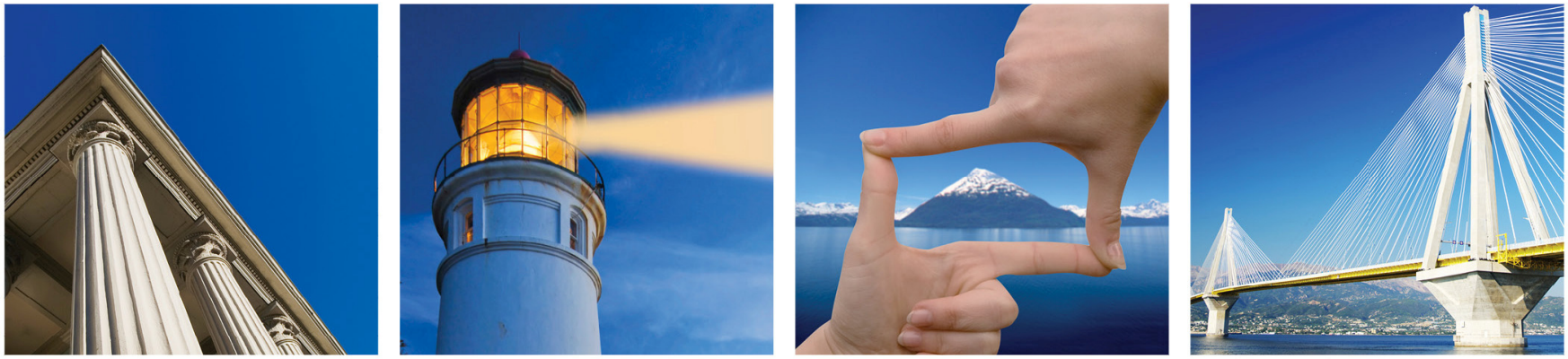

Leading Practices and National Benchmarks in Advanced Practice Clinician (APC)

Privileging, Competency Assessment and Leadership Structures

Presented to:

National Credentialing Forum – March 2, 2017

Trish Anen, RN, MBA, NEA-BC

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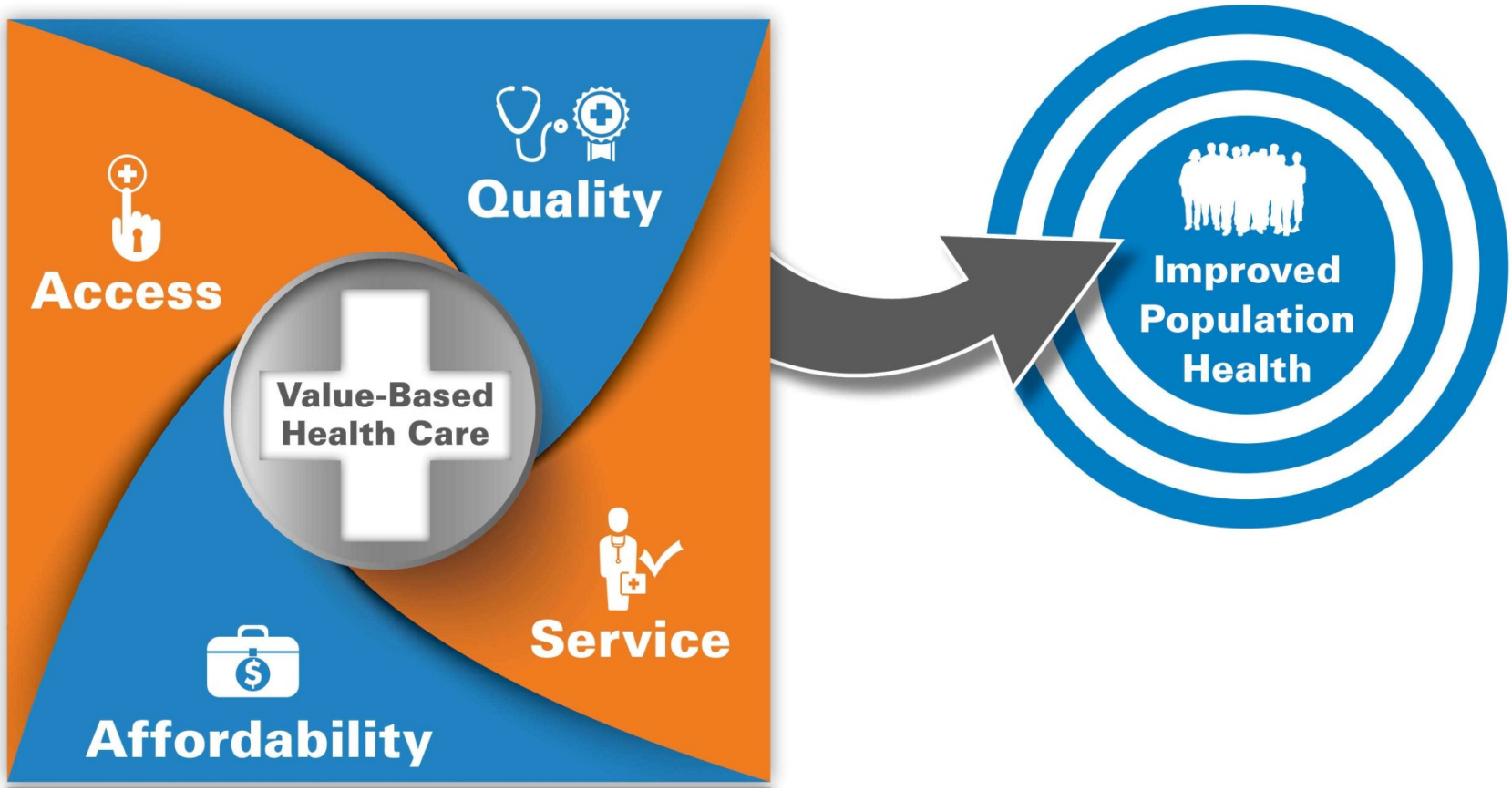
INTEGRITY INDEPENDENCE INSIGHT INFORMATION

Essential Role of APCs in Value-Based Health Care



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APC Roles and Practice Models

1. **Team-Based Care Model**
   APC works with a team of primary care providers to manage a shared panel of patients

2. **Individual Practice Model**
   APC manages and treats their own panel of patients

3. **Niche-Based Practice Model**
   APC gains expertise in one or multiple chronic disease states and works with other providers to manage the specific population

4. **Specialty-Based Model**
   APC develops expertise in a certain specialty and works with specialist physicians

5. **Continuum of Care Model**
   APC manages patient populations beyond acute and ambulatory through home, skilled nursing and telemedicine visits

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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*

U.S. News and World Report: Top 25 Jobs of 2017

- *Number 2: Nurse Practitioner*
- *Number 3: Physician Assistant*
- *Number 6: CRNA*
- Number 17: Physician

PwC Top 10 2015 Health Care Industry Issues

- Issue 8 – *Scope of practice expands:* In 2015, states will lead the way in allowing nurses, nurse practitioners, physician assistants and pharmacists to do more

Sources: Van Vleet, Amanda and Julie Paradise. "Tapping Nurse Practitioners to Meet Rising Demand for Primary Care." The Henry J. Kaiser Family Foundation. 20 January 2015.; "Top health industry issues of 2015: Outlines of a market emerge." PwC health Research Institute. http://kff.org/medicaid/issue-brief/tapping-nurse-practitioners-to-meet-rising-demand-for-primary-care/. Retrieved 10 January 2017.; "The 100 Best Jobs." US News and World Report. 2017. http://money.usnews.com/careers/best-jobs/rankings/the-100-best-jobs. Retrieved 12 January 2017.

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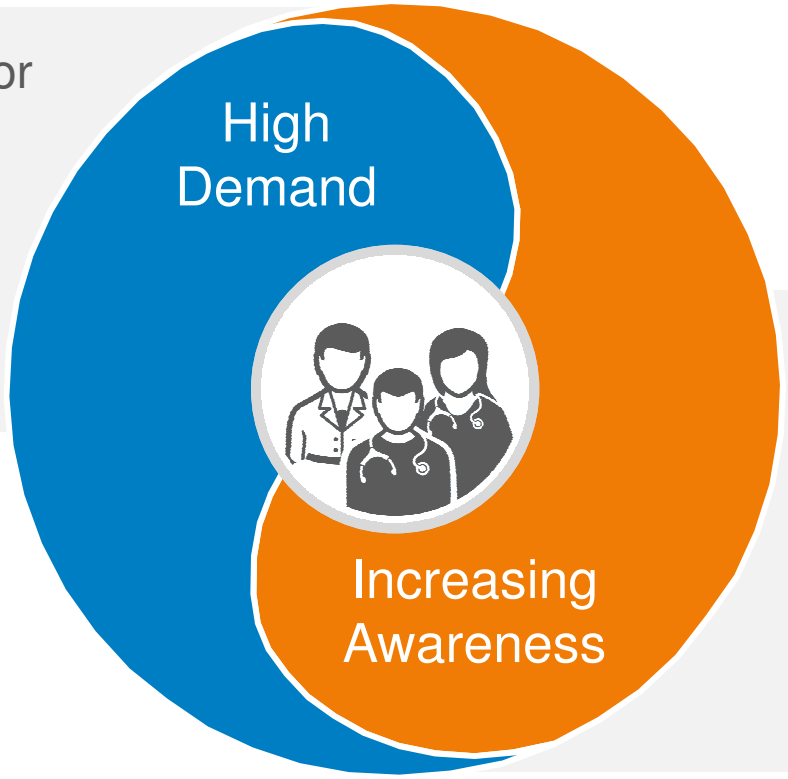
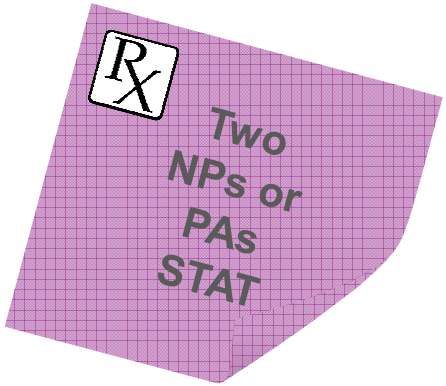
Work Environment and Scope of Practice

Increased hiring activity and higher starting pay rates with mixed results

- Increased demand for health care services
- Desired efficiencies and cost savings
- Physician shortages





- Inconsistent models of care
- Underutilization and limited scope of practice
- Lack of alignment

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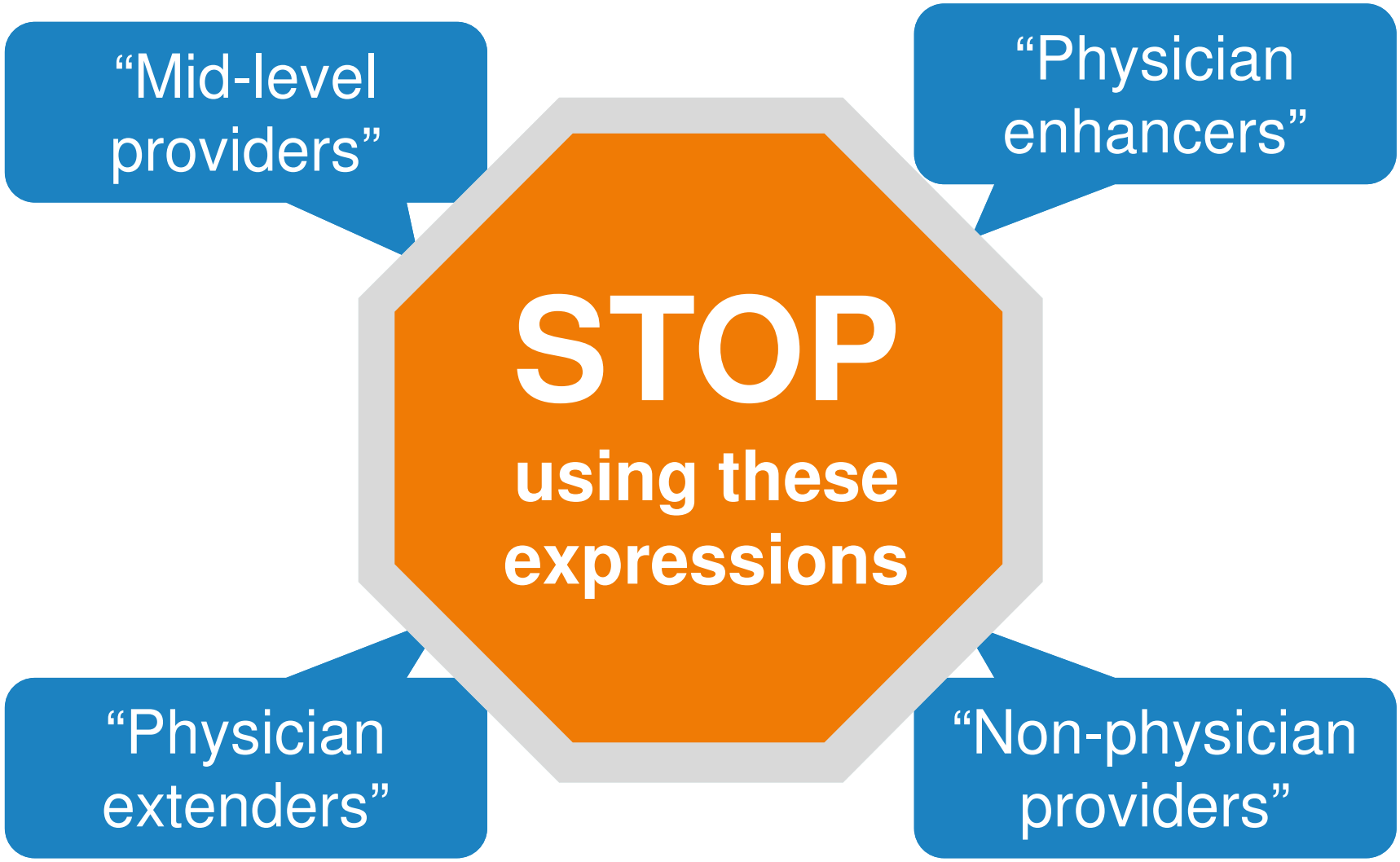
APC Nomenclature



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National APC Practice Data

- **300** organizations
  - Acute and ambulatory
  - Hospitals; health care systems
  - Academic medical centers → critical access
- Represents **25,000** APCs in **32** different states
- Includes privileges, competency assessment, orientation and leadership structure data

Center for Advancing Provider Practices (CAP2™)

Inventory

APCs are used in virtually all clinical practice areas

Clinical Practice Areas	CAP2™ Database (n=231) % of Hospitals		Clinical Practice Areas	CAP2™ Database (n=231) % of Hospitals	
	APRNs	PAs		APRNs	PAs
Allergy/Immunology	14%	6%	Neurosurgery	43%	40%
Anesthesia	79%	13%	Nurse Midwives	39%	N/A
Bariatric Surgery	16%	10%	Obstetrics and Gynecology/Women's Health	51%	20%
Breast Health	18%	4%	Occupational Health	22%	6%
Burns	11%	8%	Ophthalmology	5%	4%
Cardiology	61%	42%	Orthopedics	46%	65%
Cardiovascular Surgery	42%	41%	Otolaryngology	21%	27%
Colon/Rectal Surgery	13%	14%	Pain Management (acute or chronic)	30%	15%
Dermatology	12%	17%	Palliative Care	43%	7%
Education	17%	5%	Pediatrics (general)	39%	12%
Electrophysiology	8%	3%	Physical Medicine and Rehabilitation	19%	14%
Emergency Medicine	61%	61%	Plastic and Reconstructive Surgery	26%	28%
Endocrinology	33%	11%	Prostate	5%	2%
Family Medicine	52%	34%	Psychiatry	38%	14%
Gastroenterology/Endoscopy/Hepatology	43%	29%	Pulmonary	41%	16%
Genetics, Birth Defects and Metabolism	7%	1%	Radiology (general, nuclear, interventional)	25%	27%
Geriatrics	23%	6%	Renal/Nephrology	29%	15%
Hematology/Oncology/Bone Marrow	46%	28%	Rheumatology	14%	6%
Infectious Disease	31%	21%	Surgery (general)	49%	43%
Inflammatory Bowel Disease	7%	3%	Transplant (surgery)	17%	13%
Intensive Care	44%	22%	Transport	3%	1%
Internal Medicine	64%	45%	Urogynecology	11%	8%
Neonatal	36%	5%	Urology	39%	36%
Neurology	42%	28%	Vascular Surgery	22%	17%
			Wound/Ostomy	24%	3%

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Source: 2016 The Center for Advancing Provider Practices (CAP2™), *Practitioners by Specialty Report*

Core Privileges

APRN Core Privilege List	CAP2™ Database (n=229)	Health System Sample (n=8)							
	% of Hospitals	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	Hospital F	Hospital G	Hospital H
Write discharge orders	68%	N	Y	Y	N	Y	Y	N	N
Write transfer orders	62%	N	Y	Y	N	N	Y	N	N
Obtain history and physical	83%	Y	Y	Y	N	Y	Y	N	N
Order and interpret diagnostic testing and therapeutic modalities	82%	N	Y	Y	N	Y	N	Y	N
Order and perform referrals and consults	74%	N	Y	N	N	N	Y	Y	N
Order blood and blood products	68%	N	Y	Y	N	N	N	N	N
Order inpatient non-schedule medications	74%	N	Y	Y	N	Y	N	Y	N
Order inpatient schedule (II-V) medications	54%	N	Y	N	N	Y	N	N	N
Prescribes outpatient non-schedule medications	71%	Y	Y	Y	N	N	N	Y	N
Prescribes outpatient schedule (II-V) medications	62%	Y	Y	N	N	N	N	N	N

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Source: 2016 The Center for Advancing Provider Practices (CAP2™), *APRN Core Privileges Report*

Achieve Optimization

APRN Core Privilege List	CAP2™ Database (n=229)	Health System Sample (n=8)							
	% of Hospitals	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	Hospital F	Hospital G	Hospital H
Write discharge orders	68%	Y	Y	Y	Y	Y	Y	Y	Y
Write transfer orders	62%	Y	Y	Y	Y	Y	Y	Y	Y
Obtain history and physical	83%	Y	Y	Y	Y	Y	Y	Y	Y
Order and interpret diagnostic testing and therapeutic modalities	82%	Y	Y	Y	Y	Y	Y	Y	Y
Order and perform referrals and consults	74%	Y	Y	Y	Y	Y	Y	Y	Y
Order blood and blood products	68%	Y	Y	Y	Y	Y	Y	Y	Y
Order inpatient non-schedule medications	74%	Y	Y	Y	Y	Y	Y	Y	Y
Order inpatient schedule (II-V) medications	54%	Y	Y	Y	Y	Y	Y	Y	Y
Prescribes outpatient non-schedule medications	71%	Y	Y	Y	Y	Y	Y	Y	Y
Prescribes outpatient schedule (II-V) medications	62%	Y	Y	Y	Y	Y	Y	Y	Y

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Source: 2016 The Center for Advancing Provider Practices (CAP2™), *APRN Core Privileges Report*

Specialty Privileges

PA Orthopedic Privileges	CAP2™ Database (n=151)	Hospital Sample (n=1)
	% of Hospitals	Yes/No
Digital block, regional anesthesia and isolated peripheral nerve anesthesia evaluation and management	37%	Y
Fractures and dislocations closed reductions	60%	Y
Injections of joints, tendons and bursa	62%	Y
Joint and bursa aspirations	50%	N
Minor outpatient surgical procedures (i.e. tendon repair, needle biopsy, percutaneous pinning of fractures, k wire removal, hardware removal)	30%	N
OR First Assist	70%	N
Order, prescribe and dispense braces and other orthopedic devices	55%	N
Traction adjustment	46%	N
Wound packing	70%	Y
Wound closure/suturing	58%	Y

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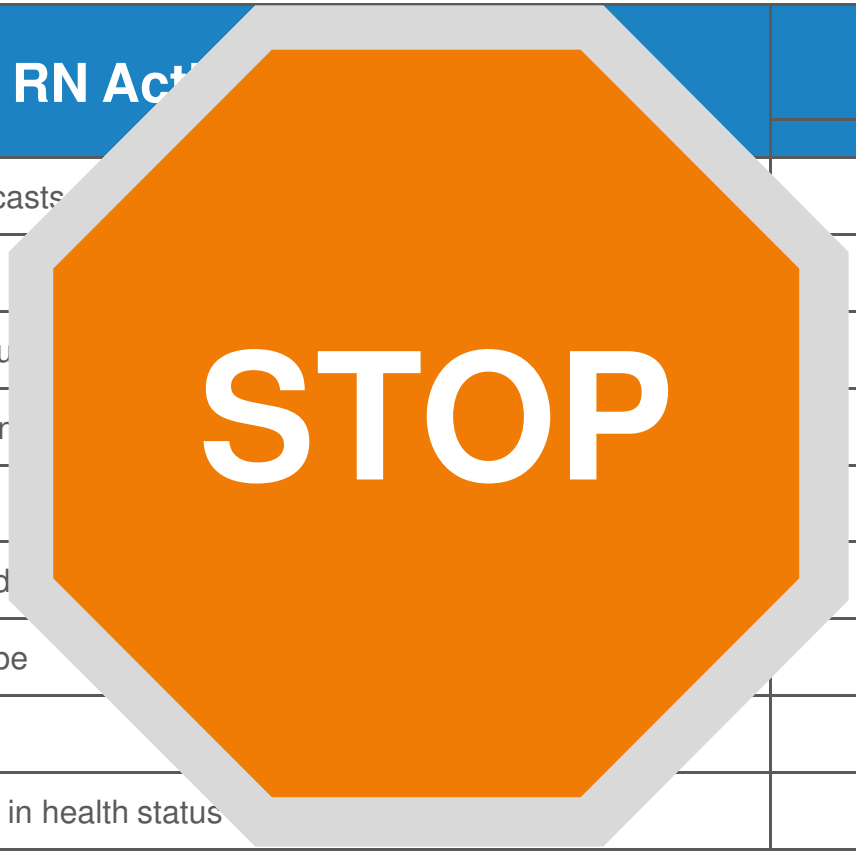
Source: 2016 The Center for Advancing Provider Practices (CAP2™), *PA Specialty Privileges Report*

What Needs a Privilege?

Would a physician ever ask for these?

RN Act	CAP2™ Database (n=230)
	% of Hospitals
Application and removal of casts	39%
Clinical breast exam	18%
Compression wrap for venou	11%
Conduct nursing research ar	16%
Drain management	33%
Performs waived tests (rapid	19%
Removal of pleural chest tube	28%
Removal of venous access	21%
Update and record changes in health status	33%



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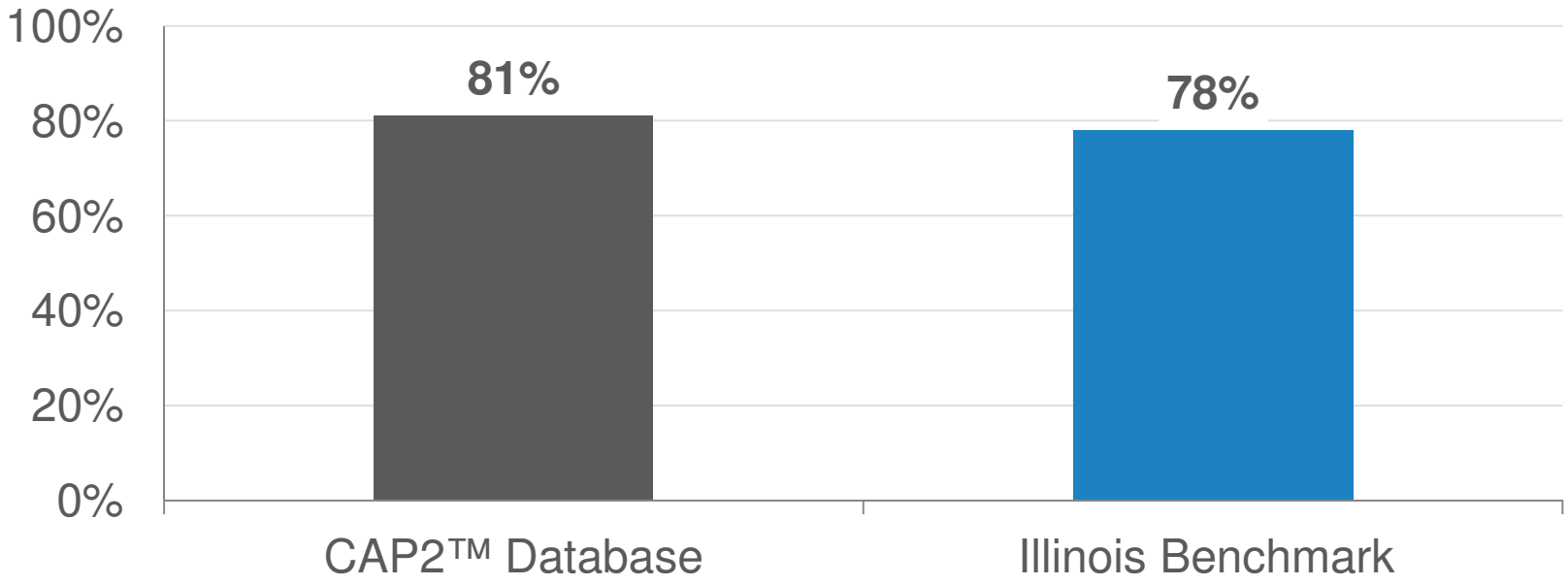
Source: 2016 The Center for Advancing Provider Practices (CAP2™), *RN Activities Report*

APC Competency Assessment Process

81% of participants report having the same competency assessment process for APCs and physicians

This is a Joint Commission requirement



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Source: 2016 The Center for Advancing Provider Practices (CAP2™), *Acute Care Organization Report*

Advanced Practice Committee

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Source: 2016 The Center for Advancing Provider Practices (CAP2™), *Acute Care Organization Report*

APC on Medical Staff Credentialing Committee

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

59% have a voting right

Provide expertise in questions about federal and state laws and regulations and also has understanding of academic programs, training and certifications

Conduct initial review of APC applicants, privileges requests and provide physician with insight and recommendations

Work closely with medical staff office to streamline and increase efficiency of APC privileging process

Follow up on medical staff concerns and regulatory interpretations

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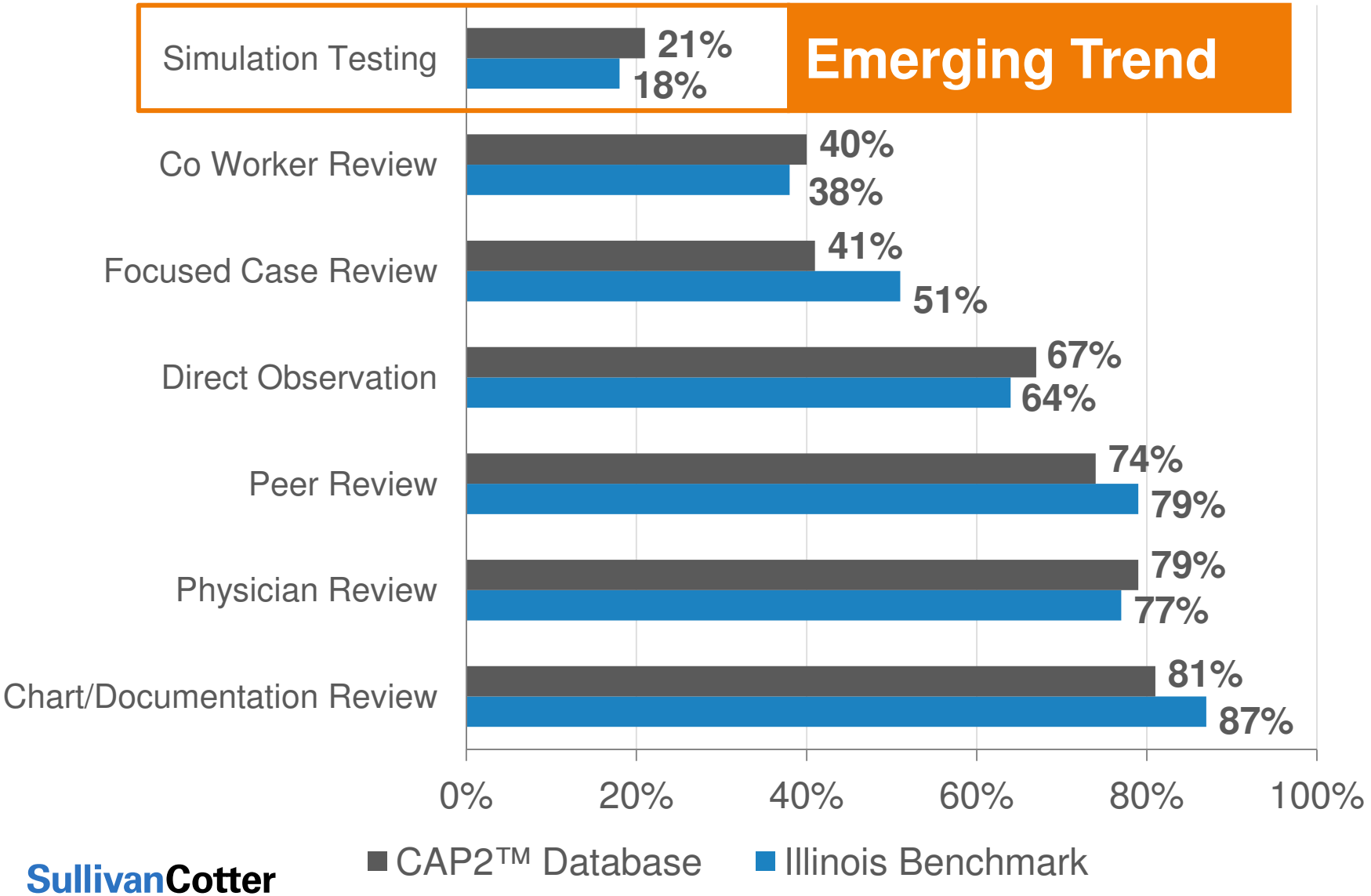
Source: 2016 The Center for Advancing Provider Practices (CAP2™), *Acute Care Organization Report*

APC Competency Assessment Approaches



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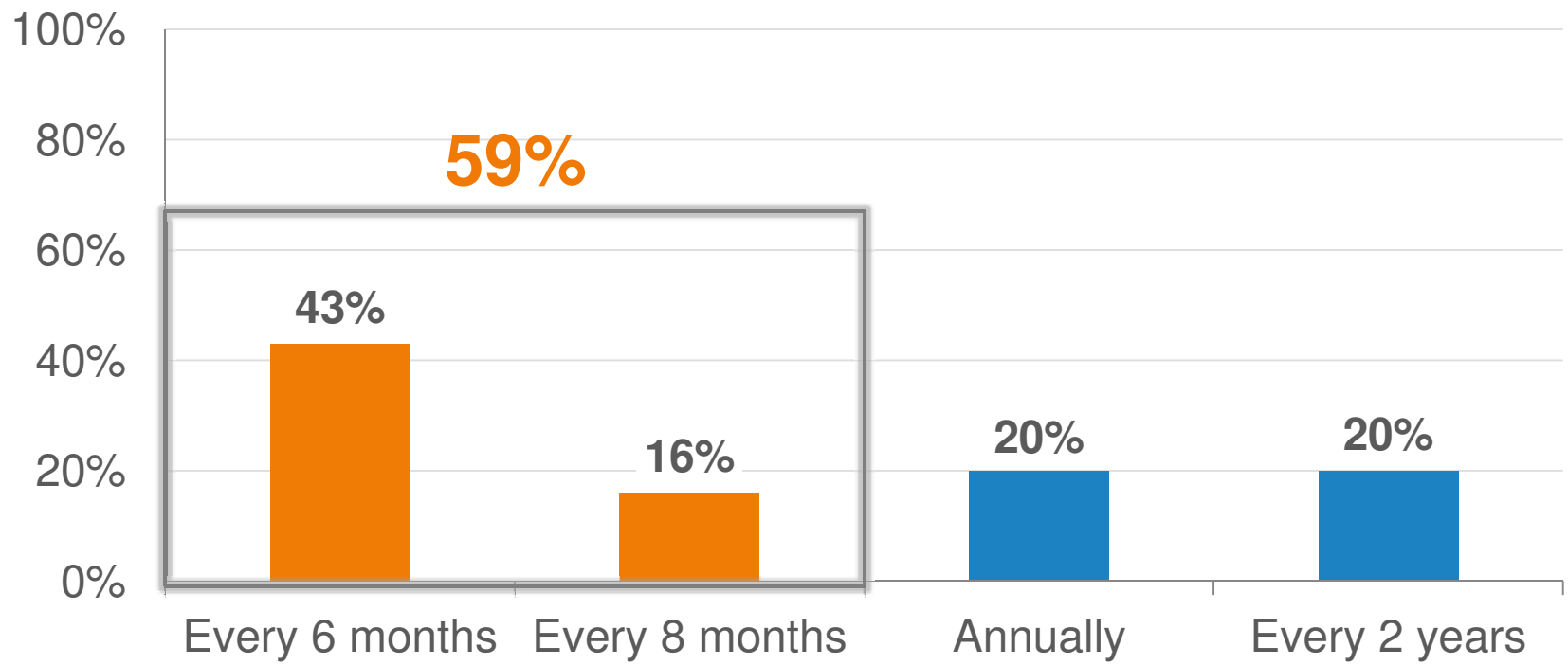
Source: 2016 The Center for Advancing Provider Practices (CAP2™), *Acute Care Organization Report*

APC Competency Assessment Frequency

59% are in compliance



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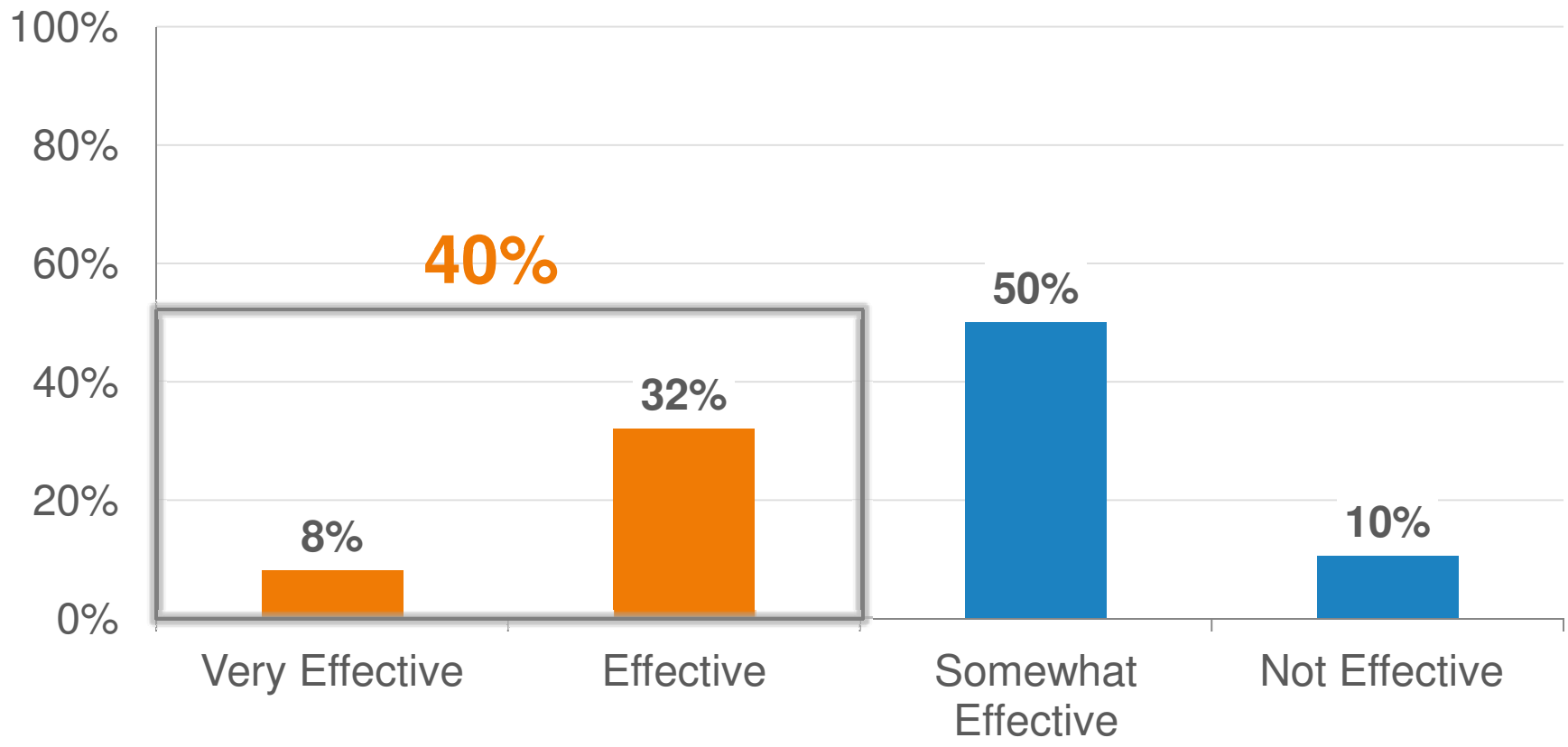
Source: 2016 The Center for Advancing Provider Practices (CAP2™), *Acute Care Organization Report*

APC Competency Assessment Effectiveness

Only 40% perceive this process to be effective or very effective



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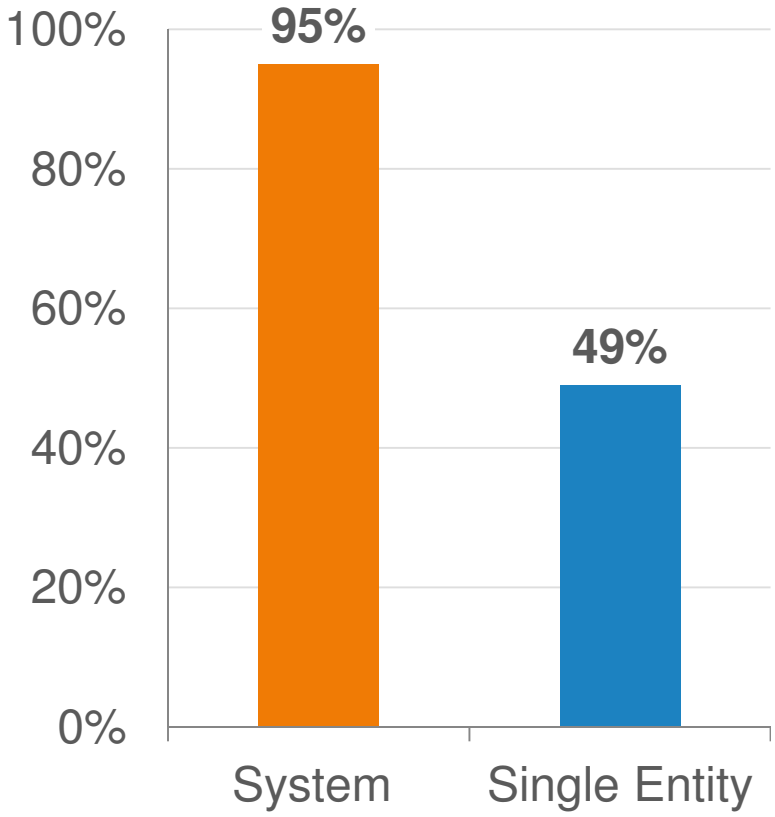
Source: 2016 The Center for Advancing Provider Practices (CAP2™), *Acute Care Organization Report*

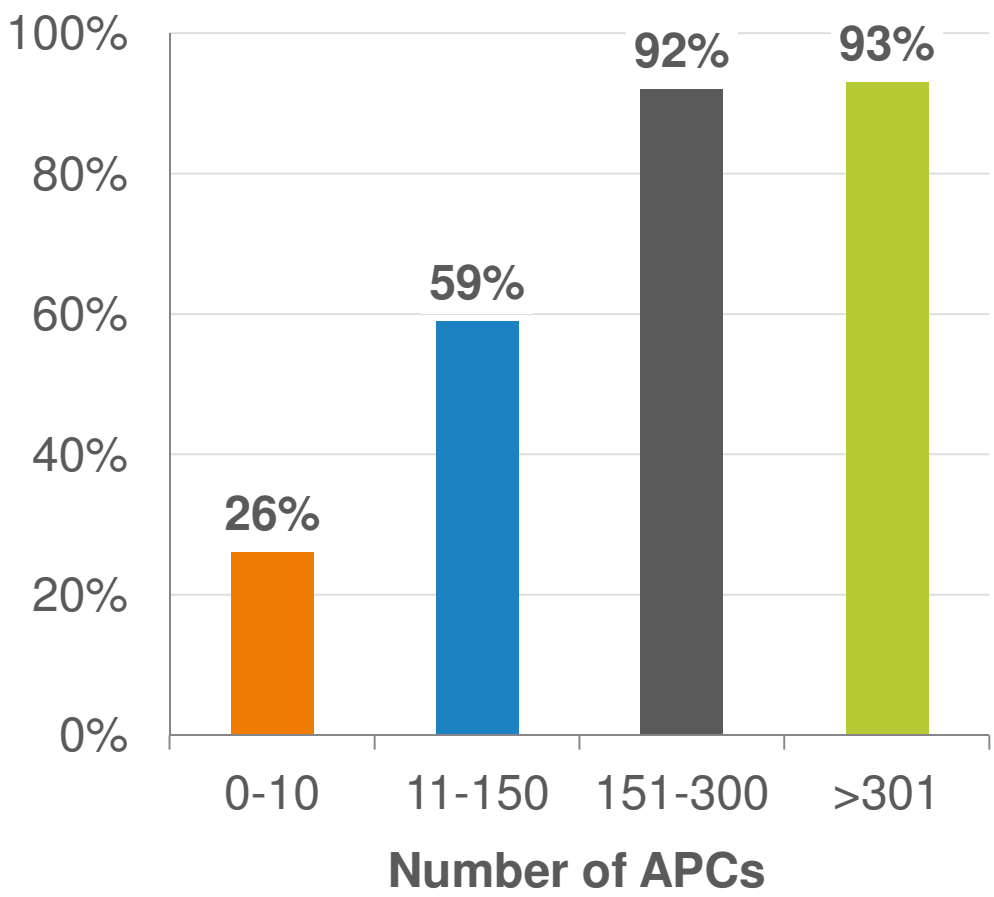
APC Competency Assessment Observations

- **Less resources** are dedicated to support APC competency assessment
- Organizations question which providers **can assess APC competency**
  - A competent, privileged provider can assess another provider for the same privileges
- APC data is **difficult to extract** due to incident-to and shared split

Designated APC Leader

63% of organizations have a designated APC Leader





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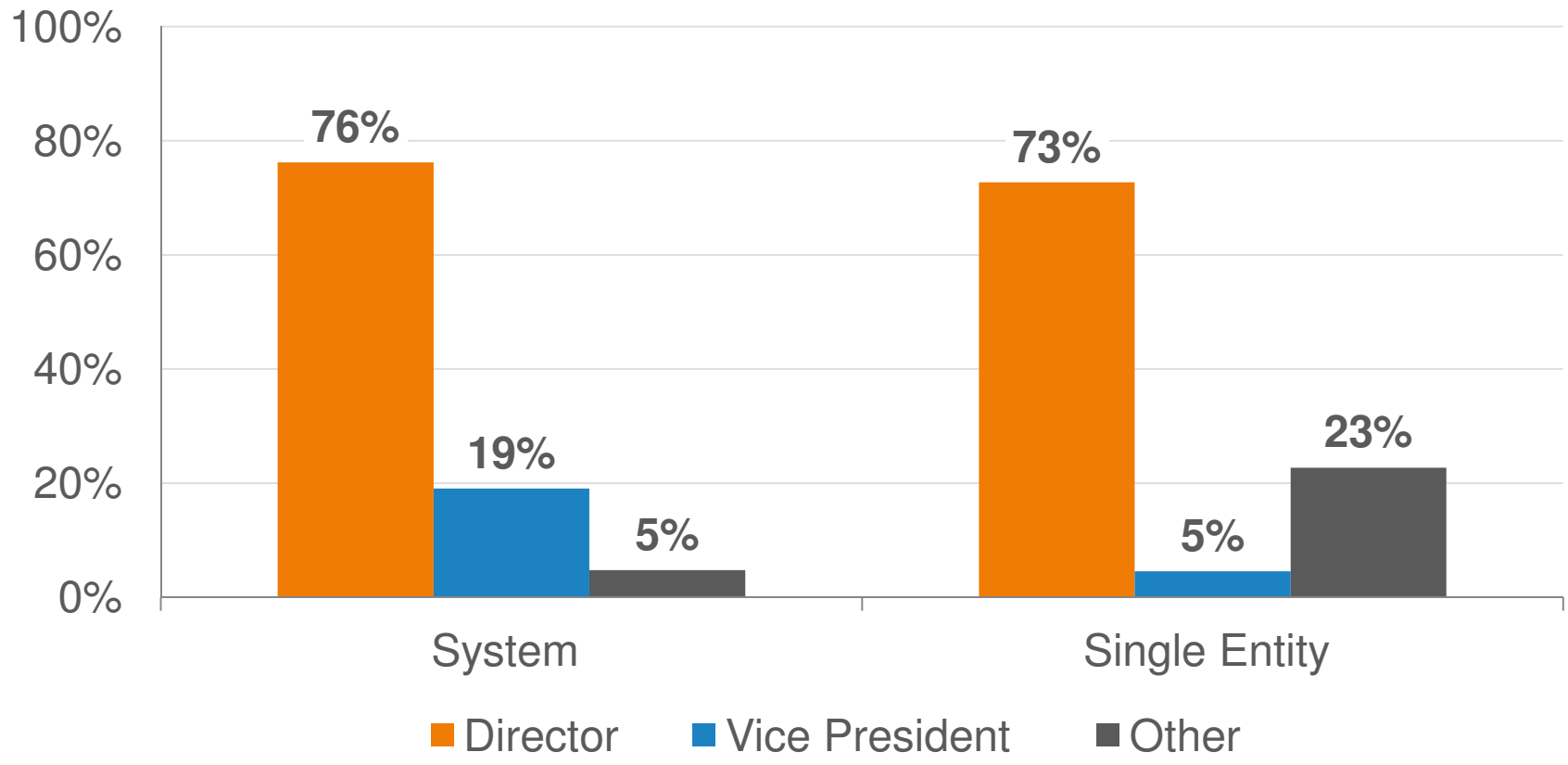
Source: 2016 The Center for Advancing Provider Practices (CAP2™), *Leadership Structure Report*

Designated APC Leader Title

Majority of APC leaders have a Director title



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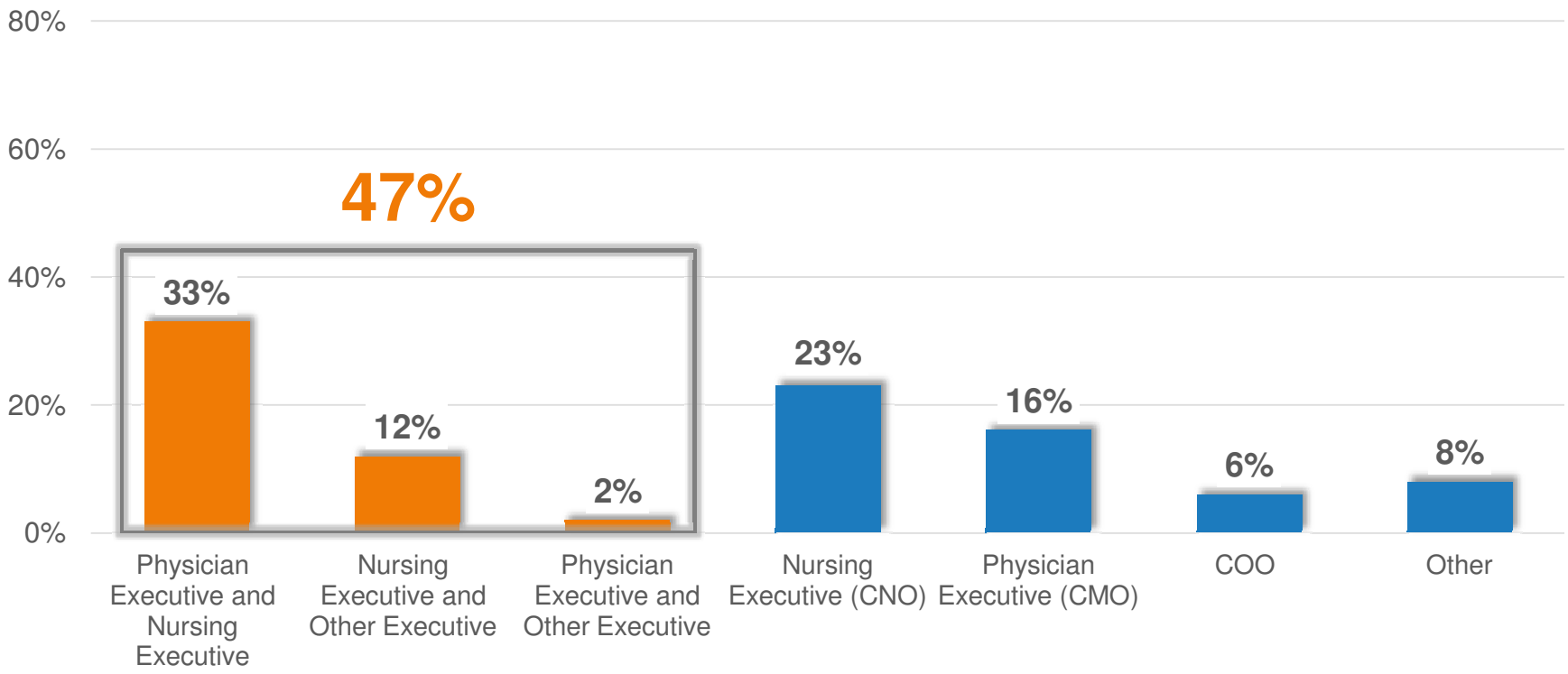
Source: 2016 The Center for Advancing Provider Practices (CAP2™), *Leadership Structure Report*

Designated APC Leader Reporting Structure

47% of designated APC leaders have a dyad reporting structure



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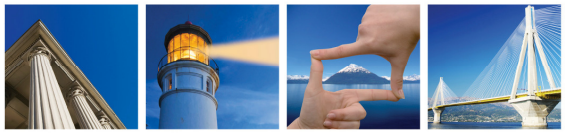
Source: 2016 The Center for Advancing Provider Practices (CAP2™), *Leadership Structure Report*



Comprehensive Care Redesign

Case Study

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Organizational Goals

- Review current use of APCs
- Design and implement a program to optimize all providers (physicians and APCs)

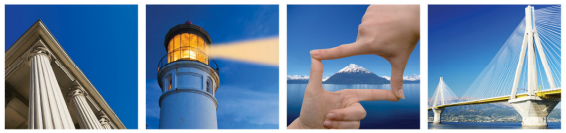
Deliverables

Models of Care

Regulatory and Compliance

Human Resources

Structure



Assessment

Core Privileges

Data showed APCs are granted the majority of core privileges

Core Privileges	APRNs		PAs
	CAP2™ Database (n=229)	Organization (n=1)	
	% of Hospitals	Yes/No	Yes/No
Write admission orders	61%	Y	Y
Write discharge orders	68%	Y	Y
Write transfer orders	62%	Y	Y
Obtain history and physical	83%	Y	Y
Order and interpret diagnostic testing and therapeutic modalities	82%	Y	Y
Order and perform referrals and consults	74%	Y	Y
Order blood and blood products	68%	Y	Y
Order inpatient non-schedule medications	74%	Y	Y
Order inpatient schedule (II-V) medications	54%	Y	Y
Order conscious sedation	53%	N	N
Order topical anesthesia	66%	Y	Y
Prescribes outpatient non-schedule medications	71%	Y	Y
Prescribes outpatient schedule (II-V) medications	62%	Y	Y
Incision and drainage with or without packing	59%	Y	Y

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Source: 2016 The Center for Advancing Provider Practices (CAP2™), *APRN Core Privileges Report*

Specialty Privileges

Emergency Medicine Specialty Privileges	APRNs		
	CAP2™ Database (n=138)	Children's Hospital Sample (n=1)	Organization (n=1)
	% of Hospitals	Yes/No	Yes/No
Anterior nasal cautery	44%	Y	N
Anterior nasal pack epistaxis	62%	Y	N
Arterial line insertion and removal	28%	Y	N
Arterial puncture	42%	Y	N
Athrocentesis	34%	N	N
Central line insertion and removal	29%	N	N
Digital block	50%	Y	Y
Foreign object removal (eyelid)	56%	Y	Y
G, j, small bowel and cecostomy tubes insertion/removal	28%	Y	N
Gynecological exams, including Pap smears	62%	Y	N
Immobilization/splinting/reduction of simple fractures	70%	Y	N
Intraosseous needle insertion	42%	Y	N
Joint Aspitation	47%	Y	N
Local anesthesia infiltration	62%	Y	N
Lumbar puncture	44%	Y	Y
Nasal and endotracheal intubation	36%	N	N
Needle decompression of the chest	22%	Y	N
Ocular tonometry	40%	Y	N
Slit lamp examination	51%	Y	N
Subungal hematoma	39%	Y	Y
Superficial foreign bodies removal	64%	Y	Y
Surgical drains insertion and removal	36%	Y	N
Thoracentesis	24%	Y	N
Trephination and removal of nail	49%	Y	Y
Wound closure/suturing	77%	Y	Y

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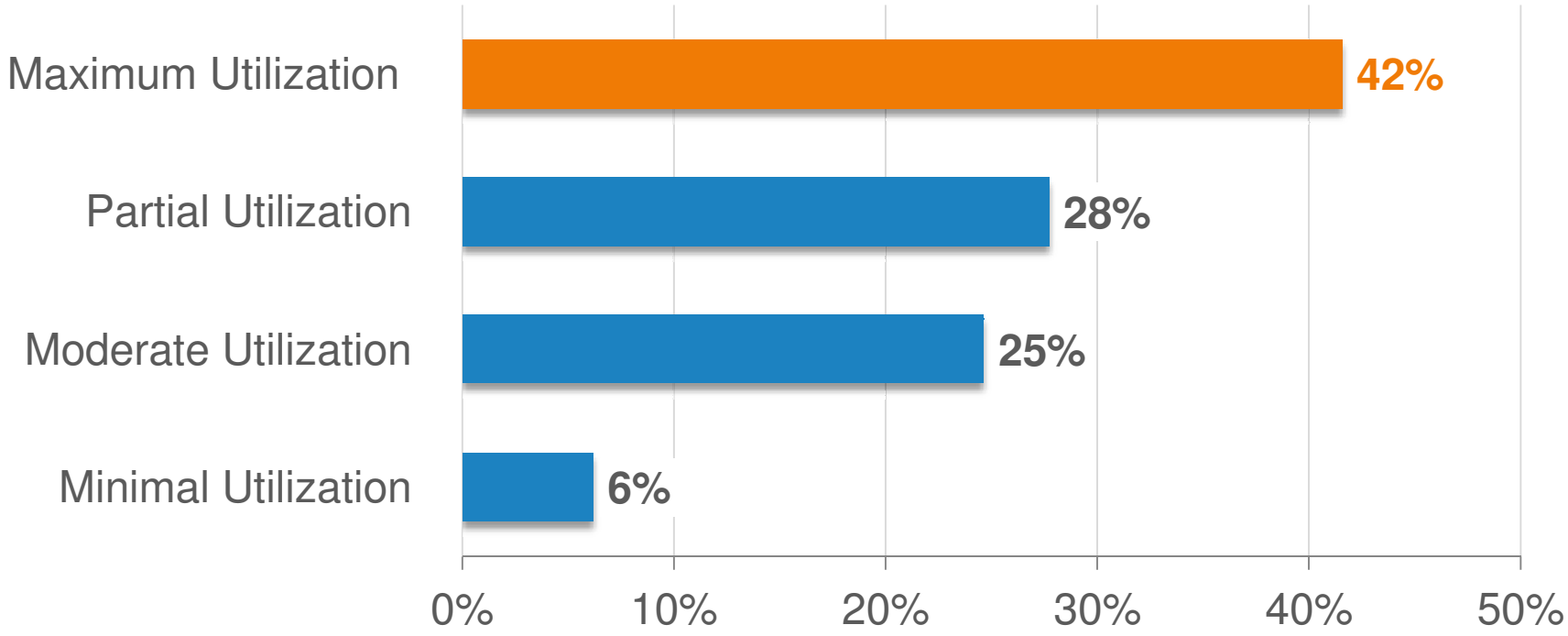
Source: 2016 The Center for Advancing Provider Practices (CAP2™), *APRN Specialty Privileges Report*

APC Utilization

Only 42% of APCs felt they were being utilized to their maximum capacity



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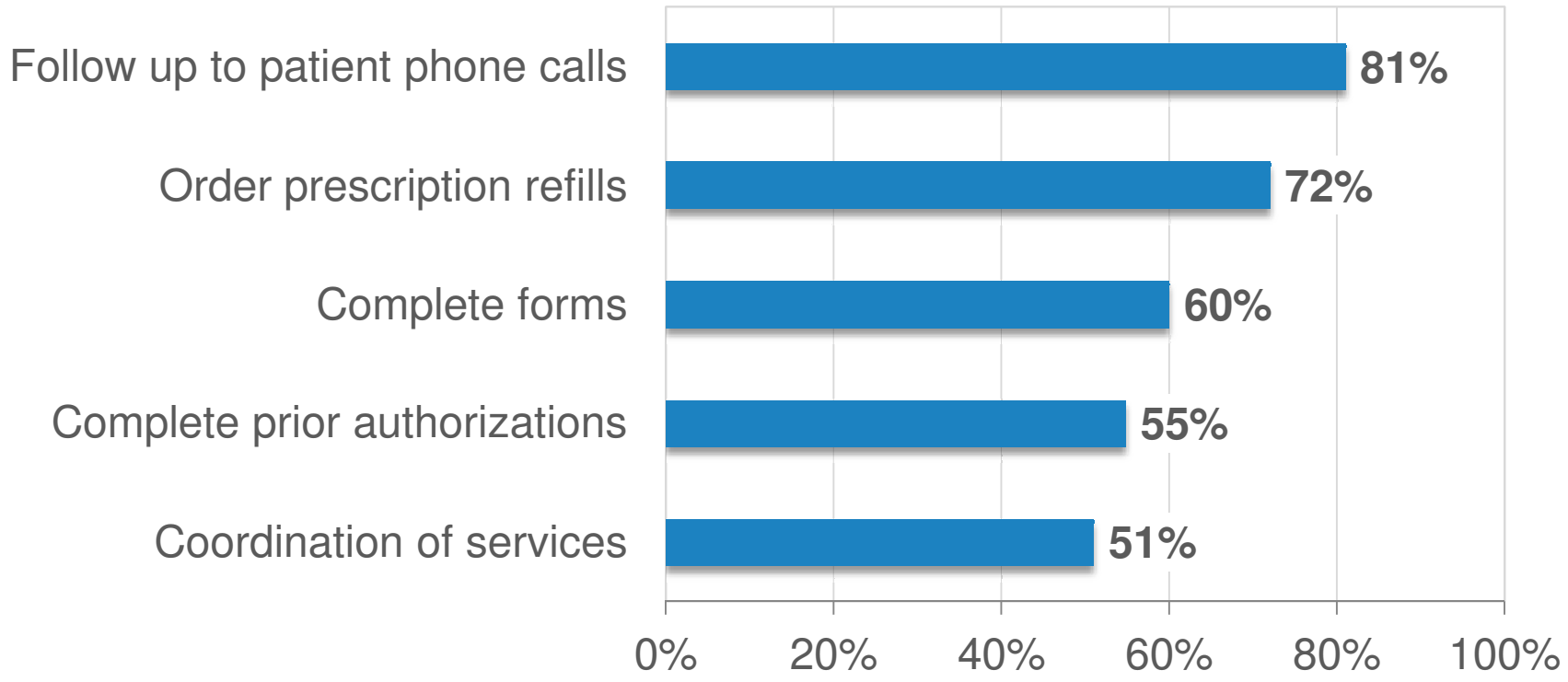
Source: 2016 SullivanCotter *Individual APC Survey*.

Outpatient Models of Care

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



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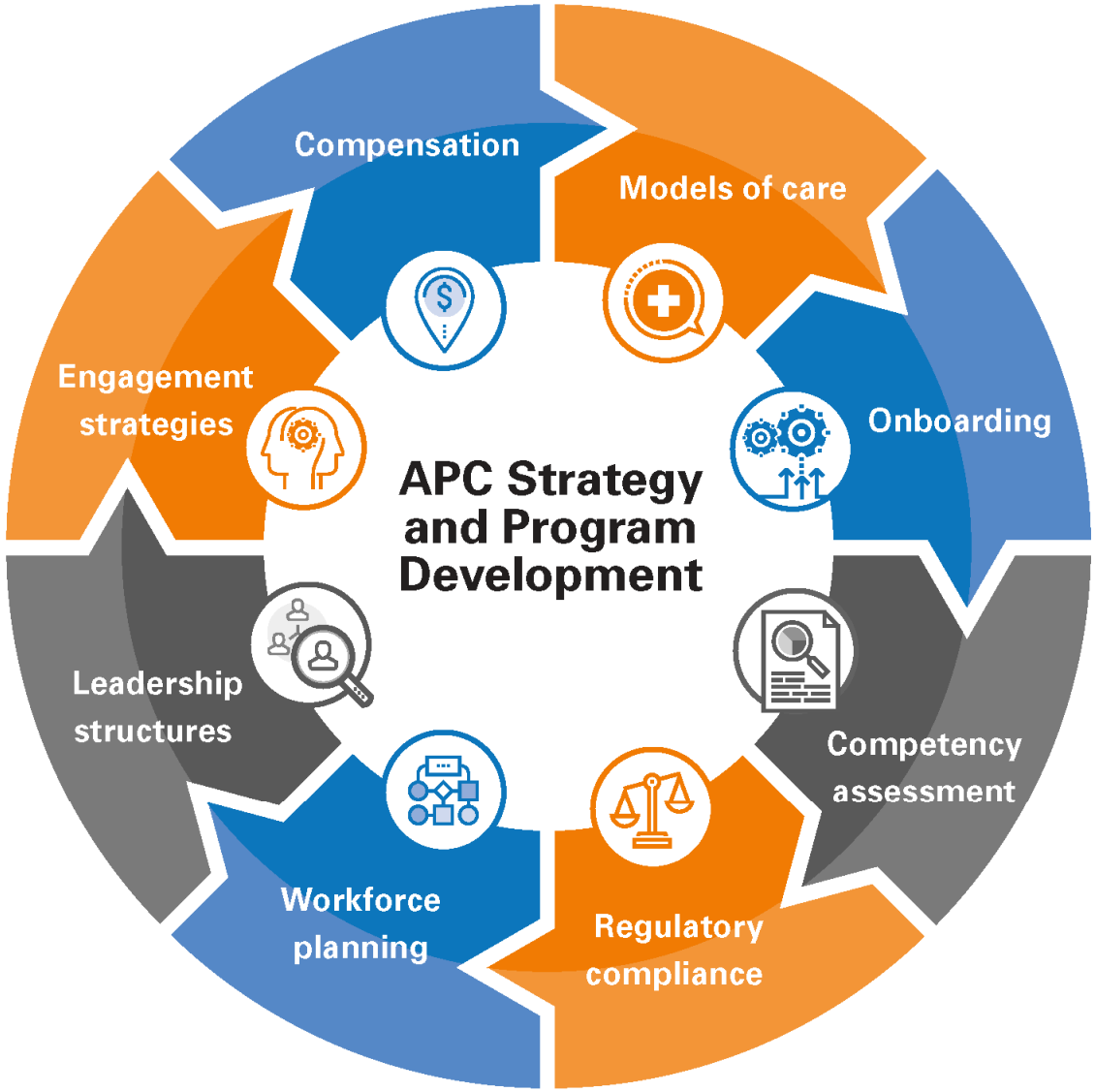
Source: 2016 SullivanCotter *Individual APC Survey*.

APC Program



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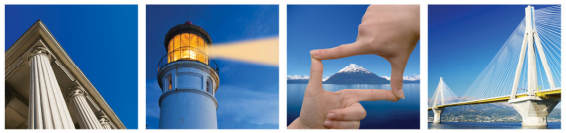


Sample APC Program Outcomes

Emergency Services/Urgent Care Model of Care

- APCs will see ESI Level III, IV and V independently and Level I and II with physicians
- Increase delineation of privileges for Emergency Services APCs
- APCs can staff Urgent Care independently
- RNs will take responsibility for patient call backs

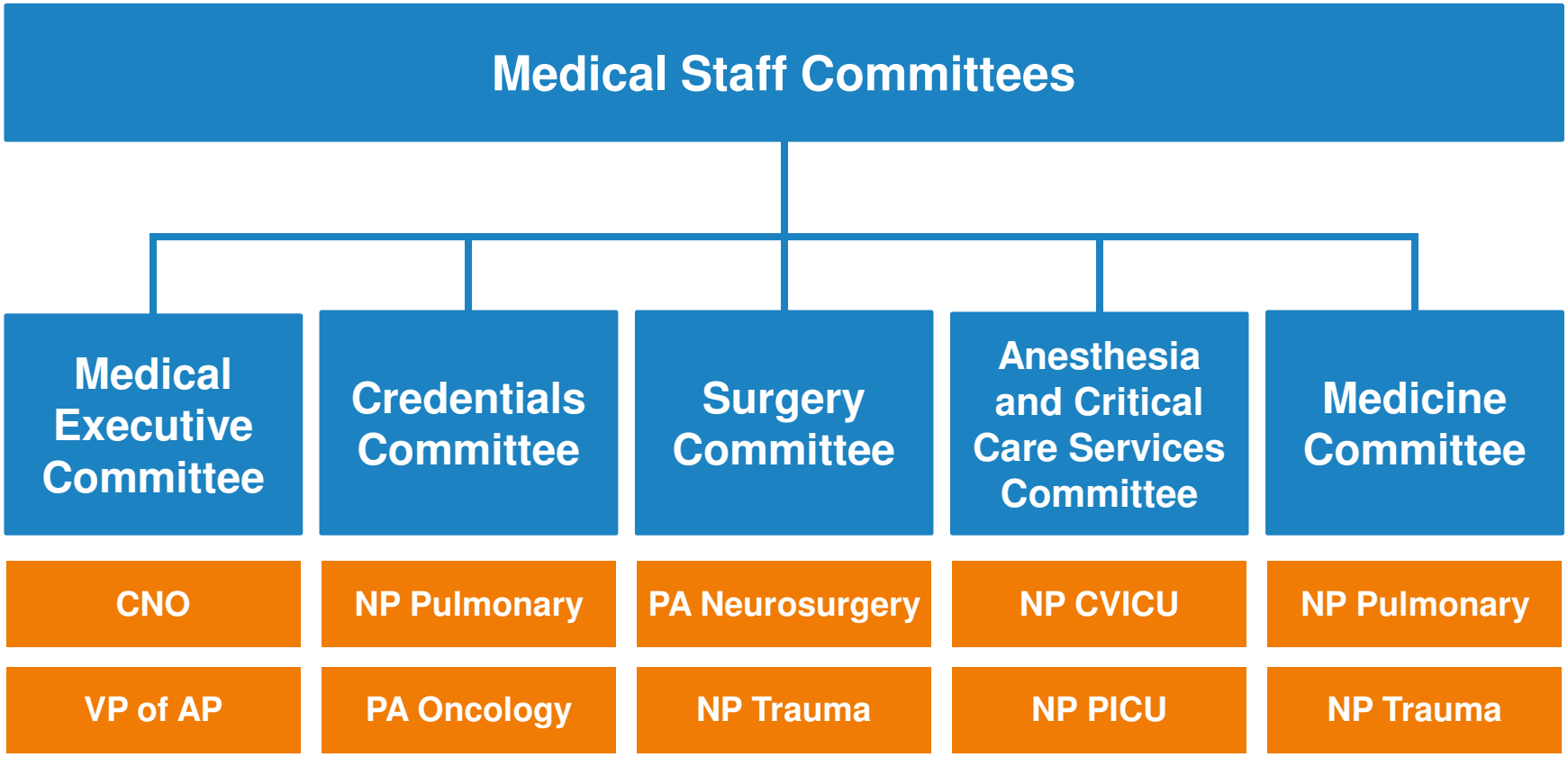
Delineation of Privileges – Before and After

APC Emergency Medicine Privileges	Initial Privileges	Expanded Privileges
	Yes/No	Yes/No
Local anesthesia and digital block	Y	Y
Foreign body removal (soft tissue or superficial body cavity)	Y	Y
G tubes insertion and removal	Y	Y
Lumbar puncture	Y	Y
Trephination and removal of nail	Y	Y
Wound closure/suturing	Y	Y
Radial head subluxation reduction	Y	Y
Anterior nasal cautery	N	Y
Anterior nasal pack epistaxis	N	Y
Arterial puncture	N	Y
Gynecological exams	N	Y
Immobilization/splinting/reduction of simple fractures	N	Y
Intraosseous needle insertion	N	Y
Joint aspiration	N	Y
Moderate/procedural sedation	N	Y
Non-complex burn care	Y	Y
Ocular tonometry	N	Y
Regional block	N	Y
Slit lamp examination	N	Y
Stain eye for abrasion	N	Y
Subungal hematoma	Y	Y

Orthopedics Model of Care

- APCs can run special population clinics independently (e.g., fracture)
- MAs will do follow up phone calls, appointment scheduling and form completion
- Assess possibility of adding scribes to teams
- APCs will document and bill for inpatient and outpatient activities performed

APC Representation on Medical Staff Committees



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The Future State

A comprehensive provider team strategy that:

- Supports organization's mission
- Aligns with organizational and business strategies
- Positions organization as the premier employer for APCs
- Encourages ongoing innovation and transformation in population health management

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Answering Your Questions

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Trish Anen

Principal and APC Workforce Practice Co-Leader

Trish Anen is a Principal and the APC Workforce Practice Co-Leader. With over 30 years of combined clinical, executive and consulting experience, Trish has a deep understanding of the evolving health care marketplace and helps organizations implement enhanced models of care and optimize provider team performance.

As hospital and health systems nationwide aim to improve quality, manage population health and lower the cost of care, the demand for advanced practice clinicians (APC) continues to grow. Leveraging her operational expertise, Trish works closely with clients to advance their provider practices and integrate APCs into the care delivery system. She also has an extensive background in APC workforce management and developing strategies to optimize, align and engage the entire provider team.

Her experience includes:

- Developing comprehensive and custom approaches to transforming team-based models of care across multiple practice environments.
- Optimizing provider team efficiency and maximizing productivity through the increased utilization of APCs.
- Conducting assessments to improve the structure of APC programs, including compensation, scope of practice, models of care, clinical operations and leadership practices.
- Improving physician assistant and nurse practitioner recruitment and retention strategies and promoting positive practice environments.
- Developing assessment tools, benchmarking reports and other advisory resources to support the management of the APC workforce.

Trish was previously with the Illinois Health and Hospital Association (IHA), where she was the Vice President of Advisory Services. She also co-founded The Center for Advancing Provider Practices (CAP2™) during her time spent as the Chief Clinical Officer at the Metropolitan Chicago Healthcare Council (MCHC). Prior to this, Trish served as both the Chief Nursing Officer and Chief Operating Officer at Edward Hospital and as the Vice President of Human Resources at Rush Copy Medical Center.

Trish is a registered nurse and holds an NEA-BC. She also has an MBA from Northwestern University in Evanston, IL and is a fellow of the University of Pennsylvania, Wharton School of Business Nurse Executive program.