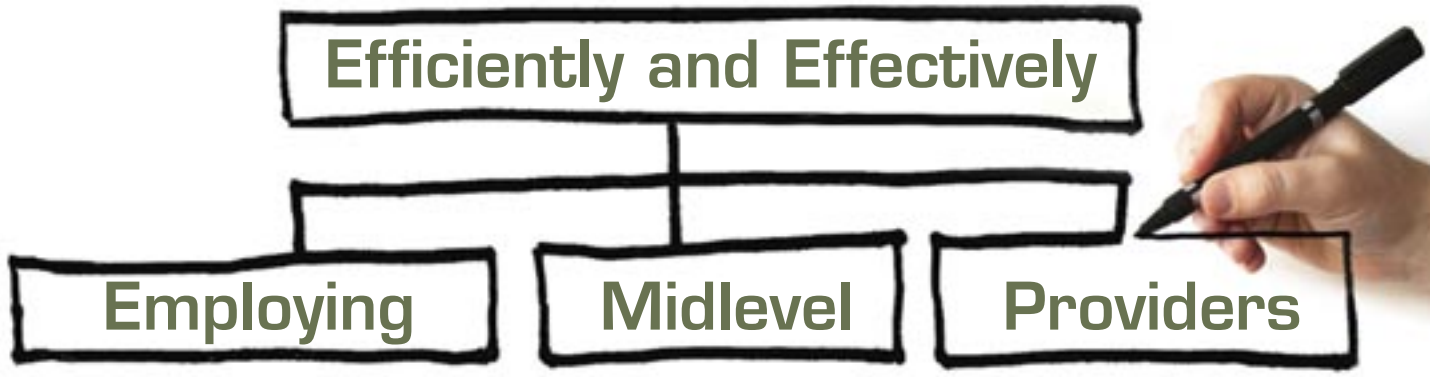
Efficiently and Effectively Employing Midlevel Providers



– Darin E. Libby and Kevin J. Duce

The Challenge

On March 23, 2010, President Barack Obama signed into law a comprehensive health reform, the Patient Protection and Affordable Care Act. While it is still relatively unknown what the exact impact will be to oncologists, it is certain future changes will place added pressure on reducing the cost of care and will reward providers who are able to demonstrate better disease management. Specifically payment reform, such as bundled payments, will call for coordinated delivery models that leverage physician expertise in specific clinical areas, while simultaneously managing care across multiple modalities in an efficient manner. With these industry changes, health-care providers, including oncologists, will be required to provide care in a more efficient way to remain profitable.

As a result of health-care reform, broader insurance coverage will increase demand for physician services. For oncologists, the challenge is compounded by the imbalance in supply and demand, as the number of medical oncologists entering the workforce is not sufficient to meet future demand. Based on recent statistics, demand for oncology services is projected to increase by 48 percent by 2020, while patient visit capacity is projected to grow by only 14 percent.[1] The result is a projected shortage of 2,550 to 4,800 oncologists by 2020.

In order to respond to payment reform and increased patient demand, oncology groups will need to incorporate more midlevel providers (e.g., nurse practitioners [NPs] and physician assistants [PAs]) into their practice. The most successful oncology practices will take proactive steps to develop more efficient and coordinated care models that better leverage physician and midlevel provider resources. This article examines key steps to efficiently and effectively utilize midlevel providers in care team models.

Scope of Practice Considerations

Midlevel providers can provide routine care, monitor ongoing treatment plans, and provide patient education, freeing the physician to attend to more complex diagnoses. NPs are independent practitioners who can diagnose and treat acute and chronic conditions, prescribe medications, update charts, and manage patient care without supervision.[1] PAs can provide treatment, coordinate care, and provide patient education, but require supervision from a physician. Each state has different regulations regarding the scope of practice for midlevel providers, such as the types of medications that can be prescribed, the types of services that can be provided independently, and the level of supervision required by the physician. Also, states have differing regulations regarding the ability of midlevel providers to bill independently for their services. As a first step, it is recommended oncologists consult the specific regulations of their state to define clinical practice parameters for their practice. In 2007, the *Journal of the American Academy of Nurse Practitioners* ranked the 50 states and District of Columbia based on the practice environment and consumer choice related to the NPs' scope of practice. The rankings considered the NPs' professional autonomy, access to related health services, ability to bill independently, and ability to prescribe medications. Table 1 summarizes several states with the most conservative and liberal practice environments for NPs.

Table 1: NP Practice Environment[3]

Most Conservative	Most Liberal
Alabama	Arizona
Missouri	Washington
Florida	Wyoming
Georgia	District of Columbia
Illinois	New Hampshire

When it comes to using midlevel providers to leverage physician expertise, medical oncologists are ahead of their physician colleagues in most other medical specialties. In 2009, the Community Oncology Alliance partnered with Avalere Health, LLC, to conduct a study to understand the components of cancer care provided by community oncologists and their associated

costs. Based on the survey responses, the average practice had approximately 0.4 midlevel providers per oncologist. However, a growing number of larger multidisciplinary cancer centers are employing higher ratios. Midlevel providers are actively involved in the clinical and operational components of the practice. Table 2 summarizes the allocation of midlevel time by care category.

Table 2: Allocation of Midlevel Time[4]

Category	NP	PA
Infusion Room-Related Services	13.5%	10.2%
Other In-Office Services	66.3%	62.9%
Hospital Services	6.2%	17.3%
Ancillary Services	1.1%	2.5%
All Other Activities	2.2%	1.6%

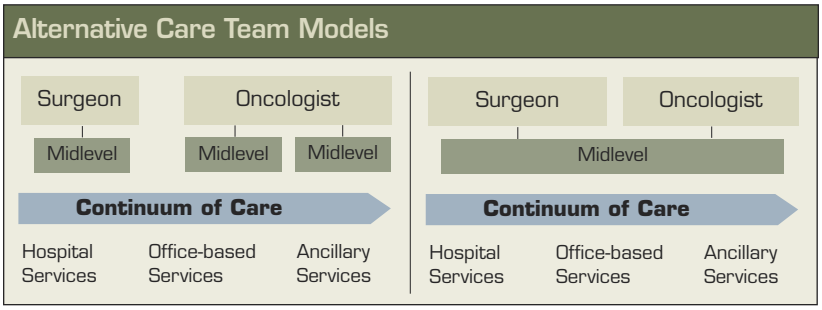
While the average staffing ratio in the Community Oncology Alliance was 0.4 midlevel FTEs per oncologist, another study showed a range of 0.2 to 1.0 midlevel providers per oncologist.[5] According to the latter study, effectively utilizing clinical staff contributed to more productive practices. Practices that utilized midlevel providers saw approximately 21 percent more new patient visits per oncology physician annually.

Benefits to the Practice

The obvious benefit of midlevels is to add a lower-cost provider to the practice and leverage the physician's time for more complex clinical activities. For instance, the average midlevel salary is $85,174,[6] which is approximately a quarter of the national median salary for an oncologist. In addition to the lower salary expense, midlevel providers can generate revenue for the practice that surpasses the total cost of supporting the position. On average, a midlevel provider practicing independently in an office setting can generate up to 85 percent of what a physician would be reimbursed for providing the same services. Based on MGMA median collections, visit volumes, and overhead rates, a midlevel provider would only need to see approximately six or seven patients per day to cover his or her salary and benefits.

However, beyond the direct economic benefit, using midlevel providers allows the oncologist to leverage his or her time to be more productive and focus on care management for a broader base of patients and devote time to more complex diagnoses. This will become increasingly important under payment models that fix payments to the episode of care or place the provider at risk for costs and quality. The new legislation provides funding to test new innovative payment models within

the Medicare system. One oncology-specific model is based on aligning nationally recognized, evidence-based guidelines of cancer care with Medicare payment incentives in the areas of treatment planning and follow-up care for Medicare beneficiaries with cancer. A key to better coordinating care is to establish a care team model. One alternative care team model involves using midlevel providers in specialized focus areas; another uses the midlevel provider as a generalized treatment provider and care coordinator. Under the specialized model, the midlevel provider focuses on a specific setting or treatment area (e.g., office-based, hospital-based, or ancillary services). Under the generalized model, the midlevel provider works with a physician to provide treatment along the entire continuum of care. The following figure depicts the two alternative care team models:



Developing a care team model also increases the quality of care given to patients. Each member of the care team can contribute to and collaborate on critical elements of the care plan. Oncologists and midlevel providers, along with other specialists, can work collaboratively to discuss the initial treatment and changes in the status of treatment. Based on the direction and ongoing management by the physician, the midlevel providers can then provide ongoing treatment and patient monitoring independently, within their scope of practice. Practices that begin to expand the role of midlevel providers will become more successful in this new legislative environment. Midlevel staffing ratios of two or three midlevel providers per oncologist will allow care teams to expand coverage and access.

As an example, in anesthesia the care team model has worked effectively, with typical staffing ratios of three certified registered nurse anesthetists (CRNAs) per anesthesiologist. The anesthesiologist is required to be present during critical elements of the case (e.g., induction, emergence), but the CRNA manages the patient independently during other components of the surgery. While the regulations and practice environment are different in oncology, a similar care team model can be applied that allows the oncologist to focus on critical aspects of the treatment plan (e.g., new patient visits, changes in status) and the midlevel providers to oversee ongoing treatment, care coordination and patient education.

Best Practices

Midlevel providers can extend physician coverage, lower the cost of care, increase revenue and improve patient satisfaction when they are successfully integrated into a team care model. Given the importance of continuity of care with cancer patients, care team models can assign midlevels to specific patients to guide them through treatment plans. In multidisciplinary centers, this is an effective way to balance continuity of care with segregation of physician expertise for different treatment modalities. In order to achieve these benefits, oncologists should follow these best practices when integrating midlevel providers into the practice:

- Research state regulations regarding scope of practice to ensure the midlevel providers are being utilized to the full extent of their training. This includes understanding billing requirements so the practice can maximize revenue for the services provided by its midlevel providers.
- Clearly define roles and responsibilities within the care team and identify the expectations for midlevel providers. The definition of responsibilities can evolve over time as physicians mentor their midlevel providers and become more comfortable with delegating duties.
- When utilizing a care team model, remember that it is important to communicate with the patient and introduce each member of the care team at the outset of a treatment program. Patients are more satisfied with the care received when they understand how the care team will work together and who will be involved in each aspect of their treatment.

In the new era of health care reform, oncology practices will need to re-evaluate how resources are utilized and identify more efficient and effective ways to use midlevel providers and care teams to coordinate care delivery. H

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