PA and APRN Parallel Team Approach to Leadership Reporting Structures

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Disclosures

- Past President, AAPA
- Member, AAPA Title Change Advisory Council
- Member, AAPA CEO search committee
- Member, AAPA Gov. Comm. Task force
- Member, AAPA Nominating Work Group
- CCHS Physician Wellness Committee
- CCHS Practice Innovations & Professional Fulfillment Council
- CHLM content expert
- OAPA GAC Chair
- OAPA Pharmacology CME chair

Learning Objectives

- Identify the process for implementing a new APRN/PA reporting structure and putting APRN/PA leaders in place
- Discuss how to get “buy in” from senior leadership to make changes in reporting and leadership structure
- Review opportunities for increased productivity/engagement of APRN/PAs with new leadership structure
- Discuss how working together (NP/PA) in leadership help grow your staffing and increase APRN/PA engagement
- Review challenges and opportunities with parallel teamwork.

CCHS FACTS AND FIGURES

- 6,000 Beds
- 18 hospitals
- >220 outpatient facilities

- London
- Abu Dhabi
- Nevada
- Toronto
- Florida
- To come: CHINA
- Ohio

- >850 PAs

Cleveland Clinic

2019 ENTERPRISE **STATISTICS**

CARE FOR PATIENTS

PATIENT CARE

2.4M Unique patients

10M Outpatient visits

309K Admissions and observations

255K Surgeries and procedures

884K Emergency department visits

59K Virtual visits

EDUCATION

1,974 Residents and fellows

104 Accredited training programs

RESEARCH

2,488 Active research projects

$307M Research funding

CARE FOR CAREGIVERS

67.5K Caregivers worldwide

including:

4.5K Physicians and scientists

2.5K Advanced practice providers

14.5K Nurses

CARE FOR THE ORGANIZATION

$10.56B Operating revenue

$390M Income from operations

CARE FOR THE COMMUNITY

$1.04B Annual community benefit (2018)

$17.8B Economic impact (2016)

To view Cleveland Clinic's *State of the Clinic 2019* report, visit **clevelandclinic.org/stateoftheclinic**.

healthessentials ConsultQD

Stats as of Dec. 31, 2019

9500 Euclid Avenue | Cleveland, OH 44195 | clevelandclinic.org

20-CCC-1841800

By the numbers

- 2017
  - >1600 APPs
    - **6.8% increase (from 1100 in 2016)**
- 2018
  - >2000 APPs
    - **8% increase**
- 2019
  - >2600 APPs
    - **7.6% increase**

Attrition

: a reduction in numbers usually as a result of resignation, retirement, or death

- For PAs:
  - < 3% turnover

- For APRNs:
  - < 7% turnover

  - We do not include transfers within system

Growing Pains and Challenges

- No standard reporting structure:
  - Report to NM, ANM, Admin, Docs, etc.
- Leader understanding of APRNs/PAs
- Hiring managers vary throughout the system
- No consistent formal transition to practice; training, onboarding.
- No standard productivity metrics in place
  - Billing varies greatly with some who do not bill at all to some one who bills independently
- Top of License/Utilization
- Various approaches to managing performance
- Professionalism within organization

Separate yet similar

- Historically, Nursing and PAs kept separate due to many factors
  - Leadership
  - Myths about practice
  - Governing bodies
  - Laws
  - Personal preference

Stronger together

- Identify strengths of working together
- Compliance (Risk management)
- Quality monitoring (JC/CMS factors)
- Onboarding (TTP)
- Professional development (monthly meetings/workshops)
- Louder voice in larger numbers (many faces at the table)
- Approach from both nursing aspect and medicine aspect (meeting needs of both)

Approach to new reporting system

- **WHO is impacted?** Hiring managers, new APRN/PA leaders, Administrators; Chairs, everyone!
- **WHAT is the ask?** Reorganization of the APRN/PAs and create leaders
- **WHERE?** Throughout the system, assess present state
- **WHY?** Enhanced engagement of APRN/PAs leads to increase productivity, compliance, decrease risk
- **WHEN?** Timeline to success/completion
- **HOW?** Outline the process for development and enactment

Goals

- Standardize reporting structure of APRN/PAs across health system
- Create standards to ensure top of license & a healthy/positive work environment
  - Practice
  - Productivity
  - Recruitment/Onboarding
  - APR
  - Quality/Compliance
  - Employee Engagement

Current State

- PROS:
- Substantial growth in APRNs & PAs
  - Total FTEs over 2,600
  - *Exec. Dir. of APRN/PAs in place*
  - *Central office for both*
- CONS:
- Hiring managers vary throughout the system
- No consistent formal transition to practice
- No standard productivity metrics in place
- Varying levels of understanding the scope of APRN/PAs
- Inconsistent expectations of role throughout the system

Proposal

- Standardize reporting structure of all APRN/PAs in every institute & hospital

- Align all APRN/PAs to report up through APRN/PA chain of command
  - Directors/Managers directly to respective Institute Chair or VPMO

- APRN/PAs governed within Chief of Staff
  - Roll up through the physician line

- HR vs. Medical staff office
  - Maintains current non-staff HR policy
  - Based on size of institute/hospital & number of APRNs & PAs
    - APRN/PA Director
    - APRN/PA Manager
    - APRN/PA Coordinator

Steps

- Identify Leadership roles
- Identify policy/procedures for process of selection
- Create a communication platform
  - Pros/cons to organization
  - Outcomes expected
- How-to guide
- Offer support in selection process
- Create a mentoring for new leaders
- Create an ongoing leadership development

APRN/PA Leadership Roles

Title	FTEs	Locations	Duties
Director	➢ Roll-up of APRNs/PAs institute or hospitals ➢ Manager & coordinators reporting to director	Multiple sites Hospital/Institute level	Recruitment APRs Accountability of productivity Strategic planning with leadership Onboarding
Manager	15-50 direct reports	Solo site or multiple sites	Recruitment Onboarding Quality monitoring Productivity
Coordinator	1-20 direct reports	One department or combined like areas with small #s	Onboarding Quality monitoring

APRN/PA Leader Strategy

- Identify **span of control** for each hospital/institute
- Determine level of APRN/PA leader need (i.e. director, manager, coordinator) for institutes/hospitals
  - Establish total # of leader roles
- Formal selection process
  - No “anointment"

- Items to consider in determining the Span of Control:
  - Number of employees
  - Number of physical sites
  - Variation in practice settings/specialties
  - Larger areas may need additional leaders

Process

- Support from: Institute Chairmen & Hospital Presidents
  - Presentation and buy in from Board of Directors/Governors/leadership
- Identify **span of control** for each hospital/institute
- Determine level of APRN/PA leader need (i.e. director, manager, coordinator)
  - FTE neutral
  - Working leader
  - Administration time dependent upon responsibilities of APRN/PA leader*

*This is not carved in stone: will be issue when accounting for RVUs

Process continued

- Standardization of and creation of policy/procedure for:
  - Job Descriptions
  - Templates for productivity: outpatient, inpatient
  - Process for posting positions, recruiting, interviewing and onboarding
- APRN/PAs governed within Chief of Staff
- Maintains current employee HR status & policies
- Track-able outcomes:
  - Productivity metrics
  - Quality
  - Patient Experience
  - Education, Research, Professional Activities

Communication

- To Whom?

- Hospital leadership to Staff Physicians
- Administration
- APRN/PA leaders
- APRN/PA caregivers
- Medical Staff Office Leadership
- Nursing Leadership

Key Messaging

“APRN AND PA ORGANIZATION AND REPORTING

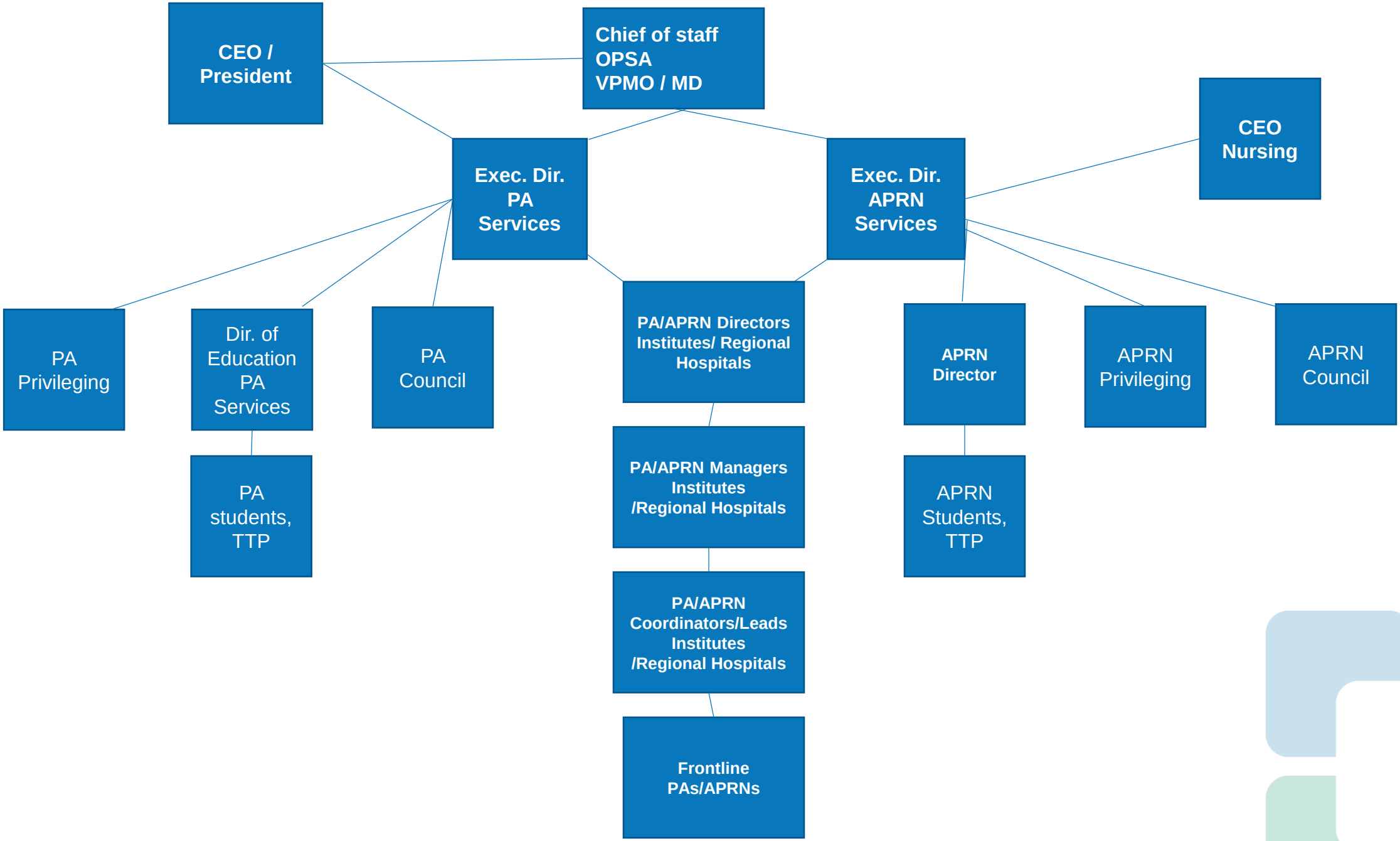
- *CREATING A STANDARDIZE REPORTING STRUCTURE OF APRNS/PAS ACROSS THE HEALTH SYSTEM*
- *EACH INSTITUTE WILL IDENTIFY THEIR OWN NEEDS FOR WHICH LEVEL OF LEADERSHIP.*
- *ALL APRN/PAS WILL BE GOVERNED WITHIN THE CHIEF OF STAFF OFFICE*
- *WILL MAINTAIN CURRENT EMPLOYEE STATUS WITHIN HR*
- *APRN/PA LEADERS WILL REPORT TO INSTITUTE CHAIRS (FOR LEADERSHIP)*
- *ALL EMPLOYED APRN/PAS WILL REPORT TO THEIR RESPECTIVE APRN/PA LEADERS*
- *APR WILL BE ALIGNED WITH PHYSICIANS MODEL DONE BY THE APRN/PA LEADERSHIP WITH PHYSICIAN INPUT*
- *PRODUCTIVITY STANDARDS AND METRICS FOR APRN/PAS WILL BE DEVELOPED*
- *TRANSITION TO PRACTICE FELLOWSHIP FOR NEW APRN/PAS WILL BE DEVELOPED”*

Our Timeline to completion

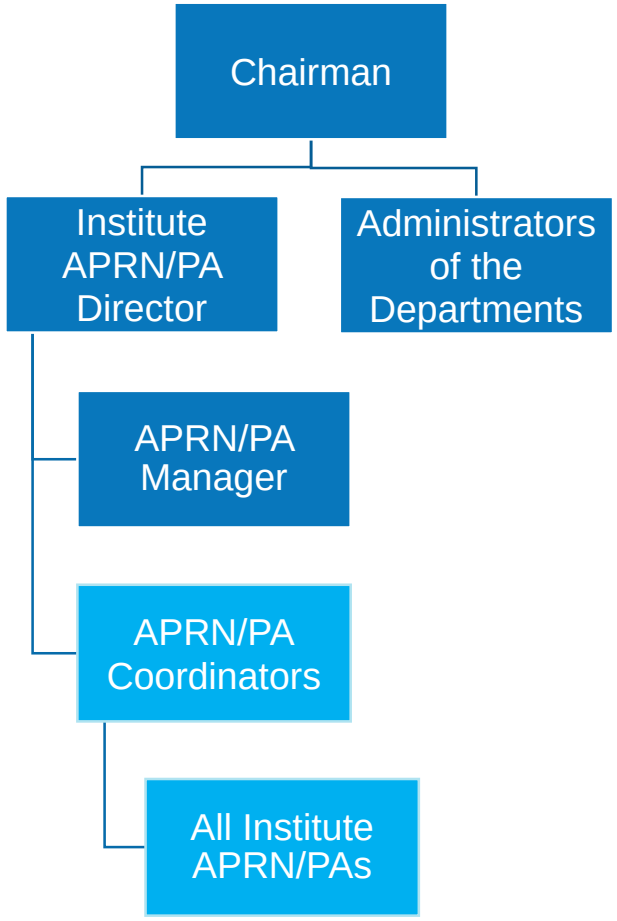
- Leaders' approval: 7/2016
- Communication to Chairs, Hospital Presidents, other Leaders
- APR standards: Implement 1/2017 (Basic standards)
- Productivity Model:
  - Initial indicators: 10/2016 (2 common ones)
  - Full template: 2nd Quarter 2017
  - 85% completion: 1st Quarter 2018
  - 100% completion: End of 2018

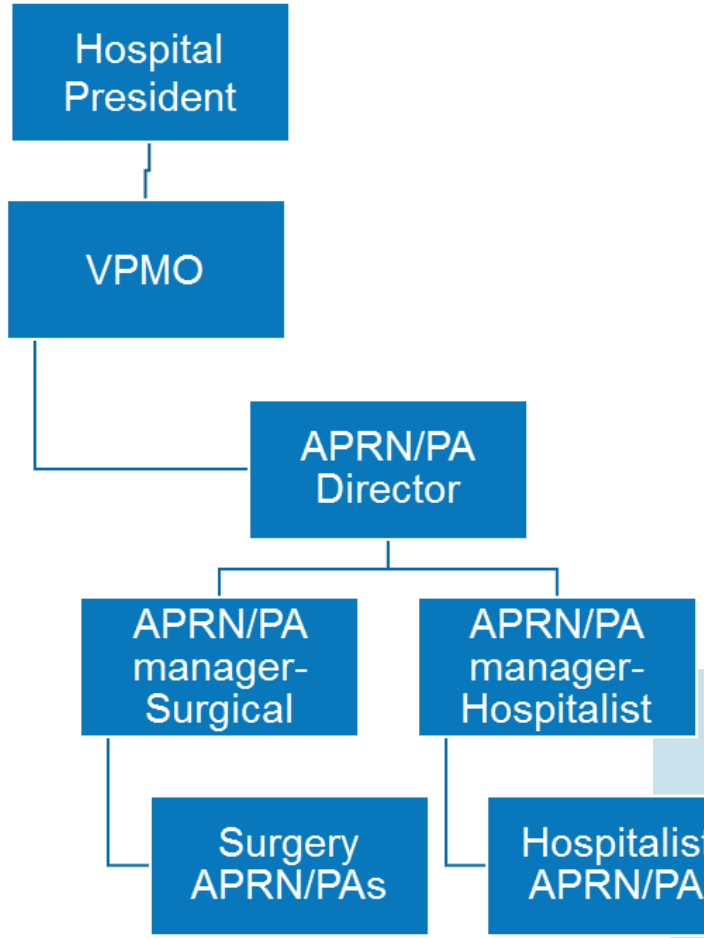
Examples

- Reporting structures dependent upon site
  - Sometimes one size does not fit all
- Metrics of measure; score cards, dashboards, etc.
- Selection process
- Outcomes/productivity
- Engagement
- Patient Satisfaction


CEO / President
Chief of staff
OPSA
VPMO / MD
CEO Nursing
Exec. Dir. PA Services
Exec. Dir. APRN Services
PA Privileging
Dir. of Education PA Services
PA Council
PA/APRN Directors Institutes/ Regional Hospitals
APRN Director
APRN Privileging
APRN Council
PA students, TTP
PA/APRN Managers Institutes /Regional Hospitals
APRN Students, TTP
PA/APRN Coordinators/Leads Institutes /Regional Hospitals
Frontline PAs/APRNs

Examples of Reporting





APRN/PA Metrics

Patient Experience
- Volume
- HCAPS, GCAPs
- Awareness of patients disease

Productivity
- Closed encounters
- Patient visits/slots
- Time to appointment
- Time to treatment

Quality
- Meaningful use
- CORE 4
- Chart decision making

Institute Specific
- Site infections
- Time online
- Door to door treat

Citizenship
- Community
- Preceptor shadow/faculty
- State and National involvement
- Response time to requests; educational modules, comet

PRODUCTIVITY

First things FIRST

- Current state
- Billing versus non-billing activities
- Defining top of license
- Is there benchmarking?

- APRN/PA leaders assess above metrics

APRN/PA Productivity

- APRN/PA Governance across CCHS
- Launched APP Productivity Dashboard
- APRN/PA Scorecard including:
  - Quality
  - Patient Experience
  - Citizenship
- Transition to Practice
- Currently: RVU accountability

Standardization

- Current RVU capture
- Billing providers
- Review of APRN/PA templates; slots available
- Establishment of benchmarks
- Capturing “non-billable” patient care

Work in Progress

- Committed to RVUs as part of productivity for all* APRN/PAs (*very small # excluded)
- Utilizing established national benchmarks
- Selected <100 categories within benchmark (about 80 that had ‘n’s >5)
- Established a “No Added Charge” code for non-billable care by APRN/PA

Best Practice: CCHS
Top of License & Utilization

- Direct scheduling of patients
- Bill for work completed (E & M’s, RVUs)
- Independent clinics to expand access/availability
- Tracking for productivity, quality & patient experience
- Team based accountability for metrics when APP cannot bill directly

APRN/PA Productivity Highlights

- DDSI/HNI:
  - Level setting of all templates
  - Converting private/same day to open access if not filled 5 days prior
    - This has added 964 slots/month
  - Inpatient-: Problem Based Charting- CORS
    - Decrease in LOS
    - Increase CMI: 2.38 → 3.24

APRN/PA Productivity Highlights

- HVI:
  - Cardiovascular Medicine
    - Outpatient
      - 75% slot utilization
        - filled 14,210 slots YTD
      - **Increase 6.2% slots**
      - **Increase 8.6% billing**
    - Inpatient
      - Add 1 APRN/PA to service- increased billing by 33% for whole service
      - APRN/PA billing increased by 36.5%

APRN/PA Scorecard

CCHS Enterprise APRN/PA Scorecard

	Outpatient Primary Care	Outpatient Specialty	Express Care	ED	OR and Pre-op	Inpatient	Critical Care
Patient Experience	Attribution feasible if APP is Primary Provider	Attribution feasible if APP is Primary Provider	TBD	Pilot Underway for ED	Attribution to Team	Attribution to Team	Attribution to Team
Quality	- HCC Score - Same Visit High BP Rechecks - Hypertension 30d follow-up - Hemoglobin A1c, Cholesterol, Weight	Problem List - Meaningful Use - E Prescribing - Patient Education - Medication Reconciliation - After Visit Summary	- Express Care Specific Metrics	- ED Specific Metrics	- Surgical Site Infection - Post-op Bleeding	- Core 4 (Individual Level/ Team Attribution)	- Core 4 (Individual Level/ Team Attribution) - Central Line, Site Infection, CLABSI, & CAUTI
Productivity	APP Dashboard	APP Dashboard	APP Dashboard	APP Dashboard	APP Dashboard	APP Dashboard	APP Dashboard
Citizenship	APR Reflection & Compliance Bundle including: - Community Service - CCLC Modules Completion - CCHS Committee/Meetings - Education- Percepting - License Renewal - Flu Shot	Same Criteria	Same Criteria	Same Criteria	Same Criteria	Same Criteria	Same Criteria
Practice Setting Specific	- Peds Combo 10 - Peds Antibiotic stewardship	Specialty-specific metrics (e.g. ORI Breakeven Analysis)	TBD	More metrics available, e.g. Time of Visit (Express) Room to Disposition (ED)	TBD	TBD	TBD

Indicators

- **CORE 4 DEFINED**:
- ADMISSION MED REC completed and signed < or = 24 hours
- DISCHARGE MED REC completed and signed prior to discharge
- Follow up appointment ordered or any appointment within 4-5 days
- Discharge summary signed by LIP < or = 48 hours

ACCOUNTABILITY

Processes in Place

- Refined APR Processed
- APRN/PA Peer Evaluation
- APRN/PA Peer Review
- Process for HR vs. Quality performance mgmt.
- Quality Monitoring, OPPE, FPPE

Annual Performance Reviews (APR)

- **Previous State:**
- Utilizing HR form
- No standard key performance indicators for role
- Various ways to obtaining feedback on performance
- Inconsistency with delivery
- **Current and Future State:**
- Utilize HR form with supplemental form for APRN/PA
- Standardize key performance indicators for role
- Inclusion of productivity metrics
- Utilization of required quality assurance documents
- Include professional activities outside of direct clinical care
- Standardize approach to obtaining feedback from physicians, peers & team
- Standardize self assessment

APRN/PA Leader Responsibilities

- APRN/PA leaders responsible for their group's APRs including:
  - Collecting feedback
  - Creating the comprehensive reviews
  - Delivery of reviews
  - Communication of overall group's performance to institute chair or hospital VPMO

Key Leadership Development

- Performance Coaching
- Change Management
- Healthy Teams
- Unconscious Bias
- Monthly Leadership Meetings
- Assigning Leader (peer) Mentors
- Administrative tools: Kronos, work day, PIP, Corrective action, scheduling, etc.

Engagement

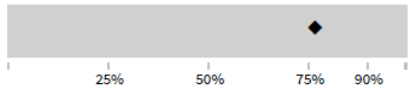
Engagement Indicator

4.25

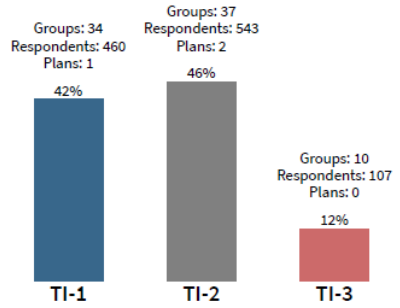
+0.13 vs. Nat'l Healthcare Avg

You are in the

77th percentile



Team Index



Leader Index

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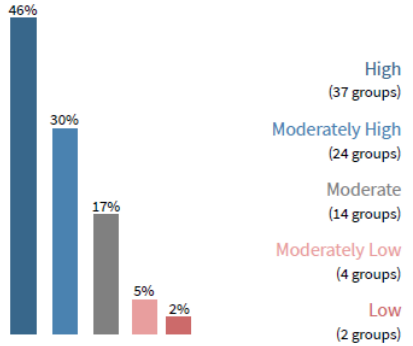


Organization

4.00

+0.05 vs. Nat'l Healthcare Avg

Manager

4.16

+0.07 vs. Nat'l Healthcare Avg

Employee

4.06

-0.04 vs. Nat'l Healthcare Avg

Resilience Index

4.08

-0.12 vs. Nat'l Healthcare Avg

	Score	vs. Nat'l Healthcare Avg
Decompression	3.53	-0.35
Activation	4.63	+0.11

Leader Engagement

Engagement Indicator

4.50

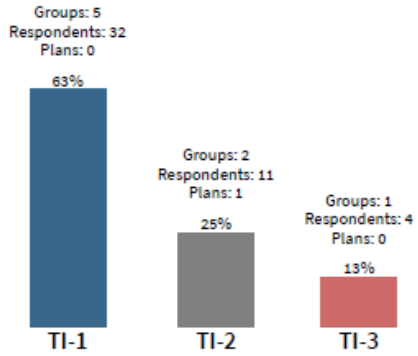
+0.24 vs. Organization

-0.09 vs. 2017 Results

Team Index

TI-1

Power Item Score 4.36



Leader Index

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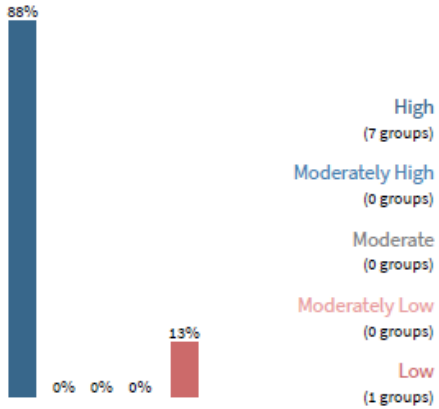

High
(7 groups)

Moderately High
(0 groups)

Moderate
(0 groups)

Moderately Low
(0 groups)

Low
(1 groups)

Organization

4.25

+0.27 vs. Organization

-0.10 vs. 2017 Results

Manager

4.45

+0.32 vs. Organization

0.00 vs. 2017 Results

Employee

4.20

+0.12 vs. Organization

-0.24 vs. 2017 Results

Resilience Index

3.86

-0.34 vs. Organization

	Score	vs. Organization	vs. 2017 Results
Decompression	2.98	-0.88	-
Activation	4.74	+0.17	-

Challenges

- Leaders agenda may not be the same as PA/APRN Directors agenda to work together
- Different levels of PA/APRN leaders voice at the table
  - Some at the C-suite, the other not
- Champions for each PA/APRN leader will be different;
  - ECNO, COO, Exec. Dir., etc.
- Governance: Federal, State, policy
  - Laws
- Perceptions: some providers' reality

Key Take-away

- Working together gives better outcomes
- Find the way to meet in the middle
- Transparency promotes collegiality
- Continual communication is key even if you don’t think it’s relevant, share it
- Best person put into leadership role, not by title/degree
- Respect for all
- Do not view each other as competition: there are enough patients for all!

Contact Information

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Cleveland Clinic

Every life deserves world class care.