NURSE PRACTITIONER HOSPITALIST PROGRAM

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TODAY’S OBJECTIVES

To understand

➢ APN hospitalist models in a rural setting
➢ Cultural engagement by medical staff and others
➢ Effect on quality, patient satisfaction and operations
➢ Regulatory requirements for start up

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.
Nurses should be full partners with physicians
Nurses should practice to the top of their license
Achieve higher levels of education and improve the educational system for a seamless educational progression
Effective workforce planning and policy making

WHY START A HOSPITALIST PROGRAM NOW?

- Hospitalist: newer specialty term
  - First used in a New England Journal of Medicine article in 1996.
- More than 50% of hospitals have a hospitalist program
  - Many CAH use APNs due to primary care shortage
- Primary focus is to improve the quality of care through system change

IMPROVE RURAL PHYSICIAN RECRUITING

➢ Of the 2,050 rural counties in the United States, 77% have primary care shortages
➢ One challenge in recruiting is the lower amount of “time away from work” in a rural area

RUSK COUNTY MEMORIAL HOSPITAL

- Federally Qualified Health Shortage area (FQHS)
- 18,000 population in primary service area
- ADC 6-8, including swing beds
- ED 6,500 visits per year

10 primary care MDs in 2010; 5 in 2015

- 1 Independent clinic and multiple specialists in 2010
- Opened Provider Based Rural Health Clinic in 2014

2013-15 dynamic radical change
WHY CHANGE NOW?

- Loss of 6 primary care MDs in 2 years
  - Suspension of OB services
- New replacement hospital 45 miles away
  - Independent physician group, also in radical change
- Recruiting challenge: call burden
- Decreased market share 2010: 43%, 2013: 21%
NUMBER OF MDs : PATIENT DAYS

10 Year History

Acute Care Inpatient Days

# Physicians

Total Acute Care Inpatient Days

# Physicians

0  2  4  6  8  10  12  14  16


Acute Care Inpatient Days

0  500  1000  1500  2000  2500
DYNAMIC RADICAL CHANGE:
THE “QUADFECTA” 2014

- Hospital opened own clinic (PBRHC)
- APN Hospitalist Program launched
- ED physician group replaced
- Remodeled facilities “Fresh Eyes”
  patient-centered care

Influence the continuum of care and outcomes
STRATEGIC GOAL — GROWTH PILLAR

We will be led by highly qualified providers (physicians and extenders) with appropriate number and compliment for the level of services and programs expected to meet community needs.
APN HOSPITALIST PROGRAM GOALS

- ↓ Call burden for MDs
- ↑ MD quality of life and recruiting potential
- ↑ Clinical quality outcomes with standardized protocols and continuity of care
- ↑ Patient satisfaction
- Retain community support and market share
TRIPLE AIM

- Improve experience of care
- Decrease per capita cost
- Improve population health

EXPLORATION OF MODELS

Ministry—Eagle River Memorial Hospital, WI
- 2 APNs 12 hour shifts
- DHS waiver telemedicine model
  - Wisconsin administrative code DHS 124.04(3)(a)
  - Nurse practitioner hospital pilot program

Aspirus-Medford, WI
- 24/7 with 3 ANPs
- 7 days on, 14 days off
- Collaborating physician (FP) Rounding
VARIATION IN MODELS

- APN:MD mixed model
  - Job description: Include ED and/or clinic coverage?
  - First responder vs. unit based vs. traditional
- Telemedicine collaborating physician
- Onsite collaborating physician
- Scheduling
  - Shift: 12 hour (day or night?) vs 24 hour
  - Pattern 7/14 vs 5/5/5 vs. ?
  - Backup coverage
- Salary/benefits; per diem locums
PHASE ONE PLANNING

- Medical staff support
- Board support/business plan
- Enabling medical staff bylaws
- Staff education
- Community education
## Inpatient Model of Care: Decision Grid

**02-26-15**

<table>
<thead>
<tr>
<th>MODEL</th>
<th>Better consistency &amp; continuity (span of hospital stay)</th>
<th>Increased coordination (handoff to outpatient setting)</th>
<th>Quality of life for providers</th>
<th>Increase in patient census</th>
<th>Increase in acuity</th>
<th>Cost Effectiveness</th>
<th>Clinic Consistency and Flow</th>
<th>Enhance Recruitment of new providers</th>
<th>Optimize Utilization Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Time Only Coverage (Physician or NP/PA)</td>
<td>$\color{red}{\text{***}}$</td>
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<tr>
<td>Night Time/Weekend Only (Physician or NP/PA)</td>
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<tr>
<td>Full Time Hospitalist 24/7 (Physician or NP/PA, or combination of current staff)</td>
<td>$\text{***}$</td>
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<tr>
<td>Hospitalist Criteria: Physician Opinion</td>
<td>Scale (1 = No and 5= Yes)</td>
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<td></td>
<td>No</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The hospitalist program will speed up the time to admission.</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2. The hospitalist program will decrease the current burden of call.</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>3. The hospitalist program will increase quality scores.</td>
<td>2</td>
<td>2</td>
<td>2</td>
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<tr>
<td>4. The hospitalist program will increase the number of admissions from our ED.</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
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<tr>
<td>5. The hospitalist program will help recruitment of new providers.</td>
<td>1</td>
<td>5</td>
<td></td>
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</tbody>
</table>

Number of Respondents: 6
MEDICAL STAFF BYLAWS KEY PROVISIONS

- Active staff privileges/voting rights for APN
  - May not be an officer
- Active staff privileges/voting rights for ED physicians
  - Collaborating agreement to authenticate admissions
- Active staff privileges for no/low volume admitters who serve on committees
- Peer review (OPPE/FPPE)
MEDICAL STAFF ENGAGEMENT

- Meetings with independent physician group clinic management
- Participation in site visits
- Opinion polls
MEDICAL STAFF ENGAGEMENT

- Bylaws revision team: Chief of Staff, ED physician, CEO, Chief Patient Care Officer and Quality Manager
- Chief of Staff updates at monthly medical staff meetings
- Medical staff invited to participate in APN interviews
REGULATORY/LEGAL

- State laws: Wisconsin Administrative Code DHS 124.04(3)(a)
- CMS rules and regulation
  - Swing bed provisions
- Medical staff bylaws

REGULATORY/LEGAL

- Collaborating Physician Agreement-Contract
- Primary Care Collaborator
- Emergency Physician Contract
- Authenticate admissions only

- State APNP Practice Act

Wis. Stat. §35.93, Ch. N 8
CRITERIA FOR APN CANDIDATE SELECTION

- Acute care experience with practicums
- Hospitalist experience preferred
- ACLS certified
- Excellent work history and references
- Cultural fit
- Collaboration/communication skills

ORIENTATION PLAN

- Hospitalist “Boot Camp” one week
- Shadow APN at another CAH one week
- Complete competency assessment
- Collaborating physician mentoring time
- General hospital orientation
COLLABORATING PHYSICIAN ROLE

- Available by phone 24/7
  - Backup physician
- Joint rounding
- Monthly quality chart review
- Sign off on H&P and discharge summary
- ED physician sign off on authentication for admission
TEAM CULTURE

➢ APN available 24/7 to answer questions and concerns
  ➢ Code response availability
  ➢ No ED tuck-in orders

➢ Multidisciplinary team rounding

➢ Improved access for discussion of admissions

➢ Increased nursing interaction and education

➢ Increased patient and family interaction and education
APN EXPECTATIONS

- Sleep space and work space
- Communication expectations with primary care provider re their patients (admission/daily care/discharge process)
- Orientation process (complete skills assessment, attend hospitalist boot camp)
- Involvement with design and testing of CPOE order sets, P&P, optimizing workflows, etc.
MULTIDISCIPLINARY TEAM ROUNDING DAILY

- MD collaborator during orientation, periodically thereafter
- APN—generally done independently
- Nursing leader
- Occupational Therapy
- Physical Therapy
- Pharmacist
- Case Manager
STANDING ORDERS

- Admission orders
- Top 10 inpatient diagnoses
- What worked
- Barriers to implementation

<table>
<thead>
<tr>
<th></th>
<th>Top DRGs 2013</th>
<th>Top DRGs 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SIGNS &amp; SYMPTOMS W/O MCC</td>
<td>REHABILITATION W CC/MCC</td>
</tr>
<tr>
<td>2</td>
<td>REHABILITATION W CC/MCC</td>
<td>REHABILITATION W/O CC/MCC</td>
</tr>
<tr>
<td>3</td>
<td>ESOPHAGITIS, GASTROENT &amp; MISC DIGEST DISORDERS W/O MCC</td>
<td>CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC</td>
</tr>
<tr>
<td>4</td>
<td>REHABILITATION W/O CC/MCC</td>
<td>SIMPLE PNEUMONIA &amp; PLEURISY W CC</td>
</tr>
<tr>
<td>5</td>
<td>FX, SPRN, STRN &amp; DISL EXCEPT FEMUR, HIP, PELVIS, &amp; THIGH W/O</td>
<td>KIDNEY &amp; URINARY TRACT INFECTIONS W/O MCC</td>
</tr>
<tr>
<td>6</td>
<td>TRAUMA TO THE SKIN, SUBCUT TISS &amp; BREAST W/O MCC</td>
<td>ESOPHAGITIS, GASTROENT &amp; MISC DIGEST DISORDERS W/O MCC</td>
</tr>
<tr>
<td>7</td>
<td>KIDNEY &amp; URINARY TRACT INFECTIONS W/O MCC</td>
<td>SIMPLE PNEUMONIA &amp; PLEURISY W/O CC/MCC</td>
</tr>
<tr>
<td>8</td>
<td>OTISIS MEDIA &amp; URI W/O MCC</td>
<td>HEART FAILURE &amp; SHOCK W CC</td>
</tr>
<tr>
<td>9</td>
<td>OTHER FACTORS INFLUENCING HEALTH STATUS</td>
<td>OTISIS MEDIA &amp; URI W/O MCC</td>
</tr>
<tr>
<td>10</td>
<td>SIMPLE PNEUMONIA &amp; PLEURISY W/O CC/MCC</td>
<td>SIMPLE PNEUMONIA &amp; PLEURISY W MCC</td>
</tr>
</tbody>
</table>
EARLY IMPLEMENTATION SUCCESSES & CHALLENGES

- Successful recruiting
  - NP projected growth: 28% from 2012-2022
  - One of 3 had delay in obtaining WI license and DEA number
- Old EMR increased documentation time/challenge for implementing clinical pathways
- Nursing staff not familiar with more acute patients

EARLY IMPLEMENTATION SUCCESSES & CHALLENGES

- Equipment Needs
  - Evaluate current equipment
  - Need for additional equipment for higher acuity patients
  - May need more BiPap equipment
  - More telemetry for higher acuity patients
  - Ventilator
  - Respiratory equipment
Early Implementation Successes & Challenges

- Educational needs
  - Assessment of higher acuity patients
  - Tertiary care nurse educator provided 2-day educational sessions
  - Working with a chest tube patient
  - Care of the pediatric population

- High volume back up plan
  - Difficulty finding part-time providers to fill in for illness
YEAR ONE OUTCOMES

- Patient satisfaction
- Quality improvements
  - CMI: Heart Failure
- Stabilize market share
- Patient continuity for the clinic start up
YEAR ONE OUTCOMES

- Outpatient program feeder/growth – Imaging and Lab
- Cardiac Rehab days increased
- Employee/physician satisfaction: anecdotal
- Successfully recruited 2 MDs to our clinic
## PATIENT SATISFACTION

### 2013 Q3 & 2015 Q3 HCAHPS DASHBOARD

<table>
<thead>
<tr>
<th>HCAHPS</th>
<th>2013 Q3</th>
<th>2015 Q3 (PRC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely recommend hospital</td>
<td>63%</td>
<td>64%</td>
</tr>
<tr>
<td>Hospital rated high (9-10)</td>
<td>39%</td>
<td>78%</td>
</tr>
<tr>
<td>Communication with nurses</td>
<td>78%</td>
<td>91%</td>
</tr>
<tr>
<td>Communication with doctors</td>
<td>77%</td>
<td>82%</td>
</tr>
<tr>
<td>Pain control</td>
<td>70%</td>
<td>76%</td>
</tr>
</tbody>
</table>
QUALITY IMPROVEMENTS: CORE MEASURES

RWHC Core Measure Program Comparison Report by Year-Quarter
Heart Failure Report
Rusk County Memorial Hospital

HF-2 14336 Evaluation of LVS Function

Reports generated prior to the end of the quarter are preview and may be subject to change after routine edits and testing. Reports are finalized within 3 months following the end of each quarter; clients will be notified when reports are final.
STABILIZE MARKET SHARE

Primary Service Area Inpatient Market Share

Percent of Market Share

Rusk County Memorial Hospital

FY 2012  FY 2013  FY 2014  YTD 2015
CARDIAC REHAB DAYS INCREASED

Cardiac Rehab Phase II Visits 2013-2015

- Q1
- Q2
- Q3
- Q4

Number of Visits

- 2013
- 2014
- 2015

RCMH Rusk County Memorial Hospital
INPATIENT ADMISSION IMPACT

Admissions by Year 2013-2015

Number of Admissions

Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec

2015
2014
2013
## OUTPATIENT/ANCILLARIES IMPACT

<table>
<thead>
<tr>
<th>Outpatient Lab &amp; Imaging (Jan-Nov)</th>
<th>2014</th>
<th>2015</th>
<th>Difference</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging</td>
<td>11,754</td>
<td>13,054</td>
<td>1,300</td>
<td>11%</td>
</tr>
<tr>
<td>Lab</td>
<td>24,331</td>
<td>36,403</td>
<td>12,072</td>
<td>49.6%</td>
</tr>
</tbody>
</table>
PHASE TWO: NEEDS OF A GROWING PROGRAM

- Respiratory Therapy added
- Patient Navigator added (RN)
- Daily operations handoff 0730 with Hospitalist, ED, collaborator and nursing
PHASE TWO: NEEDS OF A GROWING PROGRAM

- Role delineation between hospitalists and nurses/skills assessment
- Rehiring APN for cultural fit
- Increasing part time staff for back up support
FINANCIAL IMPACT

Direct costs:

- 2014 estimated 3 full time APNs (excludes locums/per diem costs)

Revenues: $ 290,000
Salaries/Benefits: - 410,000
Expenses: - 20,000

(140,000) * 2014 estimate cost

Indirect impact:

- Maintaining volume/market share est. $3,500/day
- ↑ Ancillary and outpatient revenue
WHAT WOULD WE DO DIFFERENTLY?

- Clinical pathways completed and in place
- Anticipate increased acuity
- Anticipate new equipment needs
- Back up staffing plan for illness/unanticipated gaps
- CMO on the leadership team

OUR CONSIDERATIONS

- Are we capturing all appropriate admissions?
- Do our physicians support the program?
- Has the call burden decreased?
- Are we able to recruit MDs without a Hospitalist Program?
- Do we own the clinic?
- Do we employ physicians?
LESSONS LEARNED

- KEY factors in program design:
  - Medical staff support and transition plan
  - Physician champion
  - Collaborating physicians/APN relationship
  - APN experience vs credential
  - Medical/legal risk tolerance
LESSONS LEARNED

- Disengagement of other primary care providers
- Backup support plan for illness, high census, burnout
- Cultural fit and teamwork among hospitalist group and others
- Keeping pace with growing demand
- Sharing with others creates new knowledge
GOOD THINGS TAKE TIME
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