TREND | WHITE PAPER
LOCUM TENENS NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS: A GROWING ROLE IN A CHANGING WORKFORCE

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STAFF CARE
an AMN Healthcare company
The Leader in Locum Tenens Staffing
INTRODUCTION

Today’s Mobile Healthcare Work Force

Healthcare in the United States is characterized by a variety of constants. Among these are a growing demand for healthcare services, increased complexity of care, rising costs, and a shortage of healthcare professionals.

The shortage of nurses, physicians, therapists, dentists and other clinicians has give rise to another constant – the growing use of temporary providers who move from one assignment to another. Today, tens of thousands of healthcare professionals work as “locum tenens” or “travelers,” filling gaps in medical staffs caused by shortages or by the temporary absence of clinicians due to vacations, training, illness or other reasons.

This trend began in nursing, where provider shortages first became acute, and systematically expanded to medicine, therapy, dentistry and other fields. A significant portion of today’s healthcare workforce is mobile, and the majority of healthcare facilities now use locum tenens providers to supplement their clinical staffs (see Staff Care’s 2012 Survey of Temporary Physician Staffing Trends).

Use of locum tenens providers is broadening to include both nurse practitioners (NPs) and physician assistants (PAs). These advanced practice clinicians are playing a growing role in healthcare delivery in the era of health reform, as hospitals, medical groups and other facilities seek ways to respond to a rapidly evolving environment.

This paper examines the role of PAs and NPs and how they fit into healthcare’s increasingly mobile workforce.
EDUCATION, CERTIFICATION, SCOPE OF DUTIES

A nurse practitioner is an Advanced Practice Registered Nurse (APRN) who has completed graduate-level education (either a Master of Nursing or a Doctor of Nursing Practice degree). NPs treat both physical and mental conditions through comprehensive history taking, physical exams, and ordering and interpreting diagnostic tests. NPs can then diagnose disease and provide appropriate treatment for patients, including prescribing medications.

The advanced practice nursing role developed in the 1940s and 1950s with nurse anesthetists and midwives. The current concept of NPs developed in the 1960s, driven by a shortage of physicians. The first official training program for NPs in the United States was created in 1965, with a vision to help balance rising health care costs, increase the number of providers and correct the maldistribution of physicians.

To be a licensed NP, one must first complete the education and clinical experience necessary to be a registered nurse. This must be followed by completion of a graduate-level nurse practitioner program (Master’s or Doctorate). The candidate must then pass a national board certification in their area of specialty. Registered nurses who trained at the associate (two-year) degree level must complete a Bachelor of Science in Nursing (BSN) degree before they can become an NP. The profession is state-regulated, and care provided by NPs varies widely dependent on state regulations. Some NPs work independently of physicians, while in other states, a collaborative agreement with a physician is required. The extent of this collaborative agreement, and the duties, responsibilities, medical treatments and prescriptions, etc. afforded to an NP may differ from state to state.

A physician assistant is a health care professional licensed to practice medicine with physician supervision. PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on prevention, assist in surgery, and write prescriptions.

The profession began when Dr. Eugene Stead of the Duke University Medical Center assembled the first class of PAs in 1965. He selected Navy corpsmen who received considerable medical training during their military service and during the war in Vietnam, but who had no comparable civilian training or employment. He based the curriculum of the PA program in part on his knowledge of the fast-track training of doctors during World War II.

There are now some 156 accredited PA programs in the United States. The majority are graduate programs leading to the award of Master’s degrees in either Physician Assistant Studies (MPAS) or Health Science (MHS) or Medical Science (MMSc) and require a Bachelor’s degree and GRE or MCAT scores for entry.

Professional licensure is regulated by the medical boards of each state, and what a PA does varies with training, experience and state law. The scope of a PA’s practice corresponds to the supervising physician’s practice, and PAs may practice in primary care or specialty care areas.
SUPPLY AND OTHER FACTS

Nurse Practitioners*

There are over 155,000 NPs practicing in the United States:

- An estimated 11,000 new NPs complete their training each year
- 18% practice in rural areas
- 96.5% of NPs prescribe medications, averaging 20 prescriptions per day
- NPs hold prescriptive privileges in all 50 states, with controlled substances in 48
- 88% are focused on primary care
- Mean base salary for NPs is $93,310, average full-time NP income is $98,760
- 60% of NPs see three to four patients per hour, 7% see over five patients per hour
- Only 2% have been named as primary defendant in a malpractice case
- 96% of NPs are female
- The average age for NPs is 48

The table below shows the NP population by practice area and average age:

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Percent of NPs</th>
<th>Average Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care</td>
<td>5.6</td>
<td>45</td>
</tr>
<tr>
<td>Adult +</td>
<td>19.3</td>
<td>50</td>
</tr>
<tr>
<td>Family +</td>
<td>48.3</td>
<td>48</td>
</tr>
<tr>
<td>Gerontological+</td>
<td>3.2</td>
<td>52</td>
</tr>
<tr>
<td>Neonatal</td>
<td>2.0</td>
<td>47</td>
</tr>
<tr>
<td>Oncology</td>
<td>1.0</td>
<td>47</td>
</tr>
<tr>
<td>Pediatric+</td>
<td>8.5</td>
<td>49</td>
</tr>
<tr>
<td>Mental health</td>
<td>3.0</td>
<td>52</td>
</tr>
<tr>
<td>Women’s health+</td>
<td>9.0</td>
<td>49</td>
</tr>
</tbody>
</table>

*Source: American Academy of Nurse Practitioners
+Denotes a primary care focus

Physician Assistants*

There are over 83,000 PAs in the United States:

- About one-third work in primary care, about two-thirds work in specialties
- 26,300 are in primary care, 68,700 in specialties
- PAs can prescribe in all 50 states
- The number of PAs has increased 100% over the last ten years
- PAs earn a medium salary of $91,000
- Most PAs work in clinical practice, but over 5,000 work alone or in health care administration, research, and public health
62% of PAs are women, 38% are men
21% of PAs are 30 or younger, 56% are 31 to 50 years old, and 23% are 51 or older

The numbers below show PAs by practice setting:

- Hospitals……39%
- Group practices….29%
- Solo physician practices….11%
- Federally Qualified Community Health Centers….5%
- Rural clinics….3%
- Other…..12%

The numbers below show PAs by specialty area:

- Surgical subspecialties…..40%
- Emergency medicine….19%
- Internal medicine subspecialties….17%
- Dermatology….6%
- General surgery…5%
- Hospital medicine…4%
- Pediatric specialties…3%
- Pain Management…3%
- Occupational medicine…3%

*Source: American Academy of Physician Assistants

A GROWING NEED

The United States is experiencing a pervasive and growing physician shortage. The Association of American Medical Colleges (AAMC) has projected that the nation faces a deficit of up to 159,000 physicians by the year 2025. The American Academy of Family Physicians (AAFP) projects a shortage 149,000 physicians by 2020 and the Health Resources and Services Administration (HRSA) projects a shortage of 65,000 primary care physicians by the same year. Twenty-four states and 21 medical societies have projected physician shortages. Both the AAMC and the Council on Physician and Nurse Supply have called for a 30% increase in the number of physicians trained in the United States.

The Patient Protection and Affordable Care Act (“health reform”) will greatly enhance demand for physician services, as up to 32 million previously uninsured patients may obtain access to coverage by 2019.

While the health reform law took some measures to increase physician supply, these measures are not likely to keep pace with demand. By redistributing some medical residency positions, the law is projected to increase the number of physicians coming out of residency by some three or four hundred a year. The sources cited above, however, believe this number should be
increased by several thousand a year, not several hundred. (For a detailed discussion of this topic, see Health Reform and the Decline of Physician Private Practice, The Physicians Foundation/Merritt Hawkins, 2010)

What health reform did not do is remove the cap on federal funding for residency training which was set by the Balanced Budget Act in 1997. Until the cap is removed, the supply of physicians in the U.S. will grow slowly while demand -- fueled by population growth, population aging, and greater insurance coverage -- will grow rapidly.

These trends will drive a need not only for more physicians but for other clinicians who can absorb a growing volume of patient care duties – NPs and PAs, in particular.

REDEFINING ROLES

In an era of physician shortages it will be necessary for physicians to redefine their roles. In order to accommodate patient demand, physicians will need to practice to the limits of their training, performing the most complex duties of which they are capable.

Specialists will focus their efforts on technologically advanced care for patients with complex medical conditions, using cutting edge diagnostic and surgical tools. Continuing medical advancements will require specialists to practice in ever narrower but deeper silos, driving the need for cooperation between specialists and primary care physicians who will oversee and coordinate care, in some cases through the medical home. The Accountable Care Organization (ACO) model also places increased emphasis on coordination of care and on greater communication between specialists. This may improve quality, but it will absorb physician time, requiring doctors to delegate more clinical duties to others.

Like specialists, primary care physicians will devote more time to treating complex cases and will manage patients with multiple chronic illnesses. Increasingly, they will manage the care of patients with complicated conditions through supervision of a growing number on non-physician clinicians, including NPs and PAs. The health reform law acknowledged the growing importance of NPs and PAs by increasing Medicare reimbursement by 10% for those practicing primary care. A number of states are increasing the ability of NPs and PAs to broaden their scope of practice and putting them on a closer footing with physicians. Massachusetts, for example, passed a law requiring insurers to recognize and reimburse NPs as primary care providers. Insurers in the state now list NPs with doctors as primary care choices.

It is clear that as health reform is implemented, many patients will be less likely to see a physician and more likely to see an NP or PA. This already is the case in many hospitals where NPs are doing tasks that medical residents can no longer perform because of limits on their work hours, as well as in rural and other underserved areas. As noted above, NPs and PAs also will play a growing role in emerging medical home and ACO models, and assisting in the expansion of Federally Qualified Community Health Centers (FQHCs), which received extensive funding through the stimulus package and through health reform.
While access to care will be a key issue in the era of reform, cost control will be at least as important. NPs and PAs are a relatively cost effective resource, as they can perform 80% to 90% of a physician’s duties while frequently earning 50% or less than physicians.

**PRIMARY CARE AND SPECIALTIES**

NPs and PAs commonly are thought of as being primary care providers, but as the numbers cited above indicate, this is not necessarily the case. NPs and PAs are supplementing the physician workforce in both primary care and specialty areas. While the majority of NPs focus on primary care, some 68% of PAs are involved in specialty practice.

The trend toward specialization and away from primary care is evident among both physicians and NPs and PAs. Data generated by noted physician workforce analyst Richard “Buz” Cooper, M.D. show that while the number of NPs and PAs per population is growing, the number of NPs and PAs in primary care per population peaked several years ago and is declining (see graphs below).
For this reason, it is anticipated that NPs and PAs in primary care will be particularly difficult to recruit in coming years. Dr. Cooper projects that the number of NPs and PAs focusing on specialty work also will be insufficient to meet demand. Though the number of NP and PA education programs are projected to grow by 3% to 5% annually, Dr. Cooper projects a 20% deficit of these clinicians by 2025 (see “Physicians Shortage Isn’t the Only Looming One,” Advance for NPs and PAs, July 28, 2011).

**LOCUM TENENS AND THE “STAFFING CONTINUUM”**

In today’s rapidly transforming healthcare system, strategic staffing will require the appropriate use of a wide range of clinicians along the “staffing continuum.” This includes physicians practicing in increasingly diverse styles, such as: full-time, part-time, employed, independent, hospital-based, concierge, and locum tenens. The same holds true for NPs and PAs, where staffing trends often mirror those in the physician market.

Just three to four years ago, Staff Care received virtually no requests from its clients for locum tenens NPs and PAs. In 2011, however, Staff Care’s NP and PA temporary “days requested” exceeded 31,000. If experience in other clinical areas holds true, locum tenens NPs and PAs will soon be a fixture at the majority of hospitals and other health care facilities nationwide.
KEY CONSIDERATIONS

Points to consider regarding locum tenens NPs and PAs include:

**Cost.** Locum tenens physicians, NPs and PAs are paid a daily rate. The rate for primary care physicians is less than that for specialists and the rate for locum tenens NPs and PAs is less than that of primary care physicians. Locum tenens NPs and PAs therefore can be a cost effective way to supplement the medical staff in settings where a physician is not an absolute requirement.

**Availability.** Locum tenens NPs and PAs have the ability to “mobilize” considerably faster than physicians do. For PAs, the typical state licensure process averages from 3-8 weeks. NPs are somewhat different since they are required to produce an advanced practice license as well as an RN license. If they reside in a “compact state,” then the RN license in that state is transferrable to any other state in the compact agreement, which significantly decreases the amount of time that is required to become credentialed to work.

**Stability.** The average contract length for locum tenens NPs and PAs tends to be longer than that of locum tenens physicians. This offers more stability and continuity of care for facilities using locum tenens and greater security for the providers.

**Multiple settings.** As noted above, NPs and PAs work in a wide variety of settings, including emerging settings such as ACOs and medical homes. NPs and PAs also are becoming the key providers in home assessments and in corporate wellness. They offer a high level of flexibility for facilities and companies involved in case management, wellness, quality improvement, and error and readmission reduction.

**Marketing.** Using locum tenens NPs and PAs allows health care facilities to “test market” new services before going to the expense of recruiting full-time physicians.

**Efficiency.** As in physician locum tenens, most locum tenens NPs and PAs practice through staffing companies, which pay the providers directly, provide malpractice, accommodation, travel and logistical support.

CONCLUSION

The healthcare system is undergoing a period of profound change, with the goals of increasing access to care, enhancing quality, and reducing costs. Reaching these goals will require the appropriate use of resources, including what may be the most important resource of all: the nation’s clinical workforce. All types of clinicians will be needed, including the growing number of locum tenens nurse practitioners and physician assistants.
ABOUT STAFF CARE

Staff Care is the leading provider of locum tenens staffing services in the United States and is a company of AMN Healthcare, the nation’s innovator in healthcare workforce solutions.

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