

Redeployment of Orthopaedic Advanced Practice Providers at Academic Medical Centers During the COVID-19 Pandemic

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The novel coronavirus (SARS-CoV-2) represents a rapidly evolving pandemic. Health systems are scrambling to mobilize and redeploy their medical staff in the fight against COVID-19. Orthopaedic nurse practitioners/physician assistants should be part of any redeployment strategy to address unmet needs during these unprecedented times. This article discusses redeployment considerations and strategies that utilize these providers appropriately while mitigating risks.

Introduction

Orthopaedic and sports medicine practices frequently utilize advanced practice providers (APPs), the term used for physician assistants (PAs) and nurse practitioners (NPs), to provide care for a myriad of musculoskeletal disorders. In the United States, there are more than 115,000 certified PAs, with nearly 11% practicing in orthopaedic surgery; to my knowledge, no data are available on the number of NPs practicing in orthopaedic surgery (Kidd, 2018; NCCPA, 2017). In addition, about 28% of all specialty practices employed APPs, including 21% of surgical practices (Martsolf et al., 2018). Orthopaedic NPs/PAs perform histories and examinations, order and interpret diagnostic tests, prescribe medications and therapies, perform consultations, and first assist in the operating room.

Nurse practitioners are advanced practice registered nurses (APRNs) who are graduate-educated in a specific population foci (e.g., pediatrics, acute care, women's health, family), whereas PAs are graduate-educated as a "generalist" in the medical model, which complements physician training. While there are differences in educational philosophy, certification, and licensure, both NPs and PAs perform overlapping responsibilities in orthopaedic surgery (Hass, 2016). Although not a requirement for entry-level practice, some NPs/PAs choose to complete postgraduate fellowship training in orthopaedic surgery to gain exposure to various aspects of musculoskeletal injuries and disorders. The continuous integration of NPs/PAs in orthopaedic surgery has proven beneficial to patients and surgeons (Manning et al., 2018).

The practice of orthopaedic surgery has remained a fairly stable and busy specialty, but the evolving COVID-19 pandemic has led to significant reductions in

elective procedures, in-person visit volume, and adverse financial impact. In fact, 97% of medical practices have experienced a negative financial impact related to COVID-19, which has contributed to pay cuts, furloughs, and layoffs (MGMA, 2020; Stempniak, 2020). On top of the bleak economic outlook, hospitals are scrambling to boost medical supplies and bed capacity to prepare for surge. Consequently, to mitigate the adverse effects of COVID-19, hospitals have developed plans to redeploy clinicians into new roles to respond to emerging and critical needs. Orthopaedic NPs/PAs due to their unique training and skill set are more than capable of being redeployed to address unmet needs during these unprecedented times.

Redeployment Considerations of NPs/PAs

The majority of NPs/PAs employed in orthopaedic surgery have a prior background in primary care and therefore can be repurposed to staff drive-through COVID-19 testing sites, follow-up on test results, provide telehealth services for post-COVID discharge patients, assist with telephone triage efforts, provide virtual wellness visits, support occupational health and virtual orthopaedic urgent care clinics, provide broad-scale temperature screening of employees/patients, and assist with prone positioning during mechanical ventilation. Although NPs/PAs should work at the top of their license, they may be asked to assist and/or perform oral and endotracheal suctioning, peripheral line placement, and manual chest physical therapy. Redeploying orthopaedic NPs/PAs to inpatient units to care for acute and critically ill

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patients should be based on whether these providers have sufficient education, training, and competence to shift to a more intensivist role. Moreover, redeployment should be customized to have the right provider with the right skill set in the right location. In addition, Academic Medical Centers (AMCs) considering incorporating orthopaedic NPs/PAs into pandemic preparedness planning should be familiar with the following factors: (1) state scope-of-practice (SOP) laws; (2) malpractice and credentialing considerations; (3) billing implications; (4) specific surge training needs; and (5) conducting a health risk assessment prior to redeployment.

Scope-of-Practice Restrictions

Scope-of-practice regulations vary by state and often serve as a barrier to NPs/PAs practicing at the top of their license (Kidd et al., 2019). Currently, 28 states allow NPs full practice authority to treat and prescribe without physician oversight. Conversely, the majority of states require PAs to be supervised by a physician. However, in response to COVID-19, states have begun expanding workforce capacity by lifting burdensome restrictions and regulatory hurdles that allow NPs/PAs greater practice autonomy through emergency legislation and temporary executive orders. Additionally, the Coronavirus Aid, Relief, and Economic Security (CARES) Act allows NPs/PAs to order home healthcare services for Medicare patients, which could only be done previously by a physician. The Centers for Medicare & Medicaid Services (n.d.) no longer requires Medicare patients admitted to the hospital be under the care of a physician. New York now allows NPs/PAs to practice medicine without physician supervision, and in California, the Governor signed a temporary waiver removing any limit on the number of NPs/PAs a physician can supervise at any given time. Other states are in the process of removing SOP restrictions that impede APPs' flexibility and independence during this unprecedented public health crisis.

Malpractice Considerations

Redeployment during COVID-19 can lead to angst among NPs/PAs concerned about potential liability when providing care outside of their specialties. Additionally, the U.S. Department of Health and Human Services (2020) Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19 issued a declaration providing liability immunity to licensed healthcare providers, suppliers, drug manufacturers, and others involved in a broad range of medical countermeasures to combat the pandemic. In addition, the CARES Act provides immunity for volunteer healthcare professionals acting in good faith during the COVID-19 emergency response, with some exceptions (McConnell, 2020). Nevertheless, it remains unclear at the state level, whether redeployed APPs will be afforded broad tort immunity when providing treatment in the midst of a crisis that may have led to unintended consequences. We live in a notoriously litigious society, and it is possible that after the virus dissipates, there could be a surge in malpractice litigation. In addition, NPs/PAs redeployed through a hospital incident command system to provide care during the COVID-19

pandemic may be granted immunity from potential liability absent willful or criminal misconduct, gross negligence, or SOP violations.

Credentialing Considerations

Like physicians and other healthcare professionals, APPs undergo an extensive and thorough review of their qualifications prior to employment, and it is important to include the medical staff office in any redeployment strategy to ensure APPs have the appropriate credentialing and privileging prior to temporary reassignment. For example, NPs/PAs employed primarily in office-based clinics but are being redeployed to a hospital setting will require credentialing and privileging to perform and bill inpatient/outpatient hospital services. In addition, medical staff bylaws, rules, and regulations may need to be amended to allow greater flexibility such as granting NPs/PAs admitting privileges to expedite emergency department throughput during surge.

Health Risk Assessment

Hospitals have taken an "all-hands-on-deck" approach in fighting the pandemic, but it may be important to identify those NPs/PAs at a higher risk of acquiring infection and/or COVID-19-related complications. According to a Centers for Disease Control and Prevention (CDC) report in 2020, those with chronic lung, kidney, and heart disease, or immunocompromised status are at increased risk for severe illness from COVID-19. Perhaps NPs/PAs with risk factors for severe illness should avoid exposure to patients with COVID-19. Repurposing NPs/PAs at higher risk of contracting the virus to expand the use of telehealth amid the pandemic may improve access to health services during a potential surge.

Surge Training Needs

Surge training needs vary and are dependent on the needs of the health system. It is important to conduct a quick needs assessment and survey of provider skills, experience, and board certification. This will help elucidate the training and knowledge required to narrow the skills gaps to facilitate a successful deployment. Redeploying NPs/PAs to areas where they may have limited training and competence can cause more harm than good for patients. For example, it may be inappropriate to redeploy orthopaedic NPs/PAs to provide independent comprehensive care for mechanically ventilated patients. Finally, as general rule, all NPs/PAs should be familiar with common and emergent COVID-19 signs and symptoms, when to recommend self-quarantine versus hospitalization. This information can be obtained from a variety of sources such as the CDC and local public health agencies.

Billing Implications

The pandemic continues to have a negative effect on revenue cycle, and minimizing revenue volatility is critical during these uncertain times. When redeploying NPs/PAs to assist with critical need areas, it is important

to ascertain how they will bill for their services when redeployed. Understanding the new diagnosis and treatment codes can also be helpful in capturing and attributing work performed by orthopaedic NPs/PAs. For example, NPs/PAs redeployed to help with COVID-19 testing should at least be familiar with the following two codes, which can be found at: *ICD-10-CM Official Coding and Reporting Guidelines April 1, 2020, through September 30, 2020* (CDC, n.d.):

1. *For known exposure to COVID-19 (without diagnosis of COVID-19), report Z20.828, "Contact with and (suspected) exposure to other viral communicable diseases."*
2. *For suspected exposure to COVID-19 that is ruled out after evaluation, report Z03.818, "Encounter for observation for suspected exposure to other biological agents ruled out."*

Also, as a reminder, some payers may not separately credential NPs/PAs, which, in turn, requires that claims be submitted under the assigned supervising or collaborating physician's national provider identifier. This is particularly problematic, if the NP/PA is redeployed outside of their supervising physician's medical specialty. In this situation, it may be necessary to assign another supervising physician in the medical specialty where the APP has been redeployed to facilitate care coordination and billing. It is very important to notify the billing department when NPs/PAs are redeployed to avoid billing errors that contribute to lost revenue. Also, it is important to keep apprised of payer-specific policies that may affect billing for out-of-network care providers who are redeployed to tackle COVID-19.

Conclusion

Hospitals interested in enlisting orthopaedic NPs/PAs to fight COVID-19 should establish a system for rapid streamlined deployment of these providers based on a number of factors and considerations. Skill set and training of NPs/PAs should align with redeployment strategies that utilize these providers appropriately while mitigating risks. Effective redeployment of orthopaedic NPs/PAs and other clinicians will largely depend on health systems' ability to provide scalable and sustainable surge capacity.

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