



## **Roles for Mid-Level Providers**

There are four common ways mid-level providers (physician assistants and nurse practitioners) can be used within a practice, excluding models that “sub-optimize” the skill level of the mid-level providers such as using them for “triage,” prescription refills, phone call response, chart review etc. (these tasks can be done by RNs and do not require the specialized expertise of a mid-level. provider).

### **Management of Diseases or “Body Parts”**

In this model the mid-level provider is restricted to focusing on providing either all or interim/periodic/intermittent care for patients with chronic illnesses or care for patients with specific conditions or needs (Pap tests or “well woman exams”). The recent “house model” proposes that RNs manage prevention issues, physicians manage acute issues (sometimes physicians are directed to manage the chronic issues) and mid-levels manage chronic illnesses. Any model that divides patients into body parts or into acute, chronic and prevention will increase the total number of visits due to the inevitable “system churn,” and fails to respond to what patients want: a single provider to manage all needs.

### **Management of “Urgent Care”**

In this model mid-level providers are the first line of support for all acute needs for the practice. Physicians manage a schedule of “return” patients, mostly for chronic illness, while the mid-levels function as the “urgent care” response for both physicians who are present and physicians who may be absent. This model fails to respond to what patients want: a single chosen provider for all needs. It also tends to increase system churn and results in a higher number of return visits.

### **Shared Practice**

In this model a physician shares a practice with a mid-level provider. Patients are shared between the two and customized models are used to divide the workload, for example, the mid-level sees patients for every other visit, sees all the “acute” visits, sees all the chronic illness visits etc. Since the mid-level comes to the dyad with a “cost” and the currency is panel size, the panel size for this dyad is greater than the panel size for either individual. This model works well if both providers are present. However, as soon as one of the two providers is gone, particularly the physician, the remaining mid-level is facing a panel size and demand that is unmanageable. An inevitable delay ensues. Because of that delay, this dyad model fails.

### **Management of a Panel of Patients**

In this model the mid-level providers manage their own set of patients who have chosen them as their primary care provider. If patients become more complicated than the mid-level provider’s expertise can handle, care of that patient is transferred to a physician much like the mechanism of consultation with a specialist. In this model most patients who choose the mid-level provider as their primary care provider tend to be of lower clinical complexity.

## **Hybrid Model- Management of a Panel and Management of Acute Illness from Absent Providers**

In this model, mid-level providers manage a partial panel of patients who choose them as their primary care provider, and, in addition, form the first line of support for acutely ill patients of absent physicians. Continuity is not “lost” since the physician is already absent. This model allows the physicians who are present to see more of their own patients and to manage a larger patient panel.