The Utility of an NP/PA in an Otorhinolaryngology Practice

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Abstract

Objectives: 1) Recognize the value of the Nurse Practitioner/Physician Assistant (NP/PA) in an otolaryngology practice. 2) Describe application of the care models to achieve improved outcomes for patients and increased job satisfaction for providers.

Methods: Single institution evaluation of NP/PA provider integration into an academic otolaryngology practice.

Results: Healthcare in the United States is at a crossroads. The number of insured patients seeking care will rise dramatically over the next 2 years. The number of medical doctors is declining and based on ACGME recommendations, resident work hours are decreasing. In otolaryngology accommodating the increasing needs of the population will require improved use of resources, including personnel to provide high quality, compassionate healthcare. Nurse practitioners and physician assistants are well educated and highly motivated to work alongside collaborating physician(s) to provide this care. At Mayo Clinic, the otolaryngology department employs 7 NP/PA providers. These NP/PA providers work with a variety of staff surgeons, resident surgeons, nurses and ancillary health providers to maintain high quality, highly accessible healthcare. The care model of each individual NP/PA and collaborating physician vary in otolaryngology at Mayo Clinic. However, the models work based on the needs of the practice, the patient, and the providers.

Conclusions: The NP/PA providers perform a variety of services for the patient and the collaborating physician. The care models used allow each provider (MD, NP/PA) to use their time to the best of their abilities, increasing job satisfaction and thereby providing high quality, cost effective care.

Models

Collaborative practice
- Working as a team alongside the physician.
- Gathers information, processes and verifies it, therein reports it to managing physician.
- Managing physician then meets the patient and develops a plan in collaboration with the team.
- This model allows billing under physician for greater reimbursement, increased productivity and efficiency in the clinic, and allows more providers to be familiar with the patient allowing improved continuity and quality of care.

Limited independent
- First step in transitioning a NP/PA provider to a more independent practice.
- Billing is "incident to", patient must be established in the practice and the physician must be on site.
- Increases reimbursement by billing under the physician when criteria is met.

Near complete independent
- NP/PA provider will function with the physician off site, degree of supervision regulated by the state.
- Physician, although off site, is available as questions arise for complex and challenging patient situations.
- Promotes autonomy and use of space to continue to grow and sustain a practice.
- Must have good communication skills between NP/PA and physician to work in this type of environment.

Partial independent
- NP/PA completes patient encounters independently with the physician in the office.
- Promotes autonomy but physician available for complex patients. Increases access to the clinic, lower reimbursement (roughly 85% of physician billing).
- Lower salary rates for NP/PA compared to physicians may compensate for this.

Physician workforce and Affordable Care Act

- Association of Academic Medical Colleges estimates a shortage of physicians between 124,000 – 159,000 by 2025. If the NP/PA population doubles by 2025, it would reduce the projected physician demand by 75,500.
- The Affordable Care Act was signed into law in March 2010, this will increase access to health insurance coverage for more than 30 million Americans by 2014.
- The greatest potential for decreasing the demand of physicians to provide the healthcare services for the masses may lie in the utilization of the nurse practitioners and physician assistants to work to the full extent of their training and assist in increasing physician productivity.

Resident work hours

- Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities and all moonlighting.
- Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
- Duty periods of PGY-1 residents must not exceed 16 hours in duration.VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.
- Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
- PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

References

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