

Nurse Practitioners and Physician Assistants Providing Primary Care in California Community Clinics

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ABSTRACT

As reported earlier, nurse practitioners (NPs) and physician assistants (PAs) play a critical role in the delivery of primary care in California, providing the majority of primary care services in over 20% of the state's community clinics. This follow-up, qualitative research explores how and why leaders in a sample of these clinics rely on NPs and PAs, in addition to physicians, as primary care clinicians. As described, these models help meet high patient volume in a cost-effective manner. Some of the opportunities and challenges of an integrated clinician model – staffing arrangements, oversight mechanisms, practice culture and ideas for making these models work even better – are investigated and described.

Background

Based on 2008 data collected by the Office of Statewide Health Planning and Development (OSHPD), colleagues from the Center for the Health Professions at UCSF previously reported that nurse practitioners (NPs) and physician assistants (PAs) were the principal providers of primary medical care – meaning they managed the largest share of primary medical care encounters – at over 20% of California's licensed community clinics. In other words, most of the primary care in one-fifth of the state's FQHC and FQHC look-alike clinics is being provided not by physicians (MDs) but by NPs and PAs. We undertook to better understand this phenomenon by conducting qualitative research among a sample of these clinics.ⁱ

Study Design

In early 2011, Center staff interviewed 22 representatives from eight clinics. Clinics invited to participate were drawn from a random sample of the clinics described above as reporting most of their primary care being provided by NPs and/or PAs. Project staff invited individuals from the clinics who served in roles such as Chief Executive Officer (CEO, or equivalent such as Executive Director), Medical Director (usually MD) and NP or PA clinician. We aimed to complete interviews with at least one person

Key Findings

- All of the individuals interviewed reported strong support for staffing models that include significant reliance on NPs and/or PAs to provide primary care.
- Most clinics in the study reported limited availability of clinicians willing to work at these sites. They found that they needed to define their pool of potential clinicians broadly to include NPs and PAs as well as MDs.
- All the study clinics faced extremely high patient demand. Having NPs and/or PAs on staff allowed the clinics to, for the most part, meet patient primary care needs.
- One of the key reasons why PAs and NPs play significant roles in community clinics as primary care providers is their cost effectiveness.
- While respondents reported that the current range of services NPs and PAs are authorized to provide was appropriate for practice needs, several clinic leaders questioned the usefulness of some requirements such as MD chart reviews for PAs.

in each of these roles at each clinic, although limited availability resulted in not having full representation of the three roles from all clinics. Many clinics were members of umbrella or parent organizations; when interviewing CEOs, we often learned about multiple sites including the one identified from the database as an eligible study site. All clinics were well-established, with most having been open and running for at least ten years. Clinics were spread geographically throughout California and were drawn from both rural and urban settings.

Study participants were asked a range of semi-structured questions designed to elicit perspectives on the value and challenges of relying significantly on NPs and/or PAs to provide primary care. Question themes included staffing models; differences between NPs and PAs; range of care provided, oversight and levels of autonomy; the practice culture and quality of the working relationships between providers; financing and billing; and approaches to challenges facing the clinics.

Making It Work

When asked to describe how the clinics made these staffing models work, study participants offered a broad range of practical and philosophical answers. Their responses can be grouped into several themes:

Staffing Models

Respondents reported strong support for practice models that integrated NPs and/or PAs as clinicians in primary care practices. The clinics interviewed had long, if not always, integrated NPs and/or PAs as primary care clinicians throughout the clinics' histories.

Inclusive staffing models were driven largely by provider supply. While it was reportedly difficult to recruit from any of these professions, physician availability was notably problematic. Given limited supplies of clinicians willing to work in the community clinics in the study sample, clinics looked broadly to physicians, NPs and PAs as potential primary care providers. Site representatives also reported that, due to extremely limited financial resources, they would likely not be able to afford to staff all clinical positions with medical doctors, even if supply of physicians was higher. Some clinic leaders noted that the integration of NPs and PAs as clinicians into the primary care team was a strong practice model and that they would

not necessarily choose to staff clinician positions only with physicians should supply and financial constraints not be challenges. However, clinic representatives also expressed concern over whether they could meet future demand, even with their inclusive staffing models, as patient volume continues to rise.

Respondents anticipate increases in coming years due to changing patient demographics and disease burden, economy, and expanded coverage under the federal Patient Protection and Affordable Care Act. Using an integrated, interprofessional staffing model will be necessary but possibly insufficient to keep the doors open in the future.

Ratios of physicians to NPs and PAs at the clinics interviewed varied and staffing mix was tailored to meet specific clinic needs. Variation was also reported within larger organizations to which individual clinics belonged. Several clinics had multiple sites and staffed each site differently. A common model was to have the main clinic site staffed with a nearly equal mix of MDs and PAs or NPs and the smaller satellite clinics relying on higher ratios of NPs or PAs. In these cases, physicians may play critical roles in consulting and responding to questions from the NPs and PAs, handling complex cases and oversight as needed; however, the NPs and PAs provided the bulk of routine care.

In some clinics, clinician providers (MDs, NPs, PAs) worked within a partnership model, sharing patients as needed and as appropriate. In other clinics, each provider had his or her own panel of patients for which they were responsible, checking in with their colleagues as needed. All sites reported collegial, interdependent arrangements for all clinicians and several noted that the NPs and PAs – like MDs – work fairly autonomously on most matters, but especially if they were running specialized centers (e.g. school based mobile van or women's center).

Differences between NPs and PAs

While most of the sites interviewed had both NPs and PAs on staff, some sites employed only one or the other in addition to physicians. Perspectives varied on whether differences between PAs and NPs mattered for the primary care services being provided. In hiring decisions, in addition to an individual's interest in working at a clinic, his or her experience, personality, strengths and competence were extremely important – often more so than whether their professional training

was as an NP or an PA. However, at least one CEO commented that the clinic preferred PAs because their medical model training was more familiar to the physicians who would be supervising them. On the other hand, several respondents reported preferring NPs due to their prior nursing experience. Other reasons mentioned for preferring NPs included the exclusion of PAs from federal financial incentives for meaningful use of electronic health records; and somewhat fewer regulatory constraints (e.g. MDs must conduct some PA chart reviews).

Clinician experience was highlighted by respondents as critical. A common response from CEOs and MDs was that NPs or PAs hired straight out of training programs initially had difficulty with independent clinic work. Part of the challenge was the need to gain confidence and experience with the types of clinical issues presented and part of it was that the training did not necessarily prepare them for clinic work. While perspectives varied somewhat on the quality of preparation (education and training) for NPs and PAs and readiness to practice in primary care settings, a few noted that recruiting was easier when NP or PA programs were located in close proximity to the clinics.

Range of care provided, oversight and levels of autonomy

As noted above, clinic respondents stated that having NPs or PAs as part of the provider team was a key factor in the ability to meet the demands for maintaining or increasing patient volume. Based on the number of physicians employed by the clinics, physician-only staffing models would not be able to meet patient demand. In addition to better meeting patient volume, expanded staffing arrangements also allowed some clinics to stay open for more hours, set up evening and weekend clinics, establish special chronic care clinics or services (for example diabetes care) or expand with small satellite sites.

As clinician colleagues with physicians, NPs and PAs had autonomy within their respective regulatory requirements to serve as primary care providers, offering patients the full range of services associated with primary care. In some clinics, when possible and appropriate, patients with more routine care needs might be scheduled with NPs and PAs, freeing time for physicians to handle the more complex cases. Generally, both PAs and NPs could, within relevant

regulations, see and treat patients, conduct minor and routine procedures, order tests, prescribe medications, and make referrals to specialist physicians and other clinicians. All study participants stressed that while NPs and PAs can make specialist referrals, clinicians of all professions (including MDs) at community clinics face tremendous challenges in finding specialists willing to see the clinics' patients. Wait times of six months or more were reported for some specialty care referrals.

All sites relied on the ability for NPs and PAs to provide primary care services on their own within the clinic setting and within current scope of practice laws. Respondents' perspectives on scope of practice varied. Some participants reported current laws being fine for their clinic's needs; some reported that laws could be expanded and updated; and others reported that they were confused by the differences in laws between PAs and NPs when it appeared, to the study participants, that the competencies of these two professions were comparable. No study participants thought that the current scope of practice laws were too broad. All NPs and PAs practiced with state-required written documentation outlining their practice authority at that site and, if required, under their supervising physician. Terms in these documents reportedly ranged from quite broad to fairly detailed.

Financing and billing

For the clinics interviewed, employment of PAs and NPs as primary care clinicians made sound fiscal sense. Salaries for NPs and PAs are generally lower than those for physicians but NPs and PAs can bill at the same rate as physicians for reimbursable clinical services, making NPs and PAs likely choices as complements to the physician workforce at a clinic. We did not collect actual salary information, however each site reported higher salaries for MDs than for NPs or PAs, even if the productivity expectations were the same. The higher pay was attributed to the added MD responsibility for oversight, supervision, and consultation to the NP and PA providers. Clinics also reported the fiscal reality that it was necessary to pay competitive wages in order to attract primary care physicians to clinic work.

Most services provided by NPs and PAs at the study clinics are paid at the same rates as those by physicians. Specifically, FQHCs are eligible for "Section 330" funding.ⁱⁱ Under this program, payments

to NPs and PAs are the same as those to physicians. For services provided to Medicare beneficiaries, payments to NPs or PAs are the same as those to physicians if the care provided by the NP or PA is “incident to” the diagnosis, treatment and care provided by the physician for that patient. Some dilemmas do arise for specific physical examinations for certain purposes or agencies. For example, under current laws and regulations, physical examinations for the Department of Motor Vehicles or for immigration must be done by a physician to be paid. Perhaps the more significant financial challenge reported is that not all care provided at these clinics is billable by any provider and not all submitted claims are paid. These concerns may be exacerbated by worsening fiscal challenges and increasing demand from patients with no insurance which, some fear, will put increased burdens on the safety net providers including community clinics.

Culture and quality of the working relationships between providers

Study participants spoke to the importance of the practice culture in operating a successful clinic. Key to this was a commitment to team work, a strong sense of collegial work and clinician support for one another. Trust, which grows stronger over time, was reported to be critical. Respondents spoke of the importance of the focus being on the patient with care provided by a team of clinicians as well as the importance of a culture of inclusion. All clinicians were expected to respect and work well with each other, despite their varying professional degrees and educational backgrounds. Several study participants offered stories of physician clinicians who were asked to leave the clinic because of their inability to see NPs and PAs as peers and clinical colleagues. Aside from these relatively rare experiences, the overall quality of the working relationships among clinician providers was reportedly very high.

According to study respondents, a good culture also included the equitable treatment of clinicians. When both NPs and PAs were employed in a clinic, clinic leadership reported that treating NPs and PAs equally – in terms of salaries, responsibilities and oversight requirements – was important in maintaining collegial and professional atmosphere. Although some regulations might require a higher level of oversight or supervision for one profession compared to the other,

the clinics often aimed to standardize within the law if possible and reasonable. For example, some clinic medical directors chose to review and sign patient records for NPs and well as PAs although it is only required for PAs.

Clinic leadership found that investment in NPs and PAs was important and contributed to the viability of the practice. Clinicians might arrive at the clinic with a range of different experiences, and respondents noted the significance of on-the-job training and the need for supervision of NPs and PAs at the beginning of each one’s tenure at the clinic. Some clinics, particularly those in rural areas, noted the importance of encouraging and supporting local individuals in their pursuit of clinical diplomas or certificates at NP or PA professional programs, because of the potential for them to return to the clinic to practice. Several offer training sites for professional programs and several others mentioned a desire to build partnerships with PA or NP training programs.

Some clinic leaders encouraged specialization (not necessarily certificate-based) for clinicians to help develop expertise in fields needed by the patients. Professional development and career flexibility were important factors in being able to recruit and retain high quality professionals. In some clinics, experienced NPs and PAs play top leadership roles – such as ‘medical director’ at one site and ‘clinical director’ at another – in addition to serving as primary care clinicians. Such examples offer some evidence that leaders at these clinics continued to demonstrate long-term commitment to supporting the clinicians and to supporting the decision to integrate them into the practice as full primary care providers.

Clinic representatives also noted the significance of the patient experience and of community relationships. These factors were strengthened when the clinics were able to meet patient demand needs with competent, reliable and consistent staff. According to respondents, patients were reported to be quite satisfied with NPs and PAs as primary care providers in all the clinic sites. Patients were reported to most value a consistent relationship with “their provider” whether it was a physician, PA, or NP. Some patients reportedly preferred NPs or PAs because they had experienced somewhat longer visits with these clinicians.

Challenges on the Horizon

While some of the challenges facing the community clinics in this study – such as patient volume and provider costs – have been addressed to some degree by the integration of NPs and PAs as primary care providers, other challenges continue or loom on the horizon. In addition to ongoing funding problems, increasing patient demand, and specialty referrals noted above, clinics highlighted the challenges of the patient populations they serve as well as space and facility shortcomings. They also pointed to the obvious need to begin or complete the implementation of electronic health record systems but reported limited success identifying sufficient funds, expertise, and full receptivity among providers and staff to make the shift.

Study participants at community clinics did describe several promising avenues in implementing the new care processes such as chronic care management. They noted the continuing need to address some specific challenges, including recruiting, methods of assigning patients to clinicians, and external policy rules regarding scopes of practice.

Primary Care Provider Recruiting is Enhanced by Support for Clinical Residency Training

Rural clinics in particular, reported difficulty in recruiting all types of primary care providers; MDs, NPs, and sometimes PAs. Having a relationship with a primary care training program that supports residency training at the clinics was reported as a good source of providers and often leads to long term employment for the provider who has undergone extensive training and formed relationships at the clinic and in the community. It takes a committed training program in partnership with the clinics, and funding support, to create and support those relationships.

Clinics reported few clinical criteria to help assign patients to a provider type (MD, NP, or PA)

Most clinic respondents reported that they do not have standard clinical criteria to assign patients to either MDs, NPs, or PAs. While some of the participant clinics assign a panel of patients to all three types of providers, there were few criteria used other than provider availability and a rotation of assignments. Those clinics that had some criteria for assignment

included provider specialization such as an NP who specialized in well woman visits. Walk-in patients at most clinics are seen by the next available provider regardless of the practitioner's credential.

Scope of Practice Limitations Beyond State Practice Acts

While few clinics reported clinic-initiated or state-based practice act limitations in the scope of practice for NPs or PAs, respondents reported that other health care organizations' policies and public sector payment regulations have an impact on the ability of the clinics to fully utilize NPs and PAs. Two examples illustrate the broad ranging impact of those regulations. One clinic reported that NPs could not carry a panel of patients because they were not able to obtain admitting privileges at the local hospital. In that clinic's practice, providers are expected to follow their patients through inpatient care. The restrictions from the hospital prevent the clinic's NPs from caring for a panel of patients, which is that clinic's preferred model of care. In another example, PAs have reportedly been omitted from the list of providers who can receive federal incentives through their meaningful use of health information technology and electronic health records. This has a negative financial impact on clinics that utilize PAs and may impact the hiring of PAs.

Study Limitations

Results in this research brief are based on a limited sample of clinics that met the study criteria. Although a random selection process was used to identify possible participant clinics that met selection criteria, clinic representatives had the option to participate or not. As such, a sampling bias may be present that reflects clinics willing to discuss their experiences with the researchers. In addition, the sample of study candidates was selected because the database indicated that a majority of the care in those clinics was provided by NPs or PAs. The findings may not apply to other clinics with differing staffing models. Finally, the study was limited to clinics based in California. Future studies could benefit from a broader selection of clinics with differing staffing models and clinics representing other regions of the country.

Conclusion

This issue brief reports the findings from qualitative research conducted on a sample of community clinics in California where PAs or NPs provide the majority of primary care. Based on interviews with clinic representatives, a better understanding is offered as to how these practices work, how NPs and PAs contribute to the practices, and ongoing challenges that might be addressed with new solutions. While the details and perspectives vary among the clinics regarding staffing ratios, differences between NPs and PAs, and ideas for making a strong practice culture, it is clear that at least some clinics in California have successfully integrated NPs and PAs into their primary care practices and lessons can be learned by other practices from their experiences.

Notes

- i. Bates T, Chapman S. (2010) *Physician Assistant and Nurse Practitioner Staffing Patterns in California's Licensed Community Clinics: 2005-2008*. San Francisco: Center for the Health Professions, University of California, San Francisco.
- ii. Section 330 of the Public Health Service Act. Title 42 US Code Chapter 6A. Section 330 of the Public Health Service Act defines federal grant funding opportunities for eligible organizations to provide care to underserved populations. Community Health Centers that are Federally Qualified Health Centers (FQHCs) are eligible to receive “§330” grants.

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