Advanced Practice Providers (APPs): Strategies and Structures to Support High Quality, Lower-Cost Care

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Vice President, Advisory Services, Illinois Health and Hospital Association (IHA)
Ann and Robert H. Lurie Children’s Hospital of Chicago

- More than 620,000 total patient visits
  - 15,110 inpatient admission
  - 594,784 outpatient visits
  - 19,770 surgeries
  - 84,007 emergency visits
- More than 174,000 individual patients

207 Advance Practice Providers
1,446 Physicians
70 Pediatric Specialties

Over 14% of our providers are APNs and PAs

Lurie Children’s is the only pediatric hospital in Illinois to be ranked in all 10 specialties — in fact, no other hospital scored higher in any one specialty area.

In 2015, Lurie Children’s was re-designated for a fourth time; less than 1% of hospitals have been designated three times.
Carolinas HealthCare System (CHS)

• One of the nation’s largest and most comprehensive systems (NC, SC, GA)
  – 44 hospitals / 940 Care locations
  – 7,500 licensed beds / 12.5 million encounters annually
  – 2,361 Physicians / 1,739 Advanced Clinical Practitioners

• The CHS Center for Advanced Practice positions CHS to be preeminent in defining the role of Advanced Clinical Practitioners (ACPs) in a value-driven care delivery system.
Catholic Health Initiatives (CHI)

Nation’s 2\textsuperscript{nd} Largest Nonprofit Health System

<table>
<thead>
<tr>
<th>Operations</th>
<th>Employees</th>
<th>Finances</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 19 states</td>
<td>• &gt; 90,00 employees</td>
<td>• $23 billion in assets</td>
</tr>
<tr>
<td>• 103 Hospitals including:</td>
<td>• 4,033 employed providers</td>
<td>• $15.2 billion in operating revenues</td>
</tr>
<tr>
<td>– 4 Academic Health Centers and major teaching hospitals</td>
<td>– 37% Advanced Practice Clinicians (APCs)</td>
<td></td>
</tr>
<tr>
<td>– 30 Critical Access Facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 12 CINs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physicians and APCs
9.4 million office visits annually

CAP2 Partnership since 2014
CHI’s National Presence

Pacific Northwest: Franciscan Health System (Multi-state system serving OR & WA)

Centura Health: (Multi-state system serving CO and KS, includes Adventist Health System, Denver)

CHI Nebraska: (Statewide system, includes Alegent Creighton, Omaha)

Fargo Division

Mercy Health Network: (Statewide system includes Mercy Health System, Des Moines and Trinity Health-Iowa)

Premier Health Partners, Dayton, OH: (Joint Operating Agreement between Catholic Health Initiatives and MedAmerica Health Systems Corporation, Atrium Health System and Upper Valley Medical Center)

TriHealth, Cincinnati, OH: (Joint Operating Agreement between Catholic Health Initiatives and Bethesda, Inc. Cincinnati)

St. Luke’s Health System, Bryan & Memorial Health System of East Texas: (Affiliations with Baylor College of Medicine and Texas Heart Institute)

Southeast (Includes Little Rock and Hot Springs, Arkansas and Chattanooga, Tennessee)

KentuckyOne Health: (Statewide system, includes University of Louisville Medical Center)
CAP2 NATIONAL TRENDS AND LEADING PRACTICES
CAP2 – Our Mission

Assess: Provider Team Utilization
Build: Infrastructure
Optimize: All Providers
Spread: Leading Practices
CAP2 – Our Data

- Member data represents:
  - 260 organizations
    - Acute and ambulatory
    - Hospitals; healthcare systems
    - Academic medical centers → critical access
  - Almost 25,000 APRNs and PAs
  - 31 different states
  - 50 different specialty areas
  - And growing
  - One of a kind
CAP2 Members
APP Demand and Growth

**Physician Shortages**

2020 Projection
90,000 Physicians

**APP Shortages**

2025 Projection
20% Shortage

**2016 Best Jobs**

#4 – Nurse Anesthetist
#5 – Physician Assistant
#6 – Nurse Practitioner

Sources:
### CAP2 Data Trends

**Percent Growth in APRNs by Practice Area**

<table>
<thead>
<tr>
<th>Clinical Practice Area</th>
<th>2013 APRN</th>
<th>2015 APRN</th>
<th>Count Growth</th>
<th>Percent Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics (General)</td>
<td>90</td>
<td>215</td>
<td>125</td>
<td>139%</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>38</td>
<td>59</td>
<td>21</td>
<td>55%</td>
</tr>
<tr>
<td>Neurology</td>
<td>77</td>
<td>113</td>
<td>36</td>
<td>47%</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>62</td>
<td>82</td>
<td>20</td>
<td>32%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>249</td>
<td>302</td>
<td>53</td>
<td>21%</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynecology/Women's Health</td>
<td>220</td>
<td>266</td>
<td>46</td>
<td>21%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>132</td>
<td>157</td>
<td>25</td>
<td>19%</td>
</tr>
<tr>
<td>Cardiovascular Surgery</td>
<td>150</td>
<td>176</td>
<td>26</td>
<td>17%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>257</td>
<td>298</td>
<td>41</td>
<td>16%</td>
</tr>
<tr>
<td>Gastroenterology/ Endoscopy/Hepatology</td>
<td>60</td>
<td>69</td>
<td>9</td>
<td>15%</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>142</td>
<td>123</td>
<td>-19</td>
<td>-13%</td>
</tr>
</tbody>
</table>

Data shows comparison of 37 organizations that have taken the CAP2 Acute Care Assessment in 2013 and again in 2015.
### CAP2 Data Trends

**Percent Growth in PAs by Practice Area**

<table>
<thead>
<tr>
<th>Clinical Practice Area</th>
<th>2013 PA</th>
<th>2015 PA</th>
<th>Count Growth</th>
<th>Percent Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery (General)</td>
<td>58</td>
<td>143</td>
<td>85</td>
<td>147%</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>29</td>
<td>59</td>
<td>30</td>
<td>103%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>103</td>
<td>179</td>
<td>76</td>
<td>74%</td>
</tr>
<tr>
<td>Hematology/Oncology/Bone Marrow</td>
<td>123</td>
<td>207</td>
<td>84</td>
<td>68%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>127</td>
<td>192</td>
<td>65</td>
<td>51%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>56</td>
<td>78</td>
<td>22</td>
<td>39%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>79</td>
<td>107</td>
<td>28</td>
<td>35%</td>
</tr>
<tr>
<td>Gastroenterology/Endoscopy/Hepatology</td>
<td>48</td>
<td>64</td>
<td>16</td>
<td>33%</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>253</td>
<td>290</td>
<td>37</td>
<td>15%</td>
</tr>
<tr>
<td>Cardiovascular Surgery</td>
<td>148</td>
<td>165</td>
<td>17</td>
<td>11%</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>123</td>
<td>103</td>
<td>-20</td>
<td>-16%</td>
</tr>
</tbody>
</table>

Data shows comparison of 37 organizations that have taken the CAP2 Acute Care Assessment in 2013 and again in 2015.
APP Representation

186% growth in APP representation on the Medical Staff Credentialing Committee

Data shows comparison of 37 organizations that have taken the CAP2 Acute Care Assessment in 2013 and again in 2015.
APP Orientation

Only 32% report having a formal orientation or structured transition to practice program for APPs

Data shows comparison of 37 organizations that have taken the CAP2 Acute Care Assessment in 2013 and again in 2015.
APP Leadership Structures

• 73% of reporting organizations have an identified leader
  – 60% of identified leaders have a Director title
  – 37% of identified leaders have a dyad reporting structure
Advanced Practice Leader Strategy and Structure – Lurie Children’s

- Rapidly growing Advanced Practice Nurse (APN) workforce
- Informal leadership through the APN Council
  – Voluntary and lacking authority
- Inconsistent reporting structure
- Lack of standardize onboarding, clarity of role, utilization and productivity expectations
- Oversight of regulatory, practice and legal requirements
- Need to align with credentialing and privileging within the Medical Staff Office
APN/PA Growth

Total # of APNs at year end

Senior Director Appointed

Ann & Robert H. Lurie
Children’s Hospital of Chicago™
APN/PA Council Structure

APN Board of Directors

- Senior Director, Advanced Practice Nursing
- APN Managers
- APN Council Chair and Co-Chair
- APN Committee Chairs and Co-Chairs

APN Council Committees
- Credentialing
- Education
- Publication
- Informatics
- Health Policy & Advocacy
- Transition into Practice
- Billing & Reimbursement
APN Manager Role – Demonstrating Value

• Benefits
  – Consistent Oversight
  – Increased Productivity/Accountability
  – Increased Billing – three fold
  – Increased Patient Access – 25% increase in clinic volumes
  – Competency tools and consistent evaluation
  – Academic Productivity
National Vice President, Advanced Practice

Division VP, Advanced Practice – Post Acute

Division Director – Women’s

Market AP Director – Ambulatory

Market Director – Quality & Clinic Operations

Facility AP Program Managers – Acute Care
Clinical Leadership Council (CLC)
Co-lead by CMO, CNO, SVP PE, & SVP Performance Excellence

CLC Membership: 15
3 Market physicians, 1 National physician, 4 Market nurses, 2 Market pharmacists, 1 National pharmacist
1 Market SVP Ops, 1 Supply chain rep, 1 Finance rep, 1 Communication rep, 1 Advanced Practice rep

Nurse Executive Council (NEC)
NEC Membership: 23
13 Market nurse leaders
10 National nurse leaders
With representation across the Care Continuum

Physician Executive Council (PEC)
PEC Membership: 57
17 National employees
40 Market employees
50 physicians
7 non-physicians

National Pharmacy Executive Council (NPEC)
NPEC Membership: 16
12 Market pharmacists
4 National pharmacists
Currently in transformation

Medical Group Leadership Council (MGLC)
MGLC Membership: 29
MGLC Physician Enterprise: 8
MGLC Shared Services: 6
MGLC Executive Committee: 3
MGLC Physician/Provider Compensation Committee: 8
MGLC Quality & Patient Safety Committee: 4

Advanced Practice Leadership Council (APLC)
APLC Membership: 37
35 Market clinicians & Market leaders
2 National AP leaders

Clinical Services Group (CSG) & Physician Enterprise Groups (PE)
Clinical recommendations from these groups go to the proper Clinical Council before moving to CLC for final approval.
Advanced Practice
Strategy Development

• Vision
  • Be the industry leader in Advanced Practice Care

• Strategic Focus
  • Develop strategy for innovative models of team-based care with a specific focus on leveraging the expertise and knowledge of Advance Practice Clinicians (APCs) across the care continuum. *(Challenge the conventional APC role to meet the demands of the next era healthcare)*
  • Establish consensus-based quality and financial outcome measures achieved through the effective integration of APCs and implementation of advanced practice care models.
  • Identify and fully leverage state regulation opportunities to improve patient access to APCs that support interdisciplinary, team-based care models.
1. State Regulations Resource Tool

2. “Current State” Operations
   - CAP2 Survey
   - State Regulations + CAP2 Data
     - Standardization of DOP

3. Quality

4. Compensation

5. Care Model Design
   - Advanced Practice pilots in primary care
   - Team Care

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### CHI Advanced Practice

**FY 15 & 16: Areas of Focus**

<table>
<thead>
<tr>
<th>CAP2 Data</th>
<th>Texas Hospital A</th>
<th>Texas Hospital B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Privilege</td>
<td>Practitioner</td>
<td>Privilege</td>
</tr>
<tr>
<td>Write admission orders</td>
<td>APRN</td>
<td>N</td>
</tr>
<tr>
<td>Write discharge orders</td>
<td>APRN</td>
<td>N</td>
</tr>
<tr>
<td>Write transfer orders</td>
<td>APRN</td>
<td>Y</td>
</tr>
<tr>
<td>Obtain history &amp; physical</td>
<td>APRN</td>
<td>Y</td>
</tr>
<tr>
<td>Order &amp; interpret diagnostic testing and therapeutic modalities</td>
<td>APRN</td>
<td>Y</td>
</tr>
<tr>
<td>Order &amp; perform referrals and consults</td>
<td>APRN</td>
<td>Y</td>
</tr>
<tr>
<td>Order blood &amp; blood products</td>
<td>APRN</td>
<td>Y</td>
</tr>
<tr>
<td>Order inpatient non-schedule medications</td>
<td>APRN</td>
<td>Y</td>
</tr>
<tr>
<td>Order inpatient schedule (II-V) medications</td>
<td>APRN</td>
<td>N</td>
</tr>
<tr>
<td>Order conscious sedation</td>
<td>APRN</td>
<td>N</td>
</tr>
<tr>
<td>Order topical anesthesia</td>
<td>APRN</td>
<td>Y</td>
</tr>
<tr>
<td>Prescribes outpatient non-schedule medications</td>
<td>APRN</td>
<td>Y</td>
</tr>
<tr>
<td>Prescribes outpatient schedule (II-V) medications</td>
<td>APRN</td>
<td>N</td>
</tr>
<tr>
<td>Incision &amp; drainage with or without packing</td>
<td>APRN</td>
<td>N</td>
</tr>
<tr>
<td>Write admission orders</td>
<td>PA</td>
<td>N</td>
</tr>
<tr>
<td>Write discharge orders</td>
<td>PA</td>
<td>N</td>
</tr>
<tr>
<td>Write transfer orders</td>
<td>PA</td>
<td>N</td>
</tr>
</tbody>
</table>
Objective: Implement innovative, collaborative MD/APC team-based primary care models with expanded physician to APC ratios of at least 1:3 in each Division

<table>
<thead>
<tr>
<th>Criteria</th>
<th>National Support</th>
<th>Strategic Alignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Expanded Physician/APC ratio of 1:3</td>
<td>• Develop guidelines/ standards for infrastructure design</td>
<td>• Building Out Care Continuum</td>
</tr>
<tr>
<td>• Dyad Medical &amp; AP Leadership</td>
<td>• Create “Playbook” and Comprehensive Operations Manual</td>
<td>• Single System of Care (Removing Clinical Variation)</td>
</tr>
<tr>
<td>• Team-based, top-of-license/autonomous deployment</td>
<td>• Operational support with implementation</td>
<td>• Financial Performance (Ambulatory-Primary Care)</td>
</tr>
<tr>
<td>• Complimentary make-up of team members</td>
<td>• Provide performance reporting for identified metrics</td>
<td></td>
</tr>
<tr>
<td>• Credentialing, privileging and competency assessment process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Supportive bylaws and policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Collaborative Peer Review Process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Team-based compensation methodology</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Standardized Metrics

• Access
• Clinical Outcomes
• Patient Satisfaction
• Provider Engagement
• Financial Performance
CHS Center for Advanced Practice

• AVP for CHS Center and Chief ACP for CHS
  – NP Fellowship Director (Assistant)
  – PA Fellowship Director (Assistant)
  – ACNP Clinical Program Director (0.5 Asst.)
  – Center Director (3 Support Staff)

• Reports to:
  – Chief Academic Officer
  – Chief Physician Executive
  – Chief Nurse Executive
CHS Post-Graduate Program Overview

• Largest in the Country
• NPs and PAs
• 19 unique specialty tracks/
  67 Fellows annually
• Specialty experience above and
  beyond basic NP/PA formal education
• Over 2,200 more clinical hours
• Special procedure proctoring
Fellowship Program Process

New employee goes to work with all orientation, credentialing and hospital privileging done and prepared for productive work on Day 1.
Fellowship Program Financials/Outcomes

• $18.4 million over 5 years
  – Included Center, Fellowship and Collaborative
  – Did not include expansion (32 Fellows v. 68 Fellows)

• ROI – Proj. BE 18 mo. ($27.4 million in 18 mo.)
  – Lower provider workforce cost ($18.2 m) (141 ACPs)
  – Revenue generated by Fellows ($4.5 m)
  – Decreased open position time ($2.1 m) 141 – 92 days
  – Decreased turnover rate ($2.9 m) (18 ACPs) 12 – 7%
  – Lower recruitment costs ($0.7 m) (218 ACPs)
  – Increased ACP engagement scores and Patient Satisfaction scores