UNC GI & Hepatology Policy on Advanced Practice Professionals (APPs)

This policy is to clarify roles and expectations for advanced practice professionals (APPs) working within the UNC Division of Gastroenterology & Hepatology. The goal of this policy is to better incorporate APPs into our practice, which in turn will improve access to care, enhance quality and patient experiences, and reduce operating costs. We also expect that APPs who are empowered to work at the "top of their licenses" will feel more professionally satisfied. Given the myriad tasks performed by APPs in the Division, an important goal of this policy is to allow adequate flexibility to recognize the spectrum of clinical effort of these individuals.

This policy is in part a response to our recent Carolina Value evaluation, which demonstrated substantial heterogeneity in the clinical support, clinical activity and clinical productivity of our APPs. The net result is that our APPs are generating many fewer patient visits than APPs working in gastroenterology and hepatology at other similar academic medical centers. Also, even after accounting for additional revenues billed under their supervising physicians' names, our APPs were cumulatively running a substantial financial deficit. Because our APPs are hardworking, industrious individuals, we believe that this under-performance relative to their peer group has to do with several elements:

- APPs in the division do a large amount of work that could be well-handled by nurses and/or administrative personnel, such as prior authorizations, insurance clearances, logistical arrangements, scheduling issues, medication refills, and basic patient education,
- Scheduling templates for shared clinics (i.e., those in which the APPs work jointly with a physician) do not adequately reflect the fact that two clinicians are in clinic together (i.e., combined physician-APP teams often see a similar number/just slightly more patients than a single clinician could see alone), and,
- There are several areas in the division in which APPs could be working autonomously where they are not currently. Because both state regulations and UNC policy allow (and expect) APPs to work autonomously with appropriate physician supervision (see Appendix 1), we can make better use of their capabilities to improve patient access.

We hope this document clarifies expectations for our APPs, informs physicians about appropriate working arrangements for our APPS, and better standardizes how APPs are employed across the division.

1. Who are advanced practice professionals (APPs)?

Nurse practitioners (NPs) and physician assistants (PAs) are often referred to as "mid-level providers" or as "advanced practice providers". PAs undergo master's-level training that averages 26 months in duration and is rooted in the biomedical model. NPs are practicing nurses who receive master's level training in advanced nursing and is rooted in nursing, with disease prevention and patient education emphasized.

2. What are their practice prerogatives?

In North Carolina both NPs and PAs are licensed to practice under physician supervision. Appendix 1 of this document includes specific information about the supervisory relationship. UNC Medical Staff Bylaws state that under the supervision of a physician, APP activities include taking "medical histories and performing physical examinations; ordering and interpreting lab tests; diagnosing and treating illnesses; assisting in surgery; prescribing and/or dispensing medication; and counseling patients."

3. What are their potential roles in gastroenterology?

Specific roles may include: seeing new and established patients in clinic, the emergency department, and the inpatient units; helping to manage patients longitudinally outside these traditional practice settings; interpreting diagnostic tests (e.g., motility tests); performing uncomplicated procedures (e.g., large volume paracentesis); and coordinating clinical services (e.g., triaging clinic referrals and coordinating advanced endoscopic procedures). Of note, as described below, APPs may see patients in clinic without on-site physician supervision, so long as long as the supervising physician is "continuously available."

Importantly, APPs are not employed to serve as scribes or to fulfil activities that medical assistants, LPNs, RNs, transplant coordinators, or administrative assistants can better handle.

4. How will clinical effort be assigned and recognized for GI APPs?

Going forward, similar to GI clinical faculty, every six months each APP will be assigned a clinical activity level (cFTE) based on her/his FTE (full time equivalent – the portion of their salary paid for from the Division's clinical income), as well as non-clinical internally and externally funded duties (e.g., research support). For example, a full-time APP without any non-clinical funding will be assigned as 1.0 cFTE. Likewise, a full-time APP who receives 30% salary support for research is 0.7 cFTE.

This cFTE will be translated into a specific clinical assignment. **APPs with 1.0 cFTE will expected to perform at least 7 half-days of billable clinical work/week.** APPs with less than 1.0 cFTE (due to funding from research or other activities) will have their clinical expectation adjusted downward in the same ratio. The APP, her/his primary supervising physician, and the GI Division Chief will determine the specific distribution of clinical work. This will include both time in clinic, as well as activities performed outside of clinic that generate clinical revenue, such as seeing inpatients and those in the emergency department, performing paracenteses, interpreting motility studies, and many other patient care activities. At least one half-day per week should be spent in a "shared" clinic, guaranteeing face-to-face time with the supervising physician to discuss challenging cases and also for additional learning. Except for time dedicated to referral and advanced procedure triage (which the division feels is an important value-adding process that is best accomplished by a clinician or advanced nurse), time spent outside of directly billable clinical activities (e.g., calling patients, refilling prescriptions, etc.) will not be credited to this half-day total, just as these activities are not credited to faculty physicians' clinical assignments. Through restructuring and additional nurse hires, as well as redesigning certain processes, we plan to off-load many of the APPs' current administrative/nursing activities to nurses, clinic staff, and administrative assistants, to allow an expansion of higher level clinical duties.

5. What is the expectation for shared clinics?

Shared clinics are when an APP sees patients who are scheduled on their supervising physician's scheduling template. This strategy may work well in areas where patient complexity does not allow independent function of the APP. Within these shared clinics, APPs can complement physicians by assuming tasks such as supporting patient self-management and providing routine follow-up care. Recognizing that there are two clinicians in a shared clinic, **shared clinic scheduling templates should include at least 1.5 x's the number of new and return appointment slots relative to templates for physicians who work without an APP in the same sub-specialty area**. This is because the APP's presence allows for improved access and productivity, and recognizes that the supervising physician will have supervisory duties with the patients seen by the APP. An overview of how these shared visits should be billed is provided in **Appendix 2**.

6. What is the expectation for personal APP clinics?

Here the APP will see patients who are scheduled on her/his own scheduling template. This includes newly referred patients who have relatively straightforward GI and liver conditions and have

not previously been seen by a gastroenterologist/hepatologist (i.e., secondary care). This also includes return patients who (1) the APP has previously seen in her/his personal clinic, (2) the APP has previously seen in a shared clinic who no longer require a physician's direct involvement, or (3) straightforward patients initially seen by a supervising physician who feels the patient can appropriately return for follow-up care in the APP's clinic. New and established patients seen in an APP personal clinic who become too complex should be transferred to a shared clinic.

When APPs provide care to general gastroenterology and hepatology patients in their own personal clinics, the expectation is that the APP see at least 2 new patients and 4-5 return patients in a half-day session. If there is more demand for new patient evaluations and/or less demand for return patient evaluations, 2 return patient appointment slots may be exchanged for one new patient evaluation. For those APPs working in a subspecialty area where patient needs or complexity require alteration of this standard template, such alterations will be considered on a case-by-case basis, in consultation with the supervising physician and the division chief.

As is done for GI faculty, each APP will be expected to complete a specific number of clinics each academic year as follows: (52 weeks*average clinics/week) - (5 weeks vacation* average clinics/week)-(clinics closed due to HCS holidays). The division will calculate and share the average number of new/return patients completed per expected clinic. The division recognizes that not all APPs will see the same number of patients per clinic. For instance, those who see primarily new patients and/or primarily complex patients will see fewer patients than those who do not. Still, the division will work with anyone whose visit volumes are significantly lower than expected (see above). This may include better ensuring that the scheduling team fills existing templates, modifying templates so that they are more reliably filled, and/or closing fewer clinics.

The APP should sign the EPIC clinic encounter and the charge should be placed under her/his name. According UNC Bylaws, NC Medical Board, and NC Board of Nursing the supervising is <u>not</u> required to co-sign APP notes. **T**his is left to the attending and the mid-level to decide.

7. What is the APP role in emergency department and inpatient services?

Only a small proportion of the division's APP work is done in the ED. In those situations, the supervising or consult physician should supervise the service and co-sign the note. APPs working on the inpatient services should be working under the supervision of the appropriate consult service (Luminal, Hepatology, or Advanced Endoscopy). In these cases, the supervising or consult physician from the appropriate service should supervise the service and co-sign the note.

8. What is the role of APPs in procedures?

APPs with appropriate training may perform some procedures, such as diagnostic and therapeutic paracentesis. A supervising physician must be available on site, but not necessarily in the same clinic/ward of the hospital. The APP should write and sign the procedure note and charges should be entered under the APPs name.

9. What are the arrangements for interpreting diagnostic tests?

APPs may interpret various motility tests, including hydrogen breath tests, pH studies, impedance pH studies, esophageal manometries, and anorectal manometries. In doing so they should enter their interpretation into ProVation. The attending is expected to review the test and sign off on the interpretation <u>within one week</u>. The charges should be submitted under the attending's name.

We hope and expect that this document will clarify both the roles and expectations of these important members of our Division. In order to implement this policy, we plan to meet with each APP and his/her

supervising physician jointly, to review current clinical activities, current funding, and current clinical support, and to jointly form plans to make any alterations necessary to reach the goals outlined above. Additionally, we plan to revisit this document on at least a yearly basis, and we expect revision to be necessary as the roles of the APPs in our division, and in gastroenterology and hepatology overall, continue to evolve.

APPENDIX 1: PA/NP Supervision Policies

NC Medical Board Policy on Physician Assistants: Each PA requires a primary supervising physician "who accepts full responsibility and liability for the PA's medical activities and professional conduct at all times, whether the physician personally is providing supervision or supervision is being provided by a back-up supervising physician." The primary supervising physician and PA must together define the PA's scope of practice, performance evaluation process, and relationship/access to the primary supervising physician. This must be outlined in a written supervisory agreement that must be signed and dated by both and kept onsite.

The supervising physician and PA must meet monthly for the first six months of the relationship and then at least every six months thereafter to discuss relevant clinical problems and quality improvement measures. These meetings must be documented, signed and dated by both the primary supervising physician and PA. http://www.ncmedboard.org/resources-information/faqs/physician_assistant

NC Board of Nursing and NC Medical Board joint policy on Nurse Practitioners: NPs must have a primary supervising physician who is responsible at all times for the medical acts of the NPs they supervise. The NP and primary supervising physician must create a Collaborative Practice Agreement that describes the types of patients seen, how they will be managed, the arrangement for continuous availability to each other, prescribing authority, and quality improvement process. This Collaborative Practice Agreement shall be agreed upon and signed by both the primary supervising physician and the nurse practitioner, and maintained in each practice site. It should be reviewed at least yearly. The NP and primary supervising physician should meet at least once every six months to evaluate the plan and quality of care provided for one or more frequently encountered clinical problems.
http://www.ncbon.com/dcp/i/nursing-practice-nurse-practitioner-faq--nurse-practitioner-np-1

APPENDIX 2: Shared Visit Billing

Whether the charge should be entered under the attending's name or APPs name depends on the site-of-service, the patient's insurer, and the supervising physician's level of involvement.

- The charge should be entered in the supervising physician's name if s/he actually saw the patient and can justify in the note why his/her presence was necessary. *Subsequently, the physician must co-sign the note AND document why his/her presence was necessary.*
- The charge should be entered in the PA/NP's name if the supervising physician cannot justify why his/her presence was necessary. The supervising physician does not need to cosign the note.
- One exception is that shared visit rules do not apply when Medicare and Tricare patients are seen within physician-based clinics (e.g., HMOB). Instead for these new patients the charge should be placed under the APPs name. For these return patients the charge should also be placed under the APP's name unless the visit satisfies "incident to" rules apply.
- Please direct any questions to Dana Sheffield (Dana.Sheffield@unchealth.unc.edu) in the office of Professional Compliance.