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45th National Conference on Pediatric Health Care

Challenging Cases for APRN Leaders

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1

Speaker Disclosure

- None

2

Learning Objectives

- Identify methods for managing professional conduct concerns.
- Identify methods for capturing APP productivity.
- Identify methods to assist APPs in adjusting to new staffing models.
- Identify methods of encouraging full utilization of APPs in practice.

3

Who are We?

- How long have you been in practice?
  A. <5 Years
  B. 5-10 Years
  C. >10 Years

4

Who are We?

- Does your organization have an APP structure in place?
  A. Yes
  B. No

5

Who are We?

- Do you work inpatient or outpatient?
  A. Inpatient
  B. Outpatient
  C. Both

6

Who are We?

- Are you currently in a leadership role?
  A. Yes
  B. No

7

Who are We?

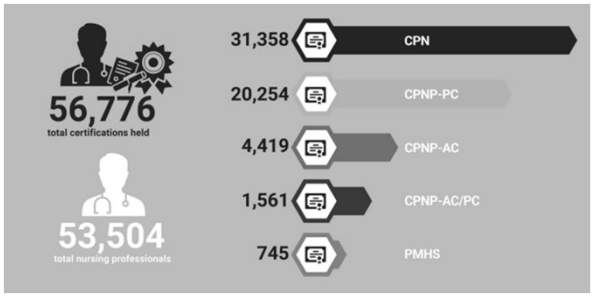
- If so, how long?
  A. <5 Years
  B. 5-10 Years
  C. >10 Years

8

Who are We?

- Which topic is the most challenging to you in your current role?
  A. Professional Conduct Concerns
  B. Capturing Productivity
  C. Developing staffing models
  D. Promoting full scope of practice

9



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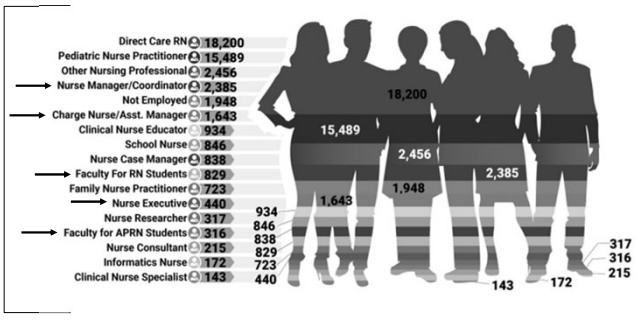


11

Background

- Nurse Practitioners are working in both formal and informal leadership roles.
- The expectation from our care partners is that nurse practitioners are competent in our leadership abilities, such as improving quality of care, enhancing professional nursing practice, communicating effectively, providing leadership on internal committees, facilitating collaboration, and mentoring/coaching.
- Organizational and system leadership is listed as a core competency for nurse practitioners according to The National Organization of Nurse Practitioner Faculties.
- It is imperative that nurse practitioners work together to build strong leaders and demonstrate successful leadership.

12

Professional Conduct Concerns

- Separate from Practice Concerns
  - Extend beyond APP leadership and into Human Relations or Office of Compliances.
  - Following step-wise approaches to improvement
    - Ongoing Professional Practice Evaluation (OPPE)
      - A process that allows the practitioner to identify- through data from multiple sources- professional practice trends that impact quality of care and patient safety on an ongoing basis. Metrics are based on six core competencies: patient care, medical and clinical knowledge, practice-based learning and improvement, interpersonal communication, professionalism, system-based practice, patient experience, national database indicators.
    - Focused Professional Practice Evaluation (FPPE)
      - A process that allows the medical staff to evaluate the competency and professional performance of a practitioner at determined points in time (i.e new credentialing, a concern is present).

13

Professional Conduct Concerns

- Literature Review – Poor inter-professional collaboration
  - Common barriers include:
    - Lack of leadership
    - Agenda conflict
    - Lack of team culture
    - Absence of a supportive health system
    - Unequal allocation of responsibilities
    - Role boundary conflict
    - Concerns regarding lack of value
  - Key steps to managing lack of inter-professional collaboration
    1. Review goals and objectives
    2. Specify/re-align tasks and responsibilities
    3. Socialization of inter-professional change
    - Professional altruism may be necessary for successful collaboration

14

Professional Conduct Concerns

- Literature Review - Microaggressions
  - A comment or action that subtly (often unconsciously) expresses a prejudiced attitude.
    - Microinsults: Communication that convey rudeness and insensitivity
    - Microinvalidations: Exclusion or negation of the psychological thoughts and perceived reality of a person
  - Recognition and training
    - OWTFD (Observe/Why/Think/Feel/Desire)
    - ACTION (Ask/Come/Tell/Impact/Own/Next)
    - XYZ (I felt X when Y because Z)
    - ERASE (Expect/Recognize/Address/Support/Establish, Encourage)
    - Stop, Talk, and Roll

15

Professional Conduct Concerns

- Literature Review - Burnout
  - Drivers for burnout
    - Interpersonal conflicts
      - Communication gaps, mistrust, personal animosity
    - Loss of control of work processes
    - Performing menial tasks
    - Overly demanding responsibilities
    - Chaotic work environments
  - Organization interventions more effective than those directed at individuals

16

Professional Conduct Concerns

• Take-Aways and Discussion

17

Question

• Are you currently billing for your services?

A. Yes

B. No

18

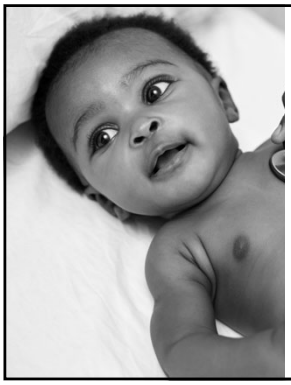
Question

• Are you currently billing for your services?

A. Yes

B. No

19



Capturing APP Productivity

• Literature Review
  • Ambulatory Care

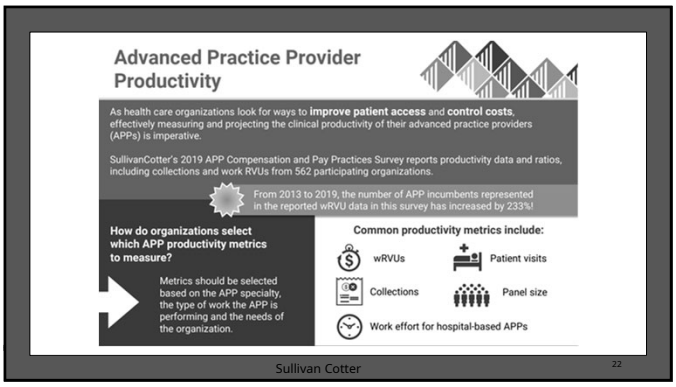
20

Capturing APP Productivity

- Literature Review
  - Inpatient

21

21



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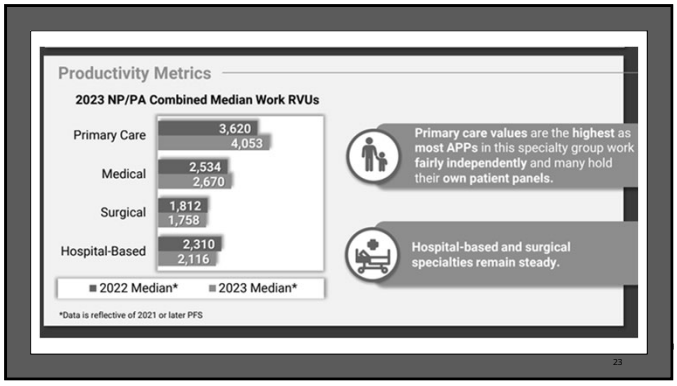

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Capturing APP Productivity

- Inpatient
  - Challenges
    - Team-based models of care
    - Bundled-codes
    - Surgical codes

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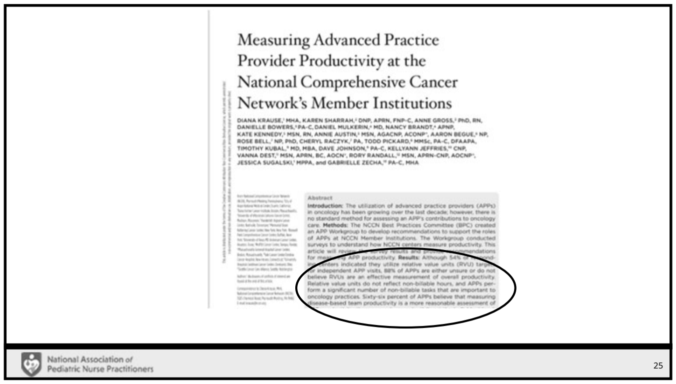

Measuring Advanced Practice Provider Productivity at the National Comprehensive Cancer Network's Member Institutions

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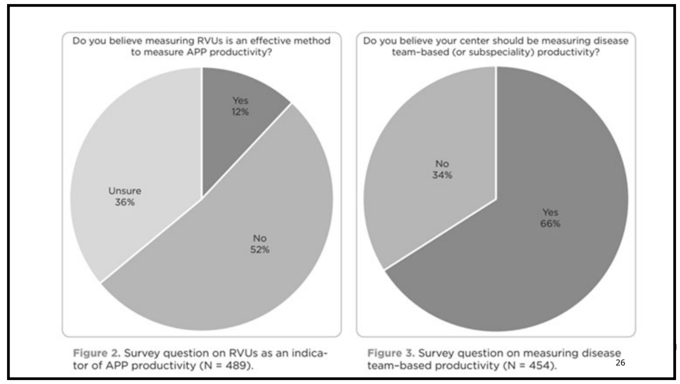
Abstract

Introduction: The utilization of advanced practice providers (APPs) in oncology has been growing over the last decade; however, there is no standard method for assessing an APP's contributions to oncology care. **Methods:** The NCCN Best Practices Committee (BPC) created an APP Workgroup to develop recommendations to support the roles of APPs at NCCN Member Institutions. The Workgroup conducted surveys to understand how NCCN centers measure productivity. This article will review the survey results and provide recommendations for measuring APP productivity. **Results:** Although 54% of responding centers indicated they utilize relative value units (RVU) targets for independent APP visits, 88% of APPs are either unsure or do not believe RVUs are an effective measurement of overall productivity. Relative value units do not reflect non-billable hours, and APPs perform a significant number of non-billable tasks that are important to oncology practices. Sixty-six percent of APPs believe that measuring disease-based team productivity is a more reasonable assessment of

25



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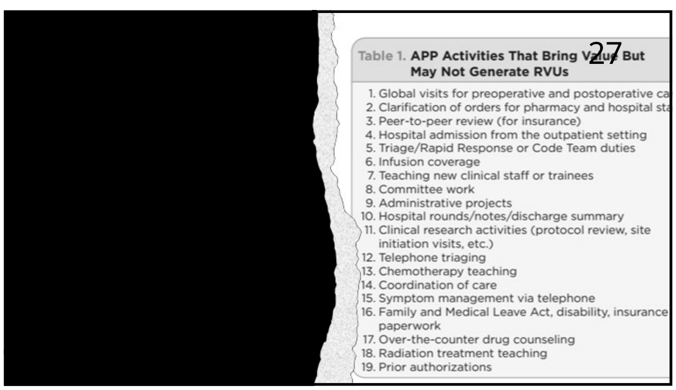
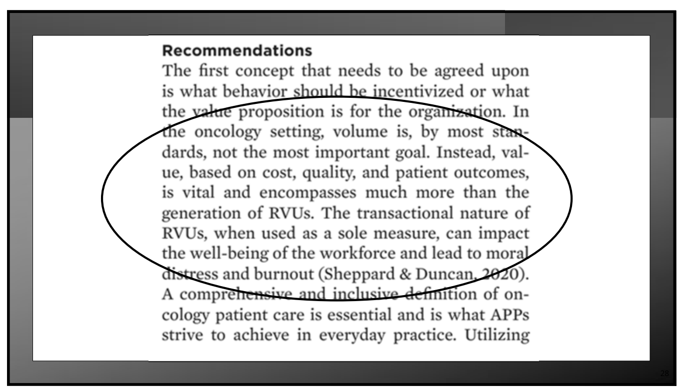


27

Table 1. APP Activities That Bring Value But May Not Generate RVUs

1. Global visits for preoperative and postoperative ca
2. Clarification of orders for pharmacy and hospital sta
3. Peer-to-peer review (for insurance)
4. Hospital admission from the outpatient setting
5. Triage/Rapid Response or Code Team duties
6. Infusion coverage
7. Teaching new clinical staff or trainees
8. Committee work
9. Administrative projects
10. Hospital rounds/notes/discharge summary
11. Clinical research activities (protocol review, site initiation visits, etc.)
12. Telephone triaging
13. Chemotherapy teaching
14. Coordination of care
15. Symptom management via telephone
16. Family and Medical Leave Act, disability, insurance paperwork
17. Over-the-counter drug counseling
18. Radiation treatment teaching
19. Prior authorizations

27



Recommendations

The first concept that needs to be agreed upon is what behavior should be incentivized or what the value proposition is for the organization. In the oncology setting, volume is, by most standards, not the most important goal. Instead, value, based on cost, quality, and patient outcomes, is vital and encompasses much more than the generation of RVUs. The transactional nature of RVUs, when used as a sole measure, can impact the well-being of the workforce and lead to moral distress and burnout (Sheppard & Duncan, 2020). A comprehensive and inclusive definition of oncology patient care is essential and is what APPs strive to achieve in everyday practice. Utilizing

28

Pediatric Surgery

Journal of Pediatric Surgery 55 (2020) 583–589

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journal homepage: www.elsevier.com/locate/jpedsurg

Original Articles

Advanced providers in pediatric surgery: Evaluation of role and perceived impact☆☆☆

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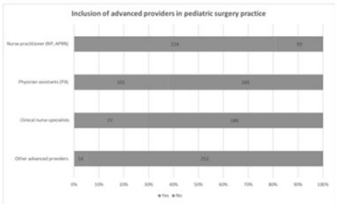
29

- 14 question survey
- Distributed to ASA members
- 266 US Pediatric Surgeons



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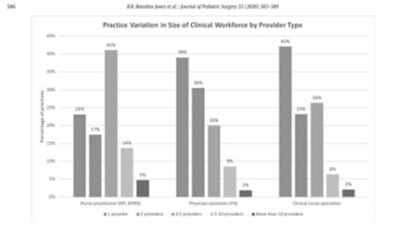

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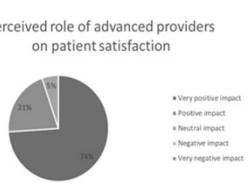

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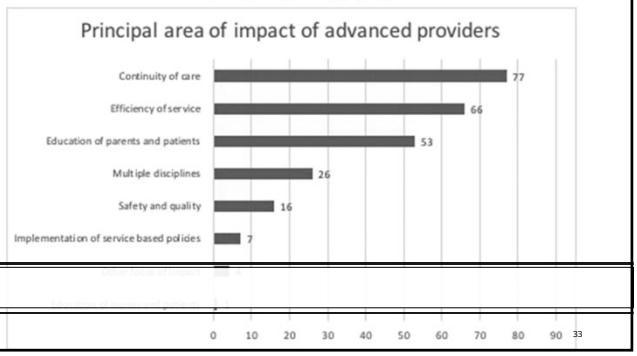

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33

Capturing APP Productivity

- Take-Aways/Discussion

34

Adapting to New Staffing Models

35

Question

- In what type of APP model do you currently practice?
  - 24/7 APP coverage
  - Mixed model APP/trainee coverage
  - Day coverage only
  - Day coverage with an on-call component

36

Adapting to New Staffing Models

- National APP vacancy rates averaged 9.2% between 2014-2019, including both permanent and temporary vacancies.
  - Increased burnout in healthcare.
    - In critical care burnout was associated with more consecutive work days, more night shifts, lack of scheduling control or fixed scheduling
  - Challenges:
    - Maintaining work life balance and retaining staff
    - Ensuring optimization of personnel
    - Non-productive time and professional growth
    - Sick coverage
    - Longevity
    - Trainee/APP collaboration

37

Adapting to New Staffing Models

- Literature Review
  - Average daily census
    - Critical care provider ratios average 1:5 but do not include insight into numbers of admission/discharges, trainee assistance, patient acuity, or consultation responsibilities.
  - Resource Pool
    - Average coast of on-boarding an APP is between $85,000-$115,000.
    - 2.5 FTE available to support ambulatory, acute care, and critical care settings.

38

Adapting to New Staffing Models

- Take-Aways
  - Workforce Optimization is key.
    - Practicing to top of scope with manageable workloads
      - Utilization (total number of visits and procedures performed independently)
      - Productivity (total number of visits and procedures both independent and shared)
  - Satisfaction important for retention and sustainability
    - Health and well-being: Reducing nightshift components, providing self-scheduling or fixed scheduling options,
    - Build in professional development time and/or continuing education opportunities to encourage non-clinical/ value-added activities
    - Recognition and appreciation

39

Adapting to New Staffing Models

- Discussion

40

Question

- Are APPs in your Practice/Department/Health System consistently practicing at top of license?
- A. Yes
- B. No

41

Question

- Are APPs in your Practice/Department/Health System consistently practicing at top of license?
- A. Yes
- B. No

42

AANP American Association of Nurse Practitioners

What is Full Practice Authority?

Practice Environment Details

Full Practice
State practice and licensure laws permit all NPs to evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine, and the National Council of State Boards of Nursing.

Reduced Practice
State practice and licensure laws reduce the ability of NPs to engage in at least one element of NP practice. State law requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care, or it limits the setting of one or more elements of NP practice.

Restricted Practice
State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team management by another health provider in order for the NP to provide patient care.

43

Why Full Practice Authority?

- **Improves Access** — FPA creates greater access to care, especially in underserved urban and rural areas. States with FPA are more likely to have NPs working in rural and underserved areas and NP practices than states with more restrictive licensure models.
- **Streamlines Care and Makes Care Delivery More Efficient** — FPA provides patients with full and direct access to NPs' services *at the point of care*. FPA removes delays in care that are created when dated regulations require an NP be part of an unnecessary regulatory-mandated contract with a physician as a condition of practicing their profession.
- **Decreases Costs** — FPA avoids duplication of services and billing costs associated with outdated physician oversight of NP practice. FPA reduces unnecessary repetition of orders, office visits and care services.
- **Protects Patient Choice** — FPA allows patients to see the health care provider of their choice. FPA removes anti-competitive licensing restrictions that interfere with patient-centered health care.

44

History

Here are some historical developments and legislative milestones:

1965: Dr. Loretta Ford and Dr. Henry Silver created the first-ever NP program at the University of Colorado.

1973: There are over 65 nurse practitioner programs by this year.

1980s: According to Kaiser Health News, Alaska, New Hampshire, Oregon, and Washington emerged as pioneers by adopting progressive licensing authority for nurses.

2001: There are about 82,000 nurse practitioners in the US at this time

2020: Florida NPs became eligible to apply for an unrestricted license if they have completed 3,000 hours of supervised practice under the guidance of a licensed MD or DO within the past five years.

2021: Introduction of Pennsylvania State Bill 25. This bill would allow NPs in Pennsylvania to practice independently without physician oversight after completing a three-year, 3,600-hour collaboration agreement with a physician. The bill is pending further action.

2023: Utah became the 27th state to embrace full practice authority for NPs.

2023: At present, there are 27 full practice authority states for nurse practitioners along with Washington, D.C.

https://nurse.org/education/np-full-practice-authority/

45

45

2024 NURSE PRACTITIONER STATE PRACTICE ENVIRONMENT

Full Practice: State practice and licensure laws permit all NPs to evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine, and the National Council of State Boards of Nursing.

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Restricted Practice: State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team management by another health provider in order for the NP to provide patient care.

See State Fact Sheets for more information.

DISCLAIMER: The material contained in this is offered as information only and not as practice, financial, accounting, legal or other professional advice. Correspondents must contact their own professional advisors for such advice.

National Association of Pediatric Nurse Practitioners

AANP American Association of Nurse Practitioners

AANP State Government Affairs
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46

46

NP Care Delivery

13 RCTS

47

47

Promoting Utilization of APPs to Full Scope

NAPNAP Position Statement

National Association of Pediatric Nurse Practitioners

NAPNAP Position Statement on Access to Care

National Association of Pediatric Nurse Practitioners, Professional Issues Committee, Emily M. McRae, DNP, APRN, CPNP-AC/PC, Amanda Lee, MSN, PPCNP-BC, Stephanie M. Key, DNP, APRN, CPNP-PC, & Maria T. McNamara, MSN CPNP-AC/PC

National Association of Pediatric Nurse Practitioners

48

48

49

Promoting Utilization of APPs to Full Scope

- Discussion

50

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52