Illinois Physician Perspectives: Mid-Level Practitioners

Welcome to the first edition of Physician Issue Brief, IHA’s publication created as a result of input from IHA’s Medical Executive Forum, and designed to share timely health care delivery topics with Illinois hospital and health system physician executives.

In the wake of the Affordable Care Act, a growing level of anxiety exists regarding the increasing shortage of physicians in the state. In response, the state’s hospitals, health systems and provider practices have taken various approaches to augment their care delivery capacity through the use of mid-level practitioners.

Nationally, advanced practice nurses (APNs) and physician assistants (PAs) comprise 26% of the primary care workforce. Despite trends in other markets, their practice integration has not been uniform across Illinois health care settings. In the legacy, fee-for-service environment, some physicians perceive APNs and PAs as economic threats, while others realize their potential in serving a higher volume of patients. Barriers to integration include concerns regarding medical liability; adequacy of training; verifying competency to deliver high-quality care; and accommodating gaps in training and experience. As health care moves to a patient-centered, value-based delivery system, the team-based delivery model is the model of the future. Regardless of the size or location of the hospital or health system, all have encountered at least one of these barriers in the ongoing transformation of health care delivery.

This Issue Brief focuses on APNs and PAs in hospitals and health systems, providing an overview of the legal and regulatory environments at the state and federal levels which govern their practice settings. Forum members share their challenges and successes with integration of APNs and PAs in their organizations, fostering a shared learning opportunity for physician leaders and organizations across the state.

Discussions across the Illinois health care community reflect a growing level of anxiety regarding the increasing shortage of physicians in the state.
The Legal and Regulatory Environment

Across Illinois, nearly 7,000 advanced practice nurses (APNs) and 2,800 physician assistants (PAs) are licensed to provide patient care. Numerous federal and state laws impose mandates on individual providers, multiple practice settings and patient care processes that ultimately converge, impacting APN and PA practice in Illinois.

Of key interest to physicians are issues regarding physician oversight, privileging, prescriptive authority, practice parameters, and practice venues. However, laws and regulations are inherently dynamic, as are the oversight efforts of multiple government agencies charged with monitoring related compliance efforts. As a result, the interplay of the legal framework with organizational culture and operational realities provides an ongoing opportunity for determining optimal governing authority, professional practices and care models that complement the commitment of hospitals and health systems to enhance quality care and patient access in a cost-effective, coordinated delivery system.

Key interest to physicians are issues regarding physician oversight, privileging, prescriptive authority, practice parameters, and practice venues.
Mid-level providers are really not competition for physicians; in the best models, they are collaborators and not meant to replace what you do, but instead enable you to focus on the things that require a physician’s expertise. If you decide to go down this path, have some patience and be realistic about what the mid-level providers can do on “day one” versus a mid-level provider with years of experience.”

Chad Whelan, MD
Associate Chief Medical Officer
University of Chicago Medical Center

Federal Regulations
The Centers for Medicare & Medicaid Services (CMS) defers to state licensure law for mid-level providers’ scope of practice parameters. CMS Conditions of Participation for hospitals (482.12) and interpretative guidelines provide that Medicare patients must be under a doctor’s care (MD or DO). However, they also explicitly reference a physician’s ability to delegate tasks to other qualified health care personnel “to the extent recognized under state law.” CMS regulations permit licensed practitioners such as nurse practitioners and nurse midwives, as allowed by the state, to admit patients to the hospital.

State Regulations
The Illinois Dept. of Financial and Professional Regulation (IDFPR) currently grants authority to and regulates the practice of APNs and PAs.

Regulations on Advanced Practice Nurses
Under the state’s existing Nurse Practice Act (225 ILCS 65), advanced practice nurses are required to be masters-prepared, nationally certified in one of four areas, and holding a current Illinois registered nurse license before recognition as a certified nurse practitioner (CNP), certified registered nurse anesthetist (CRNA), clinical nurse specialist (CNS), or certified nurse midwife (CNM). In addition, an APN may only practice with a physician delegating individual authority by a written collaborative agreement (WCA). The Nurse Practice Act also allows hospitals and hospital affiliates and ambulatory surgical treatment centers (ASTCs) the option of using the organization’s privileging process and board approval as a substitute for the WCA for their practicing APNs and PAs.

Scope of practice provisions explicitly list authorized APN activities. The law does not impose any ratio constraints on the number of APNs with whom a physician may have a collaborative agreement or vice versa. Legislation passed in 2013 explicitly references that APNs are authorized providers of primary health care services. While the APN is still relegated to provide services that their collaborating physician generally provides, the amended Act now supports that these practitioners are not limited by their collaborating physician’s scope of practice but may more fully practice and deliver services aligned with their individual education, training and competencies. A physician may delegate prescriptive authority, including for controlled substances. Under the state statute, APNs must complete 50 hours of continuing education every two years.

Regulations on Physician Assistants
A physician assistant (PA) is a licensed professional who is authorized by the state to engage in practice as a delegated physician agent. A physician assistant is a graduate of an accredited PA education program, certified by a national authority. The Illinois Physician Assistant Practice Act of 1987 (225 ILCS 95) mandates that PAs hold current certification from the National Commission on the Certification of Physician Assistants (NCCPA). Certified PAs take a recertification exam every six years and 100 hours of continuing medical education (CME) every two years. PAs who earn initial certification, or who regain certification by passing an exam in 2014, will begin a 10-year cycle with NCCPA that mandates compliance with new and more specific CME requirements. Twenty of the 50 Category I CME credits that are
already required to be obtained every two years will also need to be earned through self-assessment CME or performance improvement CME (PI-CME).

Physician assistants provide physician-level services under the general supervision of a physician (MD or DO). Supervision does not mean that a supervising physician must always be present with a PA or direct every aspect of PA-provided care. The law requires each physician-PA team to have written guidelines describing the working relationship of the PA with the supervising physician and the categories of care, treatment or procedures to be performed by the PA. In a non-hospital or community-based setting, a written supervisory agreement (WSA) is required. In 2012, the law was revised to allow interested hospitals and their affiliates and ASTCs to use their privileging process and board approval as a substitute for the WSA. Zac Sowa, MS, PA-C, President, Illinois Academy of Physician Assistants, says, “The change has provided a greater opportunity for hospitals to employ PAs. We believe more hospitals are hiring PAs due to this specific law change.”

Physician assistants may be employed by private or group practices, hospitals and their affiliates, nursing homes, or health care facilities if they function with the supervision of a physician. PAs may not bill directly for the care they deliver; only the employer may bill for the PA’s services. In 2012, the law expanded the supervisory ratio allowing a physician in a private setting to supervise up to five full-time equivalent PAs (allowing flexibility for part-time employment). There are also provisions for alternate supervising physicians to address vacation coverage within practice settings. Physicians within group practices who practice in the same general type of practice or specialty as the supervising physician may supervise the PA without being deemed the alternate supervising physician.

Each supervising physician must file a notice of employment with IDFPR. However, PAs may be employed by more than one entity; thus having more than one supervising physician. As with APNs, a physician’s delegation of prescriptive authority is optional and may include controlled substances.

**Regulations Concerning Controlled Substances**

The APN and PA practice acts and the Illinois Controlled Substance Act (720 ILCS 570) all provide the same language and compliance requirements for controlled substances. In order for APNs and PAs to prescribe controlled substances, they must obtain an Illinois mid-level practitioner controlled substance license before applying for and obtaining a federal DEA license. In addition, the delegating physician must file a notice of delegation of prescriptive authority and, when appropriate, a termination of that authority with IDFPR.

Revisions to the law in 2011 now allow delegated APNs and PAs prescriptive authority for any controlled III-IV substance aligned with their physician oversight, practice specialty and written authorization. The legislation also removed prior practice restrictions limiting the number of Controlled II prescriptions to five oral substances.

While the revision afforded broader authority, some constraints for Controlled II substances remain. Any physician delegation must identify specific Schedule IIIs by either brand name or generic name. Once delegated authority, APNs and PAs may prescribe Controlled II substances administered via the oral, topical and transdermal...
routes. However, they are prohibited from writing prescriptions for substances administered by injection or any route not explicitly identified.

Delegated PAs and APNs exercising their authority for controlled substances also are required to meet new threshold and continuing education requirements. PAs must satisfactorily complete 45 pharmacology hours from an accredited PA program for any new mid-level controlled substance license issued with Schedule II authority. APNs also are mandated to complete 45 graduate pharmacology hours for their new licenses, and both PAs and APNs are obligated to complete five hours of continuing education in pharmacology annually.

The 2011 amendment explicitly provides that Controlled II constraints for prescriptive authority do not apply to medication authority granted to an APN or PA delivering care in a hospital, hospital affiliate or ambulatory surgery treatment center. In those settings, these practitioners—qualified by their education, training, competencies, and as granted authority by their physician oversight—can write medication orders that are not subjected to the same Controlled Substance II constraints for prescriptions. The rationale is that these provider facilities are operating under their own DEA numbers, with comprehensive quality control mechanisms not present in community and office-based settings.

“What’s in a name?

The U.S. Drug Enforcement Agency (DEA) refers to licensed or registered clinicians, other than a physician, dentist, podiatrist, or veterinarian, who dispense controlled substances as “mid-level practitioners.” The Centers for Medicare & Medicaid Services (CMS) uses the term “non-physician practitioner” (NPP) in describing its payment policies for services rendered by advanced practice nurses and physicians assistants. In general, physicians refer to “mid-level providers” or “mid-levels” when referring to these practitioners.
Illinois Case Studies

To obtain a broader view of the successes and challenges of integrating APNs and PAs in Illinois hospitals and health systems, four medical executives were interviewed from a cross-section of organizations including an academic medical center, rural medical center and two community hospitals. Nationally recognized models of health care delivery which use APNs and PAs are also highlighted.

The Hospital Inpatient Setting

Advocate Trinity Hospital, Chicago, is a 188-bed medical/surgical community hospital. Diana Grant, MD, Vice President of Medical Management, discussed the initial integration of mid-level providers: “Historically, the first parlay using mid-level providers in the inpatient health care setting was Certified Registered Nurse Anesthetists in anesthesiology, then advanced practice nurses and physician assistants in the emergency department.” In some organizations, APNs and PAs are part of the surgical services team.

At Advocate Trinity Hospital, Dr. Grant stresses the importance of keeping the lines of communication open with the medical staff to foster an environment of collaboration: “The delivery of health care today must be done in an efficient and economical way,” she says. As the health care system focuses on quality, mid-level providers can enhance access to timely, patient-centered care despite the rising volume of demand for medical care.

Located in Chicago’s Hyde Park community, the University of Chicago Medical Center is an academic and research hospital, licensed for 400 inpatient teaching beds and providing more than 400,000 outpatient visits annually. In the wake of the Accreditation Council for Graduate Medical Education (ACGME)-imposed work hour restrictions for resident physicians, academic medical centers like the University of Chicago have increased the use of mid-level providers. “Residents work hours have changed compared to the traditional model. The use of mid-level providers in this setting serves as an initial workforce replacement solution,” says Chad Whelan, MD, Associate Chief Medical Officer.

Although it is routine for a patient to interact with APNs and PAs at hospitals, the level of interaction is determined by factors such as physician preference and the experience of the mid-level provider. “Some mid-level providers have a relatively restricted scope of practice, while others are practicing at the highest scope of practice,” says Dr. Whelan.

At 291-bed Advocate South Suburban Hospital, Hazel Crest, the hospital’s APNs assist in management of congestive heart failure (CHF) and diabetes patients. The APN receives consults for every patient admitted to the hospital with CHF.
diagnosis. The NICHE (Nurses Improving Care for Healthsystem Elders) APN works with patients 65 years of age and older to help decrease length of stay and readmissions. Richard Multack, DO, Vice President of Medical Management, says, “The infection control team is headed by an APN who will soon have full practice rights. Her work will significantly decrease nosocomial infections and help shorten length of stay.” APNs also serve as nurse educators on patient units.

Credentialing APNs and PAs in many organizations can be challenging due to the hospital culture, lack of medical staff acceptance and the absence of competency metrics and benchmark data for these providers. To overcome these challenges, Dr. Multack worked closely with the medical staff to create an infrastructure that ensures APNs and PAs meet the qualifications necessary to provide optimal patient care. The organization developed a Mid-level Credentialing Committee that includes APNs (including clinical nurse anesthetists) and PAs. If an application for privileges is approved by this committee, it is forwarded to the hospital’s Medical Executive Committee for final approval. “Each applicant is judged on an individual, case-by-case basis,” says Dr. Multack.

Collaboration with the medical staff has been instrumental in creating the infrastructure for greater use of APNs and PAs. Reflecting upon his experience, Dr. Multack says, “I recommend coming to the medical staff to discuss how using mid-level providers is helpful and not dangerous. It should be a collaborative experience.”

Unity Point Health-Methodist, a 311-bed hospital in Peoria, includes APNs and PAs in a number of specialty areas such as orthopedics, urology and cardiovascular departments. Recent additions include the intensivist and hospitalist service lines. These practitioners must meet certain requirements to demonstrate competency and procedural skills. “We require documentation of training and completion of a certain number of procedures under direct supervision before privileges are granted,” states Keith Knepp, MD, Vice President of System Integration. “The APNs and PAs are well accepted by the medical staff.”

**The Ambulatory Setting**

Advocate South Suburban Hospital launched a Heart Failure Clinic in April 2011. In collaboration with the medical director, protocols and standing orders were developed using evidence-based guidelines, with direct patient care provided by a nurse practitioner. From a baseline readmission rate of 23.4%, the average readmission rate dropped to 11% for the following eight months. This approach was effective in reducing readmissions and improving the quality of life for their patients.

Emergency department visit volumes have continued to climb, and the pipeline of emergency medicine specialists is not projected to keep pace with demand. In the emergency department at Memorial Hospital in Belleville, a 316-bed community hospital, mid-level providers function as dependent practitioners and are managed with oversight by the emergency department physician. “Around 2006, we enlarged our emergency department to treat 48,000 patients. We are now seeing 70,000 patients — so the new emergency department is already undersized,” says William Casperson, MD, Vice President.
Adding APNs and PAs in the emergency department has become a strategy to manage the increase in patient volumes.

With an aging population of baby boomers and a high number of individuals with limited access to preventive and primary care services, the emergency department is a safety net and primary point of access to health care for many individuals needing immediate care.

Dr. Casperson says, “The addition of mid-level providers to the health care team has been effective in managing patient volumes and expeditiously triaging the patients to the appropriate levels of care.” Mid-level providers are able to manage minor conditions in a timely fashion with physician oversight, freeing the emergency physician to focus on critically ill and injured patients. The use of mid-level practitioners in the emergency department has resulted in a decrease in the “left without being seen” rate from 4% to less than 1%.

**The Patient-Centered Medical Home**

In the outpatient setting, the Patient-Centered Medical Home is a team-based health care delivery model led by a physician and focused on improving health outcomes in the primary care environment. The model’s two important dimensions include care coordination and incorporating a team-based approach to improve quality care.

Advanced practice nurses and physician assistants are often an integral part of the team. The availability of evidence-based protocols enhances their ability to manage less complicated patients under the supervision of a physician, with complex cases referred to the physician. This approach provides a practice environment that delivers timely, effective quality patient care and helps manage the patient workload.

**Physician Group Practices**

There are unique examples of physician group practices that incorporate APNs and PAs to the full extent of their licensed skills in settings such as obstetrics and gynecology, rheumatology and geriatrics. “Mid-level practitioners in these environments can create a communal and cooperative environment,” says Dr. Multack.

About 25% of the U.S. population lives in rural communities, but only about 10% of physicians practice in these areas. Incorporating APNs and PAs in this environment is an ideal model for patient care. An integrated medical group in rural O’Fallon (located in St. Clair County, Illinois) utilizes a high functioning care management model with PAs. Merella Schandl, Manager of Medical Affairs, Memorial Hospital, Belleville, provided an overview of the processes used to demonstrate competency during reappointment. “The hospitalists render care to the inpatients of the O’Fallon medical group that includes physician assistants. At reappointment, clinical competence is derived from the level of medical management patients receive in the outpatient setting in conjunction with the care provided on an inpatient basis by the hospitalists. The hospitalist medical director reviews and attests that the level of care provided by the PAs in the outpatient setting is acceptable. The medical group’s admitted patients are considered well managed and appropriate. Our credential files indicate the care provided by physician assistants in

---

*About 25% of the U.S. population lives in rural communities, but only about 10% of physicians practice in these areas.*
the outpatient setting is ‘within the standard of care’ with no deviations noted.”

Katherine Shaw Bethea Hospital (KSB) is an 80-bed facility located in rural Dixon, Illinois. Advanced Practice Nurses and Physician Assistants are credentialed members of the employed medical group. They work in the Family Medicine clinics due to an increase in patient volumes. “There is almost an insatiable need for primary care, and it is hard to recruit primary care physicians,” says KSB Chief Medical Officer Timothy Appenheimer, MD, also a primary care and preventive physician. “As aspects of primary care becomes algorithmic and requires greater standardization, Physician Assistants and Advance Practice Nurses are very effective team members to fill this need.”

Nursing Homes
Dr. Appenheimer also serves as medical director at a nursing home where an APN group functions at the fullest extent of their certification. With a great amount of autonomy, the APN group provides daily primary care for 60–80 patients under a collaborative agreement with Dr. Appenheimer. As medical director, he receives a daily report of the patient care provided and is consulted for more complex cases. He also schedules periodic visits for Medicare patients. This model is new for the nursing home, and the APNs are “providing a great service for the patients,” according to Dr. Appenheimer.

Successful National Models
The Transitional Care Model (TCM) was developed by Mary D. Naylor, PhD, RN, Director of the New Courtland Center for Transitions and Health at the University of Pennsylvania School of Nursing. In TCM, an APN functions as the transitional care provider, conducting an initial visit and assessment in the hospital within 24 hours of enrollment of chronically ill adult patients who are most vulnerable during care setting transitions. The APN works with the patient’s physician to implement protocols, and follows up with a home visit within 24-48 hours of discharge from the hospital. A minimum of one home visit per week during the first month is made, followed by semi-monthly visits until the patient is discharged from the program. Patients in this model experienced 36% fewer readmissions through 52 weeks post-discharge.

TCM is an excellent example of a national model that successfully incorporates mid-level providers in both the inpatient and ambulatory health care settings. Another example is shown by Virginia Mason Medical Center’s Breast Clinic (Seattle, Washington), which developed a model to provide “rapid access” using an experienced APN at its clinic, which is equipped with mammography, ultrasound and magnetic resonance imaging technology. The treatment for patients with a non-malignant diagnosis is generally symptomatic and focuses on patient education rather than a surgical intervention. The results were compelling. Surgical consultation dropped 18%; the number of imaging studies decreased 29%; women received a final diagnosis in an average of four days instead of 16; and direct care costs decreased by approximately 19%.
Collaboration Key to Patient Care

Workforce shortages, an aging population and expanded insurance coverage will increase demands for greater inclusion of Illinois’ APNs and PAs. In addition, health care reform exacerbates the need for primary care practitioners. The ability to provide for accountable, coordinated patient care across all practice settings is essential in achieving the Institute for Healthcare Improvement’s Triple Aim:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Mary Barton, APN, President of the Illinois Society for Advanced Practice Nursing, agrees that the collaborative approach is best. “We are colleagues who can work together to take care of our population,” she says. “We need to retire any obstacles and provide safe, efficient, compassionate, and knowledgeable care that empowers the population to take better care of themselves.”

Dr. Richard Multack offers his insight: “I think there is a place for all levels of care, and physicians need to be free to take care of the more acute and critically ill patients. Mid-level practitioners will fill this niche, and overall it is in the best interest of patient safety and quality.”

Dr. Appenheimer states, “In the future, there will be plenty of room for primary care physicians, advance practice nurses and Physicians Assistants. Working together benefits the patients, offers a tremendous resource and will change the way primary medicine is practiced—including the role of the primary care doctor over time.”

Dr. Knepp says, “Success requires communication, planning and an ongoing investment of time to ensure the appropriate skill levels, scope of practice and good collaboration.”
Recommendations for Successful Integration of APNs and PAs

1. **Collaborate with the Medical Staff**
   and address any perceived barriers.

2. **Educate the Medical Staff**

3. **Highlight the Benefits**
   of collaboration.

4. **Establish Clear Competencies**
   and scopes of practice for mid-level practitioners with the medical staff to ensure “buy-in”.

5. **Ensure APNs and PAs**
   are practicing within their scope of practice as defined by state law.

6. ** Foster Open Communication**
   among all practitioners.

7. **Develop an Infrastructure**
   to support the services of APNs and PAs.

8. **Develop Reasonable Expectations**
   based on individual experience and skills.

“Success requires communication, planning and an ongoing investment of time to ensure the appropriate skill levels, scope of practice and good collaboration.”

Keith Knepp, MD
Vice President of System Integration
Unity Point Health-Methodist, Peoria
References


Contact Information

Derek Robinson, MD, MBA, FACEP
Executive Director
IHA Institute for Innovations in Care and Quality
630.276.5590
d robinson@ihatastaff.org

Sonya Dudley, MBA, MT (ASCP), CPHQ
Director, Performance Improvement
IHA Institute for Innovations in Care and Quality
630.276.5827
sdudley@ihatastaff.org

Illinois Hospital Association
1151 E. Warrenville Road, Naperville, IL 60563
630.276.5588
Naperville | Springfield | Washington, DC
www.ihatoday.org