

# Commentaries on health services research

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## Bending the cost curve

### ABSTRACT

“Bending the cost curve” for healthcare services in the United States challenges policy makers. A cost analysis was undertaken based on what would occur if more physician assistants (PAs) and nurse practitioners (NPs) per capita were deployed over a 10-year period. The state of Alabama was used as a case study because it is one of a handful of states with restrictive legislation affecting PA and NP scope of practice. Changing PA and NP scope of practice legislation in Alabama to match states in the upper quartile of collaborative legislation, such as Washington and Arizona, would increase the employment and distribution of PAs and NPs. Even modest changes in legislation will result in a net savings of \$729 million over the 10-year period. Underuse of PAs and NPs due to restrictive licensure reduces the cost benefits of increasing the supply of PAs and NPs and reducing the reliance on a stagnant supply of primary care physicians to meet society’s healthcare needs.<sup>1</sup>

*Commentary by Richard W. Dehn:* Professional associations often advocate with strong opinions and little analysis for self-serving governmental policies, often resulting

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in suboptimal political consequences for the average citizen. Occasionally policy is adopted that proves beneficial, such as legislation that has allowed PAs and NPs to practice closer to the full extent of their training. For example, 20 years ago when Texas permitted PAs and NPs to work distant from a supervising physician, within a very short period of time, PAs and NPs were deployed in many medically underserved areas.<sup>2</sup> The authors construct a compelling model that predicts substantial cost savings from a modest expansion in the legal scope of PA and NP practice in a state that has notably restrictive PA and NP practice laws as well as a substantial shortage of primary care providers. Economic models such as this can help raise the legislative debates over practice legislation beyond the politics of shouting matches among competing professional organizations.

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## Team-based care can reduce burnout

### ABSTRACT

Burnout is a threat to the primary care workforce. The relationship between team structure, team culture, and emotional exhaustion of clinicians and staff in primary care practices was investigated. In total, 231 clinicians and 280 staff members were surveyed. Predictor variables included team structure and perception of team culture. The outcome variable was the Maslach emotional exhaustion scale. Working in a tight team structure and perceptions of a greater team culture were associated with less clinician exhaustion. Team structure and team culture interacted to predict exhaustion: among clinicians reporting low team culture, team structure seemed to have little effect on exhaustion; among clinicians reporting high team culture, tighter team structure was associated with less exhaustion. Greater team culture was associated with less

exhaustion among staff. Fostering team culture may be an important strategy to protect against exhaustion in primary care and enhance the benefit of tight team structures.<sup>1</sup>

*Commentary by Douglas M. Brock:* The investigators report a cross-sectional survey exploring relationships between primary care teams and burnout. The value of teams for improving patient safety, reducing medical error, and improving patient satisfaction is widely studied.<sup>2</sup> Similarly, burnout is linked to a diminished quality of care and increased medical error rate.<sup>3</sup> However, few studies address the interconnections between these key constructs, especially in the smaller teams common to primary care. Among other findings, the investigators reported lower levels of exhaustion were associated with effective team culture for both clinicians and staff, suggesting effective team functioning may protect against burnout. If supported, strategies for improving the quality of team functioning may prove paramount to reducing job dissatisfaction. However, the reported associations are correlational and the investigators' interpretations mostly one-directional. A causal role for burnout in undermining team culture is not considered. Intervention studies are needed to more fully understand this relationship.

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## Does team-based task delegation affect patient panel size for primary care providers?

### ABSTRACT

Because of the shortage of primary care providers (PCPs), many face excessive patient panel sizes. Estimates of the time it takes for a PCP to provide preventive, chronic, and acute care for a panel of 2,500 patients were used to model how panel sizes would change if portions of preventive and chronic care services were delegated to other team members. Using three assumptions about the degree of task delegation that could be achieved (77%, 60%, and 50%

of preventive care, and 47%, 30%, and 25% of chronic care), researchers estimated that a primary care team could reasonably care for a panel of 1,947, 1,523, or 1,387 patients. Through team-based task delegation, primary care practices can provide recommended preventive and chronic care with panel sizes that are achievable with the available primary care workforce.<sup>1</sup>

*Commentary by Abiola O. Keller:* A key limitation of this study is that each of the task delegation models focused on teams comprising a physician leader and nonclinician team members. Although the authors acknowledge that their estimates are applicable to PAs and NPs when they have their own panels of patients, their work gives no consideration to the contributions of PAs and NPs as part of primary care teams. To justify this overt exclusion, the authors state that the previous research estimating the time needed to provide services focused on physicians only. Such statements emphasize the need for data and research on collaborative teams that involve physicians as well as PAs and NPs. Without such information, it will be challenging to demonstrate the benefits of collaborative teams and to determine the optimal distribution of patient care services between PAs, NPs, and physicians within such teams.<sup>2</sup>

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## Community health centers with diverse staffing patterns are productive

### ABSTRACT

Community health centers (CHCs) are at the forefront of ambulatory care practices in their use of PAs, NPs, and team-based primary care. The medical staffing patterns, contributions of different types of staff to productivity, and factors associated with staffing at CHCs were examined. Four different staffing patterns were noted: typical, high advanced-practice staff, high nursing staff, and high other medical staff. Overall, productivity per staff person was similar across the four staffing patterns. Physicians make the

greatest contributions to productivity, but other medical staffs also contribute. Patterns of staffing are driven by numerous factors, including the concentration of clinicians in communities, scope-of-practice laws, and patient characteristics such as insurance status. Such findings suggest that other group medical practices could incorporate more PA and NP staff without sacrificing productivity and thus profitability. However, new staffing patterns may be affected by characteristics of the practice location or the types of patients served.<sup>1</sup>

other. Eighty percent of PAs and 83% of podiatrists responded that their respective state associations should support a legislative initiative to let podiatrists supervise PAs in Tennessee. Sixty-two percent of PAs would consider working with a podiatrist, and 80% of podiatrists would hire a PA if given the opportunity; 88% of podiatrists felt their practice would operate more efficiently if they were able to use PAs. The addition of a PA to podiatric medicine is a logical extension of the PA's role in healthcare, and their inclusion could help meet the increasing demand for podiatric care.<sup>1</sup>

*Commentary by Roderick S. Hooker:* The holy grail of organization science is to find the maximum amount of productivity with the least amount of labor. Many approaches have been applied to productivity in healthcare but few have succeeded more than CHCs. Such systems have contributed to innovation and positive outcomes by task shifting and team-based care.<sup>2</sup> As workplaces evolve, researchers are increasingly interested in the social cohesion and interdisciplinary collaboration that produces such beneficial outcomes.<sup>3</sup> The authors delve into the Uniform Data System that is the central data repository of the 1,200 CHCs and weighted each medical visit by complexity of care and the influence of staff. The outcomes are strongly based on the ability to implement effective team-based care. Diversity of staff, be it nursing, PA, or NP, suggests that productivity is similar and a blend of substitution and complementary services abound. Although physicians tend to be more involved in complex conditions, the health centers demonstrate flexibility in how they manage their patient needs with all providers appearing to play coordinated roles. Those who advocate a strict hierarchy for providing medical care should take note.

*Commentary by David Mittman:* At a time when PAs are practicing more autonomously, being supervised by podiatrists would not be in our profession's best interest. Podiatry does not encompass the full practice of medicine, nor do podiatrists practice medicine. They do practice podiatric medicine, which is more limiting than the full practice of medicine that PAs are trained and licensed to practice. The practice of podiatry is limited to the diagnosis and treatment of illness of the lower leg and or the ankle and foot. It is not general medicine nor do podiatrists learn general, family, or internal medicine. PA scope of practice encompasses much more than the ankle and foot. Possibly because podiatrists are physicians and may desire assistants who can provide financial benefit, they see PAs as an attractive option.

What would happen in a podiatrist/PA practice if the PA discovers, while treating a patient, that the patient has another medical problem such as a skin infection on the chest? PAs can and should treat these diseases in their practices. Remember, however, a PA's scope of practice is not legally his or her own. A PA working with a podiatrist can't legally treat these problems. If a PA works with a surgeon or a dermatologist, the PA and physician can legally treat all medical problems, although highly specialized physicians would often refer. Would a PA be liable for observing a lesion on a patient's arm and not pointing it out? What if the patient tells a PA about a history of headaches and has a stroke shortly afterward? Was the PA responsible for knowing more, checking more, or doing more? Clearly podiatrist and physicians are not the same. Podiatrists should train and employ their own assistants. Podiatrists are well-trained and excellent providers of podiatric care. However, PA practice does not fit with podiatry.

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## Podiatry and physician assistants

### ABSTRACT

A survey of physician assistants (PAs) and podiatrists in Tennessee assessed interest in working with each

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