Optimal Utilization of PAs

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Objectives

- Review scope of practice for PA providers
- Discuss current best practice models
- Discuss opportunities for utilization of PAs

Physician Assistants practice

- Physician Assistants are health care professionals licensed to practice medicine in a team based model.
- PAs are educated in the medical model designed to complement physician training.
- Only 4 professions are licensed to practice medicine: MD, DO, DPM, and PAs
- There are about 3,000 licensed PAs in Ohio
- CCHS employs almost 400 PAs with > 45 open positions at this time

PA Education

- Over 173 accredited physician assistant programs
- All educated PAs to be generalist in medicine
- All accredited by ARC-PA
- Housed in schools of medicine or allied health
- Education based on medical model
- Full time study: 27 to 32 months
- Builds on prior knowledge in various health fields

  (www.aapa.org)

PA's Certification

- In all 50 states, a physician assistant must pass the national certification examination (PANCE).
- Certification by one organization – NCCPA.
- Must re-certify every 6 years with the NCCPA - PANRE exam. (beginning in 2014, 10 yr recert)

  (www.nccpa.net)

- Must acquire 100 CME every 2 years to maintain registration and certification. (same requirements as a physician). 12 additional hours required in pharmacology CMEs to maintain CTP

Licensure and Certification

- PAs
  - Masters prepared
  - Nationally certified –NCCPA in general medicine; specialty upon graduation
  - Licensed to practice medicine thru OBM
  - Certificate to prescribe
  - Function with a supervision agreement
  - Recertifies every 6 yrs
- APNs
  - Masters or doctorally prepared
  - Nationally certified in specialty (adult, peds, acute care…)
  - Granted certificate of authority by OBN
  - Certificate to prescribe
  - Function under collaboration agreement

Ohio Law

- http://www.med.ohio.gov/pdf/statutes/4730.pdf
- ORC: 4730

The Law governing PA's in Ohio

- 4730.02. Prohibitions.

(A) No person shall hold that person out as being able to function as a physician assistant, or use any words or letters indicating or implying that the person is a physician assistant, without a current, valid certificate to practice as a physician assistant issued pursuant to this chapter.

(B) No person shall practice as a physician assistant without the supervision, control, and direction of a physician.

(C) No person shall act as the supervising physician of a physician assistant without having received the state medical board's approval of a supervision agreement entered into with the physician assistant.

This includes RAs, RNFAs, etc.

Supervising a PA

- 4730.08.

(A) A certificate to practice as a physician assistant issued under this chapter authorizes the holder to

practice as a physician assistant, subject to all of the following:

(1) The physician assistant shall practice only under the supervision, control, and direction of a physician with whom the physician assistant has entered into a supervision agreement

approved by the state medical board under section 4730.17 of the Revised Code.

Physician Supervision Agreement

- PA's work with a physician supervision agreement or plan, approved by OSMB.
- PA's work with autonomy, with direct, in-direct, off site supervision.
- PA's may see new patients, new conditions, without physician present.
- No co-signature of notes or orders

Physician Supervision Agreement

- All Physicians supervising a PA must have a Physician supervision AGREEMENT (Hospital based), or PLAN (private practice), approved by the OSMB
- Link for supervision agreement: http://www.med.ohio.gov/pdf/Applications/physician_assistant/PAsupervisionagreement.pdf
- Link for addendum to add a PA to supervision agreements: http://www.med.ohio.gov/pdf/Applications/physician_assistant/PAaddendumsupervisionagreement.pdf
- Link for supervisory PLAN: (non health care facility): http://www.med.ohio.gov/pdf/Applications/physician_assistant/PAsupervisoryplan.pdf

PA prescriptive authority

- In all 50 states PAs may prescribe
- PA's in Ohio are able to prescribe; schedule II, III, IV and V.
- Must have master's degree to be eligible in Ohio for practice and prescribing
- Follows PA Formulary
- Formulary may be found on OSMB website
- www.med.ohio.gov

PA Privileging Process

- All PA's must be privileged prior to beginning practice *JC standard, Jan. 04; JC just confirmed must be the same process as medical staff (1/11)
- PAs fill out AAHP (application for allied health professionals) provider packet
- All references & primary sources are checked through credentialing office
- PA Privileging committee reviews and recommends
- Board of Governors committee approves
- No special privileges given within the first 90 days unless attestation from previous supervising physician
- Must be completed within 90 days of receipt of packet

PA Privileges

- Core
  - History & physical
  - Order diagnostic tests & therapies
  - Prescribe (with CTP) according to formulary
  - Re-evaluate and modify plan of care
  - Additional procedures (ORC 4730)
  - Assist in surgery
- Special Procedures
  - May be granted additional special privileges based upon education, competency by hospital credentialing body

SPECIAL PRIVILEGES

- Must show competency for additional procedures before obtaining privilege:
- Example: LP, Joint injections, harvesting veins, IABP, sheath removal, jugular lines, Arterial lines. Etc.
- QA must be done; so many procedures observed, so many done with direct observation
- Reference material

Practice Guidelines

- **PA**
  - Practices with physician supervision: Direct, in-direct or off site
  - Oversight by State medical Board
  - Physician available within 60 minutes
  - Works with autonomy; stand alone clinics;
  - Sees new patients, follow up, chronic conditions
  - Privileged by BOG
  - Privileged to perform special procedures
  - Governed by hospital policies

- **APN**
  - Practices with collaboration agreement with physicians
  - Oversight by Ohio Board of Nursing
  - Physician does not have to be onsite; must be available by telecommunications
  - Works with independence; stand alone clinics;
  - Sees new patients, follow up, chronic conditions
  - Privileged by BOG
  - Privileged to perform special procedures
  - Governed by hospital policies

Scope of Practice

- Perform H&P
- Diagnose & treat
- Develop & implement plan of care
- Order medications, Dx tests & therapies
- Advanced procedures
- Care coordination & communication
- Patient follow up
- Patient rounding
- Patient /family education
- Discharge planning/post discharge management
- Compliance with core measures, quality protocols (VAP, sepsis)
- Assist in OR
- Facilitate documentation
- Research support

Scope of Practice
Direct (patient) services

- Licensed Providers
- Recognized by all payors (85-100%)
- Perform H&P
- Order medications, Dx tests & therapies
- Develop & implement plan of care
- May admit patients to physicians service
- Coordination of care & discharge planning
- Patient education
- Perform advanced procedures
- Day of discharge management

Indirect (patient) services

- Pt follow ups:
  - Medication refills
  - Phone calls
  - Pt education
  - Coordination of care of the pt: referrals, transfers
  - Review labs
  - Med authorizations
  - Disability forms
  - Discharge summaries
  - Support of infusion services
  - Improved documentation
  - POA (present on admission)

Outpatient Practice Models—Independent/Autonomous Practice

- Practice Model
  - Own schedule of new and former pts
  - Focus on chronic disease mgmt, health promotion, pre & post-op mgmt.
  - Bill under own name & number (85-100%)
- Value:
  - ↑ billable revenue
  - ↑ patient access
  - ↓ wait times for pts
  - ↑ pt satisfaction
  - ↑ physicians productivity

Outpatient Practice Models—Shared Service Model

- Team approach– MD/PA team
- Facilitates communication with patients, caregivers
- Improves patient satisfaction
- Improves transitions of care--↑ pt safety
- Maximizes utilization of providers skills
- Increases physicians productivity
- Increased revenue (100% reimbursement)

Inpatient Models of Care
Service Line

- Member of multidisciplinary care team
- Daily rounding, progress notes, implement plan of care
- Assure compliance with CORE measures, documentation of POA indicators, VTE prophylaxis
- Decrease unnecessary testing
- ↑ nursing satisfaction
- Care coordination, promotes earlier discharge, ↓ LOS, decrease Opportunity days
- Provide continuity of care- facilitates communication & handoffs, ↓ risk for error
- Prompt patient assessment → ↑ patient satisfaction
- Prevent complications
- Patient education & follow up → ↓ readmissions

Models of Care

Key Metrics	OUTPATIENT / AUTONOMOUS	INPATIENT/OUTPATIENT SHARED SERVICE	INPATIENT SERVICE LINE
Cost	• Billable revenue • Physician productivity • PA & Physician satisfaction	• Physician productivity • PA & Physician satisfaction	• Physician productivity • PA & Physician satisfaction
Quality	• Patient Safety / Quality	• Patient satisfaction • Patient Safety / Quality • LOS • Readmissions	• Patient Safety / Quality • Patient satisfaction • Readmissions • Opportunity Days • LOS
Access	• Patient access • Patient wait times	• Inpatient management and throughput	• Inpatient management and throughput

Outpatient model

- Orthopedic/Rheumatology Institute:
  - Same day appointments
  - PA has own schedule in EPIC
  - Patient can schedule with PA
    - Increase access
    - Increase patient satisfaction

Cardiothoracic Surgery
CORE & Quality Indicator Measures

- Core Measures on HF & AMI equal to or exceeded Medicine Institute (Physician Scores)
- Quality indicator Measures compliance equal to or exceeded Medicine Institute (Physician Scores)

Hospital/service line model

- HOSPITAL SERVICE
- PA responsibilities/schedule:
- **Arrives to office @ 6:45am**
- **Reviews inpatient records, nursing notes, night fellow notes, emails**
- **Rounds autonomously on all her patients**
- **Meets with Fellow, short discussions**
- **Staff arrives on floor**
- **Fellow, PA and Staff round**
- **10:45am to 11:45am: Residents huddle; staff, fellow and PA**
- **Quick lunch**
- **Meet with fellow; discuss patient management**
- **Afternoon is completing discharges, patient orders, management**
- **Sign out to night Fellow**
- **4:30: office: finish emails, documents**
- **5pm: Residents presentations (DDI)**

Tangible productivity measures

- Decrease readmit rates to floors who utilize PAs
- Decrease opportunity days
- Increase patient satisfaction (HCAPS) (Press Ganey)
- Increase physician satisfaction (gallop)
- Decrease documentation errors
- Increase nursing satisfaction (gallop)
- Increase in quality documentation standards: POA, etc.

INPATIENT SERVICE LINE
Low Acuity Clinic (LAC) and Split Flow

- **Model**
  - Level 4 - 5 acuity patients triaged to LAC upon presentation to the ED
  - PAs do all triaging; assessment in triage, order necessary studies
  - 2-3 midlevel providers (M-F; 10am-11pm)
  - >28% of daily ED volume (55,000 / year)

- **Results**
  - Patients **discharged 38% sooner** than similar patients placed in other areas of ED
    - LOS Average = 108 minutes
  - **Overall Patient Satisfaction: 4.90 / 5**
  - **Confidence in Caregiver: 4.95 / 5**

LAC & Split Flow

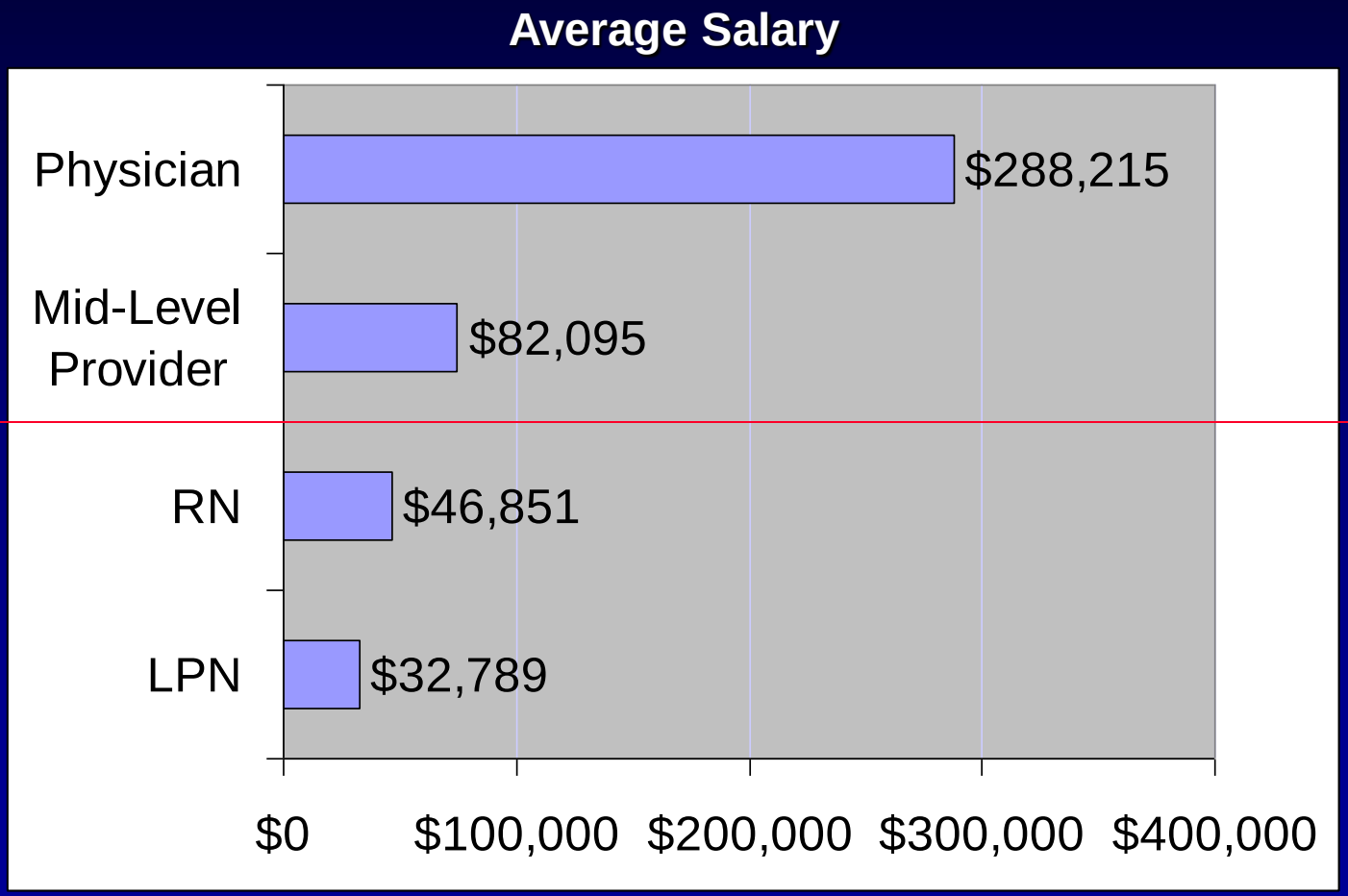
- PA average patient load/week: 300
- PA average % of volume: 28% (24 hr total ED volume)
- LOS average 108 minutes w benchmark target of 90 minutes (level 3 pts seen)
- Avg. arrival to continuing care room from triage: 32 minutes
- 2 PA students every 4 months

How do we expand MLP utilization to further improve cost, quality, and access?

Current CC Staffing levels:

Physician	**>3,000**
MLP	**900**
RN	**11,000**
LPN	**986**

MLPs are reimbursed at 85%-100% of a Physician at 25% of salary*



** CC average annual salary exclusive of benefits*

Opportunities & Challenges

- Measure outcomes
- Educate all providers and administrative personnel re: scope and utilization
- Provide full clinical support of all providers (MA's, rooms)
- Recruitment

Recommendations for the Future

- Utilize staff to peak of licensure
- Involve PAs in quality teams
- Advocate for legislative & reimbursement advances
- Move toward more collaborative practice model supporting PA practice—OPSA, recruitment

Summary

- PAs are low cost reimbursable providers
- Improve patient access
- Quality of care– (core measures, patient experience) equivalent or better than physician only model
- Decrease waste and unnecessary testing
- Maximizes physician productivity

Questions?