Adding Advanced Practice Providers to a Neurology Practice—Four Perspectives

If you could change your neurology practice to serve more patients more quickly, with no loss of care to those patients, would you do it? Before you answer, add this to the equation: What if the change made a positive financial impact to your practice? And what if it meant that you could go home on time more nights than you otherwise would?

Those are the outcomes reported by neurology practices contacted for this article that have incorporated advanced practice providers, or APPs, into their clinics.

More commonly known by such professional designations as nurse practitioners or physician assistants, APPs are being used by more medical practices nationally to extend the reach of the doctor while holding down costs—two increasingly critical outcomes in an era of doctor shortages and restricted medical reimbursement. In specialty practices such as neurology, the role of the APP may be even more critical, given the acute shortage of neurologists in some areas and the steady growth of neurology cases among the aging population.

But as simple as the equation may seem—add APP, improve practice—the reality is naturally more complicated. First, of course, there’s the question of acceptance by neurologists. Objections range from discomfort delegating patient care duties to apprehension about patient reaction to concerns about training APPs into the practice.

While resolving case management issues and patient expectations are not overly difficult tasks, training remains a significant issue for using APPs in a clinical setting. Even though nurse practitioners and physician assistants are trained and certified in their professions, they are unlikely to have extensive education on neurology cases. That leaves the doctor to provide structured, hands-on clinical training—a daunting and time-consuming task.

SLASHING PATIENT WAITING TIMES

Recently retired from a two-doctor headache center in New York state, Heidi Schwarz, MD, FAAN, understands the training dilemma firsthand. When she and her colleague first opened the center, demand for their services was very high. “We quickly realized we needed help,” Schwarz said. “We had a four- to six-month waiting list for new patients.” Having worked with an APP in a previous appointment at the University of Rochester, Schwarz realized this could be the solution they needed. They hired a nurse practitioner Schwarz knew and gave her a focused six-week orientation, first as a shadow to the doctors and then seeing patients in tandem. The results were dramatic.

“She became a huge asset to the practice,” Schwarz said. “The wait time went down to two to four weeks, she markedly improved the volume of the practice, and she cut the lag time for response to patient questions.”

At first, the APP was mainly seeing follow-up patients, but the center was still experiencing a backup with new cases. The doctors struggled with the idea of having the nurse practitioner see new patients, so they developed a screening process with the front desk. If the patient had seen a neurologist elsewhere, the nurse practitioner might take the case, depending on her comfort after reviewing the records. In most other cases, the neurologists would see the new patient.

Schwarz, who has accepted a new appointment, is looking forward to training another APP when she joins the University of Rochester Department of Neurology Division of Headache Medicine in New York next month. In her role as vice chair of the AAN Practice Committee, she will continue to explore more options for bringing APPs into neurologic practices.
BUILDING AN IN-HOUSE TRAINING PROGRAM

James C. Stevens, MD, FAAN, practices as a partner with the Fort Wayne Neurological Center and serves on the AAN Board of Directors. Like Schwarz, he is convinced of the value brought by advanced practice providers. A referral-only practice, the center was risking its relationship with referring physicians 12 years ago when the wait time for new patients climbed to four months. By incorporating APPs into the practice, they reduced the wait time to one to two weeks and realized other benefits as well: strong bonds between the patients and the APPs and the ability to expand some of the center’s programs, including the intrathecal baclofen program, the deep brain stimulator management program, and the vagal nerve stimulator program.

Perhaps surprisingly, an additional benefit has been the center’s ability to use the staffing model to recruit neurologists. For the Midwest clinic, “Recruiting neurologists is a 24/7, 365 days-a-year job,” Stevens said. “You never stop looking. Using APPs helps fill the demand, but it’s also a plus in recruiting neurologists.

PAYMENT REFORM AS AN IMPETUS

Michael Kitchell, MD, is another Midwest neurologist whose practice struggles with recruiting doctors. As Board president of McFarland Clinic in Ames, Iowa, and a member of the AAN’s Payment Alternatives team, Kitchell is used to looking at the big picture when it comes to staffing. Although his neurology team currently encompasses only four doctors and two APPs, the clinic’s total employment includes 180 physicians and 40 nurse practitioners, physician assistants, and nurse midwives. With so many specialties to consider, Kitchell sees the use of APPs as an essential area of growth for practices. “This is not just a neurology phenomenon,” he says. “We’re seeing this with other specialties as well. It’s a definite national trend.”

One reason for the trend, Kitchell notes, is the rising influence of payment reform on medical practices. “Accountable care organizations try to get everybody practicing at the top of their licenses, so they don’t hire as many specialists,” he said. Further, the Medicare payments to rural areas are drastically lower than elsewhere, disproportionate to differences in the cost of operating the practice. The combination of lower reimbursements, increased pressure from ACOs, and ongoing physician recruitment challenges leads to Kitchell’s assessment that the use of advanced practice providers is essential to the survival of rural practices.

As with the other clinicians interviewed for this article, Kitchell has seen shortened patient wait times and increased physician productivity. He has heard the argument from doctors that using APPs slows down their processes, but he doesn’t agree. “They don’t see the big picture,” he says. “Even though I staff (the APPs) 10 minutes of the hour, the other 50 minutes they’re not staffed. And it is financially viable. You’re not going to make a lot of money from nurse practitioners and physician assistants, but you’re not going to lose money either.”

Not incidental to Kitchell’s assessment are the human factors for both the doctor and the patient. “I don’t want people to wait that long to be seen. This is about meeting the needs of the community and serving the greater good.” But the staffing model also gets the doctor home earlier, a difficult trick in any circumstance. Without the APPs, Kitchell said, “I probably would be working two or three more hours each day. They take the pressure off.”
DOUBLING IN SIZE WITH APPS

As CEO of the Dent Neurologic Institute in western New York and chair-elect of AAN’s Business and Research Administrators in Neurology Society (BRAINS), Joseph Fritz, PhD, starts from a business perspective when evaluating the use of APPs in clinical practice and research. His assessment: It’s the best way to grow an organization in today’s climate while maintaining patient care quality and meeting the needs of physicians.

The proof may be in the growth Dent has experienced so far. When Fritz took the CEO role in 2008, the use of APPs was already firmly established. He and his leadership team made a conscious decision to expand the model, leading to a doubling in size for the institute in just six years. The group now employs 20 neurologists, two neuropharmacologists, three psychiatrists and two psychologists, all supported by 25 APPs who work in both the clinical arm and in the Dent Neurological Science Research Center. For Fritz, organizational size is part of the successful equation for using APPs. “Size is where this can get tricky,” he says. “A solo practice with one or two neurologists and an APP taking on follow-up or maintenance care? That can work, but there’s a lot to learn. For general neurology there’s a lot more to know to cover such a wide range. Asking too much of the APP too early in their career is the risk.”

Instead, Fritz advocates a two-step practice model: “Step one, develop the practice around subspecialties so you have the experts. And step two, free up their consults by using APPs. You now have an APP with subspecialty experience. They’re really good because they can focus narrowly on the care plans developed by the physician.”

In addition, Fritz notes the use of APPs sets the stage for positive outcomes on both cost containment and practice revenues if an outcome of seeing new patients more quickly is the neurologist’s ability to take early control of diagnostic testing. As he notes, general practitioners are then less likely to order an array of potentially unnecessary tests while the patient waits to be seen by the specialist. And if the neurologists adds those ancillary services to their own practice, “Such a neurology practice can provide a comprehensive service that improves coordination of care and provides a cost-effective, consistent setting for the patient.”

Fritz isn’t swayed by arguments that the doctor’s role is diminished by sharing care duties, or that patients suffer in this model. “Can you imagine waiting two months to be seen when you think you may have ALS or some other disease? We think that’s horrid.” As for the doctor’s role, “I think you diminish the role of the doctor when you force them to do maintenance care. You’re using 10 years of medical school and training for monitoring chronic conditions. That’s not good. Why are the doctors doing a $20 or $30 an hour job? What they’re capable of doing is solving new, complex problems, but what you’ve got them doing is follow-on work. That’s a horrible thing to do to a physician.”

THE NEXT STEPS

Schwarz agrees with that assessment, although she acknowledges that “boutique” practices may be able to ignore the trend, at least for a while. But for the majority of neurology practices, she believes the addition of advanced practice providers will be inevitable. She likens the transition to the use of electronic medical records which has become widespread despite initial misgivings by many.

If the current trends continue, then APP training for neurology specialties will become a key issue, she says. “Particularly for smaller practices, the idea of slowing your patient flow for even six weeks to train someone is a bit of a non-starter. They just don’t have the margins.” One solution advocated by Schwarz and others would be the development by the AAN of neurology-specific training for advanced practice providers. Although the Academy currently counts only about 600 nurse practitioners and physician assistants among its 27,000 members, that number would likely grow if more tailored education or certification options were made available. At that point, neurology practices hiring trained APPs could shorten their in-house training significantly, while keeping a focus on overall patient care through the case reviews and daily monitoring practices already in place.

For his part, Fritz believes the final decision on this issue will be financial. “Even if we had all the physicians we needed, the money might not be there,” he says. “The pie is only so big and physicians need to be paid. Multiply that by the total number of health care providers you need according to our aging population and it’s not affordable. It makes more sense to work with the right number of physicians with the right number of APPs. It makes economic sense, business sense, quality sense. APPs are here to stay.”