# Demonstrating PA/APRN Impact through Care Model Design

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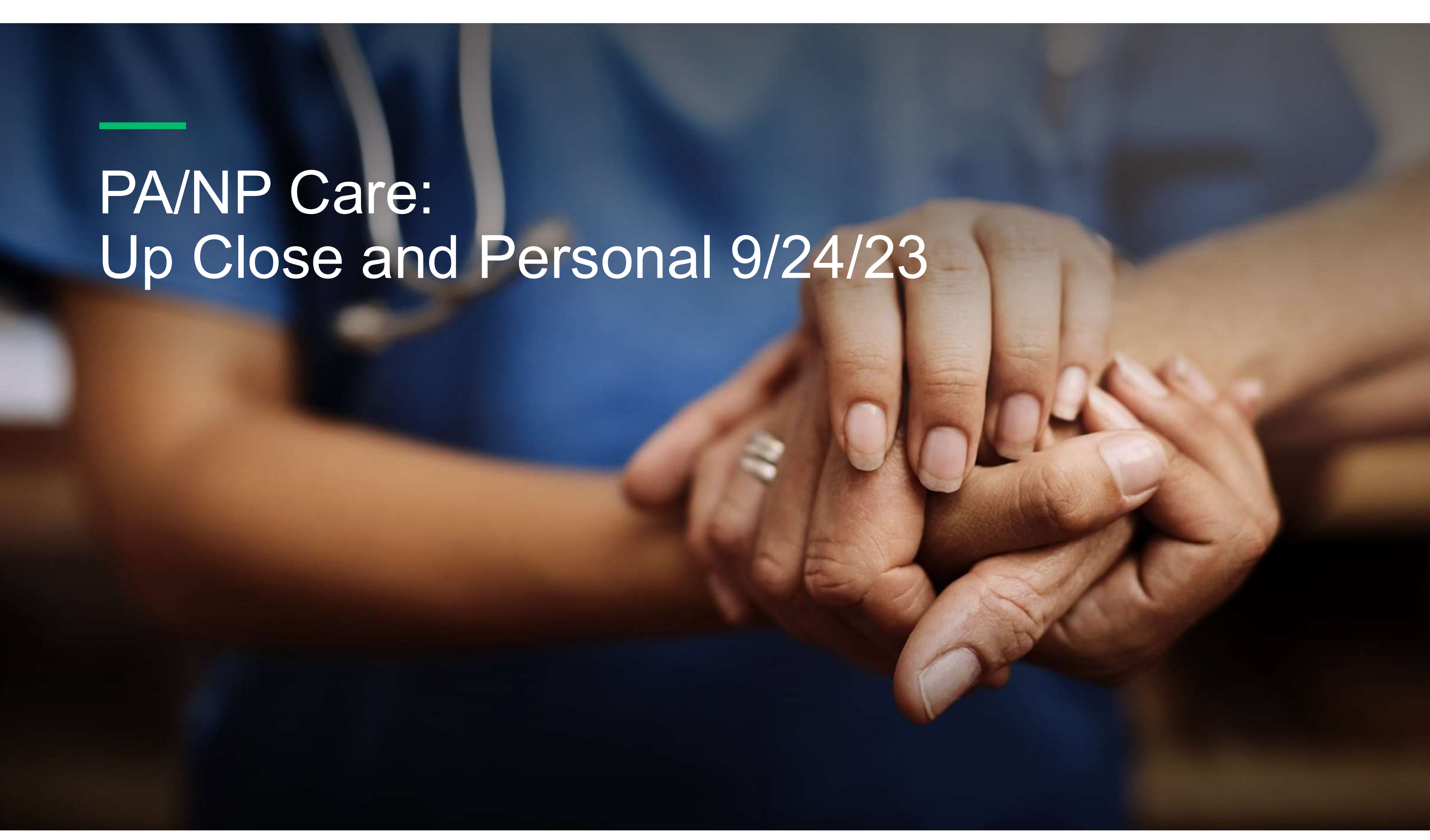
# Objectives and Disclosure

## Objectives:

- Discuss innovative strategies to leverage patient access through PA/APRN care models
- Review the value of uncoupling shared visits
- Strategize on elevation of PA/APRN contributions to health system goals

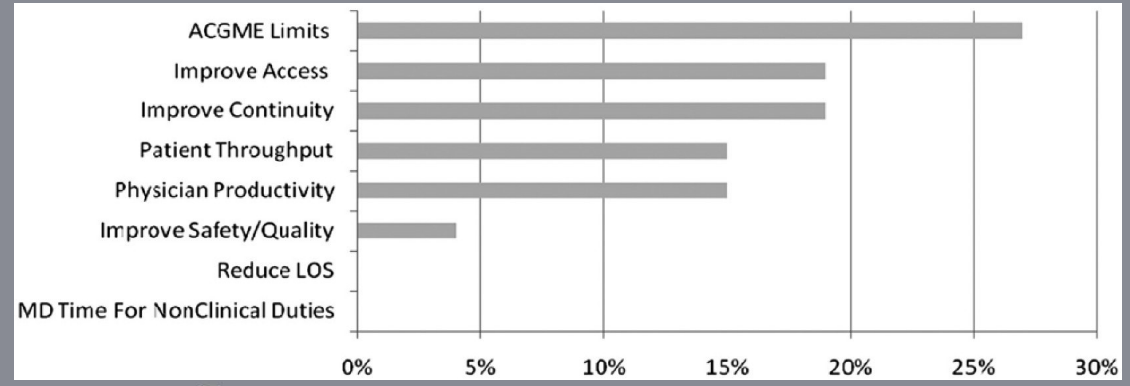
## Financial Disclosure:

None

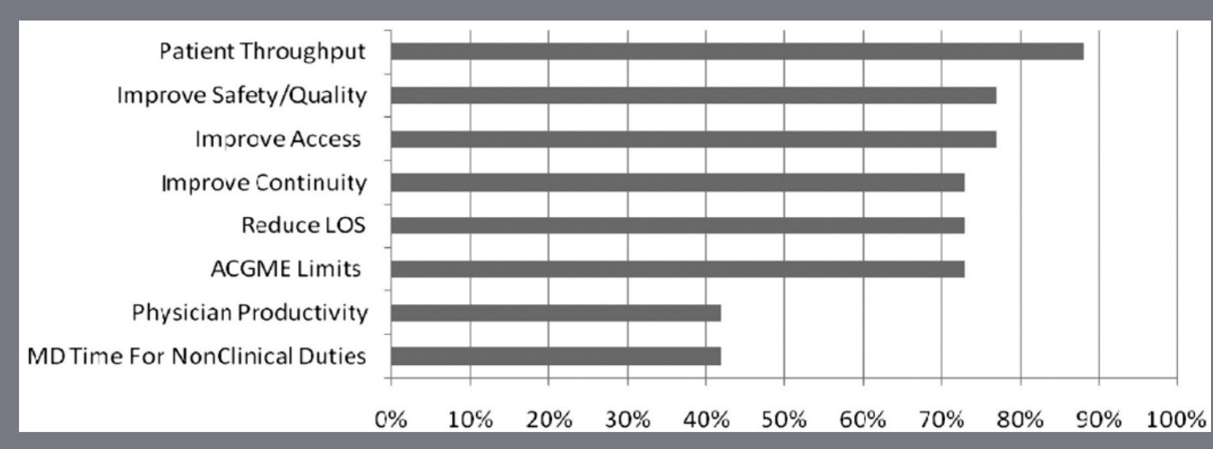

PA/NP Care:
Up Close and Personal 9/24/23

Little by little,
a little becomes a lot.
TANZANIAN PROVERB

Moote M, Krsek C, Kleinpell R, Todd B. Republished: Physician Assistant and Nurse Practitioner Utilization in Academic Medical Centers. *American Journal of Medical Quality*. 2019;34(5):465-472.



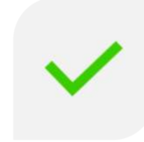

# PA/NP Modern Care Model Origins



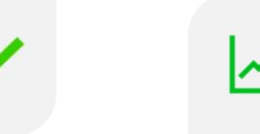
# What is Driving Care Model Change Today?

PHYSICIAN WORKFORCE SHORTAGES

POST COVID PROVIDER WELLNESS



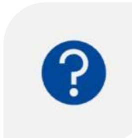
CMS PROPOSED BILLING CHANGES



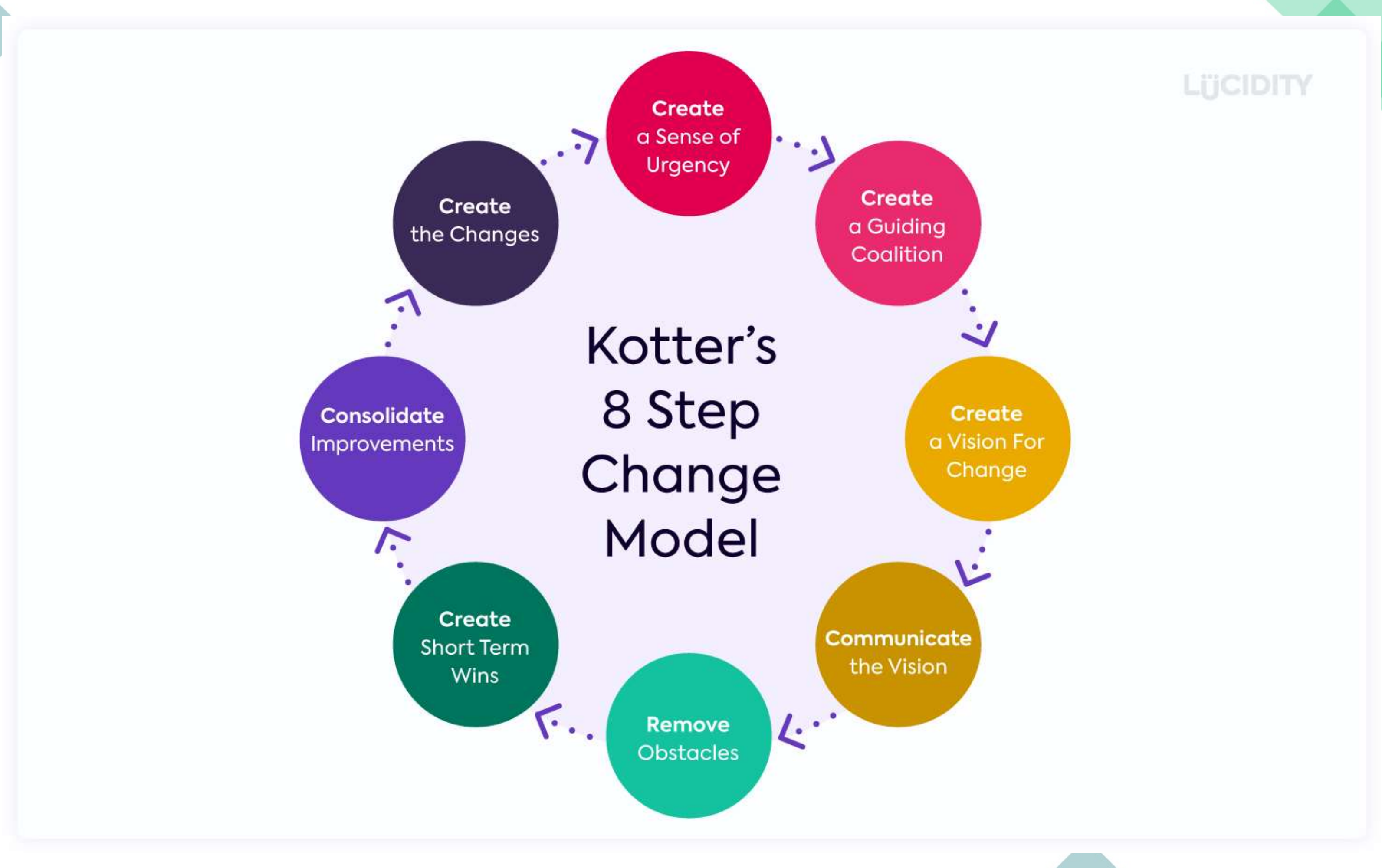
VALUE BASED CARE-INCREASED PATIENT DEMAND

PATIENT DELIVERY PLATFORMS (TECHNOLOGY!)

CONSUMER MARKET



WHAT ELSE?



LUCIDITY
Kotter's 8 Step Change Model
Create a Sense of Urgency
Create a Guiding Coalition
Create a Vision For Change
Communicate the Vision
Remove Obstacles
Create Short Term Wins
Consolidate Improvements
Create the Changes

# Proposed CMS Billing Rule Change

## Historic SHV Billing Rule 2023

When team visit occurs, can bill based on time or medical management

Principle that complex patient requires input from 2+ providers (physician and APP)

## Proposed 2024 SHV Billing Rule

When physician and APP involved in visit, bill will be sent for provider who performed the substantive time (>50%) of the visit; medical management not factored in

Delayed until at least 12/31/24

AAPA and other health care organizations advocate for current flexibility

https://www.aapa.org/advocacy-central/reimbursement/cms-releases-proposed-2024-physician-fee-schedule-rule/

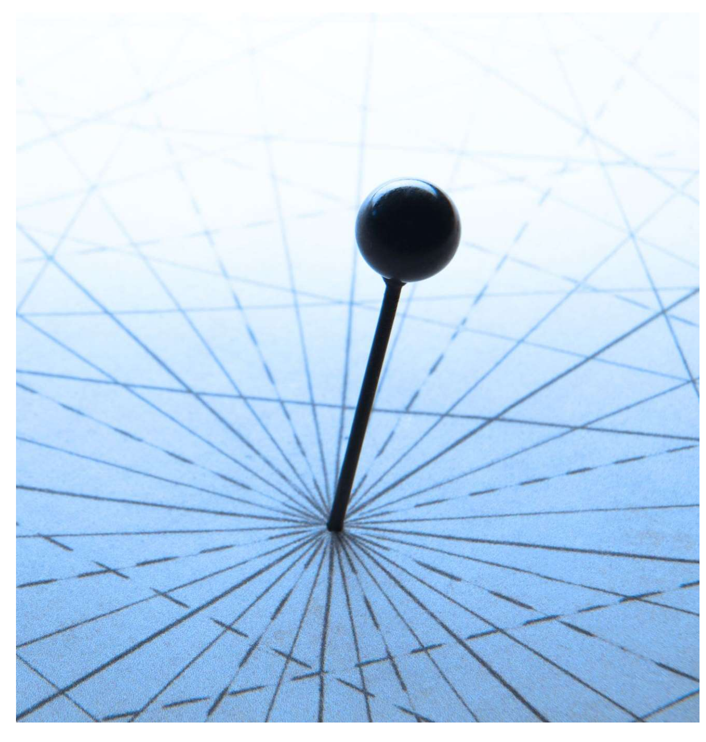
# Proactive Approach to Care Model Review

Regardless of CMS decision opportunity to look at current care models and ask critical questions

- Is current process patient centric?
- Are patient access metrics optimized?
- Is team efficiency maximized in current model?
- Are APPs seasoned and experienced versus in first 6 months of onboarding?
- Are there barriers to change?

# Understanding the Work Force Prior to Optimization

- Identification of PAs, APRNs, MDs, and Support Staff
- Confirm FTE, FMLA/BTO, Work Hours
- Work Force Changes on the Horizon
- Strategic Growth Opportunities
- Hours of Operation
- Are there gaps in meeting patient needs?



# Changing Health Care Workforce

2022 US Bureau of Labor Statistics

- APRN growth 45%
- PA Growth 31%
- Physicians 5%
- Varies by specialties

Front Public Health. 2023; 11: 1204662.
Published online 2023 Jun 19. doi: 10.3389/fpubh.2023.1204662
PMCID: PMC10315458
PMID: 37404276

Mental wellbeing of frontline health workers post-pandemic: lessons learned and a way forward

Thorsten Grünheid[1,*] and Ahmad Hazem[2]

# Post-Covid Workforce Differences

- Work hour adjustments desired
- Generational differences
- Work-Life Integration
- Priorities
- Attrition from Health Care Professions

# Ambulatory Baseline Data Review

| RVUs | 25th | Median | 75th | FTE | % of 25 | % of 50 | % of 75 |
|---|---|---|---|---|---|---|---|
| 2469 | 1755 | 2128 | 2728 | 1 | 141% | 116% | 91% |
| 3176 | 1755 | 2128 | 2728 | 0.9 | 201% | 166% | 129% |
| 454 | 1755 | 2128 | 2728 | 0.5 | 52% | 43% | 33% |
| 507 | 1755 | 2128 | 2728 | 0.5 | 58% | 48% | 37% |
| 1051 | 1755 | 2128 | 2728 | 0.75 | 80% | 66% | 51% |
| 1214 | 955 | 1224 | 1463 | 0.48 | 265% | 207% | 173% |
| 2206 | 955 | 1224 | 1463 | 1 | 231% | 180% | 151% |
| 1499 | 955 | 1224 | 1463 | 1 | 157% | 122% | 102% |

- RVUs annualized to goal benchmark
- Ambulatory Metrics:
  - % New Pts 3 and 14 days
  - New vs Return
  - In Person vs Virtual
  - True Utilization with consideration of No Shows
- Clinic Sessions/Schedulable Time
- cFTE Expectations

# Template Build Calculation Worksheet

| Calculation for Provider Openings | |
|---|---|
| Provider Name: | Dr. XYZ |
| Budgeted Visits: | 2500 |
| Prior Year Slot Utilization (use dept/clinic average, if a new provider): | 85% |
| Prior Year No-Show Rate (use dept/clinic average, if a new provider): | 10% |
| **Total Openings in Provider Templates** | **3268** |
| Filled Openings @ Historical Slot Utilization % | 2778 |
| Unfilled Openings @ Historical Slot Utilization | 490 |
| No-Shows @ Historical Rate | 278 |
| **Projected Completed Visits** | **2500** |
| **Variance to Budget** | **0** |
| Number of Working Weeks per Year | 45 |
| Number of Sessions per Week | 6 |
| Number of Sessions per Year | 270 |
| **Target Average Number of Openings per Session** | **12** |
| Minimum Number of New Patient Visit openings, per guidelines (unless approved exception) | 2 |
| Return, other visit type openings | 10 |
| Long visit type duration (in minutes) | 30 |
| Short visit type duration (in minutes) | 15 |
| Long visit time in session (in minutes) | 60 |
| Short visit time in session (in minutes) | 152 |
| **Total Time in Session (in minutes)** | **212** |
| **Total Time in Session (in hours)** | **3.53** |
| Minimum Number of Schedulable Hours per Session, per guidelines (unless approved exception) | 3.5 |
| **Variance (in hours)** | -0.03 |
| **Variance (in minutes)** | -1.6 |
| **Slot/opening adjustments to template** | -0.1 |
| | |
| | |
| Input information from department/clinic leader in orange cells | |

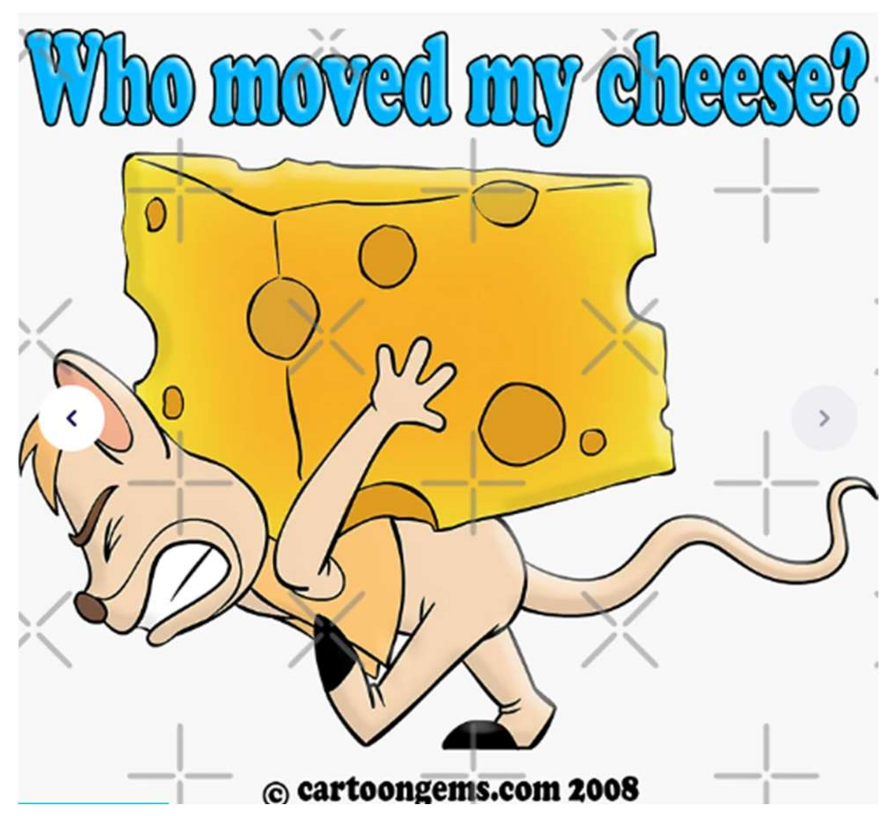
Should be consistent with clinic visit wRVU projections included in new provider request

- Template build team will facilitate discussion and review the calculation worksheet with the inputs provided from department/clinic leader
- Can be modified to account for differences in ramp up period vs. steady state, approved exceptions, etc.

# Data Only Tells Part of the Story

- Does the clinician feel optimized?
- What are strengths of model?
- What are the opportunities?
- PA/APRN input on innovative solutions
- Survey Ahead of Engagement
- In Person Evaluation

# Optimal Messaging: Purpose of Engagement


Who moved my cheese?
© cartoongems.com 2008

# How are the PAs and APRNs Functioning and What Setting Do They Practice?

**A-**Autonomous, Ambulatory, At Benchmark Productivity

**LI-**Less Independent-More Team Based Care

- Inpatient
- Improves the efficiency of the team
- New Hires/Transition to Practice

**G-**Global Billing-Surgical, Procedural Areas

- First Assist, Pre-Op, Post-Op Work

**N-**Non-Revenue Producing Clinical Work

- Call, Indirect Patient Care
- Non-Clinical Roles

# ALIGN Principles

- Goal is for patient-centered practice whether APP independent or team-based model
- Goal to maximize productivity as individual provider or team; What is goal benchmark?
- Important indirect patient care work is done that cannot always be captured
- Where feasible identify non-MD and non-APP care team members that can support indirect patient care work that is not billable
- Explore options for virtual health that supports indirect care billing

# Ambulatory Care Model

Best practice is APP in autonomous practice model, independent schedule with necessary resources to achieve productivity

- Clinic time may need to be adjusted to meet space or access constraints
- MD and APP may work out of same consult room to support collaboration
- Team based consideration of patient type delegation
- Well defined process for escalation of complex care
- Well defined admin time expectations and outcomes

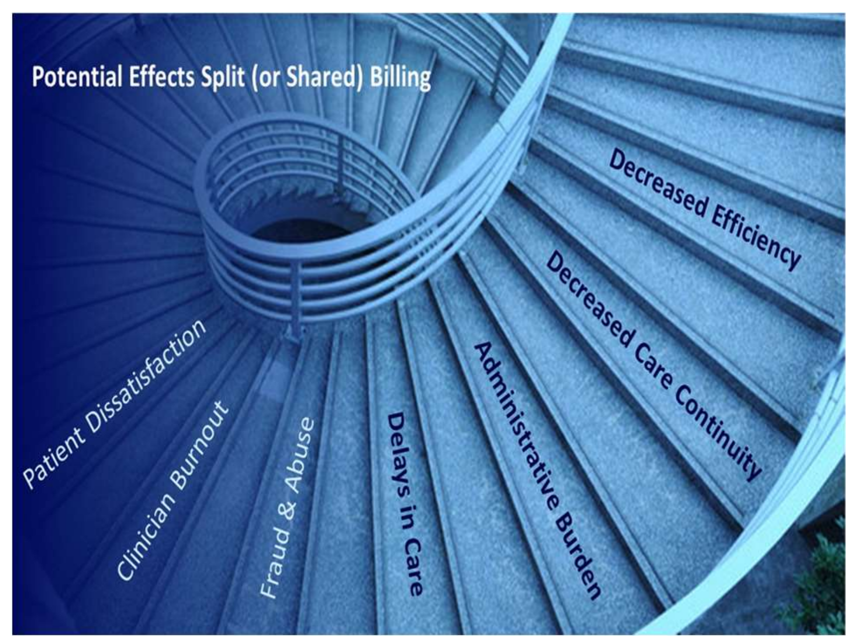
# Message of Change

Patients value efficiency of care

- Wait time or length of visit to measure change
- Patient Satisfaction metrics
- Example: CT Surgery Optimization
- “Patient perception of valued time” ⬆ 83-94%

Culture of team-based care

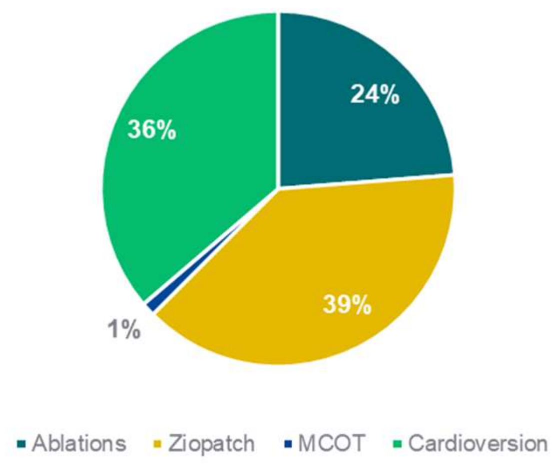
- Create mindset from visit one of collaborative care
- Messaging starts from the scheduling team to MD!
- Literature suggests team efficiency improves clinician well-being




Graphic-AAPA ELC 2023 DePalma Presentation

# All Providers Working Top of License

- APP run Afib clinic has increased access
  - 2022 Afib program resulted in 53% procedural conversion rate from referrals
  - APPs performing low acuity cases enabled MDs to backfill with higher acuity cases
  - Approximately $197 in direct contribution margin per wRVU in EP procedures



# Hematology and Oncology Care Model

PAs/APRNs/MD highly committed and engaged providers in patient care

Bruinooge, Pickard et al 2018 Independent practice in a collaborative setting ⬆ provider satisfaction and ⬆ patient care capacity

Indirect Care Considerations associated with chemotherapy management; survivorship and end of life care

# Evolution of Virtual Health Delivery

- Definition of Telehealth vs In Person Visits per Specialty
  - Type of visit (Return patient, Hospital Follow Up, Sick evaluation to determine right place of care, End of Life)
  - New Patient Intake Visit
- E-consults
  - Offload routine consults to APPs to determine if new patient evaluation needed
  - Example abnormal CBC
- E-Visits
  - Inbox management transitions to visit
  - Patient diagnoses amenable

# Inpatient Care Models

- If CMS changes, do hospital bylaws support change?
- Review current model for duplication of care, are there types of patients that can be delegated to APP only with defined escalation of care guidelines?
- If MD has less patients to round on or notes to write where does that open up efficiency? Earlier to clinic, supporting consults, supporting teaching service
- With rounding efficiencies, how are system goals optimized?
  - Length of stay
  - Readmissions
  - Mortality

# Value Based Care Initiatives

- Understand key system quality and safety metrics
- PAs/APRNs key principles align with population health initiatives
  - Patient centered-holistic care
  - Patient education
  - Social drivers of health
  - Documentation and Coding Adherence

# Evolution of a Hospitalist Team

Driver for Change:  Covid Volumes and Acuity

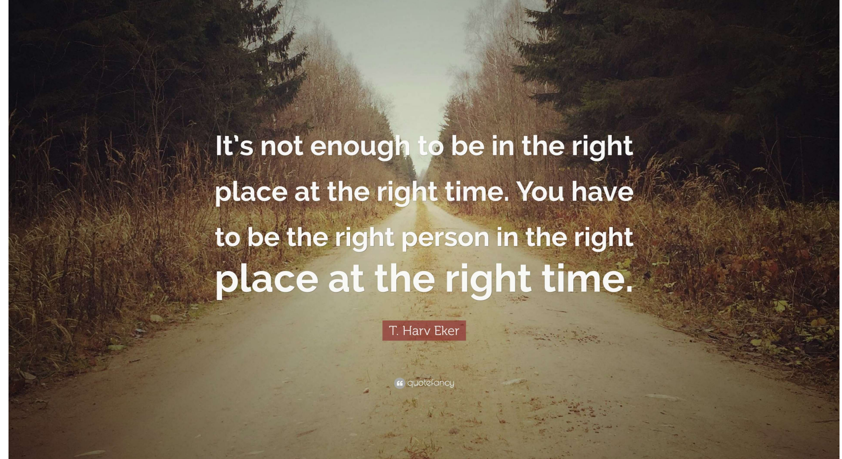
- The need for parallel hospital medicine services to expand capacity
- Leader triad (MD, APP, BA) advocating for change
- Understand barriers and establish parameters
  - Work with MDs who have reservations and bring into model as confidence grows
  - Robust transition to practice program that relies on APP and MD mentoring
  - Crucial conversations on roles, practice limitations
  - Improved provider satisfaction and retention
  - Attention to wellness for all providers
- Hospitalist at Home
  - Partnership with community paramedics to support transition to home

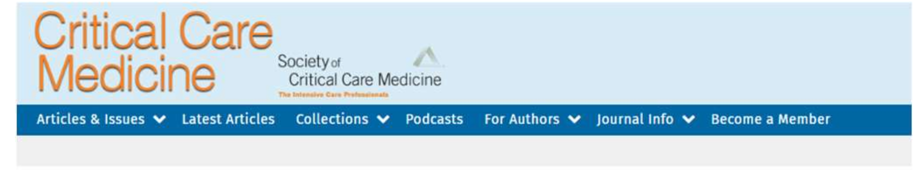
# Principles of Onboarding to Ensure Optimal Autonomy

- New Hire vs Seasoned Internal APP vs Seasoned External APP
- Onboarding expectations timeline with defined ramp up patient load and visits
- Assessment of progress with PIP as indicated
- All team members giving feedback on progress
- Evolution of less independent model to autonomous
- Not every patient requires co-management but discussion of clinical reasoning, documentation, and process to ensure competency (FPPE)

# Literature Supports the Value of NP/PA Care in Acute and Critical Care Models

- Improved Quality and Continuity of Care
- Cost of Care and Return on Investment
- Improved Efficiency of Care
- Improved Multi-Disciplinary Teams




CONCISE DEFINITIVE REVIEW

## Nurse Practitioners and Physician Assistants in Acute and Critical Care: A Concise Review of the Literature and Data 2008–2018

Kleinpell, Ruth M. PhD, RN, FCCM[1,2]; Grabenkort, W. Robert PA, MMSc, FCCM[3]; Kapu, April N. DNP, RN, ACNP-BC, FAANP, FCCM[1,4,5]; Constantine, Roy PhD, MPH, PA-C, DFAAPA, FCCM[6,7]; Sicoutris, Corinna MSN, ACNP, FAANP, FCCM[8]

Author Information

# Global Visit Care Models

## How can the MD be maximized to OR/Procedures with other parts of global visits delegated?

- First assist, pre- and post-operative care can account for 30-40% of total global visit payment
- Strategize First assist role where less teaching occurs
  - Ensure appropriate documentation to maximize first assist billing
  - Track OR efficiency and MD improved efficiency
- Pre-Operative Visit
  - PA/NP enhanced consent process; patient education; discharge planning which can reduce LOS
  - ED consult time to admission or OR reduced

# Peri-Operative Metrics of Success

<u>Post-Operative</u>

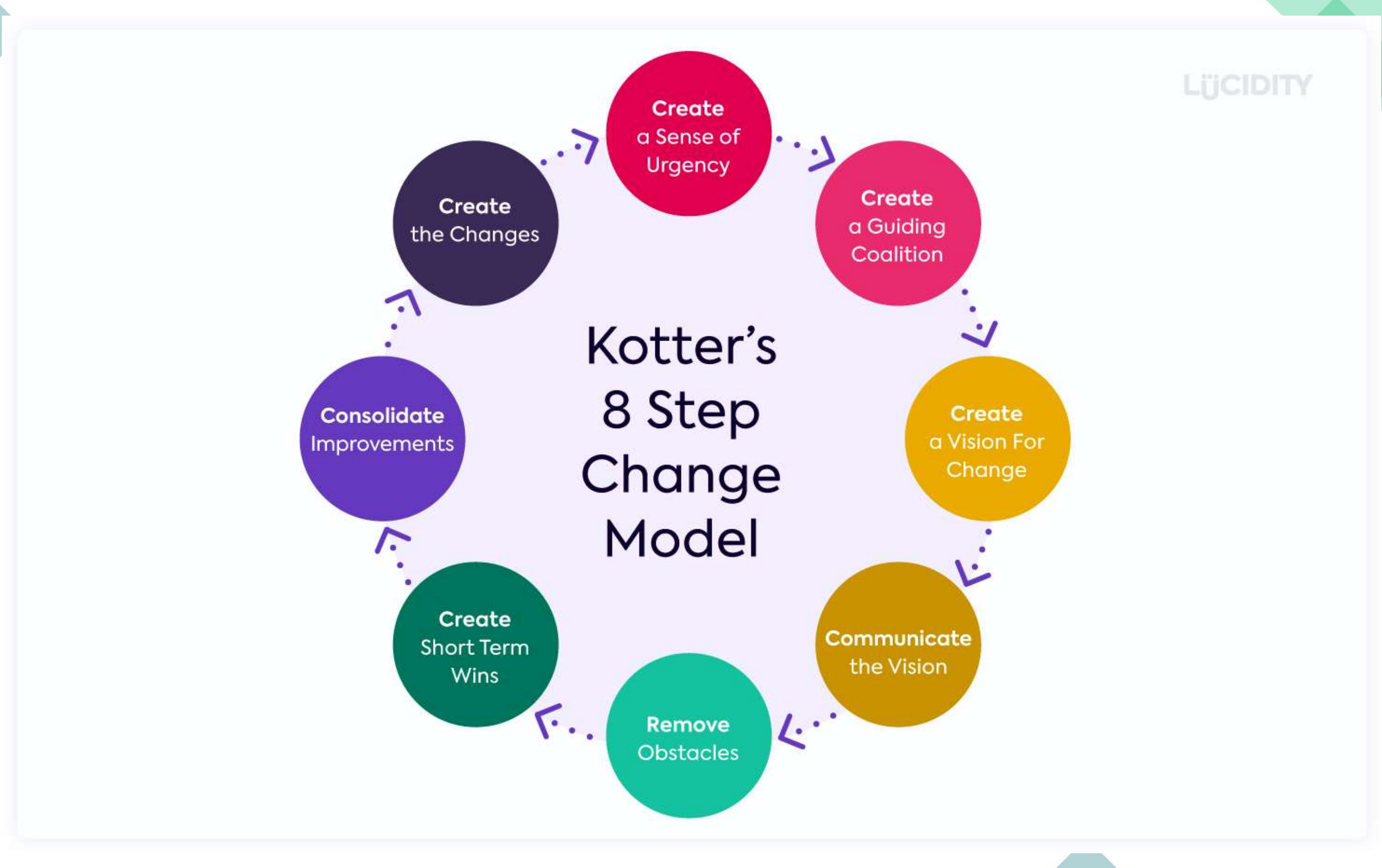
- Patient Satisfaction
- Improved Quality of Care
- System Goals
    - Length of Stay
    - Earlier Discharge Time
    - DVT prophylaxis
    - Surgical Site Infections

# Care Model Analysis Complete: Now What?

- Comprehensive Summary of Subjective and Objective Findings
- Comparison to Best Practice
  - Internal Benchmarks
  - Literature Review
  - Use Your ELC Network
- Presentation to Stakeholders
  - Physician, APP and Business Leaders
  - Engagement on Priorities
  - Goal Setting

# Implementation of Change

- Education and Implementation of Changes
- Physician and APP Champions
- Call for APP Leadership for Accountability, Engagement and Change Management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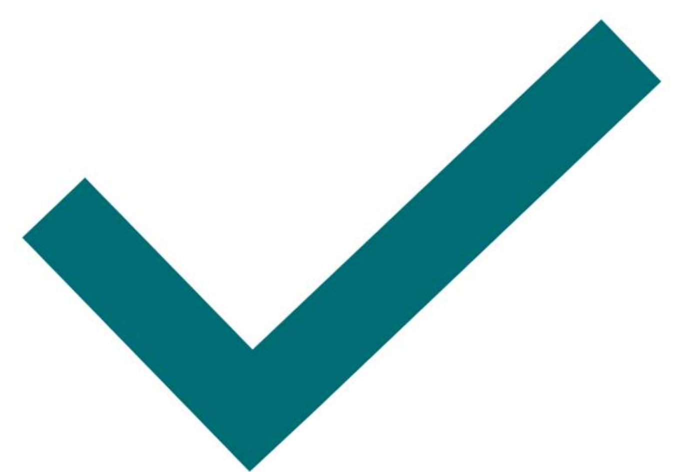
LUCIDITY

# Ensure Alignment



- Team-Based Initiative
- Patient-Centered
- Compensation Aligned
- Cannot Create Competition for Patients or $$$

# Celebrate Wins and Reward Change Agents

Monitor Data Quarterly

Transparency with Key Stakeholders

PA/NP/MD Incentives to Recognize Changes in Individual and Team-Based Goals

# "Clarion Call to Transformation"

## 3 Legged Stool of Health Care Leadership: Nursing/Physician/**Advanced Practice**

- Measure Impact of Advanced Practice on Patient Care
- Leverage Strategic Contributions to Health Care Literature
- Challenge Inaccurate Representation of PA/APRN Roles and Care Models
- Seek Opportunities to Share Work to Stakeholder Audiences
- Advocate for Optimal PA and NP Practice

# Optimal PA/NP Care: Up Close and Personal

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Questions?

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