PA Utilization and Practice

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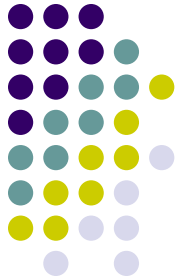
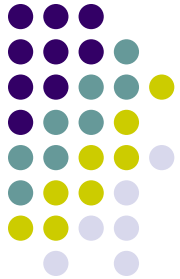
Cleveland Clinic

Objectives:



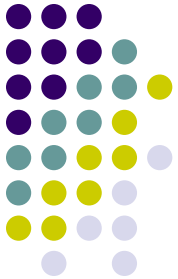
- Review the training, certification, licensure and privileging
- Discuss the new laws (implemented 12/2015) on PA practice
- Discuss measures necessary before a PA begins practice
- Discuss reporting structures of the PA to physicians and administrators

Physician Assistants practice



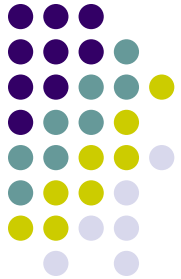
- Physician Assistants are health care professionals licensed to practice medicine.
- PAs are educated in the medical model designed to complement physician training.
- Only 4 professions are licensed to practice medicine: MD, DO, DPM, and PAs

PA Education



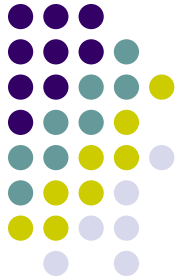
- Over 200 accredited physician assistant programs
- By 2017 projected to be 240 PA programs
- All educated PAs to be generalist in medicine
- All accredited by ARC-PA
- Housed in schools of medicine or health sciences
- Education based on medical model
- Full time study: 27 to 32 months
- Rigorous curriculum
- Builds on prior knowledge in various health fields (*www.aapa.org*)

PA programs in Ohio



- Tri-C/Cleveland State U.
- Baldwin Wallace
- Lake Erie College
- U of Toledo
- Findlay
- U of Dayton
- Kettering
- Marietta
- Mt. Union
- Ohio Dominican U
- Ohio University
- Case Western Reserve Univ
- To open 2017: St. Josephs (Dayton/Cinci area)
- Graduating 30 to 50 students every year
- Competition for seat in program: >800 applicants for 30 or 50 positions

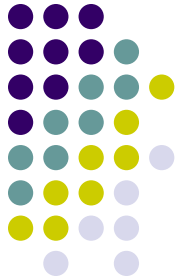
PA's Certification



- In all 50 states, a physician assistant must pass the national certification examination (PANCE).
- Certification by one organization – NCCPA.
- Must re-certify every 10 years with the NCCPA - PANRE exam. (www.nccpa.net)

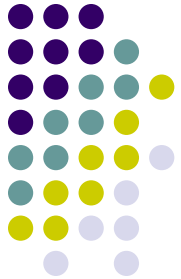
- Must acquire 100 CME every 2 years to maintain registration and certification. (same requirements as a physician).
- 20 hrs. must be PI CME or Self Assessment every two years
- Ohio requires an additional 12 additional hours in pharmacology CMEs to maintain CTP

Physician Supervision Agreement



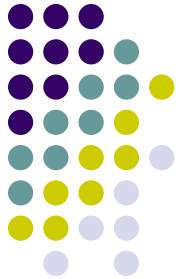
- PA’s work with a collaboration agreement (filed with OSMB)
- PA’s work with full autonomy.
- Physician directs collaboration with PA: off site, on site
- PA’s may see new patients, new conditions, no onsite requirement
- No co-signature of notes or orders

PA prescriptive authority



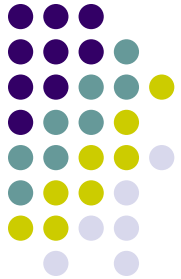
- In all 50 states PAs may prescribe
- PA's in Ohio are able to prescribe; schedule III, IV and V and schedule II.
- Follows PA Formulary

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
- Suggest: PA Privileging committee reviews and recommends (peer review)
- Board of Governors, MEC, BOT committee approves
- Suggest 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

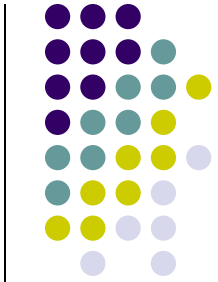
PA Privileges



- Core
- **Anything within the collaborating physicians' scope**
  - History & physical
  - Order diagnostic tests & therapies
  - Prescribe 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; in health care facilities

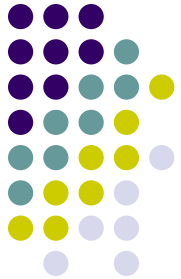
Sample delineation form



- Initial and ongoing assessment of patients' medical, physical, and psychosocial status, including: conducting history and physical assessments, development and implementation of treatment plans, performing rounds, recording progress notes, ordering tests, examinations, medications and therapies, providing consultations, and writing discharge summaries, based on interpretation of data and assisting in surgery.

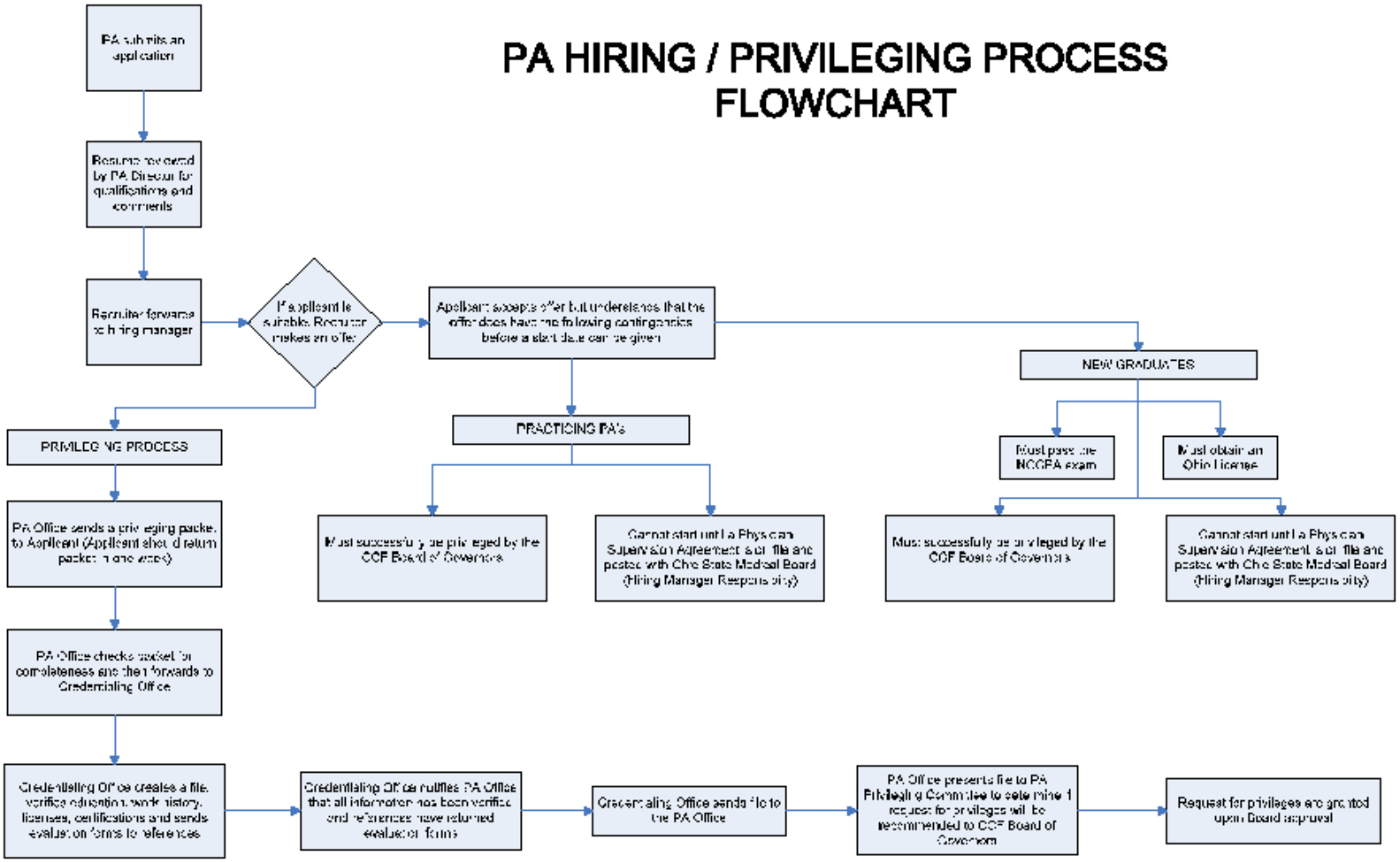
- Other duties may be assigned by the collaborating physician and approved by the privileging process.

Delineations cont.



- All privileges are conducted in accordance with the Supervision Agreement and in accordance with the scope of practice of the supervising physician.
- May also be delineated by health care facility

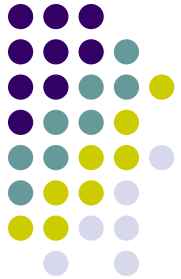
PA HIRING / PRIVILEGING PROCESS FLOWCHART



Our process

- New hire
- PA services sends out packet (electronically)
- Applicant returns packet directly to credentialing
- Credentialing office sends out references; does verifications
- Once completed: PA Privileging committee meets
- Signatures obtained
- Packet and recommendation goes to BOG for final approval
- Letters sent from PA services

Compliance Policies



- Credentialing policy
  - Attached to packet
- Re-Credentialing policy
  - Attached to re-credentialing packet
- QA policy
  - On PA website
  - Ongoing QA: chart review
    - Electronic, twice a year, 10 charts
  - OPPE - ongoing
  - FPPE – ongoing; included in new hire packet to manager
  - Competencies
    - Guidelines given

Methodology: (circle all that apply)	Chart Review – Direct Observation – Interdisciplinary Team – Staff Verbalization
Chart Review: (circle all that apply)	Retrospective – Concurrent – Prospective
Date to be Completed: < 6 months from Appt Date/New Privilege Date	
Evaluator Assigned: (Department Chair or individual assigned by Department Chair)	
Quality Indicators Reviewed: Departmental, Targeted (List)	

□ Focused evaluation not complete for **all** privileges granted.
Reason: _____

Continued focused evaluation as follows:
Period of extended focused evaluation: _____ # Days _____ # Months _____ # Cases

□ Focused evaluation completed. Competency substantiated for all privileges ***with the following exception(s)***:
Privilege: _____
Period of extended focused evaluation: _____ # Days _____ # Months _____ # Cases
Privilege: _____
Period of extended focused evaluation: _____ # Days _____ # Months _____ # Cases

□ Focused evaluation completed. Competency substantiated for all privileges without need for further evaluation.

Comments:

Evaluator's
Signature: _____ Date: _____

COMPLETED FORM TO MEDICAL STAFF CREDENTIALING: 216-445-1521

PA Quality Monitoring Review - REPORTING FORM - The Cleveland Clinic

(Please Print)
PA NAME: _____ DATE: _____

RX #: _____ DEPARTMENT: _____

		Review of Clinical Management										*Review of Pharmacological Standards*						
Patient ID#	Date of Service	Quality of patient assessment	Appropriate DX test	Differential DX	Treatment plan developed	Competence of Tech procedures	Special services	M&M reports/complications	Quality/clarity of documentation	Facilitates team care	E/M coding accurate	Appropriate use of off label drugs	Documented off label drugs in PSA	No drug-allergy interactions	No therapeutic interaction	No drug-disease contraindications	Dosage/duration appropriate	Comments:

PA Signature: _____ Date: _____

PA Printed Name: _____

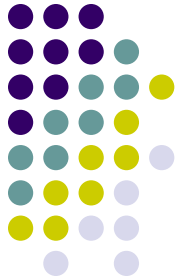
Supervising Physician Signature: _____ Date: _____

Code:
Y = Meets QA
N = Does not meet QA
N/A = Not applicable to practice

Twice a year in first year of employment
Once a year on APR
Once completed, fax to PA office: 216-636-1848, & copy to your Manager.

Rev 01.03.08 jkp

Physician Assistant Competencies: A Self-Evaluation Tool



Rate your strength in each of the competencies using the following scale:

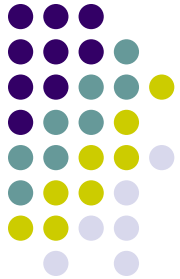
1 = Needs Improvement 2 = Adequate 3 = Strong 4 = Very Strong

MEDICAL KNOWLEDGE

Medical knowledge includes an understanding of pathophysiology, patient presentation, differential diagnosis, patient management, surgical principles, health promotion, and disease prevention. Physician assistants must demonstrate core knowledge about established and evolving biomedical and clinical sciences and the application of this knowledge to patient care in their area of practice. In addition, physician assistants are expected to demonstrate an investigatory and analytic thinking approach to clinical situations. Physician assistants are expected to:

	1	2	3	4
nderstand etiologies, risk factors, underlying pathologic ocess, and epidemiology for medical conditions	☐	☐	☐	☐
entify signs and symptoms of medical conditions	☐	☐	☐	☐
elect and interpret appropriate diagnostic or lab studies	☐	☐	☐	☐
anage general medical and surgical conditions to include derstanding the indications, contraindications, side effects, eractions, and adverse reactions of pharmacologic agents d other relevant treatment modalities	☐	☐	☐	☐
entify the appropriate site of care for presenting conditions, cluding identifying emergent cases and those requiring ferral or admission	☐	☐	☐	☐
entify appropriate interventions for prevention of conditions	☐	☐	☐	☐
entify the appropriate methods to detect conditions in an ymptomatic individual	☐	☐	☐	☐
fferentiate between the normal and the abnormal in natomic, physiological, laboratory findings, and other agnostic data	☐	☐	☐	☐
propriately use history and physical findings and diagnostic udies to formulate a differential diagnosis	☐	☐	☐	☐
ovide appropriate care to patients with chronic conditions	☐	☐	☐	☐

Suggestions for Privileging



- Include PAs within your privileging process
  - Lead PA privileging committee
  - PA Services facilitates the process of packets
  - PA Services first line for quality checking of packets to not waste any time in credentialing office (90 days completion)

  - QA: PA Services monitors QA (electronic)
    - During re-privileging
    - Ongoing: twice a year
    - Competencies: PA privileging committee monitors competencies; can be used for APR self assessment

Scope of Practice; Direct patient services

- 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

Indirect (patient) services

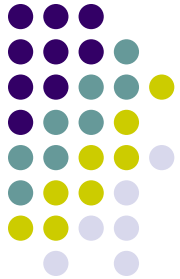
- Pt. follow ups:
  - Medication refills
  - Phone calls
  - Pt. education
  - Coordination of care of the pt.: referrals, transfers
  - Review labs
  - Med authorizations
  - Disability forms
  - Discharge summaries
  - Support of infusion services
  - Improved documentation
  - POA (present on admission)

Maximum utilization

- Direct patient services
  - Maximum use of license
  - Assessing, not rooming patients
  - Maximum revenue stream

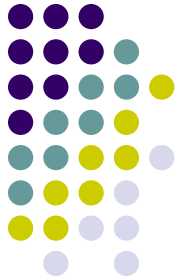
- Indirect patient services
  - Other caregivers can do this service
  - No billable services

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

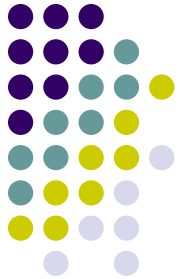


- Team approach– MD/PA team
- Facilitates communication with patients, caregivers
- Improves patient satisfaction
- Improves transitions of care-- ↑ pt. safety
- Maximizes utilization of providers skills
- Increases physicians productivity
- revenue (100% reimbursement)

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

Outpatient clinics

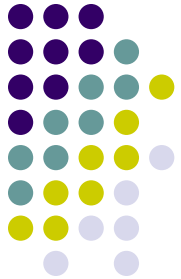


- See new patients
- See established patients
- Has own panel of patients
- Sees same day patients
- Perform procedures
- Bill independent or shared service
- If conditions are met, bills “incident to” in outpatient setting.
- Patient centered care: medical home models
- Preventive care
- Chronic conditions
- Increase access to earlier appointments

House Officer model

- Different than hospitalist
- Identified specific duties
- Complements duties of hospitalist
- Performs procedures, answers calls from staff
- Serves whole house

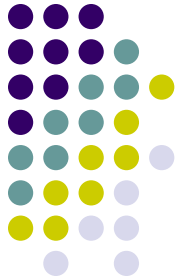
Hospitalist or House officer model



- Facilitates the care of patients on hospital services as hospitalist
- Responds to needs of patients throughout hospital as House Officer
- Perform all work ups, admissions, orders
- Continual care of patient throughout the day/evening/night
- Continuity of care: surgical specialty floors: CORs, HVI, Ortho
- Residents/ Fellows come and go, PAs stay the same

- House officer model complements the Hospitalist model:
- Hospitalist have specific patients they serve and manage
- House officer responds to calls throughout hospital: procedures, falls

Hospital/service line model



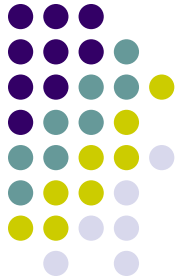
- HOSPITAL SERVICE LINE: CORS

- 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 Quality indicators

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

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

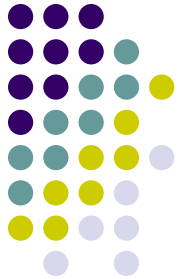


- Model
  - Level 4 - 5 acuity patients triaged to LAC upon presentation to the ED
  - PAs do all triaging; assessment in triage, order necessary studies
  - 2-3 PA/APRN on shifts
  - >28% of daily ED volume (>65,000 / year)

- 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

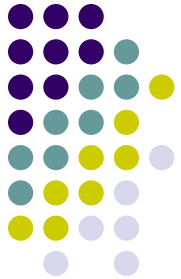
  - **This is fast track clinic: in ED PAs serve 24/7 (at main and satellite areas)**

LAC & Split Flow



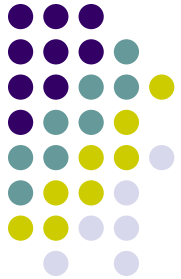
- PA average patient load/week: >300
- PA average % of volume: 28% (24 hr. total ED volume)
- LOS average 108 minutes w benchmark target of 90 minutes (level 3 pts. seen)
- Avg. arrival to continuing care room from triage: 32 minutes
- 3 PA students every 4 weeks

Surgery



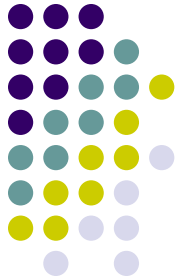
- First and second assist in surgery (non PAs should be used as second assist)
- All specialties and general surgery
- Billing as first assist
- Most providers recognized
- Pre-admission testing
- Post op follow ups
- Post op hospital coverage

Throughput PA



- Facilitates patient throughout the stay
- Throughout the entire hospital
- Attends “huddles” on floors each morning
- What ever needs to be done
- Communicator for doctors if needed
- Usually service line or entire system coverage

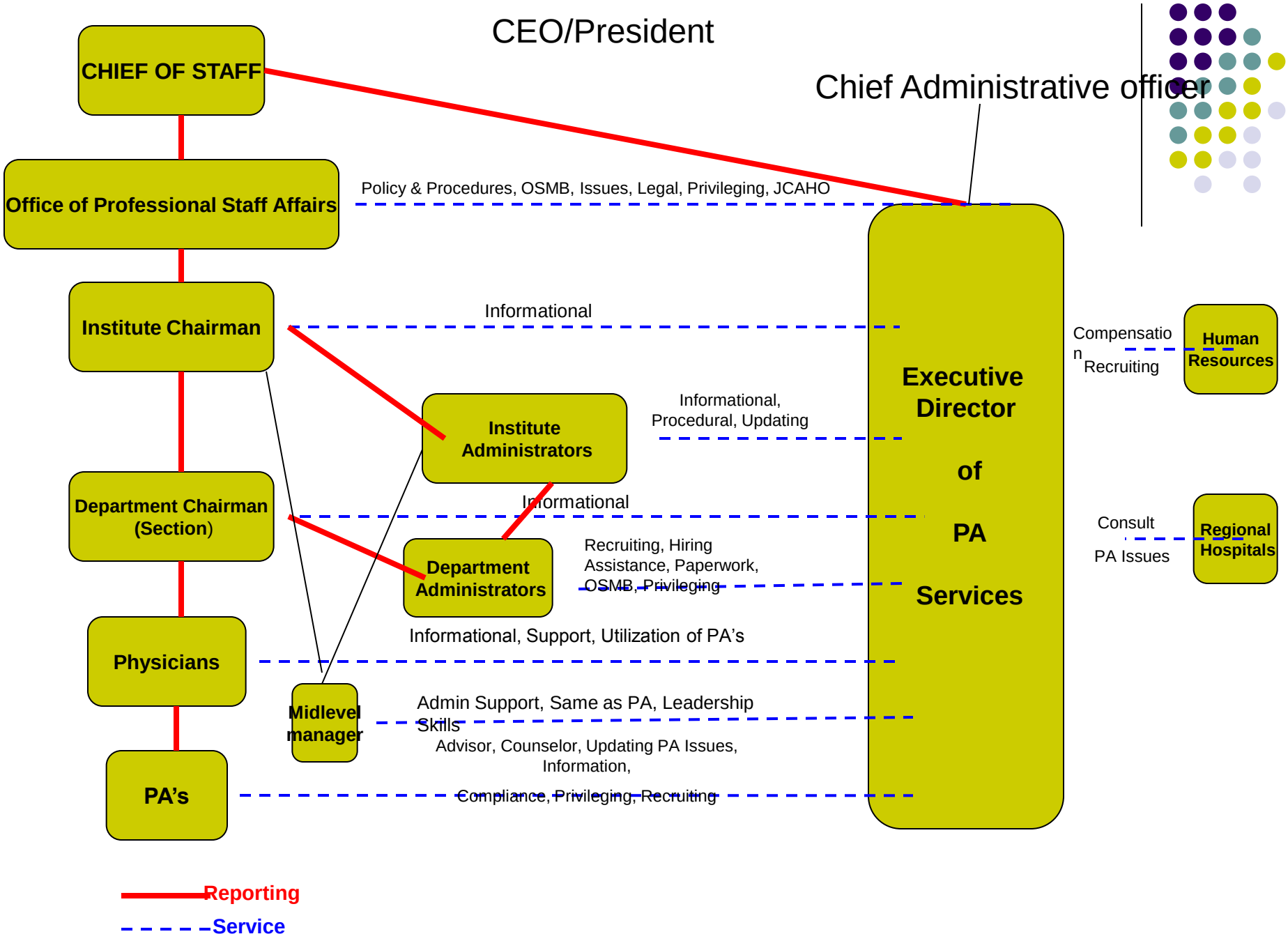
Metrics/accountability



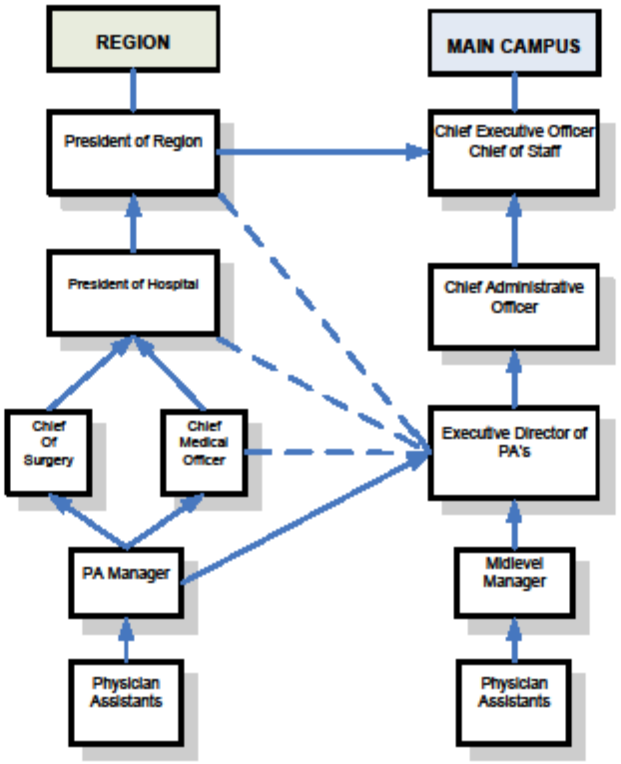
- LOS
- Orders by 10am; discharges appropriately
- Increase in quality of care/ decrease in errors
- Decrease opportunity days
- Increase patient Satisfaction
- Increase employee Satisfaction
- Continuity of care for patient
- CMS indicators will be monitored closely

Models of Care

Key Metrics	OUTPATIENT / INDEPENDENT	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
Access	↑↓ Patient access ↓ Patient wait times	↑ Inpatient management and throughput	↑ Inpatient management and throughput


CEO/President
Chief Administrative officer
CHIEF OF STAFF
Office of Professional Staff Affairs
Policy & Procedures, OSMB, Issues, Legal, Privileging, JCAHO
Institute Chairman
Informational
Executive Director of PA Services
Compensation
Recruiting
Human Resources
Institute Administrators
Informational, Procedural, Updating
Department Chairman (Section)
Informational
Consult
PA Issues
Regional Hospitals
Department Administrators
Recruiting, Hiring Assistance, Paperwork, OSMB, Privileging
Physicians
Informational, Support, Utilization of PA's
Midlevel manager
Admin Support, Same as PA, Leadership Skills
Advisor, Counselor, Updating PA Issues, Information,
PA's
Compliance, Privileging, Recruiting
Reporting
Service

Reporting Structure for Executive Director of PA's



Summary

- PAs are cost effective reimbursable providers
- Improve patient access
- Improve patient satisfaction
- Utilized fully within the scope of practice of the physician
- Quality of care– (core measures, patient experience) equivalent or better than physician only model
- Decrease waste and unnecessary testing
- Maximizes physician productivity

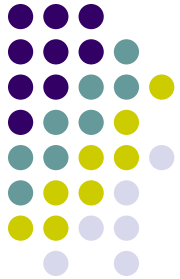
Update on PA laws

- Prescribing
- Admitting

History of PA practice acts

- 1997: PA legislation to allow a PA to be hired and called PA by hospital/ healthcare facilities
- 2006: new PA legislation allowing PAs to prescribe medications (except schedule II); see new pts. Master's degree in PA studies required
- 2006-2008: Grandfather clause for those PAs who do not have a Master's degree, but have been continuously practicing in Ohio for 10 yrs. may apply for CTP with attestation of years licensed and receive CTP without a master's degree; (No longer any grandfather clause, all PAs must have a Master's degree in PA studies to prescribe)
- 2012 PA legislation allows PAs to prescribe schedule II
- 2014: PAs and APRNs allowed to admit to their collaborating physicians practice in hospital
- 2015: PA updated practice act: removes barriers to practice and onboarding

Continuing Education



- Once a PA has prescribing, they must obtain 12 additional hrs. of Category I CME in Pharmacology every 2 yrs. in order to maintain their license. (This is in ADDITION to the 100 hrs. of CME they must obtain every two years)
- The pharmacology CME must be identified as true pharma hours and not problem based.
- OAPA offers 12 hrs. of pharmacology CME every year in April
- CCHS offers 24 hrs. online pharmacology hrs.

Admitting law

- As of 2014 PAs and APNs may admit patients to their collaborating physician's service
- Notification of admission must be made within 24 hrs.
- PA and APN must have a collaboration agreement with the physician of service.
- All subject to hospital policy
- Include in CORE privileges

SB 110

- Passed June 25, 2015
- Signed by Governor July 16, 2015
- Became law: Oct. 15, 2015
- Two changes to APRN practice
- Multiple enhancements/changes to PA practice

APN changes

- Allows out of state APRNs to take required CE courses online to obtain schedule II authority

- Allows an APRN to delegate to non-licensed personnel in identified work areas (MAs)
  - Reviewed in PA slides

PA Practice enhancements

- Changes “certificate” to LICENSE

- Combines license to practice and prescribe into one application for the PA:
  - Meets all requirements, receives a number for practice and number for prescribing
  - The new number will be: 50.-----RX
  - One number
  - Still renewed every 2 yrs: FAQs: http://associationdatabase.com/aws/OAPA/asset_manager/get_file/118162/oapaelicensefaq.pdf?ver=63

  - License lookup: https://elicense.ohio.gov/BIZC_HomeUnauth

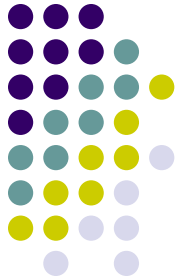
PA Practice

- Two forms still:

1. one for hospital/healthcare facilities
    1. Practice governed by facility
2. One for private practice (See model plan)
    1. Oversight by OSMB

- Removes fee for filing SA and removes fee for renewal of SA
    - Still renewed every two years

Model SA for private:

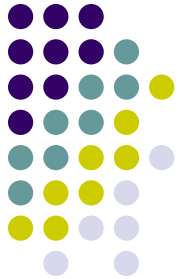


- Model Supervision Agreement – Outside a Health Care Facility January 2016
- **Responsibilities to be fulfilled by the physician in supervising the physician assistant:**
  - Comply with all the rules and regulations in ORC and OAC Chapter 4730.
  - Exercise supervision, control and direction of the physician assistant in accordance with ORC 4730.21 including development and maintenance of a quality assurance program.
  - Authorize a physician assistant to perform services that are in the supervising physician's normal course of practice and expertise and that the physician has determined the physician assistant is competent to perform.
  - Authorize the physician assistant to prescribe drugs and therapeutic devices as listed in the PA Formulary only if the PA has prescriptive authority and a prescriber number.
  - Authorize the physician assistant to delegate the performance of tasks to implement a patient's plan of care and/or delegate the administration of drugs to non-licensed personnel.
  - Authorize the physician assistant to direct the execution of procedures or techniques by a registered nurse or licensed practical nurse in the care and treatment of a person.
  - Regularly perform any other reviews of the physician assistant considered necessary.

Model continued

- **The responsibilities to be fulfilled by the physician assistant when performing services under the physician's supervision:**
  - Comply with all the rules and regulations in ORC and OAC Chapter 4730.
  - Perform services within the supervising physician's normal course of practice and expertise and that the supervising physician has determined the physician assistant is competent to perform.
  - Delegate the performance of tasks to implement a patient's plan of care and/or delegate the administration of drugs to non-licensed personnel.
  - Order and direct the execution of procedures or techniques by a registered nurse or licensed practical nurse in the care and treatment of a person.
  - Only with physician delegated prescriptive authority, order and prescribe drugs and therapeutic devices as listed in the PA Formulary and within the physician's scope of practice.

Model continued



- **Any limitations on the responsibilities to be fulfilled by the physician assistant:**
  - Unless otherwise prohibited in ORC and OAC Chapter 4730, there are no limitations placed on the PA's scope of practice.
  - Any service or drug that the supervising physician does not want the physician assistant to perform or administer.
- **The circumstances under which the physician assistant is required to refer a patient to the supervising physician:**
  - A patient requests to see the physician.
  - A patient has unresolved conditions.
  - A patient presents with critical co-morbidities that are not under control.
  - The physician requests to see the patient.

PA Practice

- Removes OSMB approval of agreements; **filing only required**
  - Becomes active 5 days after OSMB receipt
    - Rules on how to send it to OSMB
  - Copy kept at each practice site of PA and Physician
    - Important for auditing
    - OSMB does not have to post on website!
    - PA will have links to each doc, but docs license will be visible. No listing of a SA# (41.----) at this time, will come later

PA Practice

- Removes the restrictive “list” and allows the PA to practice fully within the scope of physician
- Removes restrictive 60 minute rule for supervising physician

PA Practice

- Increases the number of PAs supervised at one time to 3

- Removes the word “routine” in practice settings:
  - replaces with language to allow the PA to work anywhere a physician has oversight

- Amends procedures and requirements for out of state PAs, military or health service who apply for license w/o Master degree
  - Must be practicing/prescribing as a PA for 3 consecutive years

Delegation

- Allows PAs to delegate to non-licensed individuals
- Sec. 4730.203. (A) Acting pursuant to a supervision agreement, a physician assistant may
  - delegate a task to implement a patient's plan of care or, may delegate administration of a drug. The physician assistant must be physically present at the location where the task is performed or the drug administered.
  - (B) Prior to delegating a task or administration of a drug, a physician assistant shall determine that the task or drug is appropriate for the patient and the person to whom the delegation is to be made may safely perform the task or administer the drug.

Identified areas of delegation

- (C**) A physician assistant may delegate administration of a drug only if all of the following conditions are met:**
  - (1) The physician assistant has been granted physician-delegated prescriptive authority.
  - (2) The drug is included in the formulary established under division (A) of section 4730.39 of the Revised Code.
  - (3) The drug is not a controlled substance.
  - (4) The drug will not be administered intravenously.
  - (5) The drug will not be administered in a hospital inpatient care unit, ; a hospital emergency department; a freestanding emergency department; or an ambulatory surgical facility

PA Practice

- Clarifies those grandfathered with prescribing w/o masters' degree maintain that privilege during renewal

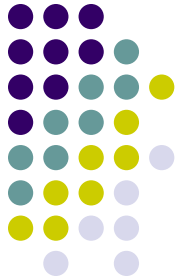
- Enhances OSMB's ability to audit practices for compliance
  - Up to $1,000 fine to physician if found not compliant with law
    - PA may lose license or probation

PA Practice

- Clarifies that an RN or LPN may practice at the direction of PAs (Nursing code)

- Clarifies language in Respiratory Therapy law to allow PAs to prescribe Respiratory care (RT Code)

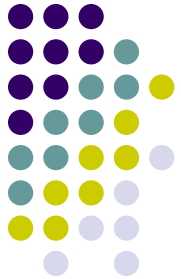
Key takeaways:



- Enables PAs to practice in any setting
- Increases number of PAs collaborating w physician
- Expedites starting and onboarding timeline for PAs
- Removes fee for agreements and renewals
- Enables PAs to fully practice at top of license

Resources

- Ohio Association of PAs: www.ohiopa.com
- American Academy of PAs: www.aapa.org
- Josanne Pagel MPAS, PA-C, DFAAPA:
  - pagelj@ccf.org



- QUESTIONS?