



Collaboration Between Physicians and Nurse Practitioners Contains Health Care Costs

Bringing down the cost of care must be a major goal of any change in health care policy in Texas. The integrated, well-coordinated care provided in a physician-led, patient-centered medical home has proven time and again to result in healthier populations while saving money. The patient-centered medical home depends on the skills, education, and expertise of a team of health care providers, including nurse practitioners, caring for patients under the medical direction of primary care physicians to succeed.

Contrary to the claims of nurse practitioner organizations, independent practice by nurse practitioners would not lead to more efficient or cost-effective care; in fact, studies show the opposite would be the likely outcome.

Because they lack the training and medical education of physicians, nurse practitioners tend to refer patients to specialists and order expensive diagnostic tests at a higher rate when they are not working with physicians.

A comparison of utilization rates among physicians, medical residents, and nurse practitioners in the same setting showed that:

- Utilization of medical services was higher for patients assigned to nurse practitioners than for patients assigned to residents in 14 of 17 utilization measures, and higher in 10 of 17 measures when compared with patients assigned to attending physicians.¹
- There was a 41% increased hospitalization rate in the nurse practitioner group, or 13 more hospital admissions per 100 patients per year than the group receiving care from physicians.¹
- There was a 25% increase in specialty visits in the nurse practitioner group, or 108 more visits per 100 patients per year than the group receiving care from physicians.¹

The researchers stated that the findings suggest that increased use of nurse practitioners as primary care providers may lead to increased ordering of expensive diagnostic tests and higher rates of specialty visits and hospital admissions for patients assigned to nurse practitioners.

- From the study: “The higher number of inpatient and specialty care resources utilized by patients assigned to a nurse practitioner suggests that they may indeed have more difficulty with managing patients on their own (even with physician supervision) and may rely more on other services than physicians practicing in the same setting.”¹

I. Hemani A, Rastegar DA, Hill C, et al. “A comparison of resource utilization in nurse practitioners and physicians.” *Eff Clin Pract.* 1999 Nov-Dec; 2(6):258-265.

To Improve Access to High-quality, Cost-efficient Health Care, Invest in Team-based, Integrated Care Led by Primary Care Physicians

When patient care is well-coordinated, as it is when provided in a patient-centered medical home led by a primary care physician, it has proven to be of better quality and of lower cost. This model features a team-based approach that relies on the appropriate use of nurse practitioners and other health care providers in a collaborative practice designed to offer coordinated, efficient, and effective health care. Consider the evidence represented by these results from across the country.

- Washington-based Group Health Cooperative implemented the patient-centered medical home in 2009 and after one year, ER visits were reduced by 29% and ambulatory sensitive care admissions were down by 11%.¹
- Community Care of North Carolina has experienced a 40% decrease in hospitalizations for asthma and a 16% lower ER visit rate after implementing the primary care medical home model for Medicaid and SCHIP beneficiaries. Total savings in those programs are \$135 million for TANF populations and \$400 million for the aged, blind, and disabled population.^{2,3}
- A leader in the delivery of high-quality, cost-effective health care, the Geisinger Health System in Pennsylvania has shown a 14% reduction in total hospital admissions relative to controls, and a 9% reduction in total medical costs after only 24 months of operation under the PCMH model.⁴
- Intermountain Healthcare Medical Group began implementing a PCMH model in 2001. The group has experienced a 10% relative reduction in total hospitalizations, with an even greater reduction among patients with complex chronic illnesses. The net reduction in total costs was \$640 per patient per year, and \$1,650 per year for each of the highest-risk patients.⁵
- The list of successes for communities implementing the physician-led, patient-centered primary care medical home continues to grow. For more information, consult the Patient-centered Primary Care Collaborative at www.pcpcc.net.

Advanced practice nurses are a vital part of Texas' health care workforce. As part of a team dedicated to improving the health of our citizens, nurse practitioners collaborate with physicians to increase access to well-coordinated medical care in communities across the state. But allowing nurse practitioners to diagnose, treat, and prescribe without any physician collaboration will only serve to further fragment the chaotic and poorly coordinated health care delivery system Texans encounter.

Nurse practitioners and physicians have the same goal: to keep Texans healthy and productive, and to ensure that when they need it, patients have access to safe, high-quality medical care. Nurses and physicians provide the highest quality health care when they work together for the well-being of their patients. They are a team, striving each day for the better health of Texans. This team should be supported and kept together by state policies that have the best interests of the patient in mind.

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1. Reid R, Fishman P, Yu O, et al. "A patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation." *American Journal of Managed Care*, September 2009.
 2. BD Steiner et al, "Community Care of North Carolina: Improving care through community health networks." *Ann Fam Med* 2008;6: 361-367.
 3. Mercer. "Executive Summary, 2008 Community Care of North Carolina Evaluation." Available at <http://www.communitycarenc.com/PDFDocs/Mercer%20ABD%20Report%20SFY08.pdf>.
 4. Geisinger Health System, presentation at White House roundtable on Advanced Models of Primary Care, August 10, 2009.
 5. Dorr DA, Wilcox AB, Bruncker CP, et al. "The effect of technology-supported, multidisease care management on the mortality and hospitalization of seniors." *J Am Geriatr Soc.* 2008;56(12):2195-202. Findings updated for presentation at White House roundtable on Advanced Models of Primary Care, August 10, 2009.

These and other studies demonstrating the benefits and successes of the patient-centered medical home can be found in a study entitled, "The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies," published August 2009 by Kevin Grumbach, M.D., Thomas Bodenheimer, M.D., M.P.H., and Paul Grundy, M.D., M.P.H. It can be found online at <http://www.pcpcc.net/content/pcmh-outcome-evidence-quality>.