



Mid-Level Providers in the Emergency Department:

How Much is Too Much?



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Phoenix Physicians takes great lengths to be proactive, listen, and educate our Hospital partners by offering expertise and tools that can enhance the overall success of their Emergency Departments. Phoenix conducts annual surveys of all our Hospital partners to ensure we are meeting their needs and concerns. These surveys have helped us learn that many key issues are on the minds of all Administrators. Thus, we have created a series of White Papers to address these issues:

- Throughput in the Emergency Department: What is the Responsibility of Your ER Physician Group?
(Released February 2011)
- Emergency Department Patient Satisfaction: The Emergency Physician Group's Role
(Released April 2011)
- Mid-Level Providers in the Emergency Department: How Much is Too Much?
(Enclosed)
- Emergency Department Physician and MLP Coverage Models: Do I Have What I Need?
(November 2011)

On August 23rd 2011, at 11:00 am EST, Phoenix will be holding a conference call led by Phoenix's CEO Dr. Rob Scott, and Phoenix's President Mr. Chris Lutes, to review the material presented in this White Paper. The purpose of the call is to answer any questions and discuss the content further. If you or another member of your Administrative team is interested in participating, please contact Jason Jacobs at the number listed below to register for the call and receive the corresponding passcode. In addition, if you would like to receive an electronic version of this document or a previous White Paper, please do not hesitate to contact us.

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Creating Emergency Departments of Excellence

Mid-Level Providers in the Emergency Department: How Much is Too Much?

The utilization of Physician Assistants (PAs) and Nurse Practitioners (NPs) in the Emergency Department (ED), commonly known as “Mid-Level Providers” (MLPs), has increased significantly in the past 20 years. More and more Emergency Departments and the clinical care teams that practice within them have embraced the role of MLPs in the ED. There is no doubt that MLPs, when used properly in the Emergency Department setting, contribute to faster throughput times and higher patient satisfaction scores. Even more, their proper use can lessen overall provider fee expenses for the ED Physician group or the Hospital, without negatively impacting revenue whatsoever. It is very obvious that the financial cost of a MLP clinical shift in the Emergency Department is significantly less than the cost of a Physician clinical shift.

Although the operational and economic value of MLPs in the Emergency Department is very real, at some point the “overuse” of MLPs in the ED can begin to negatively impact Hospital metrics involving quality, clinical outcomes, and medical staff satisfaction. Given this counterbalance, the intentions of this White Paper are to discuss in more detail the role of MLPs in the Emergency Department, and to outline the various ways in which a Hospital can assess whether the use of MLPs in their own Emergency Department is appropriate or excessive.

Very Few Exceptions to Using MLPs in the Emergency Department

As stated, the use of Mid-Level Providers in Emergency Departments today is very common. Fortunately for both Hospitals and ED Physician groups, there are now widespread MLP training programs in the United States which graduate numerous clinicians every year who have the proper medical training and experience necessary to function at a high level in the Emergency Department setting. Due to this rapid growth in MLP training programs over the past 20 years and their graduate’s subsequent entrance into the ED clinical work environment, Emergency Department care has evolved to where the use of Physicians “exclusively” in an ED setting is now the unconventional approach to clinically staffing it. Therefore, due to this large number of well trained MLPs today who desire to work in EDs, it is of our opinion that there are only two scenarios where the use of MLPs in the Emergency Department may not be appropriate:

1. The Emergency Department sees less than 14,000 patients per year.
2. The Emergency Department is a dedicated Pediatric Emergency Department.

In the first scenario, Hospitals that have low Emergency Department volumes are simply not yet in need of a second provider on duty at the same time to treat all presenting patients each day. In these small Emergency Departments, one Physician alone is sufficient and appropriate to treat all the patients. However, once the volume starts to approach/exceed 14,000 annual visits, the addition of a

MLP during the afternoon and evening hours must be considered. Of course, there are many smaller Hospitals in the United States today with annual Emergency Department volumes that exceed 14,000 right now and they are not using MLPs in their Emergency Department at all. In some cases, this single Physician only approach in an ED with annual volumes over 14,000 may still be financially and operationally appropriate for the Hospital and/or the ED Physician group. Importantly however, all parties have to realize that at some point the Physicians who work in such an Emergency Department will encounter challenges “keeping up” with the daily volume and additionally maintaining the turn-around-time goals and patient satisfaction mandates as set by the Hospital. In addition, as the workday for these solo Emergency Physicians intensifies as the ED volume continues to increase, the practice environment for these Physicians will begin to turn negative if additional coverage is not entertained. And in such cases, the cost to recruit and retain top Physicians who will consistently work in such an Emergency Department with volumes that exceed 14,000 annual visits without the help of a second provider during peak times may prove increasingly difficult. It is in these cases that the ongoing cost for recruitment and retention of top Physicians for the Emergency Department must be weighed against the cost of inserting additional MLP coverage into the Emergency Department each day and improving the practice environment for their Physicians.

Likewise, in the second scenario, Hospitals that operate a dedicated Pediatric Emergency Department that is physically separate from the adult Emergency Department must strongly consider whether MLPs have any role within their Pediatric treatment area. Of course, the low volume scenario just described would apply to a dedicated Pediatric Emergency Department as well; if the dedicated Pediatric Emergency Department sees less than 14,000 visits per year, then the need for an MLP is unnecessary. If however, the Pediatric Emergency Department sees greater than 14,000 annual visits per year, the use of a second provider (Physician versus MLP) should be considered. In Pediatrics however, the use of non-Physicians in the Emergency Department to treat children can be a challenging proposition. Such challenges arise due to a general shortage of MLPs that have the sufficient training, experience, and confidence to work in a true Pediatric Emergency Department setting. Even more, the potential “high profile” impact of a bad Pediatric clinical outcome makes using MLPs in a dedicated Pediatric Emergency Department a bit risky. Lastly, given that the financial cost of a well trained Pediatrician as compared to a highly trained MLP with significant experience in Pediatrics is not that large, many times it makes more overall sense to simply use Physicians exclusively in large Pediatric Emergency Department settings.

Maximizing the Operational and Financial Benefit of MLPs in the ED

Excluding smaller Hospitals which treat less than 14,000 Emergency Department patients per year and large Medical Centers which operate dedicated Pediatric Emergency Departments, it is safe to assume that the vast majority of all other Hospitals in the United States today are actively using MLPs in their Emergency Department on a regular basis. Once again, there are numerous advantageous reasons to utilize MLPs in the Emergency Department—ED throughput benefits, patient satisfaction gains, and financial cost savings on overall provider fees for the Hospital or ED Physician group as compared to using a Physician-only staffing arrangement.

Unfortunately, despite these aforementioned very positive operational and financial benefits, at some point the use of MLPs in the Emergency Department setting can become excessive and begin to negatively impact operational metrics, such as quality outcomes and medical staff satisfaction.

Although MLPs are extremely valuable in Emergency Departments today, one key point cannot be overemphasized enough or forgotten: *MLPs are not equivalent Emergency Physician substitutes.* As talented as MLPs can be, they do not have as much medical training as Physicians nor do they possess as much clinical knowledge as Physicians. This fact cannot be underestimated. And given this reality, a key take-home message from this White Paper is that *as the clinical complexity of a patient in the Emergency Department increases, the role of a MLP in that patient's care should diminish.*

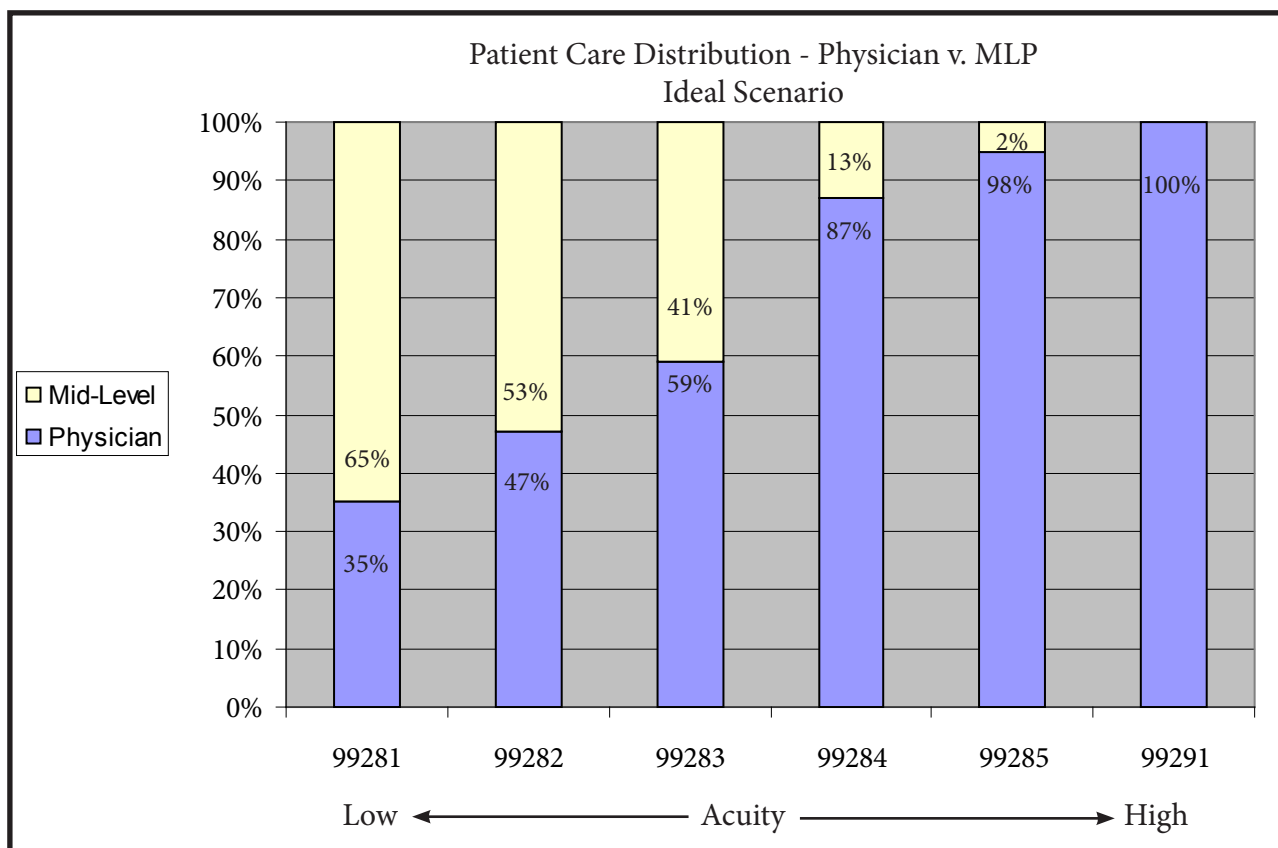
To demonstrate this point with a clinical example, nobody would dispute the fact that a 19 year-old healthy male who twisted his ankle the night before playing basketball is a very appropriate case for a MLP to manage in the Emergency Department. Likewise, nobody would disagree that a 64 year-old female presenting via EMS with 1 hour of severe substernal chest pain and a blood pressure of 80/40 is a case to be managed by the Physician on duty. Unfortunately, many clinical cases in the Emergency Department are not this straightforward as to which clinician (the Physician or the MLP) is the most appropriate to treat the patient. Thus, very often it is left up to a triage nurse who makes such a determination based on the Hospital's triage guidelines and clinical "instincts" as to whether the patient should proceed to a treatment area staffed primarily by Physicians or a treatment area staffed mostly by MLPs.

In the distant past, Hospitals only permitted MLPs to work in "fast-track" sections of the Emergency Department where the low acuity cases were treated (like our ankle sprain injury example just prior). This made perfect sense and was in accordance with MLP medical training, as such cases were of low complexity and MLPs possessed the skill, confidence, and speed necessary to care for them in a manner essentially equivalent to a Physician. Even more, it did not take the business minded folks very long to recognize that the financial expense for a MLP to staff the fast-track each day was significantly less than the cost to staff it with a Physician.

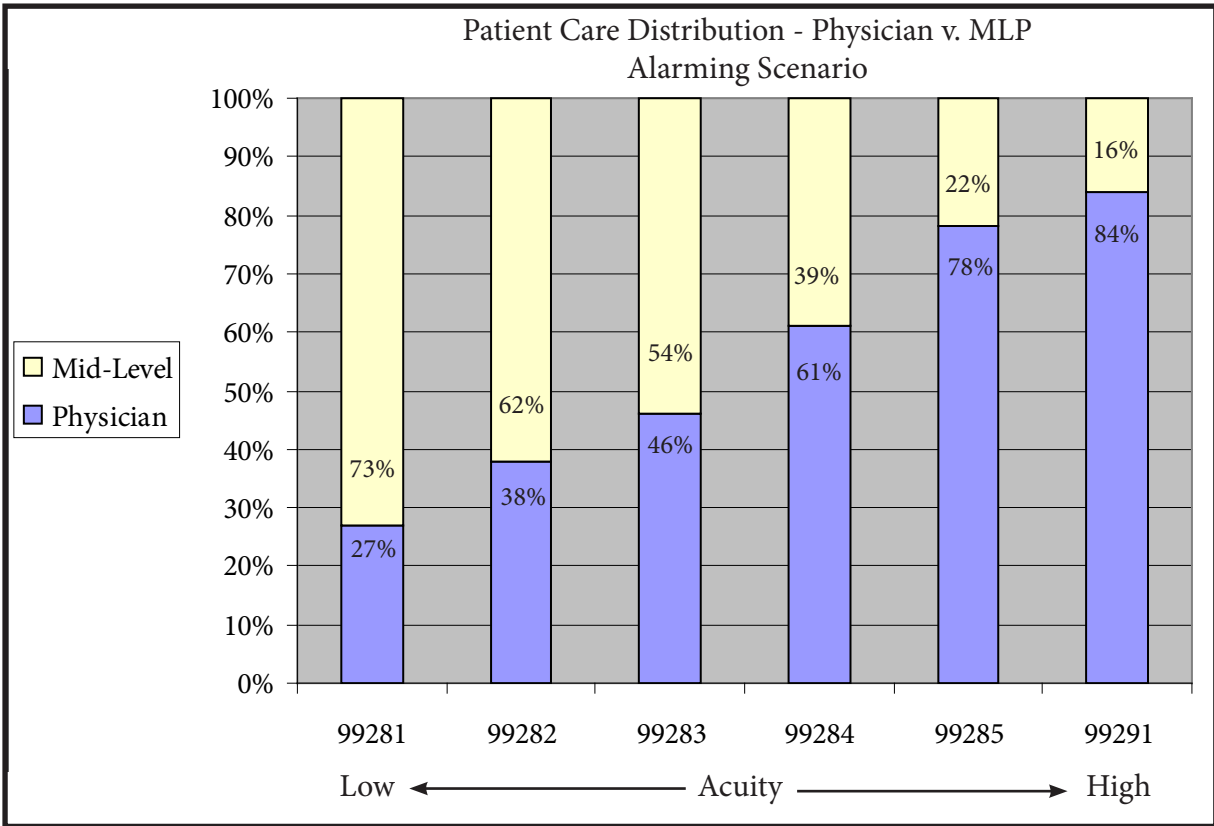
However, as economic pressures on both Hospitals and ED Physician groups have continued to escalate, it has become increasingly commonplace for MLPs in today's Emergency Departments to be additionally utilized in the areas of the Emergency Department where the highest acuity patients are treated. From a strictly economic perspective, this may make some sense (again, the cost of a MLP shift is less than a Physician shift). However, if we remember that MLPs are not equivalent Physician substitutes and they are not trained as extensively as Physicians, there are significant potential negative ramifications that must be considered and managed proactively if an expanded role for MLPs in the high acuity sections of an ED is to be considered by the Hospital or the ED Physician group.

Ultimately, if a Hospital and an ED group do agree that MLPs can be used in the higher acuity sections of their Emergency Department, one key point is absolutely critical: *The supervision of these MLPs by the Emergency Physicians must greatly increase.* As stated prior, MLPs do not have the same level of experience or as much clinical training as Physicians. Thus, the Emergency Physicians, the MLPs, the ED nurses, and the Hospital Administrators must all accept this MLP limitation and manage it proactively through extremely tight MLP supervision protocols enforced by the Physicians. If such supervision is not done well and instead the Physicians let MLPs work largely unsupervised in the high acuity treatment areas, clinical outcomes will suffer, malpractice risk will greatly increase, and medical staff satisfaction will decrease.

One beneficial way to assess how appropriately patients are being triaged and subsequently treated by the Physicians (versus the MLPs) in any Emergency Department is to analyze the ED Physician group's coding data to determine which cases had MLP involvement (and which ones did not), by escalating degree of patient acuity. In the Emergency Department setting, there are five evaluation and management (E/M) CPT codes used by Physicians to code their care (99281-99285), in addition to the critical care CPT code (99291). The CPT codes 99281, 99282, and 99283 are used for simple and straightforward cases that require less medical decision making. The CPT codes 99284, 99285, and 99291 are used for the more complex cases, where the medical decision making is greatly increased. Thus, in an ideal clinical arrangement, as the clinical complexity of cases increase (cases coded with 99284, 99285, and 99291), the amount of MLP involvement in such care should decrease. On the other hand, in the lower acuity cases (coded 99281-99283), the MLP involvement should be maximized, as it makes little financial sense for Physicians to treat lower acuity patients.



Above is a coding distribution for an Emergency Department where the use of MLPs appears very appropriate from a clinical and risk management perspective. Along the X-axis are the six E/M codes used by Physicians within the Emergency Department setting, with the far left being the least acute code (99281) and the far right being the most acute code (critical care, or 99291). Along the Y-axis is the percent of the cases in the measurement time period that had some degree of MLP involvement in the care (as determined by a coder who recognized that a MLP had charted some clinical notes within the record, indicating that a MLP had some involvement in the case). As one can see from the graph, a high percentage of the low acuity cases (99281-99283) have MLP involvement, which makes logical sense both clinically and financially. Likewise, as the clinical complexity increases (codes 99284, 99285, and 99291), the percentage of cases with MLP involvement declines. In this ED it appears that the Physicians by themselves are handling most of the high acuity cases without involving a MLP at all.



In contrast, above is a coding distribution for an Emergency Department where the use of MLPs appears worrisome from a clinical and risk management perspective. Once again, along the X-axis are the E/M codes used within the Emergency Department setting, with the far left being the least acute code (99281) and the far right being the most acute code (critical care, or 99291). Once again along the Y-axis is the percent of the cases in the measurement time period that had some degree of MLP involvement in the care. As one can see, a high percentage of the low acuity cases (99281-99283) have MLP involvement, which makes sense both clinically and financially. However, as the clinical complexity increases, the percent of the cases with MLP involvement remains high. Even more alarming, 16% of the critical care cases (99291) had MLP involvement. This data is objective clinical evidence that a bad outcome is very possible in this ED.

Of course, in reality it is essentially impossible to have 100% of the lower acuity cases (coded 99281-99283) seen by MLPs. If anything, MLPs are traditionally not on duty in the ED during the overnight hours, yet low acuity cases continue to present during those hours. Thus, the Physicians must treat them alone. In addition, it is nearly impossible to have 100% of the higher acuity cases (coded 99284, 99285, 99291) seen only by Physicians exclusively. Even if MLPs are used exclusively in the fast-track setting where all lower acuity patients are triaged, from time to time a well-appearing patient sent to fast-track will end up being sicker and more complex than first anticipated. In those instances the MLP involvement in a case coded 99284, 99285, or 99291 will be inevitable. Most importantly however, assuming that the overall fast-track triage process is done properly and triage guidelines followed, MLP involvement in high acuity cases can essentially be minimized if the Hospital or ED Physician group so chooses.

The Critical Importance of Proper MLP Supervision

Given the inevitability of MLPs seeing sick patients in fast-track settings from time to time, and even more, Hospitals and ED Physician groups more commonly choosing to use MLPs in the main ED where patient acuity is greatest, the critical importance of proper MLP supervision by Emergency Physicians cannot be overemphasized. In the most general terms, there are three methods in which a Physician can supervise the care provided by MLPs in the Emergency Department. They are (from least risky to most risky):

1. The Emergency Physician personally examines all patients, reviews the treatment plans and diagnostic tests with the MLP prior to patient disposition (admit or discharge), and personally makes a separate independent note in the medical record. This is a low risk methodology.
2. The Emergency Physician reviews the treatment plan and diagnostic tests with the MLP prior to patient disposition, personally makes a separate independent note in the medical record, but does not personally examine the patient. This is an intermediate risk methodology.
3. The Emergency Physician signs the medical record after the patient is dispositioned, and thus does not examine the patient nor review the treatment plan and diagnostic studies with the MLP prior to patient disposition. This is a high risk methodology.

Without a doubt, method 1 is the most preferable (and least risky) way for Physicians to supervise MLPs. By using this method, it greatly minimizes the chances for a diagnostic error to be made by the MLP. It also assures resource utilization is appropriate (labs, radiology testing). On the other hand, method 3 is clearly the most risky. In those latter instances, the Physicians are only reviewing and signing the medical record after the patient has physically left the Emergency Department. Thus, there is no way for the Physician to “unwind” or “undo” any treatment or diagnostic decisions that have already been made by the MLP. Method 3 is never acceptable, regardless of how low the acuity of the patients the MLPs are treating appear to be.

Most importantly, when one considers these three MLP supervisory methods in conjunction with the acuity of cases those same MLPs are treating in a given Emergency Department, a real risk assessment is possible for the Hospital as to the likelihood for bad outcomes. As an example, if MLPs are strictly working in fast-track settings with a high percentage of low acuity cases (cases coded 99281-99283), method 1 is ideal and method 2 is perhaps tolerable from a risk standpoint. On the other extreme, if MLPs are working in the main area of the Emergency Department with a high percentage of high acuity cases (cases coded 99284, 99285 and 99291) where admissions or transfers are commonplace and critical procedures (intubations, central lines, chest tubes) routine, supervisory method 1 is really the only tolerable option. Unfortunately, if a Hospital Administrator finds that their Emergency Department MLPs are seeing high acuity cases routinely and are being supervised by the Physicians via supervisory method 2 or 3, the odds of suboptimal resource utilization, bad clinical outcomes, heightened malpractice risk, and the number of medical staff complaints will greatly increase. It is this increased malpractice risk and potential for complaints from the medical staff that a Hospital and the ED Physician group must weigh against the financial savings they gain by substituting MLPs for Physicians in the high acuity treatment areas of an Emergency Department.

High Risk Patient Populations and Chart Auditing

Even when MLPs are used in the high acuity treatment areas of an Emergency Department and their supervision is deemed appropriate from a risk standpoint by both the Hospital and the ED Physician group, routine chart audits on high acuity cases involving MLPs should be done routinely to assure supervisory compliance. The following clinical scenarios are just a few “high profile” instances where chart audits may be very helpful to make certain all supervisory protocols are being followed properly:

- Adult and Pediatric cases with MLP involvement if critical care (99291) was billed.
- Pediatric cases with MLP involvement if a lumbar puncture was performed.
- Pediatric cases with MLP involvement if a CT scan was performed.

The point of such chart audits is two-fold. First, the intention of the chart review is to determine how the MLP became involved with these kinds of cases in the first place. Most Hospital Risk Managers would agree that in general, MLPs should not be involved with critical care cases involving adults or children, nor should they be working up Pediatric patients that ultimately require a lumbar puncture or a CT scan. Thus, the first reason for the chart audit is to determine if the Hospital’s triage process was followed correctly and the patient was placed in the most appropriate treatment area. Secondly, these high acuity cases should have a chart review done to make certain that the MLP supervision by the Physician was appropriate (real time exam by Physician, MLP treatment plan discussed with Physician and agreed to at the outset, admission/transfer process handled by Physician, separate detailed clinical note made in medical record by Physician). Most importantly, if a chart audit reveals that the triage guidelines were not followed correctly or if the MLP supervision by the Physician as judged by the medical record was determined suboptimal, immediate clinical feedback to the appropriate Physicians, MLPs, ED nurses, and Risk Managers is absolutely required in order to mitigate any potential future negative outcomes.

Summary

As we have outlined in this White Paper, the role of Mid-Level Providers in the Emergency Department has tremendous value from both an operational and economic perspective. Their proper use can lead to improved throughput times and patient satisfaction scores without sacrificing clinical quality. The economic savings from MLP use in the proper Emergency Department settings is also significant. However, Hospital Administrators should be aware of potential MLP “overutilization” and Physician “underutilization” in high acuity treatment areas by contracted ED Physician groups for strictly economic reasons and cost savings. If not managed very tightly, MLP overutilization in high acuity treatment areas by ED Physician groups can lead to suboptimal resource utilization, negative clinical outcomes, increased malpractice expense, and medical staff dissatisfaction. Frequent chart audits by the ED Physician group to monitor the appropriateness of MLP supervision by their Physicians on an ongoing basis is absolutely necessary for any high acuity cases that involve MLPs.

About Phoenix Physicians

Phoenix Physicians is a leading Physician-owned practice management company based in Fort Lauderdale, Florida, providing adult and pediatric Emergency Medicine services to Hospitals and Health Systems nationwide. Phoenix currently provides quality care to over 750,000 patients annually and all of our partnering Hospitals can attest that we focus our operations on key clinical initiatives that result in enhanced patient safety and satisfaction, successful Physician recruitment and retention, and positive financial outcomes for our Hospital clients.

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