Successful Integration of Advanced Practice Providers into Hospitalist Practice

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Population Over Age 65 Doubles by 2030

United States Population Projection

- Total Population
- 65+
- Supply of Physicians
Language is powerful

Appropriate terms:

1. Nurse Practitioner (NP)
2. Physician Assistant (PA)
3. Advanced practice nurse (APN)
4. Advanced practice provider (APP)

What not to say

- Physician Extender
- Midlevel provider
- Nurse
- Non Physician Provider
- Physician’s Assistant
Different Types of NPs

• Acute Care, Family, Adult

• APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee

http://www.aacn.nche.edu/education-resources/aprnreport.pdf
Resources

**Nurse Practitioners:**
- American Academy of Nurse Practitioners  [www.aanp.org](http://www.aanp.org)
- National Council State Boards of Nursing  [www.ncsbn.org](http://www.ncsbn.org)

**Physician Assistants:**
- American Association of Physician Assistants  [www.aapa.org](http://www.aapa.org)
- National Commission on Certification of Physician Assistants  [www.nccpa.org](http://www.nccpa.org)

What can an NP/PA do?

- Admit patients
- Discharge patients
- Manage patients
- Follow up phone calls
- Surgical co-management
- Diagnose
- Treat
- Prescribe
- Hold family meetings
- Provide end of life care
- Do procedures
- Succeed in administrative roles
- Participate in hospital wide committees
- Play nice with nurses and ER
- Cross cover
- Triage
- Train and onboard new employees
Landscape evaluation

- Are you ready?
- Make sure you understand the problem you are trying to solve
- Evaluate by-laws
- State regulations
- Market for NP/Pas
- Culture

Onboarding: The three “P”s

- Provider—are they new grads vs old hands
- Patients—are they “SAPs” or lower acuity
- Periphery—is this a new concept? Or does your system/hospital have experience with NP/PA providers
- All of these facts drive the duration/intervention of onboarding
Current Strategies

<table>
<thead>
<tr>
<th>Paired rounding</th>
<th>Admitting</th>
<th>Observation unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>Cross Coverage</td>
<td>Triage</td>
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Teledmedicine

Results

- Very successful
  - Safe, efficient
  - Works for new NP/PA onboarding along with more experienced NP/Pas
  - High satisfaction for both NP/PA and MD

Key factors

- Physician Buy in
- Right provider for the right

10/19/2016
Paired rounding

Pros
- Increased MD satisfaction
- Increased billing, patient encounters
- More eyes on patients

Cons
- NP/PAs can work different hours than MDs
- Resentment
- How will you cover when APP not there?
- Duplication of work

Admitting Role

Results
- Shift coverage from 7a-2am
- Success in absorbing both early am and late afternoon admissions
- Manages peak admissions in cost effective ways
- NP/PA role ownership
- May help with throughput

Key Factors
- Allows non-admitting staff to focus on patient care, etc
- Co-signature by MD based on hospital bylaws
- Optional capture of shared visit billing
Admitting

- Can help with ER/HM interface
- Can utilize a less expensive provider to get patients “tucked in”
- May not be a super satisfying role long term for NP/PA provider

Observation Unit

**Results**
- Becoming more common
- High autonomy for NP/PA
- Great role ownership
- High levels of patient satisfaction

**Key Factors**
- Need to have high functioning NP/PA
- Designated MD available when necessary
- Hospital bylaws may drive oversight
Observation

Short stay, disease-specific

Pros

- Great autonomy
- MDs can focus on higher acuity patients
- Great NP/PA satisfaction
- Lower cost-the “sweet spot”

Cons

- Coverage when APP away
- Hard for MD to jump in/out when APP needs input

Optimization

- Occurs when skill set is match for clinical need = less supervision, less cost

- How to approach:
  - Increase complexity of patients on the physician side.
  - Decrease supervision.
Physician Oversight

<table>
<thead>
<tr>
<th>5-10%</th>
<th>10-15%</th>
<th>15-20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncomplicated patient</td>
<td></td>
<td>Complex</td>
</tr>
<tr>
<td>Experienced NP/PA</td>
<td></td>
<td>New Grad NP/PA</td>
</tr>
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</table>

Physician oversight: No free lunch

- Need to recognize oversight as valued work:
  - Direct pay for role
  - Decrease physician census
  - Attribute some portion of work generated by NP/PA to physician
Innovative Leverage of NP/PAs

- Consultant
  - Manages census of only consults
  - Continuity for surgical partners
  - Becomes expert
  - From home/in-house or overnight
  - Off loads cc from admitting providers
  - High functioning NP/PA
  - Point of contact for medicine service
  - Triage all admissions from ED
  - Provider to provider call for all outside admissions
  - Post hospital discharge follow up

- Cross coverage

- Triage

Telemedicine

- Way of leveraging NP/PA providers when physicians are scarce and census is low
- Used in a variety of settings, mental health, critical access hospitals
- Difficulties with regulations/billing-varies from state to state
- You will see growth here
New Directions

NP/PA Recruitment
- Post-graduate fellowship
- APRN/PA Residency
- Clinical Rotations
- Relationship with grad schools

Care Delivery Redesign
- MD as consultant
- Brain for higher-level decision making
- Free MD for leadership, QI

Stability

NP/PA productivity

<table>
<thead>
<tr>
<th>Months</th>
<th>New Grad Productivity</th>
<th>Old Hand Productivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>&lt; 20%</td>
<td>60%</td>
</tr>
<tr>
<td>3-6</td>
<td>40%</td>
<td>80%</td>
</tr>
<tr>
<td>6-8</td>
<td>60%</td>
<td>100%</td>
</tr>
<tr>
<td>8-12</td>
<td>80% plus</td>
<td>100%</td>
</tr>
</tbody>
</table>
Will take a year to get to steady state.

Plan for:
- Training
- Ramp up of productivity
- Physician oversight

Setting Up Expectations

- Unwritten Agreement
  - MD and APP have different ideas and expectations of roles, autonomy, professional growth, scope of practice
Retention

How can I keep my APPs happy?
- Compensation, vacation, benefits
- Professional growth
- Treat like members of team
- Karaoke!

Trends in NP/PA hiring

Figure 3.6 Presence of Nurse Practitioners and/or Physician Assistants in HMGs

Key Findings for 3.6
- As compared to 2012 data, the presence of Nurse Practitioners and/or Physician Assistants had increased from 53.9% to 62.1%
- This change had occurred across all categories of HMGs
- Nurse Practitioners and Physician Assistants were much less commonly used in the Western region than in other parts of the country
- Private hospital-based groups and private multi-specialty HMGs were less likely to utilize Nurse Practitioners and Physician Assistants than groups in other employment models; management company-employed groups were the most likely to report the presence of Nurse Practitioners and Physician Assistants.

SECTION THREE

28
Trends in utilization

Figure 3.7 How Nurse Practitioner/Physician Assistant Work is Billed, Comparison to 2012

Key Finding for 3.7
* As compared to 2012, a higher portion of HMOs reported Nurse Practitioners and/or Physician Assistants were providing billable services, with independent billing up significantly.
How NP/PA Services are billed

- Probability of making a malpractice payment was 12 times less for PAs, and 24 times less for APNs
- Trend analysis suggests the rate of malpractice payments for all three groups has been steady and consistent with the growth in the numbers of providers.
- Mean MD payment was 1.7 times greater than PAs and 0.9 times that of APNs

Liability

- “Seventeen years of observation suggest that, if anything, PAs and NPs may decrease liability”
Questions
Admitter cont:

- If you are hiring NP/PA to increase volume-then measure volume with a volume metric

Admitter

- May increase total day team volume
- Have to include some physician oversight time
Need an extra body: can I do it for less?

- Will take a year to get to steady state
- May note decreased productivity at first
- Subsequently may see decreased cost
- Factor in physician oversight

Productivity

Common measures:

- Encounters
  - Limitations include whether subsequent visit or admission, each encounter looks the same.
- RVU-relative value unit
  - Held constant by the payer
  - Professional billing fee based metrics
- Revenue
  - How does one account for different payers?
Productivity

• What is Productivity?
  • Amount of goods or services produced with one hour of labor
• How do you assess productivity?
• Does your measurement really assess productivity
• What goods or services are you measuring?

Commonly used measures have limitations:
  ▶ Not really measures of traditional productivity
  ▶ Do not adequately deal with team based care (co-management, cross cover, follow up, etc.)
  ▶ Measuring with these is better than not measuring anything
Cost: What is cost of NP/PA?

- Compensation + fringe (know your fringe rate)
  - Hiring
  - Training
  - Malpractice
  - Physician oversight - more later

Compensation: Salary

- Use a similar method as for physicians
- National Benchmarks
- Local competitors
  - Markets are local
  - Inpatient providers with some markup
  - Account for off-hours premium
- SHM salary data
Revenue Streams

- Professional Fees
- Hospital Transfers for:
  - Coverage for work of the day
  - Targets or incentives for:
    - Productivity, safety, quality, experience, efficiency
- Contractual arrangements

Billing

- Most services billed by a physician to Medicare are also covered when performed by NP/PA.
- Medicare Part A covers facility fees, supply costs.
- Medicare Part B covers professional services and durable medical equipment.
Billing: How to for hospital employed NP/PA

➤ Be included in the hospital’s cost report and covered by facility Part A payment
➤ Not be included in hospital cost report and be billed under Part B

Billing: How to for hospital employed NP/PA

➤ Part B services must be billed under NP/PA NPI number to be reimbursed at 85% of the physician fee schedule, without direct and documented physician involvement.
➤ Part B services billed under the physicians NPI number are reimbursed at 100% depending on the degree of involvement and documentation.
Billing: Independent hospital practices

- All services are billed under Part B.
- NP/PAs get 85% of the physician fee schedule.
- Can bill at 100% based on physician's level of interaction, decision making, based on documentation.

Billing: Private insurance

- Contact the payor.
- Get (in writing) the representative's name.
- Obtain the written policy/contract.
- Identify specific issues of reimbursement.
Billing: Shared visit

- PA/NP and physician must be employed by the same hospital, group practice or the same employer.
- MD must provide face-to-face time.
- MD must document involvement in a “shared visit”.
- Only applies to E/M visit, does not apply to initial consultation or procedures.

Billing: Shared visit

- Bill under physician for 100% reimbursement if the MD:
  - Personally examined the patient
  - Reviewed the documentation
  - Participated in the medical decisions
  - Documented the physician involvement
Revenue: Hospital funds transfer

- Volume
- Quality
- Safety
- Experience
- Efficiency

Is this a good ROI?

- Incremental revenues > Incremental costs
  - Compare ratios to baseline total revenue/total costs including all revenues
- Incremental revenues = Incremental costs
  - Neutral, but project year-to-year change
- Incremental revenues < Incremental costs
  - Re-calculate and pro-rate funds flows transfer across the new FTE
Is this a good ROI? From whose perspective?

- Hospital funds flow transfers are usually not done to incentivize greater professional fees
- Can you demonstrate:
  - Lower hospital costs
    - Lower LOS, decreased penalty, etc.
  - Higher hospital revenues
    - Value Based Purchasing
- If your NP/PA is targeting these improvements, measure their effect as best you can

Do NP/PAs positively affect revenue at reduced cost?

- NP/PA FTE lower cost than MD FTE
- Manage the care of patients that don’t need a physician at the bedside
- Coordinate the process of care
- Can augment practice productivity
- Can be used to maximize hospital funds flow
- Services reimbursed by Medicare/Insurers
Admitter: Volume

- Day team has cap of 32
- Average AM census 24 patients
- Average 10 potential admissions during day/evening and 6 night
- Discharge average 10 per day
- Potential loss of 8 admissions/day
- Can an admitter solve your problem?

Admitter: Volume

- Admitter from 2pm-10pm (match admission flow) 4 days per week
- Average 8-10 admissions/shift
- Overall increase in admissions 6-8/shift (physician oversight)
- NP/PA does 4*9*46 = 1656 admissions/year
- Yearly increase in volume= 4*7*46= 1288 (all admissions)
Admitter

- Day team target census of 30 (2 providers)
- Average AM census 32 patients
- Average 6 admissions during day/evening and 6 night
- Discharge average 12 per day
- Each provider averaging 16 old patients, discharging 6 of them and admitting 3 news during daytime shift
- Can an admitter solve your problem?

Admitter

- Admitter from 2pm-10pm (match admission flow) 4 days per week
- Average 8-10 admissions/shift
- NP/PA does 4*9*46 = 1656 admissions/year
- Overall increase in admissions = 0
- What are you trying to fix:
  - Physician satisfaction
  - Turnover
  - LOS
Problem #2: I need more people

- Unable to find enough physicians
- Can I add people for less money?

I need more people

- Assess like an MD but recognize differences
- Target productivity.
- Evaluate cost, should be lower with NP/PA
- Factor in physician oversight
Physician type role

- Physician look-alike
  - Same patient mix
  - Estimate 85%-100% of volume NP/PA:Physician
  - Physician oversight requirements higher

- Targeted patient population
  - Low complexity
  - High touch
  - Physician oversight requirements less

Evaluating this model

- Revenue/cost ratios should be better than adding additional physicians (if available)
- If unable to hire additional physicians, if revenue/cost ratios worse, than this needs to be seen as a cost of doing business for you
- If revenue/cost ratios similar and physicians are scarce but available:
  - Would you rather have top of the class NP/PA or bottom of the class physician
Readmission problems

- First identify the problem population.
- NP/PA can provide:
  - Improved care coordination
  - Improved communication
  - Improved follow up
- Total patient experience
- Deploy the NP/PA with the most at-risk population.

Changing landscape of penalties/rewards

- Not just a simple formula anymore.
- Biggest drain right now is simply LOS - if DRG based population.
- In future need to worry about penalties and rewards.
Optimize financial model

- MD sees all patients, bills 100%, NP/PA carries out plan of care.
- MD would have to be 70% more efficient (about the cost of the NP/PA) to cover cost of NP

Optimize financial model

- Can retain MD.
- Can increase productivity - allowing physician to bill/see more patients.
- But, MD would have to go from seeing 10 patients to 17 patients in order to totally defray cost of NP/PA
Another Optimization model

- Utilize NP/PA in a specific and limited role, i.e. Observation Unit
- NP/PA would see same volume as a physician, but cost less. Don’t need to pay for physician oversight
- But, there are start up inefficiencies to NP/PA that are not there with physician.

Dollars

- About more than money
- Need to look at quality
- Efficiency
- Measure those things at the beginning of implementation
NP/PA benefits

- Can help with patient experience problems - this is difficult to measure
- LOS
- Quality
- Readmissions

Conclusion

- NP/PA additions can augment hospitalist practice in a variety of ways
- Consider the problem you are trying to solve before hiring
- Optimize skill set with patient population to reduce MD oversight
Changing landscape of penalties/rewards

- Not just a simple formula anymore
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NP/PA benefits

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Dollars

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- Measure those things at the beginning of implementation

Compensation

- Salary alone
- Salary plus shared savings program
- Salary plus productivity incentive
  - Patient encounters, RVU, patient satisfaction
Salary

- Look at National Benchmark
- Similar to way you figure hospitalist salary
- Call local people - remember, markets are local

Return on investment

- Costs less than an MD FTE
- Manage the care of patients that don’t need a physician at the bedside
- Coordinate the process of care
- Can augment practice productivity
- Services reimbursed by Medicare/Insurers
Billing

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Shared visit-continued

- Bill under physician for 100% reimbursement if:
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Independent hospital practices/non hospital employee

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