Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ENHANCING THE UTILIZATION OF NONPHYSICIAN HEALTH CARE PROVIDERS:

THREE CASE STUDIES

MAY 1993 OEI-01-90-02071

EXECUTIVE SUMMARY

This report presents case studies on how three health care organizations are working to enhance the utilization of nonphysician health care providers. Evercare, a managed care delivery system in Minneapolis, illustrates how nurse practitioners working in collaboration with physicians can enhance the delivery of care to nursing home residents. St. Joseph's Hospital of Atlanta is using professional and nonprofessional hospital staff on two units to deliver more patient care services directly at the bedside. Chicago's Mercy Hospital and Medical Center is training nonprofessional workers to perform technical tasks and to work in permanent teams with registered nurses in a hospital-wide expansion of the hospital's nursing service.

Our companion report, *Enhancing the Utilization of Nonphysician Health Care Providers* (OEI-01-90-02070), synthesizes our assessment of the potential for more effective use of nonphysician providers. In that report we describe five significant barriers to enhancing the utilization of nonphysician providers. In this case study report, we also address how health care organizations can overcome these barriers.

Professional Territorialism. Rather than encourage a teamwork approach to providing care, professional boundaries can inhibit cross-discipline sharing of knowledge and information. Professional territorialism limits health care organizations' ability to take advantage of opportunities to enhance utilization of nonphysician providers.

To address this barrier, health care organizations can:

- Clearly delineate the duties and skills that are specific to a profession. Allow members of the profession to maintain their professional identity.
- Emphasize each profession's role as part of an overall health care team, enhancing the role of the profession, rather than diminishing it.
- Hold in-service training and problem-solving sessions that involve different professions, thus providing a broader viewpoint. Include members of different professions both as "students" and as "teachers" at the in-service.

Licensure Restrictions. Licensure laws are designed to protect the public's health, safety, and economic well-being by restricting entry into the occupations to those with the proper credentials. These regulatory laws also can inhibit flexibility in how nonphysician providers may be utilized, reduce access to services, and impose higher costs.

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INTRODUCTION

BACKGROUND

This report is a companion to our inspection *Enhancing the Utilization of Nonphysician Health Care Providers* (OEI-01-90-02070). That report synthesizes our assessment of the potential for more productive use of health care personnel and the barriers in the health care system that often inhibit such efforts. Drawing on a review of the literature, interviews with experts, and these case studies, we found that health care organizations in different settings, including hospitals, nursing homes, and ambulatory sites, are taking new approaches to organizing and staffing health care services. We also identified five significant barriers that constrain the widespread adoption of these approaches:

- *Professional Territorialism.* Rather than encourage a teamwork approach to providing care, professional boundaries can inhibit cross-discipline sharing of knowledge and information. Professional territorialism limits health care organizations' ability to take advantage of opportunities to enhance utilization of nonphysician providers.

- *Licensure Restrictions.* Licensure laws are designed to protect the public's health, safety, and economic well-being by restricting entry into the occupations to those with the proper credentials. These regulatory laws also can inhibit flexibility in how nonphysician providers may be utilized, reduce access to services, and impose higher costs.

- *Educational Isolation.* Health professions education rarely includes inter-disciplinary training. This exclusion divides the professions from each other, rather than encouraging cooperative practice styles and team building.

- *Physician Resistance.* Although some physicians are working closely with NPs, PAs, and CNMs, other physicians resist broader scopes of practice for these providers. This resistance may result from physicians' concerns about quality of care, unfamiliarity with how to utilize these providers effectively, and self-interest. This resistance can hinder access to care, since these providers are able to extend the capacity of individual physicians to deliver care.

- *Institutional Inertia.* Health care organizations, like most organizations, are naturally resistant to change. Redefining organizational boundaries requires a significant change in how all health care staff--both physician and nonphysician providers--are utilized.

The case studies presented in this report describe how three health care organizations are attempting to make more productive use of nonphysician health care providers. Evercare, a managed care delivery system in Minneapolis, illustrates how nurse

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We conducted this study in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

ORGANIZATION OF THE CASE STUDIES

We present each of the case studies using the same format. Following a background section on the site, we describe the particular innovation that is being studied. Next, we discuss our assessment of its impact on quality of care, costs, physicians, staff, and other parts of the organization. We then discuss limitations and implementation impediments, and finally, our conclusions about the innovation.

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We did not intend for these organizations to be representative or even typical of other health care organizations. We selected them, in fact, because of the atypical nature of what they were doing. Our criterion for selection was that each approach was attempting to enhance the utilization of nonphysician providers by expanding the range of work and services beyond what was typical in traditional settings. We do not endorse any particular approach, and we make no claim that these organizations or approaches represent "best practices," either in outcome or in implementation. Each of these organizations is at a different phase in implementing its innovation. Each has encountered barriers and problems, but each has also adapted and maintained flexibility to overcome the barriers. At the same time, each organization has maintained a commitment to the basic goals and objectives of the approach.

METHODOLOGY

To select organizations for case studies, we first identified potential sites based on interviews with professionals familiar with institutional efforts to reorganize work in health care settings. In addition, we gathered information on potential sites from our review of policy and management literature in this field. We were particularly interested in organizations with recent experience in changing how nonphysician providers are utilized, thus leading us to exclude from consideration organizations (such as long-established health maintenance organizations) that may have been using nonphysician providers for several years. In subsequent interviews with personnel from different health care organizations, we identified the length of time the initiative had been operating, the availability of data to assess its impact, continuity of key personnel, and their willingness to participate in the study. To make our final selection, we relied on our own qualitative judgements about whether the organization was doing something innovative and had sufficient experience from which lessons could be drawn.

We conducted two-day visits to each site. During that time, we interviewed administrative personnel, service delivery staff, and physicians. We also observed the staff and their interactions with other staff members and patients. In addition, we reviewed documents from the sites, including clinical protocols, staffing and cost data, patient satisfaction surveys, training plans, and other background materials. Upon completing a written draft of the report for each site, we shared it with the chief executive officer and our key contact from the site to review the accuracy of our facts. We did not, however, change our interpretation of those facts.

EVERCARE
Minneapolis, Minnesota

BACKGROUND

Evercare is a managed care delivery system that uses geriatric nurse practitioners (GNPs) and physicians to provide acute care services to residents of several area nursing homes. A monthly premium from Medicare covers all acute health care services for enrolled members--routine and urgent physician care, hospitalization, laboratory and diagnostic services. Chronic care services provided by a nursing home, such as routine nursing care and room and board, are not part of the Evercare package and are provided under other funding sources, such as Medicaid or private payment.

As of November 1992, the Evercare membership in the Twin Cities[1] totalled about 700 members in 92 nursing homes--400 in Minneapolis and 300 in St. Paul. Although Evercare uses a GNP-physician team approach in both Minneapolis and St. Paul, there are important differences between the two cities in their delivery models:

- In Minneapolis, Evercare employs 6 GNPs directly, with physician services provided through individual physician contracts. In St. Paul, Evercare contracts with the Ramsey County Medical Center's Department of Geriatric Medicine, which employs 8 GNPs and assigns its physicians to provide nursing home care.

- In Minneapolis, the GNPs write prescriptions, and they make and sign off on monitoring visits required under Medicare regulations; in St. Paul, physician signature is required for those tasks.

Because the GNPs in Evercare-Minneapolis have a wider scope of practice than those in St. Paul, this case study focuses primarily on the Minneapolis model.

WHAT IS INNOVATIVE ABOUT EVERCARE?

GNP Practice Protocol

Evercare's protocol with the nursing homes in which its members reside provides the basis for GNP practice. The protocol is a written agreement signed by the GNP and collaborating physician that specifies that the GNP "functions collaboratively with the physician to manage the medical care." The protocol stipulates that the GNP may undertake certain tasks "acting without consultation with the physician," including:

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1. Evercare also operates in the Chicago metropolitan area. This report addresses only the Minneapolis-St. Paul component.

GNPs establish independent practices on a widespread basis, nursing home care could become even less appealing to many physicians than it is at present.

▸ *Response of Evercare to Physician Concerns*

The Evercare model addresses many physician concerns, since it is based on the premise that the GNP operates as an extension of the physician, with commensurate collaboration and coordination. The GNP can also play an important role by facilitating communication between physician and facility, since the GNPs are frequent visitors to the home.

One physician who works with Evercare told us that having GNPs available actually can attract physicians to nursing home care. According to this physician, the GNP can take on much of the burden of providing nursing home care--dealing with families, routinely monitoring members with chronic conditions, responding to questions from and needs of nursing home staff--leaving physicians to practice what he referred to as "the technical aspects of medicine."

Impact on Nursing Home Staff

▸ *Concerns of Nursing Home Staff*

Some staff nurses initially were reluctant to recognize the GNP's authority. This resistance may simply have been the result of confusion over the definition and authority of the GNP's role. On another level, however, staff nurses may have viewed the GNP as another barrier between them and the physician--an extra hoop through which they would have to jump to get anything done. At one home, the director of nursing thought that the Evercare GNPs took too much of the staff nurses' time, always asking them questions, unlike the physicians who come into the home, visit patients, and leave quickly.

Other nursing home personnel were also confused over the GNP role. For example, we learned that medical records technicians were accustomed to recording only physicians' orders; they balked at accepting the nurse practitioner's signature on a medical order or prescription. In one home, this confusion carried over to the director of nursing, who simply told Evercare not to let GNPs sign prescriptions because "medical records doesn't want you to." Only by showing the director of nursing a copy of the State law, her State authorization to write prescriptions, and the collaborative agreement with her partner physician was the GNP able to overcome the objections.

▸ *Response of Evercare to Nursing Home Staff Concerns*

Many of the initial problems associated with the nursing home staff have been overcome as they build a level of trust in the GNPs. Once they have gained experience with them, nursing home staff apparently like having the GNPs available.

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with Evercare and nursing home staff suggest that NPs can function in this role without diminishing the quality of care provided. In fact, at Evercare it appears that effective utilization of nurse practitioners in this arrangement can enhance the quality of health care services.

Effective implementation of a model such as Evercare requires that the GNP practice in a role that requires independent decisions, frequently without immediate collaboration with a physician. Consequently, that role needs to be filled by an individual who wants and is comfortable with that degree of authority and responsibility. In addition, many physicians may be uncomfortable with or unskilled in utilizing GNPs in the manner described here. It requires a great deal of trust and confidence in the GNP's abilities, as well as physician willingness to let go of many aspects of day-to-day patient care. As one GNP told us, "For this model to really work, you have to have a physician or medical group that is willing to work with GNPs as primary providers, not just have them on staff."

The Evercare model does not rely solely on the role of an independent nurse practitioner. The financial incentives to physicians and GNPs are important in making the arrangement work. By combining financial incentives for physician services--prepayment for managing care and favorable rates for visits to patients--with the availability of the GNPs, an approach such as Evercare's also holds potential for helping to ease nursing home physician recruitment problems. This approach may work particularly well in a nursing home setting, where so much of the emphasis is on chronic care and on addressing the needs of residents and their families. These tasks lend themselves closely to the skills and training that many NPs receive--assessment, psycho-social skills, interaction, and communication.

As fellow nurses, they feel more comfortable dealing with GNPs than with physicians since "they talk our language" and have actually done nursing care.

Nursing home staff have also found it easier to contact the GNP than the physician to have orders changed, medications approved, or questions about care answered. Evercare claims that its GNPs always return nursing home staffs' phone calls within an hour; nursing home staff we met said that most calls are returned within 30 minutes. The staff nurses feel free to call the GNP. In addition, when a physician's decision is needed, they believe that Evercare physicians respond more quickly to the GNP's call; they realize it is important and a situation that the GNP feels requires a physician's expertise.

Another benefit to the nursing home staff is informal continuing education. The medical director at a nursing facility told us that the GNPs help the staff nurses by increasing their nursing skills, fostering an environment for interchange and improved expectations.

Limitations

The State regulatory climate regarding the scope of practice of nurse practitioners affects the extent to which such a model can be replicated. Obviously, delivering care through an approach such as this would be easier in those States that permit NPs to practice in an expanded role, including prescriptive privileges, than in States which place more restrictions on NP practice.

The start-up costs associated with physician recruitment, member enrollment, and financial reserve requirements mean that financial feasibility may be difficult to achieve. The founders of Evercare estimate that it took more than three years to reach a break-even financial point.

In addition, the Evercare model is limited to the nursing home setting. When a member is hospitalized, the attending physician will be someone who works with Evercare, but may not be the regular geriatrician that the resident had seen for primary care services while in the nursing home. At the same time, the GNP would have limited authority in the hospital, since her protocol agreement applies to the nursing home only.

Finally, the lack of a clinic setting in which the GNP can see new patients also is a limiting factor. While the Evercare physicians' offices provide a potential location, the GNP's office is a car. She must use space either in a nursing home or a hospital emergency department for the initial physical assessment and case history.

CONCLUSIONS

Our study of Evercare highlights the leading role that nurse practitioners can play in providing care through collaborative arrangements with physicians. Our discussions

ST. JOSEPH'S HOSPITAL
SERVICE AND CLINICAL ASSOCIATES PROGRAM
Atlanta, Georgia

BACKGROUND

St. Joseph's is a 346-bed hospital in north Atlanta, specializing in cardiac, oncology, and orthopedic care. St. Joseph's payor mix is 35 percent Medicare, 60 percent private coverage, and 5 percent Medicaid. In 1990, after examining hospital operations and finding evidence that labor was the primary factor driving up the cost of health care, the hospital decided to restructure its inpatient delivery system.

As part of its work redesign project, St. Joseph's created two new job categories--service associates (SAs) and clinical associates (CAs)--that reconfigure the way patient care is provided.[4] The goals of this project were (1) to promote efficiency by delivering more services directly at the bedside, and (2) to respond to an emerging shortage of health care workers by training personnel to provide a broad array of health care services.

In April 1991, St. Joseph's added service associates and clinical associates to two units--a medical/surgical floor and a critical care unit. The changes in staff duties were based on two important assumptions. First, it was assumed that many technical tasks involved in treating patients could be performed under the direction of nurses by workers who received special training--leaving the nurses to coordinate and monitor care, do patient assessment, and use their professional judgment. Second, it was assumed that many patient care tasks could be shared by staff at different levels.

WHAT IS INNOVATIVE ABOUT ST. JOSEPH'S EFFORT?

Service Associates

The hospital designed the position of service associate (SA) to relocate services provided through central hospital staff onto the individual units. This program recruited workers such as aides, food service workers, and housekeepers, and trained them to expand their skills so that they could provide basic patient care. As of October 1992, 43 service associates were working on two 23-bed units--the Critical Care Unit (CCU) and the Medical-Surgical Unit.

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4. St. Joseph's also created an Administrative Associate position which incorporated the roles of receptionists, unit department secretaries, medical record clerks, admitting clerks, and utilization reviewers, as well as some patient comfort and transport duties. In this report, we focus only on the CA and SA positions.

MERCY HOSPITAL
CLINICAL PARTNERS PROGRAM
Chicago, Illinois

BACKGROUND

Mercy Hospital and Medical Center is a 505-bed teaching hospital, located on the South side of Chicago. Mercy's payor mix is 40 percent Medicare, 37 percent private coverage, and 23 percent Medicaid.

In 1987, Mercy faced a severe nursing shortage, compounded by declining revenues. In a review of the hospital's structures and operations, management found that staff in central departments--laboratory, housekeeping, and food services, for example--experienced a significant amount of down-time. In the course of its review, the management team also found that patients saw a large number of different hospital staff during their stays. In response, hospital management decided to undertake several projects in an attempt to increase efficiency and improve the quality of patient care management. This case study focuses on one of these initiatives, the Clinical Partners Program (CPP).

Mercy implemented its Clinical Partners Program in 1989. As of November 1992, 136 clinical partners worked in units throughout the hospital.

WHAT IS INNOVATIVE ABOUT CLINICAL PARTNERS?

Nurse-Clinical Partner Teams

A clinical partner is a person trained to provide a variety of nursing assistant and technical tasks essential to basic patient care, working in a team with a registered nurse. Clinical partners take a 6-week in-house training program, taught by nursing and central department staff. They learn how to draw blood; perform basic respiratory therapy; reinforce physical and occupational therapies; take an EKG; and provide services ordinarily performed by nursing assistants. At the end of the training program, clinical partners take a series of exams to ensure their competency. Almost ninety percent of clinical partners have been recruited from central hospital departments such as lab, environmental services/housekeeping, EKG, and food services.

The CPP relies on a fixed-team structure, with one registered staff nurse working exclusively with one clinical partner. Nurses interview and hire their clinical partners after they complete the training program. Many of the teams have been working together since the program's inception. As part of the CPP, nurses who supervise a clinical partner must take a special workshop sponsored by the hospital to enhance their management skills and develop their delegation principles. Nurses also must be proficient in all of the technical skills that their clinical partners will be performing.

educational and professional philosophies. There are overlaps in much of the technical education received by nurses, pharmacists, and respiratory therapists. Major differences emerge, however, in underlying approaches and assumptions that they bring to their professions. Nurses, for example, tend to focus on managing the entire spectrum of care, whereas respiratory therapists perform primarily mechanical tasks dealing with limited parts of the body system. These educational underpinnings are evident within the hospital where the RTs and pharmacists sought a management structure in which they were supervised by those in their own professions. They also are evident in broader areas of the health care system, such as licensure, scope of practice, and supervisory responsibilities. Clearly, these concerns are major factors that must be considered in any effort to change how the work of delivering health care is performed.

St. Joseph's experience demonstrates the importance of flexibility in changing the way in which a hospital utilizes personnel. Despite some major changes in its initial plans, the hospital maintains a strong commitment to the underlying principles behind its work redesign effort: Providing more patient care directly on the unit by using workers who are trained to perform a broader range of services.

proposed a system modification and further education for the clinical partners on this procedure; in response, the lab and the nursing department are developing a new education program to remedy the problem.

Other advantages arise from the additional time that clinical partners spend with patients and their families. The clinical partners are from diverse backgrounds and may be more attuned to patients' differing cultural needs and concerns. Nurses told us that on several occasions the clinical partners have recognized dysfunctional family behavior and have alerted them to potential problems that the patient might encounter upon discharge.

Cost

Hospital management is still in the process of evaluating the impact of the Clinical Partners Program on hospital finances. Those we interviewed were in substantial agreement that it has been expensive, particularly for training; however, they were unable to provide us with the actual costs. Managers acknowledge that they probably underestimated the cost of training when they began this program. One senior official reported, however, that the program has added significant value to patient care, despite its cost.

With the implementation of the Clinical Partners Program, Mercy was able to reduce the number of vacant RN positions. Since the program was adopted they have added more FTEs to their payroll, but these have been in non-nursing positions. By transforming the unfilled RN positions into Clinical Partner positions, the hospital estimates that it has hired 35 fewer nurses.

One physician we spoke with said that the hospital has been struggling to figure out how to measure the cost-savings of the CPP; he remarked on the difficulty of trying to prove a negative. He nonetheless thinks that the change has had positive financial and clinical benefits. "In the past, nobody was measuring the amount of time spent waiting for tests or the number of times a nurse had to make telephone calls to arrange for care. Now everyone realizes that they have more time for the patients, but it is very difficult to prove."

Impact on Staff

- ***Nurses***

Since CPP began over three years ago, the nurse vacancy rate has decreased from almost 12 percent to less than three percent. Now the hospital reports a short waiting list of nurses interested in working at Mercy. All budgeted positions were filled by July 1992--including traditionally difficult-to-fill positions in the intensive care unit. Hospital management believes that the CPP has influenced this trend.

Providing Tests and Services Directly on the Unit

In most hospitals, when staff on a patient unit need services and tests--EKGs, blood work, x-rays, lab tests--they must wait for centralized departments to provide them and communicate the results. By training clinical partners to perform these services directly on the unit, Mercy expects to decrease waiting times for both patients and providers. By bringing other services, such as physical and occupational therapy, to the patient on the unit rather than sending the patient to another part of the facility for those services, the hospital hopes to provide care more efficiently and reduce the number of personnel that patients see during a hospital stay.

IMPACT

Quality of Care

From our discussion with staff, it appears that the CPP has improved the timely delivery of services and coordination of patient care. Prior to implementing this program, unit staff requested that 25 percent of tests be done on a "stat" (immediate) basis, in order to speed up central processing. Now, because many of the tests are done directly on the unit, the proportion of stat requests has fallen to 12 percent. In addition, by drawing blood on the unit, the CPs have helped the lab by expediting specimen delivery, reducing the morning flood of lab orders, and shortening turnaround time.

Mercy also has made some changes in its quality assurance (QA) processes since the implementation of the CPP. The QA department conducts monthly assessments that examine discharge planning, patient falls, medication and lab errors, and infection rates. However, now that more services are decentralized, the hospital has designated a QA person on each unit who reports to the hospital's quality assurance office. Hospital management believes that bringing together unit and central staff through QA has opened up a valuable dialogue, contributing to better patient care and easing the transition to the CPP. For example, they have noted a decrease in the number of venipunctures per patient, as well as a decline in the number of duplicate orders for tests.

Staff from central departments expressed concern to us about the level of training that clinical partners receive. They believe that the hospital has cut corners by providing only six weeks of intensive training instead of the eight to ten weeks initially proposed.

Concerns about the competency of clinical partners and the effect on quality were addressed through the hospital's use of cross-functional groups as a problem-solving tool. These are ad hoc committees consisting of personnel from a variety of disciplines convened to address specific systems and to create new ones. One such group was formed at the request of the lab to examine the problem of an increase in the number of incorrect specimen collections. After assessing the problem, the group

implementing this initiative. Those physicians we interviewed have positive views about this innovation, but they are only a small part of the medical staff.

Third, it is clear that an effort such as this is expensive and difficult to quantify. Training staff to undertake new roles and new duties, separate from existing training programs, carries a substantial price tag.

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Educational Isolation

- Train staff in areas not covered in basic health professions curricula--*e.g.*, management, supervision, delegation.
- Establish career ladders for nonprofessional staff, with clear expectations, requirements, and goals. Involve different professions in providing training for entry level staff.
- Use in-service education to expand knowledge across professions.

Physician Resistance

- Involve physicians in development of new approaches. This will help other physicians buy into the organizational change.
- Identify, understand, and respond to major concerns of physicians.
- Make explicit that nonphysician providers, such as NPs, PAs, and CNMs, must meet the same quality assurance standards and processes as physicians, including service on medical standards committee.
- Establish clear protocols to make explicit the lines of approved delegation.

Institutional Inertia

- Openly demonstrate commitment by senior management.
- Designate a full time staff person to be responsible for implementation. This person should report directly to the organization's senior management.
- Spell out basic objectives of reform. Make implications for patient care clear.
- Involve employees early in the change process. Solicit and respond to their concerns.