WHITE PAPER

Optimizing Patient Care Through Clinical Collaboration

A data-driven approach to integrating NPs and PAs

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Nurse practitioners (NPs) and physician assistants (PAs) have been instrumental in delivering quality health care in the United States (U.S.) for over five decades. Today, as the fundamental sustainability of health care delivery is being threatened from multiple corners, it has never been more vital for hospitals and health systems to attract, train, and properly optimize this workforce.

The question, which this paper will endeavor to answer, is how?

Utilizing NPs and PAs to assist in the sustainable delivery of high-quality, affordable care for patients has always faced challenges. Chief among those is perhaps one of perception, especially amongst the very physicians who are critical in overseeing care delivery.

It is important to note that attitudes range widely, with some maintaining an innate reluctance to involve NPs and PAs in a whole range of critical tasks and decision-making, to others who believe NPs and PAs can and should assume more responsibility in a host of situations.

Debates about the utilization of NPs and PAs within acute unscheduled care settings often focus on three areas: quality, training, and education. Physicians frequently have legitimate concerns in each of these areas, some of which are grounded in personal experience, others of which are derived from entrenched historical attitudes.

The critical ingredient to resolving these debates is to consider the local circumstances. Local environments of clinical care, staffing needs, economic pressures, and patient mixes all influence staffing and care decisions made at the local level. We must recognize the importance of these factors, with the understanding that NP/PA staffing models lacking in communication and collaboration, characterized by a mismatch of clinical demand with skills, experience, and training, or resulting in a pattern of poor quality outcomes should not be supported.

Hospitals and health systems must seek partners who will prioritize quality care delivery as the primary focus and devote necessary attention to addressing issues of training, education, and oversight for NPs and PAs at their facility.

When done with sufficient collaboration, education, and training, utilizing NPs and PAs in collaborative, physician-led care teams can effectively result in high-quality, cost-effective, patient-centered care.

1 Background

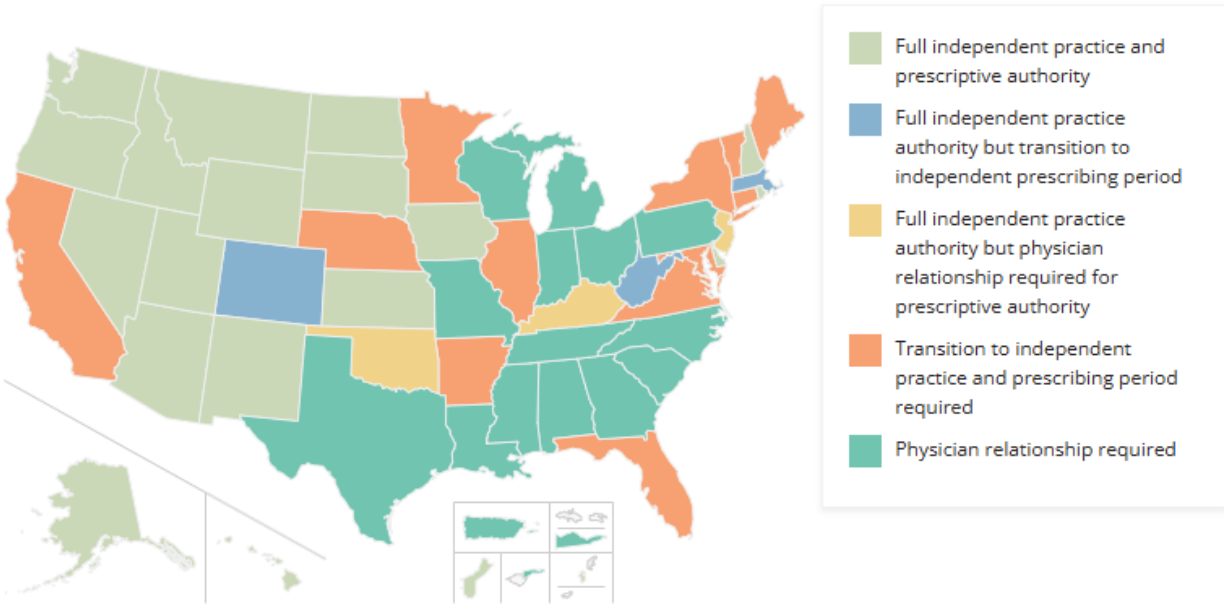
The NP & PA workforce at a critical juncture

NPs and PAs emerged in the 1960s to address clinician shortages in rural areas and primary care. Currently, there are over 355,000 licensed NPs[1] and over 168,000 PAs[2] across the country. These roles have grown beyond the initial mandate, diversifying into multiple areas of medicine, thereby allowing for specialization and expansion of physician care in multiple collaborative models.

The scope of practice for NPs and PAs is largely directed by state-specific regulations, encompassing elements such as collaborative relationships, prescriptive authority, and quality review methods. These regulations can either broaden or restrict the roles and scope of practice of NPs and PAs within the health care system.

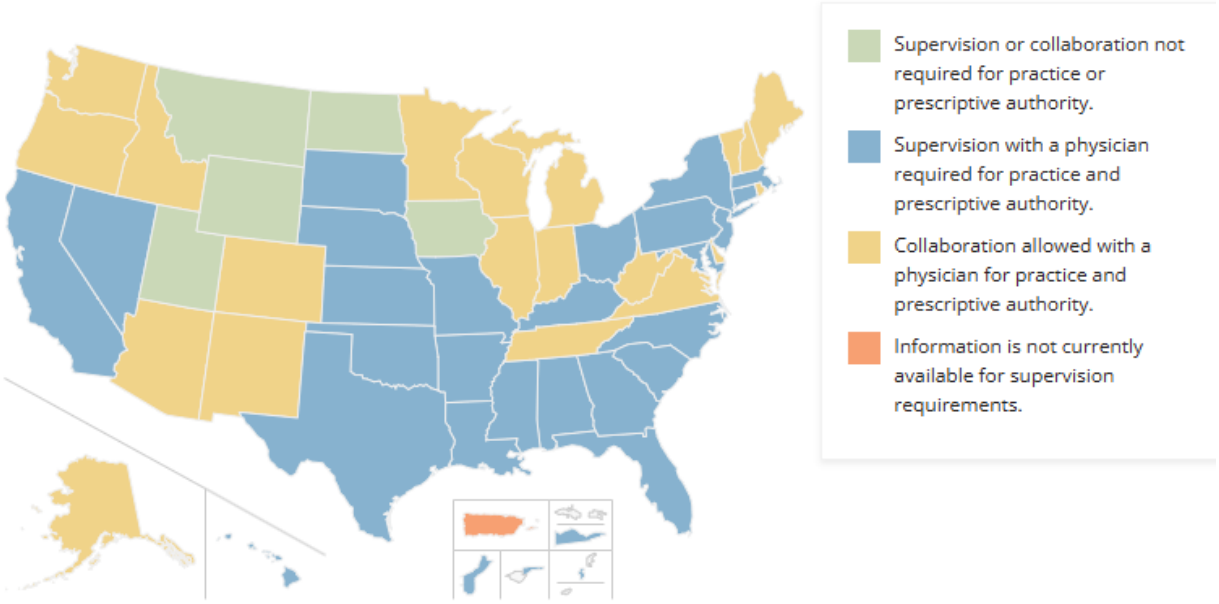
Each state's defined scope influences the utilization models for these professionals. Typically, additional specialty training for NPs and PAs allows for expanded scopes of practice, off-site collaboration, and increased health care accessibility.

Currently, 25 states in the U.S. grant NPs full practice authority, enabling them to evaluate, diagnose, order and interpret tests, prescribe treatments, and manage patient care under the state board of nursing's exclusive licensure. This full practice authority allows NPs to be governed by the state, and deliver clinical care with a full scope of practice.



Map of Advanced Practice Registered Nurses: Nurse Practitioner Practice and Prescriptive Authority. National Conference of State Legislatures (2024, December 10) https://www.ncsl.org/scope-of-practice-policy/practitioners/advanced-practice-registered-nurses/nurse-practitioner-practice-and-prescriptive-authority

Physician assistants also face varying levels of practice authority across the country. While varying practice environments exist in 26 states, allowing PAs to fully utilize their medical education and training with minimal oversight requirements, the remaining states maintain stricter administrative requirements and supervision mandates that can impact practice flexibility.



Map of Physician Assistants: Supervision Requirements (Practice and Prescriptive Authority)
National Conference of State Legislatures (2024, December 10) https://www.ncsl.org/scope-of-practice-policy/practitioners/advanced-practice-registered-nurses/nurse-practitioner-practice-and-prescriptive-authority

There is a recognized shortage of physicians, especially in rural areas. In fact, the NP and PA capacity to continue delivering quality health care in these underserved areas is enduring unprecedented stress. These include staffing shortages exacerbated by post-pandemic attrition, broad economic challenges, Medicare reimbursement issues, and continued fallout from the No Surprises Act.

More recently, several efforts have been underway to reverse or slow the progress NPs and PAs have made in expanding the breadth of their scope of practice within the health care system.

For example, the passing of SB 400 in May 2023 in Indiana made it the first state to mandate the physical presence of physicians in emergency medicine settings, thus eliminating the option for NPs and PAs to have remote collaboration. Similar legislative efforts are currently underway to impact the ability of physician groups to flexibly decide how to meet the patient care needs in each clinical setting.

Even if there were enough physicians, the geographic distribution doesn't match patient demand, and likely never will.

The reality of poor access to health care should not be the patient's burden to carry.

Thus, if we are to continue to provide access to care where it is often most needed, we must find solutions for all these challenges. The proper training and education of NPs and PAs, along with productive collaboration with and oversight by physicians simply must be a part of the solution.

2 Quality

Current debate and the academic findings

Concerns within the industry regarding the capabilities of NPs and PAs to examine, treat, and diagnose critically ill patients are both acknowledged and respected. These concerns require a data-driven mindset while acknowledging that in some situations poor quality has been caused not by inability, but by lack of education, training, and oversight.

First, let's examine the literature.

Many studies over the last two decades have compared physicians, NPs, and PAs in terms of quality and resource utilization, including in emergency departments.

It is important to note that, while individual studies in certain practice settings with certain patient populations occasionally claim the opposite, there are significant findings in academic literature showing that in many practice settings, NPs and PAs can provide comparable quality of care to physicians for certain types of patients, such as those with minor injuries and illnesses. In terms of quality indicators such as patient satisfaction, clinical outcomes, and hospital admissions, there's generally no significant difference among the three types of clinicians.

However, for complex, life-threatening, or unusual cases, physicians tend to have more extensive education and training, which can potentially lead to better outcomes. This is expected—and exactly why the proper utilization of NPs and PAs is so important.

In terms of resource utilization, the results are mixed. Some studies suggest that NPs and PAs order slightly more diagnostic tests and generate somewhat higher costs, while other studies find no significant differences. This might be attributed to the degree of clinician experience, institutional policies, or patient complexity.

Here is a sample of the research on this debate:

- A systematic review of more than 55 studies on the impact of nurse practitioners on cost, quality of care, satisfaction, and wait times in the emergency department found that NPs can reduce wait times in the ED, leading to higher patient satisfaction, while providing quality patient care.[1]
- A systematic review of 66 studies of PAs in the emergency department found that physician assistants are reliable in assessing certain medical complaints and performing procedures, and are well accepted by ED staff and patients alike.[2]
- A literature review of the impact of NPs and PAs on patient flow in emergency departments found that inclusion of NPs and PAs in staffing models can improve patient flow in medium-sized community hospitals. "Given the ongoing shortage of physicians, the use of alternative health care providers should be considered," the authors concluded.[3]

And it's not just in the emergency department where NPs and PAs can become integral members of care delivery. NPs and PAs can safely assist with the management of critically ill patients in the ICU[4] and provide essentially comparable care in primary care centers.[5]

SCP Health's data aligns with these studies. For example, SCP Health recently looked at data from the Merit-Based Incentive Payment System (MIPS), used to adjust Medicare Part B payment based on quality performance. Using data from a year of care delivery and representing approximately 1,200 physician assistants and nurse practitioners and 3,000 physicians in 267 hospital settings in 24 states, SCP Health found comparable quality scores across a range of measures:

Minimal Variance Between NP/PAs and Physician MIPS Results in 2023

Emergency Medicine Physician MIP

98.22%

Emergency Medicine NP/PA MIPS

98.74%

Hospital Medicine Physician MIPS

99.67%

Hospital Medicine NP/PA MIPS

99.42%

In 267 hospital-based practices, NPs and PAs demonstrated nearly identical MIPS quality results in both hospital medicine and emergency medicine services when compared to their physician partners.

This type of data can help address ingrained concerns about the quality of NP and PA patient care. As importantly, having clinical mechanisms that provide consistent feedback about key quality programs in each practice provides the opportunity for continuous improvement, problem-solving, and appropriate collaboration.

Still, decisions about the composition and utilization of each health care team are specific to each practice, as physicians, NPs, PAs, and other health care modalities and professionals are deployed to provide that care.

Studies show that interdisciplinary teams have a positive impact on outcomes, efficiencies, cost, and clinician resilience. Nurse practitioners and physician assistants can be an important component of this approach. Yet NP and PA scope of practice must be determined by evaluating license, certification, education, and experience as well as local, state, and federal laws and regulations.

Laws, regulations, policies, and payment models are most helpful when they provide important and broad guideposts, but ultimately allow each community to determine how to meet patient care needs in their individual clinical settings. Each community must have the ability to address access to care, affordable care, clinician shortages, and quality care. This includes health care settings that are rural, underserved, urban, suburban, academic, community-based, for-profit, volunteer, disaster response, or where other health care access or outcome disparities exist.

3 Education

Educational models for clinicians—physicians, NPs, and PAs—share foundational similarities but also possess unique characteristics reflecting their roles and expertise in health care.

Physicians undergo intensive and extensive medical education. This commitment encompasses the mastery of fundamental medicine and specialization in a specific medical field. In addition to primary medical school training, many physicians opt for further specialization through residency programs and fellowships, which could extend their training by up to 10 years before they commence independent practice.

Education, training, and subsequent specialization are fundamental to preparing physicians for quality, cost-effective clinical practice. NP and PA training are different but have significant similarities.

Nurse practitioners build on their initial nursing education, often extending their graduate studies by up to six additional years before beginning advanced practice. NPs graduate as population-specific specialists, providing them with the ability to focus on care for a specific population.

Physician assistants typically come from a medical background and follow an educational model similar to that of physicians. This model ensures a comprehensive understanding of basic medicine and a firm core foundation. PA training includes an average of 3,000 clinical hours. Unlike physicians and NPs, physician assistants graduate as generalists, but they have the opportunity to specialize later in their careers.

4 Training

Recognizing the crucial role that NPs and PAs play in health care delivery, physicians, hospitals, and health care companies have instituted quality-focused training programs to strengthen these professionals' foundational education.

Robust training programs that incorporate core competencies for newer and less experienced NPs and PAs can ensure a solid clinical foundation and success in their medical specialties.

Below is an example of two different training models that work to ensure NPs and PAs are successful in delivering quality care.

New Graduate Training Program

Understanding the educational foundation of NPs and PAs, coupled with a core collaboration model, a strategic approach can be crafted, ensuring that new graduates deliver quality care to our patients, to include:

- Core didactic training
- Procedural training
- Intensive emergency medicine & hospital medicine bootcamp
- Core competency milestones

Remote Collaboration Practice Model

NPs and PAs who work with remote collaboration, require extensive experience, and proven competency, prior to working with remote physician collaboration.

- Extensive clinical experience requirement
- Advanced procedures training
- Certification expansion
- Advanced competency milestones

Furthermore, in recent years, there has been an increase in post-graduate programs available for NPs and PAs. Recognizing that the difference between physician training and NP/PA training must be respected, there is considerable breadth and depth in the training that NPs and PAs receive. These programs provide additional didactic and clinical hours, further preparing these professionals for their unique roles within the health care landscape.

5 Conclusion

Optimizing deployment in a complex environment

The rapidly evolving dynamics of our post-pandemic health care system have underscored not just the resilience of NPs and PAs but their adaptability. NPs and PAs have proven they can step into varied roles and navigate the intricacies of care delivery.

The capacities of NPs and PAs extend beyond their conventional roles. Optimizing NP and PA utilization requires dedicated leadership with physician engagement and oversight, as well as a robust screening, onboarding, and training program.

Across various medical disciplines, these health care professionals have opportunities to contribute to collaborative, physician-led care teams that capitalize on their skills and training and can be integrated in ways that assure high-quality, accessible, and safe clinical care. Some examples:

1. **Emergency Medicine** – Optimization models may include patients of various acuity profiles, medical screening exams, and procedural applications.
2. **Hospital Medicine** – Optimization models include admitters, rounders, dischargers, and behavioral health patients.
3. **Critical Care Medicine** – Optimization includes admitters, rounders, and proceduralists.
4. **Telemedicine** – Integrated virtual hospitalists, emergency medicine, and critical care clinicians.
5. **Hospital to Home** – Deploying NPs and PAs for virtual hospital visits, urgent care visits.
6. **Primary Care** – Bridging the gap in communities to ensure accessible health care.
7. **Specialty Care** – Specialty-trained NPs and PAs extend access to specialized care.

Recognizing the profound impact, collaborative potential, and substantial value nurse practitioners and physician assistants offer is crucial for our collective progress in health care. We appeal to hospital and physician partners to support the significant contributions that NPs and PAs can deliver in service of patient well-being.

Ultimately, meeting the requirements of timely access to high quality care requires that NP and PA services are appropriately matched to clinical demands. When this is done with highly collaborative physician-led teams, successful quality and safety results follow.

The burden is ours to carry. We cannot move forward as a health care system divided; we must move forward as a health care system united.

All clinicians need to come together to ensure we uphold the commitments we embraced as medical professionals, to ensure accessible, quality health care for all.

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