

# Help in the Middle

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*Overhead* and *efficiency* are two related words that resound repeatedly within the business strategies of today's practicing physicians. The *efficient* practitioner strives to control the cancerous *overhead* that eats at prosperity. Why is it that two apparently thriving cardiology practices can find themselves at opposite ends of the spectrum of profitability? The answers often lie in those two words, which can affect each practice so poignantly. For the busy practice mired in the muck of endless days (and nights) of decreasing profitability, help is frequently in the middle!

Mid-level providers, often called physician extenders, are seen increasingly in cardiac practices. Behind the name lies a resource that can literally change the life of an exhausted, exasperated and overworked physician. Across many specialties, these professionals are playing increasingly more prominent roles, and their presence is growing very rapidly. According to the American Academy of Physician Assistants, the field of PAs is expected to grow 10% in 2001 (an increase of 4,400).<sup>1</sup> As Table 1 indicates, the presence of mid-level providers has been firmly established within our delivery system, and they are supported by well-organized national professional organizations.

In fact, according to Richard Cooper, Director of the Health Policy Institute at Medical College of Wisconsin, the projected growth rate for physician assistants, nurse practitioners and nurse midwives is expected to be four times that of physicians during the period from 1995 to 2005! Within this climate, he expects these groups to look to redefine their roles; in many cases, they already have.

A physician's time is very limited, yet much of his/her activity is consumed with routine, sometimes uncomplicated, patient care activities. Histories, physical examinations, developing and implementing patient management plans, diagnosing and treating uncomplicated illnesses, ordering and interpreting routine lab tests and x-rays, counseling and educating patients - these are very time-consuming activities that are now performed with quality and competence by physician extenders. As Table 2 indicates, because these mid-level professionals have more focused training, their services are significantly more cost-effective than sub-specialty

trained physicians, who in turn, can devote themselves to more advanced diagnostic and therapeutic challenges.

**Table 1.** Mid-level providers and professional organizations

Specialty	# Practicing in the U.S. <sup>2</sup>	Professional Organization
Nurse Anesthetist	28,000	American Association of Anesthetists (www.aana.com)
Nurse Midwife	5,700	American College of Nurse Midwives
Nurse Practitioner	70,000	American Academy of Nurse Practitioners
Physician Assistant	40,500	American Academy of Physician Assistants
Occupational Therapist	100,000	American Occupational Therapist Association (www.aota.org)
Physical Therapist	90,000	American Physician Therapy Association (www.apta.org)

It is not difficult to see that there is potentially a major role for these providers in the evolving modern physician practice. The practical application within a traditional medical office model is the key. Some relevant strategies, utilizing an example of the following hypothetical cardiology practice, are shown below.

**The heart of the matter: A model in cardiology.** Let's pick an example to highlight the impact of mid-level providers. In this case, we will look at a 7-physician cardiology practice called Cardiology Associates of South Somewhere, or CASS for short. CASS has grown from a 4-physician non-invasive group 2 years ago to its present size, with the addition of a diagnostic catheterizing cardiologists, an interventional cardiologist and an electrophysiologist. When the new physicians joined the group, their practices grew quickly. They met with hospitals and offered to work with them in any way possible to build the hospital programs along with their private practices. At the same time, they have responded to all requests made of them by referring physicians. Even their patients rave about their service, professionalism, and warm, caring demeanor. They are the quintessential customer-oriented cardiology group, and as a result, business is booming for the entire practice. However, several problems have arisen along the way:

- Business is too good: No longer can the practice accommodate every referring physician and patient request the same day. In fact, they now have several week backlogs for patient visits and many procedures.

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Table 2. Mid-level health professionals<sup>4</sup>

Specialty	Median/Mean Salary	Starting Salary	Education/Experience
Nurse Anesthetist	\$94,000	Low \$80,000s	RN with experience 2-3 years of study beyond BSN
Nurse Practitioner	\$62,044	Mid \$50,000s	RN Masters degree in nursing
Physician Assistant	\$68,800	\$58,000	BS or certificate, PA program graduate State licensure
Occupational Therapist	\$47,400	\$37,000	BS degree (Masters degree required for new entrants in 2007)
Physical Therapist	\$50,000	\$41,000	BS degree (Masters degree required for new entrants in 2002)

- The office practice is neglected: Making hospital rounds, being on reading panels, covering consults, taking call, performing hospital procedures, and so on, have pulled the cardiologists away from the office, often causing patients to wait for extended periods, be rescheduled or be rushed in between other patients.
- The cardiologists are burned out: Running from the hospital to the office and back again, along with call, committee meetings, and other obligations, have taken a serious toll on the physicians – and their lives outside the practice.
- The office staff is frustrated and demoralized: Constant rescheduling of patients, waiting on late physicians to arrive at the office, and frustrated cardiologists have caused employee morale to degenerate.
- Cardiologists' income is low: Despite the fact that they appear to be working harder than their peers, word has it that their income is significantly lower.

**An approach to the problems.** The situation described above for Cardiology Associates of South Somewhere (CASS) is not terribly uncommon. Strong professional reputations, hard work, long hours, an abundance of business -- sounds like the definition of success. In fact, it is a drain to both the morale and finances of the practice. The physicians feel like they are being pulled down by an undercurrent from which they cannot escape.

- A solution: Refocus practice efficiencies and control overhead.
- A strategy: Utilize mid-level providers to effectively take the excess load off of the cardiologists.

After some brief background information, the remainder of this discussion will focus on how the proper utilization of physician assistants and nurse practitioners will help resolve some of the issues that have overcome CASS.

**Scope of responsibilities & reimbursement.** The differences between physician assistants and nurse practitioners are not entirely clear, and are often defined relative to supervision. Physician assistants are licensed to practice with the supervision of a physician, while nurse

practitioners practice in a collaborative relationship with physicians.<sup>5</sup> The American Academy of Nurse Practitioners summarizes the range of their members' duties as: "Obtain medical history and perform physicals; diagnose and treat acute health problems such as infections and injuries; diagnose, treat, and monitor chronic diseases such as diabetes and high blood pressure; order, perform, and interpret diagnostic studies such as lab work and x-rays; prescribe medications and other treatments; provide prenatal care and family planning services; provide well-child care, including screening and immunizations; provide health maintenance care for adults, including annual physicals; promote positive health behaviors and self-care skills through education and counseling; and collaborate with physicians and other health professionals as needed."<sup>6</sup> The American Academy of Physician Assistants indicates that "...the scope of the PA's practice corresponds to the supervising physician's practice. In general, a physician assistant will see many of the same types of patients as the physician. The cases handled by physicians are generally the more complicated medical cases or those which require care that is not a routine part of the PA's scope of work." The AAPA also explains that PAs are taught to know their limits and to seek consultation from, or referral to, the physician on unusual or hard to manage cases!

Although the professional scope of responsibility is rather broad, both the AANP and AAPA emphasize the need for familiarity with state laws. There are frequent variations in laws governing supervision, scope of practice, prescriptive authority and Medicaid reimbursement from state to state.

**Reimbursement.** In the Balanced Budget Act of 1997 (Effective January 1, 1998), Medicare reimbursement for both NPs and PAs was set at 85% of the physician's fee schedule, in most circumstances. This includes hospitals, (inpatient, outpatient and ER), nursing facilities, offices and clinics, and first assisting at surgery.<sup>8</sup> Outpatient services at offices and clinics receive 100% of the fee schedule if the following "incident to" provisions are met: 1) The physician is physically on site when the extender provides care; 2) The physician treats all new Medicare patients (extenders may provide the subsequent care); and, 3) Established Medicare patients with new medical problems are personally treated by the physician (extender may provide the subsequent care).<sup>9</sup>

According to the AAPA, forty-seven states cover services provided by PAs under their Medicaid programs at levels very close to those paid to physicians. Likewise, private insurers normally reimburse the services provided by PA's when they are part of the physician's bill.<sup>10</sup> However, it is important to clarify the reimbursement policies with each program directly.

**Implementation is key.** Once he understood the expanded roles and reimbursement potential of mid-level providers, CASS' President began to map out an action plan for his practice. First, he laid out the problem areas in the practice, and undertook a strategy to respond to each:

- **Hospital coverage:** The physicians had to be present for new consults and to perform their cath lab procedures; but it was the routine patient rounds and the tedious admission and discharge notes and discharge processes that were making matters difficult.  
♦*Solution:* CASS stationed a full-time PA at each of their main hospitals to manage all of the non-urgent patient care and administrative responsibilities. This eliminated a significant number of trips between the office and hospital and interruptions to patient care in the office, and enhanced discharge efficiencies, dictation, scheduling of follow-up appointments and communication with referring physicians.
- **Call:** In addition to their hectic office and hospital schedules, night and weekend calls had all but eliminated any semblance of a family life for the physicians.  
♦*Solution:* CASS implemented a "First Call" system, in which PAs screen all practice calls and triage consult requests and emergencies to the physician on call. This eliminated the call load on the physicians by 55-65%.
- **Patient office visits:** Schedules had become a mess. Patients were made to wait long hours as physicians were pulled in all directions; cancellations and rescheduling of appointments were becoming the norm, and backlogs of several weeks were now common.  
♦*Solution:* NPs and PAs are scheduled to manage as much routine patient care as possible. Some have their own office schedule. The cardiologists no longer feel like they are neglecting patients. In fact, they now have more time to attend to those patients who truly need their attention, and to monitor/supervise the routine care of their practice. Patients are happier because they are given timely appointments, and their physical complaints are more quickly attended to and resolved. Also,

physicians see new patients. The NPs and PAs see many of the routine follow-ups, with the physician seeing an established patient 1-2 times per year, and the NP and PA the other times.

- **Ancillary testing:** Like everything else, ancillary services were backlogged and turnaround had become very slow.  
♦*Solution:* NPs and PAs are scheduled to manage routine stress tests, PET scans, and to follow-up on routine lab and radiology tests. They also man the Coumadin/Lipid/CHF and Pacemaker Clinics. The cardiologists are still responsible for final interpretations, but this can be done at a time convenient for their schedules, or can be done in concert with their other office work schedules.
- **Declining income:** To everyone's dismay, all of their exhaustive efforts have resulted in reduced revenues, profits and personal incomes for the cardiologists. Some are a function of payers, but some are correctable.  
♦*Solution:* Refocusing the staff has resulted in significant volume and revenue increases for office and hospital visits, and the very lucrative ancillary testing procedures. Ultimately, this has translated into increased income for the cardiologists.

**Reinforced position.** The doctors of CASS grew to know that the office had to be the key focus in order for their practice to be a success. The office became the repository for all patient data and contact with the practice. However, in an effort to be everything to everybody, the emphasis had unintentionally evolved primarily to the hospital. Unfortunately, this caused them to sometimes neglect their office patients, and detrimentally impacted their morale and that of their staff. To make matters even worse, neglecting the office practice meant forgoing those lucrative office-based ancillary procedures. Working harder, but not smarter, the cardiologists were becoming demoralized and their incomes were shrinking -- a recipe for disaster.

That all changed with the inclusion of mid-level providers into their practice system. Not that mid-level providers are a panacea. However, the new structure allowed CASS to renew its design of an office-based, patient-focused practice. Competent professionals at all levels were where they needed to be, when they needed to be there. Yet this new focus did not neglect the hospital, it actually improved services there.

**Summary.** The use of mid-level providers in cardiology and cardiovascular practices is certainly increasing. The way these individuals are utilized, the skills they possess and the way they perform as part of the practice team are critical components in their successful deployment. One should use the same care and precision in selecting a mid-level provider as you would in selecting a future partner.

Indeed, your patients will almost come to view your mid-level providers as physicians and at the very least they must be used in a manner that enhances the doctor-patient relationship. These physician surrogates must understand clearly the scope of their responsibilities and importantly, reflect the philosophy and values of the practice and physicians whom they represent.

In closing, let me try to put the issue of mid-level providers in another perspective. Busy clinicians have a limited amount of time at their disposal. Mid-level providers afford a clinical practice an innovative advantage in managing time and effective use of resources. They are not meant to be a complete substitute for the physician in the physician-patient relationship.

In business, there is an increasingly higher value placed upon innovation. As a practice owner, one can approach revenue growth as a top line (increased gross) or a bottom line (more efficient) event. Perhaps it would be wise to view the use of mid-level providers as a "practice innovation" that will allow you to provide more services in a new way. Innovation usually boosts earnings, speeds growth, and provides competitive advantage over competitors and appeals to those who seek our care. In fact, the value of innovation has always been recognized by cardiologists and it is one of the reasons cardiologists usually are so quick to adapt to new technology. In this instance, the innovation is not technological, but process-focused. Successful and innovative practices distinguish themselves by:

- Creating and capturing new value for their patients in creative ways;
- Developing new products, services, processes or business systems that are viewed as valuable by their patients or referring physicians;
- Creating and fostering new rules and opportunities for competitive advantage; and
- Adapting new technologies that serve their patients and referring physicians well.

The road to a successful practice need not be viewed as one of mundane treadmill-like routine activity. Cognizant of the fact that the physician-patient relationship remains at the heart of our work, successful practices will go beyond traditional service delivery sparked by adherence to a vision and strategy that will build off a strong service relationship with their patients. Appropriately qualified mid-level providers will be a significant part of the clinical team for many practices now and in the future.

*"As many fresh streams meet in one salt sea; as many lines close on the dial's [sundial's] centre; so may a thousand actions, once afoot, end in one purpose. "*

**\*William Shakespeare**  
*Henry V, Act I, Scene ii*

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