The Physician Shortage: Anticipated Impacts on Medical Models and Competency Management Programs

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Wendy R. Crimp BSN, MBA, CPHQ
The Crimp Resource Group
wcrimp@aol.com

Projected Supply and Demand, Physicians, 2008-2020
(ALL SPECIALTIES)
Shortage of Physicians

AAMC (American Association of Medical Colleges) in April, 2010 advanced the following:

• Total Physicians- 954,000
• Primary Care- 352,908
• Need 45,000 primary care specialists and 46,100 specialists by 2020
• Estimated total shortage 150,000 by 2025

Wall Street Journal April 12, 2010

Increase Life Span Compounds Problem

• Advances in care, such as a 50% reduction in mortality for cardiovascular disease, will only expand the need for more physicians. Lidia M. Niecko-Najjum, a senior research and policy analyst at the AAMC.
• Aging population
• Increases in the chronically ill

Physician Dissatisfaction and Early Retirement

• Physicians are growing dissatisfied with their work.
• Younger physicians are seeking better work-life balance seek to work fewer hours than their predecessors.
• Emergence of concierge medicine

Joe Cantlupe, for HealthLeaders Media, November 14, 2013
Impact of Politicians

• Lack of understanding (or at least preparation) regarding what is logistically required to deliver the ACA vision.
• Since 1965, Medicare has been the largest supporter of graduate medical education programs and has paid for its share of training costs. The Balanced Budget Act of 1997 imposed a cap on Medicare funded-GME at 1996 levels.
• Last March, 528 qualified 2013 medical school graduates were not matched to a residency training position, 758 qualified medical doctors who had graduated prior to 2013 also failed to be matched.

John Commins, for HealthLeaders Media, May 6, 2013

Other Environmental Factors

• Emergence of MOC
• Licensure requirements becoming more rigorous
• And the list goes on………..

Will A Surplus in Nurse Practitioners Help?

• A surplus of 34,000 nurse practitioners, about 48% above demand, and 4,000 surplus physician assistants will help relieve the doctor shortage, David Auerbach, Rand Corp.
• At least 17 states now allow NPs to work without a supervising physician.
• Lawmakers in five big states are considering similar measures California, Massachusetts, Michigan, Pennsylvania and New Jersey.
• The National Conference of State Legislatures reports that state legislatures considered 349 measures aimed at loosening NP licensing restrictions in 2011 and 2012. So far this year, 178 proposals have been considered.

Kaiser Health News, 2013
Since 2006, the PA profession has grown 34% and is expected to continue growing.

- The number of physicians grew 15% from 2005 to 2012.*

*Source: Journal of Regulation, FSMB 2013 2011
**Recent Example: Advanced Dental Therapist**

- New license in Minnesota
- 50% of practice must be applied to low income patients or in a dental health shortage area
- May dispense administer antibiotics, anti-inflammatories, etc.
- Two levels of supervision – Onsite or offsite

**Examples of Items That May Be Included in Licensed Scope of Practice**

* Dental assessment and formulation of treatment plan
* Restoration of primary and permanent teeth
* Preparation and placement of preformed crowns
* Tooth reimplantation and stabilization
* Administration of local anesthetic
* Administration of nitrous oxide
* Pulpotemies on primary teeth
* Extractions of mobile primary teeth

**Example #2: The Assistant Physician**

- Pending legislation in Missouri would create a new class of medical license, "the assistant physician."
- This new type of certificate would be available to medical school graduates who didn't get into a residency program and who passed Step 1 and 2 exams, but not the most important one, Step 3.
- The bill's proponents, including the Missouri State Medical Association (MSMA), which represents some 10,000 practicing Missouri physicians and helped draft the legislation, say Bravo! Allowing these new physicians to treat patients who otherwise have miserable access to care is a brilliant solution to a dire physician shortage.
Example: Speech Pathologists

Do we need to privilege speech pathologists who perform nasopharyngeal endoscopy?

Texas State Board of Examiners for Speech-Language Pathology and Audiology About the Profession-Scope of Practice

• "Speech-Language Pathologist" means an individual who practices speech-language pathology, who makes a non-medical evaluation, who examines, counsels, or provides habilitative or rehabilitative services for persons who have or are suspected of having speech, voice, language disorders, oral pharyngeal function, or cognitive processes, and who meet the qualifications.

Endoscopy - This procedure is not addressed in the Act or Board Rules. Licensees shall be referred to accepted professional practice guidelines (e.g., American Speech-Language-Hearing Association position statements).

From 2001 Board Minutes
It is the official position of the American Speech-Language-Hearing Association (ASHA) that endoscopy is an imaging procedure included within the scope of practice for speech-language pathologists and described in previously established ASHA documents (ASHA, 1998, 2004c, 2004d, 2004e, 2005a, 2005b, 2007). Speech-language pathologists with specialized training (ASHA, 2002, 2004a) in flexible/nasal endoscopy, rigid/oral endoscopy, and/or stroboscopy use these tools for the purpose of evaluating and treating disorders of speech, voice, resonance, and swallowing function. - See more at: http://www.asha.org/policy/PS2008-00297.htm#sec1.1

• Not typically privileged in hospital setting.
• Most organizations regard it as within the scope of licensure for Speech Pathologists
• Not high risk nor a medical act

Medical Practice? Depends Upon Your Perspective.
Insertion and Management of PICC Lines by RNs

- PICC line placement was traditionally considered a “medical act”
- Hospitals are training and deploying RN staffed PICC line teams
- For the most part the practice is being authorized by protocol not privileging; some State Boards of Nursing have included it in the scope of licensure – effectively removing it as a medical act
- Recent position statement by leading organizations that assert that RNs inserting PICC lines should also be able to obtain the complete consent effectively expanding their authority.
- Thus far three State Boards of Nursing have formally included PICC line consent in scope of licensure.

More Delegation to non-APPs

- More protocol driven medical management will be performed by RNs. Especially in the area of chronic care:
  - Coumadin Clinics
  - Asthma Management
  - Immunization Clinics
- More procedural responsibilities will be allocated to AHPs – i.e., Radiology Assistants

Two Methods of Authorizing Clinical Practice for non-APPs

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So Where Are We?

As we contemplate what may lie ahead we need to begin to envision how……

- Traditional medical models will be impacted by these changes
- The way we organize and execute competency management programs will be impacted

Alternative Models of Care

- Team Based Care
- Nurse Managed Clinics

Affordable Care Act Provides Grant Funding for Nurse Managed Health Clinics (NMHC)

The purpose of this initiative is to provide federal funding to support the development and operation of Nurse Managed Health Clinics (NMHCs) to:

1) Improve access to comprehensive primary health care services and/or wellness services (disease prevention and health promotion) across the lifespan
2) Provide these services in medically underserved and/or vulnerable populations without regard to income or insurance status of the patient

US Dept of Health and Human Services, 2010
Accelerated Emergence of Team Based Care

- Advances in cancer diagnosis and treatment and longer-term survival rates point to a growing need for interdisciplinary provider teams to meet the needs of patients as the supply of oncologists is predicted to decline.

- “Oncology nurses are embracing the move to play a bigger part in patient care”, says Mary Gullatte, PhD, RN, ANP, president of the Oncology Nursing Society.

- “Because oncology nurses are already a key part of cancer care it may be easier for his peers to accept and expect nursing’s expansion in oncology. They can see the uncomplicated patients; the patients who are in for a follow-up visit, leaving more time for the oncologist to deal with the very sick and very complex cases.” says Richard Schilsky, MD, American Society for Clinical Oncology, Chief Medical Officer.

Jacqueline Fellows, for HealthLeaders Media, March 27, 2014

Potential Impact On Future Competency Management Practices?

- Hospitals in relevant States are already considering whether they will redefine NP practice to be independent

- Medicare billing requirements promote independent practice for CRNAs, CNMs, but continue to imply that NP’s are subject to some form of physician collaboration (while at the same time referencing conformance with State Law) and PA’s to physician supervision.

- New categories of practitioners are being created in many States

- Exceptions are being granted for “pilot projects”

Implications for Privileging Programs

- Need to develop delineations that are flexible and lend themselves to adjustment over time

- Increased participation of APPs in medical staff organization committees (i.e., Credentials Committee, Peer Review or QI)

- Or, creation of APP specific ad hoc committees i.e., an Interdisciplinary Practice Committee as an ad hoc committee to the Credentials Committee
Ongoing Performance Monitoring

- Surveillance should be at the same level as it is for physicians and indicator targets should be the same
- Improved ease of data collection and indicator reporting with emergence of EMR (IF the organization imbeds the capability)
- Parity in peer review practices
- Greater participation of APPs in quality improvement committees
- Depending upon care model -- some quality improvement activities may measure team performance instead of just individual performance

Potential Implications For Governance

As APP practice begins to look more and more like physician practice:

- Less and less need for separate guidance for privileging for APPs, i.e., separate rules and regulations for APPs
- Fewer organizations will have separate process for appeals
- Creation of a more integrated credentialing, privileging and quality improvement infrastructure.

Your Role

- As these trends evolve the MSSP and QI Professional will need to......
- Monitor changes in scope of licensure for your State
- Monitor CMS posture and developments
- Monitor your own internal medical manpower challenges
Make Sure Your Competency Management Program “Keeps Up”

- Make needed modifications to governing body documents
- Privilege delineation forms need to reflect contemporary practice
- OPPE and other QI reports need to capture data needed to monitor non-physicians
- It may be beneficial to restructure your committees and program leadership to incorporate a variety of disciplines

Adopt a Receptive Posture

- Don’t resist these trends.
- Assist your organization to thoughtfully examine these trends.
- Implement new roles where it is beneficial to patients.

Bill Would Remove Cap on Number of Residencies at Teaching Hospitals

- A new bill intends to increase the number of primary care physicians by removing the cap on the number of federally funded residency slots at teaching hospitals.
- Bill would provide for 15,000 new Medicare-funded residency slots by 2019 in addition to the current 26,000 capped residencies funded through Medicare. Congress has maintained that cap since first implementing it in 1997.
- The bill would also require the National Health Care Workforce Commission to submit a report on specialty physician shortages to Congress by Jan. 1, 2016.
What Are Your Thoughts?