Ministry Health Care

- An integrated Catholic Health Care system with a broad geographic footprint covering north central Wisconsin
- An Ascension Health ministry
- 15 hospitals, 5 of which are Critical Access Hospitals (CAH)
- Multispecialty 550 member medical group

Program Objectives

- Create a low cost, high quality hospitalist service for a rural CAH utilizing Nurse Practitioner Hospitalists
- Flexibility for oversight by local FPs or through a telemedicine link to remote MD Hospitalists
CAH Physician Staffing

- Critical Access Hospitals are typically reliant on a small number of primary care physicians to provide inpatient services
- Loss of even one physician from the call rotation can often threaten hospital inpatient coverage
- Sharp decline in physicians choosing full spectrum primary care practice makes "recruiting our way" out of the problem difficult

Rural Physician Workforce Trends

- Only 7% of graduating medical students choose a primary care residency program
- Only 4% of physicians graduating from primary care residency programs want to work in communities with populations of less than 50,000
- Half of all graduating primary care physicians currently go to six states – WA, CA, TX, FL, NC and NY

Ministry Recruiting Experience

- Recently took 3 years to recruit Family Physician to Eagle River
- He is not interested in inpatient practice
- Work/Life balance is a key for young physicians. Few new grads want both inpatient and outpatient responsibilities.
**Pilot Program Concept**

- Two APNPs provide on-site hospitalist inpt services supported through telehealth to MHC (St. Mary’s) physician hospitalists
- APNPs care for a defined scope of diagnoses
  - Evidence based order sets
  - Protocol driven care pathways
- Cost of the program is the responsibility of the CAH but medical group hires and manages the personnel

**Program Flexibility**

- FP Physicians have the option to keep their inpatient practice
  - Participation in inpatient call schedule
  - Manage their own hospital patients
- FP Physicians wanting only an outpatient practice
  - Delegate inpatient care to the hospitalist service
  - Participation in inpatient night call schedule
  - NP’s pick up admissions in AM

**Program Development - Training**

- Training
  - APNP hospitalist curriculum developed
    - Mayo model
  - APNP hospitalist skills assessment tool
  - APNP case management log
  - Case review
  - Clinical rotations at St. Mary’s (6-12 months) under direct physician supervision
Program Development - Telemedicine

- Telemedicine (via a grant through Marshfield Clinic)
  - MMG physicians will be consulted via telehealth at admission, discharge, and any time during the patient’s stay
  - The MMG physician can examine the patient using a real time audio/video link
  - The physician can also utilize an electronic stethoscope, otoscope, and high resolution cameras
  - Telemedicine vs. telephone contact

Program Development – Scheduling

- Scheduling
  - 7 on 7 off rotating APNP schedule
    - 7am – 6pm
    - FP night call coverage
    - Started program with 24 call Fri-Sun, workload was unmanageable
  - Back up for high census
    - Point system

Program Development – Policies/Procedures

- Policies and procedures
  - Defined scope of practice
  - Order set use
  - Documentation requirements for MD and APNP
  - Telehealth downtime
  - Work load
  - Transfer policies
Program Development – Billing and Reimbursement

• Medicare covers specified services provided via an interactive telecommunications system if the patient is located at an originating site and services are furnished by a practitioner at a distant site.

• Originating Site
  • Must be located in a rural health professional shortage area or a county that is not a Metropolitan Statistical Area

Program Development – Billing and Reimbursement

Originating Site (continued)

• Must be one of the following types of facilities: physician/non-physician practitioner office, CAH, RHC, RQHC, SNF, CMHC, or a hospital-based or CAH based renal dialysis center

• Do not need a telepresenter

• Originating Site paid a flat rate facility fee ($24.43 for 2013)

• If site is a CAH, Medicare fee paid in addition to cost reimbursement

Program Development – Billing and Reimbursement

The practitioner

• Must be one of the following: physician, nurse practitioner, physician assistant, nurse-midwife, clinical nurse specialist, clinical psychologist, clinical social worker, and registered dietician or nutrition professional.

• The practitioner must be licensed under state law.

• The distant site practitioner is paid a fee schedule amount.
  • The practitioner must include the GT modifier to certify that the services were provided via an interactive telecommunications system.
Program Development - Contracts

• Telemedicine Coverage Agreement(s)
  – Must meet the Medicare CoPs
  – Service delivery/documentation permits compliance with CoPs
  – QAPI assessment of services/identified metrics
• Connectivity contracts
• Equipment acquisition and maintenance
• All coordinated with originating site Medical Staff Bylaws/Rules/Policies

Program Development – Credentialing/Privileging

Methods of Credentialing Telemedicine Providers
1. Go through the entire credentialing process as you would for any other member of the medical staff.
2. Request information from the distant site where the telemedicine provider is already privileged and use that information to make decision to grant the practitioner privileges: CVO-like.
3. Rely on the credentialing decision of the distant site hospital or telemedicine entity.
   • Specific, and different, requirements between CMS and TJC, and uncertainty under state law

Program Development – Credentialing/Privileging

• The current norm is full credentialing
• Some facilities have initiated “telehealth privileges,” but as telehealth providers do more and more, the case for separate privileges is declining
• OPPE/FPPE/quality oversight for telehealth providers: there are no exceptions and likely to be a developing area
Regulatory Components

• DHS Waiver
  – Section 124.04(2)(g)1 allows only a physician, dentist, or podiatrist to admit
    • Waiver requested from WI DHS by hospital
    • DHS requested ruling on scope or practice from WI Board of Nursing
    • DHS granted waiver based on BON support and the comprehensive program
  • APNP primary responsibility / remote MD functions as consultant
  • Medical Staff Bylaws
    – Legal recommendation on changes

Hospitalist programs

• MD hospitalist programs not affordable for low volume CAH. All hospitalist programs lose money.
• Community setting
  – 60% of expenses covered
• Program cost estimates – APNP vs. MD. 10 yr net present value estimate
  • (2) APNPs  -$750,000
  • (2) MDs  -$3.6 million

Income Statement

<table>
<thead>
<tr>
<th>Gross Revenue</th>
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<tbody>
<tr>
<td>Expenses</td>
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<td>MD FTE allocation</td>
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<tr>
<td>Gross Margin</td>
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Note: Salary expense includes medical director stipend and APNP CME
What about PA’s?

Physician’s Assistant Scope – WI Administrative Code

- In providing medical care, the entire practice of any physician assistant shall be under the supervision of a licensed physician. Med 8.07 – Practice
- A physician assistant may not prescribe or dispense any drug independently. A physician assistant may only prescribe or dispense a drug pursuant to written guidelines for supervised prescriptive practice. Med 8.08 – Prescribing Limitations
- The supervising physician or substitute supervising physician shall be available to the physician assistant at all times for consultation either in person or within 15 minutes of contact by telecommunication or other electronic means. Med 8.10 – Supervising

PA’s cannot admit and have primary responsibility for the patient - a cornerstone of APNP hospitalist program

Nurse Practitioner Scope – WI Administrative Code

- Advanced practice nurse prescribers shall work in a collaborative relationship with a physician. N 8.10 (7) – Case management and collaboration
- May issue only those prescription orders appropriate to the advanced practice nurse prescriber’s areas of competence, as established by his or her education, training or experience. N 8.06 (1) – Prescribing limitations

Timeline to Go Live

- Administrative Approval – Spring 2011
- DHS Waiver Requested – October 2012
- DHS Waiver Requested – December 2012
- DHS Waiver Ruling Requested – December 2012
- DHS Waiver Ruling Requested – March 2013
- DHS Waiver Granted – August 2013
- Program goes live – May 2013
- Order sets & policies finalized – March 2013
- Pilot go live – May 2013
- Program metrics
  - Core measures
    - Pneumonia, CHF
  - Patient satisfaction
  - Readmission rates
  - Length of stay
    - CAH 96 hr LOS requirement
Program Evaluation – Length of Stay

Questions?

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