

Advanced Practice Providers — Emerging Risks

November 2013

Today's host



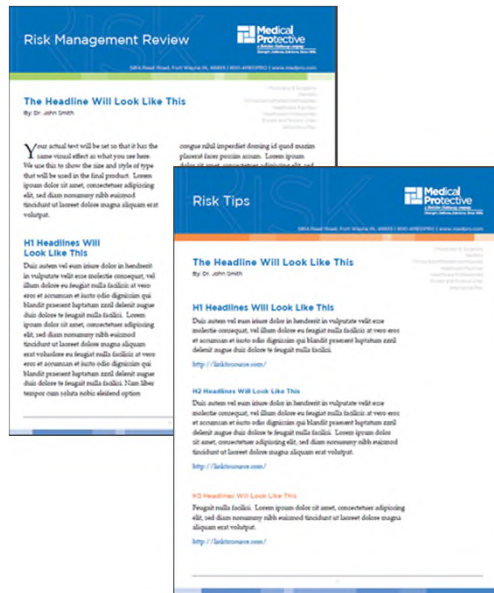
Theresa N. Essick, RN, CPHRM
VP, Clinical Risk Management

- Ms. Essick has 35 years of experience in the healthcare industry and has a broad understanding of the unique obstacles that providers must address on a daily basis. During her years as a consultant, she became an expert in electronic health record implementation and industrial health issues, including workers' compensation and wellness program development.
- Ms. Essick has held a registered nurse license in North Carolina and Georgia during the course of her career. She is a member of the American Society for Healthcare Risk Management and the North Carolina Society for Healthcare Risk Management, and she has earned her designation as a Certified Professional in Healthcare Risk Management.

Do you know...



- How to access the PowerPoint presentation being used today?
- How you can use this program for future staff education?
- All of the risk resources available to you as a MedPro insured?



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Objectives

- Review projected physician supply vs. demand and the current role of advanced practice providers (APPs) in healthcare
- Provide an overview of APP practice settings and future demand expectations
- Outline basic risks related to APPs, and offer specific strategies for risk mitigation



Survey Results will be shared
during the live webinar.

Today's speaker



Tom Snyder, PA, MBA/MS
VP, Healthcare Risk Services
Princeton Insurance

- Mr. Snyder is Vice President for Healthcare Risk Services for Princeton Insurance (a MedPro/Berkshire Hathaway Company) and has more than 25 years of healthcare, insurance, and clinical experience. He is responsible for the direction and management of Princeton's risk and loss prevention activities for its insured providers and facilities.
- Mr. Snyder's career includes clinical practice as a physician assistant and experience as a medical corpsman in the United States Air Force. He completed his physician assistant training at Hahnemann Medical College in Philadelphia and an emergency medicine residency in Portland, Maine. He also has an MBA in health administration and an MS in healthcare financial management. Mr. Snyder's past professional experience includes managed healthcare, risk/compliance consulting, and bond financing for healthcare facilities.

Today's speaker



Graham Billingham, MD,
FACEP, FAAEM
Chief Medical Officer

- Dr. Billingham has 25 years of experience as an emergency medicine physician. As Medical Protective's Chief Medical Officer, he is responsible for leading MedPro's Healthcare Advisory Boards and working with the Business Council to support clinical risk, claims, underwriting, and sales efforts.
- Dr. Billingham speaks nationally on emergency medicine and has lectured in more than 200 CME courses on risk management, operations, documentation, patient safety, information technology, coding and billing, and malpractice prevention. He is skilled at gleaning patient safety and risk management lessons from claims and incidents.
- Dr. Billingham's past professional experience includes serving as President and CEO for EPIC RRG. He has also served on advisory boards for several technology companies, as well as the American College of Emergency Physicians Medical Legal Committee and Coding and Nomenclature Committee. He is Emeritus Chairman of the Emergency Medicine Patient Safety Foundation and has served on the Board of EDPMA. He founded and served as medical director for the Center for Emergency Medical Education and was a co-founder of the National Emergency Medicine Board Review Course.

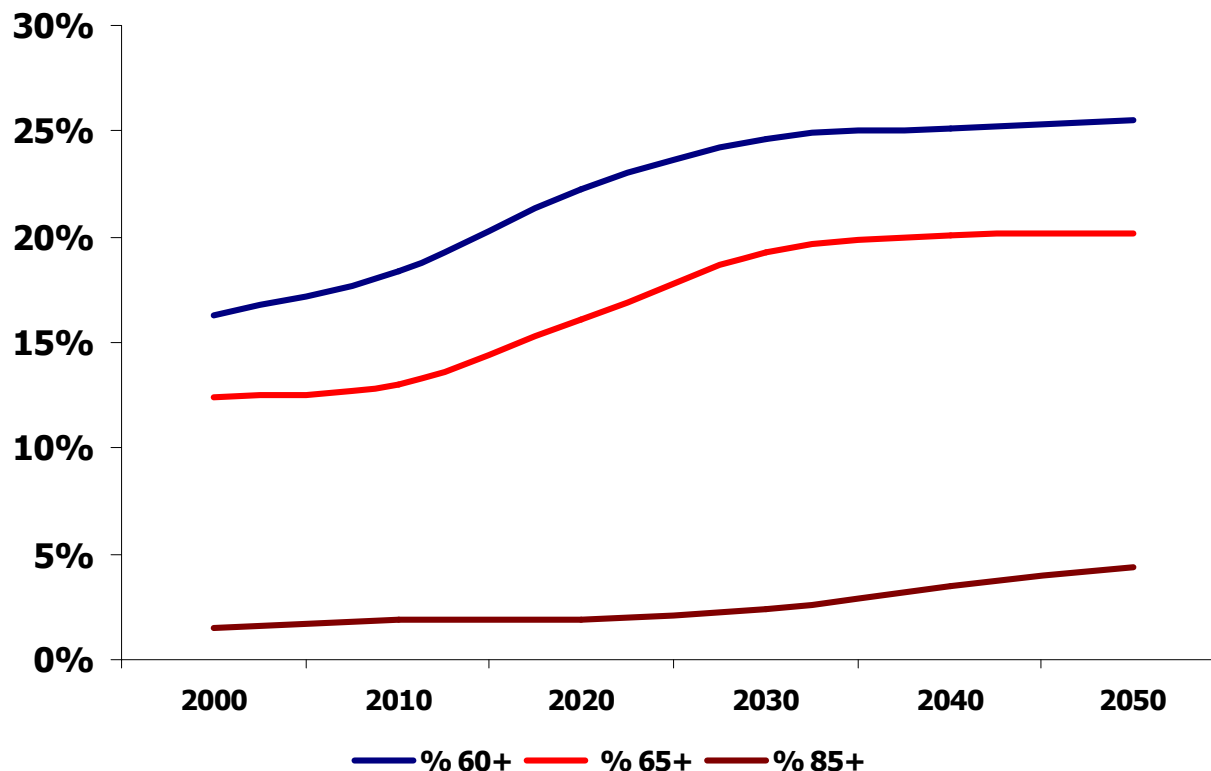


Drivers...

- Aging U.S. population
- Utilization trends
- Aging doctors and gender expectations
- Medical schools and residency programs
- Coverage does not equal access

Aging U.S. population

Percent of Population by Age: United States, 2000 to 2050

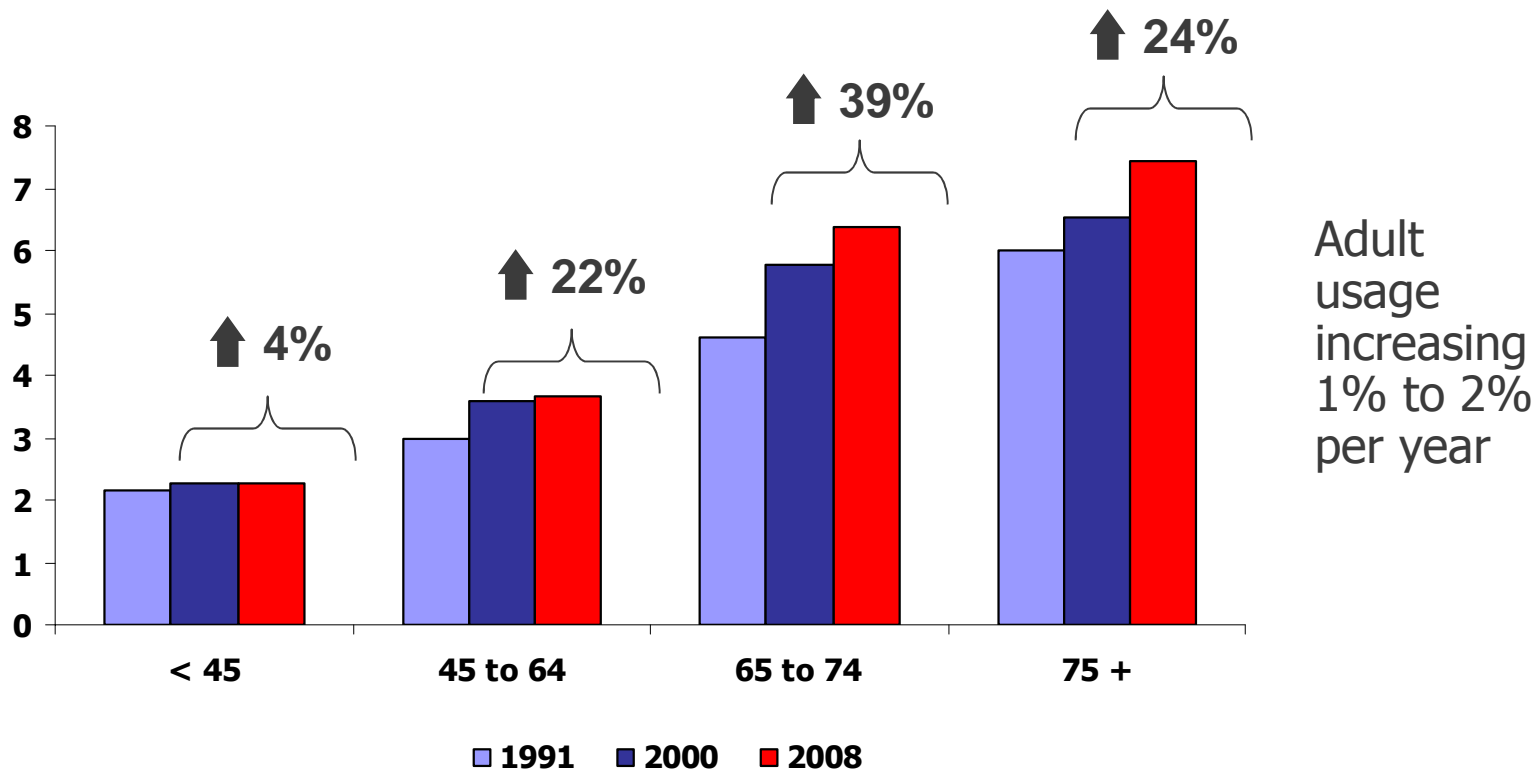


Source: Administration on Aging. (2008). Projected future growth of the older population, United States Census Bureau Data. U.S. Department of Health and Human Services.

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Utilization trends

Physicians Office Visits by Age: United States, 2000 to 2008

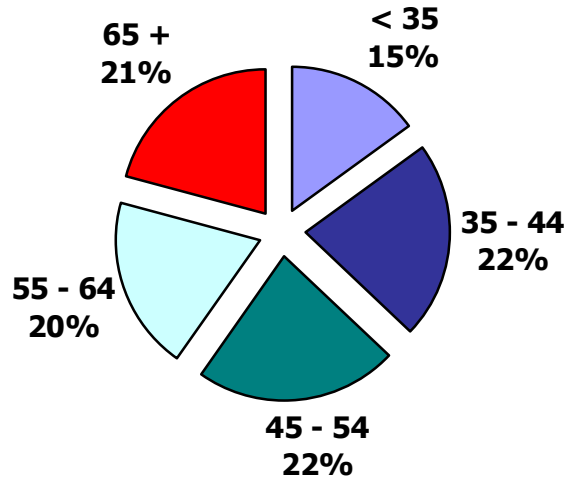


Source: Centers for Disease Control and Prevention, National Ambulatory Medical Services Surveys, 2000–2008

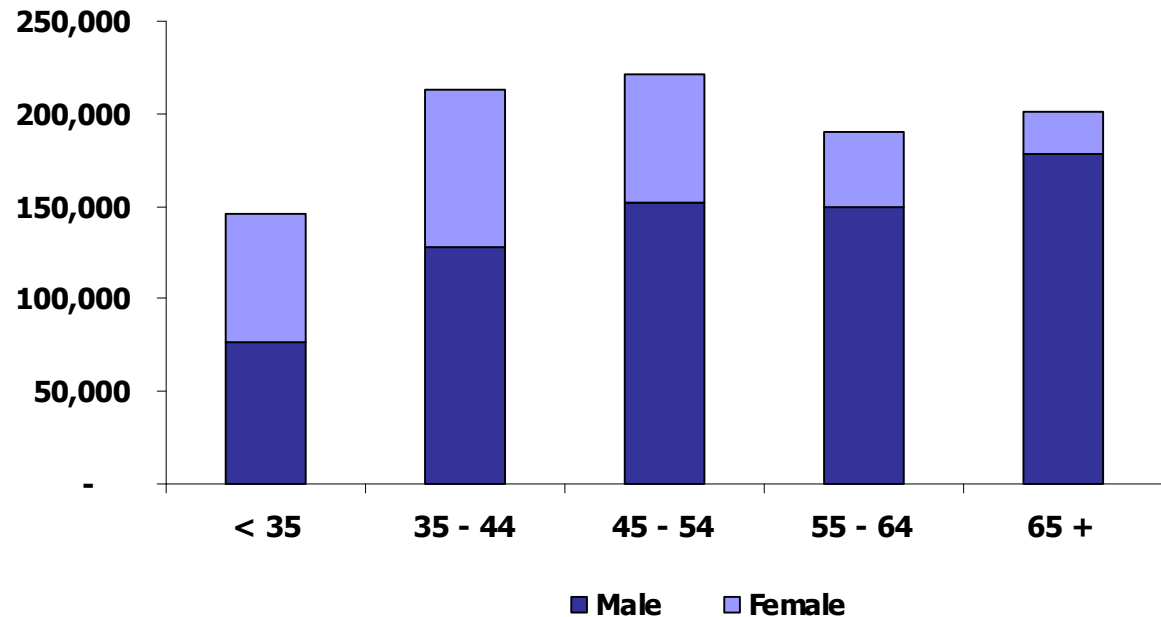
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Aging physician population

**Physicians by Age:
United States, 2009**



Physician Gender by Age: United States, 2009



Source: American Medical Association (2011). Physician characteristics and distribution in the United States.

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Gender expectations — Work patterns changing

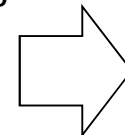
Topics Rated Very Important by Gender

Balance

	<u>Male</u>	<u>Female</u>
Time for family	66%	82%
Flexible schedule	26%	54%
No / limited call	25%	44%
Minimal practice responsibilities	10%	18%

Career/Income

Practice income	43%	33%
Long term income	45%	36%
Opportunity to advance	29%	27%



Females now ~50% of medical students

Work patterns differ between females and males:

- **Fewer hours per week**
- **More part-time work**
- **Intend to retire earlier**

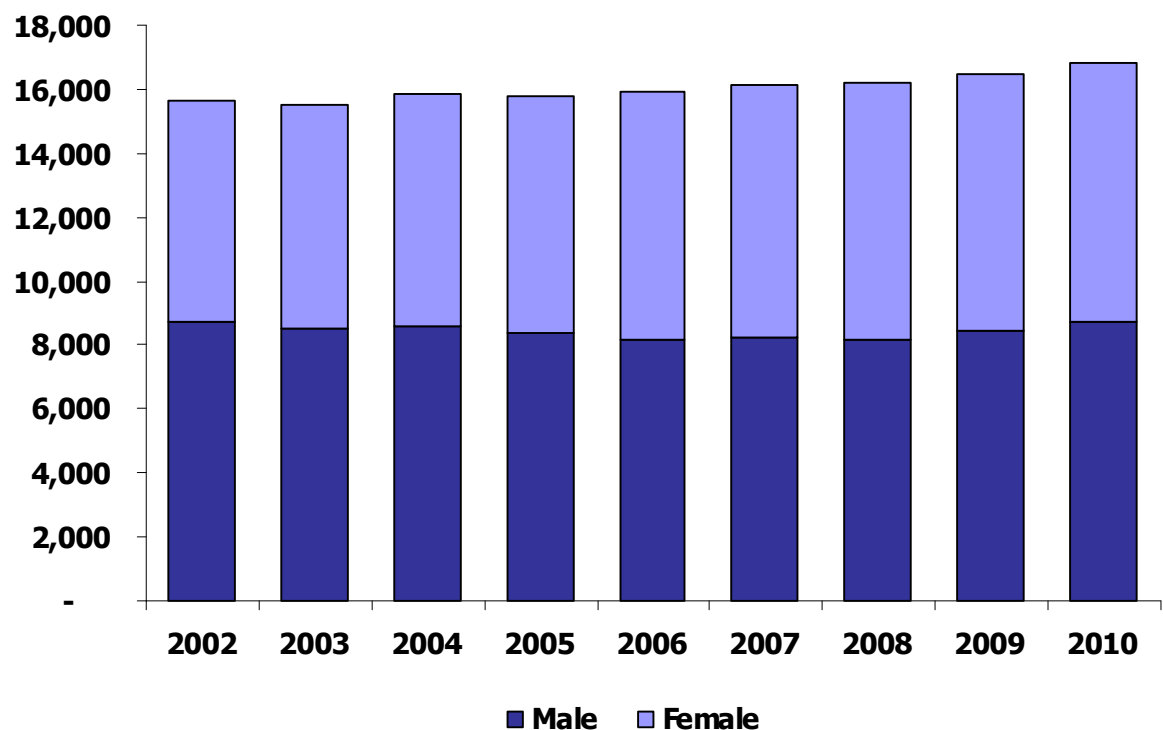
Source: Association of American Medical Colleges. (2008). The complexities of physician supply and demand: Projections through 2025. Analysis of AAMC/AMA survey of physicians under 50.

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U.S. medical schools: Supply vs. demand

Medical Graduates by Gender: United States, 2002 to 2010



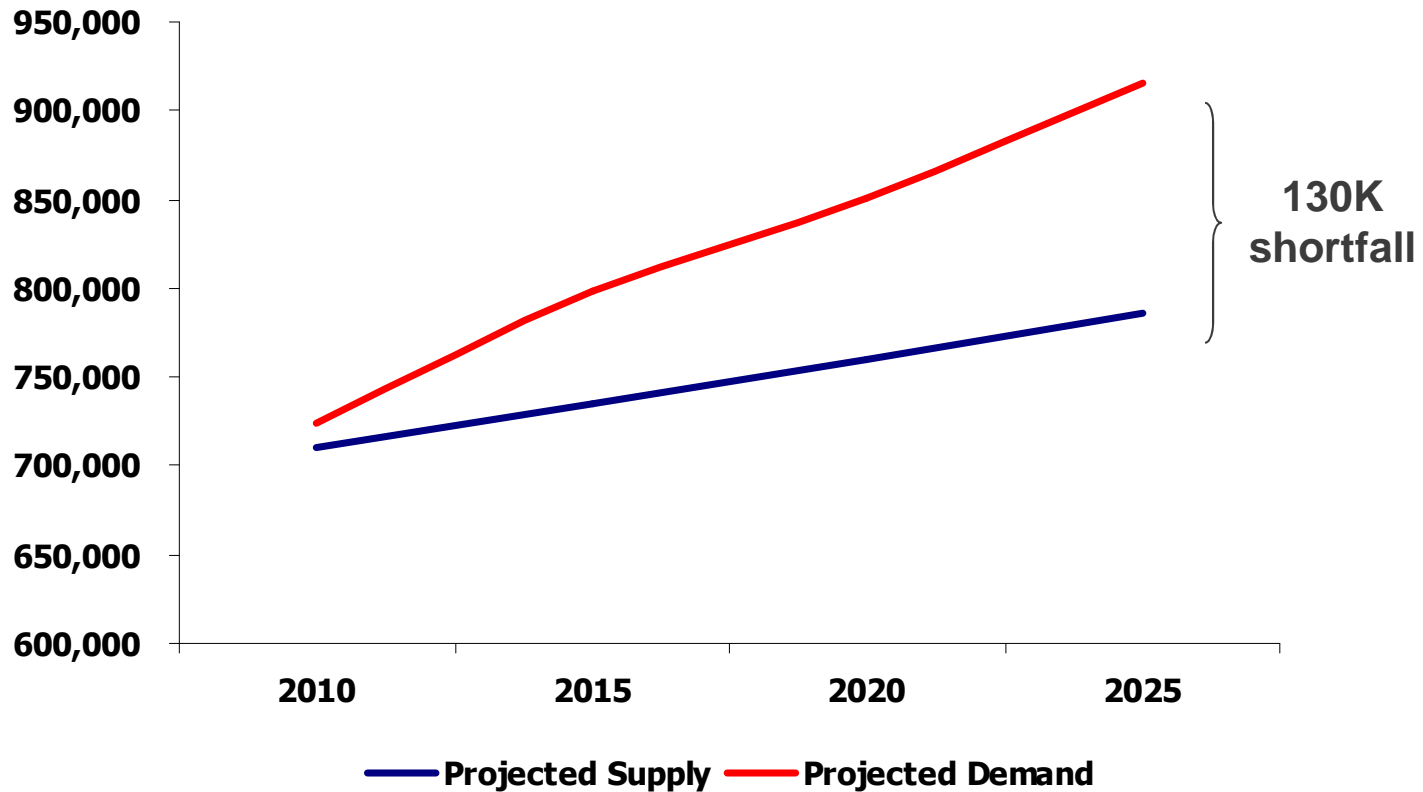
- Graduates increasing <1% per year
- ~16,000 new med school grads per year
- Med schools plan to increase enrollment by 30%, but without residency slots increase doesn't help
- Residency slots limit: ~25,000 per year per federal funding (no plan to increase)

Source: Association of American Medical Colleges. FACTS tables: Total graduates by U.S. medical school, sex, and class of year, 2002–2010 (table 27).

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Projected physician shortage

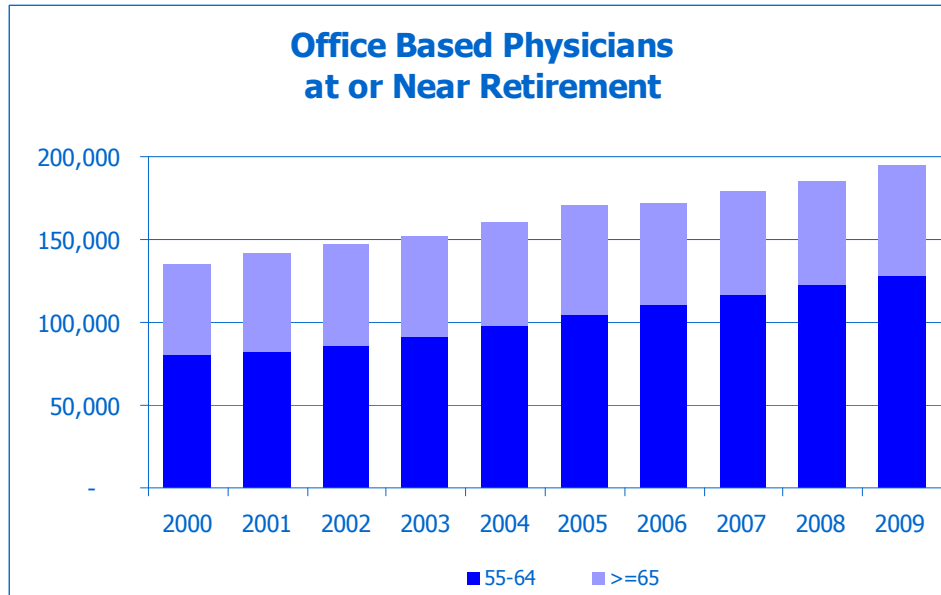
Full Time Equivalent Physician Demand: Impact of Patient Protection and Affordable Care Act



Source: Association of American Medical Colleges. (2010). AAMC Center for Workforce Studies, June 2010 Analysis.

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Future demand for NPs and PAs



Pending Physician Shortage

- Physician shortage now projected by 2025 after years of projecting surplus
- Waive of physician retirements in near future
- Medical schools not keeping up with demand; they average ~16,000 graduates per year since early 1980s
- International physicians picking up some, but not all, of the shortfall
- Aging population needing more health care services

Solutions

- Increase medical school enrollments
- Expand NP and PA roles



Source: American Medical Association. (2009). Physician characteristics and distribution in the United States.

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Physician leaders surveyed

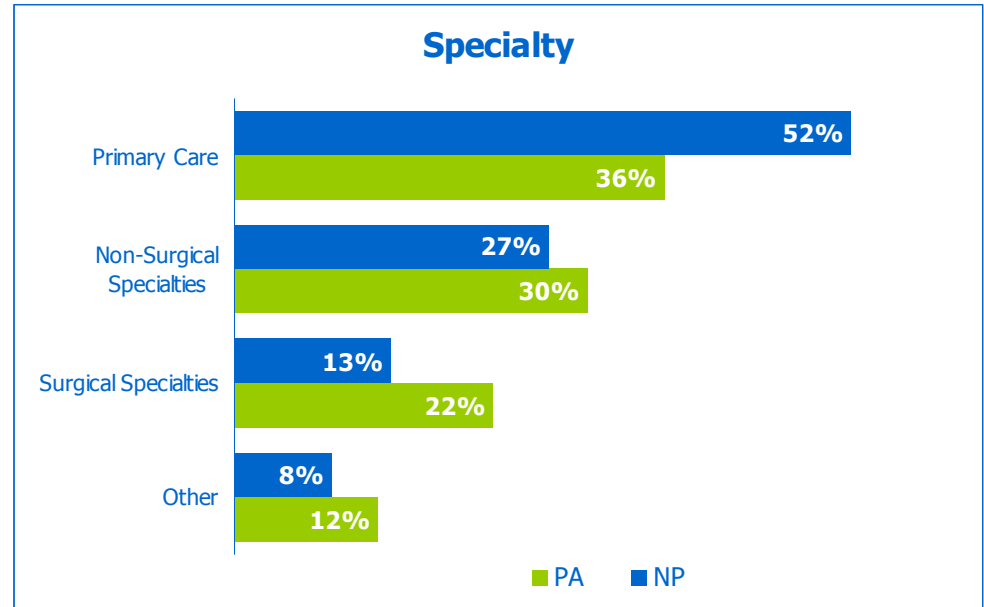
- Sixty-five percent say the expanding role of APPs in healthcare is positive.
- APPs filling a critical role in today's healthcare system.
- Nearly all surveyed remain concerned about the increasing shortage of primary care physicians.
- Recent studies suggest that the number of APPs may not be enough to fill expected provider shortages.



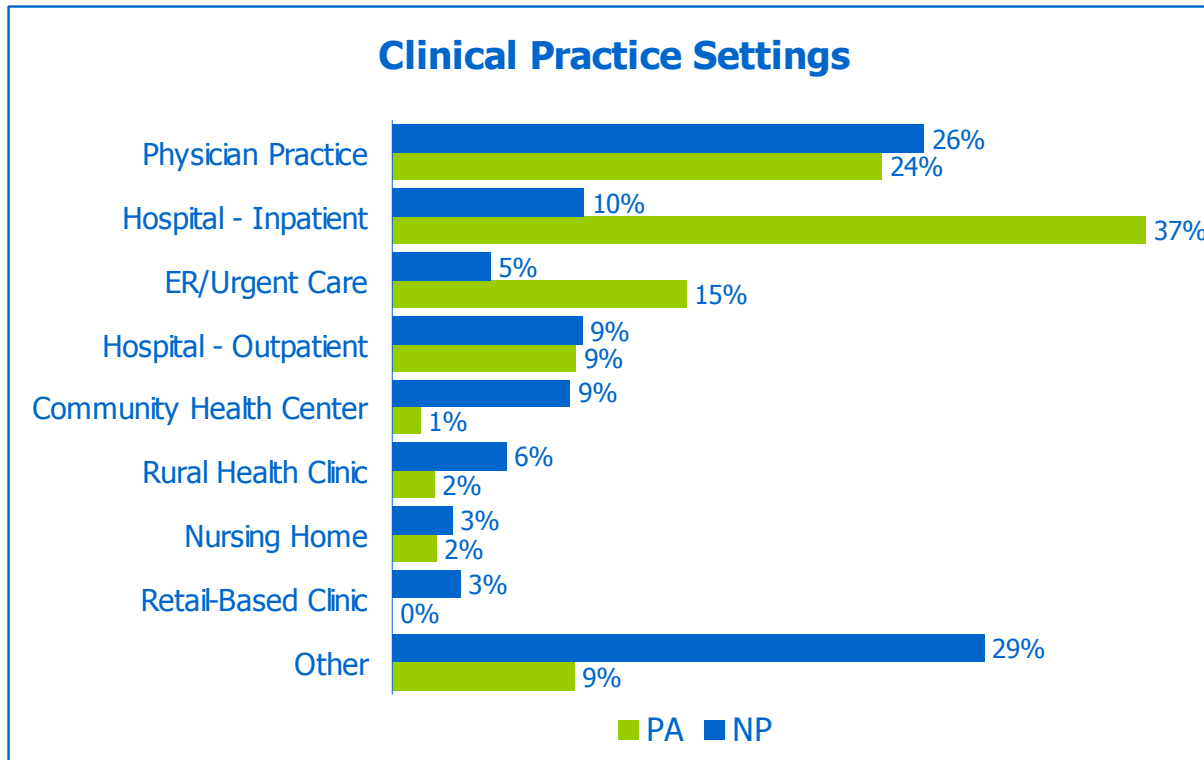
Overview of NPs and PAs

	NPs	PAs
In practice	~127,000	~68,000
Change since 2000	+34%	+70%
Graduates per year	~8,000	~5,600
2000 physician ratio*	7–1	16–1
2008 physician ratio*	6–1	11–1
% female	94%	64%
Average income	~\$90,000	~\$90,000

* Physician count based on physicians involved in patient care only



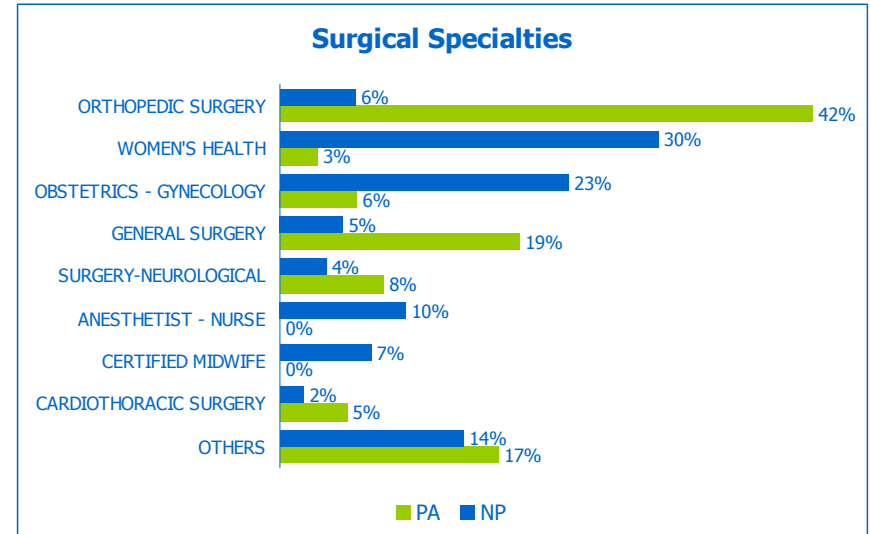
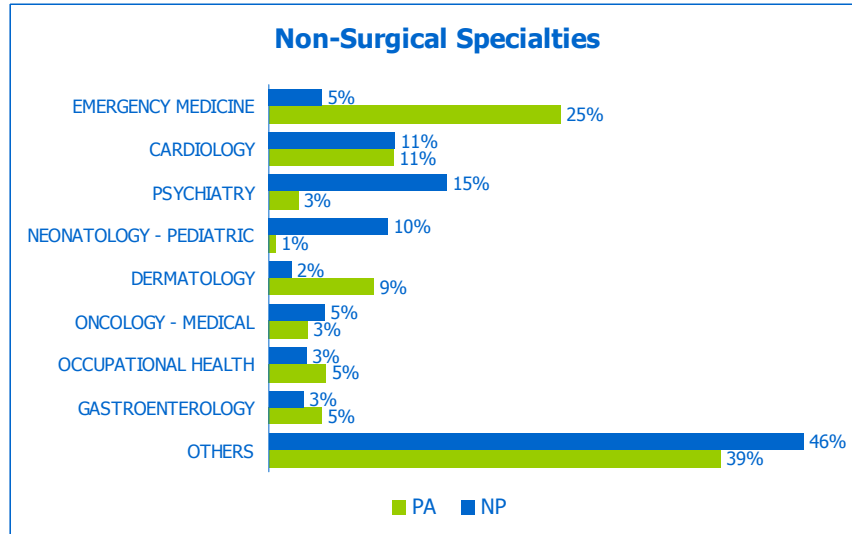
Practice settings



- NPs: Primarily office-based practice
- PAs: Large presence in hospital setting



Specialty comparisons

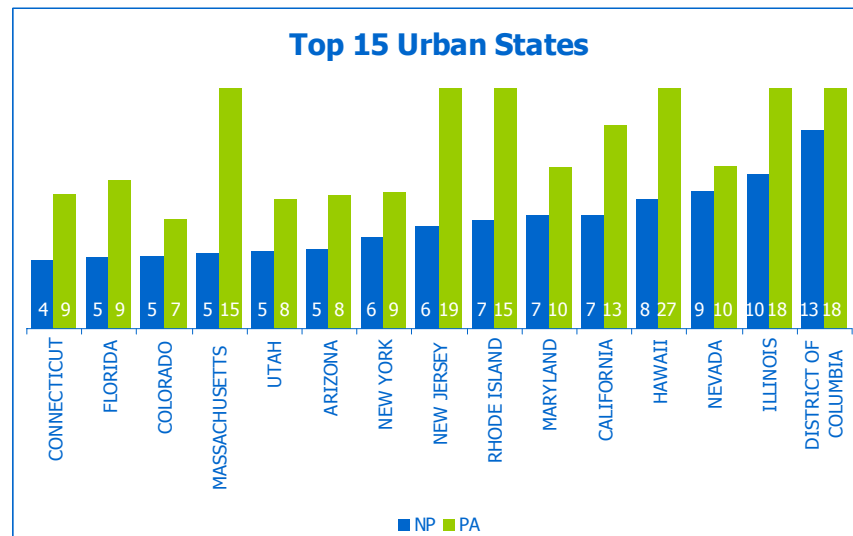
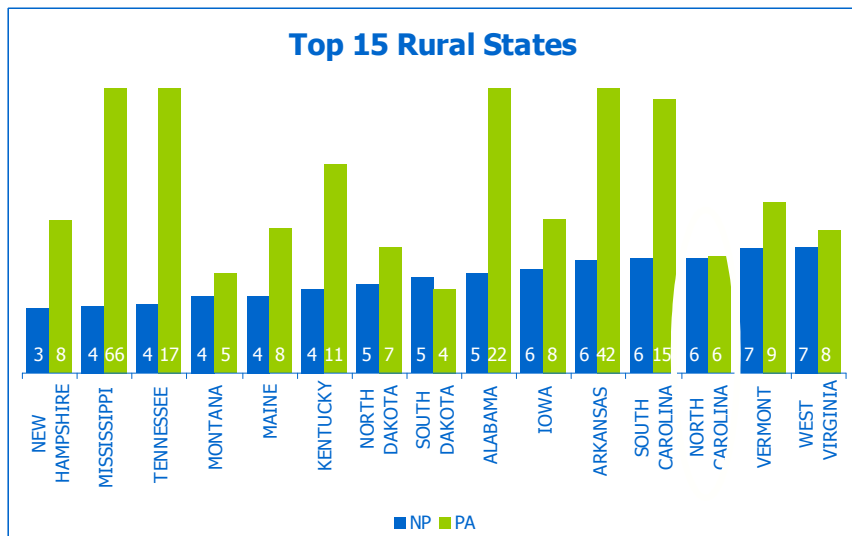


- NPs: ~34,000
- PAs: ~15,000

- NPs: ~17,000
- PAs: ~21,000



Penetration: MD–NP ratio and MD–PA ratio



- Rural states remain the stronghold for NPs.
- Federal rural health clinic program encourages use of NPs and PAs; higher Medicare and Medicaid reimbursement levels.
- PA ratios relatively the same for rural vs. urban.

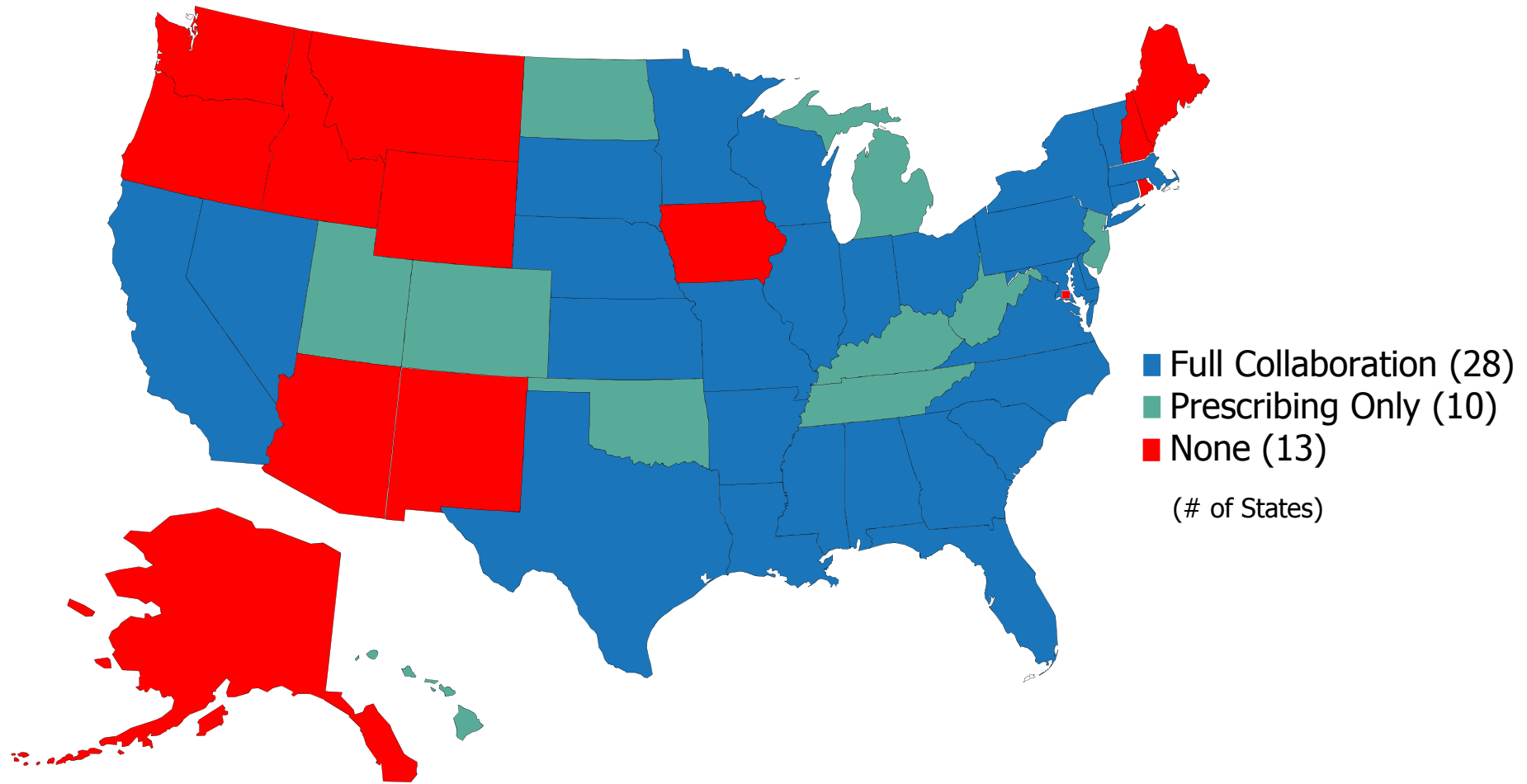
Overall Ratios

State	NP	PA
Rural	5–1	10–1
Urban	6–1	11–1
Other	6–1	10–1

Note: Urban means >84% of state population urban; rural means <64% of state population urban; physician count based on physicians involved in patient care only



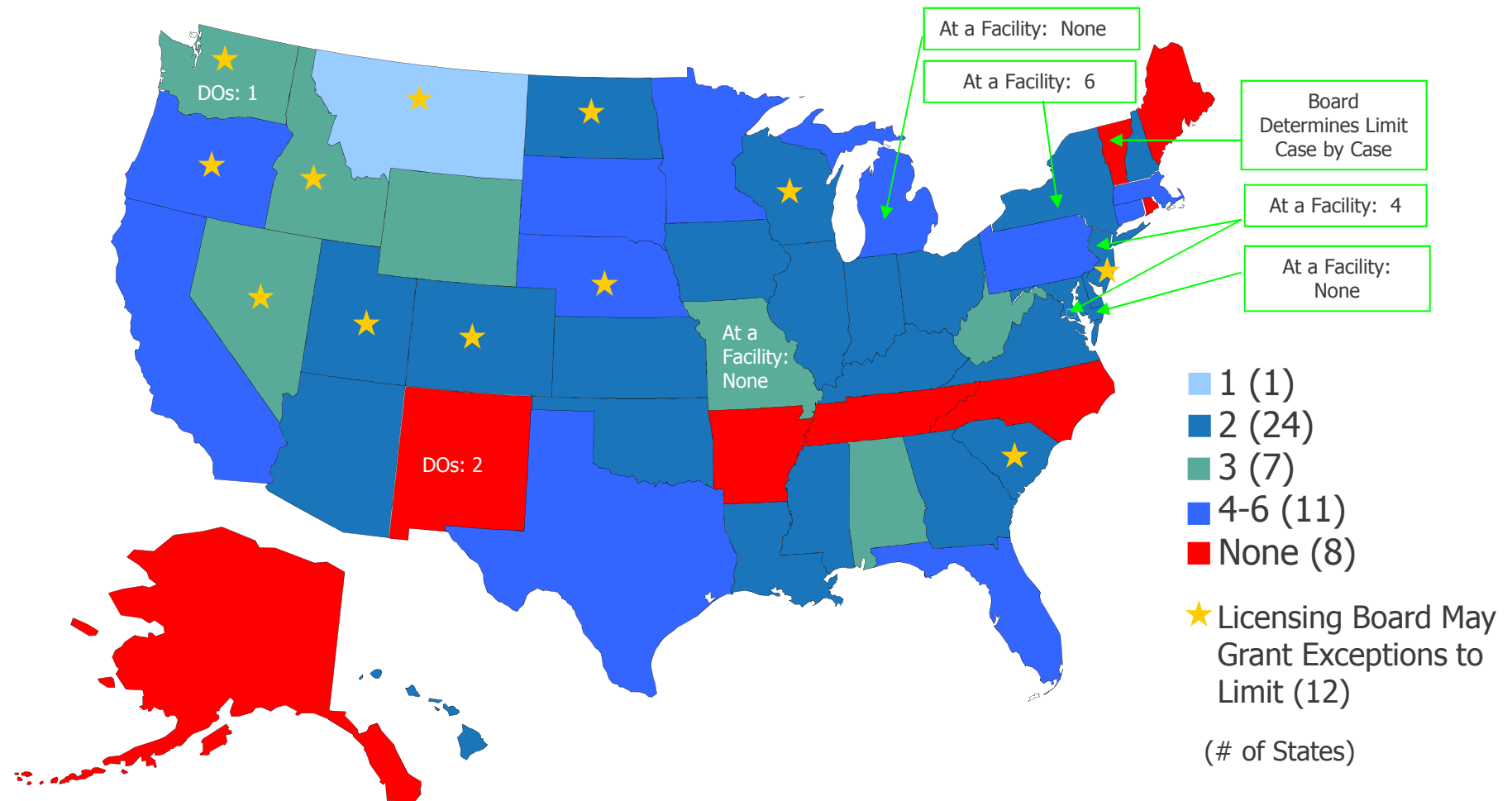
Physician–NP collaboration requirements



Source: The Pearson Report. (2009, February). *The American Journal of Nurse Practitioners*, 13(2).

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Physician-PA supervision limit



Economics of NPs and PAs

- Productivity of NPs and PAs is comparable to physicians.
- Range of services approaches 90% of what primary care physicians provide.
- Education time is approximately half that of a medical doctor.
- Entry into the workforce is less restrictive.
- Cost-effective utilization.

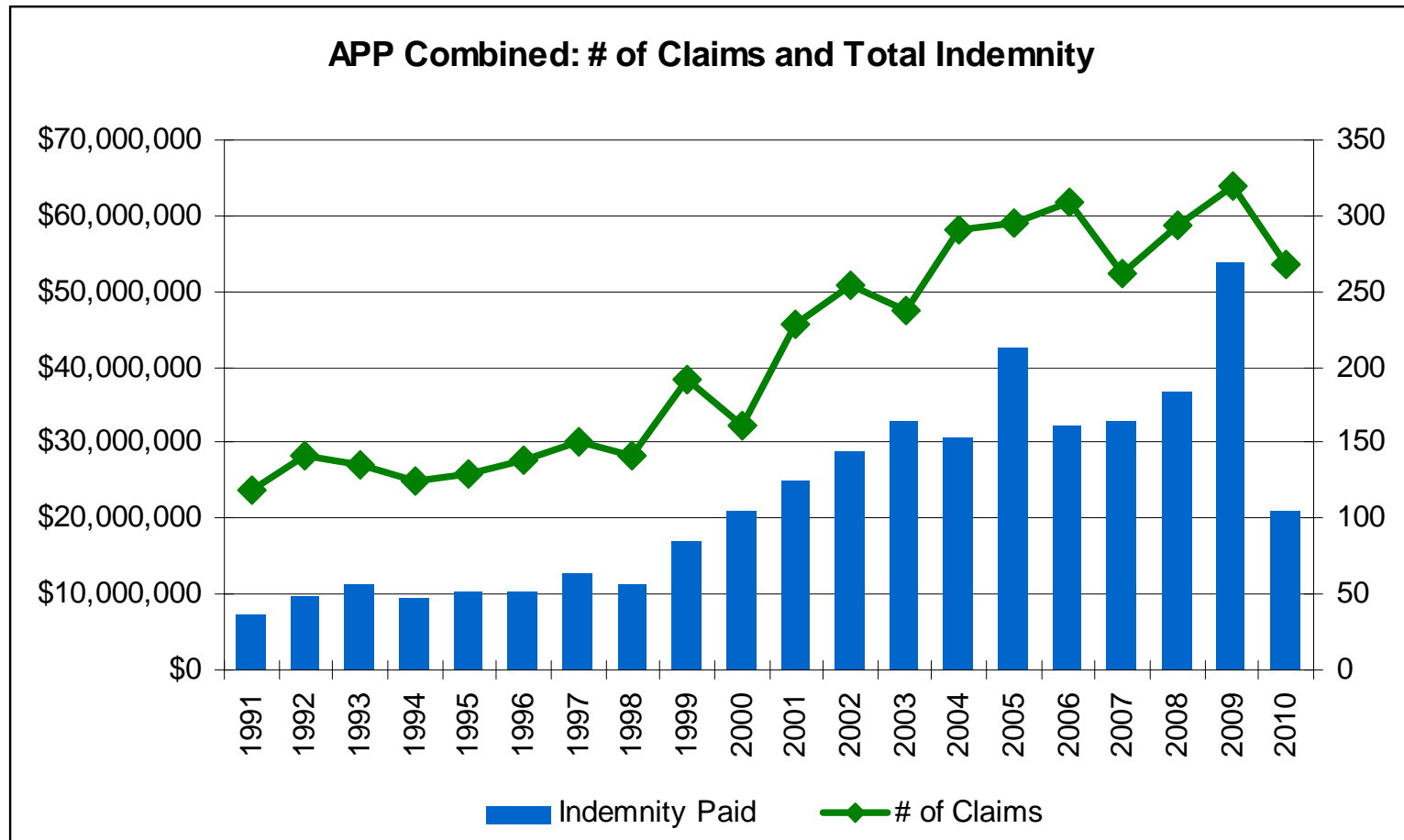


Benefits in delivering care

- Improved patient outcomes — chronic care, primary care, population disease management
- Increased time spent listening to patients and answering questions
- Decreased utilization and cost
- Improved documentation



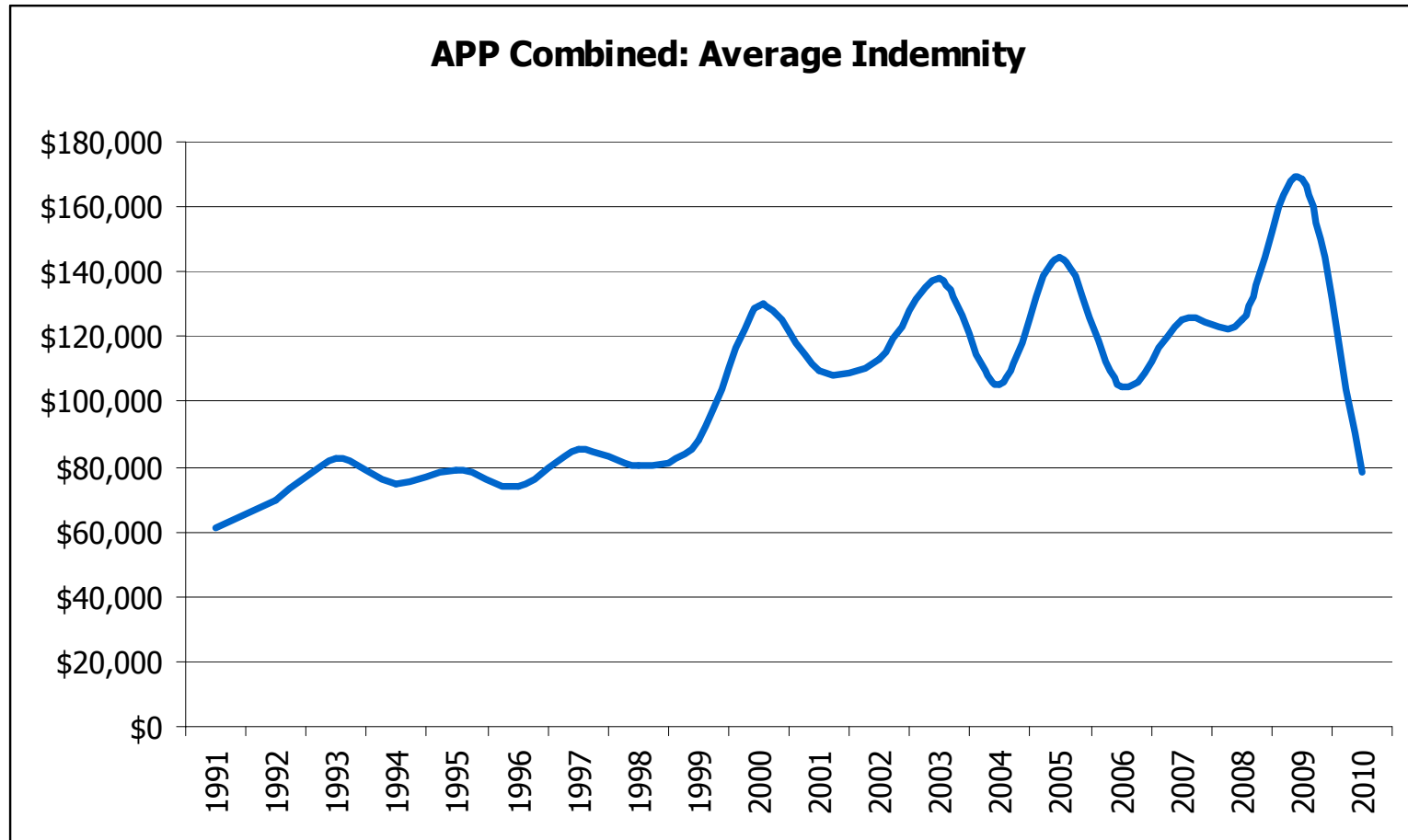
NPDB APP claims comparison



Source: National Practitioner Data Bank, Public Use File, 2011.

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NPDB APP claims comparison

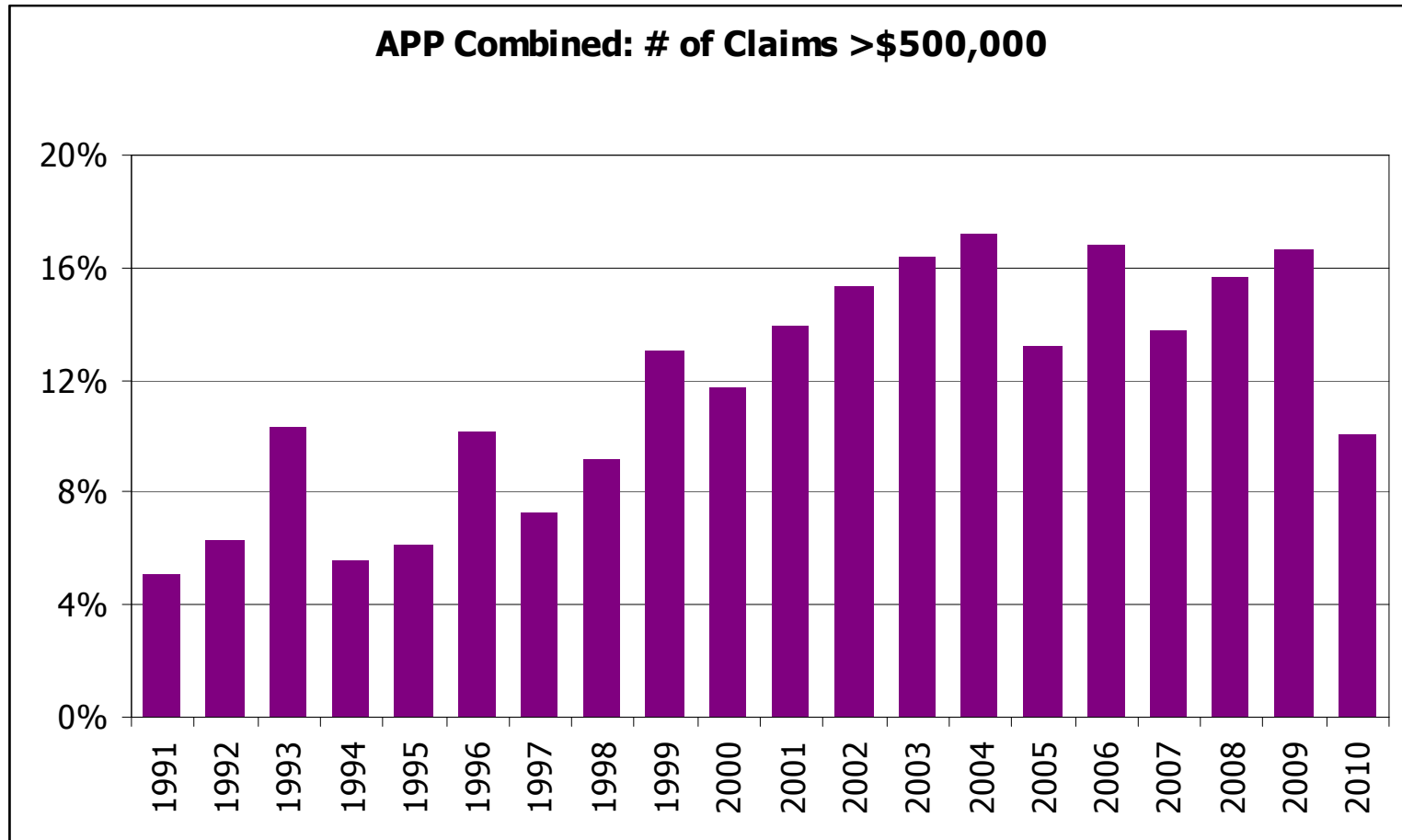


Source: National Practitioner Data Bank, Public Use File, 2011.

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NPDB APP claims comparison



Source: National Practitioner Data Bank, Public Use File, 2011.

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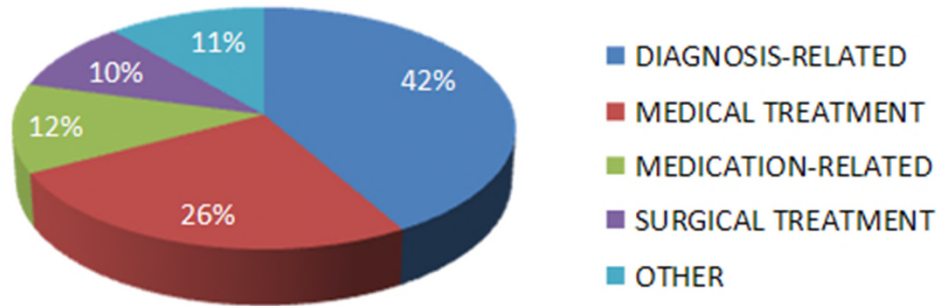
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Bridging the Gap

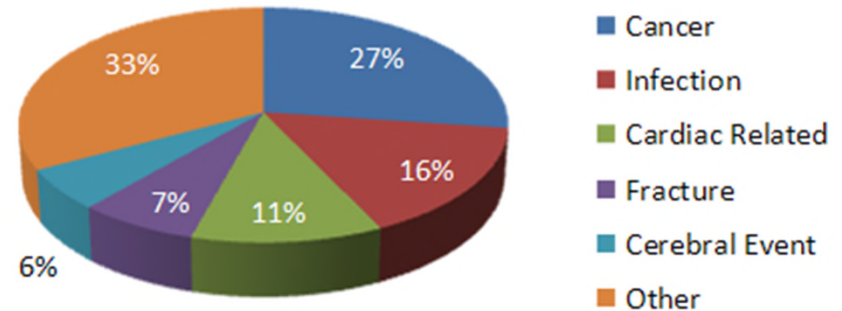


Claim types

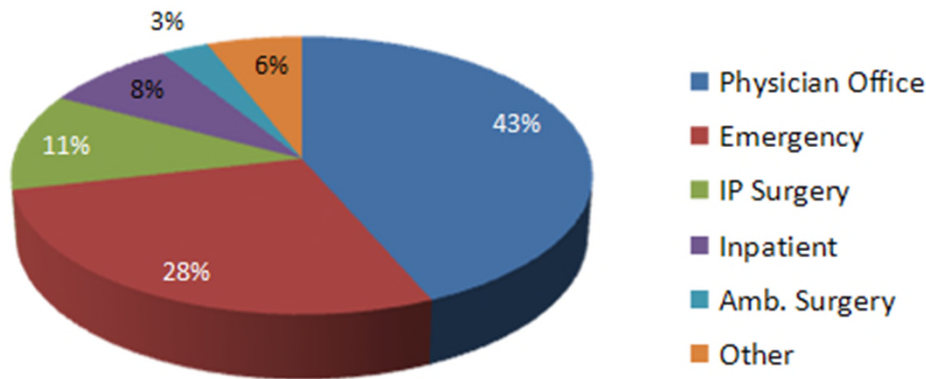
APP Allegations Frequency



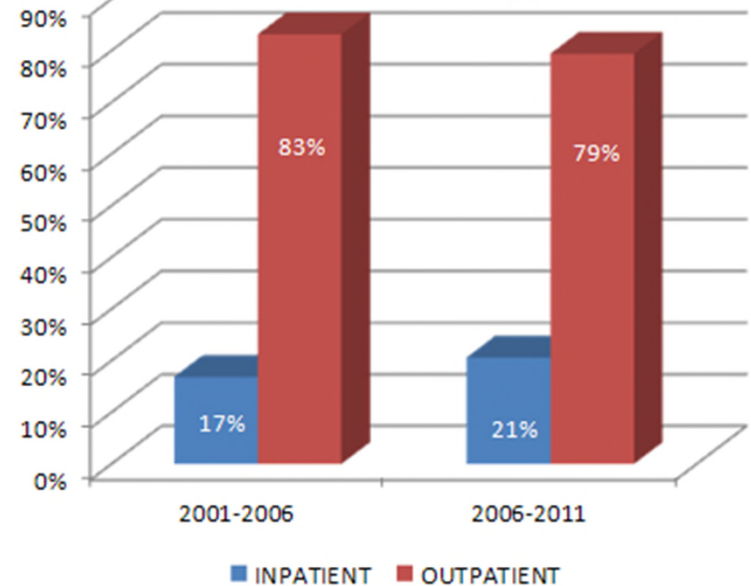
APP Diagnostic Allegations



APP Claim Locations



APP Claimant Type



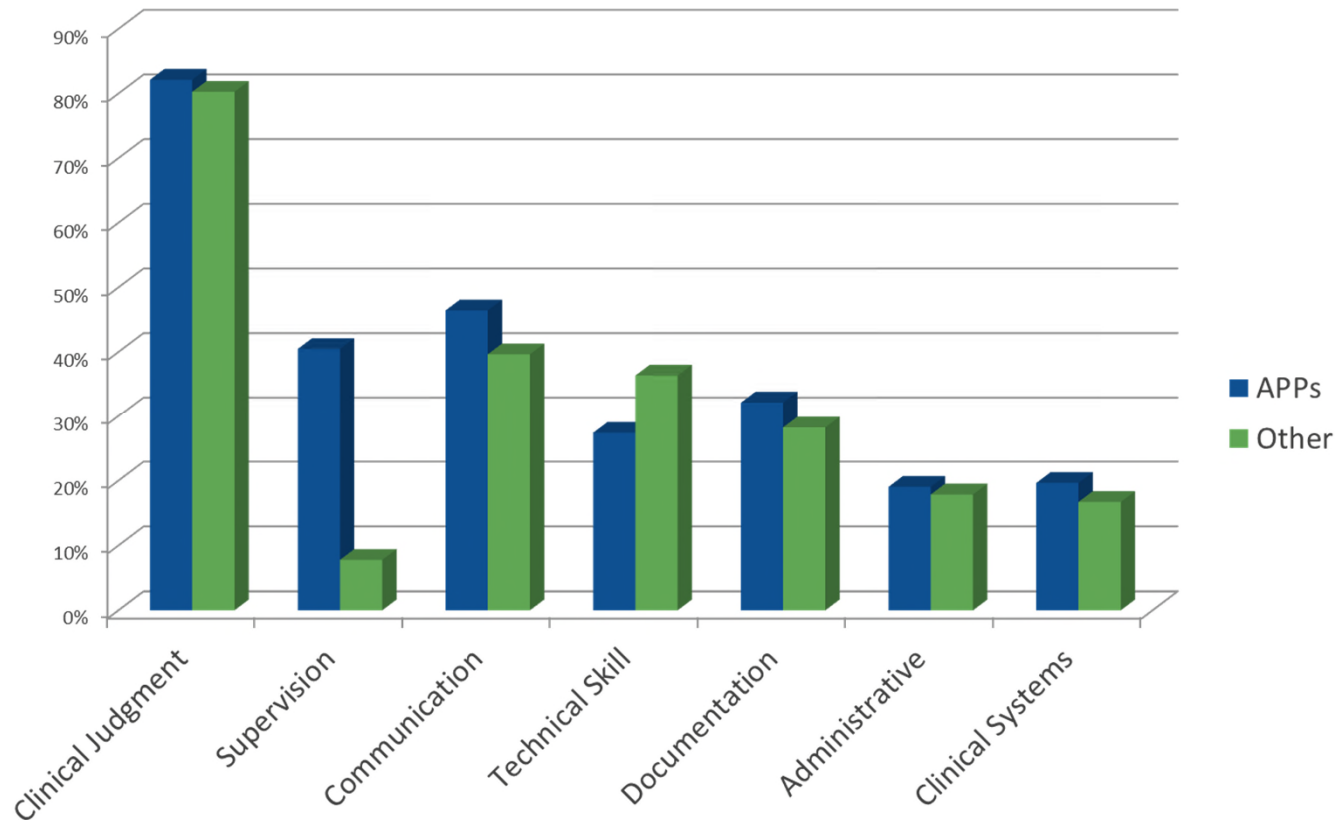
Source: Medical Protective claims data, 2001–2011

Clinical risk management: Goes without saying

- Better history taking and physical exam
 - Listen better/longer
 - Consider other diagnoses in face of nonimprovement
 - Document well
 - Refer when appropriate
 - Communicate better
 - Ensure patient understanding
 - Ensure providers understand what you know
 - Ensure you understand what they know
 - Timely ordering of tests
 - Appropriate tracking and follow-up
-*among other things*



Contributing factors



- Patient assessment failures — Narrow diagnostic focus
- Delay in ordering consult
- Lack of supervision
- Provider-to-provider communication failures
- Documentation inconsistent with physician
- Policies and procedures not followed

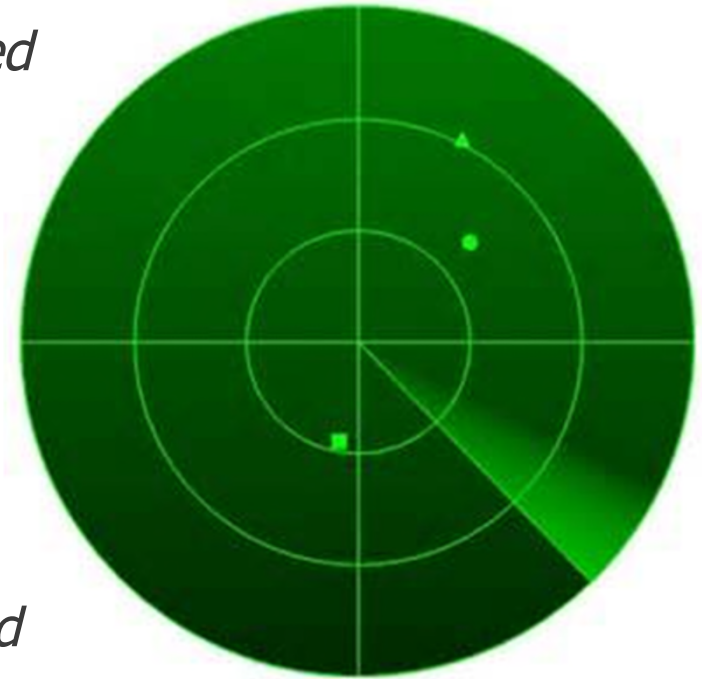


Source: Medical Protective claims data, 2001–2011

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APPs are no longer flying under the radar . . .

"Much of today's healthcare is being performed by persons who are not Physicians These healthcare providers often over-reach their qualification levels and fail to consult with physicians who are supposed to monitor and supervise them. Many of today's malpractice claims are arising out of nurse practitioner and physician assistant negligence...."



Organizational assessment to include:

- Culture/knowledge/structure
- Scope of practice
- Practice agreements
- Credentialing, peer review, competency
- Supervision/communication
- Billing and compliance



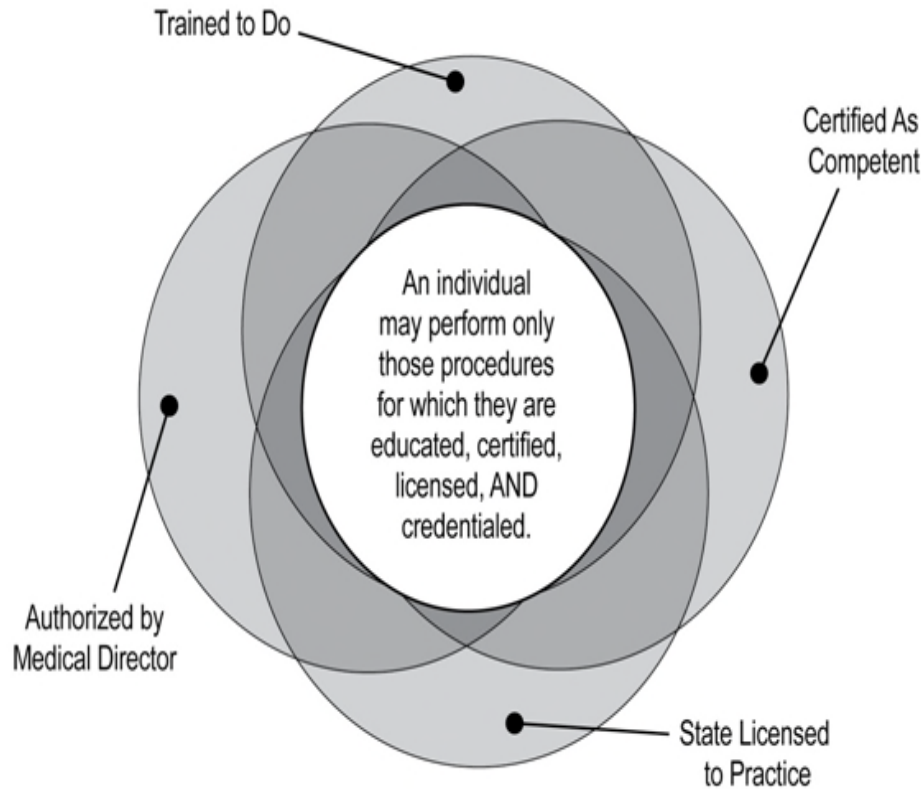
Culture/knowledge/structure challenges



- Identifying the goal of hiring
- Staff awareness
- Isolation from existing information sharing
- Lack of feedback mechanisms
- No involvement in medical staff committees
- Not aware of policy/protocol changes

- Maintain an accurate list of all of the APPs in your organization.
- Include APPs as voting/nonvoting members in medical staff meetings.
- Provide a forum for periodic review of issues.
- Include APPs in CME activities.
- Ensure clinical policies and procedures are consistent with APPs' scopes of practice.
- Include APPs in departmental meetings, committees, peer review, and quality improvement initiatives.

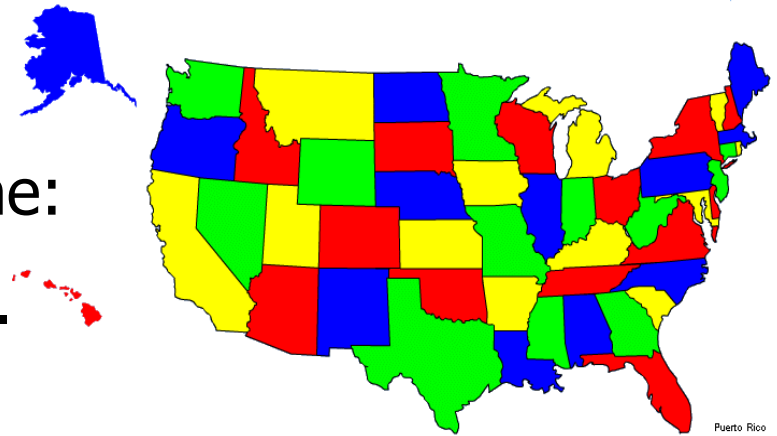
Scope of practice



- Missed opportunities in the hiring/credentialing process
- Failure to understand specifics
- Coverage issues between different roles
- Prescribing authority
- Procedures

Risk strategies

- Know state regulations.
- Organizational policy should define:
 - Supervision and collaboration.
 - Agreements with physicians.
- Know accreditation requirements.
- Confirm job responsibilities.
- Emphasize credentialing, proctoring, and supervision.
- Educate staff about APPs' scopes of practice.



Practice agreements

- Failure to define specific agreements at the state level
- Lack of consistent naming conventions/terminology
- Lack of awareness about APP to physician supervision ratios
- Scope of practice not carefully defined
- Organizational policies in conflict

Risk strategies

- Determine each APP's patient care services based on credentials, experience, and skills (in accordance with state scope of practice regulations).
- Tailor practice agreements as appropriate for individual APPs.
- Ensure completeness of all practice agreements.
- Identify practice settings and patient populations.
- Define what clinical situations require physician consultation.
- Audit prescribing, clinical assessment, and treatment decisions.
- Make sure you adhere to the practice agreement.



Credentialing/peer review/competency issues

- Failure to follow credentialing requirements
- Lack of bylaws, rules, regulations, and credentialing procedures that address APP roles
- New skills obtained are not within scope of practice
- Prior specialization
- Scope exceeds agreement
- Turnover is higher than for physicians



- Secure required information for credentialing prior to approval and any provision of services.
- Monitor and evaluate the conditions of the collaborative and/or supervising agreement.
- Monitor to satisfy employment, credentialing, OPPE, and billing requirements.
- Have APPs create and maintain a complete professional file.
- Ensure APPs are current with certifications and competency for procedures.

Supervision/communication with physician

"Failure to contact the collaborating physician is one of the top four allegations in lawsuits against physician extenders and their supervising physician."

Others:

- Practicing beyond scope
- Lack of supervision



Risk strategies

- Supervision/communication are critical to mitigating risk — poor oversight may result in the appearance of a profit motive.
- APPs and their supervising or collaborating physicians should meet on a regular basis.
- **ALL** care providers must be clear on the delineation of roles.
 - Handoffs.
 - Tracking and follow-up.
- Degree of oversight may decrease over time.
- Make sure patients are informed and understand who is providing their care.



Corporate compliance and billing requirements apply to APPs the same as they do to physician providers:

- Medical necessity requirements
- Documentation of service
- Necessary licenses
- Appropriate certifications
- Appropriate training
- Excluded provider status
- “Incident to” billing



Risk strategies

- Include APPs in corporate compliance training.
- Include APPs in all compliance reviews.
- Review all APPs and the services they provide as part of billing audits.
- Review individual HMO contracts and state Medicaid regulations for specific billing requirements.
- Include APPs in documentation training (new EHR) and audits.
- Ensure that the services that APPs are performing and billing are allowed by state law.



Is your organization prepared to utilize APPs?



1. Do APPs participate as team leaders and team members of an interdisciplinary, collaborative team that provides comprehensive health and medical care?
2. Do APPs participate in organizational quality improvement reviews, including systematic reviews of medical records and treatment plans on a regular basis?
3. Is there a process for the systematic collection of practice data specific to APP activities that is included in the organization-wide quality improvement program?
4. Does your organization have a mechanism in place to monitor and track required APP continuing education and their compliance with certification/re-certification requirements?
5. In states where it is required, does your organization have written practice protocols regarding APP supervision?
6. In states where it is required, does your organization have written practice protocols clarifying practice and prescriptive authority?
7. Does your organization have a process in place for credentialing APPs that complies with credentialing requirements for all individual managed care organizations?
8. Is there a process in place to monitor compliance with ongoing changes in state regulations relative to APPs' scope of practice?
9. Are there written guidelines addressing physician signatory verification of APPs' care that are compliant with Medicare Conditions of Participation Title 42, Section 485.631?
10. Does your organization have a clearly defined process for granting clinical privileges to APPs?
11. Are there specific written guidelines in place that outline the requirements for communication regarding seeking additional consultation when transfer of patient care to a physician is needed?
12. Is there a peer review process in place that is specific to peer review of APPs conducted by APPs?
13. Is there a process for validating, on an ongoing regular basis, the APP's competency and skill of performing clinical procedures that are within their scope of practice?
14. Does your organization use the same language throughout the organization when referring to APP? For example: "One of our [mid-level providers, physician extenders, advanced practice providers] Terry, a [APRN, CRNA, PA, Nurse Mid-wife, Clinical Specialist] will be seeing you later today."
15. Have you reviewed any collaborative agreements that may exist between an APP and a physician?
16. Is your organization in compliance with Medicare/Medicaid billing guidelines for APPs?
17. Is there documented evidence of regular meetings between APPs and the supervising physician(s)?
18. Are regular site visits conducted of facility-owned practices that utilize APPs?

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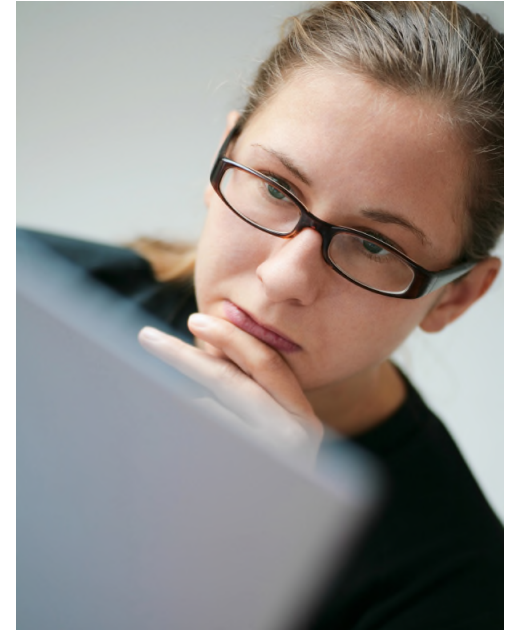


Case study



State-specific resources

- Nursing Boards by State
<https://www.ncsbn.org/contactbon.htm>
- Nurse Practitioner Legislation by State
http://www.npfreebies.com/ajnp_pearson09.pdf
- Physician Assistants Legislation by State
http://www.aapa.org/the_pa_profession/federal_and_state_affairs/resources/item.aspx?id=755
- Prescription Monitoring Programs by State
<http://www.nascsa.org/rxMonitoring.htm>



Resources

- North Carolina NP and PA Compliance Review Templates
http://www.ncmedboard.org/notices/detail/compliance_reviews_for_physician_assistants_and_nurse_practitioners_in_nort/
- Nurse Practitioners in Primary Care
<http://www.aanp.org/images/documents/publications/primarycare.pdf>
- Competencies of the Physician Assistant Profession
http://www.aapa.org/uploadedFiles/content/Your_PA_Practice/Clinical_Policy/Resource_Items/31-CompetenForProf.pdf
- Credentialing Center for Advanced Practice Nursing and Allied Health (Vanderbilt University)
<http://www.mc.vanderbilt.edu/root/vumc.php?site=CAPNAH&doc=22034>



Resources

- Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services (OIG Report, 2009)
<http://oig.hhs.gov/oei/reports/oei-09-06-00430.pdf>
- Advanced Practice Nurses and Physician Assistants, Medicare Learning Network Products
https://www.cms.gov/MLNProducts/70_APNPA.asp
- AMA Scope of Practice Data Series — Nurse Practitioners (October 2009)
<http://www.aanp.org/images/documents/state-leg-reg/08-0424SOPNurseRevised%2010-09.pdf>



What questions do
you have?



Thank You!

Disclaimer

The information contained herein and presented by the speaker is based on sources believed to be accurate at the time they were referenced. The speaker has made a reasonable effort to ensure the accuracy of the information presented; however, no warranty or representation is made as to such accuracy. The speaker is not engaged in rendering legal or other professional services. If legal advice or other expert legal assistance is required, the services of an attorney or other competent legal professional should be sought.



THANK YOU for your participation!

Please take a few minutes to answer
the polling questions.

Watch for our next webinar
in spring 2014.

