

Advanced Practice Providers (Physician Assistant and Nurse Practitioner) Medical-Legal Issues

an Information Paper

Reviewed by the ACEP Board of Directors, November 2016

Nurse practitioners (NP) and physician assistants (PA) are a growing part of the emergency department (ED) team. ACEP's Medical Legal Committee has been asked to summarize the issues of working with, hiring and supervising these Advanced Practice Providers (APPs). This document will try and answer questions related to APPs and there are attached links provided for more information.

Emergency Nurse Practitioner Educational Preparation

Nurse practitioners must be registered nurses. The minimum education level is a master's degree but they may be educated to the terminal degree of DNP or PhD. Nurse practitioners are nationally certified, and may then advance to obtain specialty knowledge and competencies in accordance with the Consensus Model for APRN Regulation.¹

Emergency Nurse Practitioners (ENPs) must be prepared to provide primary care and acute resuscitation, as well as manage complex, unstable conditions in patients of all ages; therefore, current ENP educational programs build upon Family Nurse Practitioner (FNP) education to provide specialty knowledge across the lifespan. Specialty training in emergency care is currently available through graduate academic programs and through fellowship programs. Listings of current ENP academic programs, both graduate and post-graduate, and ENP fellowship programs are available on the AAENP website (<http://aaenp-natl.org/index.php>).

The ENP scope of practice is based on educational preparation, state regulation and licensure, and institutional credentialing. Not all nurse practitioners have the same knowledge and skill sets. Competency to practice in the emergency care setting is based on academic preparation, certification in a specific patient population (most appropriately family), and specialty education in emergency care - not on prior emergency nursing experience. Therefore, it is important to evaluate the educational qualifications of nurse practitioners to ensure they possess specialty qualifications for emergency care.

Evaluation of ENP Competencies may be assessed in several ways:

- Successful completion of an academic ENP program or post-graduate emergency care fellowship program
- Organizational orientation, skill acquisition, and evaluation based on location and organization standards
- Completion of emergency-specific continuing education
- Individual portfolio documentation of skills, training and/or procedure log

1. American Nurses Credentialing Center (2008). Consensus model for APRN Regulation: Licensure, Accreditation, Certification and Education. Retrieved from <http://www.nursecredentialing.org/APRN-ConsensusModelReport.aspx>

Physician Assistant Background and Education

The physician assistant (PA) profession started in 1965 at Duke University. Well trained medics were returning from Vietnam and there was little employment for these highly skilled individuals in civilian life. Dr. Eugene Stead conceived and implemented the PA program which has grown to approximately 110,000 certified PAs and 170 accredited programs around the country, and many more now around the world.

The PA profession emphasizes previous experience for its candidates. Many programs require over 1000 hours of direct medical care for applicants. This may include paramedic, nursing, technician, medical

assistant, scribes, and many others. Most of the programs now are master's programs with a required bachelor degree with basic pre-med prerequisites. The average PA student is 24 years old with a bachelor degree and three years of healthcare experience.

PA programs are all accredited by the Accreditation Review Commission on the Education of Physician Assistants (ARC-PA). ARC-PA is the accrediting agency that protects the interests of the public and PA profession by defining the standards for PA education and evaluating PA educational programs within the territorial United States to ensure their compliance with those standards.

PA programs vary from 24-28 months. PAs are trained in the medical model. Many PA programs are associated with medical schools so the physician/PA relationship starts early in training. The first year is didactic and is mostly classroom, with some hospital-based or office-based education performing supervised history and physicals. The second year is clinical and rotates through specialty services. At least 2000 hours of clinical training, supervised by physicians and PAs is required. Rotations include:

- Emergency Medicine
- Family Medicine
- Geriatric Medicine
- Internal Medicine
- Obstetrics/gynecology
- Orthopedics
- Pediatrics
- Psychiatry
- Radiology
- Surgery

After successful graduation from an accredited PA program, the PA must successfully pass the Physician Assistant National Certifying Exam (PANCE) which is given by the National Commission on the Certification of Physician Assistants (NCCPA), similar to American Board of Emergency Medicine. This must be passed to become certified and is a requirement for all state licenses. The PANCE exam is a generalist exam and not specific to a specialty. There is a surgical and general medicine exam; either may be elected.

PAs must have 100 hours of CME every two years to keep their certification in most states. These included, up until recently, Category I and Category II CME, similar to physicians. Recently the NCCPA changed to two-year cycles. During each of those two-year cycles, the PA must earn and log at least 100 CME credits, including at least 50 Category 1 CME credits. Also -- new in the certification maintenance cycle -- 20 of the 50 Category I CME credits must be earned through self-assessment (SA) CME and/or performance improvement CME (PI-CME). By the end of the first four two-year CME cycles, PAs must have earned a total of at least 40 Category 1 CME credits through PI activities **and** 40 Category 1 CME credits through SA activities.

Until recently, PAs took a recertification test every six years. This was changed to every 10 years to more closely mirror physician colleagues. NCCPA is now considering changes to the test which may include more frequent smaller tests and more specialty emphasis, but this is currently in development. Any changes will be posted on www.NCCPA.net.

Over the last few years, the NCCPA has provided a Certificate of Added Qualification (CAQ). This is an optional additional exam that can be taken and passed to prove added education and training in a specialty. Emergency medicine is one of these specialties.

Physician assistants seeking the Emergency Medicine CAQ must demonstrate advanced knowledge and experience in emergency medicine, above and beyond that expected of entry-level PAs or PAs working in a generalist practice. PAs seeking eligibility for the Emergency Medicine Specialty Examination must meet requirements of specialty-specific CME, experience in the field, and specific knowledge and/or experience in conducting procedures and being involved in patient cases that are deemed core to the specialty area of practice. PAs will have six years within which to complete all four components for the CAQ, including passing the specialty exam.

Physician assistants seeking the Emergency Medicine CAQ must also first satisfy two basic prerequisites: (1) current PA-C certification and (2) possession of a valid, unrestricted license to practice as a PA in at least one jurisdiction in the United States or its territories, or unrestricted privileges to practice as a PA for a government agency. NCCPA's specialty CAQ process is predicated on a strong belief in the value and importance of the physician-PA team, and in support of the procedures and patient case requirement, each applicant must provide attestation from a supervising physician who works in the specialty and is familiar with the PA's practice and experience. PAs may find it helpful, however, to secure such a physician sponsor at the beginning of the process for the purpose of seeking guidance on the pursuit of the other requirements.

CME Requirement

In the six years preceding the date of application for the specialty exam, candidates must earn a minimum of 150 credits of Category 1 CME focused on emergency medicine practice with a minimum of 50 of those credits having been earned within the two years prior to the date of exam application. The 150 required CME credits must include completion of an Advanced Cardiac Life Support course. The same 150 credits **may also be used** for maintenance of the PA-C credential.

PAs are encouraged to use their best judgment when determining whether individual CME activities are related to emergency medicine, understanding that those credits may be subject to a CME auditing process.

Upon fulfillment of all CME requirements, candidates must attest to their completion at NCCPA's website.

Recommendations for CME Activities: Physician and PA emergency medicine leaders provided input in developing the following CME recommendations for PAs interested in pursuing a CAQ in that specialty. Applicants should complete a comprehensive emergency medicine course that reflects the guidelines set forth in the most current version of Model of the Clinical Practice of Emergency Medicine. Applicants should also complete the following courses:

- Pediatric Advanced Life Support or Advanced Pediatric Life Support
- Advanced Trauma Life Support
- Airway course

EXPERIENCE REQUIREMENT

Physician assistants seeking the Emergency Medicine CAQ must have gained at least 3,000 hours of experience (the equivalent of 18 months of full-time practice) working as a PA in emergency medicine within six years of the date they attest to NCCPA that the experience requirement has been satisfied. If selected for an audit, documentation substantiating that work experience will be required.

PROCEDURES/PATIENT CASE REQUIREMENT

Candidates for the CAQ must be able to apply the appropriate knowledge and skills needed for practice in the specialty, as described below. In support of this requirement, each candidate must provide attestation

from a supervising physician who works in the specialty and is familiar with the PA's practice and experience. The physician attestation must indicate that the PA has performed the procedures and patient management relevant to the practice setting and/or understands how and when the procedures should be performed.

Again, the PA may not have experience with each procedure, but he or she must be knowledgeable of the basics of the procedures, in what situation the procedures should be done, and the associated management of patients.

In determining whether a PA can satisfy the Specialty Procedures and Patient Case Requirement, consideration should be given to the following areas:

Airway Adjuncts: Invasive Airway Management

- Intubation
- Mechanical ventilation
- Capnometry
- Non-invasive ventilatory management

Anesthesia

- Local, digital
- Procedural anesthesia, conscious sedation

Advanced Wound Management

- Incision & drainage, wound debridement
- Superficial/deep wound closure

Diagnostic/Therapeutic Procedures

- Soft tissue and joint aspiration
- Lumbar puncture
- Slit lamp examination
- Thoracentesis, thoracostomy
- Tonometry
- Control of epistaxis
- Electrocardiographic interpretation
- Cardiac pacing
- Defibrillation/cardioversion
- Clearing a cervical spine
- Fracture/dislocation management

Hemodynamic Techniques

- Peripheral venous access
- Arterial access for diagnostics and placement of arterial lines
- Central venous access
- Intraosseous infusion

Radiographic Interpretation

- Chest x-ray
- Plain films (bone, soft tissues, abdominal series, etc.)
- CT scans, MRIs

Resuscitation

- Cardiopulmonary
- Fluid

THE EMERGENCY MEDICINE SPECIALTY EXAM

Once PAs have satisfied all other requirements for the Emergency Medicine CAQ, they can apply for the Emergency Medicine Specialty Exam -- 120 multiple-choice questions related to emergency medicine

targeted for PAs with experience in the practice of that specialty. It will be based on the Content Blueprint, developed using data gathered during the 2009-2010 PA Practice Analysis conducted by NCCPA.

Resources:

www.aapa.org
www.sempa.org
www.nccpa.net
www.arc-pa.org
www.paeaonline.org
www.pahx.org

**Society of Emergency Medicine Physician Assistants
Post Graduate PA Training in Emergency Medicine**

Primary PA education is designed to provide a generalist foundation upon which PAs can, over time, build specialty knowledge and skills. Historically this has been accomplished through on-the-job training alongside experienced PAs and EPs. As PAs are being utilized in ever expanding roles, the amount of specialty knowledge needed to continue to provide excellent patient care is increasing. Concurrently ever increasing time, fiscal, and liability pressures make it challenging for new graduate PAs to obtain specialty education in the standard on the job system. While some practices have developed structured orientation programs many PAs new to emergency medicine are placed in the ED to “sink or swim.” The high failure or burnout rate of these PAs has caused many employers to not entertain new grads as candidates. These factors have generated a demand for more uniform formal specialty training programs, which are now called EMPA Residencies or Fellowships.

USC Medical Center LA County Hospital had the first emergency medicine residency for PAs. It was an abridged version of EM physician residencies lasting one year. This program was very popular with PAs but there was a two-year experience requirement and they typically only took two residents a year. The program started in 1990, and unfortunately, due to budget cuts, the program was discontinued. For years after this, there was a void in emergency medicine post-graduate training for PAs. Many emergency medicine groups and physician residencies looked into providing this extra training, but because it is not reimbursed through Medicare and the federal government, or were based on grants with finite limits, many of the programs were dropped.

As the ED became more complicated with sicker patients, the PAs, NPs and the physicians found that most of the new hires were not able to be effective in the ED for up to a year. Many of the departments started an informal orientation program and some advanced to a more structured program with specific goals. Soon it was apparent the ED groups saw a need to create these programs and some even started to advertise to train PA and NPs in emergency medicine.

Over the past 5 years a more common understanding of the benefit of formal specialty training has driven an increase in EMPA postgraduate training programs for both PAs and NPs. In 2011 there were 5 programs; today there are over 30. Several of today's programs accept both PAs and NPs. Most range from 12-18 months, and are operated by hospital, university or physician groups. These programs range in class size from 1 to 20 and draw from a national pool of applicants with all levels of prior clinical experience. There is currently no accrediting body for PA postgraduate training programs in any specialty. This was done for a short period of time by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), however they have suspended this process while they determine if, and how, they will continue. While the ARC-PA was active in accrediting PA postgraduate training, the standards they used did not outline knowledge or skills required to be developed in the

programs, rather the ARC-PA accreditation process evaluated the programs means and methods for achieving self-determined educational objectives. There is currently only one ARC-PA accredited EM program- the University of Iowa.

The Association of Post Graduate PA Programs (APPAP) and the Society of Emergency Medicine Physician Assistants (SEMPA) in concert with ACEP leaders have tried to give guidance to this ever growing list of programs. In 2015 SEMPA released Emergency Medicine Physician Assistant Postgraduate Training Guidelines, which were developed by a national committee of program directors and interested parties. A list of the current self-reported programs can be found on the www.SEMPA.org and www.APPAP.org sites. The programs usually call themselves residencies like the physician model, or fellowships. Some have found billing issues when called residencies but this has not been universal. SEMPA continues to work with ACEP on these issues.

**Society of Emergency Medicine Physician Assistants
Emergency Medicine Physician Assistant Postgraduate Training and Emergency Medicine
Physician Assistant Practice Guidelines**

- I. The Society of Emergency Medicine Physician Assistants (SEMPA) strongly encourages physician groups, hospitals and educational institutions to adopt training and educational opportunities to prepare physician assistants seeking to practice emergency medicine. SEMPA recommends that hospitals, educational institutions and medical groups that are establishing postgraduate emergency medicine training programs [i] for physician assistants:
 - A. Utilize a curriculum based on The Model of the Clinical Practice of Emergency Medicine (American Board of Emergency Medicine) [ii] and one that prepares the physician assistant to manage critical, emergent and lower acuity patients.
 - B. Appoint a board-certified emergency physician as medical director and an emergency medicine physician assistant as program director.
 - C. Obtain accreditation of the program through the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) [iii].
 - D. Offer training and experience that would minimally meet the standards established by SEMPA as appended.
 - E. Where appropriate or valuable, provide clinical rotations into specialty areas to gain specific procedural or cognitive skills germane to the practice of emergency medicine.
 - F. Completion of a post-graduate training program should prepare the candidate to sit for the Certificate of Added Qualifications (CAQ) granted through the National Commission on Certification of Physician Assistants (NCCPA) [iv]. See SEMPA's official statement on the CAQ
 - G. Work collaboratively to share resources and curricula with other entities providing or hoping to provide postgraduate specialty training in emergency medicine and commit to assisting new and start-up programs.
 - H. Collaborate with SEMPA, the American Academy of Physician Assistants (AAPA) and the American College of Emergency Physicians (ACEP) in creating excellence in the practice model of the physician-PA [v] team approach to emergency medicine.
 - I. Support and encourage membership and active participation by physician assistants in SEMPA.
- II. SEMPA recommends that new graduate physician assistants without emergency medicine experience or PAs newly entering the field of emergency medicine:
 - A. Seek appropriate experience(s) and education that parallels the training curriculum for emergency medicine postgraduate training as outlined above.
 - B. Document learning and procedures in a log fashion for credentialing purposes and proof of experience.

- C. Consider the CAQ granted through NCCPA as verification of learning and experience when eligible.
 - D. Obtain basic national credentials such as Advanced Cardiac Life Support (ACLS), Comprehensive Advanced Life Support (CALS), Advanced Trauma Life Support (ATLS), and Pediatric Advanced Life Support (PALS).
 - E. Actively participate in the specialty through membership in SEMPA.
- III. SEMPA recommends that all physician assistants in emergency medicine:
- A. Pursue continuing education in emergency medicine, minimally 25 hours Category I Continuing Medical Education annually, through SEMPA-, ACEP- or AAPA-approved or sponsored educational programs.
 - B. Document maintenance of skill competency by ongoing experience or demonstration in skills lab.
 - C. Actively participate in the specialty through membership in SEMPA.
 - D. Maintain other credentials as needed such as CALS, ATLS, ACLS, PALS, etc.
 - E. SEMPA recognizes that the NCCPA Certificate of Additional Qualifications is one way for physician assistants in emergency medicine to demonstrate advanced practice knowledge.
 - F. Volunteer as preceptors for undergraduate physician assistant student rotations in emergency medicine and pursue opportunities to teach, mentor and support physician assistants seeking postgraduate training in emergency medicine.
- IV. Hospitals and emergency physician groups should have policies and practices in place that minimally:
- A. Permit emergency medicine physician assistants to practice to their full scope of knowledge and experience.
 - B. Recognize the training and experience of physician assistants who have not completed formal postgraduate training programs but can document training and experience consistent with these guidelines.
 - C. Integrate emergency medicine physician assistants into the medical staff and have opportunities to share in governance, management and other functions of the department or group.
 - D. Apply the principles of the physician-PA team as articulated by AAPA.
 - E. Have systems in place to provide meaningful and timely supervision of emergency medicine physician assistants to minimally include peer review, individual case review and ongoing quality improvement.
 - F. Support and encourage ongoing education for physician assistants in emergency medicine.
 - G. Support and encourage membership and active participation by physician assistants in SEMPA.
 - H. Have guidelines specifying supervising physician responsibilities, including factors that trigger when supervising physician consultation should be obtained.
- V. Emergency medicine residency programs should consider:
- A. Integrating training modules to enable residents to learn the role of “physician leader” of the physician-PA team.
 - B. Operate emergency medicine physician assistant postgraduate training in parallel with physician residencies to build team experience and competency.

**Standards for Postgraduate Training of Emergency Medicine Physician Assistants
Adopted by the Society of Emergency Medicine Physician Assistants, December 2012**

1. Provide a minimum 3,000 hours or 18 months of direct-patient care in an emergency department, preceptored by an experienced emergency physician.
2. Provide a didactic component based on The Model of the Clinical Practice of Emergency Medicine (American Board of Emergency Medicine) [vi] and one that prepares the physician assistant to manage critical, emergent and lower-acuity patients.
3. Provide broad experience in managing the conditions presenting to the emergency department.
4. Have documented procedural experiences to minimally show understanding of:
 - Intubation and difficult airway management
 - Emergency cricothyroidotomy
 - Chest tube insertion
 - Ventilator management
 - Procedural sedation and rapid sequence intubation
 - Fracture and dislocation management
 - Slit lamp and tonometry
 - Additional skills as determined by preceptor or program
 - Intra-osseous placement
 - Central line placement
 - Capnography
 - Advanced EKG interpretation
 - Radiographs, Computerized Tomography, Magnetic Resonance Imaging, ultrasound basic interpretation
 - Simple and advanced wound closure
 - Cardiac resuscitation (to include cardioversion and cardiac pacing)
 - Arterial access for blood gas and monitoring
 - Lumbar puncture
 - Use of bedside ultrasound
 - Joint aspiration and injection
 - Additional skills as determined by preceptor or program
 - Skills should be obtained through patient, cadaver or simulation laboratory teaching.
5. Demonstrate and document team leadership knowledge and skills in the management of:
 - Cardiac arrest
 - Shock
 - Respiratory arrest
 - Traumas
 - Unresponsive patient(s)
 - Overdose patients
 - Diabetic ketoacidosis and other endocrine emergencies
 - Obstetric and gynecologic emergencies;
 - Pediatric emergency
 - Oncologic emergency
 - Hazardous material exposure
 - Mass casualty events
 - Other situations as determined by preceptor or program

Resources

- [i] Consider using the designation “Fellowships” or other label in lieu of “Residencies” to maintain compliance with Centers for Medicare and Medicaid Services (CMS) [i]and the Accreditation Council for Graduate Medical Education (ACGME)
- [ii] American Board of Emergency Medicine -
http://www.abem.org/PUBLIC/portal/alias_Rainbow/lang_enUS/tabID_4223/DesktopDefault.aspx
- [iii] Accreditation Review Commission on Education for the Physician Assistant - http://www.arc-pa.org/postgrad_programs/
- [iv] National Commission on Certification of Physician Assistants -
<http://www.nccpa.net/Emergencymedicine.aspx>
- [v] American Academy of Physician Assistants -
http://www.aapa.org/uploadedFiles/content/Common/Files/PI_PhysicianPATeam_v5%20-
- [vi] American Board of Emergency Medicine -
http://www.abem.org/PUBLIC/portal/alias_Rainbow/lang_enUS/tabID_4223/DesktopDefault.aspx

Hiring PAs and NPs

When hiring a PA and/or a NP there are many things to consider, some of which can be found at this hyperlink: [Hiring a PA](#). PAs and NPs have been recognized by Congress and the President as crucial to improving U.S. healthcare. In the Patient Protection and Affordable Care Act, Congress recognized PAs as one of three healthcare professions in primary care.

Because of their general medical background, PAs and NPs have flexibility in the types of medicine they can practice. That makes them responsive to changing healthcare needs. PAs and NPs are uniquely suited to provide preventive care services in all settings, from primary care to surgery.

PAs work in teams with their supervising physicians and are educated in a collaborative approach to healthcare, which improves coordination of care and can improve outcomes ([PAs and Team Practice](#)) PAs are educated in intense educational programs that last approximately 26 months (3 academic years). This relatively short training period means that PAs can quickly begin practice, helping offset the worsening physician shortages. PAs extend the care that physicians provide and increase access to care.

When hiring PAs and NPs there needs to be verification of credentials and graduation from an accredited program. A purpose and scope of practice discussion between the groups should also be done, to set the expectations and goals for the PA or NP. Also considered in this discussion are state laws and hospital credentialing. Depending on state law PA's are usually supervised and NP's are either independent practice or have some form of collaboration agreement. The PA or NP should also be honest about their experience and need for further education. Goals should also be set for the department and the new providers which are realistic and will help the PA and NP be successful and grow.

Hiring is usually not difficult, but hiring the right person can be. There are ways to find the right person for the department. One way is a search and publishing the job on various websites. Another is to mentor PA and NP students during their clinical rotations. This requires establishing your department as a clinical site with an educational institution. The advantage beyond advancing provider education is the ability to evaluate a potential candidate prior to hiring. Looking for fellowship and residency programs is a way to find a PA or NP who has been trained with some structure and experience. The hiring group will need to check out those programs to make sure they are reputable and review their curriculum.

Hiring an experienced PA or NP may have many advantages, but also may have some draw backs, such

as poor habits from a previous job or limitations in the scope of practice. To increase chances of success, consider on-boarding the new PA or NP as any other member of the practice group. A designated mentor will also increase chances of success.

Also consider the credentialing and enrollment process with insurance carriers. Each payer determines credentialing and enrollment policies for PAs. In fact, the same national payer may have different rules regarding PA and NP credentialing and enrollment in different states. And, some private payers or Medicaid departments may enroll PAs or NPs while others will not.

It's important to understand that enrollment and credentialing are not synonymous with coverage or payment for services. Many payers who do not separately credential PAs or NPs will cover their services when billed under the supervising physician's name or the group practice.

The term "incident to" is occasionally used to describe coverage of services performed by a PA or NP, when those services are billed under the name of the supervising physician. That is not correct. "Incident to" is a Medicare term used to describe services billed in the office or clinic setting. The "incident to" billing concept is not utilized in the hospital (inpatient or outpatient).

Non-Medicare payer enrollment policies are made on the local payer level. The policies followed by Medicaid and Blue Cross/Blue Shield programs vary considerably by state. For example, the Medicaid program in one state may enroll PAs or NPs, while the Medicaid program in a neighboring state may only recognize physician services.

The best way to determine credentialing and enrollment policies is to contact the payers in your specific area to ascertain their policies.

Physician Supervision of Advanced Practice Practitioners

Physician assistants and Advanced Practice RNs (APRN) are valuable partners in caring for patients in the emergency department. Once considered a staffing option, they have become indispensable to the overall efficient function of the department as population growth continues to outpace physician graduation rates and an influx of newly insured patients is predicted as a result of the adoption of the Affordable Care Act.

Their value undisputed, it must be emphasized that APPs practicing in the emergency department remain predominantly *dependent practitioners*, that is they function under direct or indirect supervision of physicians. This practice model varies from group to group and department to department but, in general, mandates that the midlevel practitioner have access to consultation with a supervising physician real time, either face-to-face, by phone or by electronic media.

Supervision is codified through the use of documents known as 'supervision agreements' or alternatively as 'delegation agreements.' These documents, typically produced with input from the ED Director or a designee, detail the fundamentals of how APPs interact with their supervising physician and how they will collaborate in providing care. This list of guidelines and practice parameters would at minimum include the types of conditions and level of acuity that a midlevel practitioner is allowed/expected to see either with or without direct physician consultation. As scope of practice can vary from facility to facility, it is generally recommended that these agreements be constructed in a flexible manner that allows for variation in practice and capabilities that may exist amongst different practitioners. It should be emphasized that scope of practice is loosely defined as anything that a supervising physician feels comfortable delegating to the midlevel practitioner, but may have some limitations imposed by state law and regulation or by institutional or departmental bylaws.

As noted above, supervision of PAs and APRNs can occur either directly, where a physician personally evaluates each patient in collaboration with the midlevel, or indirectly, where the midlevel, functioning within the constraints of the supervision agreement, evaluates and dispositions patients independently and consults with a physician as needed and as dictated by their judgment and comfort level. Both practice models work effectively, but the latter may require inclusion of more specific limitations within the supervisory agreements and more diligent review of charts by the supervising physician who has not independently evaluated the patient. Likewise, it is of paramount importance to include midlevel care in the emergency department medicine quality assurance and improvement activities to ensure safe and effective collaboration.

As is the case whenever patient care is delegated or shared amongst clinicians, maintaining open lines of communication between midlevel practitioners and physicians is critical to the successful and safe functioning of this model. Whether functioning together or separately within a common ED where a collaborating physician is present on site, or in an urgent care facility where a physician's input and judgment are available 24/7 by telephonic or electronic communication, it is critical that there is no hindrance to the exchange of advice and ideas through consultation when necessary. This principle cuts both ways as it puts the onus on each party to go the extra mile in maintaining the health of this channel of communication. Particularly in the indirect supervisory model, it takes a mixture of prudent judgment and humility on the part of the midlevel to know when he/she is in over their head in a case. Though the above-mentioned guidelines delineate what should and should not be independently evaluated by a midlevel, patient sorting decisions occurring in triage are not infallible. Patients at times, on further scrutiny, turn out to be more complex than they appeared initially *and there must be no fear or reluctance on the part of the midlevel practitioner to approach the supervising physician for input*. Similarly, physicians bear a great responsibility to play their part in maintaining communication. This requires, above all, *that the physician maintain an open and welcoming attitude to midlevel approach with questions* regarding care, lab/radiologic study evaluation and requests for contemporaneous bedside assessment. Though the stress of high volumes and patient acuity can be daunting, it is important for the physician to avoid leaving the impression with our midlevel colleagues that their concerns and requests are frivolous, inept or unwelcome. Physicians must understand that they will be consulted one way or another, either at the time of the encounter or at the time of chart cosign, and it is infinitely preferable to make the correct decision early and in real time than to rectify a mistake in judgment post disposition.

Concerns over the impact of midlevel utilization on risk to the patient continue to be expressed. Though there are no published studies showing a difference in outcome resulting from use of APPs in the ED, clearly there is a legal expectation of ensuring competency of employed physician extenders. A structured approach to onboarding newly hired APPs is therefore desirable in meeting that requirement. Whether the midlevel is supervised directly or indirectly, helpful mitigating strategies include ensuring adequate orientation, training and assessment for competency such that a baseline foundation of clinical and procedural knowledge is assured. Level of clinical skills amongst practitioners entering practice will vary depending on prior training and ED work experience. Hence, flexibility must be exercised in allowing for initial closer observation by the supervising physician and/or fellow experienced midlevel practitioners as a new midlevel enters practice, as noted above, adherence to a structured supervision agreement detailing the approved subset of cases that can be safely managed by the midlevel will go a long way toward managing the inherent risks.

Finally, no discussion of midlevel supervision would be complete without addressing matters of liability. There is understandable concern on the part of physicians over risks assumed through delegation of patient evaluation and management to APPs and, in particular, the act of cosigning a midlevel chart on a patient that he/she may have only peripherally examined or, in the indirect model, were never consulted upon in the first place. Though apprehension is predictable as one cedes a measure of control, it is

important to recognize that as long as the cosigning process is conscientiously performed, the actual legal risks are likely less than imagined. Though there is no hard clad certainty when it comes to the outcome of legal proceedings, physicians are held to the standard of caring for patients in a manner that is reasonable under prevailing circumstances and are typically held responsible for decision-making based on information available to them real time. Hence, as long as established supervision policy is followed and the available chart is constructed in a manner that depicts a history, physical exam and workup that is logical and consistent with the documented disposition and follow-up instructions, the physician should have a future strong defense in the event of a filed lawsuit. The real and substantial risk comes from the ill-advised and not infrequent practice of blindly cosigning charts that may not maintain the critical consistency in illustrating a presentation that supports the prescribed therapy and disposition. The underlying message is two-fold. The midlevel should put maximal effort toward dutifully creating a chart that is logical, consistent and easy to cosign while the physician must likewise conscientiously examine the chart they are cosigning and, if necessary, respond to identified errors in care in a timely manner to facilitate return or change in therapy as necessary.

Advanced Practice Providers: Orientation

As APPs start work in the emergency department, it is essential that they begin with a formal orientation process. The purpose of this orientation is to ensure that they are familiar with specific policies and procedures relevant to the specific ED in which they are practicing, thus minimizing risk, enhancing patient safety, and improving the likelihood of a good experience for all. A common set of expectations between ED leadership, physicians, and APPs can then be created, leading to a consistent, high quality experience for patients.

Ideally, a written orientation manual or document will be created, with the expectation that it has been fully reviewed by the APP prior to the first shift. As part of the orientation process, APPs should initially work with an experienced ED physician who is tasked with helping to orient the new APP. While the number of such shifts will vary by institution, there should be a sufficient number of “orientation shifts” to ensure the APP is ready to work in the role.

Elements of an orientation for APPs should include:

- Discussion of scope of practice
- Review of department policies and procedures
- Training in the EMR being used
- Review of availability of specialists and sub-specialists
- Review of written guidelines delineating types of patients APPs may evaluate
- Review of procedures APPs may perform
- Review of expectations regarding supervision, and when to engage physician
- Expectations regarding APP documentation, for both patient care and billing
- Expectations regarding ordering of medications, lab studies and other testing
- Review of expectations regarding communication with patients and families
- Documentation of successful completion of orientation process and knowledge gained

Resources

American College of Emergency Physicians. Guidelines regarding the role of physician assistants and advanced practice registered nurses in the emergency department. [policy statement]. June 2013.
Accessed at: <https://www.acep.org/Clinical---Practice-Management/Guidelines-Regarding-the-Role-of-Physician-Assistants-and-Advanced-Practice-Registered-Nurses-in-the-Emergency-Department/>

Hospital Credentialing and Privileging

Medical or hospital credentialing has many facets and may depend on how the NP or PA is hired. The NP or PA can be hired by the hospital or by the emergency department group. Medical staff should be blind to the employer during the credentialing process. There are three areas that can affect the credentialing process.

Human Resources

The NP or PA may work for the hospital or an ED staffing group and each will have their own process. They have the responsibility to help to screen the new hire, look over the background material and recommendations. They may work with the medical staff of the hospital or system but they are separate. The contract with the hospital by the individual or group would be included in this area. The group or the hospital can define the role of the NP or PA.

Hospital Medical Staff

There are two basic credentialing bodies, one being that of medical staff which would have the responsibilities of the medical staff membership. The other is a separate sub set of the medical staff, which in many cases may cover dentists, podiatrists, CRNAs, nurse midwives, psychologists, NPs and PAs. They usually do not have full membership to the medical staff and may not have the same privileges or responsibilities.

Membership in a traditional medical staff is related to independent vs dependent practitioner status which can be defined by hospital policy, group policy or state rules. Even independent providers can be limited by the hospital by-laws even if the state rules are different. Some hospitals are moving to a professional staff which can include independent and dependent providers.

Credentialing is basically the same for all. Qualifications are verified as required by law and the organization: competence and references from collaborating physicians, employers, and past practice associates.

The hospital by-laws set the privileges of the provider and can be specific or vague. The delineation of privileges and scope of practice set what can and cannot be done as well as the level of supervision. The privileges are typically granted and renewed every two years.

If the provider is not on the medical staff they may not have a right to be heard or appeal to the medical staff or through their process. In this case, the decision on due process resides with human resources.

State Rules

State rules or laws will have an impact on the credentialing of the NP or PA. As discussed previously, these may depend on independent vs dependent status. They may also limit the privileges of the provider. The state laws are referenced with a link at the end of this document.

Basic Steps Involved in Privileging NPs and PAs

- Step 1: Establish policies and rules • Medical executive committee (MEC), and governing board are responsible for this process.
- Step 2: Collect and summarize information • Management and medical staff and MEC are responsible for this process.
- Step 3: Evaluate and recommend: This is the responsibility of the department chairs, credentials committee, and MEC

- Step 4: Review, grant, deny, or approve • This is done by the governing board or designated agent.

In 2007 and 2008, The Joint Commission published standards regarding ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) for privileged practitioners. Many hospitals have focused upon creating these structures for medical staff members (physicians) but not for NPs and PAs. The Joint Commission standards require that the same processes be applied to the NPs and PAs as well. OPPE is the routine monitoring of current competency for current medical staff members (Peer Review) while FPPE is establishing current competency for new medical staff members, new privileges and or concerns from OPPE (Proctoring or focused review).

The roles of and processes from credentialing and privileging NPs and PAs as well as other practitioners who provide a medical level of care should be outlined in a hospital's staff bylaws. Hospitals not seeking deemed status can use the organized medical staff or other equivalent process. The credentialing should involve verifying that the individual is properly certified, licensed or registered with the state and that he or she has adequate liability insurance.

As with other practitioners credentialed under the organized medical staff, hospitals should ensure that the privileges of NPs and PAs are consistent with all applicable state laws and regulations. (Joint Commission Medical Staff Handbook)

Resources:

<http://www.credentialingresourcecenter.com>
<http://www.jointcommission.org>
<http://greeley.com>
<https://www.aapa.org/workarea/downloadasset.aspx?id=513>
<http://aaenp-natl.org/>
<http://www.sempa.org>
<https://www.hortyspringer.com>
<https://www.staffcare.com/uploadedFiles/StaffCare/Content/Resources/Blogs/nurse-practitioners-physician-assistants-supply-distribution-and-scope-white-paper.pdf>

APP Practice Setting

With the projected physician shortage in the U.S. and increasing demands on the healthcare system, there has been an increased use of advanced practice providers as members of the emergency department team. Depending on their scope of practice, hospital credentialing, and state licensing requirements nurse practitioners and physician assistants can be utilized in various practice settings to achieve operational efficiency, while maintaining clinical quality. With proper emergency physician supervision and oversight, they can have various roles in the emergency department process.

Patient Arrival to ED

Advanced practice providers can be used in various approaches at the beginning of the emergency department visit. Possible advantages include decreasing door-to-provider time, decreasing patients left-without-being-seen, and early implementation of a medical screening exam required by EMTALA. Since studies show patient satisfaction increases when door-to-provider time decreases, overall patient satisfaction scores may improve. Possible scenarios include:

- After nurse triage, patients may be directed to a dedicated area within the main ED where advanced practice providers evaluate, treat, and discharge lower acuity patients. For intermediate acuity patients requiring ancillary studies, the provider may initially evaluate the

- patient, order needed studies, and direct the patient to a waiting area until the studies are completed. In this scenario a lower acuity patient not requiring ancillary studies is seen and discharged while those requiring ancillary studies have those available when seen by the dispositioning provider, who may or may not be the advanced practice provider.
- Another possible scenario is patients are triaged to a separate area of the ED (fast track or minor care area) staffed by advanced practice providers where they are evaluated, treated, and discharged. This has the advantage of separating your lower acuity patients from other patients in the main ED. If the patient turns out to be higher acuity then predicted, physician collaboration may occur or the patient can be moved back to the main ED.
 - In high volume EDs, trained advanced practice providers may be utilized for the initial triage. They would then direct the patient to the most appropriate area of the ED. Alternately, an advanced practice provider could work in the triage area to perform a limited, focused history and physical exam and initiate a preliminary diagnostic workup before advancing patients into another area of the ED for definitive care.

ED Evaluation

Advanced practice providers may also be utilized to work side by side with physicians in the main ED thereby decreasing length of stay and improving overall patient satisfaction. Depending on their scope of practice and hospital credentialing, they may evaluate, treat, and discharge lower acuity patients independently and assist the physician with higher acuity patients. Tasks could include obtaining the initial history of present illness, past medical history, and reviewing medications along with documentation of the patient encounter. Ancillary studies may be ordered, tracked, and reviewed, preparing the patient for final disposition. In an emergency department which performs a significant number of procedures, these could be performed by the advanced practice provider allowing the physician to continue with other patient care duties. The advanced practice provider could help with the discharge process including prescription writing, patient education, and follow up. In this model, physician collaboration would be immediately available, if needed, and in close proximity. This team approach allows the physician to be involved in the diagnostic decision making, management and treatment planning of more ED patients.

Other practice settings

Some hospital EDs may use advanced practice providers to staff intermediate care areas or ED observation units with physician oversight. Some states have begun to utilize properly trained advanced practice providers to solely staff rural emergency departments with available physician collaboration by phone or telemedicine.

Whatever staffing model is used, it should be flexible due to the ever changing level of acuity presenting to our emergency departments. Cooperation and buy in from the entire ED team is vital.

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3. Guarisco, Mid-Level Providers – Who they are, what they do, and why they’re changing emergency medicine, *Emergency Physicians Monthly* <http://epmonthly.com/article/mid-level-providers-who-they-are-what-they-do-and-why-they-re-changing-emergency-medicine/> accessed 8/22/16
4. Kelly, Thomas MD, Wu, Fred PA-C. Advanced practice providers: Safe supervision in the ED. Presented at ACEP Scientific Assembly 2014.

5. Silvestri A, McDaniel-Yakscoe N, O'Neill K, et al. Observation medicine: the expanded role of the nurse practitioner in a pediatric emergency department extended care unit. *Pediatr Emerg Care*. 2005;21:199-202.
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PA/NP COMPETENCE

WHAT IS COMPETENCE?

Competence is the ability to do something well, also the quality or state of being competent.¹ There are a variety of competencies ranging from functional (or technical) competencies to professional competencies. David McClelland is seen as an originator of the Occupational Competency movement and father of the modern competency movement for his 1973 paper, *Testing for competence rather than for intelligence*.² One model describes four states of consciousness and competence:

"Unconscious incompetence - this is the stage where you are not even aware that you do not have a particular competence. Conscious incompetence - this is when you know that you want to learn how to do something but you are incompetent at doing it. Conscious competence - this is when you can achieve this particular task but you are very conscious about everything you do. Unconscious competence - this is when you finally master it and you do not even think about what you have such as when you have learned to ride a bike very successfully."³

Another concept, the Dreyfus model of skill acquisition, is a model of how students acquire skills through formal instruction and practice. The five levels proposed by Dreyfus and Dreyfus^{4,5} were:

- Novice: Rule-based action
- Advanced Beginner: recognition of *situational aspects*
- Competence: Acting consciously to achieve a specific goal
- Proficient: Rules and principles give way to situational discriminations and automatic responses
- Expert: a proficient performer sees what needs to be achieved and how to achieve a goal.

Competencies allow employers to identify superior from average or below average performance. Competencies are usually measurable or observable knowledge, skills, abilities, and behaviors (KSABs) critical to success in a specific job. Knowledge is the theoretical and/or practical comprehension of a subject. Abilities and skills are capacities to perform acts. Behavior is a pattern of conduct or actions.

¹Merriam-Webster. Definition of COMPETENCE. <http://www.merriam-webster.com/dictionary/competence>. Accessed March 9, 2016.

² McClelland DC. Testing for competence rather than for "intelligence." *Am Psychol*. 1973;28(1):1-14.

³ Howell, W.S. (1982). *The empathic communicator*. University of Minnesota: Wadsworth Publishing Company, 29-33.

⁴ Professor Hubert Dreyfus. http://socrates.berkeley.edu/~hdreyfus/html/paper_socrates.html. Accessed March 9, 2016.

⁵ Dreyfus SE. The Five-Stage model of adult skill acquisition. *Bulletin of Science, Technology and Society*. 2004;24(3):177–181. doi:10.1177/0270467604264992. See also Dreyfus, Stuart E.; Dreyfus, Hubert L. (February 1980). "A Five-Stage Model of the Mental Activities Involved in Directed Skill Acquisition" Washington, DC: Storming Media. See: <http://www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA084551&Location=U2&doc=GetTRDoc.pdf>.

Competencies are used to identify the essential functions of the job. Mastery levels are a method of describing and evaluating competencies determined by multiple specific criteria.

There are 15 Core Competencies for entering medical students endorsed by the AAMC Group on Student Affairs (GSA) Committee on Admissions (COA).⁶ The competencies were developed after "an extensive literature search of the medical education and employment literatures and input from several blue-ribbon and advisory panels, such as Behavioral and Social Sciences Foundations for Future Physicians (BSSFFP), Institute of Medicine (IOM), 5th Comprehensive Review of the MCAT Review Committee (MR5), Accreditation Council for Graduate Medical Education (ACGME) Outcome Project, the MR5 Innovation Lab, and others."⁷ There is growing movement to clarify competence for health care professionals and create a framework for a standard set of competencies.⁸

Graduate medical training has undergone recent revision to create a national framework for assessment including: "Comparison data, reduction in the burden associated with the current process-based accreditation system, the opportunity for residents to learn in innovative programs, and enhanced resident education in quality, patient safety, and the new competencies."⁹ ACGME competencies and the 2013 Model of the Clinical Practice of Emergency Medicine incorporate milestones for each EM resident as part of the Next Accreditation System (NAS) which include:^{10,11}

Level 1: The resident demonstrates milestones expected of an incoming resident.

Level 2: The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level.

Level 3: The resident continues to advance and demonstrate additional milestones; the resident demonstrates the majority of milestones targeted for residency in this sub-competency.

Level 4: The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the graduation target.

Level 5: The resident has advanced beyond performance targets set for residency and is demonstrating "aspirational" goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.

Similarly, "The Training Standards for Emergency Medicine" for the American College of Osteopathic Emergency Physicians (ACOEP) and approved by the American Osteopathic Association (AOA) exist for osteopathic emergency physicians-Osteopathic philosophy & manipulative medicine; medical knowledge; patient care; interpersonal and communication skills; professionalism, practice-based learning and improvement, and systems-based practice.¹²

⁶ Koenig TW, Parrish SK, Terregino CA, et al. Core personal Competencies important to entering Students' success in medical school. *Acad Med.* 2013;88(5):603–613.

⁷ See <https://www.aamc.org/initiatives/admissionsinitiative/competencies/345340/competenciesbackground.html>. Accessed March 9, 2016.

⁸ Englander R, Cameron T, Ballard AJ, et al. Toward a common Taxonomy of competency domains for the health professions and Competencies for physicians. *Acad Med.* 2013;88(8):1088-94.

⁹ Nasca TJ, Philibert I, Brigham T, et al. The next GME accreditation system — rationale and benefits. *N Engl J Med.* 2012;366(11):1056, 1051–1056.

¹⁰ Counselman FL, Borenstein MA, Chisholm CD, Epter ML; for the EM Model Review Task Force, Keehbauch JN; for the American Board of Emergency Medicine. The 2013 model of the clinical practice of emergency medicine. *Acad Emerg Med.* 2014 May;21(5):574-598.

¹¹ See <https://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/EmergencyMedicineMilestones.pdf>. See also <http://www.acgme.org/acgmeweb/Portals/0/MilestonesFAQ.pdf>. Accessed March 9, 2016.

¹² See <http://acoep.org/education-events/graduate-medical-education/training-standards>. Accessed March 9, 2016.

CLINICAL NURSE SPECIALISTS IN EMERGENCY CARE:

A clinical nurse specialist (CNS) is a registered nurse who spends 2-3 more years in school and graduates from a program of study at the master's or doctoral level. Clinical nurse specialists provide direct care to patients in different specialties, such as pediatrics, geriatrics, oncology and emergency care. Most states require an RN license and completion of an approved graduate-level program and a national certification exam. CNS programs usually take approximately two years to complete. A bachelor's degree and evidence of a current nursing license are required for admittance and most programs include clinical courses or practicum training in a clinical setting.

In 2006, the Emergency Nurses Association (ENA) General Assembly convened the Clinical Nurse Specialists in Emergency Care Work Team to develop competencies for the CNS practicing in emergency care and initiated a plan in 2009.¹³

According to ENA: "In addition to being an expert direct care clinician ranging from primary provider to consultant, clinical nurse specialists are experts in the synthesis, integration, transformation and translation of best practices to facilitate bridging the gap between research and practice."¹⁴

APRNs wishing to specialize in emergency care must obtain educational preparation related to emergency care and may do so through various pathways including:¹⁵

- 1) Successful academic course completion specific to emergency care;
- 2) Continuing education course completion; and/or
- 3) On-the-job instruction in emergency care.

Competencies for clinical nurse specialists in emergency care include direct care with patients and families; consultation between professionals; systems leadership; collaboration to optimize clinical outcomes; coaching of patients, families and peers; research; ethical decision-making, moral agency and advocacy.¹⁶

NURSE PRACTITIONER IN EMERGENCY CARE PROGRAMS:

Nurse practitioners have completed a master's or doctoral degree program with additional clinical training beyond the registered nurse certifications. Nearly all NPs (99.3%) are nationally certified with 97.2% prescribing medications with an average of 21 prescriptions per day for full time NPs according to American Association of Nurse Practitioners (AANP).¹⁷

Nurse practitioners practice autonomously based on state regulation and provide health care within an ethical framework, through assessment, diagnosis, and management of health/illness status, to persons of all ages who seek emergency care in an environment that is complex and unpredictable. There are currently seven academic programs offering emergency nurse practitioner specialization training: Emory

¹³ Emergency Nurses Association. Competencies for Clinical Nurse Specialists in Emergency Medicine. See <https://www.ena.org/practice-research/Practice/Quality/Documents/CNSCompetencies.pdf>. Accessed March 9, 2016.

¹⁴ See: <https://www.ena.org/practice-research/Practice/Pages/AdvPractice.aspx>. Accessed March 9, 2016.

¹⁵ See: <https://www.ena.org/practice-research/Practice/Quality/Documents/CNSCompetencies.pdf>. Accessed March 9, 2016.

¹⁶ See <https://www.ena.org/practice-research/Practice/Quality/Documents/CNSCompetencies.pdf>. Accessed March 9, 2016.

¹⁷ See <https://www.aanp.org/all-about-nps/np-fact-sheet>. Accessed March 9, 2016.

University; Loyola University; Jacksonville University; Rutgers- The State University of New Jersey;¹⁸ University of South Alabama; University of Texas - Houston; Vanderbilt University.

The curricula are varied and focus on different aspects of trauma and emergency care delivery. Some schools offer a dual role program for Family NP/Adult-Gerontology NP as an emergency specialty. Some have heavy online course components, others do not. To achieve certification for emergency nurse practitioners all ANCC criteria and requirements must be met. In some programs applicants are required to have multiple years of current RN experience and sometimes clinical experience as an RN in the emergency department.¹⁹

ANCC EMERGENCY NURSE PRACTITIONER CERTIFICATION PORTFOLIO VALIDATION PROGRAM:

The American Nurses Credentialing Center (ANCC) is a subsidiary of the American Nurses Association (ANA) whose stated goals are to promote excellence in nursing. The ANCC has an emergency nurse practitioner board certification through portfolio assessment. The designation can be obtained after initial NP certification and licensure. The goal is to provide a valid and a "reliable assessment of the entry-level clinical knowledge and skills of nurse practitioners in the emergency nursing specialty."²⁰

Certification through portfolio allows for ANCC board certification. No exam is required. Eligible applicants submit an online portfolio of evidence to document skill, knowledge and application of professional nursing practice and theory. The credential lasts 5 years.

"The eligibility criteria require all applicants to complete 30 continuing education hours in the specialty area within the last 3 years. Applicants then may choose the remaining two categories from the list above. These additional categories may be beyond the 3 year time frame."²¹

Certification through portfolio is designed to objectively measure knowledge and application of "professional nursing practice and theory through the review of a collective body of work present in a nurse's portfolio."²² The portfolios are evaluated on four domains of practice including: Professional Development; Professional and Ethical Nursing Practice; Teamwork and Collaboration; Patient Safety and Quality; also including assessment by Supervisor, Peer-Evaluation; and Self-Evaluation.²³ Successful candidates are awarded board certification. ANCC certification through portfolio is renewed every 5 years.

PHYSICIAN ASSISTANT (PA-C)

Physician assistants in emergency medicine are medical professionals who provide healthcare under the supervision and direction of an emergency physician. A PA obtains formal training through an educational program approved by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).

¹⁸ See <https://www.ena.org/practice-research/Practice/Pages/AdvPractice.aspx>. Accessed March 9, 2016.

¹⁹ See <http://nursecredentialing.org/EmergencyNP>. Accessed March 9, 2016.

²⁰ See <http://nursecredentialing.org/CertificationPortfolioRequirements.pdf>. Accessed March 9, 2016.

²¹ See <http://nursecredentialing.org/CertificationPortfolioRequirements.pdf>. Accessed March 9, 2016.

²² See <http://nursecredentialing.org/EmergencyNP-PCO>. Accessed March 9, 2016.

²³ See <http://nursecredentialing.org/EmergencyNP-PCO>. Accessed March 9, 2016.

Physician assistant (PA) education is modeled after physician education, typically lasting 26 months. First year didactics are classroom-based and focus on medical science and clinical preparation including pathology, diagnosis, surgical technique, and pharmacology and research methods. Later, under the supervision of licensed physicians, students get clinical hands-on rotations where they gain direct experience in patient care.

Physician assistants require state licensure to practice. The licensing process entails passage of the Physician Assistant National Certifying Examination (PANCE). PANCE evaluates fundamental medical and surgical comprehension (www.nccpa.net). Candidates who pass the PANCE may use the Physician Assistant-Certified (PA-C) designation.

After completion of an accredited training program, all PA students must pass a national certifying exam to obtain a license. The National Commission on Certification of Physician Assistants (NCCPA) administers the Physician Assistant National Certifying Exam (PANCE) and Physician Assistant National Recertifying Exam (PANRE). The PANCE consists of 300 multiple-choice questions administered in five 60-minute, 60-question blocks and is required for licensure after graduation from an accredited program.²⁴ PAs are required to pass the Physician Assistant National Recertifying Examination (PANRE) every ten years for maintenance of certification.²⁵ Both tests are computerized and administered at Pearson VUE centers.

Physician assistants must maintain the PA-C designation by earning 100 hours of CME every two years and completion of the Physician Assistant National Recertifying Exam. PA-C's are subject to recertification and testing fees.

ADVANCED PA ACCREDITATION = CERTIFICATE OF ADDITIONAL QUALIFICATIONS (CAQ) IN EM:

Physician assistants may choose to specialize in emergency medicine. Candidates for the EM specialty certification must hold PA-C certification. The current cost of the CAQ program is just \$350, including a \$100 administrative fee and a \$250 exam registration fee.²⁶ The PA candidate must possess a state license and successfully pass the national certifying exam.

The PA must have 3000 hours of practice in emergency medicine, the equivalent of 18 months of full-time practice. Candidates for CAQ must earn a minimum of 150 hours of Category I emergency medicine CME and a minimum of 50 of those hours must be earned within the two years prior to the date of exam application. Candidates are required to complete an airway course, ACLS, PALS and ATLS. Candidates require a supervising emergency physician who works and is familiar with the PA's practice and experience to sign -off on procedural expertise with a physician attestation that indicates the candidate has performed the procedures and/or understands how and when the procedures should be performed.

The candidate must then pass the Emergency Medicine Specialty Exam, a 120 multiple-choice question exam administered at Pearson VUE testing centers that is related to emergency medicine targeted for PAs based on a content blueprint developed by the NCCPA²⁷ and the ABEM Model of the Clinical Practice of Emergency Medicine.²⁸ The Emergency Medicine CAQ is valid for ten years. There is a CME

²⁴ See <http://www.nccpa.net/BecomingCertified>. Accessed March 9, 2016.

²⁵ See <http://www.nccpa.net/MaintainCertification>. Accessed March 9, 2016.

²⁶ See <https://www.nccpa.net/specialty-caqs>. Accessed March 9, 2016.

²⁷ See <http://www.nccpa.net/Emergencymedicinecb.aspx>. Accessed March 9, 2016.

²⁸ See http://www.abem.org/public/portal/alias_rainbow/lang_en-us/tabid_3590/desktopdefault.aspx. Accessed March 9, 2016.

requirement for the CAQ beyond that timeframe. PAs must meet the PA-C and licensure requirements of those seeking the CAQ for the first time, pass the Emergency Medicine Specialty Examination before the expiration of the current CAQ, and -- during the ten-year CAQ cycle -- earn and log at least 125 credits of Category 1 CME focused on emergency medicine.

EMERGENCY MEDICINE PHYSICIAN ASSISTANT POST GRADUATE TRAINING:

Postgraduate training programs specific to emergency medicine are becoming increasingly available. The emergency medicine post grad programs are designed to be comprehensive emergency medicine training programs to enhance depth of knowledge through hand-on exposure.

Eligibility for programs is based on successful certification, state licensure/eligibility, grades and interviews. Some programs accept both highly qualified graduate nurse practitioners and physician assistants.

Upon completion of a program, physician assistant graduates may have met the procedure, patient case and clinical requirements for the National Commission on Certification of Physician Assistants (NCCPA) Emergency Medicine Certificate of Added Qualification (CAQ).

PA and NP Reimbursement **Introduction**

Reimbursement is an always changing and challenging issue as it pertains to billing for services provided by PAs and NPs. The rules vary from state to state and insurance contract to insurance contract. For example, Blue Cross reimbursement for services provided may differ under different Blue Cross Blue Shield contracts for PAs and NPs. This makes the approach to capturing reimbursement for services very challenging and ever changing. It is best to check with state policy and individual third party payer contracts and some of the resources included. Medicare requirements tend to be some of the most rigorous but defined. It is important to note that third party payers do not necessarily follow Medicare guidelines for billing of PA and NP services.

Under Medicare, practices billing for PA and NP services that are performed without face-to-face physician involvement is billable at 85% of the physician fee schedule. To fulfill and capture 100% there needs to be face-to-face physician interaction and an attestation which is discussed at the end of the document. The Medicare parameters that allow for 100% of the fee schedule are known as "shared services" in the emergency medicine realm.

Medicare Mid-Level Provider Common Questions

This document reflects changes to the Medicare Carriers Manual by the Centers for Medicare and Medicaid Services (CMS) pursuant to Transmittal 1776 implemented on October 25, 2002 (<http://www.cms.hhs.gov/transmittals/downloads/R1776B3.pdf>).

A significant change in documentation requirements occurs when an emergency department examination and management code E/M is shared between a physician and a nurse practitioner (NP) or physician assistant (PA) from the same group practice.

What follows is a set of frequently asked questions

What is a Non-Physician Practitioner (NPP) and how does the definition apply in the ED? What is the appropriate terminology for NPs and PAs in the ED?

An NPP in the ED is defined by Medicare as either a nurse practitioner (NP) or a physician assistant

(PA). Of note, there is no agreed upon terminology that encompasses NPs and PAs in the ED. In grouping these providers, the DEA uses the term "midlevel's" while the Federal agencies use a variety of references. For the sake of this FAQ, NPs and PAs will be referred to as advanced practice providers (APPs), as this seems to be gaining favor. However, it is acknowledged that, as per the American Academy of Physician Assistants (AAPA) Policy #HP-3100.1.3, "the AAPA believes whenever possible, PAs should be referred to as "physician assistants" and not combined with other providers in inclusive non-specific terms such as "midlevel practitioner", "advanced practice clinician", or "advanced practice provider". [Adopted 2008, reaffirmed 2013]"

When an APP and an emergency physician provide care to the same Medicare patient, how is the record evaluated to determine if the E/M service should be assigned to the APP or the emergency physician?

When an emergency department E/M is shared between a physician and an APP from the same group practice and the physician provides and documents any "face-to-face" portion of the E/M encounter with the patient, the service may be billed under either the physician's or the APP's NPI number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by discussing the case with the APP or reviewing the patient's medical record) then the service may only be billed under the APP's NPI and payment will be made at 85% of the Medicare physician fee schedule.

Because there are many varied circumstances under which physicians and APPs interact and the stipulation for "same group practice" is open to interpretation, you are advised to contact your local carrier for final instructions on billing when shared services arise.

What documentation is necessary for the emergency physician to indicate a shared E/M service?

The medical record must clearly identify both the APP and the emergency physician who shared in rendering the service. The emergency physician documentation should be linked to the APP documentation of the shared service, and affirmatively state one or more elements of the encounter. This element may be an element of history, physical examination, or medical decision-making.

In a shared E/M situation, both parties must document the work they performed. A generic attestation of "I have seen and evaluated this patient and agree with the PA notes" or a notation of "seen and agreed" or "agree with above" would not qualify the service as a shared visit.

Can a PA or NP perform Critical Care?

Critical care services may be provided by qualified APPs and reported for payment under the APP's National Provider Identifier (NPI) when the services meet the definition and requirements of critical care services. The provision of critical care services must be within the scope of practice and licensure requirements for the State in which the qualified APP practices and provides the service(s).

Can the APP critical care (CC) time and the emergency physician critical care time be added together and reported as a shared service?

A critical care code for the specific time period (either 99291 or 99292) cannot be reported as a split/shared E/M service. Each critical care code shall reflect the evaluation, treatment and management of a patient by an individual physician or qualified non-physician practitioner and shall not be representative of a combined service between a physician and a qualified APP. Although different practitioner types (i.e., physician or APP) cannot combine their respective CC times to qualify for a given CC code (either 99291 or 99292), once the same category of practitioners' CC time qualifies for a CC code, that CC code can be reported as part of the practice group's total CC coding.

When an APP performs an independent service must a physician also sign the chart, or can the service be billed with only the APP's signature?

The physician's requirement to provide supervision of the APP is governed by individual state licensing regulations and hospital medical staff policies and procedures. Additionally, different payers might interpret the definition of supervision differently.

What is "incident to" and is it applicable in the ED?

"Incident to" is a Medicare reimbursement policy, whereby, under certain circumstances, the physician can bill and be paid for services that were provided by non-physician practitioners who are employed by the physician.

Services covered by Medicare "incident to" are those services furnished in a physician office. It is not applicable in the hospital setting--either inpatient or outpatient --and as such it is not applicable in the emergency department. In other words, Medicare does not allow "incident to" billing in the emergency department.

*Please note that a "shared/split E/M service" (see FAQ 2 above) differs from "incident to".

Can the emergency physician bill for a procedure that is performed by an APP on a Medicare patient?

Procedures and interpretations performed by the APP must be billed using the APP's NPI number. The shared service rules only apply to E/M services and "incident to" does not apply in the ED. Any physician or APP authorized to bill Medicare services will be paid by the carrier at the appropriate physician fee schedule amount based on the rendering NPI.

Can APPs provide services to non-Medicare patients?

Yes, but be sure to consider state regulations regarding APP scope of practice. All 50 states now give PA's prescribing authority, and they have enacted fairly detailed statutes and regulations that define physician assistants, describe their scope of practice, discuss supervision, designate the agency that will administer the law, set application and renewal criteria, and establish disciplinary measures for specified violations of the law. The actual language in the scope of practice section of the regulations is generally broad allowing PA's to perform those services within the scope of the supervising physician if delegated by the physician, and within the education and training of the PA.

Unlike Medicare, which mandates coverage of services provided by PA's, each state determines whether PA's are eligible providers under its respective program. All states and the District of Columbia cover PA's in the Medicaid fee-for-service or managed care plans at the same or lower rate as that paid to physicians. There are differences, however, in how states ask PA's to identify themselves as a provider of service. In some states, medical services provided by PA's are billed under the physician's name, while in other states, PA's use a modifier code to identify their services. In the majority of states (37), the Medicaid programs enroll or credential PAs and require

them to bill with their own identifier as rendering provider. Finally, some state Medicaid programs will limit procedure reimbursement even when the state itself recognizes the procedure as within the APP's scope of service. Check with your state Medicaid carrier for specific policies and procedures.

Will our APPs need a NPI number?

Yes. If the APP will be providing services to Medicare patients, and you want to bill for such services Medicare mandates that all APPs have a NPI number. It would be wise to do a compliance audit with your company or billing entity to assure that proper NPI numbers are on the CMS1500 for services provided by APPs.

What is a modifier and how does it affect physician assistant or nurse practitioner billing?

Modifiers are two characters (alpha or numeric) codes that can be appended to CPT codes to "modify" the service. In the past, Medicare required modifiers such as "AN" or "AS" to identify services involving a physician extender. Medicare carriers have abandoned the use of modifiers for physician extenders and now require physician assistants and nurse practitioners to obtain and use NPI's to identify their services.

Can a PA and NP act as a scribe for the physician?

Yes, but be careful. A scribe records the findings of a physician. If the APP independently obtains the history and performs a physical exam, a third party payer might not consider this a scribe function but rather an independent service component by a healthcare provider, hence subject to the payer's relevant payment policies.

To what extent, if any, will Medicare rules apply when APPs treat patients who are in Medicare managed care plans?

General CMS rules should still apply, although you should check with the specific managed care plan to verify any policies in question.

What services are APPs allowed to provide in the ED?

Medicare will pay for ED E/M services for specific non-physician practitioners, i.e., nurse practitioner (NP) and physician assistant (PA). The services provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. According to Transmittal 1548, which was released by CMS in 2008, qualified APPs may provide critical care services (and report for payment under their National Provider Identifier (NPI)), when these services meet the critical care services definition and requirements. View the full transmittal on the CMS site.

Where can I get more information on mid-level providers?

The American Academy of Physician Assistants (AAPA) can be reached at the address below or at their web site <http://www.aapa.org>. This web site contains a wealth of information. Be sure to access the government and practice issues section and click on reimbursement for additional documentation

The American Academy of Physician Assistants (AAPA)
2318 Mill Road, Suite 1300
Alexandria, Virginia 22314-1552
Phone: 703-836-2272
Fax: 703-684-1924
www.aapa.org

The American College of Nurse Practitioners (ACNP)
AANP National Administrative Office
PO Box 12846
Austin, Texas 78711
Phone: 512-442-4262
Fax: 512-442-6469
www.aanp.org

Updated 03/03/2016 ACEP

Attestation Statement examples:

Attending Physician Supervisory Note: I discussed the evaluation and management of the patient with the PA/NP and agree with the PA/NP's note. Chart electronically signed by

Attending Physician Supervisory note: I have seen and discussed the evaluation and management of the patient with PA/NP and agree with note. Specifics to the patient whom I have seen:

Chart electronically signed by

Resources

Medicare Mid-Level Provider FAQ. <http://www.acep.org/Clinical---Practice-Management/Medicare-Mid-Level-Provider-FAQ/>

Transmittal 1776 <http://www.acep.org/content.aspx?id=32172&list=1&fid=2296>

American College of Emergency Physicians. PAs and NPs in Emergency Medicine. [information paper]. 2012.

<https://www.acep.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=86984&libID=86932>

Medico-Legal Issues to Consider with Advance Practice Providers.

Adapted from Graham T. Billingham MD, FACEP, Medpro

Significant changes and demands in healthcare have necessitated new models for the delivery of patient care. These changes are evidenced by the increasing number of advanced practice providers—such as nurse practitioners and physician assistants—and their evolving scopes of practice.

In the United States, approximately 11,000 NPs and 10,000 PAs are working in emergency medicine.¹ These practitioners play an important role in meeting growing demands for quality care. However, as the number of APPs has grown and their responsibilities have broadened, so too has their malpractice exposure.

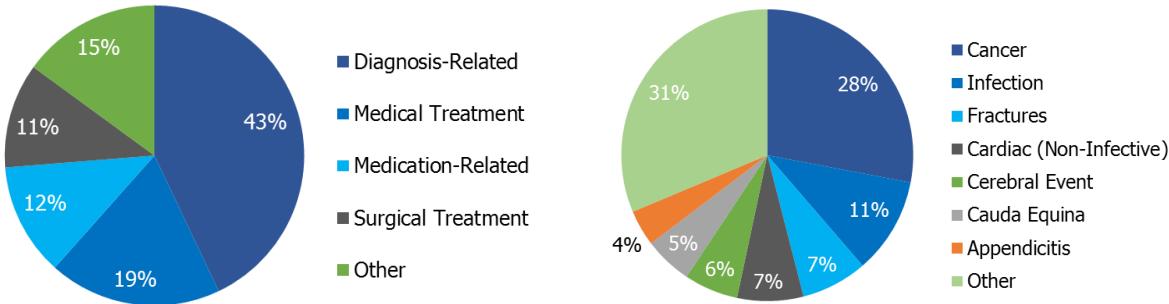
In the past, plaintiffs' bar did not put much focus on APPs; however, more and more, these providers are named as defendants in malpractice litigation. Additionally, professional liability carriers are seeing more requests for separate limits of coverage for APPs, further confirming the widening of their risk exposure.

Malpractice Trends

Although claims data can vary from year to year, data from the National Practitioner Data Bank (NPDB) demonstrate an overall increase in the volume of claims and total indemnity paid for APPs over the past 10 years.²

These trends are likely due to several factors, all of which correlate to the growing number of APPs and the expansion of their responsibilities. First, APPs are seeing a higher volume of patients. Second, APPs are increasingly treating patients who have more complex healthcare needs. Lastly, APPs have become more visible members of the healthcare team. Together, these factors make it more likely that APPs will be named in malpractice litigation.

MedPro Group claims data show that claims for APPs mirror physician claims to a large extent, in terms of both allegation categories and contributing factors. Diagnosis-related allegations account for the majority of claims and dollars paid, with cancer and infections cited as the top diagnoses in these claims (see Figures 1 and 2).



Source: MedPro Group closed claims data, NPs and PAs combined, 2005-2014; any totals not equal to 100% are a result of rounding.

Contributing Risk Factors in Malpractice Claims

Common contributing factors in claims for both APPs and physicians are clinical judgment, communication, documentation, and technical skill. When examining APP claims, however, some specific distinctions related to risk factors emerge, most notably in relation to communication issues, such as inadequate collaboration with other providers and supervising physicians.³ Other areas of risk concern include scope of practice, test tracking, and informed consent.

Communication

Delayed referral to a supervising physician has been noted as one of the primary risk areas for APPs.⁴ To avoid such allegations, APPs must be competent and exercise good judgment. Just as important, APPs and their supervising physicians must have positive professional relationships, including open lines of communication and ample time for consultation.

Individual work style preferences and communication styles can impact the effectiveness of communication and consequently affect patient care. Further, the tone and timeliness of supervising physicians' responses to APPs' queries or requests might shape behaviors and interactions.

Though more than one process for communication can be effective, each healthcare organization — along with input from its physicians and APPs — should determine the framework for effective communication and work to incorporate consistent processes and procedures among all practitioners. For example, each organization should determine specific situations that require consultation with the supervising physician, as well as minimum requirements for communication related to patient handoffs, discharges, and transfers of care.

Scope of Practice

Practicing beyond scope is a serious concern and a top reason why APPs and their employers are sued.⁵ Continuously evolving standards, as well as inconsistency in how states regulate scope of practice, can lead to confusion and increased risk exposure.

To address these risks, healthcare organizations should have a clear understanding of the scope of practice regulations in their states, as well as requirements for supervision and collaboration. Further, developing written guidelines or collaborative practice agreements that define practitioner roles within the organization can reinforce responsibilities and serve as a valuable reference.

Test Tracking

Failure to address all test results is a frequent, underlying cause of the top allegation in medical malpractice for both APPs and physicians — failure to diagnose. Further, diagnostic errors that occur as a result of faulty test tracking have been implicated in significant patient injuries.

Healthcare organizations should establish test tracking processes that ensure test results are not filed in patient records until the ordering clinician reviews the results, initials the report, notifies the patient, and documents decisions related to treatment and care. These processes should be in place for tracking all lab and test results regardless of the type of provider (APP or physician) or patient location (inpatient, outpatient, ED, or long-term care facility).

Other Contributing Factors in Malpractice Claims Involving Advanced Practice Providers

- Inadequate supervision
- Poor documentation
- Improper credentialing
- Failure to comply with regulatory and billing standards
- Medical board licensing issues
- Failure to follow policies and procedures

Informed Consent

Lack of informed consent, or documentation of the informed consent process, is another general area of risk for all types of providers. For APPs, informed consent can be directly related to the care they provide. For example, if patients are not advised that an APP is providing their treatment, they could potentially allege lack of informed consent.

Healthcare organizations can mitigate this risk by ensuring that patients are aware of their provider options and fully understand APPs' professional role within the organization. Further, organizations should honor patient requests to see a physician instead of an APP.

APPs are helping meet the growing demands of a dynamic healthcare environment. As the number of APPs grows and their scopes of practice become more complex, greater exposure to malpractice risk is inevitable. However, healthcare organizations can take proactive steps to minimize risks, such as providing comprehensive orientation and training, establishing clear standards for supervision and oversight, utilizing collaborative practice agreements to delineate scope of practice and responsibilities, defining specific situations that require consultation, and supporting a collaborative culture.

Communication and Supervision Check List When Working With Advanced Practice Providers

	Yes	No
<i>Communication</i>		
Are APPs given feedback that is constructive and specific?	<input type="checkbox"/>	<input type="checkbox"/>
Do physicians make an effort to ensure that APPs fully understand instructions?	<input type="checkbox"/>	<input type="checkbox"/>
Are APPs encouraged to ask questions and seek input from their supervising physicians?	<input type="checkbox"/>	<input type="checkbox"/>
Are APPs given adequate consultation time with, and reliable contact information for, their supervising physicians?	<input type="checkbox"/>	<input type="checkbox"/>
Are APPs included in performance improvement initiatives? Are they encouraged to provide input and suggestions?	<input type="checkbox"/>	<input type="checkbox"/>
Are APPs asked to provide feedback on communication processes?	<input type="checkbox"/>	<input type="checkbox"/>
<i>Supervision/Oversight</i>		
Does your organization take into account state regulatory requirements for supervision of APPs?	<input type="checkbox"/>	<input type="checkbox"/>
Do your state's regulations related to supervision specify:		
<ul style="list-style-type: none"> • The maximum number of APPs a physician can supervise? • The required geographic proximity between physician and APP (if offsite supervision is allowed)? • The acceptable methods of oversight (in person, electronic, via phone)? • Thresholds for review of charts (including signature) and timeframes for review? • Whether a collaborative agreement and/or written protocols related to supervision are required? 	<input type="checkbox"/>	<input type="checkbox"/>
Does your organization have written guidelines that (a) outline situations that require oversight/supervision, and (b) define specific triggers for consultation with or referral to the supervising physician?	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No
Are guidelines periodically reviewed and updated?	<input type="checkbox"/>	<input type="checkbox"/>
Do supervising physicians ensure that delegated tasks are within each APP's appropriate scope of practice?	<input type="checkbox"/>	<input type="checkbox"/>

Do supervising physicians consistently and routinely validate APPs' competency and clinical skills through review of charts, referrals, documentation, clinical decision-making, and compliance with guidelines and standards of care?	<input type="checkbox"/>	<input type="checkbox"/>
Are all supervisory meetings and consultations between physicians and APPs documented?	<input type="checkbox"/>	<input type="checkbox"/>
Are APPs monitored for compliance with billing standards and other corporate procedures?	<input type="checkbox"/>	<input type="checkbox"/>
Are contingency plans in place for supervising APPs in the absence of the designated supervising physician (e.g., during vacation, sick leave, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

¹ Danielsen, R. D. Bridge the gap between school and the ED: An approach to measuring competency in APPs. *ACEP Now*. February 2015;34(2):10–11.

² National Practitioner Data Bank, Public Use File, December 2015.

³ MedPro Group closed claims data, 2005–2014.

⁴ Page, A. E. Liability issues with physician extenders. *AAOS Now*. March 2010;4(3). Retrieved from <http://www.aaos.org/news/aaosnow/mar10/managing6.asp>

⁵ Crane, M. Malpractice risks with NPs and PAs in your practice. Medscape. January 2013. Retrieved from <http://www.medscape.com/viewarticle/775746>