Society of Hospital Medicine

Empowering hospitalists.
Transforming patient care.

Hospital Medicine NP/PA Practice Integration & Optimization

The Society of Hospital Medicine (SHM) convened a working group to develop a statement to assist clinicians and administrators in Hospital Medicine NP/PA Practice Integration & Optimization.

Purpose and Scope

The mission of the Society of Hospital Medicine (SHM) is to promote exceptional care for hospitalized patients. In order for hospital medicine practices to deliver exceptional care, each team member in the practice should provide a meaningful contribution to the delivery of care. Integrating nurse practitioners (NPs) and physician assistants (PAs) within hospital medicine programs can be an important component when developing a high-functioning hospital medicine team. NP/PA providers often perform better at targeted quality metrics, are less likely to have process variability or deviate from checklists, and may help strengthen the provider's interface with nursing, patients and families. SHM has developed this communication to outline some considerations when integrating NP/PAs into a hospital medicine practice. SHM acknowledges this integrated care model is most effective when all members of the team are working at the top of their license in order to incorporate their skills and training to deliver exceptional care and impact a reduction in the overall cost of care.

Since 2012, there has been a 42 percent increase of NP/PA integration into hospital medicine teams; in 2016, 76.5 percent of all hospital medicine teams reported team-based care inclusive of NP/PAs[1,2]. Hospital medicine is a team-based specialty, composed of high-functioning members[3,4,5]. Collaboration and coordination amongst a myriad of team members, including subspecialty providers, case management, social workers, pharmacists, physical therapists, nursing, primary care providers/physicians and hospitalists, is important for optimal care delivery during an inpatient episode[4]. To provide optimal quality of patient care, each team member is required to function at the highest level of his or her training and skills[3,4]. This is especially vital with the predicted national staffing shortage of physicians. Multiple sources demonstrate there will be a growing supply-and-demand mismatch of physicians compared to the number of clinical providers needed to care for our aging population[2]. Nationally, hospital medicine programs struggle with patient volume and staffing stability due to increased competition for physicians. This is especially notable and persistent in rural areas and smaller community hospitals. Establishing a sustainable hospital medicine team is often an elusive goal for many hospitals and hospital systems. Integrating NPs and PAs within the hospital medicine team provides a larger pool of clinical providers to access during recruitment and retention efforts in order to accomplish the goal of a sustainable hospitalist team to efficiently provide high-value care.

In addition to the supply and demand challenges, hospitals and hospital systems increasingly struggle with lower margins and decreasing reimbursements. These same hospitals must provide substantial support payments to hospital medicine programs. These economic pressures are much more acute in community, rural and safety hospitals where 82 percent of hospitalists provide care[2].

When considering these economic factors in the context of hospital medicine programs, it is important to remember that 80 percent of hospital medicine costs are related to salary and benefits[2,7]. Of note, PA/NP providers are typically compensated at about 60 percent of a physician salary and currently reimbursed by Medicare at 85 percent of the physician fee schedule[2,7]. Thus, a hospital medicine team comprising both physicians and NP/PAs can help address recruitment and retention challenges in a cost-effective manner.

In order to realize these cost efficiencies, the NP/PA providers should have a level of productivity comparable to their physician partners. If NP/PA providers work fewer shifts per scheduling cycle or see significantly fewer patients per shift

than their physician colleagues, any staffing or economic advantage may be diminished. To optimize any potential financial advantage, hospital medicine programs should implement a model that has comparable levels of productivity between physician and NP/PA team members. Even with equivalent staffing however, there exist variables such as the complexity of the patient panel, the experience of the NP/PA provider or historical institutional use of NP/PAs, which can negate economic gains. The later of the two can be expected to improve with program maturation.

To support the highest level of hospital medicine team function, appropriate hiring is an important aspect. The hospital medicine program should recruit for competencies that facilitate a team-based approach to care delivery. Team members can rely on one another for clinical and operational support while functioning within a degree of autonomy, promoting a meaningful contribution to the practice workload[3]. Also, it is important that potential hires accurately comprehend the hospitalist "lifestyle" of which weekends, evenings, holidays and maybe even night shifts constitute normal practice. This is particularly important as the proper training of a new hospitalist NP/PA is a substantial investment. Often, successful hospital medicine programs benefit from affiliation with local NP/PA schools. Taking students for clinical rotations is a skillful way to "test drive" potential recruits and indoctrinate them to the varied and challenging hospital medicine environment.

When applying hiring strategies to physician providers, it is beneficial to look for efficient communication skills and a certain degree of comfort with the idea of the multidisciplinary care delivery team[3]. Clear communication of roles and expectations for each member of the team should be part of the onboarding and orientation process. This includes communication around what type of support and supervision the physicians will provide their NP/PA colleagues. When considering training, it is important to understand that graduate-level training for NP/PAs has greater variability than for physicians. Therefore, NP/PAs require a high level of additional training by the hospital medicine program to ensure uniformity of practice and successful implementation[3].

Optimal NP/PA training includes:

- A combination of didactic and clinical training
- Structured didactic training based on an accepted curriculum (e.g., SHM Core Competencies)
- Progressive increase in clinical responsibilities with ongoing guidance and oversight by physician or experienced PA/NP
- Ongoing formal (written) assessment and feedback of progress

Though formal testing exists for PAs in hospital medicine (National Commission on Certification of Physician Assistants Certificates of Added Qualifications), and NPs may attain certification in acute care, these are not commonly adopted measures of expertise specific to hospital medicine. Instead, the hospital medicine program should consider creating a written and/or oral test that reflects both the SHM Core Competencies as well as the patient populations/clinical scenarios that commonly occur in the hospital setting.

Training programs should be time limited – perhaps three to twelve months in length depending upon the skills of the NP/PA hire, as well as the complexity of the patient population. Adult learners progress through training at different speeds. Flexibility within the training program should allow for some variability, but it is best if any exceptions to the expected training program be formally approved. Not all NP/PA providers are suited for the independence and rigor of hospital medicine programs. Therefore, careful consideration and evaluation should be undergone if a new hire fails to progress satisfactorily. If a trainee is clearly not able to assimilate information or progress in clinical responsibilities, then training should cease.

Our experience is that programs that have excelled in integrating NP and PA providers into their hospitalist practice have a defined process and structured set of responsibilities to support and train their NP/PA colleagues[3,4,5]. This process includes physicians as well as NP/PAs that are established members of the group and have successfully accomplished this training. Physicians should be provided with a standard structure and curriculum in order to successfully participate in the training of NP/PA providers. This approach assists in establishing a group standard for training, rather than introducing significant variations that may occur if each physician were to train his or her NP/PA colleagues without a standardized curriculum or assessment.

Compatibility of a subset of physicians and experienced NP/PA providers to perform in this highly impactful and structured teaching role may necessitate incentives. Not all providers seek instructional roles and, if forced to do so, the quality of such instruction is likely to be sub-optimal. Physicians and experienced NP/PAs that most positively impact new NP/PA hires excel in communication skills, are comfortable with team-based care and are able to clarify misconceptions regarding NP/PA providers.

Subsequent to additional practice-based training, a structured program that supports ongoing oversight of NP/PA providers should be implemented. Such ongoing interventions might include:

- A scheduled review of patient rounding lists until expert competence level is achieved by the NP/PA[3,6]
- Specific criteria for how often shared visits with physicians should occur, either physically or remotely via telemedicine[3,6]
- Physician evaluation of all NP/PA admits within 24 hours either physically or remotely via telemedicine[3,6]

- Specific criteria for when physicians should be included in a patient's care; e.g., any change in a patient's level of care, non-invasive ventilation, hemodynamic or respiratory instability, or any time an NP/PA feels in need of physician consultation[3,6]

Retention of NP/PA providers is a valuable objective. Considerable investment is required for an NP/PA to practice independently, but once integrated the provider can have an immense impact on the stability, quality and financial performance of a hospital medicine program. Because of the sunk costs of training and the value these providers offer, a high-performing NP/PA can easily be "poached" by subspecialty consulting services with competitive hours or pay, or other hospital medicine groups. To protect hospital medicine groups from this all too frequent event, contractual arrangements should be considered. Potential career advancement within the team through a leadership position and within the hospital as a supervisory authority mitigates this risk. Additionally, investment in social events, CME, PTO and other career development options such as coding/billing auditor, utilization management, proceduralist and palliative care should be developed. Consideration should also be given to structuring compensation in a similar fashion to physician compensation; i.e., productivity or quality bonus administration if physician members receive these. Also, NP/PA scheduling should be comparable to physician colleagues in order to cultivate engagement. Finally, team building inoculates providers from burnout and alleviates physician workload.

However, the main driver for loyalty among hospital medicine NP/PA providers is likely allowing them to truly practice at the top of their skills and license, exercising judgment and managing patients in a role that maximizes their autonomy. That is rarely recreated in other domains, and it stimulates intrinsic motivation to remain loyal to the team.

The proper optimization and integration of NP/PAs allows a hospital organization to meet the increasing demands of healthcare, including recruitment and retention of a stable team—despite national physician shortages—that delivers care in an economically viable model[3,4,5,6,7].

Regulatory inconsistencies create practice barriers for nurse practitioners and physician assistants, whose care is proscribed by state laws, regulatory agencies and employer bylaws. Hospital credentialing barriers vary, from limiting NP/PA privileges to strict requirements with regard to physician face-to-face visits and/or signature of NP/PA charts. Nationally, a majority of states allow NP/PAs to practice autonomously, but hospital bylaws are often more restrictive than state requirements for practice.

Systemic cultures within the hospitalist team can also create barriers. Expectations vary from physician to physician. As a result, misconceptions can develop that can impact trust and acceptance of NP/PA practice and further prevent NP/PA autonomy. In addition, NP/PAs can encounter resistance from other medical disciplines regarding patient care. Hospitalist physicians can assist with these barriers by accurately communicating the value and scope of practice for NP/PA providers.

Removal of unnecessary barriers to nurse practitioners and physician assistants practicing to the top of their skills, licensure and training ensures hospitalist teams provide high-value, quality-based patient care outcomes[3,4,5,6]. Federal systems such as the Veterans Affairs Medical Centers are not inhibited by state practice barriers and have implemented an expansive scope of practice with NP/PA autonomy and subsequently reduced the overall cost of care[6]. Numerous studies demonstrate that hospital medicine programs, including nurse practitioners and physician assistants along with physicians, can generate outcomes equivalent to programs based on physician-only staffing models[3, 4, 5, 6, 7]. NP/PA providers often perform better at targeted quality metrics, are less likely to have process variability or deviate from checklists, and may help strengthen the provider's interface with nursing, patients and families.

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