Advanced Practice Provider Best Practices

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Children's Hospital of Wisconsin
Medical College of Wisconsin
Children's Specialty Group

PAs and NPs: A Short History

Physician Assistants (PA) 1960's A Time of Change

- **1965** - Duke University develops the first PA program following medics returning from Vietnam
- Solution to a gap in service for the underserved

Nurse Practitioners (NP) Advancing over Time

- **1965** - Nurse Practitioner role emerged in 1960s with the first NP school established at the University of Colorado
- Solution to Medicare/ Medicaid covering women and children

Federal War on Poverty created healthcare centers that could be staffed by APRNs and PAs

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Statistics

2016: There are more than 222,000 NPs and more than 100,000 PAs practicing in the U.S. [1]

Source: AANP National NP Database, 2016; National Commission on Certification of Physician Assistants

Practice Model Quiz

- True or false:
  - Nurse practitioners can only help with care coordination activities

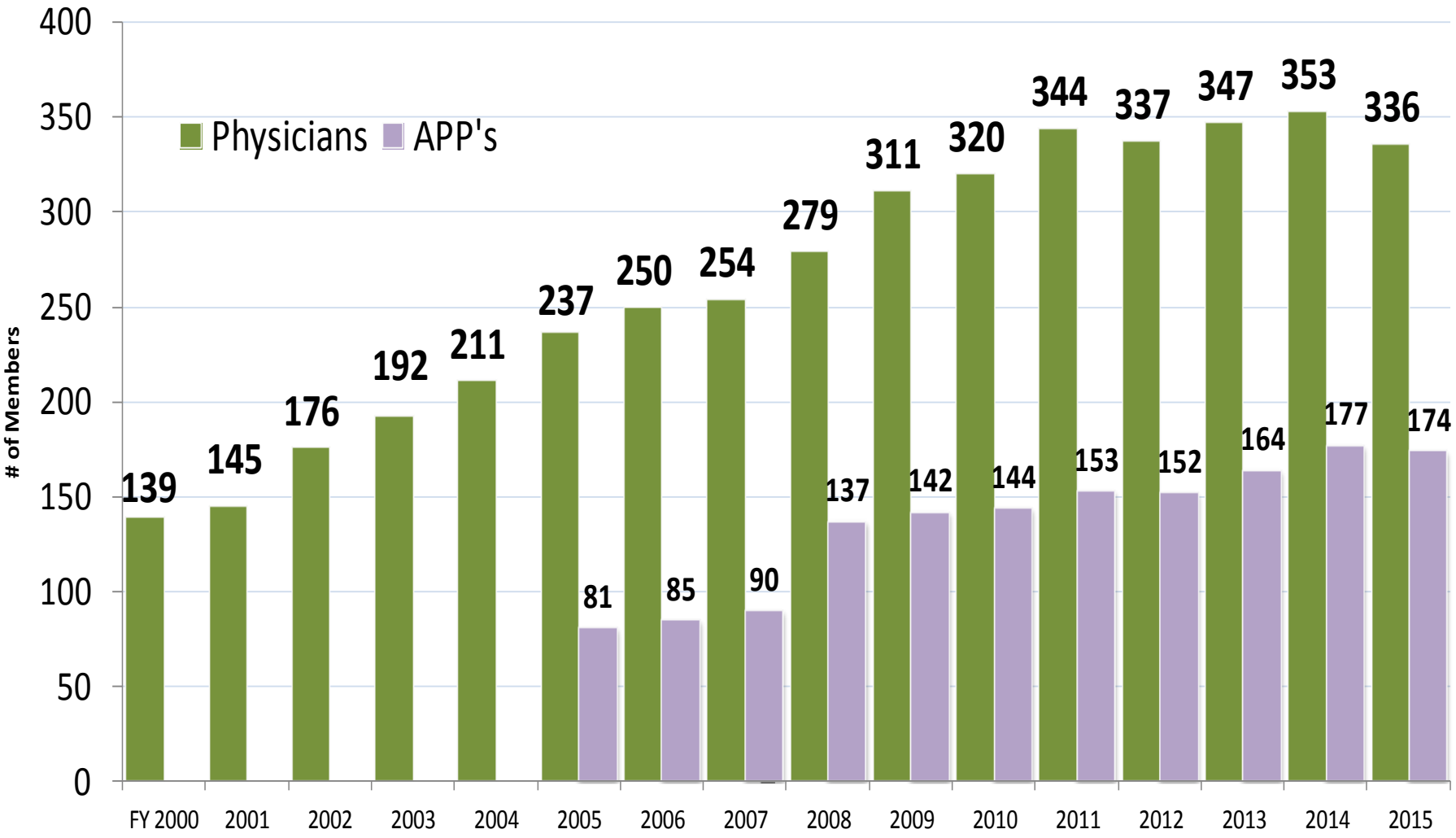
☒ False *Nurse Practitioners are trained to order and interpret diagnostic tests, diagnose and treat patients, manage patient's care while educating patients and their families towards improved wellness.*

  - Physician Assistants are mainly geared towards procedural based specialties.

☒ False *The greatest majority (20.5%) function in family practice/general medicine also diagnosing, treating, and educating.*

Source: AANP National NP Database, 2016;
National Commission on Certification of Physician Assistants

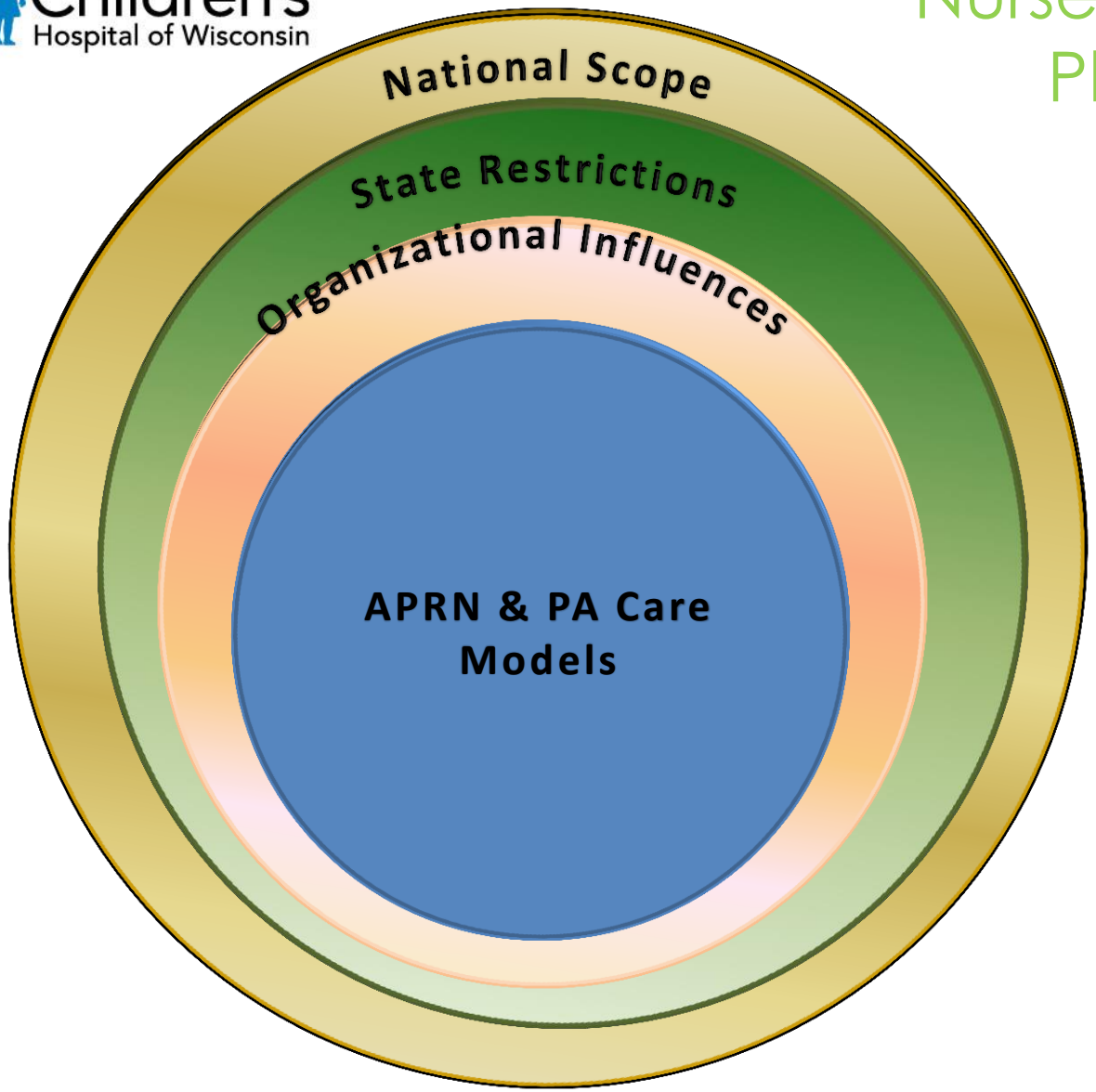
Children's Specialty Group Workforce



Practice Areas

- Anesthesiology (5)
- Dermatology (2)
- Imaging (3)
- Neurology (5)
- Neurosurgery (3)
- Orthopedics (8)
- Otolaryngology (7)
- Plastic Surgery (1)
- PM&R (2)
- Psychiatry (2)
- Surgery (7) / CT Surgery (7)
- Urology (4)
- Pediatrics:
  - Adolescent Medicine (2)
  - Allergy/Immunology (7)
  - Cardiology (12)
  - Child Development (2)
  - Child Protection (4)
  - Critical Care (19)
  - Emergency Medicine(12)
  - Endocrinology (5)
  - Gastroenterology (5)
  - Genetics (2)
  - Hem/Onc/BMT (16)
  - Neonatology (15)
  - Nephrology (2)
  - Primary Care/Urgent Care (CMG)- 32
  - Pulmonary (5)
  - Rheumatology (1)
  - Special Needs (7)

Nurse Practitioner and Physician Assistant Scope



1. Core competencies of NPs and PAs
   - Assessing
   - Diagnosing
   - Oder/prescribing
   - Procedures
   - Billing
2. State variations on scope
3. Organizational variation

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APP Best Practices

1. Right fit for the right role- Matching education, training, and certification
2. Models of Care
3. Structure
4. Compensation
5. Productivity
6. Billing platforms
7. Orientation- Supervisor/ Collaborator responsibilities

#1 APP Best Practices: Right Fit for the Right Role

1. What is the need for the hire?
   - Improved throughput
   - Increased patient access/volumes
   - Expand services
   - Procedural help

2. Does and NP or PA fill this need?
   - Or does skill set of RN, coordinator, other required?

3. What is the cost/ROI?
   - Are expectations established based on need?

APP Best Practices: Right Fit for the Right Role

4. Matching education, training, and certification

Alphabet soup:

- PNP, FNP, ACPNP, PA, AA, CRNA, etc
- Assess patient population
- Role requires adult, peds, mix?
- Chronic care coverage
- Acute care coverage

- Align job description with required credentials

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#2 APP Best Practices: Models of Care

- Inpatient
  - 24/7 accountability
  - Call?
- Ambulatory
  - Regional sites
  - Call?
- Procedural

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APP Best Practices: Models of Care

1. **Support top of licensure work**
   a. Define APP role separate from nursing and other support staff

Lacking Rigor in Deployment Evaluation

Physicians Too Often Underestimating AP Capabilities

Sample Provider Staffing Request

Requesting Practice	Perceived Need	Actual Need
Cardiovascular clinic struggling with access	 *AP*	 *Nurse* Nurse or case manager to schedule appointments, follow up with patients

First Step: Acknowledge the Problem

"Most of the time, physicians aren't asking for the right staff. We can't just throw people at problems – we want to be proactive and have an organized approach."

Kristi Henderson, DNP
Chief Advanced Practice Officer
University of Mississippi Medical Center

Case in Brief: University of Mississippi Medical Center

- Academic medical center based in Jackson, Mississippi, employing 557 physicians, 212 APs
- CAP[1] believes physicians requesting staff overestimate provider level needed at least half the time

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2 APP Best Practices: Models of Care

1. Support top of licensure work

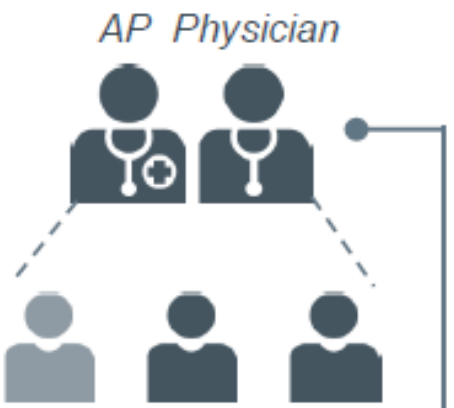
2. **Expand APP practice to maximize patient flow and access**
    1. **Parallel clinics**
    2. **Inpatient rounding**

3. Utilize APPs as comprehensive caregivers

Redefining Provider Roles Across the Practice

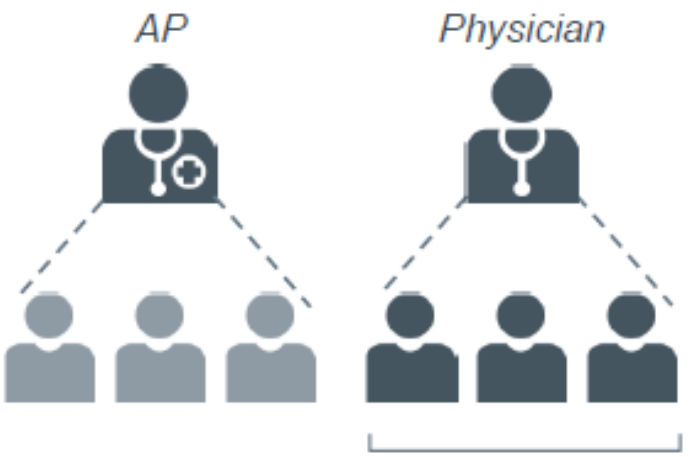
APs, Physicians Both Must Be Utilized More Effectively

Common Team-Based Staffing Model



Physician involved in each patient visit, providing care or checking AP work

Ideal Team-Based Staffing Model



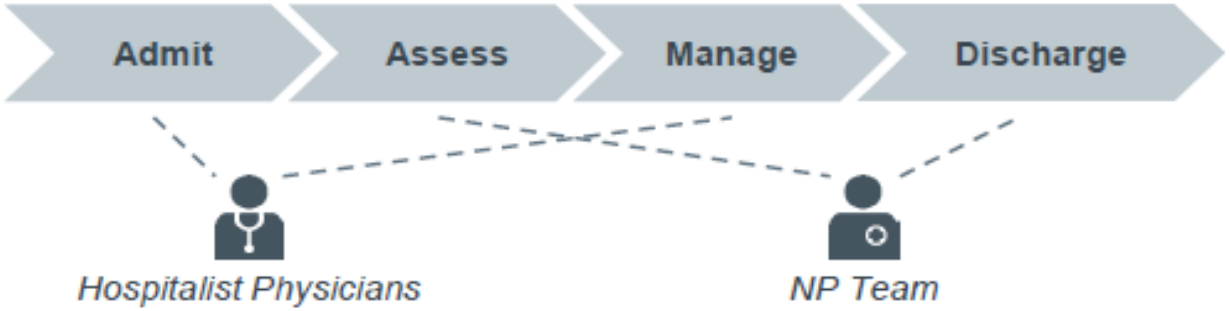
Patients requiring physician attention

Source: Medical Group Strategy Council interviews and analysis.

Sharing Clinical Responsibilities

APs Assigned Extensive Patient Care Duties

Shared Responsibilities



Hospitalist Physicians

- Admit patient, establish initial care plan, bill
- Collaborate with NPs as needed
- Rotate through NP-staffed units

NP Team

- Assess patients, manage care, perform majority of discharge planning, execution
- Assigned to support outpatient PCPs, specialists serving as primary attending[2]
- Document notes in EMR[3]

Go-To Providers

"I can't think of a diagnosis that never goes to an NP – but some diagnoses, like patients with sickle cell and those requiring peritoneal dialysis, will always go to an NP."

Lisa Norsen
Director, Sovie Institute for Advanced Practice
University of Rochester

Case in Brief: University of Rochester Medical Center

- AMC[1] based in Rochester, New York, employing 2,500 faculty physicians, 500 APs
- Team of NP hospitalists provides patient care with supervision from attending physician
- Each NP stable-staffed to a unit, cares for 8-12 patients; NP lead advises on staffing

1) Academic medical center
2) NPs provide continuity of care for patients of non-hospital-based physicians
3) NPs record notes as "covering providers"

Source: University of Rochester Medical Center, Rochester, NY; Medical Group Strategy Council interviews and analysis.

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APP Best Practices: Models of Care

1. Support top of licensure work

2. Expand APP practice to maximize patient flow and access
    1. Parallel clinics
    2. Inpatient rounding

3. **Utilize APPs as comprehensive caregivers with adequate support staff allocated.**
    1. Complex patients
    2. Autonomous Consultants
    3. Protocol based care

Prioritizing Physicians' Time for Most Complex Patients

AP Responsible for Multiple Types of Lower-Acuity Care

Advanced Heart Failure Program

- Treating acute heart failure, other complex CV conditions[1]
- Staffed by one specialist, one APRN[2]; supported by four RN coordinators

Case Types

High Acuity — *Seen by Physician*

- Complex inpatient consults
- Post-discharge patients
- New outpatients referred by PCPs, cardiologists

Lower Acuity — *Seen by APRN*

- Lower-acuity inpatient consults
- ER consults
- Post-discharge follow-ups on inpatient consults
- Outpatient follow-up

Building True Expertise

"One-third of heart failure medicine is outside cardiology. A specialized APRN can provide better care than a general cardiologist."

Heart Failure Specialist

Case in Brief: Lutz Medical Group[3]

- 300-physician, 100-AP employed group based in the Southeast
- Launched hospital-based advanced HF[4] program

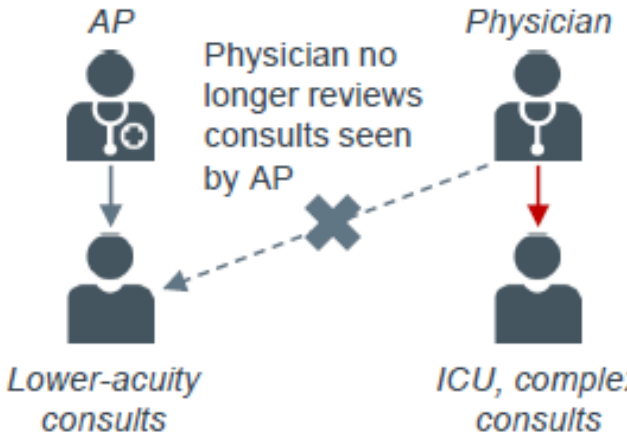
1) E.g. pulmonary hypertension, mechanical support devices, hypertension.
2) Advanced practice registered nurse.
3) Pseudonym.
4) Heart failure.

Source: Medical Group Strategy Council interviews and analysis.

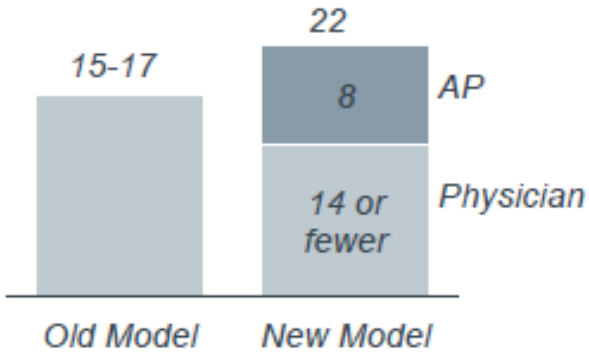
Positioning AP as Autonomous Consultant

APs Provide Hospitalist Consults to Lower-Acuity Patients

Hospitalist Consult Model



Average Daily Census



Considerations

- APs have previous consult experience
- AP, physician, other care team members huddle daily to review all patients
- AP, physician assigned to same floor; communicate frequently

Case in Brief: IU[1] Health Physicians

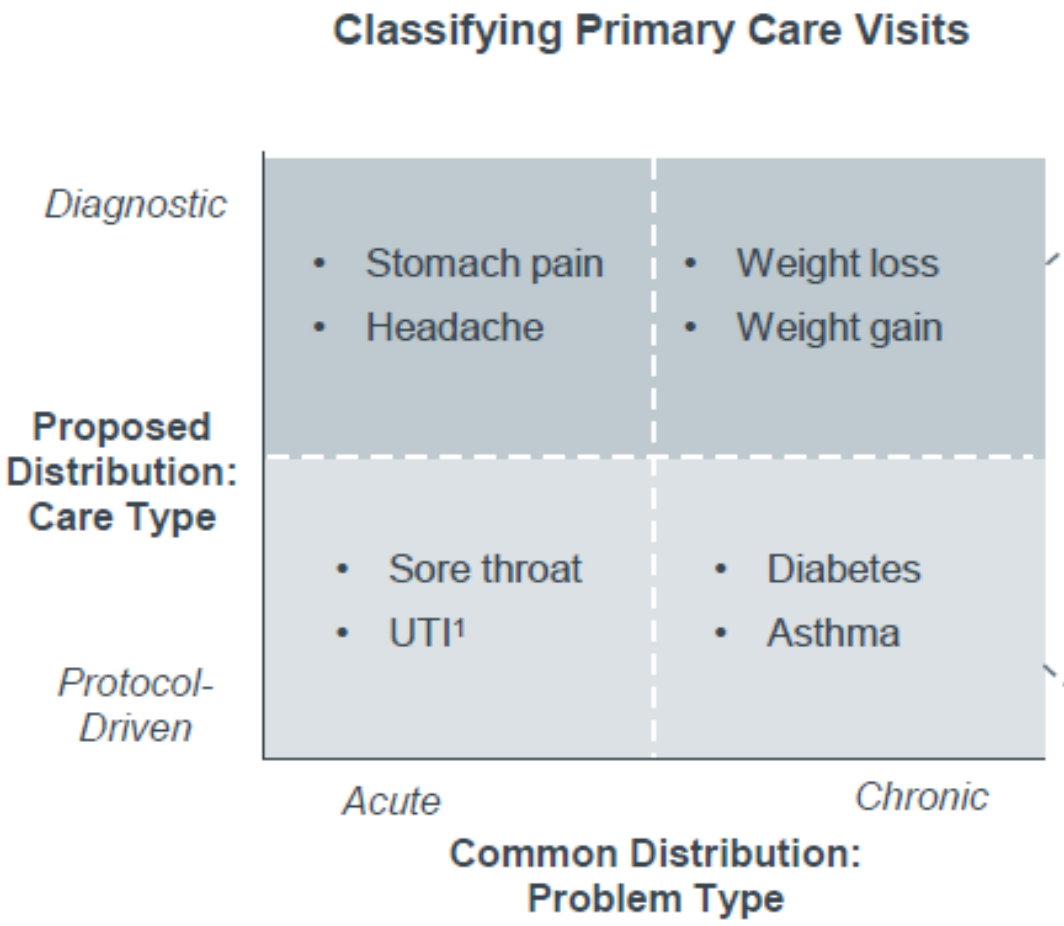
- 1,000-physician, 255-AP employed group based in Indianapolis, Indiana
- Changed hospitalist staffing to team model to reduce cost, LOS[2], readmissions
- APs now bill in own name for hospitalist consults

1) Indiana University.
2) Length of stay.

Source: Indiana University Health Physicians, Indianapolis, IN: Medical Group Strategy Council interviews and analysis.

Provider Skills Map to Care Type, Not Problem Type

Distinguishing Diagnostic From Protocol-Driven Care



Physician Advantage

- Trained in differential diagnosis
- Shorter visits help meet productivity expectations

AP Advantage

- APs trained in patient education techniques
- Cost-effective to spend more time with patient

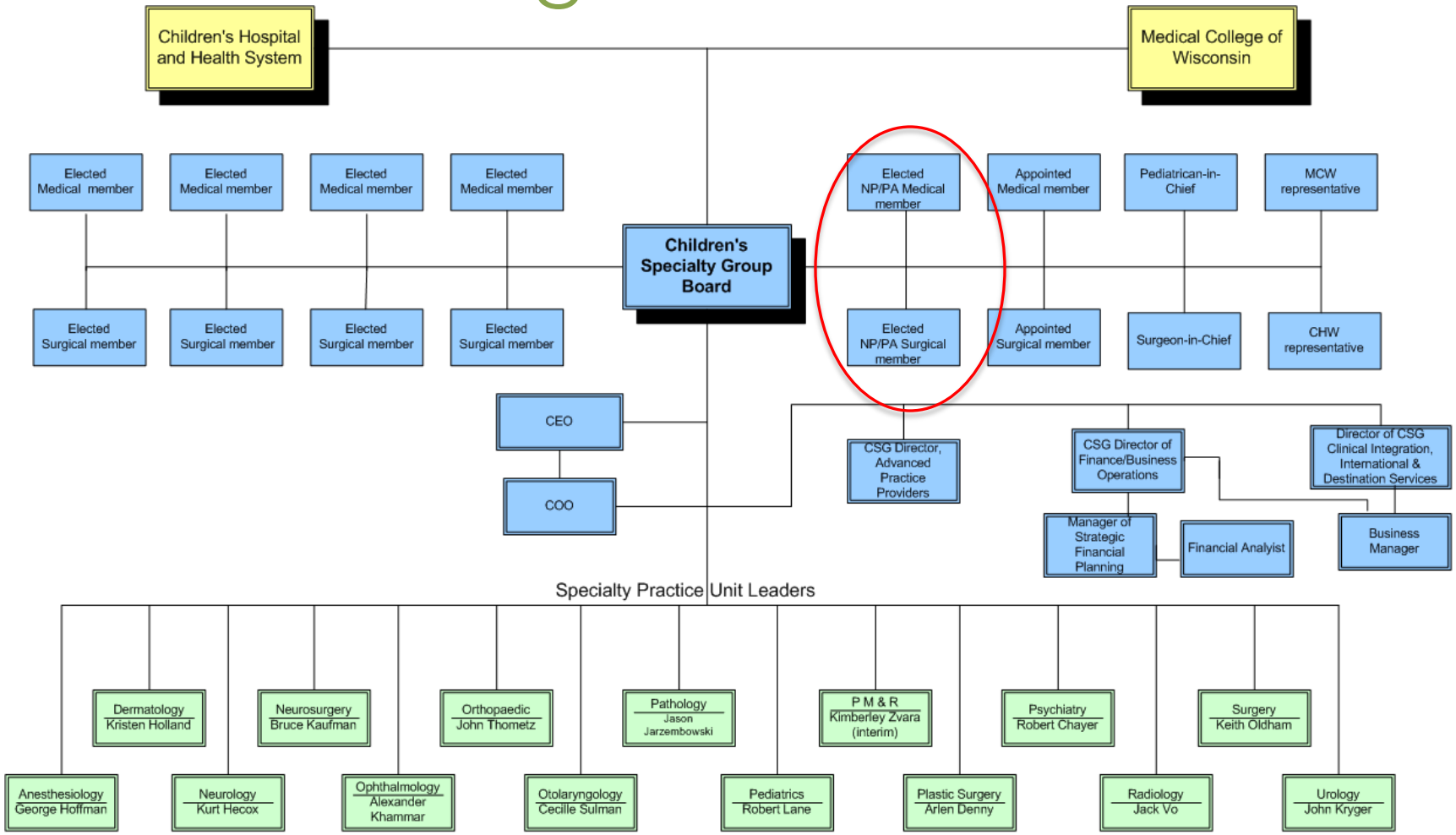
1) Urinary tract infection.

Source: Medical Group Strategy Council interviews and analysis.

#3 APP Best Practices: Structure

- Not nursing / not medicine. Unique needs.
- Centralized structure with identified leader to work with specialty administrative and physician leaders.
  - Recommended practicing NP or PA
  - Emerging role and present in most academic children hospitals
- Streamlines APP role / processes/advocacy
- Requires strong leadership support to advocate for voice – most APPs serve as front line providers and/or continuity of care given resident restrictions.
  - Holds seats within organizational committees/seats

Children's Specialty Group Organizational Chart



#4 APP Best Practices: Billing

- Set up systems for independent billing
  - Allows to demonstrate contributions more clearly
  - Remember team based benchmarks
  - Capturing teaching/time.
  - Perform audits
  - Dashboard transparency

Concerned about decreased reimbursement?

- Physician Services
  - Expenses: approx $250,000 salary/yr = $120/hr
  - Service:
    - Reimbursement: $100 for visit

✓Outcome:

(-$20/visit)

- NP/PA Services
  - Expenses: approx $100,000 salary/yr= $48/hr
  - Service:
    - Reimbursement: $100 for visit for *same service*

✓Outcome:

$36/visit

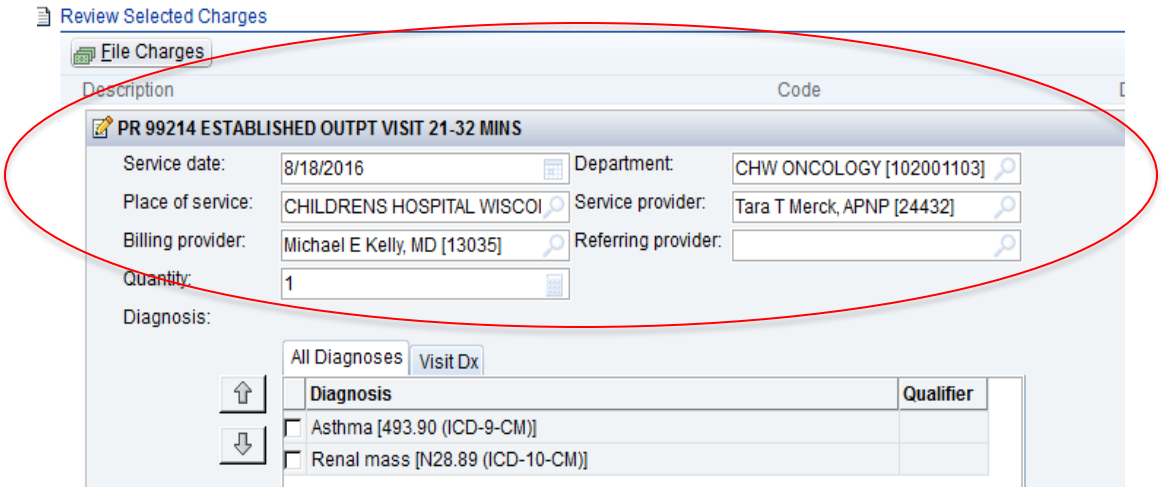
**Key is to staff right provider with right population*

Concerned about decreased reimbursement?

Key Assumptions:
-15 min appointment in ½ day clinic = 28 visits daily (not accounting for no-shows)
-General Medicare reimbursement rates for NP/PA
-Working 8 hr/day

	MD	NP/PA
Level of Service	$100 reimbursement x 28 appts = $2800	$85 reimbursement x 28 appts = $2380
Salary per day	$120/hr x 8 hrs/day = $960	$48/hr x 8 hrs/day =$384
Contribution Margin	$1840	$1996

Combined Billing Servicing Provider



With tracking, we can then decipher servicing RVUs

B	C	D	E (B+C+D)	F (B/E)	G (C/E)	H (D/E)	I	J (E+I)	K (I/J)	L (E/J)
APP Independent wRVU's	APP Combined Effort wRVU's ***Provider = APP***	APP Combined Effort wRVU's ***Provider = MD***	Total APP wRVU's	APP Independent wRVU %	APP Combined Effort wRVU % ***Provider = APP***	APP Combined Effort wRVU % ***Provider = MD***	CSG MD wRVU's	CSG Total wRVU's (MD & APP Total)	CSG MD % of Total CSG wRVU's	CSG APP % of Total CSG wRVU's

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#5 APP Best Practices: Productivity

- No national RVU benchmarks for APPs – specifically in pediatrics
- Set section "team"benchmarks
  - Utilize APPs to help with:
    - Patient Care Continuity/Coverage
    - Access
    - Chronic population management

Internal and External Reporting Implications

Individual Pediatric Physician

Name	Total FTE	Clinical FTE	wRVUs	50th Percentile	Overall UHC wRVU %tile for an individual using
Benchmark (Based n 1.00 cFTE)					
Physician X	1.0	0.80	4,000	3,000	60

Combined Pediatric Physician and APP

Name	Total FTE	Clinical FTE	wRVUs	50th Percentile	Overall UHC wRVU %tile for a team
Benchmark (Based n 1.00 cFTE)					
Physician X	1.00	0.80	6,000	3,000	80

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#6 APP Best Practices: Compensation

- Matching compensation with role
  - Call?
  - Nocturnist?
  - 24/7
- Tier implementation as supplemental pay
  - Allows flexibility with internal transfers

Tier Allocation Example

Tier assignment is based on majority of responsibilities/efforts and is determined by supervisors and the department administrators. Tier compensation will replace "critical staffing" and "on call pay."

Tier 1	Tier 2	Tier 3	Tier 4
Workweek: Monday through Friday	Workweek: Sunday through Saturday	Workweek: Sunday through Saturday	Workweek: Sunday through Saturday
Hours Worked: Days	Hours Worked: Day/Evening/Night Schedule: Weekends and holidays as required to provide on-going clinical care	Hours Worked: Approximately 30% - 75% Evening/Night Weekends and holidays as required to provide on-going clinical care	Hours Worked: 76-100% nights /weekends and holidays to provide on-going clinical care
Differential: No incremental compensation above base salary	Differential: $XX incremental compensation added above base salary	Differential: $XX incremental compensation added above base salary	Differential: $XX incremental compensation added above base salary

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#7 APP Best Practices: Orientation

1. Solidified plan (hardcopy)
2. Point person/preceptor meetings weekly at first, then monthly
3. Mix of shadowing, didactics and hands on learning
4. Identified APP mentor
5. How long until an APP feels competent?

Orientation Plan and Checklist

PEDIATRIC NP/PA ORIENTATION

NP/PA Preceptors:
Physician Mentors:

WEEK 1 MCW orientation
eLearnings
Epic training
Security and identification badges
Tours of clinical sites
Meet & greets with section/program team members
Review Departmental Checklist

WEEKLY MEETINGS/LECTURES:

Monday:	0800-0930	Sign outs
Tuesday:	0800-0930	
	1200-1300	Resident Noon Conference, Clinic Large Workroom
Wednesday:	0700-0800	
Friday:	0800-0900	Grand Rounds
	0930-1030	Meetings (as scheduled)

WEEK 2 Concentrate on XX Exam
Meet with Tara Merck, APP Director, Children's Specialty Group
Shadow APPs and other Providers in Clinic/ Inpatient wards
Focus on diagnostic exam and XX
Continue meet & greets with Section Team members

WEEK 3 Concentrate on XX
Shadow APPs and other Providers in Clinic/ Inpatient wards
Focus on XX
Continue meet & greets with Section Team members

WEEK 4 & 5 Concentrate on XX
Billing & documentation requirements
Shadow APPs and other Providers in Clinic/ Inpatient

	CSG Orientation Checklist	Team Member Responsible	Date Completed
Departmental Information	Discuss staff positions/introductions/roles		
	Discuss organizational structure		
	Discuss departmental reporting structure (medical leaders, supervisor managers, etc.)		
	Review job description /competencies/expectations		
	Clinic/ patient flow		
	Dress code		
	Order business cards		
	Department / work area tour		
	Department resources and contact numbers		
	Payroll		
	Departmental policies and procedures, including where/how to access them		
	Role of department in carrying out mission		
	Elements of CHHS strategic plan pertinent to department		
	Department goals		
	Departmental QI plan		
	Locating and ordering office supplies		
	Equipment usage (computer, fax, copy medical, etc.)		
	Telephone access / set up voice mail		
	Email access		
	CHW / MCW ID badge, include office access / office key		
	Obtain pager & have burned to include group page		
	Computer access		
	Arrange CHW ID and parking structure access with security		
	Review Isolation procedures		
	Safety: location of fire extinguishers, etc.		
	Security, threats to staff, etc		
	Non-punitive reporting of incidents		
	Office space		
Daily Work Schedule	Orientation schedule expectations		
	Weekday / weekend hour expectations		
	Unscheduled absences / scheduled absences		
	Provider / staff work schedules		

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Team based care