The CHI Journey: A Team-Based Advanced Practice Strategy to Open Access and Lower Costs

Presented by
Michelle L. Edwards, System Vice President, Advanced Practice, Catholic Health Initiatives
Benjamin W. Chaska, M.D., MBA, CHI Fargo Division CMO and Physician Enterprise Executive
Trish Anen, Principal, Co-Lead APC Workforce Practice, Sullivan, Cotter and Associates, Inc.
Learning Objectives

1. Describe how Catholic Health Initiatives (CHI) implemented an innovative, collaborative team-based primary care model which expanded the physician to advanced practitioner staffing to 1:3.

2. Discuss the strategies and structures developed to ensure long-term sustainability including leadership roles, committees, governance structures and communication plans.

3. Present key findings from the Center for Advancing Provider Practices (CAP2™) latest assessments of APC of APC utilization and leadership structures in medical group practices.
Catholic Health Initiatives (CHI)

Nation’s 3rd Largest Nonprofit Health System

<table>
<thead>
<tr>
<th>Operations</th>
<th>Employees</th>
<th>Finances</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 17 states</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 104 Hospitals including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– 4 Academic Health Centers and major teaching hospitals</td>
<td></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>
<tr>
<td>• &gt; 90,000 employees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 4,511 employed providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– 38% Advanced Practice Clinicians (APCs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• $23 billion in assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• $15.9 billion in operating revenues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physicians and APCs
10.4 million office visits annually
CHI Strategic Objectives

**Vibrant Ministry**: We will be leaders and stewards in growing, living and transforming health care.

**Energized Community**: We will build and energize relationships with employees, clinicians, consumers and partners through our commitment to our internal and external communities.

**Distinctive Value**: We will transform our health delivery models to offer distinctive value, based on access, quality, service, safety and cost.

**Exceptional Care**: We will come together as a System to engage clinicians and align resources to assure the delivery of exceptional care.
CHI Employed Providers

Employed Provider Mix
Total Providers = 4,511 *

- 62% Physician (2,779)
- 38% APC (1,732)

Number of APCs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CHI</td>
<td>1,257</td>
<td>1,409</td>
<td>1,651</td>
<td>1,732</td>
</tr>
</tbody>
</table>

12% (152 increase) 17% (242 increase) 5% (81 increase)

CHI System Recruitment Scorecard:
110 current APC openings

* As of 12/31, 2017.
Larger Workforce Not Enough
Relevance to CHI and the Future of Healthcare

Investment #1: Strategically Deployed Advanced Practitioners
“The key is to deploy APCs strategically...where they practice as autonomously as possible”

Optimizing Use of Advanced Practitioners
“Myriad obstacles, both internal and external, compromise many organization’s ability to effectively deploy them.”
Advanced Practice
Executive Leadership

• **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 new era of healthcare)*

  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.
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 VP

Nec 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.

*APC Leader Participates on Council
## State Scope of Practice Environment

By CHI Presence

<table>
<thead>
<tr>
<th>FULL</th>
<th>REDUCED</th>
<th>RESTRICTED</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>State</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nebraska</td>
<td>Arkansas</td>
<td>Texas</td>
</tr>
<tr>
<td>Iowa</td>
<td>Kentucky*</td>
<td>Tennessee</td>
</tr>
<tr>
<td>North Dakota</td>
<td>Ohio</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>Kansas</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>Indiana</td>
<td></td>
</tr>
<tr>
<td>Colorado</td>
<td>Pennsylvania</td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>Wisconsin</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Formal Collaborative Agreement required for prescribing controlled substances

CHI’s operations more restrictive than required
APC Privileging Practices at CHI
Enterprise View By State

**Average Number of APRN & PA Core Privileges NOT Granted in CHI Facilities by Division**

![Chart](chart.png)

- NE: 0 APRN, 0 PA
- ND: 0.7 APRN, 2.8 PA
- TX: 5.6 APRN, 6.5 PA
- WA: 5.9 APRN, 6.5 PA
- KY: 6.2 APRN, 7.6 PA
- IA: 9 APRN, 9 PA
- MN: 12 APRN, 12.5 PA
- AR: 14 APRN, 14 PA

(14 Total Core Privileges)
CHI “Current State” Findings
CAP2 Multi-State System Assessment

Average Number of APRN Core Privileges NOT Granted in CHI Facilities by Division

- Least restrictive scope of practice
- Moderately restrictive scope of practice
- Most restrictive scope of practice

<table>
<thead>
<tr>
<th>State</th>
<th>Core Privileges - APRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE</td>
<td>0</td>
</tr>
<tr>
<td>ND</td>
<td>2.8</td>
</tr>
<tr>
<td>TX</td>
<td>5.6</td>
</tr>
<tr>
<td>WA</td>
<td>5.9</td>
</tr>
<tr>
<td>KY</td>
<td>6.2</td>
</tr>
<tr>
<td>IA</td>
<td>9</td>
</tr>
<tr>
<td>MN</td>
<td>12</td>
</tr>
<tr>
<td>AR</td>
<td>14</td>
</tr>
</tbody>
</table>

# CHI’s Texas Data

## CAP2 Core Privileges

<table>
<thead>
<tr>
<th>CAP2 Core Privileges</th>
<th>Practitioner</th>
<th>CHI Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write admission orders</td>
<td>APRN</td>
<td>Facility A</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>N</td>
</tr>
<tr>
<td>Obtain history and physical</td>
<td>APRN</td>
<td>Y</td>
</tr>
<tr>
<td>Order and interpret diagnostic testing and therapeutic modalities</td>
<td>APRN</td>
<td>Y</td>
</tr>
<tr>
<td>Order and perform referrals and consults</td>
<td>APRN</td>
<td>Y</td>
</tr>
<tr>
<td>Order blood and 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><strong>Order inpatient schedule (II-V) medications</strong></td>
<td>APRN</td>
<td>N</td>
</tr>
<tr>
<td>Order conscious sedation</td>
<td>APRN</td>
<td>N</td>
</tr>
<tr>
<td><strong>Order topical anesthesia</strong></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 and drainage with or without packing</td>
<td>APRN</td>
<td>N</td>
</tr>
</tbody>
</table>


**MYTH: State Regulations account for APC practice variation at CHI**
CHI Recommended Core Privileges for Advanced Practice Clinicians Approved by the National Clinical Leadership

All of these privileges are consistent with the educational preparation for APCs and are basic to effective APC practice.

• Writing admission orders
• Writing discharge orders
• Documenting daily progress notes
• Documenting discharge summaries
• Documenting history and physical
• Ordering and interpreting diagnostic testing and therapeutic modalities
• Ordering and performing referrals and consults
• Formulating a working medical diagnosis
• Ordering blood and blood products
• Prescribing non-scheduled medications (non-controlled substances)
• Prescribing scheduled medications (controlled substances, in alignment with state regulations)

Markets are encouraged to implement the privilege lists in coordination with their Medical Executive committees.
Primary Care is the Centerpiece
In Any Market

Fee-for-Service

» Increase access/expand market reach
» Enhance contracting leverage
» **Manage higher levels of clinical risk**
» Manage referrals to specialists
» Control cost

Pay for Value

» Increase access
» Coordinate care management processes
» **Manage higher levels of financial risk**
» Control cost
A New Look at Primary Care

Primary Care Model Access Points

- Community Outreach
- Emergency Department
- Multi-Specialty Clinics
- Urgent Care
- Concierge/Executive Clinics
- Retail Based Clinics, Quick Care, Pharmacy
- Virtual Care
- Corporate Clinics/Direct to Employer/Primary Care Direct
- Traditional Primary Care Clinics – Clinical/Academic
- Non-Traditional Primary Care Clinics – Priority Care/Team Based Care Clinics

Growing Population
Health System’s Investment
Role of Advanced Practitioners in Primary Care

- Prioritizes assets with payoff in both volume- and value-based payment environments

Majority of Patients are Licensure-Agnostic
“63% of consumers do not rank ‘treatment by a doctor’ as preferred primary care attribute”

Tapping Nurse Practitioners to Meet Rising Demand for Primary Care
“Studies show that NPs can manage 80-90% of care provided by primary care physicians.”
Primary Care Model

Current Model

- Physician-focused
- Volume-driven philosophy
- Physician + MA, LPN, or RN
- 0 – 1 APC
- Panel size per physician ~2,500
- Care gaps
- Traditional “business hours”
- Poor access

Proposed Model

- Patient-centered
- Value-driven philosophy
- Team-based and top-of-license
- Expanded utilization of APCs
- Panel size per team: 1,500 (APC) + 2,500 (physician) = 7,000 for 3:1 (conservative)
- Standardized, evidence-based care delivery
- Expanded hours
- Open access
# Project Phases
## Primary Care Pilots

**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 and APC 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
## New APLC Subgroups

### Value (Quality + Finance)

**FOCUS: Data to drive APC practice**
- MACRA
- Productivity/ Clinical Outcomes*
- Satisfaction Data: APC and other Stakeholders
- LOM scorecard
- Core Measures

### Professional Practice

**FOCUS: Professional Development and Engagement**
- Compensation guidelines*
- Focused Provider Performance Evaluation/On-going Provider Performance Evaluation (FPPE/OPPE)*
- Advocacy of APC Practice
- Peer Review
- Mentorship/Professional Growth

### Strategy

**FOCUS: Enterprise-wide initiatives**
- Models of care delivery*
- Facility by laws
- Billing and Reimbursement
- APC Committee/Councils
- APC involvement in market level governance structures
- State/ Federal Legislative work
- Communication (e-notes, APLC updates, etc.)

### Operations

**FOCUS: Logistical utilization of APCs in the practice site**
- Specialty Privileging*
- Onboarding & Orientation*
- APC Recruitment & Retention
  - Alignment of APC role and Job function
- Job Descriptions
- Managed Care/panels establishment
- Professional liability

---

* = Denotes a subcommittee role.
Team-Based Care
Defined for CHI

Definition: A provision of evidence-based health services for consumers led by at least two health professionals who work collaboratively with patients and their caregivers to accomplish shared goals within and across care settings to achieve care that is efficient, effective, and patient-centered.

Team Members
- Interdisciplinary Providers
  - Physician
  - Advanced Practice Clinician
  - Other providers (examples)
    - Pharmacist
    - Psychologist
    - Optometrists
    - Behavior health
- Patient /Consumer
- Other caregivers (family)
- Support team members

Core Principles, Characteristics and Behaviors
- Professional Collaboration
  - Inter/Intra professional
  - Relationship-focused
    - “Partners” vs “Assistants”
- Top of license
  - Education, licensure/certification, expertise, skill
- Shared goals and aligned incentives
- Effective communication
- Measurable processes and outcomes (Equitable QA standards)
- Shared accountability
- Patient focused
- Trust
Team-Based Care Model Redesign

- Fargo Division
- Clinic Operations Manual/Playbook

“An operations manual is the single most valuable tool for optimal practice profitability, productivity, and risk mitigation”
The Goal

• Create additional capacity by developing a collaborative practice model that merges the skills and talents of the current physicians and NPs while planning for growth and improving efficiency and effectiveness
Why CHI St. Alexius Health Williston

• Shortage/Declining numbers of internal medicine physicians
  • Maximum of 5 potential recruits before 2020
  • 13 are needed now to meet population needs

• Growing numbers of patients in the community

• NP/PA already in the market and well received

• Internal medicine physicians and NP are interested in creating a new model

• Supportive hospital leadership
Why is it growing? Oil

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Population 2000</th>
<th>Change 2000-2010</th>
<th>Projected Change 2010-2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Williston</td>
<td>12,512</td>
<td>17.6%</td>
<td><strong>123.3%</strong></td>
</tr>
</tbody>
</table>
Internal Medicine Need and Supply
Williston Service Area 2010 to 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Internal Medicine Need</th>
<th>Internal Medicine Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>8.84</td>
<td>5.5</td>
</tr>
<tr>
<td>2015</td>
<td>10.31</td>
<td>4.5</td>
</tr>
<tr>
<td>2017</td>
<td>17.2</td>
<td>2</td>
</tr>
</tbody>
</table>
Barriers

- Leadership
- Project management
- Physician and APC agreement
- Capacity to see more patients
- Fee for service
- Many competing priorities
Methodology
Lean Workout Model

• Workout results
  • Identified:
    • Pilot team structure
    • Executive oversight committee
      • Infrastructure: Logistics how
      • Clinical practice area: People how
      • Evaluation: Is it working?
      • Billing/compensation/rules/regs
    • Local project owner: VP of Provider Operations
    • Local project manager
Executive Oversight Committee

Benjamin W. Chaska
Division CMO

Marvin Smoot
VP of Provider Operations
and Project Owner

Mary Helland
Division CNO

Michelle Edwards
System Vice President,
Advanced Practice

Tara Neff
Local Project Manager
Infrastructure
Logistics How

How many patients will be served?

Do we have the space?

What are the immediate priorities?
• **Conclusion:** More capacity needed.
  • **Step 1:** Recruited another NP. October 2016.
  • **Step 2:** Plan for future.
    Train NPs at local college. First available in 1 year.
Collaborative Practice
Will It Work?

- Organizational willingness
  - National → division → local
  - Physicians, APCs and staff
- Local
  - Supportive IM, NP and practice administration
  - Already share patients
  - Collocated and beginning to integrate practices
- Ongoing work to define how team-based care model will work
  - Learn from others (Omaha)
  - Learn from each other (Co-locate)
  - Learn from the team (RN, care navigator, referral coordinator, etc.)
Compensation
Group Incentives

Current
Individual contracts.
Production based with individual quality incentive.

Future
Group incentive for quality, volume, patient satisfaction.
Evaluation

Is It Working?

• Local Performance Measures:
  • Financial results
  • Quality
  • Access to care
  • Patient satisfaction
  • Physician, APC and staff satisfaction
    • HealthStream™ PCA scores

• Data Entry Tabs
• Scores
  • Meaningful Use Score
  • PQRS Score
  • CGCAHPS
• Hearing Aides (Ness)
• wRVU's
• Visits
• Percent Booked
• Actual Patient Time
• Days in Clinic
• PTO Days
• CHI Meeting Hours
• Surgery
• 5 Key Metrics
  • Clinic DOS-DOCE
  • Other DOS-DOCE
  • % Unreconciled
  • Pre-bill Rejects
  • Total Denials
  • Pass-Through Rate
• CME Tracking
• Provider Index
Where We Are Now

- Current production has been quantified
- Baseline and ongoing CGCAHPS
- Physicians and APC agreement
- Recruited new APC: October 2016
- Physical co-location in current space
- Care team modeling
- Care manual
- Operations manual
Vision for the Future

The Dream

• Collaborative practice model
• Top of the license work
• MACRA readiness
• New facility designed to facilitate collaborative practice and value based care
National APC Workforce Trends

Sullivan, Cotter and Associates, Inc.

Presented by:
Trish Anen
Essential Role of APCs in Value-Based Health Care
Demand for APCs

Tapping Nurse Practitioners to Meet Rising Demand for Primary Care

• Studies show that NPs can manage 80-90% of care provided by primary care physicians


• Number 2: Nurse Practitioner
• Number 3: Physician Assistant
• Number 6: CRNA
• Number 17: Physician

Nurse Practitioner Demand Eclipses Doctors As States Lift Hurdles

• Only family physicians, psychiatrists and internists are more in demand than nurse practitioners.
• The Merritt Hawkins annual analysis of the U.S. health care workforce showed nurse practitioners are in the top five most requested searches.

Given **rapid employment growth** and **high vacancy rates**, compensation strategies are changing rapidly.

- **High expectations** of new graduates
- **Equity issues** with experienced staff

### APC Vacancy and Turnover

**Average vacancy rates**

- 2014: 7.7%
- 2015: 9.3%
- 2016: 9.3%

**Average turnover rates**

- **External**: 10%
- **Internal**: 4%

**Source:** SullivanCotter 2014-2016 Advanced Practice Clinician Compensation and Pay Practices Survey Report
APC Total Cash Compensation

2016 Median TCC by Specialty Group

Use of Incentive Compensation

42% of organizations report utilizing incentive pay for at least some of their APCs.

32% of incentive programs contain a team-based component.

Average maximum incentive opportunity is approximately 9% of base pay.

74% are structured as add-on dollars; 14% are structured as at-risk.


Copyright © 2017 by Sullivan, Cotter and Associates, Inc.
65% of organizations have a designated APC Leader. Of these, 47% have a dyad reporting structure.


Copyright © 2017 by Sullivan, Cotter and Associates, Inc.
APC Involvement

55% of medical groups/faculty practices have an APC representative on the Governing Committee

36% of acute care organizations have an APC representative on the Medical Staff Credentialing Committee

46% of acute care organizations have an APC Committee

76% have a voting right

59% have a voting right

77% are involved in the credentialing of APCs


Copyright © 2017 by Sullivan, Cotter and Associates, Inc.
How can optimizing all providers (physicians and APCs) help achieve organizational goals?

- Increase **access**
- Improve **quality** and **patient satisfaction**
- **Reduce cost** of care
- Manage at-risk **populations**
- Increase **provider productivity** and satisfaction
Hidden Barriers

- **Perceived** regulatory requirement
- **Outdated** bylaws requirement
- **RVU** credit
- Additional **15% reimbursement**
- **Historical** practice
# APC Utilization and Variation

One state, one health system and eight hospitals

<table>
<thead>
<tr>
<th>APC Scope</th>
<th>Health System Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write discharge orders</td>
<td>A</td>
</tr>
<tr>
<td>Write transfer orders</td>
<td>N</td>
</tr>
<tr>
<td>Obtain history and physical</td>
<td>Y</td>
</tr>
<tr>
<td>Order and interpret diagnostic testing and therapeutic modalities</td>
<td>N</td>
</tr>
<tr>
<td>Order and perform referrals and consults</td>
<td>N</td>
</tr>
<tr>
<td>Order blood and blood products</td>
<td>N</td>
</tr>
<tr>
<td>Order inpatient non-schedule medications</td>
<td>N</td>
</tr>
<tr>
<td>Order inpatient schedule (II-V) medications</td>
<td>N</td>
</tr>
<tr>
<td>Prescribes outpatient non-schedule medications</td>
<td>Y</td>
</tr>
<tr>
<td>Prescribes outpatient schedule (II-V) medications</td>
<td>Y</td>
</tr>
</tbody>
</table>

Source: 2016 The Center for Advancing Provider Practices (CAP2™), APRN Core Privileges Report
APC Perception of Utilization – A Sample

Maximum Utilization: 10%
Significant Utilization: 36%
Moderate Utilization: 48%
Minimal Utilization: 6%

Source: 2016 SullivanCotter Individual APC Survey. n=234 APCs
Outpatient Models of Care - A Sample

32% of outpatient APCs report the physician must see most or all of their patients

- All patients: 16%
- Most patients (>50%): 16%
- Few patients (<50%): 2%
- Only when asked: 49%
- None: 17%

Source: 2016 SullivanCotter Individual APC Survey. n=234 APCs

Copyright © 2017 by Sullivan, Cotter and Associates, Inc.
Outpatient Models of Care - A Sample

APCs report being involved in activities which might be completed by other team members

- Follow up to patient phone calls: 96%
- Coordination of services: 88%
- Follow up to patient lab values: 88%
- Order prescription refills: 85%
- Complete prior authorizations and forms: 69%
- Other: 15%

Source: 2016 Sullivan Cotter Individual APC Survey. n=234 APCs
## Potential Cost Per Employee Category

<table>
<thead>
<tr>
<th></th>
<th>Surgeon</th>
<th>PA</th>
<th>RN</th>
<th>X-Ray Tech</th>
<th>Scribe</th>
<th>Office Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Clinical Costs</strong></td>
<td>$546,400</td>
<td>$120,000</td>
<td>$100,000</td>
<td>$64,000</td>
<td>$51,000</td>
<td>$61,000</td>
</tr>
<tr>
<td><strong>Personnel Capacity (minutes)</strong></td>
<td>91,086</td>
<td>89,086</td>
<td>89,086</td>
<td>89,086</td>
<td>89,086</td>
<td>89,086</td>
</tr>
<tr>
<td><strong>Personnel Capacity Cost Rate $/min</strong></td>
<td>$6.00</td>
<td>$1.35</td>
<td>$1.12</td>
<td>$0.72</td>
<td>$0.57</td>
<td>$0.68</td>
</tr>
</tbody>
</table>


Copyright © 2017 by Sullivan, Cotter and Associates, Inc.
Guiding Principles

- **Define models of care** to meet patient needs and **optimize** care team
- **Involve** physicians, APCs and practice managers in **decision making** process
- **Align** physician and APC **compensation**
- Build infrastructure to **support models of care**
- Develop provider **workforce plan** including APCs
- **Educate, communicate** and **measure** continuously
Define Models of Care Based On Patient Needs

Developed APC transition clinic

Situation

- Cardiac surgery patients could not be seen by cardiologists for three weeks post discharge

Solution

- Developed transition clinic run by nurse practitioners

Outcomes

- Patient seen within two days of discharge
- Increased patient satisfaction
- Reduced readmissions

Salary

- **Cardiologist:** $442,000
- **Cardiology NP:** $110,000


Copyright © 2017 by Sullivan, Cotter and Associates, Inc.
Developed new model of care

- APCs can see **new patients**
- APCs will run special population clinics **independently** (e.g., fracture)
- APCs will **document and bill** for inpatient and outpatient activities performed
- APCs will have their **own schedules**
- **MAs will do** follow up phone calls and form completion
- **Scribes may be added** to assist with documentation
Define Models of Care Based On Patient Needs

Ensured maximum use of all providers

Situation

• Planned to hire two urologists

Solution

• Assessed and elevated the use of current PAs to manage majority of pre- and post-op visits and special population clinics

Outcomes

• Re-evaluated staffing and hired one urologist
• Projected cost savings: $425,000

Cost Savings

Two Urologists
$850,000

One Urologist
$425,000


Copyright © 2017 by Sullivan, Cotter and Associates, Inc.
Answering Your Questions