

## APPENDIX B

### Summaries of Best Informant Meetings on Non-Physician Clinicians (NPCs) in Texas

#### LUBBOCK NOTES – May 9, 2001

##### Factors Affecting the Supply of NPCs

- In rural health centers, a physician/NPC blend works well.
- Initially, there was public resistance to NPCs, but this dissolved quickly, and now many patients prefer NPCs.
- The general quality of nurse practitioners (NPs) and physician assistants (PAs) is very high. Patients perceive NPs to be more skilled than PAs, although initially the reverse was true.
- NPs and PAs bring stability and continuity to rural areas, as opposed to new young physicians who have historically been “in and out.” Also, NPs and PAs can influence physician retention—physicians can receive additional supervisory pay with the restructuring of physician reimbursement.
- RNs are becoming NPs because they are fed up with hospital work.
- Shortages are primarily with physicians, but also to a lesser extent with NPCs.
- Some physicians are moving to underserved areas to get out of managed care in cities (lower penetration of managed care in underserved areas).

##### Barriers to NPC Supply

- Clinical rotation sites are becoming hard for NPC students to find—this will be problematic if educational programs are expanded to increase supply.
- NPC hometown is important in determining subsequent practice location.
- Hiring of certified nurse midwives (CNMs) is made difficult by physician resistance.
- Hospitals in rural areas tend to hire physicians who will deliver babies—since there are few births in rural areas, the physician workforce can typically handle them.
- Some physicians do not accept Medicaid patients. CNMs fill a void in rural counties, since 80% of births there may be Medicaid-funded.
- The Balanced Budget Act of 1997 changed the landscape (only rural health clinics with under 50 beds could be reimbursed):
  - Larger facilities closed shop, forcing relocation of NPCs to physician group practices and emergency rooms.
  - Continuity of services in rural communities is a problem. Rural patients are wary of new rural health clinics, which are often “here today, gone tomorrow.”
- Medically Underserved Area (MUA) and Health Professional Shortage Area (HPSA) designations have a critical impact on health care in rural West Texas.
- Rural health care seems to be a “house of cards” destined to collapse as soon as they lose their MUA and HPSA designations (public funding draws physicians and NPCs into MUAs/HPSAs, which then cease to be MUAs/HPSAs).
- Need to plan for rural health care reimbursement after MUA/HPSA designations are lifted (perhaps support from local communities, etc.).

### *NPC Scope-of-Practice*

- NPs tend to be concerned with prevention, which may ultimately make NP-based practices more cost-effective in the long run:
  - PAs are trained, as are physicians, according to the *medical model* (disease-treatment), which is vastly different from the *nursing model* with its emphasis on patient education and disease prevention.
  - *Anecdote*: In one instance, the effectiveness of NPCs in lowering the rate of infection in nursing home patients led to a backlash by administrators who saw their revenues decline as their patients got healthier and left.
- Scope-of-Practice issues are highly charged politically, even though NPCs are generally viewed as cost-effective:
  - There is a strong Texas Medical Association (TMA) lobby opposed to the broader use of NPCs (NPs, prepared according to the *nursing model*, will have to negotiate with the physician-based TMA on Scope-of-Practice issues).
  - Texas physicians, apart from the TMA, will oppose an increased Scope-of-Practice for NPCs.
  - Less-competent physicians tend to have more problems accepting NPCs.
  - DOs and foreign MDs also tend to have more resistance to NPCs.
  - Older MDs are also less accepting of NPCs (rural physicians tend to be older, 36% are 55+).
- Existing confusion on Scope-of-Practice guidelines has made collaborative practice agreements difficult to negotiate (NPCs tend to resent agreements that allow them to do only part of what they were trained to do).
- NPC privileges vary by hospital and are difficult to change, whereas changing the bylaws of long-term care facilities to grant additional privileges to NPCs is less of a problem.
- NP-based practices cost nearly as much as physician-based practices, with PA/NP income in Texas approaching physician income. [*Some disagreement here—others argued that using NPCs was cheaper than using physicians.*]
- Changes to limits on NPC prescriptive authority may not ultimately benefit rural areas since small-town pharmacies are disappearing. More cooperative agreements between rural health clinics and pharmacies may be helpful.
- PAs can be reimbursed as agents of physicians, but not independently:
  - Medicaid reimbursement is 100% if the physician is in the office, 85% if not.
  - Patients must see the physician first.
- Practice volume is a requirement for reimbursement by Medicaid and Medicare.
- Financial reimbursement will be a big problem in the future for NPs/PAs.
- It was noted that no physicians were in attendance, but that they should somehow be included as part of the project (it will lack credibility without them).
- 
- 
-

**Access to Health Care and NPCs**

- Rural areas will probably never see the availability and quality of health care in metropolitan areas for several reasons:
  - The small rural populations are scattered over too wide an area.
  - Rural incomes tend to be lower.
  - Rural ethnic populations tend to feel uncomfortable going to multicultural central facilities for treatment.
  - Illegal aliens working on rural farms fear coming forward.
  - Illegal aliens (who do not have social security numbers) cannot be referred.
- Border areas are very accepting of NPCs (migrants from other countries are generally happy to see any kind of health care provider).
- There are probably no good quantitative data out there demonstrating that NPCs have actually improved the overall health care of the population.
- NPs/PAs seem to bring stability to rural communities, causing physicians as well to stay and to bond with the community.

**LAREDO NOTES - May 16, 2001****Factors Influencing the Supply of NPCs**

- Expanded PA programs in Texas will increase PA supply. There are plenty of clinical rotation sites available for PAs.
- This is not true for NP programs:
  - NP preceptors are in short supply (some physicians feel their schedules are “burdened” by NP students).
  - Lack of preceptors makes NP clinical rotation sites difficult to find.
- Physicians and hospitals need to be educated about the benefits of having NPs on staff. A true *collaborative model* (physicians and NPCs collaborating in patient care) takes time to evolve.
- CNMs encounter resistance in the Rio Grande Valley from family practice physicians who practice obstetrics and resent the competition.
- CNM pay is very low in the Valley.
- Lay midwives:
  - Have less cumbersome practice restrictions.
  - Tend to treat patients with little money and no means of reimbursement.
- There seem to be plenty of CNM education programs available.
- Sex discrimination (against female NPs and CNMs) exists. Males receive better salaries, especially new male PAs.
- The public tends to prefer NPCs because they spend more time with patients and can communicate better.
- Hospitals and physicians are becoming more receptive to NPCs.
- RNs flock to NP programs because they want to become more autonomous.
- More subsidies (scholarships, loan forgiveness, etc.) are needed for NPCs:

- It is much easier for medical students to get financial support for their education than it is for NPCs.
- NPs must be very committed to finish their educational programs because financial support is lacking.
- Government assistance for CNMs has dried up.
- Present reimbursement policies are affecting the demand for NPCs:
  - Reimbursement is a big struggle for Advanced Practice Nurses (NPs, CNMs, etc.), especially with 3<sup>rd</sup> party payers (but NPs are reimbursed pretty well in Laredo because the big three insurers do it).
  - PAs are reimbursed 100% as part of a physician's practice, NPs less.
  - NPCs are reimbursed well in states where reimbursement is mandated
  - Texas is behind in this respect since reimbursement is not currently mandated.
  - Reimbursement is problematic in those states where "incident to" reimbursement (as incident to a physician's practice) is the norm.
  - NPs are now reimbursed at 85%, up from 65% previously (but NPs are reimbursed at 100% in rural health clinics).
  - High patient volume is needed for 100% reimbursement.
  - Current reimbursement practices tend to make patients more likely to see physicians over CNMs.
  - Some birth centers are closing and CNMs are moving to hospitals because of better reimbursement.
- Bed-limit-tied reimbursement is not having severe effects on rural health clinics in the Valley (although funding is reduced, they are not closing down):
  - Rural health clinics compensate by generating additional revenue from lab fees.
  - Care at rural clinics costs less than care at alternative health care settings (i.e., hospital emergency rooms).
- In some managed care settings, NPs are being utilized as "cash cows":
  - Their practice is tightly regulated and limited in scope.
  - They are required to see 75 patients/day in managed-care settings to meet their volume requirements.
- Such practices also have undesired negative effects:
  - No time for in-depth patient counseling, education, and disease prevention.
  - Fewer students are entering NP programs because they fear such practice restrictions once they graduate.
- Managed care has reduced the quality of patient care and has reduced the number of NPC providers, since preceptors have less time to mentor in managed care settings.
- Cost of malpractice insurance is high for CNMs (but is less of a problem for NPs and PAs).
- It might be possible to increase the supply of Texas PAs by recruiting physicians from Mexico, but there are a number of obstacles:
  - The TMA would resist such a program.
  - Mexican physicians will have problems with medical terminology in English, making it difficult for them to pass U.S. board exams.
  - Mexican physicians are more specialized, their education not as well-rounded.

**Scope-of-Practice Legal Issues**

- New CNMs will now need a Master's degree:
  - This will be a barrier in the border region, whose RNs tend to have Associate Degrees only.
  - The requirement of a Master's degree might further reduce the opportunities for minorities to enter the profession.
  - On the other hand, advanced degrees will give NPs and CNMs more respect as health care providers.
- NPCs need to work with employers to build alliances between MDs and NPCs:
  - Nurses need to stick together for positive change to occur (unity has been a problem in the past).
  - Nurses need this unity to be effective in negotiating with the TMA.
- Although prescriptive authority is broader now, it still needs to be expanded:
  - Prescriptive authority is now site-related (although in underserved areas, this limit does not apply).
  - Prescriptive authority for narcotics is needed (although CNMs already have this authority).
- The level of physician oversight has been reduced.
- Current pending legislation on controlled drugs will be beneficial.
- It is hard to attract faculty for NP programs because the salaries are pitiful.
- Some nurses move into PA programs to get more money.
- Most hospitals do not allow NPs or PAs to admit patients.
- There does not appear to be a severe lack of pharmacies along the border.
- The drug formulary is a problem for NPs. Reimbursement practices only specify certain drugs, which may not be the best ones for patients.

**Influence of NPCs on Access to Health Care by Underserved Populations in the Border Region**

- Federal rural health clinics and special incentive programs are bringing NPCs to the Valley.
- Viable indicators of NPC influence:
  - Higher patient satisfaction:
    - Less waiting time.
    - Appointments sooner.
    - Better patient compliance.
    - Greater accessibility to health care.
  - Better preventive care and education.
  - Better communication.
  - Fewer lawsuits.
  - Reduced utilization of Natal Intensive Care Units (far fewer at-risk babies).
  - Better prenatal care with women's health care more accessible.
  - NPs provide more stable care in underserved areas:
    - Deliver medicines to patients.
    - Help with transportation to medical appointments.
  - Reduced ER visits.

- Although many chronically ill patients are served, bad medical outcomes are often avoided (NPCs “catch things” early).
- Better patient education and continuity of care.
- Reduced number of unplanned pregnancies, decreased family size, and better family planning.
- Funding for medical care is a major problem, especially for “colonia” residents, many of whom are illegal aliens and cannot afford to take time off from work. A high percentage get their health care in Mexico, where office hours are typically more accessible for working people.

### Future

- There needs to be increased public awareness concerning NPCs.
- Health insurance carriers will have to become better informed about NPCs.
- NPCs will have to educate physicians about the value they can add to their practice.
- NPs need to be proactive in seeking to improve the drug formularies of 3<sup>rd</sup> party payers (so that they can choose better drugs for their patients).
- The NP role is still evolving and has not yet achieved its full potential.
- Reimbursement is the underlying key to everything.

## **AUSTIN NOTES – May 23, 2001**

### Supply of NPCs

- Market demand is going up as public awareness and acceptance increases.
- As health care reform continues, political and economic realities favor an increasingly important role for NPCs in improving health care access and delivery to the population.
- There seems to be a slight PA faculty shortage.
- The aging RN faculty and faculty salaries are problems affecting supply:
  - Because NPs/ and CNMs now need Master’s degrees, more faculty with PhDs are needed.
  - RNs typically need 10-15 years of practice experience before they are ready to become nursing faculty. Since new RNs are starting out older than in previous years, it is less likely that they will ever become faculty.
  - NPC faculty generally have to take a pay cut along with their faculty position.
- NPs have wider practice opportunities in the marketplace.
- Opportunities for NPs in independent practice have led to a surge in their numbers (by RNs seeking more autonomy).
- New BSN nurses who want advanced degrees (as now required for NPs and CNMs) generally go straight through. In the past, it was desirable to have several years of practice prior to entering graduate school.
- RNs have to give up 1-2 years of salary to become an NP or CNM, which works against workforce recruitment.
- One-third of PAs come from nursing.
- In 1995, prescriptive authority was a workplace inducement for PAs.
- In 1997, the Balanced Budget Act flattened PA salaries and PA supply.

- Outcomes evidence shows PAs and NPs provide services equivalent in many cases to what physicians provide.
- With a *productivity model* of care, the required high patient volume becomes a practice burden. NPs are being required to see as many patients as physicians do.
- There are 16 types of “first contact” providers in the U.S. Reimbursement patterns generally determine the local availability of the various types of providers.
- There is a high demand in urban areas for indigent health care. Historically, resident physicians in hospitals were the “slave labor” that met this demand. Since physician intern hours are now limited, NPCs fill the gap. The NPC professions were “developed to care for indigent patients.”
- Physician practices are opening up to NPs and PAs. Physician acceptance of NPCs has increased considerably in the past 10 years.
- Physicians can hire NPs for lower salaries than physicians, so NP demand has increased.
- Becoming a physician is not perceived to be as attractive as it once was (the work schedule is too demanding). NPCs are taking up the slack.
- There is less of a demand for NPs and PAs in Austin with its high proportion of specialists (as opposed to primary care providers).
- In 1995, the Omnibus Act encouraged economy of practice, and hence increased utilization of PAs and NPs.
- Providers will never be reimbursed as much as they should be.
- Loan repayment plans exist for PAs, but not for NPs.
- Communities need to become more involved in subsidizing their health care costs (not enough State funding to cover all health care needs—additional physicians, NPCs, etc.).
- Since physicians are required to supervise NPCs in rural areas, a local physician shortage will also affect the utilization of NPCs there:
  - Rural health clinics are reimbursed for 85% of the physician’s rate, so many clinics will not survive.
  - Rural PAs are predominantly male. If the increasingly female PA workforce is less likely to move into rural areas, rural areas may face PA shortages in the future.
  - The medical profession has been pretty good at recruiting promising students from rural areas and providing incentives for their education. These students are much more likely to practice in rural areas.
- PA demand in Texas is high (maybe the highest of any state):
  - Texas PA salaries are the highest in the nation.
  - Texas PAs lead the country in job offers per graduate.
  - Texas PAs generally remain in Texas after graduation (80% are still here 10 years later).
- Availability of PA preceptors does not seem to be a problem. [*Some dissension here.*]
- Availability of NP preceptors is a problem (preceptors can be reimbursed for medical students, but not for NP students).
- Federally funded Area Health Education Centers (AHECs) have lost some funding for placement of PA students. AHECs compete with non-AHEC programs for preceptors.
- CNMs getting full access to hospitals is an ongoing problem (hospitals do not consider NPCs “regular staff” on a par with physicians).
- The public is creating the demand for more NPs.

**Scope-of-Practice Legal Issues**

- With the growth of managed care, it is becoming more and more cost-effective to use NPCs.
- Continuity of care is threatened by provider lists (NPs must be listed to generate income, but it is difficult to become listed).
- The volume of paperwork is a limiting factor for smaller practices.
- CNMs have far fewer practice restrictions in rural counties.
- Not all billing offices are clear on proper billing procedures. For example, the Medicaid reimbursement limit for NPCs (85%) is sometimes also applied to private insurance claims, for which this is no such limit.
- The 85% figure was a political compromise. In actuality, NPC costs are about 95% of physician costs.
- The 85% figure will not soon change. [*Strong agreement here.*]
- The Medicaid “incident to” reimbursement provision obscures accountability (NPC costs are billed to the supervising physician):
  - Current record-keeping does not identify who (NPC or supervising physician) actually did what.
  - Medical outcomes data, as used by the Texas Departments of Health and Insurance, cannot therefore be directly tied to NPC providers.
  - Reimbursement accounting procedures should be changed to incorporate such information.
- Parkland Hospital has eased order and privilege restrictions for NPCs.
- NPC privileges vary from hospital to hospital and can be a disincentive to hiring:
  - Hospitals should allow NPs/PAs to refer patients.
  - Hospital regulations requiring physicians to carefully monitor NPC activities stand in the way of cost-effective care.
- Although physicians would probably be in favor of changes to enhance the practice of NPCs, the various groups involved (TMA, the Texas Hospital Association–THA, etc.) are difficult to move.
- The TMA is controlled by family practice physicians.
- Scope-of-Practice policies are “set in stone” for the foreseeable future.
- Texas Scope-of-Practice laws are complex because of turf wars.
- Site-specific prescriptive authority for NPs was a compromise.
- Texas Legislators will get behind whatever NPC legislation physicians endorse (if individual physicians do not lobby, the Legislature will default to TMA/THA thinking).
- Eleven states allow autonomous NPs.
- There needs to be state-to-state uniformity in Scope-of-Practice regulations.
- Medical education needs to become more infused with the *collaborative model* (physicians and NPCs collaborating in patient care).

**Urban Issues Re: Access to Health Care by the Underserved**

- Urban areas are often underserved:
  - Physicians do not see Medicare/Medicaid patients.
  - There are not enough NPs/PAs.

- It can be difficult to find enough Spanish-speaking providers with cultural competencies for urban areas that need them.
- Indigent patients present an enormous demand.
- Although MUA and HPSA designations are general indicators of adequacy and availability of health care services, they are not nearly specific enough to tell the entire story (certain facets of health care are simply not measured).
- Some local dentists resist HPSA designations.
- Texas law prevents the participation of Advanced Practice Nurses and PAs in the types of business relationships required for practice ownership:
  - Many NPCs resent not having control over their own practice.
  - Many are professionally dissatisfied working as part of a physician's practice.
  - This issue is particularly important to PAs, who are particularly sensitive about their subordinate roles.