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A DISCUSSION PAPER

Fuller Scope of Practice for Primary Care Providers: A Strategy to Improve Access to Specialty Care in the Safety Net

Prepared for the Specialty Care Access Initiative

A Partnership of Kaiser Permanente Community Benefits, California Association of Public Hospitals and Health Systems and California Primary Care Association

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Introduction

California's safety net institutions – both public hospital systems and community clinics and health centers (CCHCs) -- are experiencing increased demand for primary care services and a corresponding increased demand for specialty care services. Lack of access to specialty care for the uninsured and Medi-Cal populations is a widespread problem in California.

One approach that has been proposed to improve specialty access is greater use of primary care providers -- through encouragement to practice to the full scope of their training or through expansion of their scope -- to address some specialty care needs that would otherwise be unmet. Proponents of this approach note multiple benefits, including:

- quicker and better access for patients;
- more comprehensive care for patients;
- reduced demand on primary care time for patients whose specialty care needs are unmet and who therefore require disproportionate primary care time in the form of case management, research, and curbside consultations;
- improved quality of referrals to decrease need for follow-up specialty visits due to inadequate preliminary work-up;
- greater ability to triage cases to scarce specialist referrals and to prevent unnecessary referrals;
- improved access to consultative relationships with reduced demand on specialists for treatment; and
- increased physician satisfaction and physician retention.

This discussion paper explores the role of “fuller scope” primary care practice in safety net institutions, its impacts and influences, including practice trends, residency training, competency measurement, geography, technology, reimbursement and physician preferences, as well as some examples of how and where it is used in California’s safety net institutions. This paper is intended as a springboard to stimulate discussion about the issue and not as a definitive review of the subject. In researching the topic, key informants from educational and clinical settings were interviewed. (See Appendix A).

Background

To address the complex issue of access to specialty care in the safety net, Kaiser Permanente Community Benefits, the California Association of Public Hospitals and Health Systems (CAPH) and the California Primary Care Association (CPCA) formed a Specialty Care Access Initiative (SCAI) Partnership. Goals of this Partnership include: identification of barriers to specialty care access and demand; elucidation of solutions to increase access and reduce demand; dissemination of knowledge about barriers and solutions; and advocacy for needed changes.

In order to formulate a baseline understanding of the issues, SCAI engaged Pacific Health Consulting Group to conduct a survey in 2007 of the CCHCs and public hospital systems in California. The survey addressed three primary research areas: the demographics of specialty care for California’s underserved; the extent of the problem of specialty care access; and current and emerging practices currently used to improve access and manage demand. Building on knowledge gleaned from the statewide survey, the SCAI also began collecting qualitative data, hosting a series of statewide roundtable discussions and developing several discussion papers designed to spread knowledge, share promising practices and increase networking across safety net institutions. This discussion paper explores fuller scope practice for primary care providers, one of the approaches identified in the survey that has been used by some safety net institutions to increase access to specialty care.

Definitions of Scope of Practice of Primary Care

There is little consensus about the meaning of “*expanded* scope” with regards to primary care; this may be reflected in an equal lack of clarity about what constitutes the core scope of primary care practice. Definitions of primary care have historically emphasized processes (e.g., comprehensive, compassionate, personal, collaborative) and values over specific content areas.[1] In our interviews with key informants and leaders in both educational and clinical settings, this lack of apparent agreement about what “expanded” scope might mean was evident as well. Given this lack of consensus, for the purpose of this paper, the expression “fuller scope” will be used to describe a type of primary care practice that incorporates a fuller range of procedural and diagnostic activities, some of which have been relegated in recent history to specialist providers.

Primary Care Practice Trends

It is generally accepted that the scope of practice for primary care providers has narrowed over the past decades.[2] All physicians, regardless of specialty, have a broad legal scope of practice; family and other primary care physicians may, according to their licenses, provide any and all medical care. However, many factors and constraints are seen as contributing to a restriction in scope of practice for primary care providers, including training, work-load/lifestyle pressures, reimbursement levels, managed care, malpractice coverage, hospital privileging practices, patient expectations, and "turf" battles between specialists and generalists which are often intensified in particular geographic areas. [3,4]

In a related and critically important dynamic, there has, at the same time, been a dramatic decline in the number of graduates choosing family medicine, and a growing concern about physician capacity in the United States to meet the nation's needs for primary care.[5] Since 1997, U.S. medical school graduate matches in family medicine and general internal medicine programs have fallen by more than 50 percent.[6] The balance in distribution of primary care and specialist providers has shifted significantly over time and, currently, only about one-third of all physicians in United States are primary care providers, compared with roughly half in all other industrialized countries. [7]

Safety net clinics and hospitals already face challenges recruiting sufficient numbers of primary care providers. It is important to note that scope of practice impacts not only the type and scope of care patients receive from their primary care providers but the number of patients who can be seen by those providers. Where expansion of primary care provider scope to include specialty procedures and diagnostics is considered a strategy to address access to specialty care, consideration must be given to managing time demands on primary care resources. Without additional provider time, primary care access would be affected with fuller scope engagement in specialty procedures and diagnostics. Additionally, primary care physicians with specific specialty training and expertise may also be attracted to specialty setting employment opportunities. Concern about the risk inherent in supporting primary care physicians' interest in obtaining advanced training in a specialty area, and then being recruited away, was noted by some of this discussion paper's key informants.

One strategy that has been identified to fill the current void in primary care (and the anticipated increased shortage) is increased utilization of mid-level, non-physician providers, including nurse practitioners (NPs) and physicians' assistants (PAs). In a 2004 survey, the combined primary care workforce of 222,000 doctors (family medicine, general internal medicine, and general pediatrics) was augmented by more than 100,000 nurse practitioners (NPs) and physician assistants (PAs) working in primary care settings. In contrast to a dramatic decline in family medicine trainees, there has been a dramatic increase in enrollment in NP and PA training programs.[8] This approach is not without its own significant obstacles: historic turf battles between physician and non-physician advocacy groups, state and federal regulations, and a market-driven lure for an increasing percentage of non-physician clinicians to obtain advanced practice training and secure better compensated employment in specialty practices themselves [9, 10]

Training Issues: Residency and Beyond

Discussion and debate about scope of practice for generalists is active and vigorous within national family and internal medicine societies and organizations, particularly regarding training for, tracking of, and competence certification in a fuller range of procedural and diagnostic skills. The American Academy of Family Physicians (AAFP) has developed a series of procedural position papers that articulate the organization's advocacy for clinical privileges based on training and/or experience, rather than area of specialization. These include papers developed that advocate for family physician privileges for activities including: colonoscopy, esophagogastroduodenoscopy, C-section, diagnostic OB/GYN ultrasound, colposcopy, outpatient radiographs, EKG interpretation, and hospital privileging. There are advocacy initiatives from national organizations, such as the Society of Teachers of Family Medicine (STFM) that explicitly promote wider scope practice and core competencies for family medicine residents in areas considered the purview of specialty care in recent decades. Consistent with these initiatives is the emergence of "advanced procedural training" residency programs which intentionally prepare all of their family medicine trainees for fuller scope practice.

The impact of residency training on scope of practice is profound. There is little consensus, and, in fact, there is considerable controversy and debate, even among family medicine specialty training programs, about what constitutes *core* training competencies and procedures for primary care providers. There are significant disagreements regarding depth vs. breadth in scope, and about the type of future practice for which primary care trainees are being prepared. Primary practice providers emerge from residency training with ranging levels of preparation, skill and comfort in diagnostic and treatment scope. For example, while some family medicine residency programs emphasize the benefits of an increasingly specialized approach (e.g., preparing providers to manage chronic diseases of an aging population in outpatient, multi-disciplinary settings), others focus on more comprehensive, wider scope and/or procedure-intensive preparation. Residency programs that emphasize preparation for rural practice, by necessity, have a wider-scope emphasis. It has been noted that providing trainees with procedurally intensive preparation is resource intensive, with significant time, cost, and personnel challenges.

In addition to advocacy initiatives that emphasize the need to re-tool residency training programs, there are vigorous efforts to energize *current* providers' enthusiasm for a return to fuller scope practice and to build their clinical ability to engage in some specialty procedures and diagnostics that have recently fallen more under the purview of specialists (e.g., articles by Wm Rodney and John Pfenninger). There are a growing number of advanced practice, obstetrical and hospitalist fellowships available for primary care physicians. In addition, there are also successful commercial ventures (most notably, the National Procedures Institute) that offer hands-on continuing medical education procedures training for primary care providers in a wide array of "specialty" care areas, including: colonoscopy, dermatological procedures, esophagogastroduodenoscopy, fracture care, hospitalist procedures, office orthopedics, joint exams and injections, advanced suturing, x-ray interpretation and ultrasound. In addition to the relevance these training programs have for primary care providers in the safety net, they often seem to cater to boutique practice providers interested in expanding their ability to market full scope service.

Even for providers who graduate from residency programs that have prepared them for wider scope practice, post-graduate employment in settings with more limited scope can efficiently reduce willingness and ability to engage in a wider array of activities. Providers

often note that diagnostic and procedural comfort, confidence and skills erode rapidly with lack of use. Post-graduate specialty practice skills development for primary care providers is challenging to obtain, and finding and funding training opportunities and the time to pursue them can be expensive. It may also be difficult to negotiate malpractice coverage when pursing post-graduate procedural training. Cost, lost work time and availability of sufficiently intensive courses are obstacles, in addition to sorely limited precepting and mentoring opportunities necessary in order to obtain supervision to guide incorporation of newly acquired skills and procedures into regular use.

Lack of standardization in competence assessment is another key issue. There is a dearth of reliable measures by which to assess quality and competence in procedural and diagnostic skill. Lack of objective measures, or formal post-residency certification processes, can also create barriers to obtaining informal consultative relationships or specialty mentoring from specialists. Without personal experience with a primary care provider's clinical skills and judgment, consulting specialists may not be comfortable providing advice and consultation. Lack of certification may exacerbate providers' concerns about malpractice exposure, supporting perception that one's ability to remain highly competent requires a narrow, rather than fuller, scope of practice. There are currently, however, a number of new initiatives focused on development of standardized procedural competency tools and guidelines.[11]

It is important to recognize that, while primary care clinicians might more easily train to provide procedures and diagnostics that are more objectively assessed and amenable to practice guidelines (e.g., ENT, diabetes, fractures, sigmoidoscopies), the "cognitively complex," diagnostically confusing, and time-consuming areas(e.g., neurology, psychiatry, pain) pose a significant drain on basic primary care. These activities frustrate providers who lack the skills, interest or time to address them; organizations benefit when there is someone in-house to send these patients to for care. Key informants emphasize that these specialties require a primary care provider with special skills and interests in developing relevant expertise

The intersection between chronic pain management and addiction medicine is another area that creates tremendous stress on primary care providers, due to increased prevalence in the safety net population and the monumental drain on time and resources that these patients can require. Primary care providers also experience fear of malpractice exposure (and medical board investigation) that can result from under- or over-treating pain management patients. Strategies to address these concerns include: implementation of standardized guidelines and protocols, relationship-building with local addiction resources, prevention of "clinic-hopping" through uniform practices within clinic networks, combined with the provision of training for providers to improve skills and comfort levels; informants report that use of these approaches in this difficult area combine to result in greater provider satisfaction and improved retention.

Documentation of experience for primary care providers practicing fuller scope is yet another consideration needing attention. This is not a new concern. An AAFP position paper from 1992 identified the need for consistent, high quality documentation not only from residency training, but from continuing medical education, additional training and relevant patient care experiences, as the key to demonstrating competence and avoiding conflicts over hospital privileging and credentialing.[12] As described in one interview, "documentable" competency (training with specific and documentable evidence), recognized by outside agencies like JCAHO to support FTCA and, alternately, "practical" competency (internal oversight that protects patients and institutions regarding provider ability whether or not it is accreditable) are critical considerations. Individual insurance

companies, in order to reimburse for provided services, may have their own requirements to determine and demonstrate competence. Training opportunities, outside the traditional residency and fellowship options, need to be carefully assessed - a task which safety net institutions may or may not feel prepared to do. The difficulties establishing consensus agreement between family practice and specialist advocates about definitions of competence are evident, particularly in activity areas dominated by specialists in recent years.

Additional Practice Considerations

Geography impacts scope of practice. Primary care providers in densely populated urban areas or other places with greater concentrations of specialists are often in environments where competition for insured patients (even those with public insurances) is intensified. In these settings, many hospitals restrict privileges to certain types of providers, and patients and providers alike may have particular expectations regarding the norm for specialist care. It is generally conceded that these barriers to fuller scope practice are less of an issue under certain conditions: in the safety net (where loss of income is less of a risk); in rural areas which have greater difficulty attracting sufficient specialists; or for specific procedures or diagnostic activities which threaten to overwhelm specialists, which they are more willing to have taken “off their hands.” A number of the clinical leaders interviewed emphasized that fuller scope, procedural primary care happens without conflict for those activities specialists do not want to do, in locations and settings in which specialists are not interested in working (e.g., rural areas and with safety net populations).

Adoption of innovations that might otherwise support fuller scope practice is often also hampered by lack of investment. Technological innovations (EHR, clinical information systems, medical informatics, patient indexes) [13] could be used for a range of activities to support fuller scope for primary care, including: routine integration of ambulatory care guidelines into treatment plans and diagnostic approaches for a wider range of patients; support for medical decision-making; implementation of chronic disease management and prevention programs; and assessment of organizational delivery improvement efforts. It seems clear, particularly from the 2007 SCAI survey, that far less sophisticated, simple use of technology has eluded reach of most safety net institutions: 27% of CCHCs and 29% of public hospital systems do not track specialty referrals; of the minority organizations that do *any* tracking, an overwhelming majority do so with a manual log.

Safety net institutions with more restricted scope providers and less access to on-site resources rely more heavily on support staff to track and follow-up on patient needs. Limited resources, inadequate infrastructure, and the lack of efficient tracking systems make patient follow-up difficult. Without adequate case management, patients often fall through the cracks, over-utilizing primary care resources as their medical problems progress.

Other technological innovations, which may be underutilized in safety net settings, show promise in supporting fuller scope. For example, sites that have effectively integrated telemedicine report that “live” collaboration between primary care providers and specialists leads to significant increases in primary care scope of practice. In the early years following initial implementation, telemedicine referrals typically become more complex, reflecting the primary care physicians’ increased competence and comfort co-managing patients over time. Examples include family physicians managing large HIV

practices, with telemedicine access to infectious disease specialists at tertiary care centers, and improved management of common rashes and skin disease with access to teledermatology.

Reimbursement is another frequently noted obstacle to fuller scope primary care practice. Specialty activities with more complex or sicker patients are likely to be resource intensive, requiring time, special equipment and space, but lack financial remuneration to compensate added cost. In capitated or FQHC settings, time intensive services or procedures are disincentivized, because of levels of reimbursement, even if patients sorely need them. Productivity-linked compensation may further disincentivize specialty activities.

Additionally, individual preference plays a role. Lifestyle concerns are a factor; some providers prefer a more predictable work life, with regular outpatient hours, in contrast to the more unpredictable time demands necessary to meet the complex needs of a fuller range of patients. Providers differ in their dispositions toward competence, with some feeling most competent and capable of staying current within a narrower range of activities, and having differing levels of enthusiasm for and tolerance of the risks and challenges involved in acquiring and incorporating new skills and activities. In addition, providers may have strong content preferences or interests that impact willingness to practice with a wider range (e.g., they enjoy obstetrics, but dislike orthopedics or can tolerate dermatology, but not gastroenterology).

Questions for Future Discussion

Consideration of safety net specialty services provided through fuller scope primary care practice could include a myriad of inputs: patient population needs, community access to specialists, available training, and provider interests. All of the interviews emphasized the need to respect the latter. While providers might be recruited and enticed through incentives to obtain particular specialty expertise, and opportunities for training and mentorship can be a powerful retention tools, pressuring primary care clinicians to practice specialties for which they have neither interest nor proclivity is probably unrealistic. There are, though, significant organizational risks and challenges in building specialty programs around specific individuals, particularly given concerns about recruitment away and succession planning. Assessment of what specialty service(s) to provide via primary care clinicians is typically a balance across a range of factors:

- What specialties have the greatest supply/demand mismatch, with no other reasonable solutions available?
- What services can be provided efficiently, with a better balance vis-a-vis reimbursement?
- What will the net impact on productivity be for individual clinicians? institution-wide?
- What is the impact on efficiency and productivity if the service is not provided?
- What training is available, cost-effective and relatively accessible?

- What high need specialty areas can be trained to with efficiency? How can procedural training, proctoring/mentoring, and training materials (e.g. equipment, educational simulation devices) be made more affordable?

- What specialties are most amenable to allow primary care providers to increase competence through co-management with a distant specialist through telemedicine?

- What services are patients interested in/willing to receive from primary care providers?

- To what extent should primary care specialty scope be limited to those specialty activities with objective measures or evidence-based protocols?

- What specialty service/procedures might community-based specialists support being offered by safety net primary care providers?

- What strategies can safety net institutions use to balance organizational needs with provider preferences

Primary Care Specialty Activities: Examples from the Safety Net

There are a number of examples and models in safety net and other institutions where primary care providers are trained and organized to provide specialty care. A few of these are briefly highlighted below.

Camino de Salud/Roybal Comprehensive Health Center, LAC-USC

- Mini-fellowships have been designed for areas with greatest patient need, but least access as a collaborative project between 5 CCHCs and 2 comprehensive county health centers. Each clinic has a "champion" primary care provider who attends 2-3 three hour clinics with specialist "champion" (pre-selected for teaching and assessment skills). Primary care "champion" is available within CCHC to do first level of exam and then to consult formally or informally with specialist about need for patient to be seen by specialist. Lots of curbside consultation – with and without patients.
- Diabetes disease management guidelines developed to increase treatment consistency and accountability; initially provided to county clinics and made available to community clinics as well.

Community Health Clinic Ole

- Primary care provider took advanced procedure classes and precepted with local GI specialist and surgeon to improve flexible sigmoidoscopy skills and clinic purchased good video scope. On-site colon cancer screenings are now promoted and the primary care provider who received advanced training is proctoring other providers as they acquire procedural skills.
- Primary care clinicians provide simple dermatology procedures and have informal consultative arrangement with Kaiser dermatologist for "cognitively complex" cases; high level of trust has developed over time that enables specialist to work from primary care providers' notes and digital photos to provide treatment recommendations.
- Development of psychiatric medication training program to increase primary care physician facility with complex psychiatric disorders.
- Recruitment includes focus on primary care physicians who have potential to develop sub-specialty areas of need within clinics that are aligned with their individual interests and proclivities.

Contra Costa Regional Medical Center

- Primary care physicians in the public hospital system staff a wide array of specialty clinics and hospital positions, in most cases, working independently and utilizing specialists only for mentoring, consultation and referral only for the most complex cases. There are family medicine physicians working in many different specialty clinics: orthopedics, sports medicine, neurology, gastroenterology, oncology (the chief of oncology is a family physician), dermatology, neurosurgery, HIV, allergy, and pulmonary clinics. Every inpatient service has a large number of family physicians, and the chiefs of the emergency department, ICU and obstetrics are family physicians. These physicians do a full range of inpatient procedures. As a result, the hospital system hires fewer high priced specialists, and employs more versatile and less costly family physicians, while providing more extensive coverage. For example, there are four individuals in the GI call pool – two family physicians and two gastroenterologists – who, together, provide 24/7/365 coverage for GI.

- Family medicine residents obtain procedure-intensive training, rotating through specialty clinics and hospital services staffed by primary care providers.
- Many physicians leave the training program skilled in primary c-sections and other surgeries, in anticipation of working in remote rural areas and the third world.
- Similar training and practice programs are evident in Ventura County as well.

Kaiser Permanente Southern California

- Provided musculo-skeletal training/medical orthopedics training for orthopedic conditions (knee and shoulder problems, joint injections) unlikely to require surgery which are referred too quickly to specialists; three one week, intensive trainings, using some didactic teaching and interactive, hands-on experience with portable manikins.
- Development and delivery of headache and dementia clinics to improve diagnostic and treatment capacity of primary care providers.

Marin Community Clinic

- Informally arranged six month mini-residency in dermatologist office through personal connections with specialist; clinic paid salary for two days/week spent off-site over the course of six months. Primary care provider now staffs on-site dermatology clinic and treats all in-house dermatology referrals (skin cancer screening, psoriasis, acne, inflammatory skin conditions) except complex cases, which are referred out. Minimal equipment expenses.

Petaluma Health Center

- Hired "circuit rider" anesthesiologist to provide support, training and consultation for pain management primary care practice at three local clinics; developed comprehensive pain management program that standardized the management of high-risk pain patients in which all family physicians were taught how to run structured pain management group visits. Decreased provider turnover was the most important result, since this challenging population was spread equally among all providers, in an organized, coordinated fashion.
- Physicians organized early morning weekly training/educational sessions for midlevel providers to increase their skills with skin biopsies and suturing; headache management; endometrial biopsies and IUD insertions; and orthopedic procedures such as splinting, casting and joint injections; initial orthopedics advanced training was obtained through NPI by two primary care providers.
- FNPs encouraged to assume specialty focus in addition to their primary care panel (hepatitis B and C management; diabetes; Coumadin clinic; pap/colpo management; OB ultrasound; asthma; wound care).
- Organized training/mentorship arrangement with local (broadly trained) private practice family physicians so three physicians could learn vasectomies.
- Spread medical director duties among physicians as an administrative "specialty" interest, creating four associate medical directors, each with a specific focus: technology, quality, hospitalist program, and operations. This increased physician investment in the clinic, improved leadership skills, and allowed faster pace of quality improvement and program expansion.

Santa Clara Valley Health and Hospital System

- Infectious disease/ training (Hepatitis C) for primary care providers serving homeless population to strengthen “one stop shop” delivery
- Twenty primary care providers and residents learned to do musculo-skeletal injections in injection clinic with rheumatologist specialist; increases efficiency and convenience.
- A few primary care providers do flexible sigmoidoscopies; time constraints limit others from doing so because of impact on reduced primary care time. Primary care screenings reduce workload on GI specialists, who provide diagnostic interpretation and treatment planning services for patients who have been pre-screened and scoped.
- Primary care providers do fuller scope dermatology procedures: lumps, bumps, moles, fine needle aspirations.

Shasta Community Health Center

- Intensive use of community specialists to develop in-house guidelines to insure adequate primary clinician work-ups and reduce premature and inappropriate referrals out; these morphed into more comprehensive ambulatory care guidelines which were further refined by evidence-based medicine protocols and clinical disease guidelines. Currently working on integrating these with EMRs to automate procedures more fully.
- All primary care providers have special projects or sub-specialty areas (disease management, programs clinical program development, running specialty clinics). Obtain whatever training leads feel like they need to be competent and supported.
- Intensive training and specialty telemedicine consults, with primaries sitting in, to develop expertise in psychiatry.

APPENDIX A: INFORMATION SOURCES

Key Informant Interviews

- Ngoc Bui-Tong, Program Analyst, Santa Clara Vally Health and Hospital System, Ambulatory and Community Health Services, San Jose, California
- Tom Curtin, MD, Chief Medical Officer, National Association of Community Health Centers, Washington, D.C.
- William Ellert, MD, Chair, Department of Family and Community Medicine, Maricopa Integrated Health System, Phoenix, Arizona , Co-Chair, STFM Group on Hospital Medicine & Procedural Training
- Jeremy Fish, MD, Director, Contra Costa Regional Medical Center Family Practice Residency Program, Martinez, California
- Stuart Forman, MD, Assistant Director, Critical Care Unit, Contra Costa Regional Medical Center, Co-Chair, STFM Group on Hospital Medicine & Procedural Training, Martinez, California
- Robert Hoch, MD, Instructor, Health Policy and Management, Harvard School of Public Health; Vice President for Health Services, Harbor Health Services, Boston, Massachusetts
- Robert Moore, MD, Medical Director, Community Health Clinic Ole, Napa, California
- Ann Murphy, MD, Medical Director, Shasta Community Health Center, Redding, California
- Ed O-Neill, Ph.D., Director, Center for the Health Professions, UCSF, San Francisco, California
- Kelly Pfeifer, MD, Medical Director, Petaluma Health Center and Medical Director for Access, Redwood Community Health Coalition, Petaluma and Santa Rosa, California
- G. Mike Roybal, MD, Medical Director , Roybal Comprehensive Health Center, LAC-USC, Los Angeles, California
- Eric Schten, MD, Marin Community Clinic, Greenbrae, California

Websites and Journals Primarily Used

- American Association of Family Physicians
- Society of Teachers of Family Medicine (STFM)
- American College of Physicians
- American Board of Internal Medicine
- American Medical Association
- transforMED
- Center for Studying Health Change
- Robert Graham Center
- Pew
- UCSF Center for Health Professions
- American Academy of Internal Medicine
- Institute of Medicine
- National Procedures Institute
- Federation of State Medical Boards
- Agency for Healthcare Research and Quality
- Health Affairs
- Journal of Family Practice
- Family Medicine

APPENDIX B: INTERVIEW QUESTIONS AND TOPICS

GENERAL SCOPE OF PRACTICE ISSUES:

How do you define expanded scope for primary care providers? To what extent do "expanded scope" activities, procedures and treatments fall into the category of things family practitioners and internists are trained to do, but are not doing?

To what extent are there systematic differences in the range in scope of care provided by primary care providers in different settings (rural vs. urban, private practice vs. community clinics)? Are these differences documented anywhere?

What stands in the way of primary care providers doing more limited specialty services?

How can training needs be addressed for providers currently in practice?

What are the turf issues with regard to expanded specialty care?

Legal and insurance issues?

In environments in which primary care providers practice fuller scope, how have the obstacles to doing so in other settings been addressed (malpractice, turf, reimbursement)

Are the obstacles and turf issues around primary care providers performing a fuller scope of specialty activities different for primary care and specialist providers in the safety net vs. those in private practice?

In your opinion, in order to alleviate some of the pressure for specialty care, what diagnostic activities, procedures and treatments typically referred to specialists could be done by primary care providers with reasonable support, equipment, and training?

Neurology:
Dermatology:
Orthopedics:
G.I.
Other:

Are you aware of places where this approach is being discussed, assessed or evaluated as a means of reducing the strain and difficulty accessing specialty care for safety net patients?

Do you have any specific suggestions for us for other people/programs to speak with who might have some specific and relevant experience that could shed some light on these issues? Are you aware of any individual or organization taking a leadership role in this approach?

ISSUES SPECIFIC TO CLINIC EXPANDED CARE ACTIVITIES:

How have your providers' practice expanded to include specialty care? What specific activities, procedures or treatments do they now do?

What training has been obtained? Where has it been obtained?

After training, how are providers practicing expanded specialty care precepted or mentored? Other support?

What is cost of expanded practice? How does the practice of expanded scope impact productivity and scheduling?

What additional equipment and other types of support are most needed for primary care providers to provide more specialty care and procedures?

What barriers and challenges have been encountered?

In what other areas have you considered expanded scope of practice?

What advice would you give others about expanded scope activities?

What conditions do you think are necessary for success in implementing expanded practice?

REFERENCES

[1] Whitcomb M. Preparing the personal physician for practice. *The Journal of the American Board of Family Medicine*, 2007; 20(4):356-364.
[2] White B. Are the edges of family practice being worn away? *Family Practice Management*, 2000; 7(2): 35-44.
[3] Stevens RA. The Americanization of family medicine: Contradictions, challenges and change, 1969-2000. *Family Medicine*. 2001; 33:232-243.
[4] The Keystone papers: Formal discussion papers from Keystone III. *Family Medicine Journal*. 2001; 33(4)
[5] Pugno PA, McGaha AL, Schmittling GT, DeVilbiss A, Kahn NB. Results of the 2007 national resident matching program: *Family Medicine*. 2007; 39(8):562-571.
[6] Phillips RL, Starfied B. Why does a U.S. primary care physician workforce crisis matter? *American Family Physician*. 2004; 70 (3): 440-446.
[7] Starfield Bm Shi L, Grover A, Macinko J. The effects of specialist supply on populations' health: Assessing the evidence. *Health Affairs*. Web exclusive. DOP 10.1377/hlthaff.W5.97.2005 Project HOPE.
[8] Cooper RA, Laud P, Deitrich CL. Current and projected workforce of nonphysician clinicians. *Journal of the American Medical Association* 280,no.9 (1988): 788-794; National
[9] Phillips RL, Harper DC, Wakefield M, Green LA, George EF. Can nurse practitioners and physicians beat parochialism into plowshares? *Health Affairs*; 2002: 21(5): 133-142.
[10] Singer AM, Hooker RS. Determinants of specialty choice of physician assistants. *Academic Medicine*. 1996: 71(8): 917-919.
[11] SFTM work group; personal communication, Stuart Forman
[12] Norris TE, Costley M, Krause A. Documentation of experience: Preventive medicine for family physicians, The AAFP Commission on Quality and Scope of Practice. *American Family Physician*. 1992; 45(5): 2387-2388, 2391.
[13] Bates DW. The quality case for information technology in healthcare. *British Medical Informatics and Decision-Making*. 2002; 2(7)