Credentialing and Privileging of APNs and PAs

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The speaker
has no financial relationships to disclose.

Michael R. Callahan

Michael R. Callahan assists hospital, health system and medical staff clients on a variety of health care legal issues related to accountable care organizations (ACOs), patient safety organizations (PSOs), health care antitrust issues, Health Insurance Portability and Accountability Act (HIPAA) and regulatory compliance, accreditation matters, general corporate transactions, medical staff credentialing and hospital/medical staff relations.

Michael's peers regard him as "one of the top guys […] for credentialing—he's got a wealth of experience" (*Chambers USA*). Additionally, his clients describe him as "always responsive and timely with assistance," and say he is "informed, professional and extremely helpful" and "would recommend him without reservation" (*Chambers USA*). Michael's clients also commend his versatility, and say "He is willing to put on the hat of an executive or entrepreneur while still giving legal advice," according to *Chambers USA.*

He is a frequent speaker on topics including ACOs, health care reform, PSOs, health care liability and peer review matters. He has presented around the country before organizations such as the American Health Lawyers Association, the American Medical Association, the American Hospital Association, the American Bar Association, the American College of Healthcare Executives, the National Association Medical Staff Services, the National Association for Healthcare Quality and the American Society for Healthcare Risk Management.

Michael was recently appointed as chair of the Medical Staff Credentialing and Peer Review Practice Group of the American Health Lawyers Association. He also was appointed as the public member representative on the board of directors of the National Association Medical Staff Services.

He was an adjunct professor in DePaul University's Master of Laws in Health Law Program, where he taught a course on managed care. After law school, he served as a law clerk to Justice Daniel P. Ward of the Illinois Supreme Court.

Objectives

- Provide a statistical overview of APNs/PAs
- Discuss the applicable legal standards governing APN/PA credentialing and privileging
- Overview of FTC's position on the regulation of APNs
- Discussion of CAP2 studies on the utilization of APNs/PAs
- Questions and Answers

Overview - Statistics

- Nurse Practitioner
  - As of 2014, there were more than 205,000 licensed nurse practitioners in the U.S. (AANP National Nurse Practitioner Database, 2014)
  - U.S. Bureau of Labor – 136,060 employed (5/2015)
  - 99% have graduate degrees
  - 87% are trained in primary care
  - 85% see patients covered by Medicare/Medicaid
  - 49% have hospital privileges
  - 15% have long term care privileges
  - 97% prescribe medications in all 50 states; controlled substances in 45 states

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Overview – Statistics (cont'd)

- Projected Increase – Nurse Practitioners
  - 2014: 127,000
  - 2024: 172,000
- Projected Increase – Nurse Midwives
  - 2014: 5,300
  - 2024: 6,600

Overview – Statistics (cont'd)

- Physician Assistants
  - In 2014 there were 94,400 employed Pas
    - Physician Offices: 50%
    - Hospitals: 32%
    - Government: 3%
    - Educational Services: 3%
  - Most have master's degrees
  - Projected increase
    - 2014: 94,400
    - 2024: 123,200

Overview – Statistics (cont'd)

- Top Specialties
  - Primary Care: 32%
  - Surgical Subspecialties: 27%
  - Other Specialties: 19%
  - Emergency Medicine: 11%
  - Internal Medicine Subspecialties: 10%

Legal Standards

- Medicare Conditions of Participation
  - Section 482.22 Background
    - The May 16, 2012 final rule on the permitted composition of the medical staff was confusing with regard to the use of “non-physician practitioners” because it inadvertently excluded other practitioners from medical staff membership.
    - The requirement that the medical staff must include DOs and MDs also suggested that other practitioners were excluded even if they met the state’s definition of “physician.”

Legal Standards (cont'd)

- May 12, 2014 Final Rule and September 15, 2014 CMS Guidance
  - The medical staff must be composed of MDs and DOs.
  - In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians, i.e., dentists, podiatrists, and non-physician practitioners, who also are determined to be eligible and approved by the board, i.e., APNs, PAs.
  - Governing Body must approve any and all categories of medical staff membership, as permitted under state law. Even if state law allows APNs and/or PAs to be on the medical staff, the Board is not required to do so.
  - Board can approve a more limited scope of practice than what is allowed under state law but not more privileges than state law allows.

Legal Standards (cont'd)

- Most states have not yet permitted non-physicians to serve on the organized medical staff.
- Illinois, for example, permits MDs, DOs, dentists and podiatrists to be members on the Medical Staff but not chiropractors, APNs, PAs or other non-physician providers.
- Non-physicians who are credentialed generally serve on the Allied Staff but have limited membership rights and may be required to have a collaborative agreement with a medical staff member.

FTC – Policy Perspectives: Competition and the Regulation of Advance Practice Nurses

- In March, 2014, the FTC issued a Policy Paper to express concerns about unnecessary restrictions being placed on APN scope of practice standards, that are unrelated to well founded patient safety concerns.
- FTC staff has testified before many state legislators that laws affecting APN practices should take into consideration the following factors:
  - Consumer access to safe and effective health care is of critical importance.
  - Licensure and scope of practice regulations can help ensure that health care consumers (patients) receive treatment from properly trained professionals.

FTC – Policy Perspectives: Competition and the Regulation of Advance Practice Nurses (cont'd)

- Competition yields important consumer benefits in terms of access, cost and quality.
- Freedom from unnecessary practice restrictions will allow APNs to serve in medically underserved areas and to fulfill unmet health care needs.
- Productive collaboration between physicians and APNs does not necessarily require direct supervision.
- States should obtain actual data to support proposition that physician direct supervision through collaborative agreements and other means actually improves care or, instead, is an unnecessary restriction which may increase health care costs and prices and constrain innovation.

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State Laws

- Scope of practice for APNs and PAs varies from state to state.
- Despite FTC concerns, some states limit APN privileges and/or require collaborative agreements with an employer/supervising physician depending on the APN specialty even if not required under state law and even if treated as an independent practitioner.
  - Approximately 19 states and DC allow nurse practitioners to practice independently of a physician.
  - 19 states require APNs to have collaborative agreements throughout their entire career.

State Laws (cont'd)

- Limitations can vary between hospital owned/controlled facility, in-patient v. out-patient, rural v. urban, etc.
  - Termination of the agreement or employment of the APN/PA oftentimes results in the automatic termination of the provider's clinical privileges and membership – independent APNs/PAs usually are entitled to same internal review process although not full hearing rights under the Bylaws.

State Laws (cont'd)

- Prescriptive Authority
  - APN in most states can prescribe medications and drugs. Some require a level of physician oversight and supervision.
  - Most states, however, require some degree of physician approval for controlled substances depending on the category/class.
  - Prescriptive authority is becoming less restrictive.
  - PAs have broader and less restrictive prescription authority although still limited in twelve states.

State Laws (cont'd)

- APRN Consensus Model
  - Consensus Model is an attempt to have states adopt common and uniform standards for licensure, accreditation, certification and education.
  - Endorsed by over 44 professional nurse association.
  - All states have adopted some of the model elements according to a scoring grid based on 28 different points.

Credentialing and Privileging

- CoPs
  - §482.12 Condition of Participation: Governing Body
    - §482.12(a) Standard: Medical Staff. The governing body must:
    - §482.12(a)(2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff: TAG: A-0046
    - §482.12(a)(6) Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and TAG: A-0050

Credentialing and Privileging (cont'd)

- §482.12(a)(7) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society. TAG: A--0051

- §482.22 Condition of Participation: Medical Staff

  The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.

  - §482.22(a) Standard: Composition of the Medical Staff

    The medical staff must be composed of doctors of medicine or osteopathy and, in accordance with State law, may also be composed of other practitioners appointed by the governing body. TAG A: 0339

Credentialing and Privileging (cont'd)

- §482.22(a)(1) – The medical staff must periodically conduct appraisals of its members. TAG: A-0340
- §482.22(a)(2) – The medical staff must examine credentials of candidates for medical staff membership and make recommendations to the governing body on the appointment of candidates. TAG: A-0341

- Joint Commission Accreditation Standards
  - MS.06.01.07
    - The organized medical staff reviews an analysis all relevant information regarding each practitioner's current licensure status, training, experience, current competence, and ability to perform the requested privilege

Credentialing and Privileging (cont'd)

- ❖ The hospital develops criteria that will be considered in the decision to grant, limit or deny a requested privilege.

– MS.08.01.01

- ❖ The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance
- ❖ A period of focused professional practice (FPPE) is implemented for all initially requested privileges using performance criteria
- ❖ FPPE to be used when patient safety issues relating to competence, behavior and ability to perform are identified via a performance monitoring process

Credentialing and Privileging (cont'd)

- MS.08.01.03
  - Ongoing professional practice evaluation (OPPE) information is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal

Bottom Line: Must credential and privilege and monitor performance of APNs and PAs in the same manner as physicians in accordance with applicable bylaws, rules and regulations using APN/PA scope of license and related standards

Credentialing and Privileging (cont'd)

Issues and Concerns

- Performance of APNs/PAs is difficult to track and therefore performance is not adequately monitored.
- Where collaborative agreements are in place, supervising physicians do not provide the required oversight.
- Limiting scope of practice otherwise permitted under state laws can adversely affect quality, access to care and continuity of services.
- APNs/PAs should be evaluated by their peers and not just physicians during appointment/reappointment and ongoing monitoring activities.
- Hospitals are not applying FPPE/OPPE standards to APNs/PAs.

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Utilization of APRNs/PAs

CAP2 – Our Members

Academic Medical Centers

- CHI Health Creighton University Medical Center
- CHI St. Luke's Health - Baylor St. Luke's Medical Center
- Duke University Hospital
- Fletcher Allen Health Care (University of Vermont)
- Harborview Medical Center
- Loyola University Medical Center
- Froedtert and the Medical College of Wisconsin
- MedStar Georgetown University Hospital
- Nebraska Medical Center
- Northwestern Memorial Hospital
- NYU Langone Medical Center
- Oregon Health & Science University
- Parkland Health & Hospital System
- Rush University Medical Center
- Saint Luke's Health System
- Truman Medical Centers
- UNC Health Care
- University of Alabama at Birmingham (UAB) Hospital
- University of California – Davis Medical Center
- University of California - San Francisco Medical Center
- University of Chicago Medical Center
- University of Colorado Hospital
- University of Illinois Hospital and Health Sciences System
- University of Iowa Hospitals and Clinics
- University of Kansas Hospital
- University of Kentucky Hospital
- University of Wisconsin Hospital and Clinics
- University of Washington Medical Center
- Vanderbilt University Medical Center
- Vidant Medical Center
- Virginia Commonwealth University (VCU) Medical Center
- Wake Forest Baptist Medical Center
- West Virginia University Hospitals

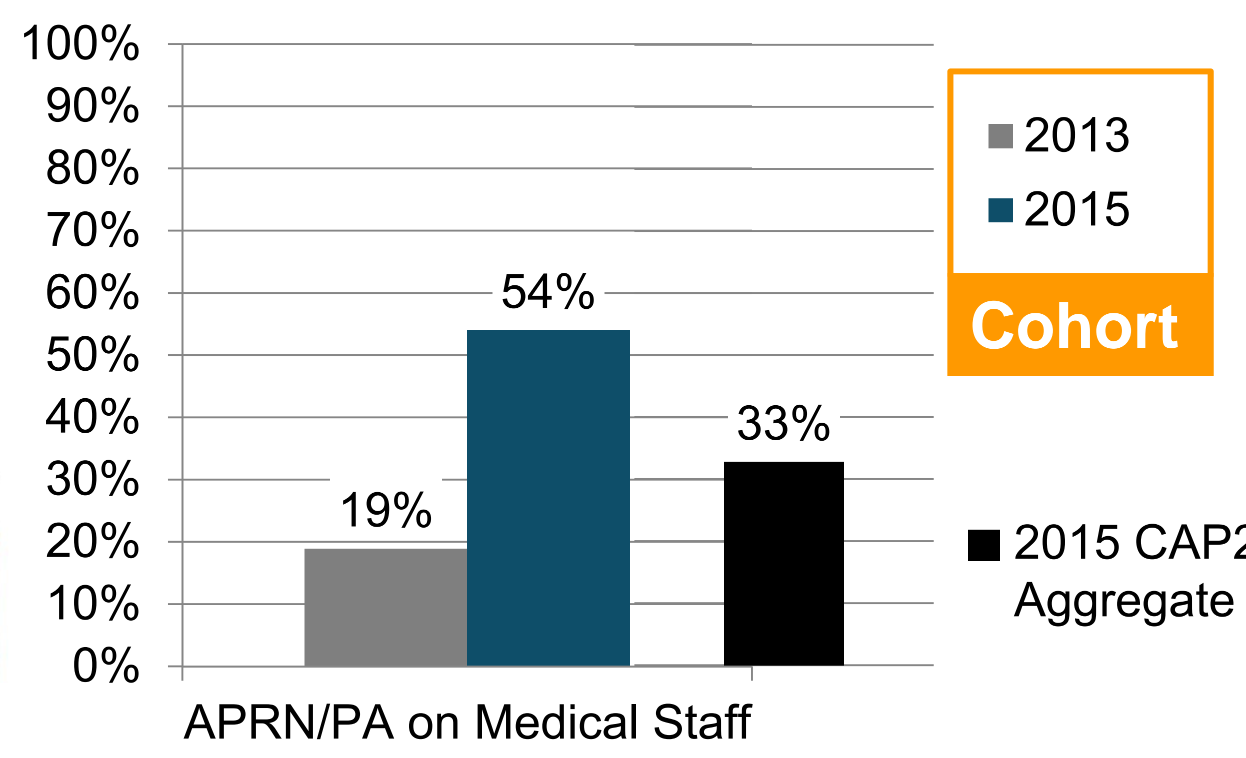
CAP2 – Our Data

- Member data represents:
  - 260 organizations
    - **Acute and ambulatory**
    - *Hospitals; healthcare systems*
    - *Academic medical centers → critical access*
  - Almost 25,000 APRNs and PAs
  - 31 different states
  - 50 different specialty areas
  - And growing
  - **One of a kind**

Allergy/Immunology
Anesthesia
Bariatric Surgery
Breast Health
Burns
Cardiology
Cardiovascular Surgery
Colon/Rectal Surgery
Dermatology
Education
Electrophysiology
Emergency Medicine
Endocrinology
Family Medicine
Gastroenterology/ Endoscopy/Hepatology
Genetics, Birth Defects and Metabolism
Geriatrics
Hematology/Oncology
Infectious Disease
Inflammatory Bowel Disease
Intensive Care
Internal Medicine
Neonatal
Neurology
Neurosurgery
Nurse Midwives
Obstetrics Gynecology/ Women's Health
Occupational Health
Ophthalmology
Orthopedics
Otolaryngology
Pain management, Acute or Chronic
Palliative Care
Pediatrics (General)
Physical Medicine & Rehabilitation
Plastic/Reconstructive Surgery
Prostate
Psychiatry
Pulmonary
Radiology, Nuclear, Interventional
Renal/Nephrology
Rheumatology
Surgery (General)
Transplant (Surgery)
Transport
Urogynecology
Urology
Vascular Surgery
Wound/Ostomy

APRN/PA Representation

186% growth in APRN/PA representation on the Medical Staff Credentialing Committee



Data shows comparison of 37 organizations that have taken the CAP2 Acute Care Assessment in 2013 and again in 2015

FPPE/OPPE Frequency

*21% increase in compliance requirement**

2013 = 52% compliant

2015 = 62% compliant

50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

38%
14%
24%
11%
35%
27%
14%
8%

2013
2015

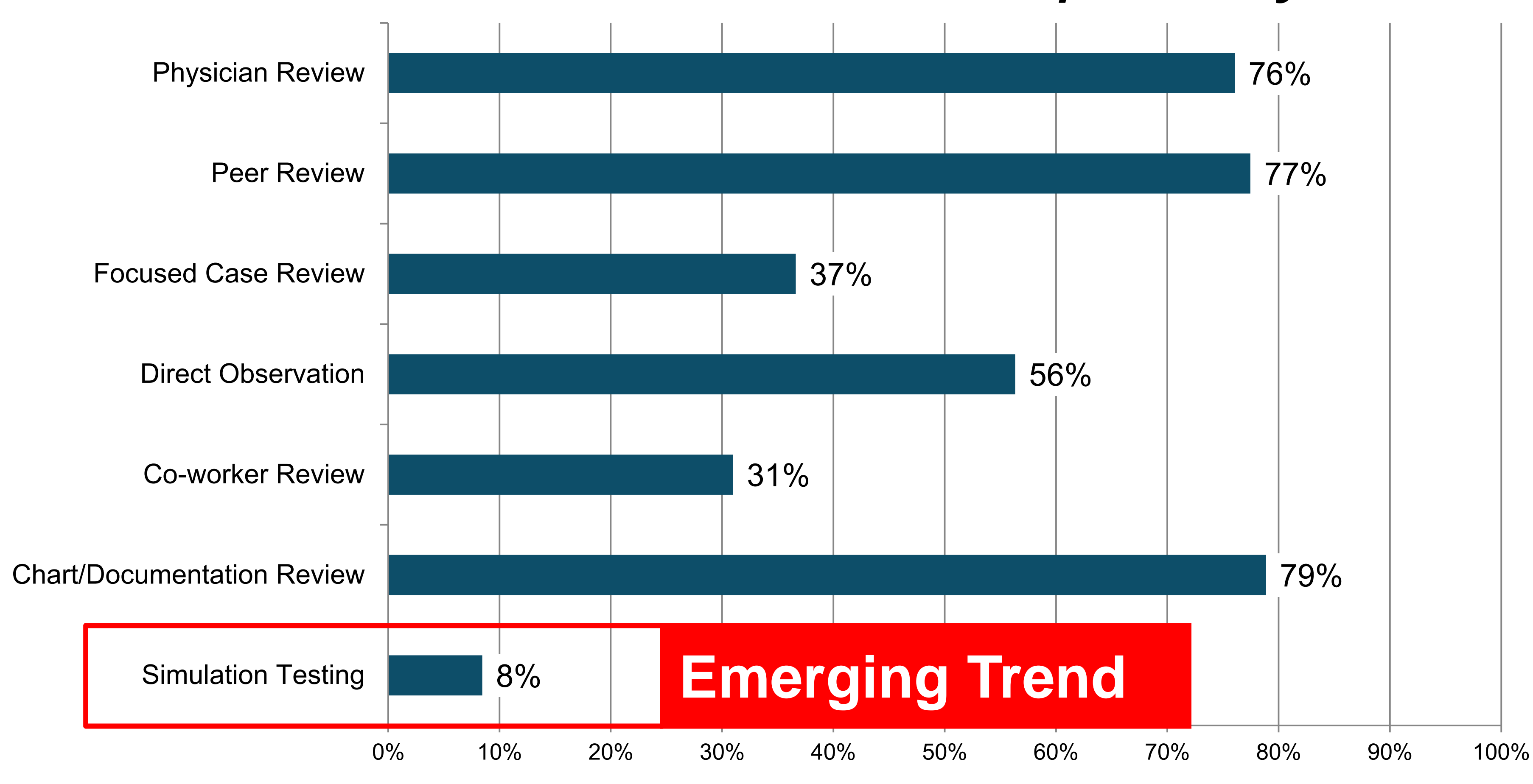
Every 6 months
Every 8 months
Annually
Every 2 years

**more often than annually*

Data shows comparison of 37 organizations that have taken the CAP2 Acute Care Assessment in 2013 and again in 2015

FPPE/OPPE Process

Hospitals use a variety of approaches to assess APRN/PA competency



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