The Physician Shortage Crisis & The Use of Allied Healthcare Providers

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Overview of Discussion

1. Medical & legal challenges of MD shortage crisis
2. Using allied health: the why, who, where & how
3. The scope of practice debate – collaborative vs. independent practice of NPs and PAs
4. The changing model of care delivery & what can be learned from the LTC interdisciplinary model
5. Practical legal risk management tips when employing NPs, PAs, & allied health providers
The Physician Shortage Crisis

Projected shortfall of MDs: 46,100 – 90,400 by 2025

Why?

- MDs retiring
  - Age (1 out of 3 > age 50; 1 out of 4 > age 60)
  - Opting out (many retiring early, w/in next 1-3 yrs)
- Fewer med school grads choosing primary care
- Flood of patients overwhelming MD availability
Why the flood of patients?

• **ACA impact**: millions of newly insured patients now entering the healthcare system
  • 60% of patients aged 50-64 have at least 1 chronic disease

• **Immigration reform impact**: potentially millions of new patients will seek treatment

• **Rapidly aging Baby Boomer generation**
  • 75.8M Americans born 1946-1964, now reaching age 65, and living longer
Medical & Legal Challenges of the MD Shortage

- **Patient care suffers**
  - Acute health needs not timely/properly addressed
  - Preventative wellness needs not met

- **Increased liability risk to MDs/healthcare entities**
  - Failure to take comprehensive history (rushed)
  - Missed diagnoses (inattentive)
  - Med errors/mistakes (short-staffed)
  - Poor documentation (lack of time)
  - Failure to follow-up (busy)
The Use of Allied Healthcare Providers

...and the Transformation of the Traditional MD Delivery of Patient Care Model
First, the Nomenclature

- The term “ALLIED HEALTH” is used to identify hundreds of different types of health care providers
- Allied health providers work collaboratively with physicians, physician assistants and nurse practitioners to provide direct patient care
- Allied health professionals represent more than 60% of all health care providers
Some Examples of Allied Health:

- Certified Medical Assistant
- Certified Surgical Assistant
- Home Health Aide
- Nutritionist
- Occupational Therapist
- Paramedic
- Perfusionist
- Phlebotomist
- Physical Therapist
- Registered Dietician
- Respiratory Therapist
- Speech Language Pathologist
• Advanced Practice Registered Nurses (Nurse Practitioners) and Physician Assistants do NOT consider themselves “allied health” but the healthcare industry still uses the phrase loosely.

• NPs and PAs work independently and/or collaboratively with MDs depending on their licensure and scope of practice under state law, which varies considerably across the nation.
The Language Debate – and why

Advanced Practice Registered Nurse (Nurse Practitioner)
Physician Assistant

“Non-Physician Provider”
“Allied Health Provider”
“Physician Extender”
“Mid-Level Provider”
“Limited License Provider”
“Indep. Licensed Provider”
“Primary Care Provider”
“Health Care Professional”
“Clinician”
“Doctor of Nursing”
Advantages to Using NPs/PAs

Access to more providers allows:

- Availability of care; shorter wait time for patient
- Longer consultation time with patient (hx, Q&A)
- More time for detailed charting documentation
- More time for follow-up monitoring re labs/tests
- More time for detailed referral consultations
- More time for preventative wellness
- Different scope of practice perspective on care
Consensus: The Use of NPs/PAs/Allied Health is Necessary

• Wave of the future
  • 2013 survey of U.S. physicians: 8 in 10 MDs agree that mid-level professionals will play a bigger role in direct primary care delivery
• It’s now an issue of “how” rather than “should”
• Everyone agrees with collaborative care but not necessarily with independent/autonomous care
History of NP & PA Professions

- Current MD shortage situation & scope of practice discussion are not new
- **1965**: NP concept took flight due to MD shortage situation resulting from millions of new insureds under Medicare/Medicaid
- **1965**: 1st clinical training program for NPs started in Colorado by nurse Loretta Ford and pediatrician Henry K. Silver, M.D.
- **1965**: 1st formal educational system for PAs started at Duke by Dr. Eugene A. Stead, Jr.
Differences in Education, Training, Licensure, Certification & Scope of Practice

- Physician
- Physician Assistant
- APRN/NP
The Physician

• 4 years undergraduate pre-med studies
• 4 years at an accredited medical or osteopathic medical school (M.D. vs. D.O. degree)
• 3–7 years graduate medical education (GME) via a residency program with specialty training
• Optional 1–3 years of sub-specialty training through a fellowship
• Optional Board Certification
• Licensure is through state Medical Board
The Physician Assistant

- 4 year B.A. with pre-med studies or 5 year accelerated program for B.A./M.A.
- Usually need patient care hours in health industry
- 2+ yr. program with science, clinical med, rotations
- Can specialize with certifications
- **Supervised by MD** but licensed in own name
- Scope of practice varies considerably by state
  - Can take hx, do exams, order labs, do tx plans
  - Maybe: Rx auth, co-signing charts, MD chart reviews
- 100,000 PAs in U.S.; work in many clinical settings
The Advanced Practice Nurse (NP)

- To be a nurse, need Associate’s Degree in Nursing or Bachelor’s of Science degree in Nursing
- To be an APRN, the nurse must have at least a Master’s degree in 1 of 4 specialty roles: NP, CNM, CRNS, or CNS
- New Doctor of Nursing Practice (DNP) degree available
- Many additional subspecialty certifications available
- Licensed by state nursing board, which regulates scope of practice to work independently vs collaboratively
- NPs can usually dx, treat, order tests, prescribe meds
- More than 205,000 licensed NPs in U.S.
NP Facts as per the American Association of Nurse Practitioners (AANP):

- 86.5% are prepared in primary care
- 84% see Medicare and Medicaid patients
- 44.8% hold hospital privileges
- 15.2% have long term care privileges
- 69.5% see 3 or more patients per hour
- 97.2% prescribe some meds (19 scripts/day av.)
Common Arguments Cited Against Using NPs/PAs

• Less and different education/training than MDs so quality of patient care will suffer
• Lower reimbursement rates, less income to employer MDs/healthcare entities
• Patients will be confused or unhappy
• Independent NP practice = invasion of MD turf
What We Can Learn and Apply From the Long Term Care Setting
LTC’s Interdisciplinary Approach to Patient Care

Healthcare professionals collaborate on patient care and each work at the top of their own scope of practice

- Medical – Medical Director, PCP, contract MDs, consultant MDs, NPs/PAs in MD offices
- Nursing – DON, NPs, RNs, LPNs, Med Techs, CNAs
- Therapy – PT, PTA, OT, OTA, ST (SLP), SLPA, RT
- Dietary – RD
- Social Services – MSW
• **Team care planning meetings** – communication, brainstorming for joint strategy on care
• **Patient/family care conferences** – opportunity to educate, hear new info, address concerns
• **Shared access to documentation** of other providers in one chart
ACA’s Patient-Centered Medical Home (PCMH)

“The PCMH model involves transformation of the underlying processes of care, such as shifting from physician-centric care processes to those incorporating all members of the health care team practicing at the level of their licenses.” – AHRQ

- PCMH involves use of a Practice Facilitator, MDs, NPs, PAs, allied health providers, electronic records, and telemedicine.
ACA: Sec. 5501
“Strengthening Primary Care and Other Workforce Improvements” and “Expanding Access to Primary Care Services”

“PRIMARY CARE PRACTITIONER” means an individual who is a physician (who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine) or is a nurse practitioner, clinical nurse specialist, or physician assistant.
So Where/How Can NPs, PAs, and Allied Health Be Used?

IN TRADITIONAL DELIVERY CARE MODELS:
Physician offices, hospitals, outpatient clinics, nursing facilities, rehab facilities, home health, etc.

IN NEW DELIVERY CARE MODELS:
Retail clinics, Patient-Centered Medical Homes (PCMH), Nurse Managed Health Centers (NMHC), Medically Underserved Areas/Populations (MUA/Ps), Community Paramedicine (EMS + primary care), tele-medicine, & other emerging models...
Types of Liability Claims

• Direct liability claim against provider
  • Negligent care
• Direct liability claim against MD/Employer
  • Negligent care/hiring/retention/supervision
• Vicarious liability claim (*respondeat superior*)
  • Negligent care by employed provider
  • Critical issue: MD’s control or direction over the NP/PA/allied health’s work activities
Collaborative Care: Top Types of Negligent Malpractice Claims

- Non-existent or delayed consultation with supervising MD
- Failure to supervise
- Insufficient patient examination
- Failure to diagnose or identify medical problem
- Failure to monitor/follow up
- Poor documentation (can’t prove gave proper care)
Risk Management Tips for Employment of NPs/PAs

Pre-Employment

• Thorough background/credentialing checks
• Ensure malpractice coverage includes NP/PA
• Know your state’s scope of practice limitations
• Understand applicable reimbursement policies
• Practice Agreement should be comprehensive
More Risk Management Tips

During Employment

• Train allied health staff about role of NP/PA
• Educate patients about role of NP/PA
  • Title on name badge
• Periodically audit charts; discuss work performed
• MD should be available for consult; be responsive
• Maintain credentialing & continuing education file
• Periodically perform updated licensure check
• Use patient satisfaction forms to identify problems
Questions?

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