The nurse practitioner will see you now
Marcia Frellick
Trustee; May 2011; 64, 5; ABI/INFORM Global pg. 8

With physician shortfall projections hovering at 63,000 by 2015, the promise of 32 million more Americans gaining health insurance, and a patient population rapidly aging and saddled with chronic disease, hospitals are scrambling to line up caregivers.

One strategy gaining momentum is the increasing use of nurse practitioners and physician assistants, clinicians who do much of the same work a physician does at about half the cost.

NPs and PAs commonly are called mid-level providers, though that term has its critics. The American Academy of Physician Assistants, the American Academy of Nurse Practitioners and several other organizations object to the term, saying it implies a lower level of service. They prefer such terms as advanced-practice providers.

In fact, NPs and PAs, found among almost all medical and surgical settings, are a patient's primary provider, particularly in rural areas. Much of their practice areas overlap, and they are trained similarly in diagnosing and treating medical conditions, ordering tests or therapy, counseling patients and families, and prescribing medicine. PAs must be supervised by physicians by law; NPs are licensed to practice independently in some states. Laws vary widely.

What's universal is the potential to spend less for services physicians typically provide. Savings come in the form of lower salaries and lower liability insurance, the ability to add more patients to the schedule and the potential to free up doctors to take care of higher-risk procedures.

Salaries for the two professions are similar: NPs make on average $89,450 in base salary, according to 2009 AANP salary data. For PAs, the median salary is $87,500, according to the AAPA. Both are less than half the annual salary for a physician who treats adults.

Medicare reimbursement also works in favor of a hospital using mid-level providers, says Tricia Marriott, director of reimbursement policy for the AAPA. "The first struggle most hospitals have is figuring out how to get reimbursed for the work the PA is doing," she notes. "You bill Medicare as a professional under the PA's national provider-identifier number. You get reimbursed under Medicare at 85 percent of the physician rate. However, you're not paying that PA 85 percent of the physician's salary. You're typically paying them less than that. So, for the same work that a physician would have to do, you're actually..."

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8 MAY 2011 Trustee

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getting paid more for the PA's work." NPs are reimbursed the same way.

By delegating duties such as daily rounds and admissions to mid-levels, "the physician can go and take care of the higher-risk, higher-energy admissions, medical interventions and procedures," she adds.

Mid-levels also can help in a casualty event such as an ice storm when ankle fractures pour in. While a doctor may be on call for several hospitals, a PA or NP could take care of the X-rays, decide whether to medicate the patient and make a huge difference in length of stay or waiting times, Marriott says.

"I've been in that situation where I had to beg for FTEs ... to add extra people in the operating room so the surgeons could get two more total joint replacements done in a day," Marriott says. "Think about the facility fee and the revenue for those two extra cases in a day. And what was the cost of that PA's salary for the day?"

**Quality, Continuity in the ICU**

NPs and PAs have been used increasingly in intensive care units with promising results, says Ruth Kleinpell, R.N., director of the Center for Clinical Research and Scholarship at Rush University Medical Center in Chicago.

She co-authored a review of the literature in 2008 for *Critical Care Medicine* and found that research shows that integrating NPs and PAs into intensive care units enhances patient care and that outcomes are similar to those of resident physicians.

One driver of those results, Kleinpell says, is that NPs and PAs offer continuity of care in overseeing admission, management and discharge planning as opposed to care under medical residents and fellows who are rotated in and out of settings as they train.

"Also, by virtue of their background and training ... they are used to educating patients and families," she notes.

Beyond direct patient care, Kleinpell says mid-levels are improving quality and safety with quality-improvement projects by teaching colleagues and by making sure evidence-based best practice protocols are being used.

The benefits of integrating mid-levels come without added liability costs to hospitals, she says. Studies show liability claims have not increased with increased use of NPs and PAs. "Actually, there's some thought that patients and families are more satisfied and less likely to bring up litigation because there's someone there who's coordinating their care and educating more," she says. —M.F.

**Essential Rural Caregivers**

Bobbe Teigen, CEO of Paynesville Area Health Care System in rural central Minnesota, says availability of mid-levels is particularly important in such rural settings as Paynesville where one health care provider sees about 1,000 patients and hiring a physician may take a year or two.

Paynesville increasingly is hiring NPs and PAs for the hospital and outpatient clinics, and the system now has about a 1-to-1 ratio of mid-levels to physicians, Teigen says.

Many of Paynesville's mid-levels have their own patients and run their own clinics. By law, PAs have to have some level of supervision by a physician, but the amount of supervision varies by state and doesn't always mean they have to be in the same room.

"You get out in a very rural area—you may have only a couple of physicians and they're trying to run a 24/7 emergency department," she says. "The physicians can't cover all those shifts, so they often depend on mid-levels and communicate carefully with them.

"We probably invest six months to a year in training them, getting them up to speed and building their confidence," she adds.

**Recruiting Becomes Competitive**

Mid-level hiring even has increased in areas that have not had great difficulty in finding and retaining enough physicians.

Ron Byerly, director of the Advanced Practice Council at Geisinger Health System in Danville, Pa., says there has been a surge in hiring NPs and PAs even though Geisinger hasn't been hit too hard by the physician shortage. In this fiscal year, Geisinger has hired 62 of the 66 new budgeted mid-level positions, more than twice the number hired in the previous fiscal year, he says.

Ratios of mid-levels to physicians are determined by state law, and needs also vary by hospital department. For example, Geisinger has 15 physicians and two physician assistants in the internal medicine outpatient clinic, but six physicians and 12 PAs in neurosurgery, Byerly says.

Geisinger offers mid-level incentives beyond base salary. They get pay incentives based on such benchmarks as patient satisfaction and their use of patient portals in the system's electronic medical record.

"In my experience, it's relatively unusual for advanced practitioners to get any incentives," Byerly says.

Henry Ford Health Care System in Detroit long has recognized the value of mid-level providers in supplementing the physician staff, says Folusho Ogunfiditimi, manager of the Mid-Level Provider Program at Henry Ford. The health system has increased its numbers of NPs and PAs by about 50 percent over the past five years, he says, fueled partly by the opening of a new hospital whose inpatient staff primarily is made up of mid-level providers.

Ogunfiditimi says the cost-benefit analysis makes sense even with lengthy acclimation periods. It can take up to a year before mid-level providers feel comfortable in their roles. While mid-levels have the educational and clinical background to adapt quickly to clinical demands, whether in previous roles as RNs, EMTs or surgical techs, they have to learn the delivery side of the profession, he says.

"As a practitioner you know that if a patient has this symptom I can treat it with this or that. But what they don't show you is how you deal with a patient who doesn't have adequate insurance," Ogunfiditimi says.

It's becoming increasingly difficult to recruit NPs and PAs, he says. While it's still easier to recruit mid-level providers than physicians, the time from the start
Bringing Peace to Turf Wars

The success of physician assistants and nurse practitioners in delivering quality, cost-effective patient care has much to do with their relationship with physicians. Because duties overlap and because mid-levels are growing in numbers and influence, hospitals must be clear before an NP or PA is hired as to how the relationship with physicians will work—everything from what duties will be performed to how schedules and billing will be handled.

"Generally the physicians will welcome the help, but you need to have a very frank conversation up front," says Tricia Marriott, director of reimbursement policy for the American Academy of Physician Assistants. A physician needs to be aware that if a PA or NP is assigned a task, they will bill for it. Some physicians will not be comfortable with that and will decide to do a task themselves. Others will happily delegate.

Learning together is one way to increase teamwork, Marriott says. "We only practice what the physician delegates to us and what the physician knows how to do. If he learns a new procedure he should be bringing his PA along, and in my experience, that's what happens."

Even when mid-levels know what needs to be done, physicians must be engaged in the decisions and be respected as 'captain of the ship,' she says. Mutual respect, she says, has grown now that physicians are starting to get more training alongside mid-levels. Penny Kaye Jensen, president of the American Academy of Nurse Practitioners, says interprofessional teams learning together, rather than in parallel but separate tracks, is crucial to patient-centered care. A pilot program to establish Centers of Excellence in Primary Care at five selected Veterans Administration centers starts later this year and is an example of that kind of training, she says. Each center will be federally funded at a level of approximately $1 million per year for five years.

"Our system will have a nurse practitioner student actually co-managing panels with medical residents and working as a team. Within the VA system it's called patient-aligned care teams, but on the outside it's called the medical-home model," Jensen says.

Ron Byerly, a physician assistant at Geisinger Health System in Danville, Pa., says he sees turf wars not so much between physicians and mid-levels but between NPs and PAs, who traditionally have competed for jobs and salaries. Twenty years ago, he says, PAs made more than NPs for doing the same job, but that has since leveled out.

Byerly helps lead the Advanced Practice Council at Geisinger, a group established almost two years ago to help resolve such issues. Collaboration starts with having three directors—one each for NPs, PAs and certified registered nurse anesthetists—with equal access to the administration.

"We decided right from the start that we were going to close that chasm to recognize our differences and recognize that 90-plus percent of what we do, especially between nurse practitioners and PAs, is so similar that it's not worth an argument," he says.—M.F.
on this issue in its 2010 report “The Future of Nursing: Leading Change, Advancing Health.” Among its conclusions were that current laws in some states were hampering the ability of advanced practice nurses to contribute to innovative health care delivery solutions.

The IOM called on the federal government to get rid of outdated scope-of-practice variances and reform advanced practice nursing by disseminating best practices across the country and creating incentives for their adoption. States with broader nursing scopes of practice have experienced no deterioration of patient care, the IOM noted.

The American Medical Association is one of the organizations that has opposed the use of mid-levels to alleviate the physician shortage and is fighting proposals in about 28 states that are considering steps to expand what nurse practitioners can do.

In a statement in response to the October IOM report, the AMA said it is “committed to expanding the health care workforce, so patients have access to the care they need when they need it. With a shortage of both nurses and physicians, increasing the responsibility of nurses is not the answer to the physician shortage.”

While it may not be the only answer, adding NPs and PAs has been shown to enhance care and extend the provider pool for a health system strained by demand.

More than 14,000 NPs and PAs graduate each year, and the numbers in clinical practice have doubled in the last 15 years. Their appeal may increase in July, when the Accreditation Council on Graduate Medical Education restrictions kick in, reducing the number of continuous duty hours first-year residents can work. Shifts that now span 24 hours will be capped at 16 hours, and another provider will need to pick up the slack.

But no one provider model will work for all hospitals, says Pamela Thompson, R.N., CEO of the American Organization of Nurse Executives, an American Hospital Association subsidiary and a national organization of nurse leaders who design, facilitate and manage care. “The guiding principle is that having coverage doesn’t mean you have access,” she says. “Hospitals need to look at how best to meet the needs of the population they serve. In some areas that’s going to be by increasing the number of primary care physicians. In some cases that will be by increasing the team that cares for the patient.”

Thompson adds, “If we do our planning based on what we’ve identified as the needs of the community—what our patients require in order to receive the quality care that we want to provide for them—we can design our systems around meeting that and putting in place the best providers for that care.”

Marcia Frellick is a writer in Chicago.

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