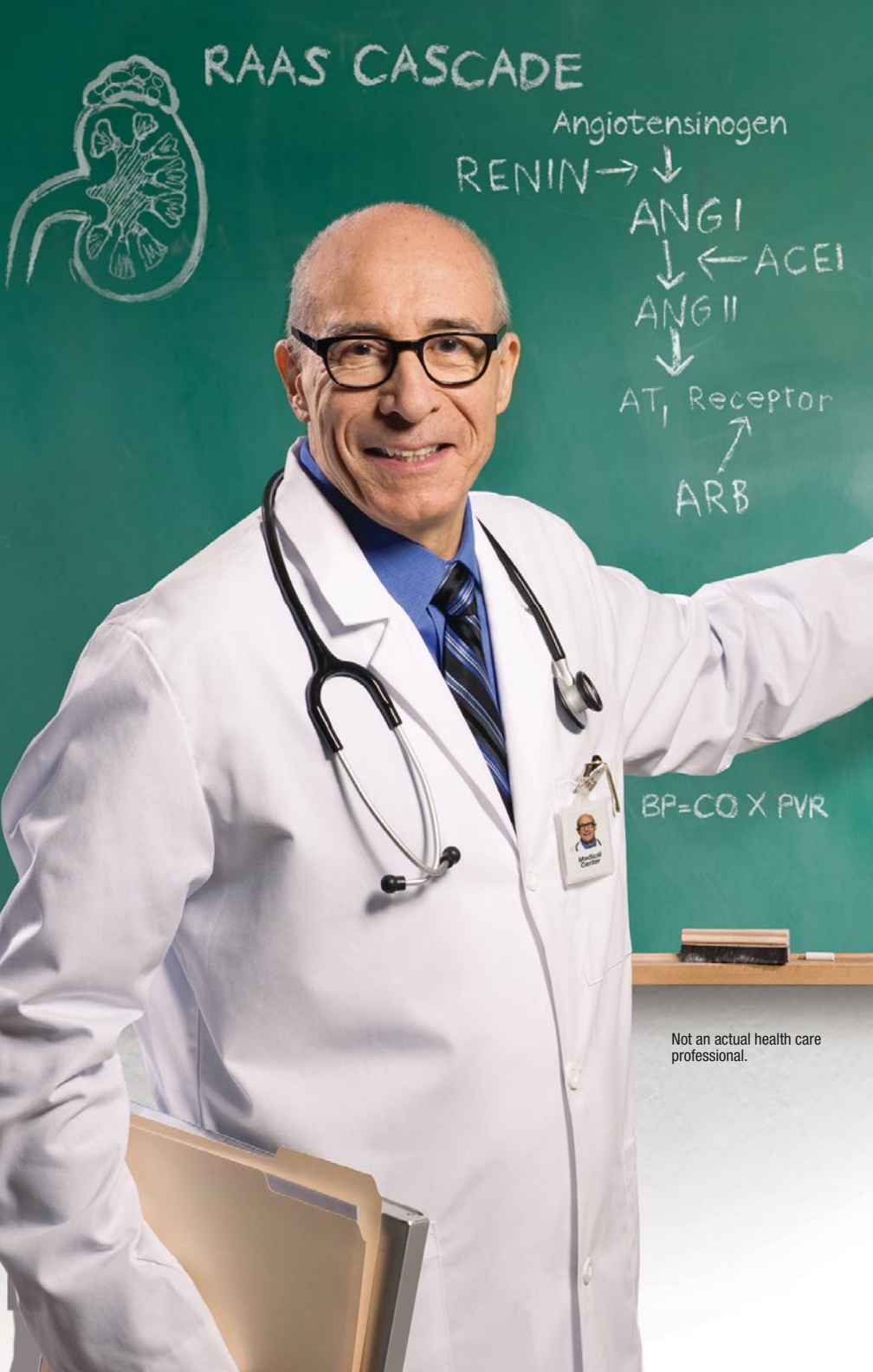

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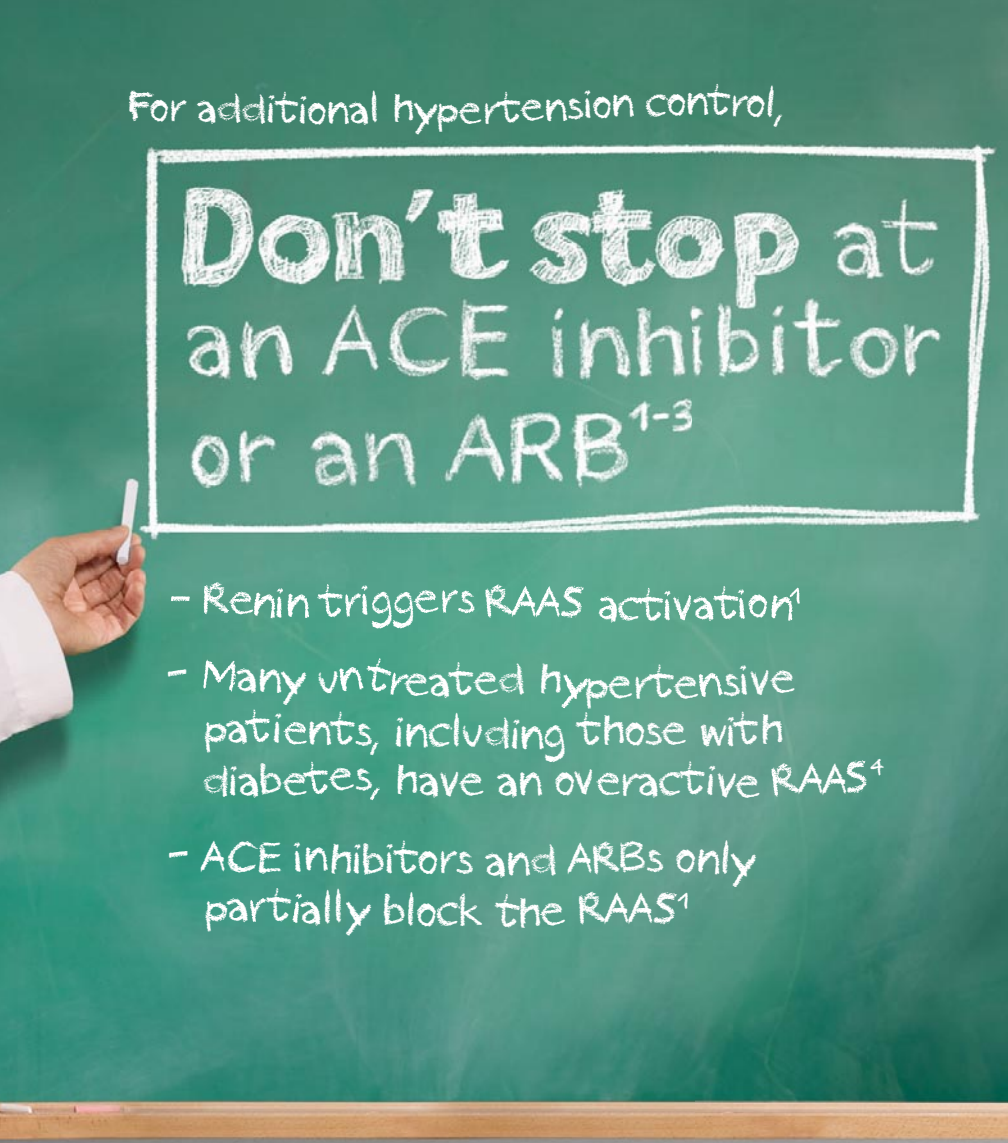

ACEI, angiotensin-converting enzyme inhibitor; ARB, angiotensin receptor blocker; BP, blood pressure; CO, cardiac output; PVR, peripheral vascular resistance; RAAS, renin-angiotensin-aldosterone system.

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mary care physicians: A 2008 report by ACP projects a shortage of 35,000 to 44,000 primary care physicians by 2025. The federal Health Resources and Services Administration more conservatively predicts a shortage of 7,000 to 20,000 primary care physicians by 2020, but those projections don't take into account

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Joseph W. Stubbs, MD
Past President
American College of Physicians

any changes in utilization or the impact of payment reform. If the Patient Protection and Affordable Care Act (PPACA) survives the current political imbroglio in anything like its original form, millions of new patients will be in the market for the kind of preventive care that primary care physicians provide.

In response to the physician shortage and increasing patient demand for primary care, the ranks of mid-level practitioners are growing quickly. NPs currently number 140,000, up from about 100,000 five years ago, according to the American Academy of Nurse Practitioners (AANP). The AAPA estimates that last year 74,469 people were in clinical practice as PAs, up from 63,000 in 2005. The Bureau of Labor Statistics (BLS) predicts that the demand for PAs will grow 39% between 2008 and 2018, a substantially higher increase than the rate for all jobs. (The BLS does not break out statistics for NPs separately from nurses in general although the whole nursing field is expected to grow more than 20% by 2018.)

Emerging data also support the quality of care and economic advantages of using mid-level practitioners. A study of national medical expenditure data between 1996 and 2004, published in 2008 in *Health Services Research*, found that patients who saw PAs instead of physicians had 16% fewer office visits per year on average without any concomitant increase in resources used

in other settings. The authors conclude that using PAs doesn't increase the use of healthcare resources and may actually decrease it.

Considering Mid-level Practitioners

If you're feeling overworked and unable to spend enough time with your patients, adding a mid-level practitioner could be a solution. Mid-level practitioners are frequently used to care for the rapidly growing number of patients with chronic illnesses like diabetes and congestive heart failure, because they are trained to handle monitoring, medication adjustment, and education for the chronically ill. (See "Definitions and Distinctions.")

Internist Joseph W. Stubbs, MD, past president of the ACP, sees increasing use of mid-level practitioners in internal medicine practices in general and cites the benefits of using them in his own practice. "Not only does it make good sense, but the cost of hiring another physician is so high now that it's beyond what that physician can bring in," at least right away, he says. Because mid-level practitioners are paid less than physicians, it takes less time for them to build their productivity to the point where their ability to generate revenue for the practice exceeds the cost of their salary and benefits.

Assessing your need for a mid-level practitioner should start with "the wait," says Steven Peltz, founder and managing partner of Peltz Practice Management in Brewster, N.Y. "A new patient should be able to get in today or tomorrow," he says.

'"And an established patient who has to wait five or six days will take his or her problem somewhere else. If the wait is more than three days, you need a mid-level."

Mr. Peltz notes that it's becoming more difficult to find an

Definitions and Distinctions

The term "mid-level" encompasses several categories of practitioners. Three main types work in primary care.

Physician assistants, as their name implies, work under the supervision of a physician. They have completed a 24- to 32-month course of study—partly in the classroom and partly in clinical training—and hold a document of completion issued by their training program. Most programs also award a master's degree. The typical PA program requires applicants to have at least four years of college and some healthcare experience before admission. There are more than 140 PA programs in the United States. They are accredited by the Accreditation Review Commission on Education for the Physician Assistant. PAs receive their national certification from the National Commission on Certification of Physician Assistants (NCCPA). Only graduates of an accredited PA program are eligible to take the Physician Assistant National Certifying Examination (PANCE).

PAs perform medical functions including taking histories, conducting physicals, ordering tests, diagnosing and treating illnesses, counseling patients, promoting wellness, and assisting in surgery. They are authorized to prescribe in all 50 states and the District of Columbia. They're usually licensed through the state's physician licensing board. Regulations governing PAs vary somewhat from state to state. (For details on legal issues see Chapter 5.)

Nurse practitioners practice in ambulatory, acute, and long-term care as primary and/or specialty care providers. In most states they are overseen by the board of nursing although in some states they are licensed by both the board of medicine and the board of nursing. They can practice autonomously or in collaboration with a physician. They diagnose and manage both acute and chronic illnesses, and can order tests and prescribe medications. Teaching and counseling as well as health promotion are usually a major part of their practice. To be credentialed for practice, NPs need licensure as a registered nurse, a master's or doctoral degree from an accredited program, and certification in a specific area of care,

additional physician for a practice, even if you want to go that route. Many primary care residents and fellows are choosing to become hospitalists because of the healthy salaries and predictable hours. "Those benefits can't be replicated in a private

such as neonatal, pediatric, family, women's health, adult, geriatric, psychiatric, or acute care. There are several recognized certifying bodies, such as the American Nursing Association's American Nurse Credentialing Center, the Pediatric Nursing Certification Board, and the American Academy of Nurse Practitioners.

Because nurse practitioners can "hang their own shingle," some physicians regard them as competition; but Ms. Olmstead says the NPs themselves don't look at it that way. "We don't want to fill someone else's shoes or replace a physician," she says. "It's not about competing—we're another option."

Certified nurse midwives (CNMs) are registered nurses who have graduated from a nurse-midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME) and have passed a national certification examination. They have practiced in the United States since the 1920s. Another designation, "certified midwife" (CM), applies to those who are not RNs but have some other type of professional healthcare background and have graduated from an ACME-accredited midwifery program. They take the same certification exam as CNMs. CNMs are legally authorized to practice in every state in the United States and in the District of Columbia. CMs are currently legally authorized to practice in New York, New Jersey, and Rhode Island, according to the American College of Nurse-Midwives.

Nurse midwives' scope of practice is similar to that of NPs, but they focus on primary care for women with a special emphasis on pregnancy, childbirth, and gynecologic and reproductive health. They perform comprehensive physical exams, prescribe medications including contraceptive methods, order laboratory and other diagnostic tests, and provide health and wellness education and counseling. The scope of practice for CNMs and CMs also includes treatment of male partners for sexually transmitted infections, and care of the normal newborn during the first 28 days of life. They may practice independently or in association with a physician practice. State regulations vary regarding their relationship with physicians. (For details see Chapter 5.)

practice, so there are going to be fewer primary care physicians available to join a practice," he says. "The growth of physician assistants and nurse practitioners in practices is dramatic.

"Practices that are feeling overwhelmed and have bad patient flow, long wait times, and low patient satisfaction" may benefit from adding a mid-level practitioner.

Ellen Rathfon
Senior Director of Professional Advocacy
American Academy of Physician Assistants

There's never been a better time to be a PA or an NP."

Practice management consultant David Hunt says practice economics favor employing mid-level practitioners. "When you realize you could have a mid-level who brings in $160,000 to $200,000 a year and costs you maybe $65,000 to $85,000 a year for salary and benefits, it's a no-brainer that they'll pay for themselves and make you some money," says Mr. Hunt, managing consultant with BKD, LLP CPAs and Advisors. Even if a mid-level practitioner doesn't generate revenue much beyond his or her costs (see Chapter 4 for more details), there may be other reasons to add one to your practice, says Ellen Rathfon, the AAPA's senior director of professional advocacy. "Practices that are feeling overwhelmed and have bad patient flow, long wait times, and low patient satisfaction" may benefit, she says. "You should think about why you want a PA, what you want that person to do, and how much interaction you want to have" with the PA. Physicians who don't want to supervise someone may be happier trying to hire another physician, Ms. Rathfon says; but if you don't mind providing high-level backup, a mid-level practitioner may suit your needs.

Practice management consultant Jackie Coult, president of Valley Technology, Holladay, Utah, suggests benchmarking your practice against national averages, which are available for a price from the Medical Group Management Association or the American Medical Group Association, to help determine

whether adding a mid-level practitioner would be a good option for you. For example, if a physician with a practice similar to yours sees 20 patients a day and you're seeing 23, it's probably time to get some help. (For more details on how to determine how this will work out for you, see Chapter 4 and consult with your accountant or healthcare consultant.) The numbers don't always tell the whole story, Ms. Coult cautions. "It really depends on the kind of care you want to give, especially with patients who need a lot of follow-up," she says. "It's hard for providers to make sure all the 't's' are crossed and all the 'i's' are dotted." For example, chronically ill patients are often the focus of quality reporting requirements such as those in Medicare's Physician Quality Reporting Initiative (PQRI) or Health Information Technology for Economic and Clinical Health (HITECH) programs, which provide incentive payments in exchange for proof that routine tests and exams are being performed.

Mid-level practitioners can also expand the services that a practice offers, says Ann Davis, senior director of state advocacy and outreach for the AAPA. For example, a PA can manage a wound clinic to help patients heal their normally hard-to-manage decubitus ulcers. "They can help patients with positioning, nutrition, pain management, and home care," Davis says. "It's more efficient than using a physician's time." (See "First-hand Perspectives on Mid-level Practitioners in Primary Care.")

Coordinated Care

Payers, employers, and lawmakers are all looking to care coordination to keep patients healthier and to provide more value for their healthcare dollar. Payers are increasingly interested in rewarding coordinated care, especially to keep chronically ill patients stable and out of the hospital. "We are seeing more and more multi-payer pilot projects trying to move this model forward," says Roland A. Goertz, MD, president of the American Academy of Family Physicians (AAFP). "I think there are almost as many patient-centered medical home pilots in the private sector as in the Medicare and Medicaid programs." Mid-level practitioners play a key role in the success of care coordination, Dr. Goertz says. "The medical home model allows

First-hand Perspectives:
Mid-level Practitioners in Primary Care

An Internist's View:
The Internal Medicine Group, Norristown, Pa.

This three-physician practice has employed a full-time NP for two years; and one of the physicians, Charles Cutler, MD, says he wouldn't change a thing. "She's become an incredibly important part of our practice, and my worst nightmare would be losing her and going back to the old form of practice," adds Dr. Cutler. "Having an NP do the things that she is trained to do frees me to care for more complex patients."

"Professional satisfaction is a big item for me, and that fits right into the conversation. I feel so much better taking care of patients because I'm doing what I'm trained to do, and the NP is happy because she's doing what she was trained to do."

Charles Cutler, MD
The Internal Medicine Group
Norristown, Pa.

The practice does a lot of nursing home care, and the physicians began noticing the NP at one of the homes, where she was working with another doctor. She was interested in making a change, and Dr. Cutler and his partners were interested in hiring a practitioner who could take care of the more routine nursing home visits—taking vitals, talking to the patient, reviewing recent history and orders—so that the physicians could attend to the seriously ill patients. She now does nursing home care for the practice in addition to dealing with urgent and semi-urgent office visits. She and the physicians currently share the patient panel and divide up the work as it comes.

Reimbursement is probably a wash, Dr. Cutler says. Some payers pay him more for seeing more complex patients; on the other hand, those patients take more time, so he's not sure he makes more money by seeing one complex patient in half an hour than his NP makes by seeing three simpler patients. "I'm not sure money is part of the equation," he says. "Professional satisfaction is a big item for me, and that fits right into the

conversation. I feel so much better taking care of patients because I'm doing what I'm trained to do, and the NP is happy because she's doing what she was trained to do. I love my job more than I did before."

A Nurse Practitioner's View:
St. Jude Heritage Medical Group, Fullerton, Calif.

Nurse practitioner Jill Olmstead was doing screening and medication reconciliation for several assisted-living patients when she encountered one who was having unusual trouble sleeping. A scan of her nightstand revealed a secret stash of diphenhydramine, which she had been taking at triple the recommended dose in her search for sleep—not realizing that its rebound effect was actually keeping her awake and worsening her issues with incontinence and falling. Ms. Olmstead quickly arranged for the patient to be seen by the internist she works with.

Ms. Olmstead, president-elect of the American College of Nurse Practitioners (ACNP), wears two hats in St. Jude's 150-physician multispecialty practice. She assists both a gastroenterologist and an internist, and her practice ranges from doing diagnostic sigmoidoscopies to handling the chronic illness care programs that result in interventions like the one just noted. The physicians in her practice refer patients to her in what she calls a "team approach." She has patients, especially in the practice's women's health clinic, who request her for appointments; and she handles check-ups and acute visits for other patients, drawing in a physician on acute or complex cases. She also alerts a physician if she refers one of his or her patients to the emergency room.

"We don't spend a lot more time with the patient than a physician would, but we spend that extra five minutes to go over health promotion and wellness information," Ms. Olmstead says. Depending on the payer, her visits are generally reimbursed at the same rate as physician visits. "So many people in the healthcare system touch these patients, that the more services we can coordinate, the better," she says.

A Physician Assistant's View:
Family practice, Lisbon, Conn.

Physician assistant Cynthia Lord has her own panel of patients at a two-physician family practice in Lisbon, Conn. Some of those patients are of long standing; she's been with the practice more than 17 years, though her main role these days is director of the PA program at nearby Quinnipiac University, and she spends only one day a week seeing patients.

Ms. Lord handles all routine care: physicals, acute visits, and care of the chronically ill. She coordinates care for the latter in addition to providing

it. "It can get quite complicated," she says. "I check whether they've seen the cardiologist, confirm that he didn't change any meds, get an operative note from their orthopedic surgeon, and make sure they schedule an appointment with their endocrinologist." She uses the practice's two physicians as in-house consults when a diabetic or hypertensive patient

"Dependent doesn't mean [the physician is] standing next to me. It just means I don't hang my own shingle."

Cynthia Lord
Physician Assistant
Family practice
Lisbon, Conn.

hasn't responded to changes in medication or diet. "I ask them, 'What am I missing?'" she says.

Ms. Lord and the other PAs in her practice are booked the same as the physicians, with appointments every 15 minutes or half an hour for a physical. Most of the practice's private insurers recognize PAs as "dependent providers" and reimburse them at the same rate as physicians. "Dependent doesn't mean he's standing next to me," Ms. Lord says. "It just means I don't hang my own shingle." Medicare pays PAs at 85% of the physician rate if a physician isn't on hand at the time of the visit (see Chapter 4 for more details), but Ms. Lord simply bills under her own Medicare number and accepts that rate rather than routinely pursuing the extra 15% and having to worry about whether there's a physician in the office at the time. She says the practice still comes out ahead because it can see more patients overall.

The practice's most recent PA hire has a specialty in diabetes education, and it's gradually embracing practice guidelines that will help it fulfill the requirements for being a PCMH. It's now collecting body-mass index information on all Medicare patients, and making sure all diabetes patients are getting hemoglobin A1c tests every three months. "We're taking it in small bites," Ms. Lord says. "These are the kinds of things that PAs can monitor. RNs can do some of it, but you need a medical provider to interpret results."

physicians and mid-levels to work together and gives patients access to all of them as appropriate," he says.

The patient-centered medical home (PCMH), a team-based approach to care that emphasizes careful monitoring and patient education, is gaining momentum in areas in which mid-level practitioners could play a role. As of the end of last year, almost 7,700 clinicians in 1,500 sites had achieved recognition as medical homes from the National Committee on Quality Assurance (NCQA), the not-for-profit organization whose medical home recognition program is often used by payers who give incentive payments for medical-home-style care. The NCQA issued revised requirements in January for medical home recognition, including greater access to care during and after office hours, and managing care in collaboration with patients and families. The organization will also put increased emphasis on the ability to provide services in patients' preferred languages, to help them with self-care, and to facilitate their access to community resources—all areas in which mid-level practitioners can potentially be invaluable.

The PPACA includes a provision for the creation of Accountable Care Organizations (ACOs), which are hospital-physician collaborations intended to improve care coordination. The final rules for ACOs are still in flux at this writing, and the PPACA itself continues to be controversial; but experts say that one way or another, the concept of coordinated, accountable care will be critical in the next few years. Practices that employ mid-level practitioners will be well positioned to take part in ACOs, says the AAPA's Ms. Davis. "PAs have always been the utility infielders of the healthcare system. They're just great at doing follow-up and keeping good track of routine care—it's their middle name," she says. The team model of care delivery is a fundamental part of mid-level training for both PAs and NPs. (For more details on how reform may affect your practice, see the May/June 2011 issue of *Doctor's Digest*, "Preparing for Healthcare Reform," at *http://www.doctorsdigest.net/issue/0703.php*.)