Meet the Family
Identity Crisis
New Identity
• 10 primary care providers in 2012
• 1 non-affiliated clinic and multiple specialists
• 88 providers on Medical Staff
• 18,000 people in primary service area
• Federally qualified shortage area
Disruptive Change
2013

The Challenges

- Lost six MDs in 2.5 years
- Suspended OB services
- Recruiting difficulties
- Decreasing market share
Number of MDs: Patient Days

10 Year History

- Total Acute Care Inpatient Days
- Hospitalists

Rusk County Memorial Hospital
Feeling like the UNDERDOG?
Be the Top Dog, Not the Big Dog.
Today’s Objectives

• Adapting an APNP program to meet your hospital’s needs
• Understanding the impact of an APNP model and implementation considerations
• Identifying metrics for success: clinical, financial and satisfaction
• Identifying practice, policy, education and payment opportunities for improvement
Identify Areas Of
INNOVATION
Evolutionary Change

THE “QUADFECTA”

- Opened own clinic (PBRHC)
- Hired own ED physician group
- Launched APNP Hospitalist Program
- Remodeled facilities for patient-centered care
PLANNING PROCESS

Stage 1 – PROVIDER BASED RURAL HEALTH CLINIC

- Creative Development
- Evaluation
- Execution
- Service Line Prioritization
PLANNING PROCESS

Stage 2 – ED CONTRACT

- Information Review
- Internal Interviews
- Market Analysis
- Competitive Analysis
PLANNING PROCESS

Stage 3 – HOSPITALIST PROGRAM

- Insight & Hypotheses
- Primary Research
- Brand Development
- ROI
PLANNING PROCESS

Stage 4 – FRESH EYES

- Evidence-based design
- Objectives
- Strategies
- Tactics
APNP Hospital Medicine Program
Report on the Future of Nursing
by RWJF and Institute of Medicine

- 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?

• Hospitalist: Newest medical specialty field
  ▪ First cited in a *New England Journal of Medicine article in 1996 with 100 hospitalists

• +70% of hospitals have hospitalist programs
  ▪ Primary care shortage causing CAHs to use APNPs

• Primary focus: Improve the quality of care

Improve Physician Recruiting

• 77% of rural counties in US have primary care shortages

• Rural recruiting challenge* is “less time away from work”
  ▪ On Call requirements

Triple Aim

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

Exploration of Models

• Ministry–Eagle River Memorial Hospital
  ▪ 2 APNPs 12 hour shifts
  ▪ DHS waiver telemedicine model
    ▪ WI Administrative Code DHS 124.04(3)(a)
    ▪ Nurse practitioner hospital pilot program

• Aspirus–Medford
  ▪ 24/7 with 3 APNPs
  ▪ 7 days on, 14 days off
  ▪ Collaborating physician (FP) Rounding
Variation in Models

• APNP:MD mixed model
  ▪ Job description: Excludes ED and/or clinic coverage
  ▪ Difference: First responder vs. unit based vs. traditional

• Telemedicine collaborating physician

• Onsite collaborating physician

• Scheduling
  ▪ Shift: 12 hour (day vs night) or 24 hour
  ▪ Pattern 7/14, 5/5/5 or other

• Salary/benefits or per diem locums
APNP 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
Implementation of Program

• Medical staff support
• Board support/business plan
• Medical staff bylaws
• Staff education
• Community education
Medical Staff Engagement

• Meetings with independent physician groups
• Participation in site visits
• Opinion polls
• Attorney meetings
Medical Staff Engagement

• Bylaws revision team
  ▪ Chief of Staff, ED physician, CEO, Chief Patient Care Officer and Quality Manager

• Updates at medical staff meetings

• Medical staff invited to participate in interviews
<table>
<thead>
<tr>
<th>Hospitalist Criteria: Physician Opinion</th>
<th>Scale (1 = No and 5 = Yes)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>1. The hospitalist program will speed up the time to admission.</td>
<td>2</td>
</tr>
<tr>
<td>2. The hospitalist program will decrease the current burden of call.</td>
<td>2</td>
</tr>
<tr>
<td>3. The hospitalist program will increase quality scores.</td>
<td>2</td>
</tr>
<tr>
<td>4. The hospitalist program will increase the number of admissions from our ED.</td>
<td>3</td>
</tr>
<tr>
<td>5. The hospitalist program will help recruitment of new providers.</td>
<td></td>
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</table>

Number of Respondents: 6
Regulatory/Legal

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

Regulatory/Legal

- State APNP Practice Act
- Collaborating Physician Agreement-Contract
  - Primary Care Collaborator
  - Emergency Physician Contract
    - Authenticate admissions only
Collaborating Physician Role

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

- Active staff privileges/voting rights for APNPs
  - 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
  - Option to admit and follow own patients
- Peer review (OPPE/FPPE)
Candidate Selection Criteria

- Acute care experience with practicums
- Hospitalist experience preferred
- ACLS certified
- Collaboration and communication skills
- Cultural fit

Orientation Plan

- Hospitalist “Boot Camp” one week
- Shadow APNP at another CAH one week
- Complete competency assessment
- Collaborating physician mentoring time
- General hospital orientation
Team Culture

- APNP available 24/7 to answer questions and concerns
  - Code response availability
  - No ED tuck-in orders
- Multi-disciplinary team rounding
- Improved access for admission discussions
- Increased nursing interaction and education
- Increased patient and family interaction and education
APNP Expectations

• Sleep space and work space
• Communication expectations with PCP regarding their patients
  ▪ Admission/daily care/discharge process
• Thorough orientation
  ▪ 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
- APNP—generally done independently
- Nursing leader
- Occupational therapy
- Physical therapy
- Pharmacist
- Case manager
Early Implementation
Successes & Challenges

• Successful recruiting
  ▪ NP projected growth: 28% from 2012-2022
  ▪ One of three had delay in obtaining WI license and DEA number

• Old EMR increased documentation time
  ▪ Challenge for implementing clinical pathways

• Nursing staff challenged by patient acuity

Wisconsin Hospital Association (2015)
Retrieved from
Clinical Pathways

- Top 10 inpatient diagnoses before and after
- Admission order sets required
- ERH barrier

<table>
<thead>
<tr>
<th></th>
<th>Top DRGs 2013</th>
<th>Top DRGs 2015</th>
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<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>
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<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>
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<td>TRAUMA TO THE SKIN, SUBCUT TISS &amp; BREAST W/O MCC</td>
<td>ESOPHAGITIS, GASTROENT &amp; MISC DIGEST DISORDERS W/O MCC</td>
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<tr>
<td>7</td>
<td>KIDNEY &amp; URINARY TRACT INFECTIONS W/O MCC</td>
<td>SIMPLE PNEUMONIA &amp; PLEURISY W/O CC/MCC</td>
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<tr>
<td>8</td>
<td>OTISIS MEDIA &amp; URI W/O MCC</td>
<td>HEART FAILURE &amp; SHOCK W CC</td>
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<tr>
<td>9</td>
<td>OTHER FACTORS INFLUENCING HEALTH STATUS</td>
<td>OTITIS MEDIA &amp; URI W/O MCC</td>
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<td>10</td>
<td>SIMPLE PNEUMONIA &amp; PLEURISY W/O CC/MCC</td>
<td>SIMPLE PNEUMONIA &amp; PLEURISY W MCC</td>
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Early Implementation
Successes & Challenges

• Equipment Needs
  ▪ Evaluate current equipment
  ▪ Need for additional equipment for higher acuity patients
  ▪ 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 backup 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

## 2014 Q2 & 2015 Q4 HCAHPS Dashboard

<table>
<thead>
<tr>
<th>HCAHPS</th>
<th>2014 Q2</th>
<th>2015 Q4</th>
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<tbody>
<tr>
<td>Definitely recommend hospital</td>
<td>61%</td>
<td>75%</td>
</tr>
<tr>
<td>Hospital rated high (9-10)</td>
<td>57%</td>
<td>71%</td>
</tr>
<tr>
<td>Communication with nurses</td>
<td>81%</td>
<td>78%</td>
</tr>
<tr>
<td>Communication with doctors</td>
<td>84%</td>
<td>88%</td>
</tr>
<tr>
<td>Pain control</td>
<td>68%</td>
<td>80%</td>
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Quality Improvement: Core Measures

Performance Leadership in Clinical Outcomes Award

presented to

Rusk County Memorial Hospital

for overall excellence in Clinical Outcomes, reflecting top quartile performance among all acute care hospitals in the nation.

National Rural Health Day 2015

November 19, 2015
Stabilize Market Share

Primary Service Area Inpatient Market Share

-3 MDs

+1 MD in July

-3 more MDs

Rusk County Memorial Hospital
Inpatient Market Share

<table>
<thead>
<tr>
<th>Year</th>
<th>Qtr</th>
<th>Percent of Market Share</th>
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<tr>
<td>2014</td>
<td>Qtr 3</td>
<td>13.54</td>
</tr>
<tr>
<td></td>
<td>Qtr 4</td>
<td>17.74</td>
</tr>
<tr>
<td>2015</td>
<td>Qtr 1</td>
<td>19.89</td>
</tr>
<tr>
<td></td>
<td>Qtr 2</td>
<td>16.16</td>
</tr>
<tr>
<td></td>
<td>Qtr 3</td>
<td>19.18</td>
</tr>
<tr>
<td></td>
<td>Qtr 4</td>
<td>18.11</td>
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- **RCMH**: Market Share Trend
- **Trend line**: Linear Trend Analysis
# Admissions Summary

<table>
<thead>
<tr>
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<th>2014</th>
<th>2015</th>
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<tbody>
<tr>
<td>Acute Admits</td>
<td>339</td>
<td>420</td>
</tr>
<tr>
<td>Swing Bed Admits</td>
<td>105</td>
<td>108</td>
</tr>
<tr>
<td>Total Outpatients</td>
<td>24,427</td>
<td>27,903</td>
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<tr>
<td>Riverside Clinic Visits</td>
<td>503</td>
<td>3,184</td>
</tr>
<tr>
<td>ED Visits</td>
<td>5,409</td>
<td>5,693</td>
</tr>
<tr>
<td>UC Visits</td>
<td>1,071</td>
<td>814</td>
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</table>
## Impact on Case Mix Index

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
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<tbody>
<tr>
<td>Acute</td>
<td>1.0374</td>
<td>1.0330</td>
<td>1.0673</td>
</tr>
<tr>
<td>Swingbed</td>
<td>1.1268</td>
<td>1.1396</td>
<td>1.1667</td>
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</table>

![Graph showing the impact on case mix index from 2013 to 2015 for Acute and Swingbed cases.](image-url)
### 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>
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<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>
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</table>
Cardiac Rehab Days Increased

Cardiac Rehab Phase II Visits 2013-2015

Number of Visits

Q1  Q2  Q3  Q4

2013

2014

2015
Needs of Growing Program

• Respiratory Therapy added
• Patient Navigator (RN) added
• Daily operations handoff with hospitalist, ED physician, collaborator and nursing
Needs of a Growing Program

• Role delineation between hospitalists and nurses/skills assessment
• Rehiring APNP for cultural fit
• Increasing part time staff for backup support
Financial Impact

• Direct costs:
  - 2014 estimated 3 full time APNPs (excludes locums/per diem costs)

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

    ($140,000) * 2014 estimate cost

• Impact:
  - Maintaining volume/market share est. $3,500/day
  - ↑ Ancillary and outpatient revenue
What Would We Do Differently?

- Clinical pathways established
- Anticipate increased acuity
- Anticipate new equipment needs
- Backup staffing plan for illness/unanticipated gaps
- CMO on leadership team

Lessons Learned

• KEY factors in program design:
  ▪ Medical staff support and transition plan
  ▪ Staffing model
  ▪ Physician champion
  ▪ Collaborating physicians/APNP relationship
  ▪ APNP experience vs credential

• Medical/legal risk tolerance
  ▪ State laws
Lessons Learned

• Disengagement of other PCPs
• 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
QUESTIONS?
References


Wis. Stat. §35.93, Ch. N 8