APNs/PAs at Children’s – An Overview of Advanced Practice Services

Dallas, Texas
APN/PA Professional Billing and Productivity
In 2008, CHCA conducted a review of the utilization of nurse practitioners at 4 children’s hospitals across the United States.

The goal of the review was stated as “Improving Access in the Children’s Hospital Environment by Modifying and Maximizing the Role of the Nurse Practitioner”

The participants in the study included:

– Joe Don Cavender, Children’s Medical Center Dallas
– Anne Mohan, Children’s Hospital of Philadelphia
– Shannon Fitzgerald, Seattle Children’s
– Lynn Parsons, Children’s Mercy Hospital and Clinics in Kansas City
– Antonette Silvestri, Children’s Hospital of Philadelphia

The following slides are a review of the findings from this review.
Our Process:

• Based on 2006 analysis of 10 hospitals (Pat Givens led effort), NP leaders from four CHCA hospitals conducted additional site visits in 2008 to 4 hospitals representing disparate geographic regions, disparate organizational structures and disparate use of the nurse practitioner – Dallas, Philadelphia, Seattle and Kansas City

• Executive leaders provided recommendations for standardization; clinicians provided details for maximizing the use of the NP to maximize access in selected subspecialties – ortho, ED, NICU, GI, HemOnc. (30-100 interviews per hospital)

• In the final session with NP leaders – we were able to easily identify key message and overarching principles regardless of organizational structure or state specific regulation
• If Children’s Hospitals want to solve the dual problem of increased patient demand and physician time constraints, they must have an organizational goal -

   — To have the NP practice in an autonomous, reimbursable manner, in ways that target the high-volume, low-acuity patient and provide case management for the medically complex patient.
CHCA: Care Models and the Nurse Practitioner

• **This Guideline:**
  – Drives access and throughput
  – Drives revenue and productivity
    • NP billing revenue potentially covers up to 50% of the total cost of the NPs; now at $15-20 million.
  – Drives the appropriate organizational structure
  – Enables specialty specific analysis to get the right provider in the right role
  – Better targets the orientation and credentialing process to assure quality

• **Alternatively, without this principle, children’s hospitals have:**
  – Expensive providers in nursing roles
  – Duplication of effort
  – Lack of trust in provider roles, and
  – Compliance Issues
CHCA: Care Models and the Nurse Practitioner

• **Strong designated NP leader needed**
  – An organizing influence over the delivery of care
  – Addresses system-wide issue

• **Subspecialty specific standards needed for care provision by the NP**
  – specific patient populations
  – specific allowable practices
  – billing parameters and billing support
  – productivity parameters
  – resource support

• **Training on Billing**
  – Train NPs to code and document properly and then audit performance
  – Create an awareness that billing provides professional satisfaction, clarity in roles and spurs access and therefore patient satisfaction
Some good examples; lots of variation

• How variable are CHCA hospital practices with respect to the use of the NP, the understanding of billing parameters, and the autonomy in care provision?
  
  ─ The question is not simply variability across hospitals, but also variability within an individual institution.
  
  ─ No one organization thinks they have it right.
    • Overarching organizational principles and standards are needed to move to best practices.
  
  ─ The following case studies provide examples for maximizing the use of the NP; all examples are within a subspecialty.
ED - Dallas

- NPS PROVIDE COVERAGE 7 AM TO 11 PM; 7 DAYS/WEEEK WITH EXTENDED COVERAGE ON HIGH CENSUS DAYS UNTIL 3 AM
- ONE NP TO COVER START CARE 7 DAYS PER WEEK
- AVERAGE OF 5-8 PATIENTS PER 12 HOUR SHIFT IN THE MAIN ED (LEVEL III)
- 3-12 HR DAYS PER WEEK WITH 8 HOURS OF ADMINISTRATIVE TIME EVERY 2 WEEKS
- NP ROLE: EVALUATION AND MANAGEMENT OF LEVEL 3 ED PATIENTS – THOSE PATIENTS NOT TRIAGED OUT OF THE ED GO A PRIMARY ACUTE CARE CLINIC
- NP ROLE: EXAMINATION AND MANAGEMENT, DISCHARGE PLANNING. PROCEDURES INCLUDE SPLINTING, SUTURING, LUMBAR PUNCTURE.

Personnel

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Patients</th>
<th>Billing</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 ATTENDING PHYSICIANS</td>
<td>96,621 visits (2007)</td>
<td>1 NP CREDENTIALED TO BILL INDEPENDENTLY</td>
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<tr>
<td>9 EMERGENCY MED FELLOWS</td>
<td>AVE DAILY ED: 264</td>
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<tr>
<td>MOONLIGHTERS</td>
<td>65% HOSPITAL ADMISSIONS THROUGH THE ED</td>
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<tr>
<td>9 NPS FT</td>
<td>73 BEDS</td>
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<tr>
<td>2 NPS PT</td>
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Achievements:

- 3 NPs trained for sexual assault patients, frees physician time and provides more extensive support to patients
- Database designed to track NP encounters and productivity
- Process improvement initiative: NP role in Rapid Assessment area (Start Care) to initiate treatment faster, decrease congestion and increase family satisfaction

Challenges:

- NP assuming too many new responsibilities – NPs become the safety net for multiple ED processes
- Recruiting acute care NPs and PAs – high demand, short supply
- Billing in Start Care clinic - currently no billing due to lack of process for NPs to bill professionally (lost revenue)

Recommendations:

Additional NPs credentialed to bill independently. To maximize ED patient access and throughput, the NPs must be able to bill professionally so that they can function in an autonomous role that allows them to manage patients within their scope of practice while escalating those outside their scope to Attending Physicians.

Dallas, Texas
Privileged and Confidential
GI- DALLAS

- Each NP has seven half day clinic sessions per week
- NPs see 4 to 7 patients per session
- NP sees 35% of patients
- 80% of NP practice is independent
- 55 days to 3rd next exam/appointment
- NPs focus individually on a set of patients in addition to general GI: One liver disease, one IBD, one constipation & abdominal pain

LEGACY CAMPUS
1 NP

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<tr>
<th>PERSONNEL</th>
<th>PATIENTS</th>
<th>BILLING</th>
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<tbody>
<tr>
<td>10 attending physicians</td>
<td>9,000 total pts (2008) (of which 3,100 seen by NP)</td>
<td>3 of the 4 NPs bill for professional services</td>
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<tr>
<td>6 Fellows</td>
<td>Liver transplant program</td>
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<tr>
<td>4 NPs (3 PNP; 1 FP)</td>
<td>Small bowel transplant program</td>
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<td>1 RN assigned to each NP</td>
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RECOMMENDATIONS:
The NPs ability to see patients autonomously by billing professionally for their services can have a tremendous impact on patient access and throughput.

ACHIEVEMENTS:
NP role maximized for efficiency
Access increased by having NPs see new patients for simple issues such as constipation
NPs supported in same fashion as MD by clinic RN and MAs
NPs able to bill for their professional services

CHALLENGES:
None currently identified – physicians and NPs comfortable with current arrangement
**ORTHO - DALLAS**

- 10-12 MD half day clinic sessions per week, 7-8 NP half day clinic sessions per week - run concurrently
- Average number patients per half day clinic session is 30-40
- Time to next 3rd available appointment: 3-5 days
- NPs work 3-12 hour days per week which includes inpatient rounding, overnight in-house call 3 nights per week, and 8 hours administrative time per 2 weeks
- NP Role: *outpatient* - see new patients with MDs, independently manage follow-up patient visits; *inpatient* round with MDs; *ED coverage* - provide primary coverage for any ED ortho consult with MDs available via pager for any urgent surgical needs
- NP Functions: Fracture reductions, casting, joint aspirations, management of inpatients, consultations, assist in OR, ED coverage, outpatient clinic management, research, administrative duties

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<tr>
<th>PERSONNEL</th>
<th>PATIENTS</th>
<th>BILLING</th>
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</thead>
<tbody>
<tr>
<td>11 Orthopedic surgeons (5 FT, 6 PT)</td>
<td>MD visits: 10,196 (2007)</td>
<td>No NP billing: but in process of changing</td>
</tr>
<tr>
<td>13 NPs (9 @ Dallas campus, 6 @ Legacy campus)</td>
<td>NP visits: 6,812 (2007)</td>
<td>Texas medicine rules NP can bill directly @100% of physician rate</td>
</tr>
<tr>
<td>6 PNPs, 1 acute care NP, 1 Family NP, 2 PAs</td>
<td>Cast Check: 224</td>
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**RECOMMENDATIONS:**
Ortho NPs should be able to bill professionally in order to maximize their role and function. Without the ability to see and manage patients autonomously, impact on patient access and throughput is severely hampered.

**ACHIEVEMENTS:**
Maximizing the role for NP and the RN
RN manages clinic flow, prescription refill call-ins, and all patient phone calls for the call center
NP focus on tasks that require their specialized skills and knowledge

**CHALLENGES**
Direct billing capabilities
Ability to consult
Stand alone clinics from NPs
Key Questions and Action Steps for Building the Role of the NP as an Autonomous, Reimbursable Provider.
Question #1: How can children’s hospitals get the right providers in the right roles in order to gain trust in quality?

Action: Assure quality by specifying NP roles and standard protocols by subspecialty. This includes having:
- Standardize the appropriate skill set and level of work;
- Carve out specific patient populations exclusive to NPs;
- Identify the NP’s role in clinic, perioperative, procedures, and floor;
- Physicians communicate the role of the NP to colleagues;
- Experienced NPs mentor newer NPs in the role;
- Physicians coach NPs on needed skill sets; and
- Physician and NP evaluate each other in team building, skill sets, areas of growth, areas of strength, and competency.

We also identified the tasks most often suggested as appropriate for maximizing the role and skill sets of the nurse practitioner. (Be sure to avoid the trap of NP as resident supervisor.) These include:
- Ambulatory clinic visits for specific populations;
- Pre-surgery and post-op visits;
- Procedures;
- Chemotherapy patient admissions.
Question #2: How can children’s hospitals best designate the NP role to provide more autonomous care?

Action: Eliminate professional competition and obstacles to reimbursement; and revise policies and by-laws:

- Eliminate professional competition.
  - Children’s hospitals employing both physicians and NPs find some reticence on the part of physicians when NP billing exceeds physician billing.
  - Moreover, and perhaps more importantly, physicians also worry that they will see a revenue drop with the addition of NPs.
  - If hospitals fail to address this issue, they will continue to mismatch incentives between physicians and the hospital, and between access and revenue.
  - We suggest many children’s hospitals would require less NPs if roles are structured as outlined here.
Question #2: How can children’s hospitals best designate the NP role to provide more autonomous care?

- **Eliminate obstacles to reimbursement.**
  - Many hospital administrators seem to look for reimbursement obstacles rather than appoint the appropriate personnel to raze them.
  - If an organization has not yet decided to commit to billing, nor requires NPs to apply for their own billing number, nor approaches payers to credential NPs, it loses the benefits of access and throughput, and the ability to recoup the revenue to cover at least part of the NPs’ salary.

- **Revise policies and by-laws.**
  - Strict rules demanding a physician’s presence in all types of care and treatment fail to recognize the extent to which healthcare providers have overshot the needs of most patients.
  - They also fail to solve problems engendered by current or impending issues centered on physician shortages.
Question #3: What key actions can maximize access?

**Action: Ten strategies to leverage the NP’s role to increase patient access**

1. Evaluate the NP in physician and patient satisfaction scores, to expand knowledge across the organization about appropriate roles the NP can play;
2. Never treat the NP as a resident, and make sure that physicians, residents, and fellows understand the NP role as both separate and unique, for an equally unique population of patients with skill sets in health promotion and care coordination;
3. Create a benchmark that approximately 50% or more of the organization’s NPs should see patients independently and bill under their own provider numbers;
4. Identify the allowable CPT codes for NP procedures billing under their own provider number;
5. Identify all opportunities for unique NP clinics (e.g. Saturday/evening NP clinics) to reduce patient appointment wait times and clinic visit wait times;
Question #3: What key actions can maximize access?

6. Make sure that funds-flow analyses of potential productivity drives the addition of NPs;
7. Ensure the availability of appropriate support staff to meet the required NP productivity;
8. Relieve NPs from wasting valuable patient clinic time on faxing and scheduling duties;
9. Set standard NP practice within each subspecialty, either through protocols or smaller teams, to ensure patient continuity, quality outcomes, and the development of trust in NP capabilities; and
10. Write practice standards for the NP across the specialty rather than for physician-specific use.
Question #4: Why does NP billing drive the benefit of the new care model?

**Action: Bill, Bill, Bill**

- A critical component for success, billing:
  - Provides moderate revenue for the hospital;
  - Spurs access and therefore patient satisfaction;
  - Provides the ability to track patients and outcomes by NP;
  - Satisfies the professional;
  - Provides clarity in roles;
  - Drives productivity; and
  - Drives autonomous practice
Question #5: How can children’s hospitals overcome billing obstacles, including issues centered on politics and policies?

Action: *Follow in the trend toward NP billing:*

- Consider NP billing within an overall funds-flow analysis to provide clearer opportunities for billing and reimbursement;
- Place NP professional billing revenue and NP salary expense within the professional cost center to enable ease of financial reporting to align incentives across providers;
- Develop coding audit processes and related documentation;
- Develop systems for billing professional fees; and
- Ensure managed care contracts include reimbursement for the provision of care by NPs.
Question #6: How should we approach compliance?

Action: Maximize compliance

- NPs must bill if practicing independently, and they must receive authorization to do so;
- Physicians cannot bill for services provided by the NP;
- Hospitals must train NPs to code and document properly, as well as to understand which services they can bill; and
- Hospitals must develop NP-specific billing codes based on NP privileges.
Question #7: How can children’s hospitals become more efficient?

**Action: Focus efficiency efforts on each subspecialty.**

- These should include:
  - Setting next-available-appointment wait-time goals;
  - Allocating to the NP, rather than the physician, the management of a set of patients who require quick, simple work efforts;
  - Developing work standards for a specified set of duties for the NP; and
  - Creating standards that help to evaluate MD and NP productivity.
Question #8: How should the children’s hospital evaluate satisfaction patterns with the referral process?

**Action: Communicate and re-evaluate with the referring PCP**

- To smooth the transition from primary care physician to NP, children’s hospitals need to:
  - Communicate the NP’s role to the primary care physician and emphasize the ability of the NP to navigate access to the hospital; and
  - Re-evaluate, on a regular basis, the satisfaction of primary care physicians with the NP.
Question #9: Improving the Organizational Structure—Who’s in Charge?

Action: Assign a single NP leader capable of:

- Organizing influence over the delivery of care and addressing system-wide issues;
- Providing oversight of opportunities to generate revenue;
- Coordinating hiring, job descriptions, and evaluations;
- Expanding training that addresses critical thinking, complex health systems, leadership, chaos theory, and inter-collaboration;
- Streamlining the credentialing process;
- Mentoring professional development;
- Establishing quality and productivity parameters; and
- Developing a professional provider mentality.
Children’s Medical Center Dallas
Obstacles

• Texas – “Corporate Practice of Medicine”
  – Hospitals cannot employ MDs

• BON/Medical Staff: MD oversight of NP
  – NPs do not have independent practice in Texas – must have a collaborative practice agreement with a physician
  – Medical diagnosis and prescriptive authority are delegated

• Direct Medicaid reimbursement @ 92% of MD rates (in Texas)
  – However, for private payers the negotiated fee schedules will likely be 120% of Medicare (vs. 160-200% of Medicare for UTSW NPs and MDs)
Employment Model & Compliance Concerns

• Employment model drives the billing model:
  – To bill and collect for NP/PA services, the billing entity must bear the cost of the NP/PA.

• Potential employment models include:
  – Physicians and NPs/PAs employed by one entity (medical school vs. pediatric practice group)
  – Physicians and NPs/PAs employed by hospital (not allowed in Texas)
  – Physicians employed by medical school or practice group, NPs/PAs employed by hospital (the Dallas situation)
“Lease Arrangements”

- Our initial approach
  - NPs/PAs were “leased” to the medical school for their salary and benefits
  - The NPs/PAs remained employed by CMC
  - The NPs/PAs were enrolled in Medicaid and managed care contracts as medical school providers
  - The medical school billed for and retained revenue generated by NPs/PAs
Professional Billing for NP and PA

- Our current approach:
  - We are enrolling our NPs and PAs in Medicaid and managed care payers as providers employed by CMC
  - We pay the medical school division chiefs a fee ($4500 per NP/PA – based upon FMV for this arrangement) to supervise the NP/PA (as required in Texas)
  - The professional bills will be submitted by CMC with revenue collected by CMC
  - Live on EPIC (EHR) this year – super bills will be created within the EPIC system for the provider that sees the patient (MD or NP/PA)
    - MD super bills sent to the medical school for them to bill
Obstacles

- Process of enrolling Medicare, Medicaid, and private payers
  - We only had a Medicare part A number!
- Lack of precedence within our institution
  - Professional billing new to our system
- Fee schedules likely to be less than what medical school can negotiate
- Now need to negotiate appropriate practices for NPs/PAs within CMC
  - Starting with specialties that are eager and have history (due to former lease arrangements):
    - Ortho
    - Endo
    - GI
APS Database

• In 2005 we realized that we had no mechanism for identifying or quantifying the work of NPs and PAs

  – Patients were admitted under the Attending’s name
  – QRM collected quality data and attributed that to the Attending
  – No manner for:
    • Researching quality of NP/PA work
    • Identifying productivity
    • Tracking procedures for ongoing competency/privileging
We created an electronic database (with help from IS) to track our work

- A Crystal Database embedded and accessed via our EHR.
- Brief data collection – make it easy and doable
  - Include pt. identifiers for research if needed (MR# and Encounter Date)
- Data includes:
  - Patient management (outpatient and inpatient visits)
  - Procedures performed
  - Also (though not required at this time) the following activities:
    - Research
    - Educational
    - Organizational
    - Managerial
## APS Database

### Patient Care Activity Format

<table>
<thead>
<tr>
<th>APN</th>
<th>Activity Menu</th>
<th>Patient Care Reports</th>
<th>Other Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return to APN List</td>
<td>Activity Menu</td>
<td>Patient Care Reports</td>
<td>Other Reports</td>
</tr>
<tr>
<td>Last: CAVENDER, RN, CPNP</td>
<td>First: JOE DON</td>
<td>Specialty: CCBD-ONCOLOGY</td>
<td></td>
</tr>
</tbody>
</table>

### Patient Care Activity

- **Pat Id:** 524636
- **Type of Activity:** Outpatient Visit
- **Outpatient Visit Type:** Established
- **Patient Outcome:** Management as Documented
- **Date of Service:** 08/14/2009
- **Time Spent:** 45
APS Database

Procedure Activity Format

Patient Care Activity

- Pat Id: 439892
- Type of Activity: Procedure
  - Procedure Type: Lumbar Puncture with IT chemo
    - Independent Completion
    - Observation
  - Provider Action: Completed with Assistance
- Success?: Yes
- Complication Description:
- Date of Service: 07/24/2009
- Time Spent: 15
APS Database

Education Activity Format

APN

Return to APN List    Activity Menu    Patient Care Reports    Other Reports

Last: CAVENDER, RN, CPNP    First: JOE DON    Specialty: CCBD-ONCOLOGY

Education Activity

Role: -- select role --

Audience: -- select audience --

Location: -- select location --

Activity: -- select activity --

Title:

Contact Hours/CME:

Hours Spent: [ ] Minutes Spent: [ ]

Date: 06/27/2009
Quarterly Time Studies

• Implemented in 2006 as we embarked upon billing professional fees for APNs and PAs
• Utilized to remove the cost of APNs’ and PAs’ time spent in direct patient care from the Medicaid cost report
  – Performed quarterly
  – All employed APNs and PAs must complete a time study each quarter
# Quarterly Time Study

**APN/PA Activity Record - Week 1**

<table>
<thead>
<tr>
<th>Please insert your name here.</th>
<th>Please insert the name of your specialty.</th>
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</thead>
<tbody>
<tr>
<td>Work day start time:</td>
<td>Work day end time:</td>
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<tr>
<td>Non-work day (PTO, regular day off)</td>
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</tbody>
</table>

**Date:** 19-Jul-2009 20-Jul-2009 21-Jul-2009  
**Day:** Sunday Monday Tuesday

## Direct Clinical Care/Consultation

<table>
<thead>
<tr>
<th>Activity</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient clinic visits (H&amp;P, Dx., Plan and documentation (either dictated or written clinic note))</td>
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<tr>
<td>Consults (H&amp;P, diagnosis, &amp; plan for specific problem)</td>
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<tr>
<td>Procedures (i.e. L.P., chest tube removal/insertion, drain removal/insertion, sutures, I&amp;D, etc.)</td>
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<tr>
<td>First Assist activities in the OR</td>
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## Other Direct Patient Care

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<tr>
<th>Activity</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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</thead>
<tbody>
<tr>
<td>Inpatient care - Direct Management in a Resident type role for patients admitted with a medical diagnosis (i.e. not part of a global surgery fee) (Interim Hx, Daily PE, Daily progress note, orders, presentation in rounds)</td>
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<tr>
<td>Postoperative Inpatient care - Direct Management in a Resident type role for patients admitted after a surgical procedure (i.e. Likely part of a global surgery fee) (Interim Hx, Daily PE, Daily progress note, orders, presentation in rounds)</td>
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<tr>
<td>Preoperative H&amp;P</td>
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<tr>
<td>Correspondence (creation, review, or edit of dictations/letters/summaries)</td>
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<tr>
<td>Writing/preparing admission &amp; discharge orders in advance of admission</td>
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<tr>
<td>Writing/preparing clinic visit orders (such as lab orders, scan orders, drug orders)</td>
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## Indirect Patient Care

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| Direct Clinical Care/Consultation | 0 | 0 | 0 | 0 |
| Other Direct Patient Care | 0 | 0 | 0 | 0 |