CREATING THE MID-LEVEL PROVIDER INFRASTRUCTURE TO ENHANCE CLINICAL CARE TEAMS’ ACCESS AND PRODUCTIVITY
Creating the Mid-Level Provider Infrastructure to Enhance Clinical Care Teams’ Access and Productivity

Through the expansion of healthcare access with the Affordable Care Act, healthcare organizations will experience unprecedented patient demand. Combined with the expected shifts in age demographics nationally, the increased patient demand may not be adequately served by the supply of physicians available:

- The U.S. Department of Health and Human Services estimates that the physician supply will increase by only 7 percent in the next 10 years. At the same time, the Census Bureau projects a 36 percent growth in the number of Americans over age 65, the very segment of the population with the greatest health care needs.
- The Association of American Medical Colleges suggests that by 2020 our nation will face a serious shortage of both primary care and specialist physicians to care for an aging and growing population. According to the AAMC’s Center for Workforce Studies, there will be 45,000 too few primary care physicians – and a shortage of 46,000 surgeons and medical specialists – in the next decade.

Further, the demand to shift from fee for service to fee for value models being supported through the Affordable Care Act (e.g. Medical Home) require a greater clinical care team work effort that includes increased needs for mid-levels. The three aforementioned market forces reinforce a need to address a pressing question posed by many healthcare systems and medical groups today, “How do we properly leverage the use of mid-level providers to enhance access and productivity across my inpatient and outpatient settings?”

Mid-level providers (MLPs) are traditionally defined as Nurse Practitioners and/or Physician Assistants that support physicians and clinical support teams in the provision and monitoring of patient care. Across the country, mid-levels are being utilized in healthcare settings in a variety of roles that are critical as the healthcare system transitions from a fee for service to fee for value system. The following are common questions that arise regarding mid-levels when discussing how to leverage their roles:

1. How many MLPs are required to support our organization taking into consideration site and clinical needs such as:
   a. Coverage for Call
   b. Supplementing Residents and MLP roles in education
   c. Need for Assists in Operating Rooms
   d. Support of outpatient and/or ambulatory clinical needs
   e. Support of inpatient services
2. How do we monitor MLP productivity in the outpatient and inpatient environments?
3. How do we compensate MLPs and align incentives within the care teams?
4. How do we ensure that MLPs will be maximized in their roles and “fit” well with paired physicians?
5. How do we ensure that MLPs are billed appropriately given the payor and/or state requirements?

Case Study

Recently, a large hospital system requested a meeting with FTI to discuss the financial challenges that they were experiencing through supporting the employment of a large medical group. The health system was experiencing the challenge of increasing employed physician compensation and benefits costs with the leveling and in some cases diminishing of overall patient access and provider productivity. The CEO and CFO were concerned that they were not getting the most of the $50+ Million dollar loss/investment with their physician practices. During the course of the discussion, something interesting happened when we started to discuss mid-levels; the leadership team did not know how many mid-levels there were and/or how they were used to enhance physician access and productivity. After further analysis, the organization had greater than 100+ mid-levels throughout the organization, which was bigger than most of their physician practices.

It seemed as if the MLPs had proliferated in inpatient environments as a response to the limitation on resident work hours, but in many cases, the physicians were using them as “life-style” mid-level providers.

“Life-style” MLPs are mid-level providers that enhance the ability of the physician to maintain a more comfortable work/life balance versus Access/Productivity = “Value Enhancing” extenders that increase overall patient access and provider productivity.
There is a place for “life-style” MLPs in organizations where their recruitment strategy focuses on balancing and maintaining the work/life balance needs of the physicians, but too often in most organizations, the strategy and defined use of mid-levels has not been agreed upon and defined by the organization to measure the relative financial, access, and quality impacts of adding mid-levels.

The challenge across the nation for healthcare organizations is that there are few that are rationally and strategically considering how to maximize the benefit of mid-level providers. In most cases, they are simply employing mid-levels by physician practices and/or are brought on as legacy practice employees. In this article we will define and discuss methods to leverage mid-levels to enhance patient access and provider productivity and prepare for a healthcare system transitioning from a fee for service to a fee for value world:

1. **Leverage the Team Care Model Concept**
   The team care or coordinated care model is not a new concept. It has recently gained traction through the Affordable Care Act incentives to support Medical Home, Clinically Integrated and/or Accountable Care Organization models of care. Mid-levels are an essential element to these new models of care and will be increasingly important going forward as the nation’s care model shifts over time.

   1. **LESSON LEARNED #1:** Patient engagement and communication is critical to understanding how a care team is leveraged in the phases of care that the patient will experience.
   2. **LESSON LEARNED #2:** Standards related to not only how mid-levels are utilized, but how the important clinical support functions of RNs, LPNs, Medical Assistants, etc are very important to outline. Mid-levels are often the unspoken leaders of this cohort of clinical support staff because they are onsite clinically more often than the physicians.

2. **Identifying and Empowering a Mid-Level Leader that Fosters a Clinical Care Team Culture**
   There is a need for a defined MLP leader to set the standards for effective mid-level use and measurement of performance given the variation in the:

   1. Use of mid-levels across multiple care settings (inpatient, surgery, and outpatient practices) and their role in resident education.
   2. Preparation for the demands of healthcare reform related to the development of clinical care teams and MLPs roles in managing population health.
   3. Interpretation of legal requirements regarding the appropriate use of mid-levels.
   4. Requirements that payors have associated with reimbursement for mid-level care.

   An identified mid-level leader can provide direction and accountability as it relates to navigating the measurement, legal restrictions, and payment requirements of mid-levels.

   **LESSON LEARNED #1:** High performing organizations that employ mid-level leaders are often able to clearly delineate the goals and use of mid-levels organization wide which leads to overall improvement in financial performance and preparation for fee for value based care.

   **LESSON LEARNED #2:** A lesson learned from multiple organizations is that not centering accountability regarding understanding of state and payor standards can often lead to:

   1. Misinterpretation of legal restrictions and undo limitations around the use of mid-levels.
   2. Underperformance or misuse of MLPs (e.g. using MLPs for tech and/or nurse roles).
   3. Increased denials for payment.

   Identifying a mid-level leader can mitigate the aforementioned situations and create a clear understanding of the role of mid-levels organization wide.
3. Define and Measure Mid-Level Productivity, Access, and Patient Satisfaction Standards including the Development of MLP Care Team Model Outcome Standards

For many healthcare organizations, the measurement of physician productivity, as well as, access, and patient satisfaction is critical to monitoring operational and financial performance. Further, the development of MLP care team models that manage patient populations require outcomes measurement systems.

One of the key delineation points between advanced versus earlier stage employed physician groups is how they account for mid-level operational measures. Successful organizations clearly establish mid-level productivity goals that are able to be measured against benchmarks. Further, mid-level access and patient satisfaction measurements are also established because patients often want to see a mid-level sooner than a physician if it means they gain more timely access to care.

LESSON LEARNED #1: The most important lesson learned is that mid-levels that are not measured through regular reports are not able to be aligned effectively with the organizations productivity, financial, and quality goals which often correlates directly with poor operational and financial performance.

LESSON LEARNED #2: It’s important to understand the difference between types of mid-levels. Mid-levels of different specialties and modalities should have different benchmarks that are commensurate with the:

1. Sub-specialty physician benchmarks and needs.
2. Location and call coverage requirements (e.g. inpatient, emergency department, surgery, outpatient, etc).
3. Teaching and/or other administrative responsibilities required.
4. New models of care requirements (e.g. Medical Home, Value based/Population based models).

4. Create Patient Schedules for Mid-Levels

Healthcare organizations that not only monitor measurable mid-level standards, but implement mid-level specific patient schedules generally are more successful. Through the creation of mid-level patient schedules in the supporting IT systems, one can more effectively monitor the impact of their overall contribution to access and productivity.

LESSON LEARNED #1: FTI has observed that many health system’s newly acquired physician practices often have the most effective MLP models to emulate. For example, a healthcare system in Philadelphia, copied a care model used by an acquired physician practice that emphasized proper MLP triaging. MLPs were scheduled patients that optimized the physicians’ time and enhanced patient service.

LESSON LEARNED #2: A common statement is, “the patient has come to see me and not just a mid-level”. In these situations, many leading organizations work to create mid-level schedules that coincide in parallel with the physician schedules to allow for brief interaction and/or physician visit time if the patient has a question of the doctor.

5. Align Mid-Level Incentives with Physicians to Increase Accountability

Compensation models drive performance through most industries with healthcare not being an exception. Leading FTI clients create compensation incentive models for mid-levels that are often similar to the physicians that they support, so that they are aligned in their organization’s financial, access, and quality goals.

LESSON LEARNED #1: Given that mid-levels are often shared across multiple physicians in a given practice, many clients have engaged in group compensation incentive models that mid-levels participate in. Further, care team models are requiring that mid-levels provide a significant role and compensation incentives should be aligned across the provider care teams to ensure desired patient outcomes.

LESSON LEARNED #2: Productivity goals should increase significantly for physicians when a mid-level is added to a practice. In physician compensation arrangements, it is important to clearly delineate how mid-level costs and/or contributive productivity will be accounted for in their compensation arrangements.
In Conclusion

At most healthcare organizations where rapid physician practice and/or employment is taking place, there is a challenge in understanding how many mid-levels there are and how they are used. By deploying the best practices discussed, organizations can get a better handle of MLP deployment and maximize the value that these key professionals offer patients, physicians and their organizations.

References

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