EMPLOYMENT GUIDE

Information on Nurse Practitioners

A collaborative project of the WisTREC
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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 exercise a high degree of independent judgment, complex clinical decision making, and skill . . .

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.

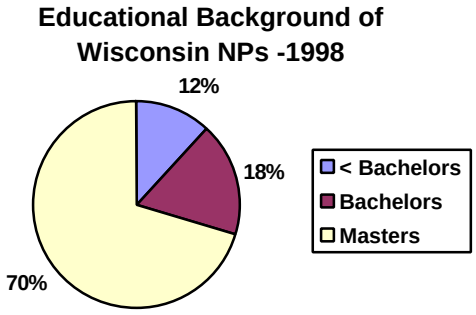
The roles, safety, and cost effectiveness of NP practice have been extensively studied and validated over the past 20 years (Brown & Grimes 1995, Buppert 1999, Mundinger 1994, Safriet 1992). According to the Wisconsin Nurses Association (WNA):

- 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

By 1996, an estimated 41,600 nurse practitioners had obtained national certification.

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.

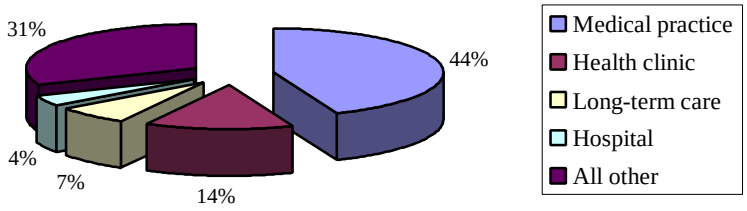
In Wisconsin, a total of 461 candidates, both full- and part-time, were enrolled in NP programs for the 2000-01 academic year.

Marquette University - Milwaukee	107	Concordia University - Milwaukee	110
University of Wisconsin - Eau Claire	55	University of Wisconsin - Oshkosh	55
University of Wisconsin - Madison	83	University of Wisconsin - Milwaukee	51

Practice Settings

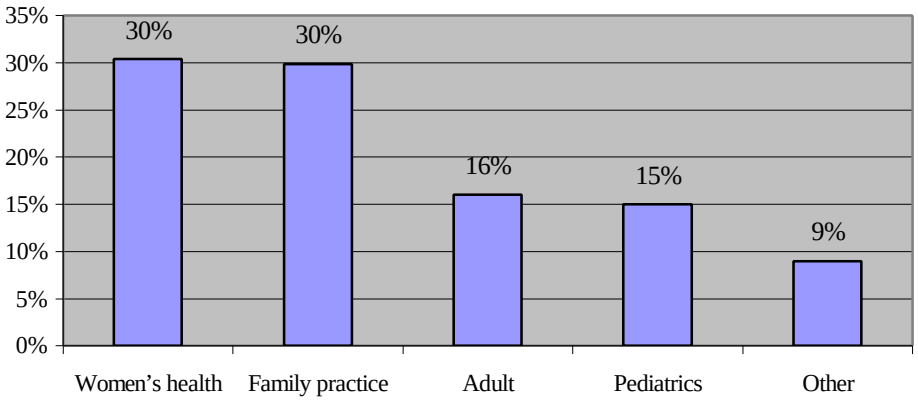
Nurse practitioners practice in communities spanning the most densely urban to the most remote and rural. Nationally, nearly one quarter of NPs practice in rural (non-metropolitan statistical) areas. Most NPs work in ambulatory care sites. The 1998 WisTREC survey data indicated that 44 percent of nurse 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.

NP Practice Settings in Wisconsin



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.

Distribution of NPs by Specialty in Wisconsin



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 regulations permit a certified nurse practitioner to independently prepare prescription orders.

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.

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.

. . . 69% were compensated on a straight salary basis, whereas 28% had a salary plus a bonus or incentive payment.

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.

MGMA and WNA data suggest that a nurse practitioner, on average, will treat 10 to 16 outpatients per eight-hour day.

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.

The role of the NP within the medical practice can have a direct impact on the amount of patient charges . . .

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.

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

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 NPs.

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

certification as a specialty NP, or have completed a master's degree as an advanced practice nurse. All NPs providing services to Wisconsin Medicaid recipients must be individually certified by the Wisconsin Medical Assistance Program (WMAP) in order to be reimbursed.

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."*

Nurse practitioners can play a key role in the success of medical practices operating in a managed care environment.

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 I
Fee-for-Service Model
Sample Analysis

	(1) Physician Only	(2) Physician/ NP Team	(3) Difference
REVENUE			
Gross charges – Physician	$395,000	$395,000	$0
Gross charges – NP	0	193,000	193,000
Adjustments – Physician (25%)	(98,800)	(98,800)	0
Adjustments - NP (30%)	0	(57,900)	(57,900)
Total Net Revenue	296,200	431,300	135,100
VARIABLE EXPENSES			
Salary & Fringes – Physician	180,000	180,000	0
Salary & Fringes – NP	0	72,000	72,000
Salary & Fringes - Medical Asst.	25,000	25,000	0
Salary & Fringes - Medical Asst.	0	25,000	25,000
Malpractice Insurance – Physician	7,000	7,000	0
Malpractice Insurance – NP	0	900	900
Total Variable Expenses	212,000	309,900	97,900
Contribution to Overhead	$84,200	$121,400	$37,200

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.

. . . 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.

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 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 II
Managed Care Model
Sample Analysis

	(1) Physician (2,400 Panel)	(2) Phys./NP (2,400 Panel)	(3) Phys./NP (3,000 Panel)	(4) Phys./NP (3,600 Panel)
REVENUES				
Capitated Payments	$432,000	$432,000	$540,000	$648,000
Total Net Revenue	432,000	432,000	540,000	648,000
VARIABLE EXPENSES				
Salary & Fringes - Physician	180,000	180,000	180,000	180,000
Salary & Fringes - NP	0	72,000	72,000	72,000
Salary & Fringes - Medical Asst.	25,000	25,000	25,000	25,000
Salary & Fringes - Medical Asst.	0	20,000	20,000	20,000
Malpractice Insurance - Physician	7,000	7,000	7,000	7,000
Malpractice Insurance - NP	0	900	900	900
Total Variable Expenses	212,000	304,900	304,900	304,900
Contribution to Overhead	$220,000	$127,100	$235,100	$343,100

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

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 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

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Education and Certification

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

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

National Organization of Nurse Practitioner Faculties (NONPF)
Web site - http://www.nonpf.com/

American Association of Colleges of Nursing (AACN)
Web site - http://www.aacn.nche.edu/

American Nurses Credentialing Center (ANCC)
Web site - http://www.nursingworld.org/ancc/index.htm

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

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Wisconsin Office of Rural Health. (1995). *A Look at Nurse Practitioner and Physician Assistant Practice in Wisconsin* (video). Madison, WI: Author. [Contact WI ORH at (608) 265-5339].

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

Wisconsin Nurses Association, Public Policy Council. (1998). *The Contemporary Scope of Practice for Professional Nursing in Wisconsin.* Madison, WI: Author. (Available from the WNA, 6117 Monona Dr., Madison, WI 53716).
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Spectrum of Practice Settings

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

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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

Medical Group Management Association. (2000). *Physician Compensation and Production Survey: 2000 Report Based on 1999 Data*. Denver, CO: Author.
Web site - http://www.mgma.org

Medical Group Management Association. (1998, October). *Information Exchange Questionnaire: Salaries & Fringe Benefits - Mid-Level Providers*. Denver, CO: Author.

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Bourne, H. (1998). *A Great Deal! Compensation Negotiation for Nurse Practitioners & Physician Assistants*. P.O. Box 4313, Arcata, CA 99518.

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

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EDS Provider Maintenance; phone (608) 221-9883

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

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American Nurses Association

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

National Association of Pediatric Nurse Associates & Practitioners (NAPNAP)

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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