NP’s and PA’s Practice Issues and Beyond

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Objectives
- At the conclusion of this program the participant will be able to:
  - Describe the new Texas State laws regarding the delegation of prescriptive authority for NP’s and PA’s
  - Discuss barriers that exist within hospitals and institutions which prevent NP’s and PA’s from practicing to the full extent of their education and training

Disclosures
- Neither presenter has any disclosures

Education, Certification, Licensure & Accreditation
- History – RN’s with certificate of advanced training – informal and no certification mechanism – 1960’s
- Master’s Degree/Post Master’s Certificate
- Doctorate of Nursing Practice – 2015

- APRN – Consensus Model 2008
  - Create uniform model for APRN practice across the states

History
- Dr. Loretta Ford co-founder of the first Pediatric Nurse Practitioner model of advanced practice at the University of Colorado Medical Center in 1965.
  - Inducted into Women’s Hall of Fame

- Dr. Henry Silver co-founder. Went on to found the first pediatric PA program at Colorado Medical Center
Literature

- Institute of Medicine Report
  1. Nurses should practice to the full extent of their education and training.
  2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
  3. Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States.


- RCT comparing NP’s with Physicians
  - Results:
    - No significant differences in health status at 6 months
    - Physiologic test results for pts with diabetes and asthma were not different at 6 months.
    - For Hypertension – diastolic pressures were lower in NP group
    - No difference in health services utilization
    - No difference in satisfaction after initial appt but physicians were rated higher in one of the 4 dimensions measured – provider attributes (4.2 v 4.1 on scale where 5 was excellent).
    - In ambulatory care situation…where NP’s had the same authority, responsibilities, productivity and administrative requirements as physicians, patient’s outcomes were comparable.

Literature – Comparison NP/MD

Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial
Mary O. Mundinger, DrPH; Robert L. Kane, MD; Elizabeth R. Lenz, PhD; Annette M. Totten, MPA; Wei-Yann Tsai, PhD; Paul D. Cleary, PhD; William T. Friedewald, MD; Albert L. Siu, MD, MSPH; Michael L. Shelanski, MD, PhD JAMA. 2000;283(1):59-68.
Outcome Measures: After initial vs – satisfaction and health status. 6 months later – satisfaction and physiologic test results and service utilization 1 year after initial appt.

Systematic Review Comparing NP/MD

- AIM: Compared to other providers are APRN patient outcomes of care similar?
- NP’s – 14 RCTs and 23 Observational Studies
  - Two RCT of children
    - < 8 without chronic illness
    - 3 mos to 17 years inpatient trauma
  - Four observational
    - Children with asthma
    - Neonates ELBW
    - Adolescents with cystic fibrosis
    - Neonatal unit
Systematic Review - Outcomes

- Lipid control – better management with NPs
- Patient Satisfaction – equal
- Self Reported Perception of Health – equal
- Functional Status – Equal
- Glucose control – equal
- Blood Pressure – equal
- ED/Urgent care vs – equal
- Hospitalization – equal
- LOS – equal
- Mortality – equal
- Duration of Mechanical Vent – equal


- Physicians are from Mars/NP’s are from Venus
- “Physicians and NP’s do not agree about their respective roles in the delivery of primary care”

“The ideal health system comprises multiple providers who communicate with and are accountable to each other to deliver coordinated care.”


What’s in a Name?

- AVOID
- Physician Extenders
- Mid level Provider
- Non-Physician Practitioner
- Allied Health practitioners

- RECOMMENDATIONS
- independently licensed providers
- primary-care providers
- health-care professionals/providers
- clinicians
- NP/PA or PA/NP

Primary Care v. Acute Care NP’s

Primary Care
PNP-PC and FNP

Acute Care
PNP-AC
Matching Practitioner to Populations

- Primary Care NP (PNP & FNP)
  - Comprehensive, chronic and continuous care. Provides for most health needs and coordinates specialty care.

- Acute Care NP (PNP-AC)
  - Restorative care in rapidly changing clinical conditions. Unstable chronic conditions, complex acute illness and critical illness


<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Primary Care PNP/FNP</th>
<th>Acute Care PNP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Clinic</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Subspecialty Service</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Endocrine, pulmonary, oncology or surgery</td>
<td></td>
<td></td>
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<tr>
<td>Stable disease management or long term follow up</td>
<td></td>
<td></td>
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<tr>
<td>Interventional Radiology/Cath lab</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Perioperative or postoperative management in hospital care of complex acute illnesses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalist Service</td>
<td>✓</td>
<td></td>
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<tr>
<td>PICU</td>
<td>✓</td>
<td></td>
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NP Salaries by Work Setting

<table>
<thead>
<tr>
<th>Setting (% of respondents)</th>
<th>2011 Setting</th>
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</thead>
<tbody>
<tr>
<td>Emergency Department (2.8%)</td>
<td>$118,729</td>
</tr>
<tr>
<td>Neonatal (5.9%)</td>
<td>$114,300</td>
</tr>
<tr>
<td>Pediatric (2.9%)</td>
<td>$116,300</td>
</tr>
<tr>
<td>Hospital (12.3%)</td>
<td>$116,124</td>
</tr>
<tr>
<td>Gastroenterology (9.77%)</td>
<td>$104,400</td>
</tr>
<tr>
<td>Medical (9.83%)</td>
<td>$103,785</td>
</tr>
<tr>
<td>Cardiology (3.3%)</td>
<td>$102,906</td>
</tr>
<tr>
<td>Surgery (2.04%)</td>
<td>$101,233</td>
</tr>
<tr>
<td>Oncology (2.11%)</td>
<td>$99,962</td>
</tr>
<tr>
<td>Cardiology Clinic (2.3%)</td>
<td>$98,570</td>
</tr>
<tr>
<td>ER (24.6%)</td>
<td>$97,040</td>
</tr>
<tr>
<td>Family Practice (3.8%)</td>
<td>$93,217</td>
</tr>
<tr>
<td>Diabetes, Endocrinology (0.77%)</td>
<td>$98,387.97</td>
</tr>
<tr>
<td>Allergy &amp; Immunology (0.19%)</td>
<td>$96,106</td>
</tr>
<tr>
<td>Elective Medicine (7.08%)</td>
<td>$87,905</td>
</tr>
<tr>
<td>Academics (6.88%)</td>
<td>$87,640</td>
</tr>
<tr>
<td>Corrections (0.72%)</td>
<td>$85,329</td>
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<tr>
<td>Women’s Health (5.75%)</td>
<td>$82,185</td>
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<tr>
<td>Pediatrics (3.81%)</td>
<td>$60,348</td>
</tr>
<tr>
<td>College Health (12 months+ 1.1%)</td>
<td>$60,223</td>
</tr>
<tr>
<td>Elementary or Secondary School (0.29%)</td>
<td>$58,960</td>
</tr>
<tr>
<td>College Health (9 months- 0.5%)</td>
<td>$50,684</td>
</tr>
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What is a PA?

*“a health professional who practices medicine with the supervision of a licensed physician”*

http://medicine.yale.edu/pa/profession/history_profession.aspx

PA 101 Texas Style

- PA practice includes medical services within the education, training and experience of the PA that are delegated by the supervising physician.
- Supervision must be continuous but does not require constant physical presence of supervising physician where PA services are being performed.

TEX. REV. CIV. STAT. ANN. §157.051

History

- Founder: Eugene Stead Jr.
- Physician shortage
- First PA class – 1967
PA Education

Training
- PA education programs typically last between 24 and 48 months.
- The curriculum includes both classroom and clinical instruction.
- Prerequisites: Bachelor's degree in a health-related field.
- Average length of a PA education program: 27 months.
- Rotations include:
  - Family medicine
  - Internal medicine
  - Obstetrics and gynecology
  - Pediatrics
  - General surgery
  - Emergency medicine
  - Psychiatry

Lifelong learning must complete 100 hours of continuing medical education every two years.

Certification and Licensure
- Initial Certification:
  - PANCE: 5 hour, 300 multiple choice exam
- Certification Maintenance:
  - Current: Graduate from an accredited program
  - 6 year certification maintenance: 100 CME hours
  - PANRE: 4 hour, 240 multiple choice questions
- New: beginning 2014
  - CME credits earned through self-assessment CME or performance improvement CME

PA Practice Specialties

DISTRIBUTION OF CLINICALLY PRACTICING PAs BY PRIMARY SPECIALTY
- Family Medicine 24.8%
- Surgical Subspecialties 23.2%
- Other 11.7%
- Emergency Medicine 10.5%
- Internal Medicine Subspecialties 10.3%
- General Internal Medicine 4.8%

PA Work Environments

DISTRIBUTION OF CLINICALLY PRACTICING PAs BY PRIMARY WORK SETTING
- Hospital 39.4%
- Single-specialty physician group 19.7%
- Solo-physician practice 11.0%
- Multi-specialty physician group 9.5%
- Other 7.8%
- Community health center 3.1%
- Certified rural health facility 2.7%
- Other freestanding outpatient health facility 2.2%
- Federally qualified health center 2.1%
- HMO facility 0.9%
- Nursing home or long-term care 0.9%
- University/college student health facility 0.5%

Source: 2010 AAPA Census
Licensure in Texas

**QUALIFICATIONS**
- Successful completion of PA program accredited by CAHEA, its predecessor or successor
- Current NCCPA certification (must pass the NCCPA exam within 6 attempts)
- Ability to mentally and physically function as a PA
- Good moral character
- No disciplinary action in another jurisdiction
- Any additional information requested, including malpractice claims
- To be able to practice, PAs must have a state license and work with a physician.

**Source:** 15 TAC 140.1(1)

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PA Salary data 2012

**Setting (% respondents)**
- Radiology Practice (0.38%) $150,000
- Mental Health (1.72%) $125,840
- Pediatric Practice (2.30%) $117,060
- Emergency Department (10.94%) $116,366
- Surgery Setting (11.51%) $110,479
- Urgent Care/Non-Inpatient (0.87%) $108,000
- Emergency (11.32%) $101,769
- Cardiology Practice (2.30%) $95,129
- Family Practice (11.51%) $93,773
- Pediatrics (11.51%) $93,367
- General Surgery Setting (11.51%) $92,489
- Urgent Care/Walk-In Clinic (9.98%) $104,237
- Hospital Unit (11.32%) $101,769
- Long-Term Care Facility (0.57%) $101,000
- Internal Medicine (6.90%) $98,555
- Worksite Clinic (1.91%) $98,400
- Family Practice (11.51%) $93,773
- Urology Clinic (0.76%) $92,000
- Correctional Facility (0.57%) $91,218
- Rural Clinic (4.60%) $91,116
- Aesthetic/Dermatology Practice (2.87%) $90,500
- Endocrinology Practice (0.19%) $90,000
- Correctional Facility (0.57%) $89,259
- Community Health Clinic (4.60%) $87,618
- Hospitalist Group (1.34%) $87,027
- College or University Clinic (2.49%) $84,299
- Acute Care Facility (0.95%) $83,367

**Source:** http://nurse-practitioners-and-physician-assistants.advanceweb.com

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Certificate of Added Qualifications

- CAQ specialty areas: Cardiothoracic Surgery, Emergency Medicine, Nephrology, Orthopedic Surgery, Psychiatry.
- Coming Soon: Pediatrics, Psychiatry
- Requirements:
  - Category I specialty CME
  - Two years of experience
  - Procedures and patient case experience appropriate for the specialty
  - Specialty exam.

**Source:** https://www.nccpa.net/SpecialtyCAQs

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PA/NP Qualifications

- **PA**
  - Must be licensed by the state to practice as a PA
  - Graduated from an accredited PA program or passed the PANCE
- **NP**
  - Registered professional nurse authorized to practice
  - Certified as a NP by national certifying body
  - Has a Master's degree in nursing or a DNP

**Billing**

- NP/PA must bill under their NPI number.
- A supervising physician must bill under his or her NPI for services that a NP/PA furnishes incident to their professional services.

**Source:** https://www.nccpa.net/SpecialtyCAQs
Payment

• Services are paid at 85% of the amount that a physician is paid under the Medicare PFS.
• Assistant-at-surgery services are paid 85% of 16% of what a physician is paid under the PFS.
• Payment for services furnished incident to services of a NP/PA in a setting outside of a hospital NP/employer at 85% of what physician is paid under Medicare PFS.

Delegation of Prescriptive Authority

• Protocol/Collaborative Agreement
  - Must maintain a permanent record of protocol
  - Must list to whom the delegation is made
  - Date of original delegation
  - Annual review

Texas Lawmakers Expand Access to Primary Care Services with Passage of SB 406

• Eliminates requirement for onsite phy supervision and allowing delegation of drug and durable medical devices
• Increases from 4 to 7 number of APRN’s or PA’s to whom one physician can delegate prescriptive authority
• Improves coordination between TMA and BON and BPA
• Allows physicians to delegate prescribing authority to APRN’s and PA’s for Schedule II controlled substances in hospitals and hospice settings.

Barriers
Barriers to Practice

- Medical Staff By-Laws
- Membership - Medicare allows NP/PA medical staff membership if permitted by state law
- Committee Membership with voting privileges
- Limitation of clinical privileges – not allowing NP/PA to do procedures that they have training and education to do.
  - Requiring supervision of procedures or a set number of procedures they must do in a year for credentialing. Requiring co-signatures on all orders.
  - JACBO says that facilities must use same privileging process for NP’s and PA’s that it uses for physicians.

Everyone Wins

- Expanding consumer choice and access to care
- Improving continuity of care
- Increasing cost-effectiveness
- Improving interprofessional collaboration and team care
- Using available health care workforce most efficiently to coordinate and deliver quality health care