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AUA Consensus Statement on Advanced Practice Providers

LTC Timothy C. Brand, MD, FACS

WORKGROUP MEMBERS:

Christopher M. Gonzalez, MD, MBA, Chair
Timothy Brand, MD, AUA Education Council
John Gore, MD, AUA Quality Improvement and Patient Safety Committee
Tim Irizarry, PA-C, on behalf of the Urological Association of Physician Assistants
Lou Koncz, PA-C, AUA Advanced Practice Nurse and Physician Assistant Education Committee (Chair)
Ken Mitchell, MPAS, PA-C, AUA Advanced Practice Nurse and Physician Assistant Membership Committee
Christopher Porter, MD
Susanne Quallich, ANP-BC, NP-C, CUNP, FAANP, on behalf of the Society of Urologic Nurses and Associates
Jonathan Rubenstein MD, AUA Coding and Reimbursement Committee
Pablo Santamaria, MD, FACS, AUA Practice Management Committee
Howard Snyder, MD, FACS, AUA Legislative Affairs Committee
Aaron Spitz, MD, AUA Public Policy Council

AUA STAFF:

John Kristan, AUA Government Relations and Advocacy Coordinator
Kathleen M. Zwarick, PhD, CAE, AUA Associate Executive Director, Public Policy and Practice Support

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BLUF (Bottom Line Up Front)

The AUA acknowledges the important (and growing) role of advanced practice providers (APPs) in urology, and this document helps to clarify roles, to highlight opportunities for growth, and to provide a scaffolding for urologists and APPs as the role of APPs increases in urology.

There is a Growing Access Problem for Management of Urologic Disorders

- # Urologists per capita decreasing since 1991
- In 2009 there were 3.18 urologists/100,000 folks (30 year low and decreasing)
- 2nd oldest surgical sub (52.5), 18% ≥ 65
- One of the most severe specialty shortages

Pruthi, R. S., Neuwahl, S., Nielsen, M. E., and Fraher, E.: Recent trends in the urology workforce in the United States. Urology, **82:** 987, 2013.

Institute of Medicine (IOM) Report to Congress 2010

"The Future of Nursing: Leading Change, Advancing Health"

- Increase in primary care reimbursement should be extended to APPs
- Consider limiting funding for nursing education to states that have not adopted National Council of State Boards of Nursing advanced practice registered nurse model rules

American Medical Association Response

- Acknowledged the shortage of nurses and physicians
- Endorses a physician-led team approach to the provision of high-quality, value-based health care

Patchin, R. J. AMA responds to IOM report on future of nursing. American Medical Association website. Updated 10-5-2010. Accessed 5-10-2014.

Demographics – APPs in Urology

November 2012 Survey

- 3,338 nurse practitioners (NPs)
- 4,002 physician assistants (PAs)
- 411 clinical nurse specialists

November 2013 Survey

- 62% of urologists have an APP in their practice
- Highest pct with center age group and urban

AUA Definitions – Feb 2014

APPs are Advanced Practice Registered Nurses (APRNs) and PAs

Allied health professionals are nurses, technicians, and assistants

Of the APRNs (Clinical Nurse Specialist, Certified Nurse Midwife, Certified Registered Nurse, and NP), NPs are most active in urology

Quallich, S. A.: A survey evaluating the current role of the nurse practitioner in urology. Urol Nurs, **31:** 330, 2011.

Training of the NP

350 NP training programs in the US

- Didactics followed by clinical
- Based in primary care, with additional education based on specialty population focus
- Includes a graduate degree or postgraduate certificate
- Courses include pathophysiology, pharmacology, health promotion, and research

Role of the NP

Diagnosis and treatment of acute and chronic conditions – many in primary care, but others in specialties

- Comprehensive H&P
- Preventative screening
- Ordering and interpreting lab and imaging
- Prescribing medication, PT, OT, and durable medical equipment
- *Often includes health education*

Training of the PA

160 PA training programs in the US

- **Prerequisite 2 years of college courses in basic or behavioral sciences**
- **Includes a graduate degree – typically a master's degree**
- **Courses include pathophysiology, pharmacology, laboratory science and microbiology**
- **Rotations are diverse but emphasize primary care**
- **Certification for licensure includes exam and 1,000 - 2,000 clinical hours**

Role of the PA

Part of a team with physician supervision - "delegated autonomy"

- Comprehensive H&P
- Preventative screening
- Ordering and interpreting lab and imaging
- Prescribing medication
- Assisting in surgery
- Often in specialty practices

NPs and PAs

Different training, but roles after certification can be quite similar.

- Many PAs have rotations where they assist in surgery
- NPs specialize with a particular population focus prior to receiving their degree, and PAs specialize after graduation
- Lesser clinical hours for certification for NPs – but all have prior experience as RNs

Supervisory/Collaborative Model

The official position of the AUA is that APPs work in a closely and formally defined alliance with a urologist that serves in a supervisory role.

-- Delegated autonomy, with natural growth over time to lead the team to the highest level of urologic care.

American Urological Association. Urological allied health professionals. American Urological Association website. Accessed 9-22-2014.

1995 AMA Supervision Guidelines

- Physician must be available for consultation with the PA at all times either in person or through telecommunication or other means
- Physician is responsible for clarifying and familiarizing the PA with his or her supervising methods and style of delegating patient care

Evolving Duties for the APP

- As the physician-APP relationship grows, the APP moves into indirect supervision
- Dynamic and interactive process involving trust, excellent communication, and mutual goals
- Newly graduating APPs, and APPs new to urology will require a period of closer supervision and orientation

Team-Based Integrative Care

Opportunities

- Assisting in surgery
- Seeing postoperative patients
- Hospital consults
- Emergency room consults
- Overflow office patients

Enables physicians to see more complex urologic patients and do more cases

Other Opportunities

- Outreach clinics (experienced APPs)
- Preoperative educational classes

Consider APP education level, APP proficiency, state scope of practice laws and level of comfort of the physician and APP

General trend across states has been to broaden the definition of physician supervision

Mentorship and Training

Grooming the APP for indirect supervision shares commonality with educational processes for training urology residents

Milestone Concepts	Resident Competency • Adapted from "Urology Milestone Project" Document	Nurse Practitioner Competency • Adapted from NONPF core competencies, 2011 • 9 categories of competencies	Physician Assistant Competency • Adapted from AAPA/PAEA core competencies revised 2012 • 6 categories of competencies
Foundation in urologic/medical and scientific knowledge	Patient care, practice-based learning and improvement, medical knowledge	Scientific foundation	Medical knowledge, patient care
Leadership	Practice-based learning and improvement, interpersonal and communication skills, professionalism	Leadership	Professionalism, interpersonal and communication skills
Evidence-based practice	Practice-based learning and improvement	Quality, scientific foundation	Patient care, practice-based learning
Quality improvement and research	Practice-based learning and improvement	Practice inquiry	Systems-based practice, practice-based learning

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Use of technology in patient care	Systems-based practice	Technology and information literacy	Systems-based practice
Healthcare policy, regulation	Systems-based practice	Policy	Professionalism, systems-based practice
Organizational practice/ resource allocation	Systems-based practice, professionalism, interpersonal and communication skills	Health delivery system, quality, ethics, health delivery system	Interpersonal and communication skills, systems-based practice, professionalism
Role as part of healthcare delivery team	Systems-based practice, practice-based learning and improvement, professionalism,	Independent practice, healthcare delivery system	Systems-based practice, professionalism

Milestone Concepts	Resident Competency • Adapted from "Urology Milestone Project" Document	Nurse Practitioner Competency • Adapted from NONPF core competencies, 2011 • 9 categories of competencies	Physician Assistant Competency • Adapted from AAPA/PAEA core competencies revised 2012 • 6 categories of competencies
Patient care/ professional ethics	Professionalism, Interpersonal and communication skills	Ethics, quality	Professionalism, patient care
Scope of practice	Professionalism	Independent practice	Medical knowledge, professionalism
Procedural competencies	Patient care	Independent practice, scientific foundation	Professionalism, medical knowledge, practice-based learning

“Continuum of Skills Acquisition”

Value to assigning stratification – rating/expectations/?reimbursements

Progression from Level 3 to Level 1

Adapted from Crecelius et al., Journal of Palliative Medicine.

Level 3

May be a newly graduated APP and new to urology

- May not be able to triage multiple complaints well
- Close supervision (usually physician examines)
- May not be ready to prescribe meds until after discussion with physician
- Consider a urology training curriculum
- Should move to Level 2 in weeks to months

Level 2

May be an APP new to urology

- Role of physician is to verify, validate, and provide constructive feedback
- Supervision may be over telephone, but some time should be face-to-face
- Benefits from opportunities to enhance diagnostic and therapeutic skills for complex patients
- Coordination with physician to plan complex interventions
- Expected to mature to Level 1 over time

Level 1

Highly skilled clinician

- Routine distanced communication with physician – ie. progress notes, unless changes in plan identified, or a new diagnosis
- Care collaboration
- Quality improvement initiatives
- Educational sessions
- Families trust these APPs similarly to physicians

Educational Opportunity

"Education for APN/PA/Allied Health" on AUAnet.org

- Overactive bladder
- Urologic oncology
- Male sexual dysfunction
- Surgical assistance
- Stone management
- Female sexual dysfunction

Federal Statutory Requirements

42 CFR 483.40 Supervision – "the medical care of each resident (US) is supervised by a physician."

42 CFR 410.75 Collaboration – "a process in which a nurse practitioner works with one or more physicians to deliver health care services within the scope of the practitioner's expertise …as provided by the law of the State in which the services are performed"

Medicare Regulations

- "Incident-to" services are integral, yet incidental to the professional and personal services of a physician in diagnosing and treating illness.
- These may be billed as if the physician performed them
- But there are rules…

"Incident-to" Rules

- Must be performed in the physicians office – inpt services do not count
- Those performing the service must be employed by the billing practice
- The physician must have personally performed the initial service and established plan on care
- Physician must be immediately available (direct supervision)
- Otherwise 85% for APPs
- 3rd party payers have their own rules

Federal Legislation

In 112th and 113th Congresses, bills were introduced that

- Would expand Medicare reimbursement rates for APPs
- Expand scope of practice

States

NPs and supervision

- In 20 states and DC, NPs are allowed to practice independently
- In 12 states, NPs must be supervised
- In 17 states a collaborative agreement is allowed

Some settings (ie. nursing facilities) use federal regulations – and important to know local (facility rules)

Patient Satisfaction

146,880 randomly sampled Medicare benificiaries – generalist setting

- 30.5% treated by physician
- 33.3% by PA
- 38.7% by NP

Consumer Assessment of Health Plans Survey administered with similar satisfaction

Hooker, R. S., Cipher, D. J., and Sekscenski, E.: Patient satisfaction with physician assistant, nurse practitioner, and physician care: a national survey of Medicare beneficiaries. Journal of Clinical Outcomes Management, **12:** 88, 2005.

Kaiser Study Regarding APPs - 1995

Included Internal Medicine, Family Practice, and Pediatrics

Bottom line: APPs have gained patient acceptance

Hooker, R. S., Potts, R., and Ray, W.: Patient satisfaction: comparing physician assistants, nurse practitioners, and physicians. The Permanente Journal, **1:** 38, 1997.

Integration of APPs into Academic Medical Center Practice

26 surveyed institutions

- Ratio of APP to physician ranged from 1:3.7 to 1:18.5
- Outpatient clinics, primary care, surgical environments
- Meeting ACGME requirements and improving patient throughput

Moote, M., Krsek, C., Kleinpell, R., and Todd, B.: Physician assistant and nurse practitioner utilization in academic medical centers. Am J Med Qual, **26:** 452, 2011.

Liability Statistics

From 1991 to 2007, $74 billion paid out for liability claims

- Awards against PAs 0.003% of this total
- 0.007% for NPs

PA 12-times less likely to incur a liability pay out than a physician

NP 24.4-times less likely

Payouts similar for NPs ($306,310) to physicians ($308,383), but 25% less for PAs ($232,066)

Hooker, R. S., Nicholson, J. G., Le, T. Does the employment of physician assistants and nurse practitioners increase liability? Journal of Medical Licensure and Discipline, **95:** 6, 2009.

Understanding (and mitigating) Risk

Even though number of liability actions have been modest since incorporation of APPs, risk deserves attention:

- Physician can be held solely responsible under "respondeat superior"
- Physician can be held accountable for "negligent hiring"
- Physicians must notify their liability carrier when they hire an APP (may be shared limit)

There May be State Specific Rules

Especially for PAs

- Signed "Delegation of Services Agreement"
- Patient is examined by supervising physician (SP) day of care, and notes are signed by SP within 30 days
- Protocols issued and documented for treatment plans

COMMUNICATION IS PARAMOUNT

For NPs

State rules vary

- Scope of practice needs to be clear and based on educational background, clinical experience, and relationship with physician
- Negligence evaluated in the context of scope of practice

COMMUNICATION PARAMOUNT

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Innovations in Telemedicine and Opportunities for Remote Supervision

Precedence has been established for video link, remote sensors, and point of service diagnostics

- IBM's "Watson" has been used for some of these communication links
- These methods do not seem to erode patient satisfaction rates

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., and Sibbald, B.: Substitution of doctors by nurses in primary care. Cochrane Database Syst Rev, **CD001271**, 2005.

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Opportunities in Telemedicine

- Patient perception of “cutting-edge”
- Physician travel eliminated
- Ability to service multiple locations
- Greater availability
- More time with patients

Physician functions like a CEO, whose responsibility is to ensure access to high-quality, rapidly available urologic care

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Case Scenarios

Examples of physician led team based approach to patient care with APP’s

- Recurrent UTIs
- Kidney stone
- Erectile dysfunction

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Recurrent UTIs

- A 66-year-old healthy woman was referred to the urology practice of Dr. Smith and Dr. Jones for recurrent UTIs.
- She was initially seen by Dr. Smith who examined her and create a plan for her including self start therapy at the onset of symptoms.
- She is scheduled for follow-up in 6 months with the APP.

Recurrent UTIs- Billing – New Visit

- For this encounter, this would be a new patient, outpatient visit under Dr. Smith's NPI # for 100% reimbursement.
- Patients such as this can be initially scheduled with the APP and billing can be done either by APP alone or as a shared visit.
- A shared visit occurs when the MD and the APP both see the patient, however the APP and MD must document their involvement in the visit.

Recurrent UTIs-Billing-Follow-up Visit

- 6 months later the patient returns to the office and is seen and examined by the APP.
- The APP recommends continuing the plan of care and schedules follow-up for 6 months.
- Dr. Smith is not in the office but his partner Dr. Jones is.
- The encounter is billed as an established outpatient visit under Dr. Jones' NPI number for 100% reimbursement as the patient is being seen "incident to" Dr. Jones.

Recurrent UTIs-Billing-Urgent Visit

- 3 months later the patient is seen urgently for fevers, chills, and back pain by the APP.
- Dr. Smith is in the operating room but is available to discuss cases by telephone and Dr. Jones is out of town.
- The APP obtains labs, and orders CT scan and antibiotics. The APP discusses the case with Dr. Smith.
- This is billed as an established outpatient visit using the APP's NPI for 85% reimbursement.

Kidney Stone

- A 47-year-old male presents to the ED with renal colic and a 6 mm ureteral stone. There are no signs of infection and pain is controlled. A referral was faxed to the urologist's office.
- The APP see the patient in clinic and the supervising physician is available over reliable electronic means but is not in the office.
- The APP continues MET, reviews labs and imaging and schedules follow-up in one to 2 weeks.
- This is billed as a new outpatient visit using the APP's NPI # @ 85% reimbursement.

Kidney Stone - Billing

- At follow-up, symptoms persist and low-dose CT scan demonstrates the stone remains in the proximal ureter.
- The APP and the urologist review his CT and the APP discusses the options with the patient and the patient elects to undergo ureteroscopy.
- This is billed as an established outpatient visit under the APP's NPI number @ 85% (cannot do "incident-to" since initial visit was not with MD).
- Note: if the MD is in the office and examined the patient and documents involvement, the visit can be billed under the MDs NPI number at 100% reimbursement.

Kidney Stone - Billing

- The patient undergoes ureteroscopy. The urologist meets with the patient in preop holding and the patient undergoes uneventful ureteroscopy with lithotripsy and stent placement.
- Billing is by CPT code by the urologist and pre- and postoperative work that day falls within the global period of the procedure.

Kidney Stone - Billing

- A week after the procedure the patient is seen by the APP, the stent is removed by string, the patient is instructed to complete a renal ultrasound a month after, to proceed for lab work to evaluate for metabolic stone disease, and the patient is scheduled for follow-up in 6 weeks.
- This is billed as an established outpatient visit under the APP's NPI number at 85% reimbursement.
- Note: If the stent was removed by a cystoscopy by the urologist, CPT code 52310 (0 day global would be billed).

Kidney Stone - Billing

- 6 weeks later, the APP meets with the patient, counsels regarding ultrasound and lab findings and is discharged to follow up as needed.
- Established patient under APP's NPI # for 85% reimbursement.

Erectile Dysfunction

- A 55-year-old male is referred to urology for erectile dysfunction. The patient is initially seen and examined by the APP, the case was discussed with the physician, the physician examined the patient and helped create a step-wise plan.
- The patient elects for intracavernosal injection and he is educated and received injection in clinic.
- This is billed as office consultation under the physicians NPI number at 100% reimbursement and for CPT code 54235 for injection of corpora.

Erectile Dysfunction - Billing

- At the follow-up the patient returns to clinic to see the APP and the dose of the injection is increased, and it was recommended the patient undergo a penile Doppler.
- This is billed as an established patient under the APP's NPI number at 85% reimbursement

Erectile Dysfunction - Billing

- The penile Doppler was performed by the APP and interpreted in consultation with the urologist.
- Based on those results the APP counseled the patient that prosthesis may be necessary to restore erections.
- This is billed as an established patient under the APP's NPI number at 85% reimbursement, and the penile Doppler is coated under the CPT code 93980 and billed by the MD.
- Note: if the physician visited with the patient to discuss the prosthesis and risks and documented involvement, the billing would be under the physicians and NPI number.

Erectile Dysfunction - Billing

- The patient contacts the APP by phone and indicates he would like to proceed with a prosthesis.
- The patient is referred to the urologist within the group who specializes in prosthetics and the patient completes an uneventful prosthetic placement.
- CPT code for prosthesis billed by the MD.

Erectile Dysfunction - Billing

- The surgeon sees the patient for the two-week postoperative follow-up visit and returns 3 weeks later to see the APP for a final wound healing check and device activation.
- These are postoperative visits that fall within the global for the CPT code.

Erectile Dysfunction - Billing

- The patient is seen by the APP 3 months later to ensure the patient is satisfied with the prosthesis and that there are no other issues.
- This established patient visit is billed under the APP's NPI number at 85% reimbursement.

Summary

Access to urologic care is a growing problem

- APPs in urology in a physician-led team-based care may be part of the solution
- Goal is to roll it out safely and in a reproducible format that will keep our customers happy!