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Preventing Delirium

Hospitalized patients suffer serious setbacks from undiagnosed delirium. Primary care physicians hold the key to better outcomes.

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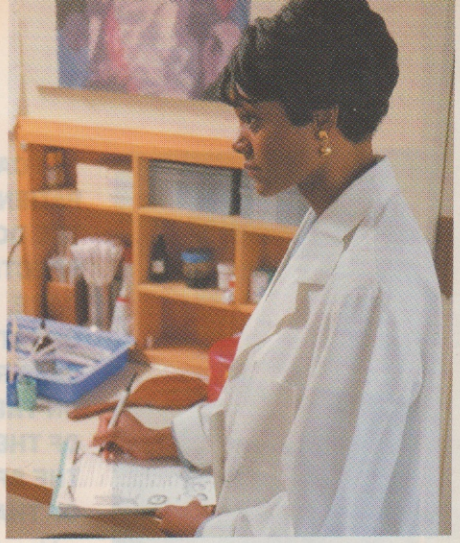
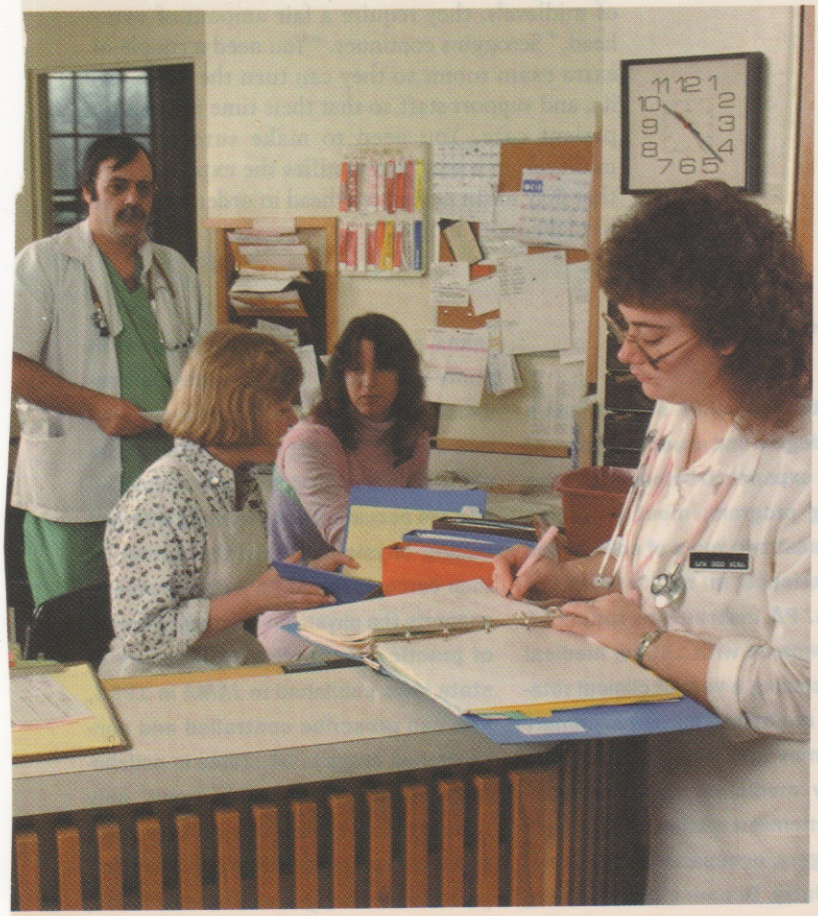


MAKING THE MOST OF Midlevel Providers

Nonphysician clinicians can help lighten the load in primary care.

BY LAUREN M. WALKER



THEY GO BY MANY NAMES — midlevel providers, nonphysician or advanced practice clinicians, and the common but misleading "physician extenders." In primary care, they are usually nurse practitioners and physician assistants, trained to handle many patient needs, but their ranks also include nutritionists, occupational therapists, physical therapists, nurse educators, and even psychologists. And as their numbers increase, they are bringing a new kind of teamwork and flexibility to primary care practice. They can give physicians more free time and patients more attention, and help improve revenues under capitation. But midlevels are not a panacea, and a practice that adds them must be clear about its goals for the effort to be a success.

There are more than 36,000 PAs working in the U.S., 47% of them in family/general practice medicine or general internal medicine practices, according to 1999 figures from the American Association of Physician Assistants (AAPA). There are approximately 63,000 working NPs, according to a 1998 study published in *JAMA*. About 95% work in primary care. And their numbers are growing rapidly — the *JAMA* study estimates the supply of nonphysician clinicians in 10 of the most common disciplines (including NPs and PAs) will grow twice as fast as the number of doctors between 1995 and 2005, with the greatest increase among

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– Mary Knudtson

those who provide primary care services. An AMA report found that 24% of solo practice physicians in general/family practice employed PAs, and 10% employed NPs. In group practices, 42% employed PAs, and 22% NPs.

The rise of midlevel providers is in part a response to managed care. In the simplest analysis, an NP or PA should be able to see at least half, and possibly as many patients as a physician — services that can usually be billed at physician rates — while costing half or less than that of a salaried physician associate. And in these days when physicians sometimes feel they can't spend enough time with patients who need them, midlevel providers can take care of relatively routine matters, freeing doctors to spend more time with more complex cases. "It's a viable means of treating patients economically," says Janice Cunningham, consultant with The Health Care Group in Plymouth Meeting, PA. "Some of the equation depends on your reimbursement mix and whether you're taking a lot of capitation. In many situations, it's more cost effective to add a midlevel than to add a partner."

But midlevels are no longer an automatic bargain, especially in primary care.

In some places, a midlevel provider may cost nearly as much as an entry-level physician. The average salary for an NP in primary care was $60,000 in 1998, according to the Nurse Practitioner Support Services annual salary survey; the average for PAs in family/general medicine was about $61,500, according to the AAPA annual survey. But PAs with 18 or more years of experience averaged almost $72,000, and high-end NPs in primary care commanded over $90,000. "In some areas, NPs and PAs are getting too expensive for primary care practices," notes David Scroggins, a principal in Clayton L. Scroggins Associates, a Cincinnati practice management consultancy. "Clinics and institutions have hired so many of them that they've driven the salaries up. Now instead of paying $45 or $50 thousand for a midlevel, we're seeing salaries of $60, $70, even $80 thousand. That doesn't leave enough margin for them to be profitable for some primary doctors."

It's not just the salary that may make a midlevel provider expensive. "If you're making the best use of midlevels, they require a fair amount of overhead," Scroggins continues. "You need a couple of extra exam rooms so they can turn the extra visits, and support staff so that their time is spent on patient care. You need to make sure you use midlevels in a way that justifies the expense. And that may mean raising overhead in order to be able to make more money."

PA or NP? Who's Best for You?

Although there are important differences in the training and licensing of NPs and PAs, in primary care practice there is often little functional difference between the two disciplines. The individual's area of specialization, personality, and approach may be more important factors in finding a good fit in most cases.

PHYSICIAN ASSISTANTS

PAs are trained in what's called a "medical model," in medical schools, universities, teaching hospitals, and in the armed forces, to work under the supervision of a physician in patient care. According to the AAPA, the typical PA student has a bachelor's degree and about four years of health care experience before entering a PA training program; most programs require at least two years of college and some experience in health care for admission. PA instruction runs 111 weeks (compared with 155 for medical school), including a year of clinical rotations. They are trained initially in primary care, but may specialize further, into emergency medicine, family/general medicine, internal medicine, ob-gyn, pediatrics, surgery, occupational medicine, and psychiatry. Because their training takes place in medical settings — in many programs, PAs and physicians-in-training take some of the same courses, and clinical training is also often in the same facilities that train physicians — PAs are accustomed to working with and among physicians from the outset of their careers. The AAPA's official stance supports the physician-supervised model of practice. According to a survey of state laws published in *JAMA* in 1998, PAs can prescribe controlled and noncontrolled drugs in 34 states in collaboration with a physician, and only noncontrolled in nine others; they can't prescribe independently in any. They may prescribe dietary guidelines; draw blood;

If the financial benefits aren't always clear cut, there may be other compelling reasons to bring in NPs or PAs. They can allow a physician to concentrate on more complex cases, help a practice see patients with acute problems more quickly, provide more in-depth patient education, or give a physician a few more hours a week to spend at home. "There are many reasons," says Debi Croes, a partner with Massachusetts-based practice management consultants The Croes-Oliva Group, "and not all of them are reflected in the bottom line."

Midlevels can help a practice cope with increasing patient demands. "Physician assistants have allowed us to provide a better service," says Dennis Tafflin, DO, an FP in Bucks County, PA, whose four-doctor family practice includes two full-time PAs. "Especially in a family practice atmosphere, where people often need to be seen within the day, the PAs allow us to handle the overflow of patients. It allows our practice to provide a higher level of care, to satisfy our patients' wants and needs."

In the future, midlevels may help practices handle managed care in ways beyond merely providing a lower-cost way to see patients. "A PA can manage care and cost," notes Ron L. Nelson, chair of the board of directors of the AAPA. "We tend to have more experience practicing in that environment, and where it might be burdensome for physicians to keep track of formularies, authorizations, and referral restrictions, the PA can spend the time learning those systems and act as an advisor to physicians and patients. A midlevel can allow physicians to deliver care more effectively in that complex environment, by dealing with the obstacles. Ultimately that translates to better care for the patient."

Before You Begin

The biggest decision in choosing a midlevel happens long before you interview any candidates. "It all starts with adequate planning, and the physicians' attitude," says Cunningham. "Those are critical ingredients to making it successful. The physicians in the practice have to agree to hiring a midlevel, and using that person to the full extent of their licensure and capabilities. So if you have some physicians who think they're hiring a 'glorified nurse' who really can't do anything, your NP or PA is not going to be successful."

A practice needs to be clear on what it hopes to accomplish in hiring a midlevel. "I've seen too many practices where the plan was to add the midlevel and then figure out where he or she fits, and it's usually a disaster," says Croes. "That doesn't mean you can't adjust your expectations after you've hired someone, but you need to have reasons for what you're doing."

It's important to determine what types of patients and problems the midlevel will see, from both clinical and financial perspectives. Will the practice use the midlevel for longer health maintenance visits, for episodic sick visits, or both? "I'm trained to do primary care," explains NP Mary D. Knudtson, MSN, president of the American College of Nurse Practitioners, who practices at the Primary Care Medical Group at the University of California at Irvine, where she's also an assistant clinical professor in family medicine. "So I can see 90% of the patients that come in the door. I can see patients with abdominal pain, acute respiratory infections, sprains, strains, fractures, pneumonia, health maintenance, diabetes, hypertension — the whole spectrum of primary care. What kind of

order tests, X-rays, CTs, and MRIs; and interpret test and X-ray results in all states. PAs also perform minor surgery — for instance, dermatological procedures — and assist in surgery. They are permitted to suture in all states; and can perform lumbar punctures and joint aspirations in 43 states.

NURSE PRACTITIONERS

NPs are trained as nurses — often, they are nurses who have gone back to school for further training. Most hold graduate degrees, and most programs are at the master's level. Their training takes place primarily in nursing schools, and typically focuses on primary care, with an emphasis on patient education, management of chronic diseases, and wellness care. Most specialize in adult health, pediatrics, geriatrics, women's health, or family health, but there are also specialties, including critical care and emergency care.

There has been controversy in recent years over NPs practicing independently. They are authorized to do so in 21 states, according to the *JAMA* report, and are advocating for the right nationally. They are also lobbying payers to reimburse them as primary care providers, and increasingly, health plans are doing so. NPs can prescribe independently in 12 states. In a third of the states, they can only prescribe noncontrolled drugs under physician supervision, and can prescribe both controlled and noncontrolled under supervision in most of the rest. Like PAs, they can prescribe dietary guidelines; perform venipuncture; order tests, X-rays, and scans and interpret results in all states; and suture. Although PAs have traditionally been more likely to perform minor surgery, in fact under the law, NPs are also permitted to do so in all states, and training programs are now more likely to include procedures. In addition, they can perform X-ray exams, treat musculoskeletal disorders and pain, and perform lumbar punctures in all states.

Some physicians may choose midlevels to change their lifestyle. The net may be less but the physician may have more free time.

patients an NP sees really depends on the preference of the practice and the specialization of that individual."

While NPs and PAs have different training and licensing requirements, either can fit well into the primary care environment. NPs may specialize in family medicine, women's health, pediatrics, geriatrics, or adult medicine. PAs also specialize; the ones most prevalent in primary care are trained in family/general medicine or general internal medicine. The midlevel you hire obviously should be educated in the areas where you plan to use them. If you want an NP or PA to do small procedures make sure the person you're considering is trained in those specifics. PAs have traditionally done procedures, but increasingly, NPs are also being trained to perform them. Knudtson's program at UCI, for example, trains NPs in procedures such as shave and punch biopsies, suturing, IUD insertions and removals, cervical cap and diaphragm fittings, toenail removal, and incision and drainage of abscesses.

Midlevels can also help with call duties, taking care of patient concerns that are within their purview, but need physician backup — which means the physician is really still on call, too, although the number of interruptions may be smaller. In a small or isolated practice this may still be a significant help, but many practices don't use their midlevels for call for this reason.

Because a midlevel can be an expensive addition to the practice, it's important to assess your financial expectations in advance. While an experienced midlevel can see as many patients in a day as a physician, according to Knudtson, obviously that won't work if the NP or PA is scheduled in half-hour slots, spending more time with patients on education and preventive care. Having a midlevel spend that extra time can free physicians to see more complex patients and help reduce the overall cost to the practice of capitated patients, but won't necessarily show up in the midlevel's own productivity figures. "You need to calculate productivity in terms of the group," says Michael Prislin, MD, a professor of clinical family medicine at UCI, "rather than point to individuals. The person who sees the patients with more complicated psychosocial situations, for instance, may take longer, but that means the rest don't have to take that time. So we tend to be busier in terms of numbers. You have to see it as the practice taking care of a whole population." That attitude works best in practices that have a lot of capitated patients — one of the reasons NPs and PAs are so prevalent in California, with its high managed-care penetration.

But there are also times when money is not the object. "I've met small-practice physicians who choose to have a midlevel to change their lifestyle," notes Croes, "in which case the net may not be quite as great but the physician may have a little more free time. That's fine, too, so long as that's what you're trying to get."

A related decision is whether midlevels will have their own panels of patients. "In primary care, usually they should have their own schedule and their own caseload — their own appointment times, clinic times," says Cunningham. "If the physicians are intending to just have someone assist them and follow them around, they're really not utilizing that person to their fullest." Seeing patients independently can take the form of the midlevel covering certain times and days, certain types of patient visits, or a panel of patients who've chosen the midlevel as their primary provider. In the latter case, a practice should still set guidelines for what kinds of patients are appropriate.

"We let our patients choose a provider," says Dr. Tafflin, "especially if they have chronic, recurrent conditions — hypertension, diabetes, things like that. For the most part, they don't

WILL MIDLEVELS SUPPLANT PRIMARY CARE PHYSICIANS?

The number of midlevels is growing fast. The projected number of nurse practitioner graduates in 2001 is 7,250, compared with 1,500 in 1992, according to workforce projections published in *JAMA*. In 2001, there will be a projected 3,400 new PA graduates, up from 1,360 in 1992. Add these to the existing population, and there will be a projected supply of 106,500 NPs in practice by 2005, and 53,200 PAs.

They are not all training to enter primary care, however — approximately 55% of PAs and 95% of NPs now work in primary care, but the *JAMA* report predicts that while the proportion of PAs in primary care will remain stable, more NPs will go into nonprimary specialties, about 15% by 2015.

By 2005 there will be as many NPs in clinical practice as there are family physicians, and more PAs than there are general pediatricians, the *JAMA* report notes, but reserves judgment on how these demographics will affect physicians. Because much of what midlevels do is basic, uncomplicated primary care, it's likely these changes will have an impact on demand for primary care physicians; almost certainly they will at least promote a shift in duties, so that primary care physicians will be more involved in care of complex cases requiring their higher-level skills and training.

choose the PAs. Then you have the 5% to 8% of the patient population that are in the office fairly frequently, with minor ailments, and they often prefer the PAs. A lot of the younger folks choose the PAs, school-age kids who need a yearly physical and get sick once or twice a year may choose to see one of our PAs as their regular provider. But we generally don't encourage patients with chronic, recurrent multisystem diseases to have the PA as their primary."

Supervising Midlevels

But because the physician is ultimately responsible for the care provided by the practice — both legally and ethically — midlevels shouldn't operate in a vacuum. So another point that should be settled up front is how the midlevels will be supervised.

State laws, insurers, and government programs set some standards for supervision. At a minimum, the physician must be available for consultation, but the specifics vary by state and payer. For instance, under Massachusetts law, a physician can be responsible for supervising no more than two PAs at one time, but the physician is not required to be physically present when the services are rendered. Under Medicare, the midlevel's services can be billed at 100% of the doctor's fee schedule — the so-called "incident to" provisions — so long as the physician has treated the patient on his or her first visit, or if the patient comes in with a new medical condition, and is on the premises at the time of subsequent visits to the midlevel. In many instances, the rules for NPs differ from those for PAs; in some states, NPs can practice independently of physicians, and bill for their services directly. In some underserved areas, what an NP or PA can do without direct supervision is expanded. "For instance, in underserved counties in rural Michigan, PAs can make house calls, or staff a clinic in which the physician is only present part of the time," explains Nelson, who practices at Community Care in Grant, MI.

It's crucial that a practice have an agreement in writing that spells out the scope of the midlevels' activities, how they will interact with their supervising physicians, and how the physicians will review the midlevels' work. A practice may want to specify certain conditions that are automatically seen by the physician on site — for instance an acute painful abdomen, or chest pains. The supervising physician should review some set percentage — perhaps 10% — of a midlevel's charts on a regular basis. At UCI, that's done as part of the regular peer-review system applied to all the providers, physicians and midlevels alike. Other practices have a special review process for their midlevels. "There has to be some sit-down time every week — it doesn't have to be long, maybe an hour — where you sit down together and discuss cases, raise issues," says Croes.

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– Ron Nelson

Some also use duplicating prescription pads, so there's a handy copy of each prescription for the physician to review. "That's a good place to have extra backup," says Croes, "because prescribing errors are among the things that can really harm a patient, and the NPs and PAs appreciate being supported in those decisions. I advise practices to go through the prescription duplicates on a daily basis. It only takes a few minutes and it's a good security measure."

Physicians ideally also should be available to be pulled into the exam room, or do a hallway consult, if a midlevel wants guidance on a specific patient problem. "I'm fortunate in my practice in that there's always a physician on site, if I want them to take a look at a patient," says Knudtson. "If it's a more general question, for instance, a lab result comes back and I want to know what to do next, I can ask when the patient isn't there."

What may be hard for independent-minded physicians to understand is the degree to which many midlevels often appreciate physician review. "These are such conscientious, serious people, as a rule," says consultant Scroggins. "You often hear from them, 'I wish the doctor would look at my charts more, I wish they'd spend more time talking about what they might do with a patient.' They want the interaction."

Putting the Pieces Together

Supervision issues are especially important when hiring a new midlevel. A new employee needs to learn the practice's style, and the physicians need to develop confidence in them. "My recommendation is that in the first year, the supervising physician should review every chart," says Blaine P. Carmichael, AAPA vice president. "Sit down with the midlevel every morning, and thumb through the charts from the day before. That gives me a better flavor of how you like to treat patients, and helps me learn to mirror that style. And if I can't mirror that style, the relationship won't last, and that's something we need to know, too."

"Once physicians have worked with midlevel providers, they quickly come to appreciate the advantages of having a team to provide the appropriate level of care."

For Knudtson, too, "spending time reviewing patients is probably one of the best ways" to integrate a new midlevel into the practice. "Those consultations provide a wonderful opportunity for the physician to let the NP know if they do something a little bit differently, or if they have a concern about the NP's lack of knowledge in an area. The consultation provides the most opportunity to really get to know each other's practice styles," she says.

Handling cases together can also help keep things in sync. "Especially at the beginning, the midlevel is going to need support, including being able to call the physician in to consult on patients more often than they may later," notes Croes. "You just book the physician a little less tightly when a midlevel is new, so the schedule has a little more slack time to accommodate it."

Of course, there can be problems bringing a midlevel provider into a practice, too. If the decision doesn't have the support of all the physicians, difficulties may ensue. Again, adequate preparation is the key. "The biggest problem area we see is if the midlevel is not treated with the appropriate level of respect," says Cunningham. "If they're not utilized appropriately, to the full extent of their capabilities, they won't generate as much income and they won't be happy. You wind up having a lot of hard feelings on both sides."

"With NPs and PAs, 90% of acceptance depends on how you introduce that person to the rest of the staff and to your patients," adds Cunningham. "If you treat them as inferior, if you make it sound like grade B medicine, it won't work out. You have to introduce them as another level of professional, who can answer questions, run tests, do exams, and help deliver care."

Croes says the practices she's called in to help most often have made just those mistakes. "In some practices, we find midlevels saddled with extensive duties that don't require their license and skills. Maybe they are being asked to supervise the medical assistants, order medical supplies, or stand in for a practice nurse. A lot of practices give midlevels extensive phone duties. When you look into the situation, the reason midlevels aren't billing what you'd hoped is because 20% of their time is being taken up with tasks other than patient care. If you want midlevels to take on those duties, you'll have to accept that they may not generate enough revenue to cover their salaries, and adjust your expectations accordingly."

If physicians in the practice have never worked with a midlevel before, they may have problems knowing what the NP or PA can do. "Our first PA really taught us what a PA is and does," says Dr. Tafflin. "Now I wouldn't practice without them." The experts agree that it's in working with midlevels that physicians learn to be comfortable with them. Knudtson recommends working in a setting that already employs these health professionals, or at least observing them in another practice, to get the feel for how to integrate them. "Once physicians have worked with NPs, they quickly learn which patients are most appropriately seen by the NP and which need to be seen in consultation, and come to appreciate the advantages of having a team to provide the appropriate level of care," she says. In California's Orange County, Knudtson says, a lot of practices that had never used them before added NPs or PAs in the past decade to cope with managed-care requirements. "Most of those midlevels have kept their jobs, and the practices have added more," she notes. "So obviously they did learn to adapt."

The biggest change midlevels bring to a practice may be turning patient care from an enterprise of independent players into the work of a team. "I think it works best when it is truly a collaborative practice," says Knudtson, "where both parties are respected for the skills and abilities they bring to the practice, and where you collaborate and refer patients back and forth to each other. If you can have that collaboration and that respect, it ends up being beneficial for the midlevel, the physician, and most of all for the patient." **H**

Lauren M. Walker is a senior editor at HIPPOCRATES. *Her last feature, "Talking to Your Patients About Managed Care," appeared in the November issue.*

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