

# A Nurse Practitioner and Primary Care

---

Sharon A. Cullinan, RN-C, MSN, FNP

I GRADUATED FROM A HOSPITAL school of nursing in 1968, when Medicare was new. In the ensuing years, I have worked in university and community hospitals, in home health, and in research. These diverse work experiences have given me a well-rounded view of the difficulties people face in coping with their health problems. To obtain the training and credential I needed to enter the field of primary care, I entered the Family Nurse Practitioner program at UNC-CH and graduated in 1996. I took a position as a provider in the Southeast Raleigh office of Wake Health Services Inc. (WHSI), a community health center established in 1972. That organization's mission, "to provide quality primary health care services responsive to the need of our communities with emphasis on reaching the medically underserved," expresses my own interests as well.

As a federally qualified health center, WHSI receives reimbursement from Medicare and Medicaid based on annual costs rather than a fee schedule. This means the reimbursement for a Medicaid or Medicare visit is the same whether the visit is for a complete physical exam or for care of a sore throat. Our funding also allows us to see uninsured patients using a sliding fee scale. Our mission, funding characteristics, and location shape a patient population ranging from infants to elders, who have challenging primary care needs.

## The Organization

Since its inception in 1972, WHSI has employed nurse practitioners and physician assistants (PAs) as semi-independent providers. Like the physicians, we have our own panels of patients; physicians serve as our consultants and care for our hospitalized patients. One provider is available

---

The author is a Family Nurse Practitioner at Rock Quarry Road Family Medicine, an office of Wake Health Services, Inc. She can be reached there at 1001 Rock Quarry Road, Raleigh, NC 27610. Telephone: 919/833-3148 ext. 212.

on Saturday mornings for acute care and sports physicals, and we have evening hours one night per week. Physicians share after-hours and weekend call. Hospitalizing physicians make rounds on their patients (and mine) before office hours. Emergency room visits are covered by the emergency room doctors unless the patient requires an admission, in which case the patient's regular physician goes to the hospital to do the admission, usually during lunch or after office hours. In the early years, nurse practitioners outnumbered physicians, but now, in response to the increasing numbers of Medicare patients, the reverse is true. Today among our four medical offices and dental practice we employ 13 physicians, two nurse practitioners and two dentists.

## The Patients

My patient mix matches that of the five physician providers I work with at the Southeast Raleigh office. The distribution of coverage among our registered patients is Medicare 19%, Medicaid 31%, private insurance 25%, and uninsured 24%. As those in primary care know, however, the registered patient mix does not match the patient mix seen on any given day. Of the 20 patients I see on an average day, 38% have Medicare, 34% have Medicaid, 18% are uninsured, and 10% have private insurance. Medicare and Medicaid patients make up 70% to 80% of our hospital census, which ranges from 10 to 20 patients.

## Clinical Care

Our office is fully staffed at present with six providers. Half of us have been with WHSI for six or more years, the other three for less than one year. Six physicians have come and gone from our office in as many years, so problems related to continuity and accessibility of service have ebbed and flowed.

Once a month I make a half-day visit to a rest home to give routine follow-up care to patients with chronic illnesses. The rest home visit is a particular benefit to these registered

patients, especially those who have great difficulty leaving the facility because of dementia or mental health problems. One of my partners does half-day visits to our patients at a nursing home once a week; another will be spending a half-day per week on community outreach. We all meet for lunch once each week to discuss clinical problems, quality issues, and office processes on the local level. Providers also serve on organization-wide committees, and providers from all offices meet on a monthly basis.

When my patients require hospitalization, one physician is mainly responsible for them, affording some continuity in their care. I consult with any of the providers for questions that arise, according to their areas of expertise. One of my colleagues, for example, is an internist with extensive experience treating HIV; another colleague with particular expertise in gynecological problems gets all our patients needing colposcopies. I learned a great deal from an internist who joined us fresh from residency, and I was always happy to help him in turn with common primary care problems he had not encountered in his residency. Teamwork is an essential element in our office and has been valued by all the physicians I have worked with. Perhaps respect for teamwork is a characteristic of providers who choose to work with underserved populations.

Providing primary care to our patients is challenging. Most patients have less than a high school education; an increasing number of them speak little or no English; and the stressors they face—financial and otherwise—are reflected in the number of crossed-out home phone numbers and addresses on patient data sheets. Comorbidity with diabetes, hypertension, and obesity are prevalent in this population, but dollars are scarce for the needed medications. The complexity of economic, educational, social, and medical problems our patients bring to us begs for the coordination a primary care provider can give. I hope to illustrate this with two patient descriptions.

## Patient Descriptions

Mrs. Smith was 84 years old and lived alone. She was legally blind, had hypertension and diabetes, and had been hospitalized twice with heart failure. Her daughter and son, trying to support her tenacious hold on independence, visited daily and did her shopping. She had caring neighbors. Her son, recovering from a partial colectomy done after a screening colonoscopy revealed colon cancer, was being followed by one of my partners. We were able to coordinate their visits when needed so that Mrs. Smith's son brought her to her appointments with me.

Noncompliance with medications (due to her inability to afford them) and difficulty keeping them straight were both contributing factors in Mrs. Smith's hospitalizations. We addressed these problems through the center's Drug

Assistance Program (DAP), which covers Medicare and uninsured patients who meet our sliding fee scale requirements. The DAP coordinator accesses the patient assistance programs at the various pharmaceutical companies; three-month supplies of medicines are delivered to our offices and sorted; and patients are notified to pick them up and sign reapplication forms. In Mrs. Smith's case, I kept the medications and filled four weeks of mediplanners for her son to pick up. When medicines ran short, I supplemented from the sample closet.

After the medication compliance problem was solved, Mrs. Smith did not require further hospitalization. Gradually her health declined, and with increased frailty she finally agreed to move in with her daughter. She continued to come for monthly visits. I knew her wishes regarding end-of-life decisions from early in our relationship. We were able to respect these with assistance from hospice care, and Mrs. Smith died quietly at home with family at her bedside. I was able to visit her at home in the last month. Within the structure of a community health center, home visits to Medicare patients by nurse practitioners or physicians are reimbursed in the same way as office visits.

As an example from the other end of the age spectrum, there are my patients Betty and her three children. All of them are covered by Medicaid. I follow Betty for hypertension, well-woman care, and smoking cessation. (She has quit once but has relapsed since returning to school.) Her son Alex, 16, is autistic and mentally retarded. Younger brother Mike and sister Sheniqua are healthy but have struggled in school over the years. Both were diagnosed with attention deficit/hyperactivity disorder. They took medication for this in elementary school but are now in middle school and off medication. Betty is very active in the school life of her children—not typical, unfortunately, among my patients.

Alex fractured his hip twice in falls during seizures before he was 10 years old, so when I met him six years ago he was being followed by an orthopedist and a pediatric neurologist. With a finding of hypocalcemia, a pediatric endocrinologist entered the specialist team. Alex is now off seizure medication, and his mother gives him calcium injections to treat a parathyroid disorder. I have served as a central clearing house over these years, and Alex has submitted to multiple labs drawn by our lab tech, who has known him since infancy.

I often see all three children together, for a sick visit for one or more children or for well-child checks for all. Three active children and their mom in an exam room are a high-energy affair, but one that gives good insight into family dynamics. Mom and I are both talking to Mike and Sheniqua regarding the risks of early sexual activity, a prevalent problem among my young patients. I see Sheniqua and Mike alone on some visits, and hope that I have nurtured a relationship in which they will feel free to discuss issues such as sexuality.

## Services

Many of the single mothers I see move on and off Medicaid and other insurance rolls. Some of our patients lost jobs and insurance with the recent downturn in the economy. Some are temporarily without insurance as they change jobs. Fortunately they all can continue to see their providers by using our sliding fee scale. Visits cost as little as \$10. Lab costs are charged according to the sliding fee scale and are waived for those at the \$10 level.

Many of our pediatric patients have learning and social problems, which affect their progress in school. In response to the prevalence of these and other problems, we hired an on-site social worker. Her day may include communication with teachers, helping HIV patients to find access to resources, helping family members to place an elder in long term care, or certifying patients for the sliding fee payment plan. The providers would like to add another social worker to the staff, to run parenting classes and do family counseling, but funding for this is not available at present. There is no charge to patients for the social worker's services.

Our practice has taken advantage of community programs to help provide services for our patients. Project Direct, funded by the US Centers for Disease Control and Prevention, is a demonstration project targeting people at risk for and diagnosed with diabetes. As part of its grant, Project Direct provides free diabetes care classes in our waiting room one evening a week. It also supports walking programs in many of our local neighborhoods and helps uninsured patients to obtain glucometers. This program is a wonderful resource for us.

In response to a growing Latino population, we have hired one of our Spanish speaking patients to act as a translator. She works every Monday morning, and we try to schedule Spanish-speaking patients on those mornings. We have one full-time bilingual staff member who helps out as needed with translation. None of the providers in our office is bilingual, but several of us have taken beginning medical Spanish. Our salary scale makes it difficult to hire and keep

bilingual support staff. We are constantly working to remove this barrier for the increasing Latino population in our area.

## Wish List

Our practice, like many others today, places computer-based medical records high on the wish list. A computerized system would greatly facilitate care and ease the burden of call. At present, however, the cost is high and our center has many other pressing needs. There is great need among our patients, particularly uninsured diabetics, for affordable eye care. And an on-site pharmacy would decrease the time I spend gathering a month of medicines in the sample closet. Unless they have Medicaid, most of my patients cannot afford even generic medication. On a janitor's or dietary worker's salary, even those who have a pharmacy benefit with their insurance often cannot afford the copayment required. When choosing a medication for a hypertensive patient, I consider factors such as the likelihood of sample availability and which company has an active patient assistance program. I have only one patient who has requested my email address. I have many who have requested assistance with medications. An on-site pharmacy would provide more benefit to my patients than paperless records. It would be wonderful to have both.

## Summary

As a nurse practitioner employed by a community health care center, I find that I am able to practice primary care the way I imagined I might when I was a student. The characteristics and needs of the particular population I serve have given me ample opportunities. The community health center administrators have not always prioritized expenditures the way my colleagues and I think they should, and we are not immune from the financial and market forces that affect primary care in private practices. However, the essence of primary care is valued by the organization, and it offers me the opportunity to provide this care to a community that needs it.