August, 2001

Dear Wisconsin Employers, Insurers, Providers and Students:

On behalf of the Utilization Committee of the Wisconsin Program for Training Regionally-Employed Care Providers (WisTREC), we would like to share the second edition of our Employment Guide with you. This guide brings together the most accurate, comprehensive, and up-to-date information on how to effectively use Physician Assistants, Nurse Practitioners, and Certified Nurse Midwives. It contains recent data on the three provider groups including: legal scope of practice, supervisory responsibilities, billing and reimbursement for services, compensation arrangements, sample contracts and a list of additional resources.

WisTREC is a collaborative project initiated by the Wisconsin Area Health Education Center (AHEC) System and funded by the Robert Wood Johnson Foundation’s Partnerships for Training project. The project's overall mission is to increase access to primary care in rural and urban shortage areas. This is accomplished through educating and employing health care providers in their home communities through the use of distance education technology.

The materials presented in this booklet are the product of collaboration between numerous statewide partners. Current information was acquired from Wisconsin’s professional organizations in the three disciplines, insurers, the Medical Group Management Association, published data and surveys conducted by WisTREC of PA, NP, and CNM practitioners and employers.

It is our privilege to pass on this practical product. Please feel free to share this resource with your colleagues. The Employment Guide is available on WisTREC’s website at http://academic.son.wisc.edu/wistrec/. Your comments and feedback on the Guide for subsequent versions will be appreciated. Do not hesitate to contact us if we can be of further assistance.

Sincerely,

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WisTREC’s Mission
WisTREC (Wisconsin Program for Training Regionally Employed Care Providers) is a statewide collaboration between public and private academic institutions, employer partners, businesses, health care corporations, and state and professional organizations. The WisTREC program is designed to improve access to health care for people living in underserved communities by increasing the number of physician assistants, nurse practitioners, and certified nurse-midwives working in these areas. Our strategy is to recruit and train individuals already residing in and committed to an underserved community by providing educational degree programs in the applicant’s home community through distance education.

You’ve Got the Solution
As a health care professional, you are well aware of the challenges experienced by communities whose health needs are not being fully met and who have difficulty with the recruitment and retention of new physicians. We believe the solution to meeting the health needs of your community already exists - in your own backyard. WisTREC will work with you to assess your community’s unique situation and develop a strategy that will allow your citizens access to the type of health care they deserve.

Through our “homegrown” approach, we will help you identify an individual or individuals in your community well-suited to take the next step - to become a physician assistant, nurse practitioner, or certified nurse midwife through additional education. The distance learning opportunities and clinical experiences in or near your community decrease the time away from home, family, and work.

Our community-based strategies have many advantages. Successful cultivation of “homegrown” health providers means that these health professionals are likely to stay and work in your community. You will avoid the high cost of recruiting outsiders that often move on to other communities.

And best of all, you invest in the best that your community has to offer - its own people. The immediate trust and credibility of someone who is already known and respected in the community is vital to the long-term success of this program.
Will you consider becoming a mentor?
A “homegrown” approach to health care education requires participation from community members to provide additional support to physician assistant, nurse practitioner, and nurse-midwifery students and recent graduates while they complete their education programs and as they transition into their primary care provider roles. Therefore, we are always looking for community-based mentors, especially from underserved populations.

Roles and Responsibilities of a Mentor
Mentoring is a nurturing process in which a more skilled/experienced person serving as a role develops an ongoing, caring relationship with a less skilled/experienced person. The mentor’s role includes teaching the mentee, sponsoring them in the workplace and community and with professional organizations, encouraging them, counseling them, and befriending them.

Qualifications of a WisTREC Mentor
Primarily we are looking for mentors who have faced similar challenges as the mentees in their journey to becoming a health care professional. Ideally, the mentor would be in the same type of practice as the mentee, though it is not essential. A mentor should have two or more years in active clinical practice. It is best, though not absolutely necessary, that the mentor and mentee come from the same community to help prevent professional isolation and to encourage role acceptance by other professionals.

The mentor and mentee together determine the frequency and form of their communication. Initially this might be every one to two weeks. Communication may be face-to-face, by telephone, or by email. The mentor-mentor relationship should be maintained a minimum of six months after graduation.

Benefits to the Mentor
- Satisfaction of assisting new colleagues in their development
- Realization of one’s own knowledge and expertise
- Collaboration and networking opportunity with mentee
- Collaboration and networking with the academic community
- Professional development through association with the academic program

What Next?
If you are interested in becoming a mentor or want more information, please contact WisTREC:
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K6/218 CSC-2455
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Visit the WisTREC web site at:
http://academic.son.wisc.edu/wistrec/
Frequently Asked Questions

1) What is WisTREC?
WisTREC is an acronym for Wisconsin Program for Training Regionally Employed Care Providers. The core group of WisTREC partners includes twenty-six higher education institutions, government agencies and community organizations. WisTREC’s goal is to improve health care by increasing the number of primary health care providers in target areas throughout the state. The partners are working together to expand opportunities for the recruitment, education, and retention of “homegrown” practitioners in health professional shortage areas (HPSAs) in Wisconsin’s rural and urban communities. WisTREC is funded, in part, by a grant from the Robert Wood Johnson Foundation and is administered by the University of Wisconsin Madison School of Nursing.

2) Who is considered a primary health care provider?
For this project, primary health care providers include certified nurse-midwives (CNMs), nurse practitioners (NPs), and physician assistants (PAs).

3) What is meant by a “homegrown” provider?
The “homegrown” concept, literally, means something which is produced locally. When applied to primary health care providers, it refers to a community’s ability to recruit, educate, and retain a group of health care providers within their local area. Supporters of this “homegrown” recognize that there are: a) individuals currently living and/or working in a health underserved communities who are qualified to become primary care providers, b) potential resources within the community or work environment for training primary health care providers, and c) increased incentives for individuals trained locally to maintain a presence and remain in the community. Thus, the idea of “growing your own” primary health care provider is crucial to the WisTREC goal of increasing their numbers and, subsequently, improving health care in target areas of Wisconsin.

4) Does WisTREC have other goals?
Yes. A closely related goal of WisTREC’s is the expanded use of technology, primarily computer-based, to facilitate flexible learning. Flexible learning will allow a WisTREC student to remain in their local community for some, if not all, of their education/training. In addition, WisTREC is working with its partners to enhance the practice climate for each discipline by reducing barriers to hiring and utilizing NPs, PAs and CNMs.

5) What is a WisTREC student?
WisTREC students, as a group, are expected to be culturally diverse, service-oriented, self-directed, working, adult, lifelong learners who are able to tolerate some degree of ambiguity as this program evolves. Potential WisTREC students must meet the following criteria:
1) Be committed to working with Wisconsin’s underserved communities;
2) Reside or work in a health professional shortage area (HPSA) or other underserved area
   OR be a member of a federally defined minority; and
3) Meet the admissions criteria for the educational program of interest.

7) Who are the WisTREC educational institutions and what do they offer?
WisTREC educational institutions include WisTREC Distance Programs and Partners. Distance Programs have agreed to facilitate students being able to stay in their home communities by delivering courses to students via flexible learning. Partners support WisTREC students in every way except by providing distance courses.

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Partnerships for Training
8) What is a WisTREC “home institution?”
Each WisTREC student will select, apply to and enroll in one of the WisTREC educational institutions - their “home institution” – from which the student will receive their degree. The student will complete an application to their “home institution.”

9) How will WisTREC deliver academic and clinical courses locally?
WisTREC education partners have agreed to use innovative learning technologies including, but not limited to, distance education through Internet-delivered courses and video and audio conferencing.

10) Will I need a computer?
Access to a computer with Internet capabilities and connection is mandatory for WisTREC students. However, if you do not have computer access, WisTREC will work to provide that access to you, as well as computer training should you require it.

11) What are the benefits of being a WisTREC Student?
Besides the potential of flexible learning opportunities, the student may receive various types of support. Ideally, a WisTREC student represents a “four-way street” of commitment between the student, the employer, the community, and the WisTREC partners. Usually support will be in the form of financial assistance, i.e. tuition, reimbursement, scholarship, loan repayment, release time, or flex time. Support may also take the form of the designation of a WisTREC distance learning site workspace, including a computer with Internet-connectivity for the student’s use. Other commitments to WisTREC students may include clinical preceptors and training sites in the home community.

12) Will WisTREC pay the educational costs for students?
WisTREC does not directly pay for tuition or fees to the student’s “home institution.” The WisTREC coalition strives to obtain support from communities, local organizations, and employers who will benefit directly from the preparation of “homegrown” advanced practice health care providers. As a result, the amount of tuition and fee support available to each WisTREC student will vary depending on the financial support and tuition reimbursement offered through the particular community or employer. Students may also receive financial aid in the form of scholarships and loans.

13) What is the advantage of WisTREC over traditional education?
The features which make WisTREC unique are: the emphasis on maintaining the student/learner in their own community for the majority of their education/training program; the use of interactive technology and computers for courses and individual study; the support of the student’s employer and/or community in the education process. Traditionally, education has required that the student enter the environment of the institution. WisTREC proposes the opposite by bringing education to the environment of the student.

14) Is WisTREC for me?
WisTREC is a new option for training and education of primary health care providers in Wisconsin. Each WisTREC Distance Program now maintains its campus-based program and is developing a technology-based program. WisTREC believes that unique, individual circumstances frequently prevent working adults from taking advantage of current educational offerings. As the total WisTREC approach evolves, WisTREC will work to ensure that both the learner’s and the institution’s goals are met. WisTREC is not for everyone. It requires a high level of self-directedness and independence. However, we believe that WisTREC is ideal for many potential primary care providers who cannot leave their families and/or work to return to school. WisTREC is also designed for those who prefer to utilize flexible learning options for study and those who are especially committed to community-based education. Only you can decide if WisTREC is the program for you.

We appreciate your interest in WisTREC and look forward to hearing from you. If you have any further questions feel free to contact the WisTREC office at 608-262-8755 or eahorn@facstaff.wisc.edu.
WisTREC Publications and Resources:

For any of the WisTREC products outlined below, contact our office or go to our web site. [http://academic.son.wisc.edu/wistrec/](http://academic.son.wisc.edu/wistrec/)

**Directory of Distance Courses**
A listing of courses available at a distance to WisTREC Students.

**Physician Assistants, Nurse Practitioners, Certified Nurse Midwives: Employment Guide**
A comprehensive guide for current and prospective employers and students outlining requirements for the professions, scopes of practice, reimbursement and financial analysis, and general employment information.

**Employer Survey**
This survey was conducted in the spring of 1999 to collect information from employers in rural and urban shortage areas in Wisconsin about their current and future use of NPs, PAs, and CNMs and to determine their interest in ongoing dialogue with academic programs about the need for providers and population health needs.

**Academic Survey**
A two-part survey of the academic program in Wisconsin that educate NPs, PAs and CNMs was conducted in the spring of 1999. The purpose of the survey was to identify: 1) the nature and extent of current dialogue with employers of their graduates in shortage areas; and 2) the nature and extent of academic partner efforts to help their graduates locate employment in shortage areas.

**Non-Physician Clinicians in Wisconsin: A Descriptive Examination of Physician Assistants, Nurse Practitioners, and Certified Nurse Midwives**
This study was conducted to better understand the role of Wisconsin PAs, NPs and CNMs. The study population included all the PAs, NPs, and CNMs who practiced in Wisconsin in 1997. The report includes data concerning advanced training needs, practice autonomy, barriers to practice, and an assessment of current market conditions for these providers.

**Primary Care**
This brochure outlines the scopes of practice, collaboration, supervision and prescriptive authority for PAs, NPs and CNMs.
“Survey of Employers’ Current and Planned Utilization of Physician Assistants, Nurse Practitioners, and Certified Nurse Midwives In Health Professional Shortage Areas in Wisconsin”

Spring 1999

S.K. Riesch, DNSc, RN, FAAN; J.B. Henriquez, PhD; H. Herger, MS, RN; M. LaForte, MS, RN; K. Loppnow, BS, RN; J.N. Worel, MS, RN
And the WisTREC Utilization Committee

Purposes:
A. Current use and plan for use of PAs, NPs, and CNMs;
B. Issues, concerns, and barriers about hiring and utilizing PAs, NPs, and CNMs;
C. New marketplace needs or populations to be cared for if these providers were trained differently; and
D. Current communication and interest in additional communication with academic programs about training and recruitment of PAs, NPs and CNMs.

Method:
A telephone survey was conducted of health care employers located in or serving residents in Health Professional Shortage Areas (HPSAs). Of the 83 institutions contacted 40 were interviewed and a majority were located in rural HPSAs. These included: Wisconsin Staff Physician Recruiters (13), certified rural health clinics (16), community health centers (5), and tribal health centers (6). The survey was conducted in the spring of 1999 by a group of graduate nurse practitioner students and their faculty advisor at the University of Wisconsin School of Nursing – Madison.

Results:
A. Current use and plans to recruit additional PAs, NPs and CNMs
   • Current use – 73% of employers reported use of any one of the 3 provider types
   • Future use – Expect more use in hospital and nursing home rounds and clinical research
   • Plans to recruit - The 40 survey respondents reported plans to hire 14 PAs, 28 NPs and 7 CNMs over the next year, and reported the perception that there is a more than adequate supply from which to recruit.
B. Issues, concerns and barriers to hiring and using PAs, NPs and CNMs
   • Barriers include physician resistance and lack of experience with 3 provider types, confusion about scope of practice and supervision requirements on both sides, and confusion about billing/reimbursement.

C. New marketplace needs or population needs that could be addressed by training
   • Emerging population needs – frail elderly, chronically ill, mental health in urban areas, and additional competence to meet the needs of rural populations.
   • Emerging skill needs – acute care and life support certification, community health education and computer skills.

D. Current communication and interest in additional communication with academic programs about training and recruitment.
   • Employers were generally satisfied with level of training of providers.
   • Training sites – 55% of employers indicated they already provide training sites.
   • Employers report some communication with academic programs (45% through surveys) and report a willingness for more collaboration (48%).
   • Employers expressed interest in collaborating on more job fairs for graduating students.
Wisconsin Area Health Education Center System

Wisconsin AHEC System Office

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The Wisconsin Area Health Education Center (AHEC) System is a statewide project dedicated to improving access to quality health care in the state’s rural and urban underserved communities. It focuses on developing health professions training programs that encourage future and present health care providers to practice in the areas where they are needed most.

Launched in 1991, the AHEC System brings together Wisconsin’s academic programs and its underserved communities. The state is divided into four regional Centers: Eastern, Milwaukee, Northern and Southwest. These four regional AHECs work with community and academic partners to develop health professions education programs that address the specific needs of their target areas.

WISCONSIN

Wisconsin Area Health Education Center System

The four regional Centers are independent, non-profit, 501(c)3 organizations with their own governing boards. A System office is maintained at the University of Wisconsin-Madison to coordinate numerous statewide programs.

The Wisconsin AHEC System is supported by state appropriation, supplemented by federal and other grants and resources provided by AHEC’s academic and community partners.

In partnership with the University of Wisconsin Medical School, a twenty person board of directors provides statewide direction and oversight. This AHEC System Board is comprised of twelve representatives from the regional AHEC boards (three from each of the four Centers) and eight other health professions, academic program and at-large members.

Program Areas

The AHEC System conducts and supports programs in four general categories:

- community-based education programs to develop and support clinical education for medical and other health professions students in rural and urban underserved communities;
- continuing education programs to enable health professionals in underserved communities to provide the highest quality health care;
- health career programs to help high school and college students from under-represented populations prepare for careers in the health professions;
- community health outreach programs developed in collaboration with local health agencies, schools and other local organizations.

Community-Based Education

AHEC programs expand and enrich opportunities for health professions students to spend part of their training in community settings. Students gain important community-based clinical experience at sites throughout the four AHEC regions.

AHEC supports clinical rotation sites in many ways, including programs to prepare preceptors for their role as teachers and distance learning initiatives that link sites to expand their resources. Such programs increase the educational value and appeal of these sites for students while providing help for local practitioners.

These community-based educational experiences are supported by changes in the curriculum of health professions schools as well as by special programs in the community and schools that increase students’ understanding of cultural differences affecting the delivery of health care.

Students from several health professions fields, including medicine (medical students and residents), nursing (undergraduate, nurse midwife, and nurse practitioner), social work, pharmacy, and physician assistant programs participate in AHEC-supported programs.

Interdisciplinary Training

At some sites, students, faculty, and community providers from several disciplines work as a team to deliver health services. This interdisciplinary approach is the hallmark of clinical training sites called Community
Education Centers (CECs), which the AHEC System helped establish in each region. Each CEC targets the health care needs of a specific population such as home-bound elderly people or adolescents.

**Medical Students**
UWMS now has more than 10 percent of its medical student clinical training in the AHEC-related programs. This was accomplished by creating new off-campus medical student clerkships and preceptorships, and by enhancing existing off-campus clinical opportunities.

**Residents**
Family practice, general internal medicine, and pediatric residents in the state participate in clinical experiences at AHEC-supported community training sites.

**Physician Assistants**
Working with the regional AHECs, the AHEC System is expanding community placements for students in the UW physician assistant programs.

**Nursing**
Nursing programs throughout the state (undergraduate, nurse practitioner, and nurse midwife) are participating in AHEC sponsored community-based education programs. The Wisconsin AHEC System was also involved in creating the state’s first certified nurse midwife program at Marquette University.

**Continuing Education Programs**
Isolation from major medical centers and resources can lead practitioners to leave underserved areas and can discourage health professionals from training or establishing practice there. Therefore, AHEC programs help expand the educational resources available to local practitioners and students.

UWMS provides continuing education programs in underserved areas. The Wisconsin AHEC System also co-sponsors continuing medical education activities with other health care groups.

The AHEC System seeks to increase access to technology resources at community sites. Working with UWMS, the regional centers have also expanded library resources available in communities.

**Health Careers Programs**
The focus of AHEC programs goes beyond students who already have chosen to pursue health professions. To improve access to care, AHEC programs also seek to attract more people from under-represented populations to the health professions.

The health professions programs at UW-Madison have worked with AHEC on summer programs to stimulate interest in health professions among minority and disadvantaged youth. Regional AHECs support a variety of local programs that enable pre-college students to learn first-hand what it means to be a health professional.

**Community Outreach**
The AHEC System works closely with health professions schools, community groups and providers, and other health care organizations in the state in planning and implementing programs.

In addition to local partnerships, Wisconsin AHEC also collaborates with several statewide organizations, including:

- Wisconsin Department of Health and Family Services, Division of Public Health;
- Wisconsin Office of Rural Health;
- Consortium for Primary Care in Wisconsin;
- Wisconsin Tribal Health Centers;
- Wisconsin Geriatric Education Centers;
- Wisconsin Primary Health Care Association; and
- Migrant and Community Health Centers and Health Care for the Homeless programs.

**Special Initiatives**
The AHEC System’s work is enhanced by a number of grants the system has been awarded to fund special initiatives aimed at expanding access to care in underserved areas.
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www.medsch.wisc.edu/ahec/
EMPLOYMENT GUIDE

Information on Physician Assistants

Revised: January 2003

A collaborative project of the WisTREC Utilization Committee initiated by the Wisconsin AHEC System and funded by The Robert Wood Johnson Foundation.
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INTRODUCTION

This booklet was developed by the Wisconsin Program for Training Regionally Employed Care providers (“WisTREC”) utilization task force. WisTREC is a project of the Wisconsin Area Health Education Center System, is funded by the Robert Wood Johnson Foundation-Partnerships for Training program, and is administered through the University of Wisconsin-Madison School of Nursing.

WisTREC is focused on increasing access to primary care in underserved areas and for underserved populations by increasing the training and use of physician assistants, nurse practitioners, and nurse midwives in these areas and populations.

WisTREC and its collaborating partners are committed to sharing the information in these guides with all interested parties. These guides may be copied and distributed or excerpts used if the WisTREC project is credited.

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**FACTS ABOUT PHYSICIAN ASSISTANTS**

*General Description*

The role of the physician assistant (PA) continues to expand in importance to providers in institutional, private primary care, and specialty practices and to the communities in which they serve. Physician assistants are finding growing occupational opportunities within acute and long-term care facilities, in the offices of independent practice physicians, and with physicians in group practice.

... the role of the PA continues to expand in importance ... 

Whether serving in primary care or specialty disciplines, or in the role of a significant adjunct to public health resources, the professional PA augments the capacity of traditional health care delivery systems by offering greater efficiencies in the delivery of care. PAs afford more rational allocation of time and resources while also retaining high levels of patient satisfaction.

*Education and Certification*

Basic admission requirements for most PA programs require two years of college and some prior health care experience. According to the 2002 Physician Assistant Census conducted by the Association of Physician Assistant Programs, 73 percent of the students enrolled in 2001 had earned at least a baccalaureate degree prior to entering PA school. Further 2002 data gathered from the American Academy of Physician Assistants (AAPA) on all currently practicing PAs is provided in the chart below.

As of November, 2002, there were 130 accredited physician assistant programs in the U.S. All PA programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). The governing body of the ARC-PA includes members from the American Medical Association, the American Academy of Family Physicians, the American College of Physicians–American Society of Internal Medicine, the American Academy of Pediatrics, the American College of Surgeons, the American Academy of Physician Assistants, and the Association of PA Programs.

The first year of the two-year PA program includes classroom study in basic and behavioral/social sciences: anatomy, biochemistry, clinical laboratory, clinical medicine, health promotion, medical ethics, microbiology, pathology, pharmacology, physiology, and
psychology. The second year encompasses over 2,000 hours of clinical rotations in emergency medicine, family practice, internal medicine, obstetrics/gynecology, orthopedics, pediatrics, and surgery.

Upon graduation from an accredited PA program, candidates for the profession must sit for the certifying examination developed by the National Board of Medical Examiners and administered by the National Commission on Certification of Physician Assistants (NCCPA). Wisconsin requires candidates to pass this examination prior to licensure as a PA. However, a nonrenewable temporary license may be obtained in Wisconsin as long as a qualified graduate is either scheduled to take the PA examination or has taken the examination and is awaiting the results. Those who successfully pass the examination may use the title “Physician Assistant-Certified” (PA-C). Physician assistants must complete 100 hours of continuing medical education every two years and pass recertification exams every six years to maintain national certification. A minimum of 50 hours must be earned in Category 1 CME credit as defined and approved by the AAPA or other accrediting body.

**Characteristics of Practitioners**

**Practitioner Demographics**

According to AAPA figures gathered in 2002, the vast majority of PAs responding to the association’s annual census were employed in clinical practice (88%); with most of those individuals practicing on a full-time basis (87%).

The same census reports that Wisconsin’s gender ratio (43% male, 57% female) is similar to the national figures (42% male, 58% female). 97% of Wisconsin respondents reported their ethnicity as White, 1% reported Black, 1% reported Hispanic and 1% American Indian.

**Number of Practitioners**

AAPA estimates that approximately 51,607 physician assistants were eligible for clinical practice as physician assistants in the United States as of May, 2002. The national membership of AAPA at that time was nearly 28,000. According to the Wisconsin Medical Examining Board, a total of 1116 PAs were licensed to practice in the state of Wisconsin in October, 2002. 990 of these licensees had Wisconsin residence addresses.

**Enrolled Candidates**

Nationally, according to the Association of PA Programs’ Annual Report about 8256 candidates were enrolled in 130 accredited physician assistant programs during the 2000-2001 academic year. The number of graduates in 2001 was estimated at 4416 and the number of graduates in 2003 is expected to exceed 5,000. In Wisconsin, approximately 77 physician assistant students graduate each year: 30 students from the University of Wisconsin-Madison, 35 students from Marquette University in Milwaukee and 12 students from the University of Wisconsin-La Crosse.
**Practice Settings**

Physician assistants practice in communities spanning the most densely urban to the most remote and rural. AAPA 2002 census data reveal that 35% of Wisconsin respondents describe their practice sites as rural compared with 22% nationally. 5% report their employment setting as inner city compared to 12% nationally; 58% report an urban or suburban work setting compared to 64% nationally.

The Wisconsin subset of the same census reveals that only 5% of Wisconsin PAs are employed by a solo physician practice compared with 12% nationally. 41% of Wisconsin PAs are employed by single or multiple specialty groups compared with 28% nationally; 6% of Wisconsin PAs are employed by HMOs compared with 4% nationally. Over one-third of all PAs work in the hospital setting, 38% nationally, 37% in Wisconsin.

1998 WisTREC survey data indicated that 58 percent of physician assistants worked in physician practice sites; 13 percent in various types of community health centers; 2 percent in long-term care facilities; 13 percent in hospital departments; and the remaining 14 percent in various public and private settings including home health care, governmental agencies, and other practice settings.

According to the American Academy of Physician Assistants, PA professionals practice in over 60 specialty fields of medicine nationwide. The majority of practicing physician assistants are active in the primary care fields—family/general practice, general internal medicine, pediatrics, and obstetrics/gynecology. Other prevalent specialties with PA involvement include general surgery/surgical subspecialties, emergency medicine, and the subspecialties of internal medicine. In addition, PAs frequently work in the areas of education, clinical supervision, and administration.
Scope of Practice
The scope of practice of physician assistants currently licensed in the state is defined under Chapter Med 8 of the Wisconsin Administrative Code governing the state’s Medical Examining Board.

In providing patient services, the entire practice of any physician assistant shall be under the supervision of a licensed physician. A physician assistant’s practice may not exceed his or her educational training or experience and may not exceed the scope of practice of the supervising physician. A medical care task assigned by the supervising physician to the physician assistant may not be delegated by the physician assistant to another person.

Thus as their scope of responsibilities is determined within the practice of a supervising physician, the PA is a medical team member who provides a broad range of services. These services may include:

- patient histories and physical exams;
- a variety of diagnostic studies to form a diagnostic impression;
- initiation and management of therapies for acute or chronic health problems;
- health screenings, preventive care, patient education, and counseling;
- minor surgical procedures;
- family planning, perinatal, and gynecological care;
- assisting with surgery, ER, acute hospital, and long-term care;
- referral and follow-up care with physician specialists; and
- issuing prescription orders for medications.

Employment Requirements
Chapter Med 8 sections 9 and 10 of the Wisconsin Administrative Code refer to employment requirements for physician assistants.

No physician assistant may be self-employed. If the employer of a physician assistant is other than a licensed physician, the employer shall provide for, and may not interfere with, the supervisory responsibilities of the physician.

No physician may supervise more than two physician assistants concurrently unless that physician submits a written plan and receives approval; however, more than one physician is allowed to supervise a PA.
The supervision requirements in Med 8.10 allow a physician assistant to practice at a site other than the supervising physician’s office. In fact, it is quite common for a physician assistant to practice in a facility a substantial distance away from the supervising physician. The supervising physician must be available for consultation by telephone or other means of telecommunication within 15 minutes of contact. Another licensed physician can be designated by the supervising physician to provide substitute supervisory responsibilities for up to eight weeks per year.

The supervising physician is required to conduct an on-site review of facilities attended by the PA at least once a month. However, certain payor requirements may be more stringent. For example, Medicare regulations for certified rural health clinics require that a physician be present in the clinic at least once every two weeks unless there are extraordinary circumstances that require postponement of the scheduled visit.

**Spectrum of Practice Settings**

Physician assistants may offer a solution to the national shortage of primary care physicians and help provide both primary and specialty care for many Americans who would otherwise lack access to ongoing health care services. Working side-by-side with a physician as an assistant-at-surgery or practicing with minimal supervision in a remote rural clinic, PAs continue to address the health care needs of millions of Americans each year.

A wide range of health care organizations have found that physician assistants contribute significantly toward their overall mission of providing high-quality, cost-effective health care services. Physician assistants are most commonly found in clinic settings where they conduct physical exams, diagnose and treat illnesses, order and interpret diagnostic tests, and in most states, prescribe medications. Many hospitals utilize the expertise of PAs in emergency rooms and urgent care settings. Residents of long-term care facilities benefit from the collaborative effort among provider teams consisting of physicians and PAs. As an integral member of a surgical practice, the PA is often called upon to perform routine pre- and post-surgery follow-up care in addition to directly assisting in surgeries.

This broad range of practice settings can help to explain the strong demand for physician assistants and the tremendous growth in the number of practicing PAs from less than 1,500 in 1973 to more than 56,000 practicing PAs across the country today. Medical practice managers and physicians often cite the following benefits that physician assistants can bring to an organization:

- **Better patient flow.** Physician assistants can see walk-ins, urgent care cases, and routine follow-up visits such as blood pressure checks.

- **Shorter waiting time for appointments.** Patients have the option of seeing the PA when a physician is not available. This can improve patient satisfaction with greater availability of care.

- **Greater emphasis on prevention and patient education.** Physician assistants can oversee
nutrition and exercise programs for weight management, hypertension, and diabetes care, as well as smoking-cessation programs.

- **Ability to extend care into the community.** Physician assistants can extend care to patients in rural communities, medically underserved areas, and nursing homes that may not have access to physician services.

- **Enable physicians to focus on difficult problems.** Perhaps one of the greatest benefits is that a physician assistant can shift the workload. He or she can handle routine office visits, freeing physicians to manage the more challenging cases.

- **Professional fellowship.** For solo physicians, especially those in rural or frontier practice, a physician assistant can provide professional fellowship.

**Prescriptive Authority**

A number of recent legislative changes in Wisconsin became effective on February 1, 1999. Wisconsin Statute 448.21(3) permits a physician assistant to issue a prescription order for a drug or device in accordance with guidelines established by a supervising physician and the PA and with rules promulgated by the Medical Examining Board. Physician assistants in Wisconsin are now recognized as practitioners under state controlled substance law, s.961.01(19), which permits them to distribute and dispense controlled substances including schedule II through schedule V medications. Wisconsin PAs were already recognized as individual practitioners under federal controlled substance law, s.21 CFR 1300.01(17)(28), and are eligible to apply for midlevel provider DEA registration numbers.

Chapter Med 8.08 of the Wisconsin Administrative Code requires that written guidelines for prescribing be kept on-site and reviewed at least annually by the PA as well as the supervising physician. The actual format of these guidelines is left up to the discretion of the physician and the PA; but it is recommended that they should at least include the classes of medications (reference to a drug formulary is acceptable) which the PA has been delegated the authority to prescribe as well as any restrictions. Prescription orders prepared by the PA must contain the name, address, and telephone number of the supervising physician. Under changes to Med 8.08 approved by the Medical Examining Board in February of 1998, the supervising physician is required to review and countersign either the prescription order or the patient record prepared by the PA within 72 hours. The countersignature requirement only applies to patient records for which prescriptions are written or medications are ordered. If a PA practices in a facility apart from the supervising physician, review by telephone within 72 hours and countersignature of the patient record within one week is required.
REIMBURSEMENT AND FINANCIAL ANALYSIS

Compensation Arrangements

Salary and Benefit Structure

Arrangements for the compensation of physician assistants vary by organization; however, the direct compensation for most PAs is typically based on a straight salary, a salary plus bonus incentive payment, or a production formula. A year 2000 survey conducted by the Medical Group Management Association revealed that of 282 employed PAs, 60 percent were compensated on a straight salary basis, whereas 37 percent had a salary plus a bonus or incentive payment. The remaining 3 percent were compensated on a production basis, computed by gross charges, net charges, or on a relative value unit formula.

The benefit structure for employed PAs also varies by organization. According to the AAPA Census, typical benefits of practicing PAs include nearly three weeks paid vacation (including six to ten paid holidays), paid sick and continuing medical education leave, pension/retirement fund, malpractice insurance, health insurance, group term life insurance, group long-term disability insurance, annual dues/licensures, and an average continuing education allowance over $1,300.

National Salary Data

Several organizations accumulate and report annual salary data for physician assistants. According to data collected in 2002 by the AAPA, the mean annual income for PAs nationwide was $72,241; the median was $69,567. The 2002 AAPA Census also reported the mean annual income for PAs with less than one year of experience upon graduation from a PA school was $63,168; the median was $61,363. The Medical Group Management Association’s Physician Compensation and Production Survey: 2002 Report Based on 2001 Data reported that the mean compensation of surgical PAs was $74,764; the median was $71,566. The MGMA survey also reported that the mean compensation of primary care PAs (pcp) was $68,056; the median was $65,704.

National survey data has revealed wide variations in the earnings among PAs due to factors such as years of experience, specialty of practice, population of the geographic area, whether the PA takes call, and whether the PA has administrative and/or supervisory responsibilities for other PAs. For instance, the AAPA reports that primary care PAs have mean incomes below the overall average for all PAs. Specialties with incomes above the overall mean income include surgery, emergency medicine, and occupational/industrial medicine.
Wisconsin Salary Data

The AAPA 2002 Census reported a mean salary of $73,073 for Wisconsin respondents and $61,213 for Wisconsin respondents who were employed for approximately one year or less. In December 2001, the University of Wisconsin-Madison Physician Assistant Program compiled salary data on alumni employed as full-time PAs. Based on the alumni survey of 240 respondents residing in Wisconsin, the mean annual income was $65,702 and $57,580 for residents employed for one year or less. In the fall of 2002, the Wisconsin Academy of Physician Assistants received 372 responses to its first employment survey. The mean annual salary was $66,890. Also, Dean Medical Center of Madison, Wisconsin, conducted a 2002 survey of physician assistant compensation and benefit arrangements of nine major health care provider organizations. Data from this survey indicated an average salary range for primary care PAs of $41,308 - $78,458, with an average midpoint salary of $63,960.

**Comparative Wisconsin PA Annual Salary**

![Comparative Wisconsin PA Annual Salary](chart)

**Contribution to Practice Revenue**

**Pricing of Services**

In most medical practices, the amounts charged for services rendered by the physician assistant are identical to the amounts charged for comparable services performed by a physician. Therefore a patient may be charged the same amount for the same service, whether a PA or a physician performs it. However, the average complexity of patient health care needs and services rendered by the PA may be less than the typical physician. A difference in the mix of services delivered will result in lower average charges per patient treated by the PA (for example, an established patient with a minor illness) as opposed to the physician (for example, a new patient with multiple, acute illnesses).

**Volume Indicators**

Patient visit statistics, or ambulatory encounters, can be an effective barometer of the financial performance of a health care provider, particularly in a primary care practice setting. A patient visit is typically defined as an identifiable contact between the patient and a health care provider where advice, a procedure, service, or treatment is provided. Important volume indicators for PAs in surgical practices may also include the number of surgical assists.

AAPA’s 2002 Census data indicates that of those PAs working full-time in
the treatment of outpatients exclusively, the average number of patient visits per week is 98. The mean number of patient encounters per week for those who work full-time treating inpatients exclusively is significantly lower (60). The Medical Group Management Association also reports the number of ambulatory encounters for PAs in primary care practices. The 2002 MGMA Survey reported the average number of annual ambulatory encounters for primary care PAs as 3,438. Assuming the average PA works approximately 48 weeks per year (allowing for vacation and CME), the MGMA data would translate into approximately 71 ambulatory patient visits per week. The MGMA and AAPA data suggests that a physician assistant, on average, treats 14 to 20 outpatients per eight-hour day in a primary/ambulatory care setting. This data has been further corroborated by the University of Wisconsin-Madison 2002 Physician Assistant Alumni Survey. This survey reported that an average of 17.5 outpatient encounters were treated each day by 329 responding PAs.

Production Data

Production (revenue) generation by physician assistants is not widely reported in trade journals or medical surveys, but patient charges can be another key indicator of the financial performance of the PA. The role of the PA within the medical practice can have a direct impact on the amount of patient charges resulting from services provided by the practitioner. For instance, the role of a surgical PA could be primarily limited to pre- and post-surgery evaluation and patient education; services that are usually bundled in the surgeon’s charge for the surgical procedure and not separately billed. In this instance, therefore, revenue generation may not be a proper indicator of financial performance since the work of the PA is intended to relieve the surgeon of these functions and allow him or her to focus more attention on performing billable surgical procedures.

In most situations, however, gross charges generated by the PA are tracked separately by practice managers to evaluate the financial contribution of the PA to the employing organization. The 2002 Medical Group Management Association Physician Compensation and Production Survey reports the average annual gross professional charges for PAs in primary care practices as $261,293. Average annual gross professional charges for surgical PAs is slightly higher at $270,029. It should be noted that these amounts exclude the technical component of all ancillary services such as laboratory and radiology.

Third-Party Coverage and Payment

Medicare Coverage and Payment

The first Medicare coverage of physician services provided by physician assistants was authorized
by the Rural Health Clinic Services Act in 1977. In the following two decades, Congress incrementally expanded Medicare Part B payment for services provided by PAs authorizing coverage in hospitals, nursing facilities, rural Health Professional Shortage Areas, and for first assisting at surgery. In 1997, however, the Balanced Budget Act extended coverage to all practice settings at one uniform rate.

As of January 1, 1998, Medicare pays the PAs’ employers for medical services provided by PAs in all settings at 85 percent of the physician’s fee schedule using the Resource-Based Relative Value Scale (RBRVS) system. This includes hospitals (inpatient, outpatient, and emergency departments), nursing facilities, offices and clinics, and first assisting at surgery. Medicare assignment is mandatory, and state law determines supervision and scope of practice. Hospitals that bill Part B for services provided by PAs may not at the same time include PAs in the DRG calculations by including PA salaries in the hospital’s cost reports.

Outpatient services provided in offices and clinics may still be billed under Medicare’s “incident-to” provisions if Medicare’s restrictive billing guidelines are met. This allows payment at 100 percent of the physician’s fee schedule if: (1) the physician is physically on-site when the PA provides care; (2) the physician treats all new Medicare patients (PAs may provide the subsequent care); and (3) established Medicare patients with new medical problems are personally treated by the physician (PAs may provide the subsequent care).

Medicare-certified rural health clinics (RHCs) and federally qualified health centers (FQHCs) receive cost-based reimbursement for covered services to Medicare beneficiaries regardless of the provider of care, physician or PA. In general, RHCs and FQHCs receive an all-inclusive reimbursement rate for each patient visit up to the Medicare maximum payment limit. The 2000 maximum payment limit per encounter for RHCs was $61.85, rural FQHCs was $82.55, and urban FQHCs was $96.02. These payment limits apply to all covered services furnished during the patient visit including all physician services, PA services, incidentals, and diagnostic laboratory tests. As of January 1, 1998, the all-inclusive payment limitation for RHCs is waived only for those clinics in rural hospitals with fewer than 50 beds.

Medicaid Coverage and Payment

Nearly all state Medicaid programs cover medical services provided by physician assistants. To be certified by the Wisconsin Medicaid program, physician assistants must be certified and registered pursuant to Wisconsin Statutes and the Wisconsin Administrative Code. All PAs providing services to Wisconsin Medicaid recipients must be individually certified by Wisconsin Medicaid in order to be reimbursed and are issued a nonbilling performing provider number. PAs must bill under the Medicaid billing number of a supervising physician or employing clinic and under the conditions of physician delegated services. Employers and billing offices need to review and follow Medicaid billing policies as detailed in the various Medicaid provider manuals.

Physician assistant reimbursement by Wisconsin Medicaid is limited to 90 percent of the reimbursement allowed for the physician who would have otherwise performed the service. The only exceptions are that physician assistants are reimbursed up to 100 percent of the physician’s
maximum fee for injections, immunizations, and lab handling fees. However, Wisconsin Medicaid provides incentive payments to primary care and emergency medicine providers, including PAs, who either serve Medicaid recipients residing in Health Professional Shortage Areas (HPSAs) or practice within a designated HPSA zip code. The incentive payment for HPSA-eligible primary care and emergency medicine procedures is 20 percent of the physician maximum allowable fee. HPSA-eligible obstetrical procedures receive the HPSA bonus and an additional 25 percent incentive payment.

Medicaid-certified rural health clinics and federally qualified health centers receive cost-based reimbursement for covered services to Medicaid recipients regardless of the provider of care, physician or PA. In Wisconsin, all RHCs receive an all-inclusive reimbursement rate for each patient visit up to the Medicare maximum payment limit. An additional 10 percent incentive payment is made to RHCs who serve Medicaid recipients residing in HPSAs. The 2000 Wisconsin Medicaid maximum payment limit per encounter for RHCs was $68.04, including the HPSA incentive payment. Wisconsin Medicaid cost-based reimbursement for FQHCs is not limited by the maximum payment rates.

**Commercial Insurance Coverage and Payment**

Most commercial insurance companies allow for the coverage of PA-provided medical services. However, insurance companies often differ in both how medical services provided by PAs are covered and how insurance claim forms should be submitted. Most commercial insurance companies will extend coverage for medical services provided by a PA if those services are included as part of the physician’s bill. The majority of insurers require that the bill for medical services provided by PAs be filed under the physician’s name and provider number. Since some insurers prefer the claim to be filed under the PA’s name, billing personnel should check with the individual insurance company to determine the particular policy on coverage for medical services provided by PAs. Below is an excerpt from a commercial insurance plan document in defining coverage for professional services, including the physician assistant:

> Such services also include services provided by . . . a physician assistant, provided such person is lawfully employed by the supervising physician or the facility where the service is provided and he/she provides an integral part of the supervising physician’s professional services while the physician is present in the facility where the service is provided. With respect to such services provided by a . . . physician assistant, such services must be billed by the supervising physician or the facility where the service is provided.

**Managed Care Coverage and Payment**

Consistent with this approach, the American Medical Association has long recommended that the charge for services provided by the PA be a part of the physician’s usual, customary, and reasonable charge. Reimbursement for services provided by the PA when billed by the physician will not differ from the reimbursement for services performed solely by the physician.

Historically, the financial health of a medical practice depended on its ability to provide an expanding array of services to an increasing number of patients. The traditional model of health care delivery was fueled by the absence of price competition for health services as well as a seemingly endless demand for patient services. However, the emergence of managed care organizations (MCOs) has changed the financial incentives among health care providers. Instead of focusing on increased patient utilization of costly services, medical practices with managed care
contracts are focusing on how to manage patient care more efficiently and reduce utilization.

Payment arrangements vary from one MCO to the next, but a common reimbursement strategy is to pay health care providers a fixed amount for the care of a covered population. The fixed payment may represent the total amount for all care delivered (i.e., a global capitation payment) or the amount for primary care professional services only. Nevertheless, an emphasis in most managed care arrangements is placed on shifting the financial risk for the provision of health care services from an employer or insurance carrier to the health care provider.

Health care providers have responded to the demands of the managed care market by developing strategies to lower operating costs, improve patient satisfaction, and enhance the overall health of the patient population. Physician assistants can make significant contributions in each of these areas through their involvement in patient education, wellness programs, patient recalls, telephone triage, utilization review, and quality assurance programs, as well as their efficient treatment of those individuals requiring medical attention.

**Cost/Benefit Analysis**

The following tables provide two compelling illustrations of the financial benefits of a physician/PA practice model. Revenues for this analysis are from all professional services, excluding diagnostic services such as laboratory tests and radiology procedures. Only certain variable expenses are presented, including salaries and fringe benefits for a physician, a PA, and medical assistants. Malpractice insurance premiums have also been included. This analysis has been simplified to clearly show the variability in contribution to overhead expenses under both a traditional fee-for-service operating environment and under a 100 percent capitated payment arrangement.

Financial data for this analysis was drawn from the Medical Group Management Association 2000 Cost Survey, the 2000 Physician Compensation and Production Survey, and actual data from various medical practices.

**Fee-for-Service Model**

Table I below illustrates the traditional fee-for-service model. Column 1 with a single physician staff results in a contribution margin of $84,200. Table I, column 2 presents the same traditional fee-for-service arrangement but includes a physician assistant provider in addition to the original physician.

<table>
<thead>
<tr>
<th>TABLE I</th>
<th>Fee-for-Service Model</th>
<th>Sample Analysis</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Physici Only</td>
<td>Physician/ PA Team</td>
<td>Difference</td>
<td></td>
</tr>
<tr>
<td>REVENUES</td>
<td>Gross charges – Physician</td>
<td>$395,000</td>
<td>$395,000</td>
<td>$-0-</td>
<td></td>
</tr>
</tbody>
</table>
Based on the data presented in Table I, the PA can add $147,700 in net revenue, $73,600 in salary and fringe benefit cost, a medical assistant of $25,000 in annual cost, and roughly $700 in malpractice insurance premiums. The computed net increase in contribution margin as a result of adding the PA is $48,400. The new contribution to overhead for the two providers combined has increased to $132,600.

**Managed Care Model**

Table II illustrates a much different environment consisting of a prepaid (capitated) HMO patient population. Revenue is depicted as fixed payments of $15 per member per month for the patient panel. In Table II, column 1, with a panel of 2,400 health plan members, total net capitated revenue for the year is estimated at $432,000. Associated variable expenses are $212,000 leaving a net contribution of $220,000. In column 2, there is an addition of a PA, but together both providers are still managing the same panel size. Obviously the contribution will drop commensurate with the additional costs of the PA and support staff. In columns 3 and 4, the panel is shown to increase by 600 members each, resulting in increased capitated payments and a higher contribution margin. In column 4, representing a panel size of 3,600, the contribution has grown to $336,700, or more than 50 percent of the net revenue.

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**TABLE II**
Managed Care Model
Sample Analysis

<table>
<thead>
<tr>
<th></th>
<th>(1) Physician (2,400 Panel)</th>
<th>(2) Phys./PA (2,400 Panel)</th>
<th>(3) Phys./PA (3,000 Panel)</th>
<th>(4) Phys./PA (3,600 Panel)</th>
</tr>
</thead>
<tbody>
<tr>
<td>REVENUES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2021</td>
<td>2022</td>
<td>2023</td>
<td>2024</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Capitated payments</td>
<td>$432,000</td>
<td>$432,000</td>
<td>$540,000</td>
<td>$648,000</td>
</tr>
<tr>
<td>Total Net Revenue</td>
<td>432,000</td>
<td>432,000</td>
<td>540,000</td>
<td>648,000</td>
</tr>
<tr>
<td><strong>VARIABLE EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salary &amp; fringes - Physician</td>
<td>180,000</td>
<td>180,000</td>
<td>180,000</td>
<td>180,000</td>
</tr>
<tr>
<td>Salary &amp; fringes - PA</td>
<td>-0-</td>
<td>73,600</td>
<td>73,600</td>
<td>73,600</td>
</tr>
<tr>
<td>Salary &amp; fringes - Medical Asst.</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Salary &amp; fringes - Medical Asst.</td>
<td>-0-</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Malpractice insurance - Physician</td>
<td>7,000</td>
<td>7,000</td>
<td>7,000</td>
<td>7,000</td>
</tr>
<tr>
<td>Malpractice insurance - PA</td>
<td>-0-</td>
<td>700</td>
<td>700</td>
<td>700</td>
</tr>
<tr>
<td><strong>Total Variable Expenses</strong></td>
<td>212,000</td>
<td>311,300</td>
<td>311,300</td>
<td>311,300</td>
</tr>
<tr>
<td><strong>Contribution to Overhead</strong></td>
<td>$220,000</td>
<td>$120,700</td>
<td>$228,700</td>
<td>$336,700</td>
</tr>
</tbody>
</table>
EMPLOYMENT INFORMATION

Employment Contracts and Agreements

In most instances, a written agreement is presented to the employed physician assistant outlining the key terms of his or her employment status. This agreement may be in the form of an employment contract or may be less formally drafted into a letter of employment. However written, several key areas are commonly addressed within the employment document. These areas include:

Job Description
- Scope of practice
- Physician supervision
- Administrative responsibilities
- Office location(s)
- Hours of operation
- Expected hours per week
- Call schedule
- Holidays/weekends

Insurance
- Malpractice insurance
- Health/dental insurance
- Life/disability insurance

Professional Expenses
- CME program and travel costs
- CME paid time off
- Certification expenses
- Membership dues

Compensation Package
- Base salary
- Bonus arrangement
- Annual salary adjustments
- Pension/retirement benefits
- Profit sharing
- Paid time off

Contractual Provisions
- Effective date
- Probationary period
- Renewal
- Termination provisions
- Notifications

The above items represent basic areas of employment that should be clarified when the PA, employer, and supervising physician discuss the terms of employment. It is advisable to have a written contract or practice agreement that clearly spells out the terms of employment.

Credentialing

Hospital Privileges

Data collected by the AAPA show that more than a quarter (29.4%) of the clinically practicing PAs have inpatient responsibilities in hospitals. Of these PAs who provide inpatient medical care, 58 percent are employed by hospitals in inpatient settings. Another 17 percent are employed by hospitals primarily to work in outpatient settings, but have some inpatient responsibilities. The remaining 25 percent are employed outside the hospital and are privileged to provide inpatient medical care.
Physician assistants practice medicine with physician supervision. Within the hospital setting, PAs may be granted privileges to conduct rounds; perform histories and physicals; evaluate changes in a patient’s condition; issue orders for such things as medications, treatments, and laboratory tests; record progress notes; and write discharge summaries. Employment of physician assistants as first assistants in surgery is also a common practice.

Hospitals that grant privileges to PAs to practice in their facilities should verify that the PAs are properly licensed, certified, or registered by the state and have adequate professional liability insurance. On demonstration of satisfactory training and experience, and after approval by the hospital board or designated individual, a PA may be granted privileges with supervision of a physician who has appropriate privileges. The criteria and process for granting clinical privileges to PAs should be outlined in the medical staff bylaws. It is recommended that the actual PA privileges be stated, not in the bylaws but in the medical staff rules and regulations, where amendments can be made more easily and efficiently. Preferably, this may be done in a category specifically for physician assistants as medical staff members.

Hospitals typically have a system for granting physicians provisional approval on particular privileges until competence is shown. A similar system may be established for PAs. Likewise, many hospitals use virtually the same form for physicians and physician assistants who are applying for privileges.

**Patient Satisfaction**

Patient acceptance and satisfaction with care has only recently received attention in the medical literature. Measurement of patient satisfaction levels by health care providers is important because increasingly popular health plans are interested in ensuring member satisfaction. Understanding patient satisfaction with care is therefore critical if health plans are to be successful in attracting and retaining large employer groups and other health plan members.

Early studies of patient acceptance and satisfaction on physician assistants showed that, compared with physicians, PAs function at comparable levels, use no more health care services, and are accepted by patients at a comparable level. A more recent study conducted in 1995-96 by Kaiser Permanente of the Northwest (KPNW), a health maintenance organization, explored differences in patient satisfaction with physician and nonphysician providers. An analysis of this study confirmed earlier findings that patients are satisfied with their care regardless of the type of practitioner delivering the care. This study further suggests that patient satisfaction appears to depend on the communication skills and style of the provider and not on the type of provider. Therefore, the incorporation of physician assistants in the health care delivery system can result in greater patient satisfaction, along with the economic benefits commonly associated with nonphysician providers.

**Liability Insurance**

**Employer Coverage and Individual Policies**

Professional liability insurance for the physician assistant can be obtained through the employing clinic, personally by the PA, or by a combination of both parties. The American Academy of Physician Assistants reports that of 19,745 practicing PAs responding to a recent survey, 97% indicated that their employer funded the entire premium for their professional liability insurance.
Even though many employers offer to pay the cost of the professional liability insurance for employed PAs, the AAPA generally advises that all physician assistants consider obtaining an individual policy instead of relying on a group insurance policy through their employers. Many employers have the option of simply adding coverage for the physician assistant as a rider to an existing physician policy. Often, such policies do not name the individual for whom this coverage is obtained. These “no name” policies may link certain key provisions, such as coverage limits and type of coverage, with other employed providers. An individual policy, on the other hand, will establish individual coverage limits and define the type of coverage, either occurrence or claims made, without regard to any other such policy in effect for other employed providers. For this reason, it is preferable for the PA to be specifically named on an individual liability insurance policy.

Costs for professional liability insurance policies vary depending on the PA’s scope of practice, the type of coverage, and the policy limits. The AAPA has worked closely with the American Continental Insurance Company in developing occurrence form policies tailored to the needs of physician assistants. Annual premium costs range from $600 to over $5,000 depending on the location of the practitioner, the PA’s scope of practice, and the policy limits.

**Patient Compensation Fund**

Professional liability insurance in Wisconsin is a two-tiered structure whereby commercial insurance is obtained for coverage up to a mandated limit. Coverage beyond the mandated limits is provided through a statewide fund entitled the Patient Compensation Fund. Beginning in 1997, the mandated coverage limits were $1,000,000 per occurrence and $3,000,000 aggregate. Based on these limits, an individual policy for a Wisconsin PA offered through the American Continental Insurance Company would cost anywhere from $1,200 to $5,000 per year. The extended coverage through the Patient Compensation Fund would cost approximately $500.

**Recruitment and Retention**

There are a number of federal and state loan repayment and scholarship programs that can assist primary care clinics, in rural and urban shortage areas, in the recruitment and retention of physician assistants. There are also federal and state reimbursement incentives to retain PAs who provide primary care in designated rural and urban shortage areas.

**Loan Repayment and Scholarship Programs**

The National Health Service Corps (NHSC), a federal program, offers loan repayment or scholarship assistance to physician assistants who agree to provide primary care for at least two years in a rural or urban federally designated HPSA. A NHSC scholarship can cover full tuition, or NHSC loan repayment can provide up to $50,000 for a two-year obligation. The Wisconsin Division of Public Health - Primary Care Section helps clinics and physician assistants by providing information and applications for these programs.

The Wisconsin Health Professions Loan Assistance program can provide up to $25,000 for a three-
year obligation for physician assistants who agree to provide primary care in federally designated rural and urban HPSAs in Wisconsin. The Wisconsin Office of Rural Health helps clinics and physician assistants by providing information and applications for this program.

Recruitment Strategies

Physician assistant educational institutions and professional associations provide several means of assisting potential employers of PAs in finding the right candidate for their organization.

- **Clinical Preceptorship**
  A large percentage of annual PA graduates are hired by one of their clinical preceptor sites. By mentoring students as preceptors, physicians can assess the applicants whose level of health care experience, clinical capabilities, and personality best fit their practice environment.

- **Job Fairs and Bulletin Boards**
  Most PA programs or their student associations sponsor an annual employment Job Fair as students near graduation. Additionally, most PA programs keep a bulletin board of job announcements for both new graduates and practicing physician assistants.

- **Newsletters**
  The Wisconsin Academy of Physician Assistants publishes a monthly newsletter called *The Spectator* that has space available for employment opportunities and announcements for both new graduates and practicing physician assistants.

- **Employment Exchange Program**
  The Wisconsin Office of Rural Health provides this practice opportunity listing service free of charge to both the health professional and the employer/community. Positions listed are available via a monthly bulletin provided to all inquiring health professionals on request. The monthly bulletin includes the basic elements of a position vacancy, and potential practitioners can contact the prospective employer directly for further information.

Retention Assistance

The WisTREC project, Wisconsin AHEC System, and academic training programs are partnering on a variety of programs to help rural and urban underserved areas recruit and retain primary care providers. These programs include: recruiting more students from rural and underserved populations, developing more student experiences in rural and urban shortage areas, and developing more distance education to help students live and work closer to home. It is believed that PA students who are able to work and/or reside in rural and underserved areas while enrolled in the educational program are much more likely to remain in these communities after completion of the nurse practitioner educational program. These students are likely candidates for employer recruitment efforts in rural and urban health professional shortage areas.

Wisconsin Medicaid offers a primary care HPSA bonus payment to encourage primary care providers, including physician assistants, to practice in HPSAs or to provide services to Medicaid recipients who live in designated shortage areas. Wisconsin Medicaid provides a 20 percent HPSA bonus payment for certified providers who render selected primary care services for covered Medicaid recipients. Also, providers of obstetrical services may be eligible for an additional 25
percent obstetric HPSA bonus payment for covered recipients.

The federal Rural Health Clinic Services Act authorizes favorable Medicare and Medicaid cost-based reimbursement to certified rural health clinics for services provided by physician assistants and other midlevel providers. As a condition of participation in the RHC program, certified clinics are required to employ a physician assistant, or other qualified nonphysician provider, to serve patients at least 50 percent of the time the clinic is open. Once certified, the RHC is required to retain the physician assistant or lose the favorable cost-based reimbursement for Medicare- and Medicaid-covered patients.
RESOURCE GUIDE AND REFERENCES

Facts About Physician Assistants

Education and Certification

American Academy of Family Physicians, 8880 Ward Parkway, Kansas City, MO 64114; phone (816) 333-9700; e-mail fp@aafp.org.

Information Regarding the Education and Training of Nurse-Midwives, Nurse Practitioners, Pharmacists, and Physician Assistants, March 1997

American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314-1552; phone (703) 836-2272; fax (703) 684-1924; e-mail aapa@aapa.org.


1998 AAPA Physician Assistant Census Report

1998 AAPA Physician Assistant Census Summary

Association of Physician Assistant Programs, 950 North Washington Street, Alexandria, VA 22314-1552; phone (703) 548-5538; fax (703) 684-1924; e-mail apap@apap.org.


Marquette University, Physician Assistant Program, P.O. Box 1881, Milwaukee, WI 53201-1881; phone (414) 288-5688.

Accredited Master’s Degree Program

University of Wisconsin-La Crosse, Physician Assistant Program, 1725 State Street, La Crosse, WI 54601; phone (608) 785-6620; fax (608) 785-6647; e-mail paprogram@uwlax.edu.

Accredited Bachelor’s Degree Program

University of Wisconsin-Madison, Physician Assistant Program, 1050 Medical Sciences Center, 1300 University Avenue, Madison, WI 53706; phone (608) 263-5620.

Accredited Bachelor’s Degree Program

Wisconsin Program for Training Regionally Employed Care Providers (WisTREC), UW Madison School of Nursing, CSC K6/218, 600 Highland Avenue, Madison, WI 53792; phone (608) 262-8755; fax (608) 263-5170.

Web site - http://academic.son.wisc.edu/wistrec/
Characteristics of Practitioners

American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314-1552; phone (703) 836-2272; fax (703) 684-1924; e-mail aapa@aapa.org.
AAPA Web site - http://www.aapa.org
1998 AAPA Physician Assistant Census Summary
AAPA Facts at a Glance - June 9, 1998

Wisconsin Academy of Physician Assistants, P.O. Box 1109, Madison, WI 53701; phone (800) 762-8965; fax (608) 283-5402; e-mail WAPA@SMSWI.ORG.
Web site - http://www.wapa.org

Wisconsin Office of Rural Health, Primary Providers for Wisconsin, 109 Bradley Memorial, 1300 University Ave, Madison, WI 53706. Office phone (608) 265-3608.
Web site - http://www.3rnet.org/worh.html

Scope of Practice

State of Wisconsin, Department of Regulation and Licensing, Medical Examining Board, P.O. Box 8935, Madison, WI 53708; phone (608) 266-2811.
Wisconsin Administrative Code, Chapter Med 8.
Web site - http://badger.state.wi.us/agencies/drl/Regulation

Prescriptive Authority

State of Wisconsin, Department of Regulation and Licensing, Medical Examining Board, P.O. Box 8935, Madison, WI 53708; phone (608) 266-2811.
Wisconsin Administrative Code, Chapter Med 8.
Web site - http://badger.state.wi.us/agencies/drl/Regulation

Spectrum of Practice Settings

American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314-1552; phone (703) 836-2272; fax (703) 684-1924; e-mail aapa@aapa.org.
AAPA Web site - http://www.aapa.org
AAPA Facts at a Glance - June 9, 1998


Reimbursement And Financial Analysis

Compensation Arrangements

American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314-1552; phone (703) 836-2272; fax (703) 684-1924; e-mail aapa@aapa.org.

AAPA Web site - http://www.aapa.org
1998 AAPA Physician Assistant Census Report


Contribution to Practice Revenue

American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314-1552; phone (703) 836-2272; fax (703) 684-1924; e-mail aapa@aapa.org.

1998 AAPA Physician Assistant Census Report


Third-Party Coverage and Payment

American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314-1552; phone (703) 836-2272; fax (703) 684-1924; e-mail aapa@aapa.org.

Third-Party Reimbursement for Physician Assistants
Physician Assistants as Medicaid Managed Care Providers
Expanded Coverage of Medical Services Provided by PAs Under Medicare
Physician Assistant Third-Party Coverage


EDS Provider Maintenance; phone (608) 221-9883

WPS Health Insurance, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708; phone (800) 221-6951.

WPS-Medicare Part B, 1717 West Broadway, P.O. Box 1787, Madison, WI 53701; phone (608) 221-4711.
Cost/Benefit Analysis


**Employment Information**

**Employment Contracts and Agreements**

American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314-1552; phone (703) 836-2272; fax (703) 684-1924; e-mail aapa@aapa.org.


**Credentialing**

American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314-1552; phone (703) 836-2272; fax (703) 684-1924; e-mail aapa@aapa.org.

Patient Satisfaction


Liability Insurance

American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314-1552; phone (703) 836-2272; fax (703) 684-1924; e-mail aapa@aapa.org.

Malpractice Insurance: What PAs Should Know
Introduction to the AAPA-sponsored Professional Liability Program, February 1998


Recruitment and Retention

Wisconsin Division of Health, Primary Care Section. (1997, March). Recruitment Resources Linked Available to Shortage Areas in Wisconsin. Madison, WI: Author. [phone (608) 267-4882; See appendix].

Wisconsin Division of Health, Primary Care Section. (1997, April). Primary Care Recruitment & Retention Resources Available to Shortage Areas in Wisconsin. Madison, WI: Author. [phone (608) 267-4882; See appendix].

Wisconsin Office of Rural Health. 109 Bradley Memorial, 1300 University Ave, Madison, WI 53706. Office phone (608) 265-3608

Primary Providers for Wisconsin: Employment Exchange: (800) 488-9512.
EMPLOYMENT GUIDE

Information on Nurse Practitioners

A collaborative project of the WisTREC Utilization Committee initiated by the Wisconsin AHEC System and funded by The Robert Wood Johnson Foundation.
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INTRODUCTION

This booklet was developed by the Wisconsin Program for Training Regionally Employed Care providers (“WisTREC”) utilization committee. WisTREC is a project of the Wisconsin Area Health Education Center System, is funded by the Robert Wood Johnson Foundation-Partnerships for Training program, and is administered through the University of Wisconsin-Madison School of Nursing.

WisTREC is focused on increasing access to primary care in underserved areas and for underserved populations by increasing the training and use of physician assistants, nurse practitioners, and nurse midwives to meet these needs.

WisTREC and its collaborating partners are committed to sharing the information in these guides with all interested parties. These guides may be copied and distributed or excerpts used if the WisTREC project is credited.
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Facts About Nurse Practitioners

General Description

Nurse Practitioners (NPs) are registered nurses with advanced preparation in a clinical specialty. NPs typically provide care in ambulatory settings, such as HMOs and primary care clinics, and also provide care in schools, community health centers, workplaces, and nursing homes. Additionally, there is increasing demand for hospital-based NPs to manage acute health problems and chronic illnesses.

NPs are educated to assess, counsel, diagnose, prescribe, and manage the primary care needs of a caseload of clients in collaboration with other health care professionals (e.g., physicians, pharmacists, physician assistants, dieticians, and therapists). The practice of NPs emphasizes comprehensive assessment, health promotion, disease prevention, and clinical management. NPs exercise a high degree of independent judgment, complex clinical decision making, and skill in managing health care environments (American Nurses Association, 1996). NPs are eligible for reimbursement from private and public third-party payors. NPs are licensed by the state in which they practice and are certified through national examination.

The roles, safety, and cost effectiveness of NP practice have been extensively studied and validated over the past 20 years (Brown & Grimes 1995, Buppert 1999, Mundinger 1994, Safriet 1992). According to the Wisconsin Nurses Association (WNA):

- NPs can safely provide up to 90 percent of primary care needed by children and 80 percent of health care needed by adults; and
- NPs improve access to care by providing care in rural and inner city shortage areas.

Advanced practice nursing is built upon basic nursing education and practice, and NPs possess comprehensive assessment, interviewing, patient and family education, counseling, communication, and care management skills. The nurse practitioner practice is evidence-based and evolves in response to developments in nursing research, advances in medical therapeutics, and changes in the health care delivery system.

Education and Certification

NPs achieve their advanced preparation in a clinical specialty through study in nationally accredited graduate programs. Clinical specialization includes adult or family health, acute care, geriatrics, pediatrics, or women’s health. NPs are eligible for national certification as experts in their specialty.
Graduate education serves as the background for NP preparation. The curriculum is based upon the behavioral, natural, and humanistic sciences, pharmacotherapeutics, and supervised clinical experiences. Several semesters of supervised practica serve as the basis for clinical practice. Advanced practice nursing curricula are based upon standards developed by the National Organization of Nurse Practitioner Faculties (NONPF) and content recommended by the American Association of Colleges of Nursing (AACN). All graduate curricula have specific, uniform, and essential components. Institution-specific missions, goals, and methods will reflect the strengths and values of a particular nursing faculty.

Graduate nursing programs include advanced level course work in health promotion and disease prevention, health assessment, pathophysiology, diagnostic assessment, clinical decision-making, pharmacology and therapeutics, research, human diversity, health policy, economics, and ethics. Content in the specialty addresses the unique needs of the patient in the context of human development, health and illness, and family.

Some early NP training programs were certificate-based, and some reproductive health NP training programs continue to be certificate-based. There are NPs from these training programs who have been “grandfathered” through maintaining national certification. Many of these NPs have completed graduate degrees to be eligible for independent prescribing authority and third-party reimbursement.

NPs are educated to assume accountability and responsibility for:

(a) management of health and illness through the use of in-depth history taking, health assessment, diagnostic testing, intervention strategies (with special emphases on the patient’s culture, lifestyle habits and stresses, genetics, health risk factors, and treatment goals), and follow-up evaluation;

(b) teaching and counseling strategies to enhance the patient’s self-care abilities. These strategies include an understanding of the patient’s readiness to learn, sensitive explanations of the client’s condition, treatment choices, and rationale for procedures and lifestyle adjustments, and joint problem-solving with patients to develop treatment plans;

(c) organizational and role competencies that include coordination of care to meet multiple client needs, collaboration and use of an interdisciplinary team, establishing priorities for care, and ensuring continuity of care. Examples of the broader role and organizational competencies include: serving as a preceptor for students, participating in professional organization and legislative activities, and advocating for underserved populations.

NPs with a master’s degree, national certification, and preparation in pharmacotherapeutics can become advanced practice nurse prescribers (APNP). A nurse who uses the initials APNP is legally certified to prescribe medications for the treatment of illness and the prevention of disease.

National certification is voluntary for NPs but is becoming increasingly common, particularly since it signals expertise in a specialty. Many employers are requiring certification. In a recent survey of NPs in Wisconsin, sponsored by WisTREC (1998), almost 97 percent of NPs in clinical practice are nationally certified. Certification and recertification assure national consistency of professional standards, impose standard titles, and assure ongoing participation in peer review and continuing education. There are four national certifying groups:
• American Nurses Credentialing Center (ANCC)
• National Certifying Board of Pediatric Nurse Practitioners (NCB/PNP)
• American Academy of Nurse Practitioners (AANP)
• National Certification Corporation (NCC)

Certification is valid for five to six years after which time recertification is necessary to assure continuation of practice and knowledge base. Recertification is also valid for five to six years. Recertification criteria typically include a minimum of 1,500 direct clinical practice hours plus 75 contact hours of continuing education.

Characteristics of Practitioners

Practitioner Demographics

According to a report prepared by the U.S. Department of Health and Human Services in 1996, almost 90 percent of approximately 71,000 NPs nationwide were employed in clinical practice. Nearly all of the remaining 10 percent of NPs were employed in nursing educational positions. Roughly 80 percent of the NPs employed in nursing had national nurse practitioner certification and/or state licensure/certification as advanced practice nurse or nurse practitioner.

A survey conducted in 1998 for the WisTREC Partnership for Training program compiled information on 450 nurse practitioners in the state of Wisconsin. This study found that nearly all of the NPs were female (98.1%) and white (94.8%), over 70 percent were married, and 97.0 percent were certified by a national organization.

Number of Practitioners

In its 1996 report, the U.S. Department of Health and Human Services (HHS) estimated there were approximately 71,000 NPs employed in clinical practice nationwide. The HHS data estimated that the number of registered nurses with formal NP preparation increased about 47 percent since March 1992 to March 1996.

The 1998 WisTREC Survey concluded that approximately 621 NPs reside and practice in the state of Wisconsin. This survey was distributed to all NPs identified as currently practicing in the state.

Enrolled Candidates

Nationally, the growing numbers of NP programs and enrollments has resulted in substantial increases in the number of new NPs eligible for certification. Based on data derived from the educational program surveys, the number of yearly graduates more than doubled between the 1991-92 and the 1994-95 academic years. In the 1994-95 academic year, about 5,300 nurses graduated from post-RN certificate, master’s degree, and post-master’s programs.
In Wisconsin, a total of 461 candidates, both full- and part-time, were enrolled in NP programs for the 2000-01 academic year.

<table>
<thead>
<tr>
<th>Institution</th>
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<tr>
<td>Marquette University - Milwaukee</td>
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<td>University of Wisconsin - Madison</td>
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**Practice Settings**

Nurse practitioners practice in communities spanning the most densely urban to the most remote and rural. Nationally, nearly one quarter of NPs practice in rural (non-metropolitan statistical) areas. Most NPs work in ambulatory care sites. The 1998 WisTREC survey data indicated that 44 percent of nurse practitioners worked in physician practice sites; 14 percent in various types of community health centers; 7 percent in long-term care facilities; 4 percent in hospital departments; and the remaining 31 percent in various public and private settings including home health care, governmental agencies, and other practice settings.

According to the recent data compiled by the WisTREC program, nearly all of the nurse practitioners are active in the following areas—women’s health, family practice, adult health, and pediatrics. Other NP practice areas include neonatology, school health, mental health, home care, geriatrics, and acute care. In addition, NPs frequently work in the areas of education, clinical supervision, and administration.

**Scope of Practice**

A nurse practitioner is a registered nurse, licensed by the Wisconsin Board of Nursing, and also meets additional education, training, or experience criteria established by a national nurse practitioner credentialling body. In Wisconsin, the credentialling body must be recognized by the Board of Nursing (WI Board of Nursing, Administrative Code Chapters 6 - 8).
Nurse practitioners with additional education, training, or experience can apply for additional certification from the State Board of Nursing to be Advanced Practice Nurse Prescribers (APNP). The APNP independently issues prescriptions for laboratory testing, radiographs or electrocardiograms appropriate to her or his area of competency. APNPs are required to practice within a **collaborative relationship** defined as:

"Collaboration" means a process which involves 2 or more health care professionals working together, in each other's presence when necessary, each contributing one's respective area of expertise to provide more comprehensive care than one alone can offer. N8.02 (5)

The nurse practitioner’s scope of practice may include, but is not limited to, the following nursing and medically delegated services:

- Advanced physical assessment (patient histories and physical exams);
- Selection and performance of appropriate diagnostic and therapeutic procedures (suturing, casting, and minor office surgeries);
- Ordering and interpreting lab tests;
- Diagnosis, treatment, and monitoring of common acute and chronic clinical conditions;
- Prescription and administration of drugs, treatments, and therapies; and
- Patient case management and referral to physicians and other specialists.

Nurse practitioners, as registered nurses, do not require on-site physician supervision. Delegated medical care can be provided by NPs who are competent based on their education, training and experience, and under the general supervision of a physician. General supervision means the regular coordination, direction, and inspection of the practice of another. Protocols or written or verbal orders are required for delegated medical acts. See second paragraph above for expanded scope of practice for advanced practice nurse prescribers.

Nursing care is provided by NPs as an independent function, ranging from comprehensive patient assessment and care management to population health assessment and interventions. Because of the increasing complexity of health care and an increasing commitment to providing more comprehensive care, many licensed health care professionals provide care in a collaborative, team practice setting.

**Spectrum of Practice Settings**

Nurse practitioners contribute to meeting the needs for primary and specialty care for many Americans who would otherwise lack access to ongoing health care services.

A wide range of health care organizations have found that nurse practitioners contribute significantly toward their overall mission of providing high-quality, cost-effective health care services. Many hospitals utilize the expertise of NPs in emergency rooms, subspecialty clinics, and urgent care
settings. Residents of long-term care facilities benefit from the collaborative effort among provider teams consisting of physicians and NPs. Primary care practices, including family practice, internal medicine, pediatrics, and obstetrics/gynecology, are the predominant settings for nurse practitioners.

This broad range of practice settings can help to explain the strong demand for nurse practitioners and the tremendous growth in the number of practicing NPs from the first NP program in 1965 to more than 70,000 practicing NPs across the country today. Medical practice managers and physicians often cite the following benefits that nurse practitioners can bring to an organization:

- **Efficient patient care.** Nurse practitioners are efficient at managing ongoing patient care, as well as walk-ins, urgent care, and routine follow-up care for chronic illnesses.

- **Reduced patient waiting time.** Patients can be provided the option of seeing the NP for routine appointments or urgent care visits. This can improve patient satisfaction with greater availability of care.

- **Increased emphasis on health promotion and disease prevention programs.** Nurse practitioners are skilled at developing programs for individual patients, families, and groups for screening, prevention, behavior modification, and chronic illness management (e.g., women’s health, immunization, smoking cessation, and diabetes).

- **Outreach and case management for underserved and special need populations.** NPs can extend care and case management into rural and urban underserved areas, nursing homes, other community-based organizations, and to special need and culturally diverse populations.

- **Enable physicians to focus on more complex medical problems.** Perhaps one of the greatest benefits is that a nurse practitioner can shift the workload. The NP can handle routine office visits and acute/chronic illness management, enabling physicians to manage patients with more complex medical problems.

- **Team practice and professional fellowship.** NPs bring nursing expertise and are trained to provide care through collaborative relationships with physicians, physician assistants, nurse midwives, pharmacists, and other providers.

### Prescriptive Authority

Current state regulations under Chapter N 8 of the Wisconsin Board of Nursing Administrative Code permit a certified nurse practitioner to independently prepare prescription orders. To qualify for certification as an advanced practice nurse prescriber, a nurse practitioner must comply with the following:

1) Have a current license to practice as a professional nurse in the state.

2) Be currently certified by a national certifying body approved by the Board of Nursing as a nurse practitioner.

Current regulations permit a certified nurse practitioner to independently prepare prescription orders.
3) For applicants who receive national certification as an NP after July 1, 1998, hold a master’s degree in nursing or a related health field granted by a college or university approved by the Board of Nursing.

4) Have completed at least 45 contact hours in clinical pharmacology/therapeutics within three years preceding the application.

5) Have passed a jurisprudence examination for advanced practice nurse prescribers.

Chapter N 8.06 describes the prescribing authority of the NP. The NP may issue those prescription orders appropriate to the prescriber’s areas of competence, as established by his or her education, training, or experience. APNPs are allowed to prescribe controlled substances II-V, but schedule II can be prescribed only in specific instances.

A DEA registration number is required for all controlled substance prescriptions. Prescription orders prepared by the NP must contain the name, address, and telephone number of the NP prescriber. Advanced practice nurse prescribers must maintain in effect malpractice insurance as specified in Chapter N 8.08.
REIMBURSEMENT AND FINANCIAL ANALYSIS

Compensation Arrangements

Salary and Benefit Structure

Arrangements for the compensation of nurse practitioners vary by organization; however, the direct compensation for most NPs is typically based on a straight salary, a salary plus bonus incentive payment, or a production formula. A 1997 survey conducted by the Medical Group Management Association (MGMA) revealed that of 310 employed NPs, 69 percent were compensated on a straight salary basis, whereas 28 percent had a salary plus a bonus or incentive payment. The remaining 3 percent were compensated on a production basis, computed by gross charges, net charges, or on a relative value unit formula.

The benefit structure for employed NPs also varies by organization. Typical benefits of practicing NPs include three to four weeks paid vacation (including six to ten paid holidays), paid sick and continuing medical education leave, pension/retirement fund, malpractice insurance, health insurance, group term life insurance, group long-term disability insurance, annual dues/licensures, and a continuing education allowance.

National Salary Data

Several organizations accumulate and report annual salary data for nurse practitioners. The Medical Group Management Association’s Physician Compensation and Production Survey: 2000 Report Based on 1999 Data reported that the median compensation of NPs was $57,100; the mean was $57,375.

National survey data has revealed wide variations in the earnings among NPs due to factors such as years of experience, specialty of practice, population of the geographic area, whether the NP takes call, and whether the NP has administrative and/or supervisory responsibilities for other NPs.

Wisconsin Salary Data

In 1998, the WisTREC survey reported salary data on nurse practitioners. Based on the survey respondents residing in Wisconsin, 52.3 percent of NPs reported an annual income between $45,000 and $55,000. The survey also identified that 14.4 percent of the NPs were paid less than $45,000, whereas 33.3 percent were paid in excess of $55,000 annually.

Contribution to Practice Revenue

Pricing of Services

In most medical practices, the amounts charged for services rendered by the nurse practitioner are identical to the amounts charged for comparable services performed by a physician. Therefore a patient may be charged the same amount for the same service, whether a NP or a physician
performs it. However, the average complexity of patient health care needs and services rendered by the NP may be less than the typical physician. A difference in the mix of services delivered will result in lower average charges per patient treated by the NP (for example, an established patient with a minor illness) as opposed to the physician (for example, a new patient with multiple, acute illnesses).

**Volume Indicators**

Patient visit statistics, or ambulatory encounters, can be an effective barometer of the financial performance of a health care provider, particularly in a primary care practice setting. A patient visit is typically defined as an identifiable contact between the patient and a health care provider where advice, a procedure, service, or treatment is provided. Important volume indicators for NPs in surgical practices may also include the number of surgical assists.

The Wisconsin Nurses Association NP Forum 1997 survey of nurse practitioners indicates that of those NPs working full-time, the average number of outpatient visits per day is 16 (based on a sample of 72 NPs). The Medical Group Management Association also reports the number of ambulatory encounters for NPs in primary care practices. The 2000 MGMA report listed the average number of annual ambulatory encounters for NPs as 2,887. Assuming the average NP works approximately 48 weeks per year (allowing for vacation and CME), the MGMA data would translate into approximately 60 ambulatory patient visits per week. The WNA NP Forum and MGMA data suggest that a nurse practitioner, on average, will treat 10 to 16 outpatients per eight-hour day in a primary/ambulatory care setting.

**Production Data**

Production (revenue) generation by nurse practitioners is not widely reported in trade journals or medical surveys, but patient charges can be another key indicator of the financial performance of the NP. The role of the NP within the medical practice can have a direct impact on the amount of patient charges resulting from services provided by the practitioner. For instance, the role of a NP could be primarily limited to prenatal visits or patient education—services that are usually bundled in a physician’s charge for a global service and not separately billed. In this instance, therefore, revenue generation may not be a proper indicator of financial performance since the work of the NP is intended to relieve the physician of these functions and allow him or her to focus more attention on performing billable services.

In most situations, however, gross charges generated by the NP are tracked separately by practice managers to evaluate the financial contribution of the NP to the employing organization. The 2000 Medical Group Management Association *Physician Compensation and Production Survey* reports the average annual gross professional charges for NPs in primary care practices as $192,652. It should be noted that these amounts exclude the technical component of all ancillary services such as laboratory and radiology.
Third-Party Coverage and Payment

Medicare Coverage and Payment

The first Medicare coverage of physician services provided by nurse practitioners was authorized by the Rural Health Clinic Services Act in 1977. In the following two decades, Congress incrementally expanded Medicare Part B payment for services provided by NPs in collaboration with a physician in rural hospitals, nursing facilities, physician’s office or clinic, and in a rural independent practice setting. In 1997, however, the Balanced Budget Act extended coverage to all practice settings at one uniform rate.

There are currently two mechanisms for billing under Medicare services for NPs: direct billing or “incident-to”. As of January 1, 1998, Medicare pays for medical services billed under the NP's Medicare provider number in most settings at 85 percent of the physician’s fee schedule using the Resource-Based Relative Value Scale (RBRVS) system. This includes hospitals (inpatient, outpatient, and emergency departments), nursing facilities, physician offices, and clinics. Medicare assignment is mandatory, and state law determines supervision and scope of practice. However, urban hospitals that employ nurse practitioners may choose not to separately bill Part B for services provided by NPs in an urban hospital setting. These services can be bundled with other facility services of the hospital and would be covered by the intermediary payment to the facility.

Outpatient services provided in offices and clinics may still be billed under Medicare’s “incident-to” provisions, using the physician's provider number, if Medicare’s restrictive billing guidelines are met. This allows payment at 100 percent of the physician’s fee schedule if (1) the physician is physically on-site when the NP provides care; (2) the physician treats all new Medicare patients (NPs may provide the subsequent care); and (3) established Medicare patients with new medical problems are personally treated by the physician (NPs may provide the subsequent care).

Medicare-certified rural health clinics (RHCs) and federally qualified health centers (FQHCs) receive cost-based reimbursement for covered services to Medicare beneficiaries regardless of the provider of care, physician or NP. In general, RHCs and FQHCs receive an all-inclusive reimbursement rate for each patient visit up to the Medicare maximum payment limit. The 2000 maximum payment limit per encounter for RHCs was $61.85, rural FQHCs was $82.55, and urban FQHCs was $96.02. These payment limits apply to all covered services furnished during the patient visit including all physician services, NP services, incidentals, and diagnostic laboratory tests. As of January 1, 1998, the all-inclusive payment limitation for RHCs is waived only for those clinics in rural hospitals with fewer than 50 beds.

Medicaid Coverage and Payment

Nearly all state Medicaid programs cover medical services provided by nurse practitioners. To be certified by Wisconsin Medicaid, nurse practitioners must be licensed in Wisconsin as registered nurses and meet Medicaid certification criteria, have national professional

As of January 1, 1998, Medicare pays for medical services provided by NPs in most settings at 85% of the physician’s fee schedule...

Nearly all state Medicaid programs cover medical services provided by NPs.
Nurse practitioners can play a key role in the success of medical practices operating in a managed care environment.

NP reimbursement by Wisconsin Medicaid is 100 percent of the maximum allowable fee established for physician services. Medicaid-certified NPs can file claims as the billing or performing provider. Employers and billing offices need to review and follow Medicaid billing policies as detailed in the various Medicaid provider manuals.

Wisconsin Medicaid also provides incentive payments to primary care and emergency medicine providers, including NPs, who either serve Medicaid recipients residing in Health Professional Shortage Areas (HPSAs) or practice within a designated HPSA zip code. The incentive payment for HPSA-eligible primary care and emergency medicine procedures is 20 percent of the physician maximum allowable fee. HPSA-eligible obstetrical procedures receive the HPSA bonus and an additional 25 percent incentive payment.

Medicaid-certified rural health clinics and federally qualified health centers receive cost-based reimbursement for covered services to Medicaid recipients regardless of the provider of care, physician or NP. In Wisconsin, all RHCs receive an all-inclusive reimbursement rate for each patient visit up to the Medicare maximum payment limit. An additional 10 percent incentive payment is made to RHCs who serve Medicaid recipients residing in HPSAs. The Wisconsin Medicaid maximum payment limit per encounter for RHCs in 2000 was $68.04, including the HPSA incentive payment. Wisconsin Medicaid cost-based reimbursement for FQHCs is not limited by the maximum payment rates.

Commercial Insurance Coverage and Payment

Most commercial insurance companies allow for the coverage of NP-provided medical services. Insurance companies often differ in both how medical services provided by NPs are covered and how insurance claim forms should be submitted. Typically, commercial insurance companies will extend coverage for medical services provided by a NP if those services are included as part of the physician’s bill. The majority of insurers require that the bill for medical services provided by NPs be filed under the physician’s name and provider number. Since some insurers prefer the claim to be filed under the NPs name, billing personnel should check with the individual insurance company to determine the particular policy on coverage for medical services provided by NPs. Below is an excerpt from a commercial insurance plan document in defining coverage for professional services, including the nurse practitioner:

“Such services also include services provided by . . . a nurse practitioner, provided such person is lawfully employed by the supervising physician or the facility where the service is provided and he/she provides an integral part of the supervising physician’s professional services while the physician is present in the facility where the service is provided. With respect to such services provided by a . . . nurse practitioner, such services must be billed by the supervising physician or the facility where the service is provided.”

Managed Care Coverage and Payment

Historically, the financial health of a medical practice depended on its
ability to provide an expanding array of services to an increasing number of patients. The traditional model of health care delivery was fueled by the absence of price competition for health services as well as a seemingly endless demand for patient services. However, the emergence of managed care organizations (MCOs) has changed the financial incentives among health care providers. Instead of focusing on increased patient utilization of costly services, medical practices with managed care contracts are focusing on how to manage patient care more efficiently and reduce utilization.

Payment arrangements vary from one MCO to the next, but a common reimbursement strategy is to pay health care providers a fixed amount for the care of a covered population. The fixed payment may represent the total amount for all care delivered (i.e., a global capitation payment) or the amount for primary care professional services only. Nevertheless, an emphasis in most managed care arrangements is placed on shifting the financial risk for the provision of health care services from an employer or insurance carrier to the health care provider.

Health care providers have responded to the demands of the managed care market by developing strategies to lower operating costs, improve patient satisfaction, and enhance the overall health of the patient population. Nurse practitioners can make significant contributions in each of these areas through their involvement in patient education, wellness programs, patient recalls, telephone triage, utilization review, and quality assurance programs, as well as their efficient treatment of those individuals requiring medical attention.

Another strategy to improve patient health outcomes and reduce unnecessary utilization (and can include NPs) is the use of an interdisciplinary team to provide group outpatient care in addition to traditional individual care. Kaiser Permanente conducted a recent study (Beck et al, 1997) of group care delivery for a sample of geriatric patients and demonstrated:

- decreased visits to the emergency room and subspecialists,
- decreased repeat hospitalizations,
- increased immunizations,
- more calls to nurses and fewer calls to physicians,
- greater patient and physician satisfaction,
- comparable clinical outcomes to traditional care, and
- lower cost per member per month compared to traditional care.

**Cost/Benefit Analysis**

The following tables provide two compelling illustrations of the financial benefits of a physician/NP practice model. Revenues for this analysis are from all professional services, excluding diagnostic services such as laboratory tests and radiology procedures. Only certain variable expenses are presented, including salaries and fringe benefits for a physician, a NP, and medical assistants. Malpractice insurance premiums have also been included. This analysis has been simplified to clearly show the variability in contribution to overhead expenses under both a traditional fee-for-service operating environment and under a 100 percent capitated payment arrangement. Financial data for this analysis was drawn from the Medical Group Management Association 2000 Cost Survey, the 2000 Physician Compensation and Production Survey, and actual data from various medical practices.
Fee-for-Service Model

Table I below illustrates the traditional fee-for-service model. Column 1 with a single physician staff results in a contribution margin of $84,200. Table I, column 2 presents the same traditional fee-for-service arrangement but includes a nurse practitioner provider in addition to the original physician.

<table>
<thead>
<tr>
<th>TABLE I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-for-Service Model</td>
</tr>
<tr>
<td>Sample Analysis</td>
</tr>
<tr>
<td>(1) Physician Only</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REVENUE</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross charges – Physician</td>
<td>$395,000</td>
<td>$395,000</td>
</tr>
<tr>
<td>Gross charges – NP</td>
<td>0</td>
<td>193,000</td>
</tr>
<tr>
<td>Adjustments – Physician (25%)</td>
<td>(98,800)</td>
<td>(98,800)</td>
</tr>
<tr>
<td>Adjustments - NP (30%)</td>
<td>0</td>
<td>(57,900)</td>
</tr>
<tr>
<td>Total Net Revenue</td>
<td>296,200</td>
<td>431,300</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VARIABLE EXPENSES</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary &amp; Fringes – Physician</td>
<td>180,000</td>
<td>180,000</td>
</tr>
<tr>
<td>Salary &amp; Fringes – NP</td>
<td>0</td>
<td>72,000</td>
</tr>
<tr>
<td>Salary &amp; Fringes - Medical Asst.</td>
<td>25,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Salary &amp; Fringes - Medical Asst.</td>
<td>0</td>
<td>25,000</td>
</tr>
<tr>
<td>Malpractice Insurance – Physician</td>
<td>7,000</td>
<td>7,000</td>
</tr>
<tr>
<td>Malpractice Insurance – NP</td>
<td>0</td>
<td>900</td>
</tr>
<tr>
<td>Total Variable Expenses</td>
<td>212,000</td>
<td>309,900</td>
</tr>
<tr>
<td>Contribution to Overhead</td>
<td>$84,200</td>
<td>$121,400</td>
</tr>
</tbody>
</table>

Based on the data presented in Table I, the NP can add $135,100 in net revenue, $72,000 in salary and fringe benefit cost, a medical assistant of $25,000 in annual cost, and roughly $900 in malpractice insurance premiums. The computed net increase in contribution margin as a result of adding the NP is $37,200. The new contribution to overhead for the two providers combined has increased to $121,400.

Managed Care Model

Table II illustrates a much different environment consisting of a prepaid (capitated) HMO patient population. Revenue is depicted as fixed payments of $15 per member per month for the patient panel. In Table II, column 1, with a panel of 2,400 health plan members, total net capitated revenue for . . . a 50% increase in panel size can result in a greater contribution margin than an individual physician may be able to achieve on his or her own.
the year is estimated at $432,000. Associated variable expenses are $212,000 leaving a net contribution of $220,000. In column 2, there is an addition of a NP, but together both providers are still managing the same panel size. Obviously the contribution will drop commensurate with the additional costs of the NP and support staff. In columns 3 and 4, the panel is shown to increase by 600 members each, resulting in increased capitated payments and a higher contribution margin. In column 4, representing a panel size of 3,600, the contribution has grown to $343,100, or more than 50 percent of net revenue.

<table>
<thead>
<tr>
<th>TABLE II</th>
<th>Managed Care Model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sample Analysis</td>
</tr>
<tr>
<td></td>
<td>(1) (2) (3) (4)</td>
</tr>
<tr>
<td></td>
<td>Physician Phys./NP Phys./NP Phys./NP Phys./NP</td>
</tr>
<tr>
<td></td>
<td>(2,400 Panel) (2,400 Panel) (3,000 Panel) (3,600 Panel)</td>
</tr>
<tr>
<td>REVENUES</td>
<td></td>
</tr>
<tr>
<td>Capitated Payments</td>
<td>$432,000</td>
</tr>
<tr>
<td>Total Net Revenue</td>
<td>432,000</td>
</tr>
<tr>
<td>VARIABLE EXPENSES</td>
<td></td>
</tr>
<tr>
<td>Salary &amp; Fringes - Physician</td>
<td>180,000</td>
</tr>
<tr>
<td>Salary &amp; Fringes - NP</td>
<td>0</td>
</tr>
<tr>
<td>Salary &amp; Fringes - Medical Asst.</td>
<td>25,000</td>
</tr>
<tr>
<td>Salary &amp; Fringes - Medical Asst.</td>
<td>0</td>
</tr>
<tr>
<td>Malpractice Insurance - Physician</td>
<td>7,000</td>
</tr>
<tr>
<td>Malpractice Insurance - NP</td>
<td>0</td>
</tr>
<tr>
<td>Total Variable Expenses</td>
<td>212,000</td>
</tr>
<tr>
<td>Contribution to Overhead</td>
<td>$220,000</td>
</tr>
</tbody>
</table>
EMPLOYMENT INFORMATION

Employment Contracts and Agreements

In most instances, a written agreement is presented to the employed nurse practitioner outlining the key terms of his or her employment status. This agreement may be in the form of an employment contract or may be less formally drafted into a letter of employment. However written, several key areas are commonly addressed within the employment document. These areas include:

Job description
- Scope of practice
- Physician supervision
- Collaboration Agreement
- Administrative responsibilities
- Office location(s)
- Hours of operation
- Expected hours per week
- Call schedule
- Holidays/weekends

Insurance
- Malpractice insurance
- Health/dental insurance
- Life/disability insurance

Professional expenses
- CME program and travel costs
- CME paid time off
- Certification expenses
- Membership dues

Compensation package
- Base salary
- Bonus arrangement
- Annual salary adjustments
- Pension/retirement benefits
- Profit sharing
- Paid time off

Contractual provisions
- Effective date
- Probationary period
- Renewal
- Termination provisions
- Notifications

The above items represent basic areas of employment that should be clarified when the NP, employer, and supervising physician discuss the terms of employment. It is advisable to have a written contract or practice agreement that clearly spells out the terms of employment.

Credentialing

Hospital Privileges

Nurse practitioners practice medicine with physician collaboration. Within the hospital setting, NPs may be granted privileges to conduct rounds; perform histories and physicals; evaluate changes in a patient's condition; issue orders for such things as medications, treatments, and laboratory tests; record progress notes; and write discharge summaries.

Hospitals that grant privileges to NPs to practice in their facilities should verify that the NPs are properly certified, licensed as RNs, or registered by the state and have adequate professional liability insurance. On demonstration of satisfactory training and experience, and after approval by the hospital board or designated individual, a NP may be granted privileges with supervision of a physician who has appropriate privileges. The criteria and process for granting clinical privileges to NPs should be outlined in the medical staff bylaws. It is recommended that the actual NP privileges
be stated, not in the bylaws but in the medical staff rules and regulations, where amendments can be made more easily and efficiently. Preferably, this may be done in a category specifically for nurse practitioners as medical staff members.

Hospitals typically have a system for granting physicians provisional approval on particular privileges until competence is shown. A similar system may be established for NPs. Likewise, many hospitals use virtually the same form for physicians and nurse practitioners that are applying for privileges.

**Patient Satisfaction**

Early studies of patient acceptance and satisfaction on nurse practitioners showed that, compared with physicians, NPs function at comparable levels, use no more health care services, and are accepted by patients at a comparable level. A more recent study conducted in 1995-96 by Kaiser Permanente of the Northwest (KPNW), a health maintenance organization, explored differences in patient satisfaction with physician and nonphysician providers. An analysis of this study confirmed earlier findings that patients are satisfied with their care regardless of the type of practitioner delivering the care. This study further suggests that patient satisfaction appears to depend on the communication skills and style of the provider, and not on the type of provider. Therefore, the incorporation of nurse practitioners in the health care delivery system can result in greater patient satisfaction, along with the economic benefits commonly associated with nonphysician providers.

**Liability Insurance**

**Employer Coverage and Individual Policies**

Professional liability insurance for the nurse practitioner can be obtained through the employing clinic, personally by the NP, or by a combination of both parties.

Even though many employers offer to pay the cost of the professional liability insurance for employed NPs, it is generally advised that all nurse practitioners consider obtaining an individual policy instead of relying on a group insurance policy through their employers. Many employers have the option of simply adding coverage for the nurse practitioner as a rider to an existing physician policy. Often, such policies do not name the individual for whom this coverage is obtained. These “no name” policies may link certain key provisions, such as coverage limits and type of coverage, with other employed providers. An individual policy, on the other hand, will establish individual coverage limits and define the type of coverage, either occurrence or claims made, without regard to any other such policy in effect for other employed providers. For this reason, it is preferable for the NP to be specifically named on an individual liability insurance policy. Costs for professional liability insurance policies vary depending on the NPs scope of practice, the type of coverage, and the policy limits. Annual premium costs range from $600 to over $5,000 depending on the location of the practitioner, the NPs scope of practice, and the policy limits.

**Patient Compensation Fund**

Professional liability insurance in Wisconsin is a two-tiered structure whereby commercial insurance is obtained for coverage up to a mandated limit. Coverage beyond the mandated limits is provided through a statewide fund entitled the Patient Compensation Fund. Beginning in 1997, the mandated
coverage limits were $1,000,000 per occurrence and $3,000,000 aggregate. The extended coverage through the Patient Compensation Fund would cost approximately $900.

**Recruitment and Retention**

There are a number of federal and state loan repayment and scholarship programs that can assist primary care clinics, in rural and urban shortage areas, in the recruitment and retention of nurse practitioners. There are also federal and state reimbursement incentives to retain NPs who provide primary care in designated rural and urban shortage areas.

**Loan Repayment and Scholarship Programs**

The National Health Service Corps (NHSC), a federal program, offers loan repayment or scholarship assistance to nurse practitioners who agree to provide primary care for at least two years in a rural or urban federally designated HPSA. A NHSC scholarship can cover full tuition, or NHSC loan repayment can provide up to $50,000 for a two-year obligation. The Wisconsin Division of Public Health - Primary Care Section helps clinics and nurse practitioners by providing information and applications for these programs.

The Wisconsin Health Professions Loan Assistance program can provide up to $25,000 for a three-year obligation for nurse practitioners who agree to provide primary care in federally designated rural and urban HPSAs in Wisconsin. The Wisconsin Office of Rural Health helps clinics and nurse practitioners by providing information and applications for this program.

**Recruitment Strategies**

Nurse practitioner educational institutions and professional associations provide several means of assisting potential employers of NPs in finding the right candidate for their organization.

- **Clinical Preceptorship**
  A number of NP graduates are hired by one of their clinical preceptor sites. By mentoring students as preceptors, physicians can assess the applicants whose level of health care experience, clinical capabilities, and personality best fit their practice environment.

- **Job Fairs and Bulletin Boards**
  Most NP programs or their student associations sponsor an annual employment Job Fair as students near graduation. Additionally, most NP programs keep a bulletin board of job announcements for both new graduates and practicing nurse practitioners.

- **Newsletters**

- **Employment Exchange Program**
  The Wisconsin Office of Rural Health provides this practice opportunity listing service free of charge to both the health professional and the employer/community. Positions listed are available via a monthly bulletin provided to all inquiring health professionals on request. The monthly bulletin includes the basic elements of a position vacancy, and potential practitioners can contact the prospective employer directly for further information.
Retention Assistance

The WisTREC project, Wisconsin AHEC System, and academic training programs are collaborating on a variety of programs to help rural and urban underserved areas recruit and retain primary care providers. These programs include recruiting more students from rural and underserved populations, developing more student experiences in rural and urban shortage areas, and developing more distance education to help students live and work closer to home. It is believed that NP students who are able to work and/or reside in rural and underserved areas while enrolled in the educational program are much more likely to remain in these communities after completion of the nurse practitioner educational program. These students are likely candidates for employer recruitment efforts in rural and urban health professional shortage areas.

The Wisconsin Medicaid Program offers a primary care HPSA bonus payment to encourage primary care providers, including nurse practitioners, to practice in HPSAs or to provide services to Medicaid recipients who live in designated professional shortage areas. Wisconsin Medicaid provides a 20 percent HPSA bonus payment for certified providers who render selected primary care services for covered Medicaid recipients. Also, providers of obstetrical services may be eligible for an additional 25 percent obstetric HPSA bonus payment for covered recipients.

The federal Rural Health Clinic Services Act authorizes favorable Medicare and Medicaid cost-based reimbursement to certified rural health clinics for services provided by nurse practitioners and other midlevel providers. As a condition of participation in the RHC program, certified clinics are required to employ a nurse practitioner, or other qualified nonphysician provider, to serve patients at least 50 percent of the time the clinic is open. Once certified, the RHC is required to retain the nurse practitioner or lose the favorable cost-based reimbursement for Medicare- and Medicaid-covered patients.
RESOURCE GUIDE AND REFERENCES

Facts About Nurse Practitioners

General Description


Education and Certification

American Nurses Association (ANA)


National Association of Pediatric Nurse Associates & Practitioners (NAPNAP)


National Organization of Nurse Practitioner Faculties (NONPF)


American Association of Colleges of Nursing (AACN)

*Web site* - [http://www.aacn.nche.edu/](http://www.aacn.nche.edu/)

American Nurses Credentialing Center (ANCC)

*Web site* - [http://www.nursingworld.org/ancc/index.htm](http://www.nursingworld.org/ancc/index.htm)

National Certification Board of Pediatric Nurse Practioners and Nurses (NCBPNP/N)

*Web site* - [www.pnpcert.org](http://www.pnpcert.org)
American Academy of Nurse Practitioners (AANP)
Web site - http://www.aanp.org/

National Certification Corporation (NCC)
Web site - http://www.npginc.com/ncc/

Academic programs (WisTREC has list and Web sites; see below)
Wisconsin Program for Training Regionally Employed Care Providers (WisTREC), UW Madison School of Nursing, CSC K6/218, 600 Highland Avenue, Madison, WI 53792; phone (608) 262-8755; fax (608) 263-5170.
Web site – http://academic.son.wisc.edu/wistrec/

Characteristics of Practitioners


Wisconsin Nurses Association (WNA) - Nurse Practitioner Forum
Web site - http://www.wisconsinnurses.com/

American Nurses Association (ANA)
Web site - http://www.ana.org/

National Association of Pediatric Nurse Associates & Practitioners (NAPNAP)
Web site - http://www.napnap.org

Scope of Practice

Wisconsin Department of Regulation and Licensing, Board of Nursing, P.O. Box 8935, Madison, WI 53708; phone (608) 266-2811; fax (608) 261-7083.
Wisconsin Administrative Code, Chapters N 6-8.
Web site - http://badger.state.wi.us/agencies/drl/Regulation

Web site - http://www.wisconsinnurses.com/
Spectrum of Practice Settings

American Nurses Association (ANA)
Web site - http://www.nursingworld.org/


Prescriptive Authority

Wisconsin Department of Regulation and Licensing, Board of Nursing, P.O. Box 8935, Madison WI 53708; phone (608) 266-2811; fax (608) 261-7083.
*Wisconsin Administrative Code, Chapter N 8.*
Web site - http://badger.state.wi.us/agencies/drl/Regulation

Reimbursement and Financial Analysis

Compensation Arrangements

Web site - http://www.mgma.org


Contribution to Practice Revenue

Web site - http://www.wisconsinnurses.com/


**Third-Party Coverage and Payment**


WPS-Medicare Part B, 1717 West Broadway, P.O. Box 1787, Madison, WI 53701; phone (608) 221-4711.


WPS Health Insurance, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708; phone (800) 221-6951.


**Cost/Benefit Analysis**


**Employment Information**

**Employment Contracts and Agreements**


**Credentialing**


Web site: [http://www.jcaho.org](http://www.jcaho.org)


**Patient Satisfaction**


**Liability Insurance**

Wisconsin Department of Regulation and Licensing, Board of Nursing. (1999, April). APNP Malpractice Insurance Coverage. *Regulatory Digest*. [P.O. Box 8935, Madison, WI 53708; phone (608) 266-2811; fax (608) 261-7083].

Web site - [http://badger.state.wi.us/agencies/drl/Regulation](http://badger.state.wi.us/agencies/drl/Regulation)


American Nurses Association  
   Web site - http://www.nursingworld.org

National Association of Pediatric Nurse Associates & Practitioners (NAPNAP)  
   Web site - http://www.napnap.org

**Recruitment and Retention**

Wisconsin Division of Public Health, Primary Care Section. (1999, April). *Recruitment Resources Linked Available to Shortage Areas in Wisconsin*. Madison, WI: Author. [phone (608) 264-6528; See appendix.]

Wisconsin Division of Public Health, Primary Care Section. (1999, April). *Primary Care Recruitment & Retention Resources Available to Shortage Areas in Wisconsin*. Madison, WI: Author. [phone (608) 264-6528; See appendix.]

Wisconsin Office of Rural Health. 109 Bradley Memorial, 1300 University Ave, Madison, WI 53706. Office phone (608) 265-3608.  
   *Primary Providers for Wisconsin: Employment Exchange*; phone (800) 488-9512
EMPLOYMENT GUIDE

Information on Certified Nurse Midwives

A collaborative project of the WisTREC Utilization Committee initiated by the Wisconsin AHEC System and funded by The Robert Wood Johnson Foundation.
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INTRODUCTION

This booklet was developed by the Wisconsin Program for Training Regionally Employed Care providers ("WisTREC") utilization committee. WisTREC is a project of the Wisconsin Area Health Education Center System, is funded by the Robert Wood Johnson Foundation-Partnerships for Training program, and is administered through the University of Wisconsin-Madison School of Nursing.

WisTREC is focused on increasing access to primary care in underserved areas and for underserved populations by increasing the training and use of physician assistants, nurse practitioners, and nurse midwives in these areas and populations.

WisTREC and its collaborating partners are committed to sharing the information in these guides with all interested parties. These guides may be copied and distributed or excerpts used if the WisTREC project is credited.
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FACTS ABOUT CERTIFIED NURSE MIDWIVES

General Description

Certified Nurse-Midwives (CNMs) are registered nurses with advanced preparation in both nursing and midwifery. Most CNMs work in clinic settings, hospitals, and/or birthing centers. CNMs attend women during labor and birth and are trained and experienced in prenatal, postpartum, normal newborn care, and routine gynecological care. Thus, they carry on a centuries-old tradition of assisting women in the safe birth of babies, using their professional skills, while incorporating the advances of modern medicine.

The word midwife means “with woman”. The term refers to a care provider prepared in the discipline of midwifery who has specialized in women’s health. It is an ancient word, reflecting the historic tendency for women to attend to each other and offer close and attentive support during labor, birth, and the adjustment period afterwards. However, the evolution and expansion of nurse-midwifery practice has resulted in the current identification of CNMs as primary care providers who also incorporate gynecologic services for women throughout the life span.

CNMs are educated to assess, counsel, diagnose, prescribe, and manage many of the primary care needs of their clients. Nurse-midwifery care focuses on wellness and consumer choice. They work in collaboration with other health care professionals such as physicians, pharmacists, and physician assistants. CNMs are eligible for reimbursement from private and public third party payers. CNMs are licensed to practice by the State in which they practice and are certified upon national examination.

- Ninety percent of visits to CNMs are for primary, preventive care including care outside of the maternity cycle. Examples of this kind of care include annual exams and reproductive health visits. (Readership and Practice Profile of the ACNM, Journal of Nurse-Midwifery, 39).

- Currently, 70 percent of the women seen by nurse-midwives are considered at additional risk by virtue of their age, socioeconomic status, education, ethnicity, or location of residence (Scupholme et al. 1992).

- Certified nurse-midwives offer prenatal care, support in labor, added comfort measures, and woman-centered birth, resulting in a cesarean section rate that is half the national average in comparable patient populations (Gabay and Wolfe, 1997).

- The care provided by certified nurse-midwives has been shown to reduce the incidence of low birth weight especially among socioeconomically high-risk women, thus lessening the primary reason for the persistently high rate of infant mortality in the United States when compared to other developed countries (Rooks, 1997).
CNMs possess comprehensive assessment, interviewing, counseling, communication, and case management skills. CNMs, like NPs, exercise a high degree of independent judgement, complex clinical decision making, and skill in managing health care environments (American Nurses Association, 1996). As advanced practice nurses, CNMs practice evolves in response to developments in nursing research, advances in medical therapeutics, and changes in the health care delivery system.

**Education and Certification**

To become a CNM in the United States, one must complete an accredited educational program, demonstrate that the core competencies in practice areas have been met, and pass a credentialing examination to receive national certification. In Wisconsin, CNMs must first obtain certification to become licensed to practice. Graduate nurse-midwifery programs include advanced level course work in health promotion and disease prevention, health assessment, pathophysiology, diagnostic assessment, clinical decision-making, pharmacology and therapeutics, research, human diversity, health policy, and advanced ethics. Content in the specialty addresses the unique needs of the patient in the context of human development, health and illness, and family. The US Department of Education has recognized the American College of Nurse-Midwives, Division of Accreditation (DOA) as the accrediting agency for nurse-midwifery education programs since 1982.

The American College of Nurse-Midwives (ACNM) Certification Council, Inc. administers the national certification examination to all graduate nurse-midwives. The certification for individuals who passed the ACNM Certification Council, Inc. national exam after 1996 will expire after 8 years, and will require re-certification to maintain the professional designation. In addition to certification, a CNM must receive necessary licensure(s) for practice and maintain these by meeting renewal requirements. Each CNM may enroll in a certification maintenance program and/or continuing competency assessment to demonstrate lifelong accrual of current knowledge, thereby maintaining active certification through meeting re-certifying requirements. In addition, CNMs are committed to quality assurance. Wisconsin CNMs voluntarily participate in peer review through a Wisconsin Chapter ACNM committee and are active in other continuous quality improvement measures.

A CNM with a master's degree, national certification, and preparation in pharmacotherapeutics can become Advanced Practice Nurse Prescribers (APNP). A nurse who uses the initials APNP is legally certified to prescribe medications for the treatment of illness and the prevention of disease. In Wisconsin, eighty-six percent of Wisconsin CNMs hold either a masters degree or a doctorate.
Characteristics of Practitioners

Practitioner Demographics

The American College of Nurse-Midwives currently has more than 7,000 members. Of those, approximately 5,700 are in clinical practice. The rest are students, faculty members, retired, or outside of clinical practice for a variety of reasons. According to a report prepared by the U.S. Department of Health and Human Services in 1996, roughly 82 percent were employed in clinical practice.

A survey conducted in 1998 for the WisTREC Partnership for Training program compiled information on 60 Certified Nurse-Midwives in the state of Wisconsin. This study found that nearly all of the CNMs (98%) were female and white (98%), over seventy percent were married, and all were certified by the national organization.

Number of Practitioners

In its 1996 report, the U.S. Department of Health & Human Services (HHS) estimated there were approximately 5,337 CNMs employed in clinical practice nationwide. Similar data published by the Journal of the American Medical Association (JAMA) showed that the national supply of CNMs increased from 3,000 in 1990 to approximately 6,000 in 1997.

The 1998 WisTREC Survey concluded that approximately 80 CNMs reside and practice in the state of Wisconsin. This survey was distributed to all CNMs identified as currently practicing in the state.

Enrolled Candidates

Nationally the growth in the midwifery workforce has been steady but modest in terms of total numbers. For example, although the production of new CNMs more than doubled between 1992 and 1997, the total number of nurse-midwives newly certified in 1997 was less than 600. Each year, approximately 400 nurse-midwives pass the national certification exam. The number of nurse-midwives who are certified each year has increased by 25 percent since 1991.

In Wisconsin, a total of 20 candidates, both full- and part-time, were enrolled in nurse-midwife programs for the 2000-2001 academic year. Marquette University in Milwaukee had 15 candidates enrolled in its program during the 2000-2001 academic year. The remaining students are enrolled in various out-of-state distance-learning programs.

Practice Settings

CNMs practice in communities spanning the most densely urban to the most remote and rural. Nationally, nearly one quarter of CNMs practice in rural (non-metropolitan statistical) areas.

CNM Practice Settings in Wisconsin

By 1996, an estimated 5,700 Nurse Midwives had obtained national certification.
The 1998 WisTREC survey data indicated that 61 percent of CNMs worked in medical practice sites; 17 percent in various types of community health centers; 10 percent in hospital departments; 5 percent in governmental agencies; and the remaining 7 percent in various other settings. Data also revealed that nearly 88 percent of Wisconsin CNMs were employed in urban settings, as defined by the Census Bureau.

<table>
<thead>
<tr>
<th>Practice Scope</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Scope</td>
<td>88%</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>4%</td>
</tr>
<tr>
<td>Well Women</td>
<td>6%</td>
</tr>
</tbody>
</table>

According to the recent data compiled by the WisTREC program, most of the Certified Nurse-Midwives in Wisconsin provide a full scope of nurse-midwifery services, which includes antepartum, intrapartum, postpartum, gynecological, well-woman and minor acute illness care. Only 10% of Wisconsin CNMs do not provide full scope care.

**Scope of Practice**

A Certified Nurse-Midwife is licensed by the Wisconsin Board of Nursing both as a Registered Nurse and as a CNM. Wisconsin licensure for CNMs requires national certification and recognizes the ACNM Certification Council Inc., as the credentialing body. CNMs are licensed to provide:

“the overall management of care of a woman in normal childbirth and the provision of prenatal, intrapartal, postpartal and nonsurgical contraceptive methods and care for the mother and the newborn.” CNMs can collaborate in but not independently manage the care of patients with complications and patients requiring Cesarean section or mechanical assistance with delivery. Management of these patients must be referred to the physician providing general supervision and who has training in obstetrics (Wisconsin Board of Nursing, Administrative Code Chapter 4).

Certified Nurse-Midwives with additional education, training, or experience can apply for additional certification from the State Board of Nursing to be Advanced Practice Nurse Prescribers (APNP). The APNP independently issues prescriptions for laboratory testing, radiographs or electrocardiograms appropriate to her or his area of competency. APNPs are required to practice within a *collaborative relationship* defined as:
"Collaboration" means a process which involves 2 or more health care professionals working together, in each other's presence when necessary, each contributing one's respective area of expertise to provide more comprehensive care than one alone can offer. N8.02 (5)

The certified nurse-midwife's scope of practice may include, but is not limited to, the following nursing, nurse midwifery, and medically delegated services:

- Advanced physical assessment (patient histories and physical exams);
- Selection and performance of appropriate diagnostic and therapeutic procedures;
- Ordering and interpreting lab tests;
- Diagnosis, treatment and monitoring of common acute and chronic clinical conditions;
- Prescription and administration of drugs, treatments and therapies; and
- Patient case management and referral to physicians and other specialists.

Certified nurse-midwives do not require on-site physician supervision. Delegated medical care can be provided by CNMs who are competent based on their education, training and experience, and under the “general supervision” of a physician with training in obstetrics. The supervising physician must be available for consultation and emergencies with deviations from normal (including Cesarean sections and mechanical assistance with deliveries), and must enter into a formal written agreement with the CNM. The written agreement must be annually reviewed and approved and must outline collaborative practice protocols, conditions of referral, and identification of health care facilities to be used (including home deliveries when appropriate).

Nursing and nurse-midwifery care are provided by CNMs as an independent function, ranging from comprehensive patient assessment and care management to population health assessment and intervention. Because of the increasing complexity of health care and an increasing commitment to providing more comprehensive care, many licensed health care professionals provide care in collaborative, team practice settings.

**Spectrum of Practice Settings**

CNMs contribute to meeting the needs for women’s health, and childbirth related care, for many Americans who would otherwise lack access to ongoing health care services. CNMs practice in public, private, university, and military hospitals. Many work in health maintenance organizations, in private practices, public health clinics, and in birth centers. CNMs are also active in international health programs working worldwide to improve the health of mothers and their babies.

The broad range of practice settings can help to explain the strong demand for certified nurse-midwives and the steady growth in the number of practicing CNMs.

- Nurse-midwifery practice is legal in all 50 states and the District of Columbia.
Over half of all CNMs work primarily in an office/clinic environment. Most list a hospital or physician practice as their place of employment.

Most CNM attended births occur in hospitals. In 1997, 96 percent of CNM attended deliveries occurred in hospitals, 2.4 percent in freestanding birth centers and 1 percent in the home.

The typical nurse-midwife sees up to 140 clients a month and attends 10 births a month.

The 1991 infant mortality rate for nurse-midwives was 4.1 per 1,000 live births, the national average for that year was 8.6 per 1,000.

A collaborative relationship between physicians and CNMs offers services which can enhance the medical practice.

Clients can be offered the option of seeing the CNM for routine and/or urgent care visits. The reduced waiting time and the CNM’s emphasis on education can improve patient satisfaction.

CNMs can provide outreach, care coordination and case management of underserved and special need populations. In fact, many Wisconsin CNMs are working with those at additional risk based on age, socioeconomic status, ethnicity, or location of residence.

A collaborative practice between CNMs and physicians allows the physicians to focus on those patients with more complex medical problems.

The addition of CNM care brings both expertise in midwifery and nursing into a practice. CNMs are skilled in providing education and care through collaborative relationships with the health care team, including physicians, physician assistants, nurse practitioners, nurses, pharmacists, and other providers.

**Prescriptive Authority**

Current state regulations under Chapter N 8 of the Wisconsin Board of Nursing Administrative Code permit a certified nurse midwife to independently prepare prescription orders. To qualify for certification to be an advanced practice nurse prescriber (APNP), a nurse midwife must comply with the following:

1) Have a current license to practice as a professional nurse in the state.

2) Be currently certified by a national certifying body approved by the Board of Nursing as a certified nurse midwife.
3) Applicants who receive national certification as a CNM after July 1, 1998, must hold a master’s degree in nursing or a related health field granted by a college or university approved by the Board of Nursing.

4) Have completed at least 45 contact hours in clinical pharmacology/therapeutics within 3 years preceding the application.

5) Have passed a jurisprudence examination for advanced practice nurse prescribers.

Chapter N 8.06 describes limitations to the prescribing authority of the CNM. The CNM may only issue those prescription orders appropriate to the prescriber’s areas of competence, as established by his or her education, training, or experience. The prescribing CNM may not issue a prescription order for any schedule I controlled substances. Prescription orders for schedule II controlled substances can only be issued in specific instances.

Prescription orders prepared by the CNM must contain the name, address, and telephone number of the CNM prescriber. Prescription orders for Schedule III, IV, and V controlled substances require the APNPs’ DEA registration number. APNPs must maintain malpractice insurance as specified in Chapter N 8.08.
Compensation Arrangements

Salary and Benefit Structure

Arrangements for the compensation of Certified Nurse Midwives vary by organization; however, the direct compensation for most CNMs is typically based on a straight salary or a salary plus bonus incentive payment. A 1997 survey of 537 group practices conducted by the Medical Group Management Association revealed that of 39 employed CNMs, 51 percent were compensated on a straight salary basis, whereas 44 percent had a salary plus a bonus or incentive payment. The remaining 5 percent were compensated on a production basis, computed by gross charges, net charges, or on a relative value unit formula.

The benefit structure for employed CNMs also varies by organization. Typical benefits of practicing CNMs include three to four weeks paid vacation (including six to ten paid holidays), paid sick and continuing medical education leave, pension/retirement fund, malpractice insurance, health insurance, group term life insurance, group long-term disability insurance, annual dues/licensures, and a continuing education allowance.

National Salary Data

Several organizations accumulate and report annual salary data for Certified Nurse Midwives. According to data collected in 1996 by HHS, the mean annual income for CNMs nationwide was $54,182. The Medical Group Management Association’s Physician Compensation and Production Survey: 2000 Report Based on 1999 Data reported that the median compensation of CNMs was $67,250; the mean was $68,857.

National survey data has revealed wide variations in the earnings among CNMs due to factors such as years of experience, population of the geographic area, whether the CNM takes call, and whether the CNM has administrative and/or supervisory responsibilities for other CNMs.

Wisconsin Salary Data

In 1998, the WisTREC survey reported salary data on Certified Nurse Midwives. Based on the survey respondents residing in Wisconsin, the majority of CNMs (59%) reported an annual income between $50,000 and $70,000. The survey also identified that 10.3% of the CNMs were paid less than $50,000, whereas 66.6% were paid in excess of $65,000 annually.
**Contribution to Practice Revenue**

**Pricing of Services**

In most medical practices, the amounts charged for services rendered by the CNM are identical to the amounts charged for comparable services performed by a physician. Therefore a patient may be charged the same amount for the same service, whether a CNM or a physician performs it. However, the average complexity of patient health care needs and services rendered by the CNM may be less than the typical physician. A difference in the mix of services delivered will result in lower average charges per patient cared for by the CNM (for example, CNMs have been shown to use less technology, have lower cesarean section rates, and fewer low birthweight babies) in comparison to the physician, thus reducing overall expenses.

**Volume Indicators**

Patient visit statistics can be an effective barometer of the financial performance of a health care provider, particularly in a primary care practice setting. A patient visit is typically defined as an identifiable contact between the patient and a health care provider where advice, a procedure, service, or treatment is provided.

The 1998 WisTREC research indicates that of those CNMs working full-time, the average number of outpatient visits per week is 38 and the average number of inpatient visits is six per week. The Medical Group Management Association reports the number of ambulatory (outpatient) encounters for CNMs in primary care practices. The 2000 MGMA Survey reported the average number of annual ambulatory encounters for CNMs as 1,716. Assuming the average CNM works approximately 48 weeks per year (allowing for vacation and CME), the MGMA data would translate into approximately 36 ambulatory patient visits per week.

In addition to outpatient visits, CNMs either share call or are on call continuously supporting pregnant clients and their families during labor and birth. CNM practices thus generate outpatient clinic charges as well as intrapartum charges.

**Production Data**

Production (revenue) generation by Certified Nurse Midwives is not widely reported in trade journals or medical surveys, but patient charges can be another key indicator of the financial performance of the CNM. The role of the CNM within the medical practice can have a direct impact on the amount of patient charges resulting from services provided by the practitioner. For instance, the role of a CNM could be primarily limited to prenatal visits; services that are usually bundled in a physician’s charge for a global service and not separately billed. Therefore, revenue generation may not be a proper indicator of financial performance since the work of the CNM is intended to relieve the physician of these functions and allow him or her to focus more attention on performing billable services.

*The average annual gross professional charges for CNMs: $291,241.00 (MGMA, 2000)*
In most situations, however, gross charges generated by the CNM are tracked separately by practice managers to evaluate the financial contribution of the CNM to the employing organization. The 2000 Medical Group Management Association *Physician Compensation and Production Survey* reports the average annual gross professional charges for CNMs as $291,241. It should be noted that these amounts exclude the technical component of all ancillary services such as laboratory and radiology.

**Third-Party Coverage and Payment**

**Medicare Coverage and Payment**

The first Medicare coverage of physician services provided by Certified Nurse Midwives was authorized by the Rural Health Clinic Services Act in 1977. In the following two decades, Congress incrementally expanded Medicare Part B payment for services provided by CNMs in collaboration with a physician in rural hospitals, nursing facilities, physicians’ office or clinic, and in a rural independent practice setting.

As of January 1, 1998, Medicare pays for medical services provided by CNMs in most settings at 65 percent of the physician’s fee schedule using the Resource-Based Relative Value Scale (RBRVS) system. This includes hospitals (inpatient, outpatient, and emergency departments), nursing facilities, physician offices and clinics. Medicare assignment is mandatory and state law determines supervision and scope of practice. However, urban hospitals that employ Certified Nurse Midwives may choose not to separately bill Part B for services provided by CNMs in an urban hospital setting. These services can be bundled with other facility services of the hospital and would be covered by the intermediary payment to the facility.

Outpatient services provided in offices and clinics may still be billed under Medicare’s “incident-to” provisions if Medicare’s restrictive billing guidelines are met. This allows payment at 100 percent of the physician’s fee schedule if: (1) the physician is physically on-site when the CNM provides care; (2) the physician treats all new Medicare patients (CNMs may provide the subsequent care); and (3) established Medicare patients with new medical problems are personally treated by the physician (CNMs may provide the subsequent care).

Medicare-certified rural health clinics (RHCs) and federally qualified health centers (FQHCs) receive cost-based reimbursement for covered services to Medicare beneficiaries regardless of the provider of care, physician or CNM. In general, RHCs and FQHCs receive an all-inclusive reimbursement rate for each patient visit up to the Medicare maximum payment limit. The 2000 maximum payment limit per encounter for RHCs was $61.85, rural FQHCs was $82.55, and urban FQHCs was $96.02. These payment limits apply to all covered services furnished during the patient visit including all physician services, CNM services, incidentals, and diagnostic laboratory tests. As of January 1, 1998, the all-inclusive payment limitation for RHCs is waived only for those clinics in rural hospitals with fewer than 50 beds.
Medicaid Coverage and Payment

All state Medicaid programs cover medical services provided by Certified Nurse Midwives. To be certified by Wisconsin Medicaid, CNMs must be licensed by the Board of Nursing in Wisconsin as registered nurses and as certified nurse midwives (e.g., including national professional certification as a CNM). All CNMs providing services to Wisconsin Medicaid recipients must be individually certified by the Wisconsin Medical Assistance Program (WMAP) in order to be reimbursed. CNM reimbursement by Wisconsin Medicaid is 90% of the maximum allowable fee established for physician services. Medicaid-certified CNMs can bill independently for covered services using their Medicaid provider number.

CNMs may also meet Wisconsin Medicaid criteria to be certified as a Medicaid Nurse Practitioner billing provider, if the CNM has completed a master’s degree program for advanced clinical practice nursing. CNMs who are certified as Medicaid NP providers are reimbursed at 100% of the maximum allowable fee established for physician services, and can bill independently for the covered NP services using this Medicaid provider number. Employers and billing offices need to review and follow Medicaid billing policies as detailed in the various Medicaid provider manuals.

Wisconsin Medicaid also provides incentive payments to primary care and emergency medicine providers, including CNMs, who either serve Medicaid recipients residing in Health Professional Shortage Areas (HPSAs) or practice within a designated HPSA zip code. The incentive payment for HPSA-eligible primary care and emergency medicine procedures is 20 percent of the physician maximum allowable fee. HPSA-eligible obstetrical procedures receive the HPSA bonus and an additional 25 percent incentive payment.

Medicaid-certified rural health clinics (RHCs) and federally qualified health centers receive cost-based reimbursement for covered services to Medicaid recipients regardless of the provider of care, physician or CNM. In Wisconsin, all RHCs receive an all-inclusive reimbursement rate for each patient visit up to the Medicaid maximum payment limit. An additional 10 percent incentive payment is made to RHCs who serve Medicaid recipients residing in Health Professional Shortage Areas (HPSAs). The Wisconsin Medicaid maximum payment limit per encounter for RHCs in 2000 was $68.04, including the HPSA incentive payment. Wisconsin Medicaid cost-based reimbursement for FQHCs is not limited by the maximum payment rates.

Commercial Insurance Coverage and Payment

Most commercial insurance companies allow for the coverage of CNM-provided medical services. However, insurance companies often differ in how medical services provided by CNMs are covered and how insurance claim forms should be submitted. Typically, commercial insurance companies will extend coverage for medical services provided by a CNM if those services are included as part of the physician’s bill. Many insurers require that the bill for medical services provided by CNMs be filed under the physician’s name and provider number. Since some insurers prefer the claim to be filed under the CNMs name, billing personnel should check with the individual insurance company to determine the particular policy on coverage for medical services provided by CNMs.

Managed Care Coverage and Payment
Historically, the financial health of a medical practice depended on its ability to provide an expanding array of services to an increasing number of patients. The traditional model of health care delivery was fueled by the absence of price competition for health services as well as a seemingly endless demand for patient services. However, the emergence of managed care organizations (MCOs) has changed the financial incentives among health care providers. Instead of focusing on increased patient utilization of costly services, medical practices with managed care contracts are focusing on how to manage patient care more efficiently and reduce utilization.

Payment arrangements vary from one MCO to the next, but a common reimbursement strategy is to pay health care providers a fixed amount for the care of a covered population. The fixed payment may represent the total amount for all care delivered (i.e., a global capitation payment) or the amount for primary care professional services only. Nevertheless, an emphasis in most managed care arrangements is placed on shifting the financial risk for the provision of health care services from an employer or insurance carrier to the health care provider.

Health care providers have responded to the demands of the managed care market by developing strategies to lower operating costs, improve patient satisfaction, and enhance the overall health of the patient population. Certified Nurse Midwives can make significant contributions in each of these areas through their involvement in patient education, wellness programs, patient recalls, telephone triage, utilization review, and quality assurance programs, as well as their efficient treatment of those individuals requiring medical attention.

**Cost/Benefit Analysis**

The following tables provide two compelling illustrations of the financial benefits of a physician/CNM practice model. Revenues for this analysis are from all professional services, excluding diagnostic services such as laboratory tests and radiology procedures. Only certain variable expenses are presented, including salaries and fringe benefits for a physician, a CNM, and a medical assistant. Malpractice insurance premiums are also included. This analysis has been simplified to clearly show the variability in contribution to overhead expenses under both a traditional fee-for-service operating environment and under a 100 percent capitated payment arrangement.

Financial data for this analysis was drawn from the Medical Group Management Association 2000 *Cost Survey*, the 2000 *Physician Compensation and Production Survey*, and actual data from various medical practices.
Fee-for-Service Model

Table I below illustrates the traditional fee-for-service model. Column 1 with a single physician staff results in a contribution margin of $185,250. Table I, column 2 presents the same traditional fee-for-service arrangement but includes a CNM provider in addition to the original physician.

<table>
<thead>
<tr>
<th>TABLE I</th>
<th>Fee-for-Service Model</th>
<th>Sample Analysis</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Physician</td>
<td>Physician/ CNM Team</td>
<td>Difference</td>
</tr>
<tr>
<td>REVENUES</td>
<td></td>
<td></td>
<td>Only</td>
<td>CNM Team</td>
<td>Difference</td>
</tr>
<tr>
<td>Gross charges – OB/GYN Phys.</td>
<td>$785,000</td>
<td>$785,000</td>
<td>-0-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross charges – CNM</td>
<td>-0-</td>
<td>290,000</td>
<td>290,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustments – Physician (35%)</td>
<td>(274,750)</td>
<td>(274,750)</td>
<td>-0-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustments – CNM (35%)</td>
<td>-0-</td>
<td>(101,500)</td>
<td>(101,500)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Net Revenue</td>
<td>510,250</td>
<td>698,750</td>
<td>188,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VARIABLE EXPENSES</td>
<td>Salary &amp; Fringes – OB/GYN Phys.</td>
<td>275,000</td>
<td>275,000</td>
<td>-0-</td>
<td></td>
</tr>
<tr>
<td>Salary &amp; Fringes – CNM</td>
<td>-0-</td>
<td>80,000</td>
<td>80,000</td>
<td></td>
<td></td>
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<tr>
<td>Salary &amp; Fringes – Medical Asst.</td>
<td>25,000</td>
<td>25,000</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salary &amp; Fringes – Medical Asst.</td>
<td>-0-</td>
<td>25,000</td>
<td>25,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malpractice Insurance – Physician</td>
<td>25,000</td>
<td>25,000</td>
<td>-0-</td>
<td></td>
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<tr>
<td>Malpractice Insurance – CNM</td>
<td>-0-</td>
<td>7,000</td>
<td>7,000</td>
<td></td>
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<tr>
<td>Total Variable Expenses</td>
<td>325,000</td>
<td>437,000</td>
<td>112,000</td>
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<tr>
<td>Contribution to Overhead</td>
<td>$185,250</td>
<td>$261,750</td>
<td>$76,500</td>
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<td></td>
</tr>
</tbody>
</table>

Based on the data presented in Table I, the CNM can add $188,500 in net revenue, $80,000 in salary and fringe benefit cost, a medical assistant of $25,000 in annual cost, and roughly $7,000 in malpractice insurance premiums. The computed net increase in contribution margin as a result of adding the CNM is $76,500. The new contribution to overhead for the two providers combined has increased to $261,750.
Managed Care Model

Table II illustrates a much different environment consisting of a prepaid (capitated) HMO patient population. Revenue is depicted as fixed payments of $15 per member per month for the patient panel. In Table II, column 1, with a panel of 2400 health plan members, total net capitated revenue for the year is estimated at $432,000. Associated variable expenses are $325,000 leaving a net contribution of $107,000. In column 2, there is an addition of a CNM, but together both providers are still managing the same panel size. Obviously the contribution will drop commensurate with the additional costs of the CNM and support staff. In columns 3 and 4, the panel is shown to increase by 600 members each, resulting in increased capitated payments and a higher contribution margin. In column 4, representing a panel size of 3600, the contribution has grown to $211,000, or nearly 33 percent of the net revenue.

<table>
<thead>
<tr>
<th>TABLE II Managed Care Model Sample Analysis</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician (2400 Panel)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitated Payments</td>
<td>$432,000</td>
<td>$432,000</td>
<td>$540,000</td>
<td>$648,000</td>
</tr>
<tr>
<td>Total Net Revenue</td>
<td>432,000</td>
<td>432,000</td>
<td>540,000</td>
<td>648,000</td>
</tr>
<tr>
<td>Salary &amp; Fringes – Physician</td>
<td>275,000</td>
<td>275,000</td>
<td>275,000</td>
<td>275,000</td>
</tr>
<tr>
<td>Salary &amp; Fringes – CNM</td>
<td>-0-</td>
<td>80,000</td>
<td>80,000</td>
<td>80,000</td>
</tr>
<tr>
<td>Salary &amp; Fringes – Medical Asst.</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Salary &amp; Fringes – Medical Asst.</td>
<td>-0-</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Malpractice Insurance - Physician</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Malpractice Insurance – CNM</td>
<td>-0-</td>
<td>7,000</td>
<td>7,000</td>
<td>7,000</td>
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<tr>
<td>Total Variable Expenses</td>
<td>325,000</td>
<td>437,000</td>
<td>437,000</td>
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</tr>
<tr>
<td>Contribution to Overhead</td>
<td>$107,000</td>
<td>$(5,000)</td>
<td>$103,000</td>
<td>$211,000</td>
</tr>
</tbody>
</table>
EMPLOYMENT INFORMATION

Employment Contracts and Agreements

In most instances, a written agreement is presented to the employed CNM outlining the key terms of his or her employment status. This agreement may be in the form of an employment contract or it may be less formally drafted into a letter of employment. However written, several key areas are commonly addressed within the employment document. These areas include:

Job Description
- Scope of practice
- Physician supervision
- Administrative responsibilities
- Office location(s)
- Hours of operation
- Expected hours per week
- Call schedule
- Holidays/weekends

Compensation Package
- Base salary
- Bonus arrangement
- Annual salary adjustments
- Pension/retirement benefits
- Profit sharing
- Paid time off

Insurance
- Malpractice insurance
- Health/dental insurance
- Life/disability insurance

Professional expenses
- CME program and travel costs
- CME paid time off
- Certification expenses
- Membership dues

Contractual provisions
- Effective date
- Probationary period
- Renewal
- Termination provisions
- Notifications

The above items represent basic areas of employment that should be clarified when the CNM, employer, and consulting physician discuss the terms of employment. It is advisable to have a written contract or practice agreement that clearly spells out the terms of employment.

Credentialing

Hospital Privileges

Certified Nurse Midwives practice nurse-midwifery with physician collaboration. Within the hospital setting, CNMs may be granted privileges to conduct rounds; perform histories and physicals; evaluate changes in a patient’s condition; issue orders for such things as medications, treatments, and laboratory tests; record progress notes; write discharge summaries; manage labor and births; perform circumcisions; and assist in surgery.

Hospitals that grant privileges to CNMs to practice in their facilities should verify that the CNMs are properly certified, licensed both as RNs and CNMs, and have adequate professional liability insurance. On demonstration of satisfactory training and experience, and after approval by the hospital board or designated individual, a CNM may be granted privileges with general supervision of a physician who has appropriate privileges. The criteria and process for granting
clinical privileges to CNMs should be outlined in the medical staff bylaws. It is recommended that the actual CNM privileges be stated, not in the bylaws but in the medical staff rules and regulations, where amendments can be made more easily and efficiently. Preferably, this may be done in a category specifically for Certified Nurse Midwives as medical staff members.

Hospitals typically have a system for granting physicians provisional approval on particular privileges until competence is shown. A similar system may be established for CNMs. Likewise, many hospitals use virtually the same form for physicians and Certified Nurse Midwives that are applying for privileges.

**Patient Satisfaction**

Early studies of patient acceptance and satisfaction on Certified Nurse Midwives showed that, compared with physicians, CNMs function at comparable levels, use no more health care services, and are accepted by patients at a comparable level. A more recent study conducted in 1995-96 by Kaiser Permanente of the Northwest (KPNW), a health maintenance organization, explored differences in patient satisfaction with physician and nonphysician providers. An analysis of this study confirmed earlier findings that patients are satisfied with their care regardless of the type of practitioner delivering the care. This study further suggests that patient satisfaction appears to depend on the communication skills and style of the provider, and not on the type of provider. Safriet (1992) also demonstrated patient satisfaction with CNM care. She found CNM care is cost-effective especially given the diversity of the populations they serve. In addition, she found CNM care results in at least equivalent and sometimes better outcomes, perhaps more quickly, given their patients’ enhanced adherence to care regimes; the substantially lower cost of their training; and the collateral benefits of increased consumer choice and satisfaction. Therefore, the incorporation of Certified Nurse Midwives in the health care delivery system can result in greater patient satisfaction, along with the economic benefits commonly associated with nonphysician providers.

**Liability Insurance**

**Employer Coverage and Individual Policies**

Professional liability insurance for the CNM can be obtained through the employing clinic, personally by the CNM, or by a combination of both parties. Most CNMs currently in practice are insured by their employers.

Costs for professional liability insurance policies vary depending on the CNM’s scope of practice, the type of coverage, and the policy limits. Annual premium costs range from $900 to over $7,500 depending on the location of the practitioner, length of practice, the CNM’s scope of practice, and the policy limits.

**Patient Compensation Fund**

Professional liability insurance in Wisconsin is a two-tiered structure whereby commercial insurance is obtained for coverage up to a mandated limit. Coverage beyond the mandated limits is provided through a statewide fund entitled the Patient Compensation Fund. Beginning in 1997,
the mandated coverage limits were $1,000,000 per occurrence and $3,000,000 aggregate. The extended coverage through the Patient Compensation Fund would cost approximately $7,500.

**Recruitment and Retention**

There are a number of federal and state loan repayment and scholarship programs that can assist primary care clinics, in rural and urban shortage areas, in the recruitment and retention of Certified Nurse Midwives. There are also federal and state reimbursement incentives to retain CNMs who provide primary care in designated rural and urban shortage areas.

**Loan Repayment and Scholarship Programs**

The National Health Service Corps (NHSC), a federal program, offers loan repayment or scholarship assistance to Certified Nurse Midwives who agree to provide primary care for at least two years in a rural or urban federally designated Health Professional Shortage Area (HPSA). A NHSC scholarship can cover full tuition, or NHSC loan repayment can provide up to $50,000 for a two-year obligation. The Wisconsin Division of Public Health – Primary Care Section helps clinics and Certified Nurse Midwives by providing information and applications for these programs.

The Wisconsin Health Professions Loan Assistance program can provide up to $25,000 for a three-year obligation for Certified Nurse Midwives who agree to provide primary care in federally designated rural and urban HPSAs in Wisconsin. The Wisconsin Office of Rural Health helps clinics and Certified Nurse Midwives by providing information and applications for this program.

**Recruitment Strategies**

Educational institutions and professional associations provide several means of assisting potential employers of CNMs in finding the right candidate for their organization.

- **Clinical Preceptorship**
  A large percentage of annual CNM graduates are hired by one of their clinical preceptor sites. By mentoring students as preceptors, CNMs and physicians can assess the applicants whose level of health care experience, clinical capabilities, and personality best fit their practice environment.

- **Bulletin Boards**
  Most CNM programs keep a bulletin board of job announcements or notify CNMs of open positions for both new graduates and practicing Certified Nurse Midwives. In addition, the ACNM maintains a list of job openings on their web site (www.midwife.org).

- **Newsletters** such as the ACNM publication, *Quickening*

- **Employment Exchange Program**
  The Wisconsin Office of Rural Health provides this practice opportunity listing service free of charge to both the health professional and the employer/community. Positions listed are available via a monthly bulletin provided to all inquiring health professionals on request. The monthly bulletin includes the basic elements of a position vacancy and
potential practitioners can contact the prospective employer directly for further information.

Retention Assistance

The WisTREC project, Wisconsin AHEC System and academic training programs are partnering on a variety of programs to help rural and urban underserved areas recruit and retain primary care providers. These programs include: recruiting more students from rural and underserved populations, developing more student experiences in rural and urban shortage areas, and developing more distance education to help students live and work closer to home. It is believed that CNM students who are able to work and/or reside in rural and underserved areas while enrolled in the educational program are much more likely to remain in these communities after completion of the nurse-midwifery educational program. These students are likely candidates for employer recruitment efforts in rural and urban health professional shortage areas.

The Wisconsin Medicaid Program offers a primary care Health Professional Shortage Area (HPSA) bonus payment to encourage primary care providers, including CNMs, to practice in HPSAs or to provide services to Medicaid recipients who live in designated shortage areas. Wisconsin Medicaid provides a 20 percent HPSA bonus payment for certified providers who render selected primary care services for covered Medicaid recipients. Also, providers of obstetrical services may be eligible for an additional 25 percent obstetric HPSA bonus payment for covered recipients.

The federal Rural Health Clinic Services Act authorizes favorable Medicare and Medicaid cost-based reimbursement to certified rural health clinics (RHCs) for services provided by Certified Nurse Midwives and other non-physician providers. As a condition of participation in the RHC program, certified clinics are required to employ a nurse practitioner, or other qualified nonphysician provider, to serve patients at least 50 percent of the time the clinic is open. Once certified, the RHC is required to retain the nurse practitioner or lose the favorable cost-based reimbursement for Medicare- and Medicaid-covered patients.
**Facts About Certified Nurse Midwives**

**General Description**

ACNM membership department figures, 1999


Education and Certification

American College of Nurse-Midwives
Web site – http://www.midwife.org

Marquette University College of Nursing
Dr. Leona VandeVusse, Program Director
(414) 288-3842 for information
Web site – http://www.mu.edu.dept.nursing

Wisconsin Program for Training Regionally Employed Care Providers (WisTREC), UW Madison School of Nursing, CSC K6/254, 600 Highland Avenue, Madison, WI 53792-2455; phone (608) 263-5170; fax (608) 263-5170.
Web site - http://academic.son.wisc.edu/wistrec/

Characteristics of Practitioners


Scope of Practice

American College of Nurse-Midwives
Web site - http://www.midwife.org

Wisconsin Department of Regulation and Licensing, Board of Nursing, P.O. Box 8935, Madison, WI 53708; phone (608) 266-2811; fax (608) 261-7083.
Wisconsin Administrative Code, Chapters N 6-8.
Web site - http://badger.state.wi.us/agencies/drl/Regulation

Web site - http://www.wisconsinnurses.com/

Spectrum of Practice Settings

American College of Nurse-Midwives
Web site - http://www.midwife.org

**Prescriptive Authority**

Wisconsin Department of Regulation and Licensing, Board of Nursing, P.O. Box 8935, Madison WI 53708; phone (608) 266-2811; fax (608) 261-7083.

Wisconsin Administrative Code, Chapter N 8.

Web site - [http://badger.state.wi.us/agencies/drl/Regulation](http://badger.state.wi.us/agencies/drl/Regulation)

**Reimbursement And Financial Analysis**

**Compensation Arrangements**

American College of Nurse-Midwives

Web site - [http://www.midwife.org](http://www.midwife.org)


Web site - [http://www.mgma.org](http://www.mgma.org)


**Contribution to Practice Revenue**


Third-Party Coverage and Payment


WPS Health Insurance, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708; phone (800) 221-6951.

WPS-Medicare Part B, 1717 West Broadway, P.O. Box 1787, Madison, WI 53701; phone (608) 221-4711.


EDS Provider Maintenance; phone (608) 221-9883.

WPS Health Insurance, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708; phone (800) 221-6951.

Cost/Benefit Analysis


Troyer, K. A. (1996, September). Midlevel providers extend practice services and value,*Family


**Employment Information**

**Employment Contracts and Agreements**


**Credentialing**

American College of Nurse-Midwives
Web site - [http://www.midwife.org](http://www.midwife.org)


Web site: [http://www.jcaho.org](http://www.jcaho.org)


**Patient Satisfaction**

American College of Nurse-Midwives
Web site - [http://www.midwife.org](http://www.midwife.org)


**Liability Insurance**

American College of Nurse-Midwives  
*Web site* - [http://www.midwife.org](http://www.midwife.org)


Wisconsin Department of Regulation and Licensing, Board of Nursing. (1999, April). APNP malpractice insurance coverage. *Regulatory Digest*. Madison, WI: Author. [P.O. Box 8935, Madison, WI 53708; phone (608) 266-2811; fax (608) 261-7083].  
*Web site* - [http://badger.state.wi.us/agencies/drl/Regulation](http://badger.state.wi.us/agencies/drl/Regulation)

**Recruitment and Retention**

American College of Nurse-Midwives  
*Web site* - [http://www.midwife.org](http://www.midwife.org)


Wisconsin Division of Public Health, Primary Care Section. (1999, April). *Primary Care Recruitment and Retention Resources Available to Shortage Areas in Wisconsin*. Madison, WI: Author. [phone (608) 264-6528, See appendix].

*Primary Providers for Wisconsin: Employment Exchange*; phone (800) 488-9512.
SAMPLE
LETTER OF EMPLOYMENT

Dear ____________:

On behalf of the Medical Center I am pleased to welcome you as a Physician Assistant for our Medical Clinic. This letter contains details about your starting salary and the fringe benefit programs currently available. After reviewing this letter, please sign and return one copy to indicate your acceptance of employment with the Medical Center.

Your starting compensation at our Medical Clinic will be $__________ paid on a biweekly payroll schedule. This will be a full-time position and will consist of 40-45 hours per week. The probationary period will be 90 days, and your first performance review will be at six months. You will accrue fringe benefits during the probationary period and will be eligible to use these benefits upon completion of the period. You will have another evaluation at 12 months and then annually thereafter.

The Medical Center has an Earned Time Off Program designed to combine traditional vacation, sick, funeral, and personal holiday time into one account. Traditional holidays are not considered to be a part of the earned time program. This time is prorated for part-time employees. This accrued time may be used once the employee has completed the 90-day probationary period. For 1-5 years of service accumulation per month will be 1¾ days (14 hours) or 21 days (168 hours) per year with a maximum accrual of 31½ days (252 hours). For six or more years of service accumulation per month will be 2½ days (20 hours) or 30 days per year (240 hours) with the maximum accrual of 45 days (360 hours).

The Medical Center will provide single or family hospitalization and medical/surgical and dental insurance coverage.

The Medical Center pays the premium for a term life insurance policy equivalent to one times the annual salary for all full-time employees. (Rounded to the nearest $1,000, to a maximum of $100,000). This benefit also includes Accidental Death and Dismemberment coverage. Supplemental life insurance policies are available to the employee, spouse, and dependent children. Premiums for all supplemental plans are deducted monthly via payroll check.

The Medical Center provides a short-term disability - salary continuation program for employees averaging 20 or more hours per week. The plan will provide income replacement during short periods of disability. The benefit amount is equal to 100% of base salary from the 1st day of disability and continues through the 90th day of disability.

The Medical Center also provides long-term disability insurance for employees who are working 30 or more hours per week on a regular basis. Long-term disability begins on the 91st day of disability and pays 60% of annual income, not to exceed $15,000 per month.
The retirement plan includes profit sharing and a voluntary 401(k) feature with an additional employee matching contribution. Eligible employees may enter the plan January 1 or July 1 after 12 months of service and 1,000 work hours. Example: Date of employment is June 26, 1994; entry into the plan is July 1, 1995. Date of employment is September 26, 1994; entry into the plan is January 1, 1996. The exact date participation begins is dependent on the date you begin employment and on the plan terms.

The Medical Center will pay both the state component as well as the private component of your malpractice insurance.

The Medical Center will also pay state (The Wisconsin Academy of Physician Assistants) and national (The American Academy of Physician Assistants) dues.

The Medical Center will provide five (5) days of educational time per year. Each Physician Assistant will be granted $1,500 annually for continuing education and expenses. If you choose not to use the $1,500 during the calendar year, it may be carried into the next year. Maximum accrual is $2,000.

The Medical Center also requires that all medical staff must have a medical evaluation to comply with the Americans With Disabilities Act. We will try to schedule this for you during your orientation.

You must obtain a valid Wisconsin Physician Assistant License before you will be able to start working at the Medical Center.

Please note that the benefits and programs are subject to change or discontinuance without prior notice.

This letter covers the items we discussed and summarizes the current benefits and practices available to Physician Assistants at the Medical Center. It is not a contract of employment or an offer of a contract. This offer of employment is valid for a period of two (2) weeks from the date of this letter and the acceptance of employment must be signed by you within this time period or the offer will be void. Physician Assistants are employed on an at will basis.

If you have any questions or if I can be of any assistance, please feel free to give me a call.

Sincerely,

Medical Staff Recruiter

I accept employment as outlined above.

__________________________  _________________________
Date: ______________________
SAMPLE
EMPLOYMENT AGREEMENT

This agreement is effective as of ________________, by and between ____________________ (a Wisconsin Service Corporation), with a place of business at ____________, Wisconsin, hereinafter referred to as “Employer,” and ________________, P.A., hereinafter referred to as “Employee.”

Section 1 - Recitals

1.1 Employee desires to accept employment as a Physician Assistant for the Employer’s business.

1.2 Employer has offered Employee employment under the terms and conditions set forth in this agreement, and Employee is willing to accept employment on such terms and conditions.

1.3 In consideration of the above recitals and the mutual promises and agreements contained in this agreement, it is mutually agreed as provided herein.

1.4 Employee shall not have nor vest into any ownership of Employer’s business as a result of this agreement.

1.5 Employee shall perform his or her duties under this agreement in an ethical and professional manner.

1.6 Employee shall work hours as assigned by Employer. However, it is expected that Employee shall work five (5) full days each week.

Section 2 - Term

The term of this agreement shall begin on the above stated effective date and shall continue until terminated as provided in this agreement. This agreement shall terminate upon either party giving written notice at least 30 days prior to terminating.

Section 3 - Compensation

Base Salary - Employee shall be paid a base annual salary of $___________ paid at the rate of $___________ per month.

Incentive Compensation - In addition to the base salary, Employee shall be entitled to incentive-based compensation. Said compensation to be 33% of receipts attributable to Employee’s charged services in excess of $___________.

Receipts credited to Employee are defined as the gross charges billed directly for Employee professional services times Employer’s collection percentage for the period.

Incentive compensation to be paid no less than annually with the initial calculation due no later than 15 days following July 1 of each year.
Section 4 - Continuing Education Expenses

During the term of this agreement, Employer shall reimburse Employee a maximum of $1,500 per year for continuing education expenses. Said expenses to include transportation, registration, lodging, meals, and other properly documented education expenses submitted to Employer.

Employer shall pay or reimburse Employee for dues paid to one state and one national physician assistant society or association.

Section 5 - Benefits

Retirement Plan - Employee will be eligible to receive a contribution to the Corporation’s Pension and Profit Sharing plan on the first August 1 after his or her initial year of employment. See Summary Plan Description for details of eligibility and entry dates (available from Employer).

Liability Coverage - Employer shall provide professional liability coverage for Employee.

Vacation - Employee shall be granted three (3) weeks vacation with pay. Pay to be computed as 1/52 of Employee’s base salary for each week’s vacation.

A week’s vacation shall be defined as the equivalent of five (5) working days. Vacation days must be taken in no less than half-day increments.

Sick Leave - Employee shall be allowed up to seven (7) days per year with pay for time off due to sickness or illness of Employee.

Continuing Education - Employee shall be granted one (1) week (5 working days) per year for purposes of attending continuing education meetings/courses.

Holiday Pay - Employee shall be eligible for paid holidays falling on a day he or she is regularly scheduled to work.

Other Benefits - Employee may be eligible for other fringe benefits as may be provided employees as determined from time to time and at the discretion of the Board of Directors.

Section 6 - Governing Law

It is agreed that this agreement shall be governed by, construed, and enforced in accordance with the laws of the state of Wisconsin.
Section 7 - Entire Agreement

This agreement shall constitute the entire agreement between the parties, and any prior understanding or representation of any kind preceding the date of this agreement shall not be binding upon either party except to the extent incorporated in this agreement.

Section 8 - Modification of Agreement

Any modification of this agreement or additional obligation assumed by either party in connection with this agreement shall be binding only if evidenced in writing signed by each party or an authorized representative of each party.

Section 9 - No Waiver

The failure of either party to this agreement to insist upon the performance of any of the terms and conditions of this agreement, or the waiver of any breach of any of the terms and conditions of this agreement, shall not be construed as thereafter waiving any such terms and conditions, but the same shall continue and remain in full force and effect as if no such forbearance or waiver has occurred.

Section 10 - Effect of Partial Invalidity

The invalidity of any portion of this agreement will not and shall not be deemed to affect the validity of any other provision. In the event that any provision of this agreement is held to be invalid, the parties agree that the remaining provisions shall be deemed to be in full force and effect as if they had been executed by both parties subsequent to the expungement of the invalid provision.

In witness whereof, each party to this agreement has caused it to be executed at __________, Wisconsin, on the date indicated below.

Dated: _______________________  Employer: _____________________________

By: _____________________________

Dated: _______________________  Employee: _____________________________

By: _____________________________
SAMPLE

PHYSICIAN ASSISTANT PRESCRIPTION AUTHORIZATION

As the supervising physician(s) of _________________________, PA-C, I authorize the writing of all scheduled and nonscheduled prescriptions listed in the American Hospital Formulary with the following exceptions:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

We have reviewed this authorization form together on _________________________.

Physician Signature(s)          PA Signature

____________________________________   ________________________________

____________________________________

____________________________________

____________________________________

____________________________________

____________________________________
SAMPLE
ADVANCED PRACTICE NURSE/COLLABORATIVE AGREEMENT

This agreement between _______________ (Nurse Practitioner) and _______________ (Physician) outlines that portion of advanced practice nursing which constitutes delegated medical acts. Both clinicians are licensed by the state of Wisconsin.

1. Nurse practitioner is approved to:
   – Evaluate patients by eliciting the health history, performing physical examination, ordering and interpreting diagnostic tests, and referring to specialists and therapists.
   – Treat conditions by prescribing therapies and performing procedures according to the nurse practitioner’s education, training, and experience.
   – Sign documents (within legal limitations) as indicated.

2. The collaborating physician (and/or his or her designee[s]) will be available for consultation within a reasonable period of time.

3. Emergencies will be handled according to the clinic policy.

4. Quality of nurse practitioner’s performance will be evaluated by periodic chart review, at least quarterly.

5. Credentials: Nurse practitioner will maintain licensure and certification as an RN and APNP during the term of this agreement.

6. Term: This agreement will be reviewed at least yearly.

Accepted: _______________________________ _______________________________
Collaborating Physician (Date) Nurse Practitioner (Date)
The Geriatric Nurse Practitioner (GNP) has advanced skills in the assessment of the physical and psychosocial health-illness status of elderly individuals through health history taking and physical examinations. GNPs also function as health counselors and educators for patients and their families. The GNP functions collaboratively with the patient’s physician to manage medical care.

1.0  Acting with or without physician consultation, the GNP may order the following in order to evaluate a patient’s condition and/or response to a treatment. These may be implemented immediately by the nursing home staff. These orders include but are not limited to:

1.1  Diagnostic laboratory tests, such as but not limited to:

- Chemistry profile
- CBC
- Ua/Uc
- Drug levels
- X-rays
- Cultures

1.2  Clinical monitoring, such as but not limited to:

- Vital signs
- Weight
- I and O
- Fingerstick glucose monitoring
- Stools for occult blood
- Oxygen saturation levels

1.3  Activity levels

1.4  Rehabilitative and psychological services evaluation or treatment

1.5  Diet changes, including oral and enteral feedings

1.6  Infection control techniques

1.7  Skin/wound care

1.8  Restraint orders

1.9  Consultation with other health care providers/specialists and appropriate follow-up care
2.0 Prescription orders

2.1 The GNP, an advanced practice nurse, has been given (by the Wisconsin Board of Nursing) the authority to perform delegated medical acts, which includes the authority to prescribe medications (Wisconsin Board of Nursing Statutes, Chapter N6.03(2) sub paragraph [(a), (b), (c), (d)]), excluding prescribing controlled substances. The nursing home and the pharmacy may accept the GNP’s signature as authorization to dispense or administer the medications prescribed.

2.2 Effective March 1994, Wisconsin Act 138 granted certified Advanced Practice Nurse Prescribers (APNP) certain prescriptive writing privileges. Per Wisconsin Nursing Statutes (N8.06), “The APNP may issue only those prescription orders appropriate to the advanced practice nurse prescriber’s areas of competence, as established by his or her education, training, or experience”; may not prescribe Schedule I controlled substances; and must adhere to the anabolic steroid rules. No physician co-signature is necessary. To prescribe controlled substances, the APNP must include his or her controlled substances number [N.807(2)]. The nursing home and the pharmacy may accept the APNP’s signature to dispense or administer the medications prescribed.

3.0 Telephone and written communication from all departments should be directed to the GNP first. The GNP may assess the urgency of patient care situation and decide whether to call the physician immediately or to use routine communication. Events which the nursing home is required to report (e.g., falls, skin tears, medication errors) may be reported to the GNP who will assure that the physician is notified.

4.0 The GNP may independently, or in consultation with the physician, verify admission orders.

5.0 Following the initial visit to a newly admitted patient, required visits may be alternate between personal visits by the physician and visits by the GNP.

6.0 The GNP may perform procedures as delegated by the physician for which the GNP has been trained, educated, or has experience.

7.0 The GNP may perform examinations in conjunction with the nursing home admission process as well as annual examinations, if required by the nursing home. Wisconsin Administrative Code HSS132.52(2) requires that admission to a nursing home be physician ordered.

8.0 The GNP can assess, monitor, and manage common acute and chronic health problems of the elderly in collaboration with the patient’s physician.

9.0 The GNP functions collaboratively with the physician who assumes ultimate responsibility for the patient’s medical care.
## RECRUITMENT RESOURCES *
**LINKED WITH WISCONSIN HEALTH PROFESSIONAL SHORTAGE AREAS (HPSAs)**

*NOTE:* Many programs will not provide financial assistance if provider has service obligations from another federal or state program that have not been fulfilled.

### National Health Service Corps (NHSC) - Scholarship (federal)

<table>
<thead>
<tr>
<th>Eligible Students</th>
<th>Eligible Sites &amp; Requirements</th>
<th>Provider Benefits &amp; Service Obligations</th>
<th>Application Information and Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>US citizens, Students in medical, family nurse practitioners (FNP), nurse midwifery (CNM), or physician assistant (PA) school who agree to go into primary care specialties.</td>
<td>Approved sites in high need HPSAs. Sites provide comprehensive care and financial access (community health centers, rural health &amp; tribal clinics, private clinics, and state facilities).</td>
<td>Full tuition &amp; fees, monthly stipend &amp; educational expenses. 1 year of service at an approved high need site for each year of scholarship.</td>
<td>Student applications due last Friday of March. Call NHSC for applications at (800) 221-5993. For info on state sites call Wisconsin Primary Care at (608) 264-9779.</td>
</tr>
</tbody>
</table>

### National Health Service Corps (NHSC) - Loan Repayment (federal)

<table>
<thead>
<tr>
<th>Eligible Providers</th>
<th>Eligible Sites &amp; Requirements</th>
<th>Provider Benefits &amp; Service Obligations</th>
<th>Application Information and Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>US citizens, Primary care providers: physicians/ MD &amp; DO (family, ped, obst, psych, ob/gyn), dentists and surgeons, NPs, CNMs, and clinical psychologists, clinical social workers, psychiatric nurses, marriage &amp; family therapists.</td>
<td>Approved sites in high need HPSAs. Sites provide comprehensive care and provide financial access (community health centers, rural health &amp; tribal clinics, private clinics, state &amp; county facilities).</td>
<td>Up to $50,000 for a 2-year commitment. Plus up to $30,000 for a 3-year commitment. Payment of up to an additional 30% of loan repayment to cover tax liabilities.</td>
<td>Application accepted throughout year. Loans must be approved first. Provider applications available from NHSC at (800) 221-5993. For vacancy info or site assistance call WI Primary Care at (608) 264-9779.</td>
</tr>
</tbody>
</table>

### Wisconsin Health Professions Loan Assistance (state)

<table>
<thead>
<tr>
<th>Eligible Providers</th>
<th>Eligible Sites &amp; Requirements</th>
<th>Provider Benefits &amp; Service Obligations</th>
<th>Application Information and Assistance</th>
</tr>
</thead>
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<tr>
<td>Primary care providers: physicians/ MD &amp; DO (family, ped, obst, psych, ob/gyn), NPs, PAs, and CNMs.</td>
<td>HPSAs. Community primary care, tribal, and mental health sites.</td>
<td>Up to $50,000 over 3 years for MD/DO. Up to $25,000 over 3 years for NP, PA, CNM. Providers agree to provide financial access.</td>
<td>MD applications are due December 1. Other applications are due April 1. Provider application and info on vacancies available from WI Office of Rural Health (608) 385-9003 or (608) 265-5005.</td>
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<tr>
<td>Nursing Education Loan Repayment (federal)</td>
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<tr>
<td><strong>Eligible Providers</strong></td>
<td><strong>Eligible Sites &amp; Requirements</strong></td>
<td><strong>Provider Benefits &amp; Service Obligations</strong></td>
<td><strong>Application Information and Assistance</strong></td>
</tr>
<tr>
<td>US citizens, Registered nurses who completed a diploma or academic degree in nursing (associate, baccalaureate, masters).</td>
<td>Nurse shortage counties (22 in WI); Sites include tribal and rural health clinics, community health centers, public hospitals, and certain non-profit facilities.</td>
<td>Maximum of $30,000; Up to 80% of principal &amp; interest on loan for 2 years; Additional 25% for 3rd year; Minimum 2-year commitment.</td>
<td>Provider application and info available from federal office at (800) 435-4464.</td>
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<th>Indian Health Service Scholarship (federal)</th>
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<tr>
<td><strong>Eligible Students</strong></td>
<td><strong>Eligible Sites &amp; Requirements</strong></td>
</tr>
<tr>
<td>American Indian or Alaska Native students in pre-professional or academic health professions program (call for more information).</td>
<td>Indian Health Service facilities, tribal health centers supported by BHS, and private practice in a BPSA serving a large number of Indians.</td>
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<th>Indian Health Service Loan Repayment (federal)</th>
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<td><strong>Eligible Providers</strong></td>
<td><strong>Eligible Sites &amp; Requirements</strong></td>
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<tr>
<td>Primary care physicians (family, intern, ped, geriat, ob/gyn, psych); Doctors of Osteopathy; dentists, NPs, NMs, RNs; nurse anesthetists; mental health and allied health practitioners.</td>
<td>Indian Health Service facilities &amp; approved tribal health centers.</td>
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<th>J-1 Visa Waivers to Recruit Foreign Medical Graduates (federal)</th>
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<tr>
<td><strong>Eligible Providers</strong></td>
<td><strong>Eligible Sites &amp; Requirements</strong></td>
</tr>
<tr>
<td>J-1 visa physicians who have completed a primary care residency in the US (family prac, intern, ped, ob/gyn, gen ped)</td>
<td>Primary care facilities located in designated BPSAs. Sites agree to provide financial access.</td>
</tr>
</tbody>
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Wisconsin Department of Health and Family Services
Division of Public Health
Primary Care and Health Promotion Section
P.O. Box 43,000 – 4495
PRIMARY CARE
RECRUITMENT & RETENTION RESOURCES
AVAILABLE TO SHORTAGE AREAS IN WISCONSIN

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA)

A “HPSA” is a federal designation that reflects a shortage of primary care health professionals in one of the following: a geographic area (rural or urban), a specific population (e.g., low income or homeless), or a public or non-profit facility (correctional or mental health). A HPSA designation is used to help determine eligibility for many federal and state recruitment and retention resources for primary care entities.

- Char White (608) 264-7735 WI Division of Public Health (DPH)
  - Primary Care Section

RECRUITMENT RESOURCES LINKED WITH HPSAs

1. National Health Service Corps
   This federal program can provide loan repayment and scholarship assistance to primary care providers who agree to practice at least two years in a designated HPSA. Eligible providers include primary care physicians, nurse practitioners, physician assistants, nurse midwives, dentists and dental hygienists, and mental health professionals. To be eligible, community sites must be in HPSAs with the greatest shortages and must offer financial access to care.

   Earnestine Moss (608) 264-9779 WI DPH, Primary Care Section

2. Immigration Waivers to Recruit Foreign Medical Graduates
   Clinics located in HPSAs can recruit foreign primary care physicians who have completed an U.S. residency program, by requesting a waiver of the home residence requirement for J-1 visa foreign medical graduates. Recommendations for J-1 visa waivers can be requested through the state health department (20 per year) or through the U.S. Department of Agriculture. The foreign physicians must agree to practice for three years in a HPSA.

   Anne Dopp (608) 267-4882 WI DPH, Primary Care Section

3. Wisconsin’s Health Professions Loan Assistance Programs for Primary Care Providers
   These state programs can provide loan repayment to primary care providers who agree to practice in shortage areas. Eligible providers include: primary care physicians, nurse practitioners, physician assistants, nurse midwives, and psychiatrists. The Wisconsin Department of Commerce and the Wisconsin Office of Rural Health administer these programs.

   Mark Shapleigh (800) 385-0005 WI Office of Rural Health
DATE: June 2, 1999

TO: Interested Persons

FROM: Board of Nursing

SUBJECT: Advanced Practice Nurse Prescriptive Authority

At a meeting on May 13, 1999 the Board of Nursing again addressed the issue of the ordering of diagnostic lab tests, X-rays and EKGs by advanced practice nurse prescribers. The board and representatives of advanced practice nurse prescribers, including the Wisconsin Nurses Association, discussed current prescriptive practice related to the authority granted in Chapters 441 and N8.

To clearly establish authority for the advanced practice nurse prescriber to independently order diagnostic lab tests, X-rays and EKGs related to prescribing drugs or devices, the Board of Nursing will promulgate a rule. Chapter 227, Stats., states that "each agency shall promulgate as a rule each statement of general policy and each interpretation of a statute which it specifically adopts to govern its enforcement or administration of that statute."

Section N8.02(4), Wis. Admin. Code, defines the educational requirements in clinical pharmacology/therapeutics that advanced practice nurse prescribers must complete for certification by the Board of Nursing to prescribe drugs or devices. Included in the definition of clinical pharmacology/therapeutics is "test selection and interpretation." Furthermore, under section N8.06(1), Wis. Admin. Code, the advanced practice nurse prescriber may issue only those prescription orders appropriate to his or her areas of competence, as established by his or her education, training or experience. Therefore, under a rule to be promulgated by the board, independent ordering of diagnostic lab tests, X-rays and EKGs must be related to prescribing drugs or devices and must be done within the advanced practice nurse prescriber's area of competence.

The Board of Nursing appreciates the focus on consumer health and welfare emphasized by advanced practice nurse prescribers. The board believes that a positive, collaborative effort to support promulgation of a rule will clearly enhance advanced practice nurse prescriptive authority in the interest of the consumer.