shm
Society of Hospital Medicine

Empowering hospitalists.
Transforming patient care.

Nurse Practitioner and Physician Assistant Hospital Medicine Onboarding Toolkit

Updated: September 2017

hospitalmedicine.org

"The most recent data from SHM's 2016 *State of Hospital Medicine* Report reveals that about 63% of groups use advanced practice providers (APPs). Clearly there is evolving growth and enthusiasm for NP/PAs in hospital medicine."

Tracy Cardin, ACNP-BC, SFHM
University of Chicago
SHM Board Member

Table of Contents

The following resources and commentary were compiled by the Society of Hospital Medicine's (SHM's) Nurse Practitioner/Physician Assistant Committee and are intended to be used as a toolkit for integrating Nurse Practitioners (NPs) and Physician Assistants (PAs) into hospital medicine practice groups.

This document will be periodically reviewed and updated.

Last updated: September 2017

Society of Hospital Medicine
NP/PA Committee 2015-2017

SECTION 1

Resources for Recruiting and Interviewing
NPs and PAs

Resources for Recruiting and Interviewing NPs and PAs

The use of nurse practitioners (NPs) and physician assistants (PAs) in hospital medicine groups (HMGs) has shown significant growth, both in the overall number and utilization of NPs and PAs, in a wide array of practice settings across the country.

The 2016 *State of Hospital Medicine* Report showed the proportion of Adult HMGs employing NPs/PAs increased from 53.9% in the 2012 survey to 64.6% in 2016.

With an expected increase in the overall number of NPs and PAs entering the workforce, it is likely that this growth will continue within HMGs.

It is important to consider many factors impacting NP and PA practice when recruiting and hiring these providers. This is true whether you are filling a new position, hiring a replacement or expanding the team. In addition, having a clear understanding of the role and expectations for the position to be filled is critical to successful recruitment. Training, education, scope of practice, and rules and regulations governing NP and PA practice are the first elements to be considered in the recruiting and hiring process. NPs typically complete a master's or doctoral advanced nursing degree with additional clinical training. PA programs use a medical school-based curriculum with didactic and clinical training to award a master's degree. NPs are regulated through state nursing boards, whereas PAs are regulated through state licensing or medical boards. The level of collaboration/supervision required and prescriptive authority is determined at the state level. It is crucial that you understand the practice acts governing NPs and PAs prior to integrating them into your HMG.

To recap, the scope of practice for each individual NP and PA is determined by the provider's education and experience, state law, facility policy and the needs of the patients.

The following is a chart that categorizes the difference in certification, practice sites, and certifying entities for NPs and PAs:

Certification	Potential Practice Sites				Certifying Entity
Family Nurse Practitioner (FNP)	Adult and pediatric Ambulatory Primary Care	Ambulatory internal medicine clinics	Ambulatory subspecialty chronic disease clinics	Walk-in clinics and/or Urgent Care	AANP ANCC
Adult-Gerontology Nurse Practitioner Primary Care (AGNP)	Adult Ambulatory Primary Care	Ambulatory internal medicine clinics	Ambulatory subspecialty chronic disease clinics	Walk-in clinics and/or Urgent Care	AANP ANCC
Adult-Gerontology Acute Care Nurse Practitioner (AG-ACNP)	Adult critical care; inpatient	Adult subspecialty care inpatient	Adult subspecialty care ambulatory		ANCC AACN
Clinical Nurse Specialist (CNS)	Patient type is dependent upon which type of CNS certification they have (i.e. Adult, Critical Care, Psychiatry, etc.). May work in all settings (Hospital, Clinic/Ambulatory, Community Practice Sites, Psychiatry) but is population & service dependent.				ANCC AACN

Key:

ANCC – American Nursing Credentialing Center
AANP – American Association of Nurse Practitioners
AACN – American Association of Critical Care Nurses
NCB – Pediatric Nursing Certification Board

Additional Certifying Entities:

AMCB – American Midwifery Certification Board
NBCRNA – National Board of Certification/Recertification for Nurse Anesthetist
NCC – National Certification Corporation
NCCPA – National Commission on Certification of Physician Assistants

The following list of publicly accessible resources provides additional foundational elements to assist you in recruitment program development and/or enhancement:

- **Recruitment and Retention Guide for Small Rural Hospitals**

- **A National Survey of Hospital Executives Examining Clinical Workforce Issues in the Era of Health Reform**

- **Nurse Practitioner and Physician Assistant Utilization in the Future of U.S. Healthcare**

- **Integrating Nurse Practitioners and Physician Assistants in the ICU**

- **2013 Guide for New Nurse Practitioners and Physician Assistant Graduates**

- **Centralized Resources for Nurse Practitioners: Common Early Experiences Among Leaders of Six Large Health Systems**

Tips for Selecting and Interviewing NPs and PAs

Selecting and interviewing potential candidates for NP and PA positions can be time consuming.

The following suggestions can help you make the best use of your time during this process:

- Where you have multiple applicants for one position, the first step is to review all CVs and applications and select those with the most relevant experience.

- In the case of newly graduated NPs, look at nursing experience. Depending on your situation, you may want to interview only new grad PA and NP applicants whom you have had the opportunity to observe during rotations within your hospital system, or RNs who possess robust nursing experience.

- Once you have selected the candidates you wish to interview, conduct a phone screen. This is an informal telephone discussion about the job and what it entails. Phone screening may be conducted by an NP or PA, group supervisor or an HR specialist. Work hours are a deal breaker for some, so if your position involves weekends/nights/on call and the applicant finds these hours unacceptable, you can save everyone time by discovering this during a phone screen. Other impediments to hiring may include factors such as pay and benefits.

- After you have narrowed the pool of applicants, begin setting up in-person interviews. It is important that key members of your team be included in the interview process.

- Make good use of your time during the interview. You have a very limited amount of time to assess potential candidates. Just as you expect the candidates to be prepared for the interview, it is also important for the interviewers to make the best use of that time.

Behavioral Interviewing

Behavioral interviewing is somewhat intimidating, and candidates who are truly interested in the position should have done their homework prior to the interview. A well-prepared candidate should be able to respond to "what would you do" scenarios. These scenarios should be tailored to the candidate, keeping in mind his or her years of practice, work experience and education.

It is important to distribute the candidate's CV/resume to all interviewers prior to the interview so that they can prepare their questions for the candidate. Questions should be relevant to the position, keeping in mind the candidate's prior work history. They

should be worded so as not to put candidates on the spot; i.e., candidates should not feel as though their knowledge is being tested.

Questions should be designed to gather the following information:

- How much does the candidate know about your institution or practice?

- Have they done their homework; i.e., what have they learned about your institution or practice prior to coming to the interview?

- How have they dealt with difficult situations in their previous positions? Ask questions such as "How did you deal with situations when you have had disagreements on management of a patient with a prior attending physician?" Can they give specific examples?

- How confident do they feel in certain situations? If you have a recent situation as an example of something they may encounter, it will help them to clarify their answer.

- Will there be instances in the position where there is an expectation of autonomy or minimal supervision? If so, what is the candidate's level of comfort?

- In what areas do they feel least confident? Phrase such questions in the following ways: "What about this practice do you think will provide you the greatest challenge?" "What areas are you looking forward to expanding your knowledge base in?" This is a gentler way of asking the standard question, "What are your weaknesses?"

- If providers in the practice are expected to perform procedures, do they have the necessary experience? Are they comfortable with learning new procedures?

- Are the candidates truly interested in hospital medicine and, more specifically, in

this position? What do they know about the field, and what steps have they taken to work toward expertise in this field?

- Are they familiar with the work schedules of a hospitalist advanced practice provider (APP)?

- **Don't Forget** to ask candidates what questions they have for you. Good candidates will come with specific questions, and typically the interview process should generate more questions for them. On the flip side, be sure to answer questions as openly as possible. If there are issues that may be deal breakers later, it is best that they know them up-front.

As with any professional interview, questions that reveal age, race, national origin, gender, religion, marital status and sexual orientation are off-limits. State and federal laws make discrimination based on certain protected categories, such as national origin, citizenship, age, marital status, disabilities, arrest and conviction record, military discharge status, race, gender or pregnancy status, illegal.

Group vs. Individual Interviews

Group interviews can be intimidating, and candidate responses may be affected. On the plus side, large group interviewing saves time for both the candidate and the interviewers. Here are some tips for conducting group interviews:

- Be aware that coordinating an "all-day" interview can be difficult. The longer the day and the more interviewers involved, the more opportunity for delays. If interviewers need to cancel their part at the last minute, the practice can appear disorganized. If members of the group are too busy to make it to the interview, it says to the candidate that the workload may be overwhelming.

- Create a schedule of times and interviewers that is sent to the candidate prior to the interview.

- Have a representative greet the candidate at the front entrance of the institution.

- Assign someone to escort the candidate from one interview to the next. This helps to keep the meetings on schedule.

- Consider individual interviews or small group interviews with multiple team members. The pairing of the candidate with each small group or with each individual creates a different dynamic and brings out different attributes and responses. This also mimics the working relationships that the candidate would encounter if hired (i.e., working with multiple providers and the need to "shift gears" depending on the makeup of the team).

- Personality should also be considered when interviewing possible candidates. A lunch session creates an informal atmosphere and tends to be more relaxed. Providing a stress-free atmosphere over lunch leads to more open discussion. Much can be learned about a candidate from an informal discussion or chat.

- Keep in mind the attributes you enjoy in your best performers and look for such traits in applicants.

Post-interview Evaluation

The post-interview evaluation can be completed through the use of standardized forms asking interviewers to list strengths and weaknesses/pros/cons to rate the candidate, or through an open written feedback method. This is important when there are multiple candidates being considered for a single position. It is also helpful to try to get the same members of the group to see all candidates and to keep the interviews as close together as possible. Interviewing one candidate now and the next in two weeks makes it difficult to compare them. Whatever method is chosen, immediate feedback, preferably in writing, is ideal.

Finally, be sure to give the candidate contact information in case questions/concerns come up after the interview, and be available to address such concerns.

Risk Benefit of New Graduate vs Experienced Provider

Common experience has been that when hiring experienced providers, those with hospitalist experience (vs. clinic experience) seem to fare better — both in that they have the skills needed for hospital practice and they understand the hospitalist work schedule.

Hiring new graduates does give the group the opportunity to train the provider. If staffing allows for an extended orientation, new graduates can be a great addition to a hospitalist service.

If you are in a teaching hospital and have PA and NP students rotating on your service, you may come across excellent candidates. Prior students have had an "extended" interview already. You have had an opportunity to evaluate both their practice as well as their ability to interact with other team members, other personnel and patients. If you have the opportunity to precept and identify suitable candidates in the process, it is a good idea to maintain contact following the rotation. If positions come up in the future, you will have a list of potential candidates on hand.

SECTION 2

Orientation and Onboarding

Orientation and Onboarding

The integration of a new hire, whether experienced or not, requires up-front organization and planning for the employee as he or she enters into a new practice. Prior to the new hire's first day on site, there has likely been a great deal of coordination to complete the credentialing process. One idea to consider is assigning a senior NP or PA mentor once the candidate been extended an offer to ensure there is a point of contact to prevent delays in the start date. This will also allow the candidate to begin building relationships within the group early on. Try to remember to check in frequently with the candidate to ensure he or she has everything needed during this time.

Consider creating an orientation manual for the new hire that includes not only essential information but also space where they can add and organize their own notes. This is a good chance to provide some history of the department, the leadership structure and background about the team that the new hire is joining. Include important things to know, i.e., nursing station numbers, consultant information, Wi-Fi/internet access and examples of order sets, billing information and documentation guidelines.

Typically, the first few days on site include a lot of introductions and a tour of the new facility. Depending on the hospital setting, there may be an organizational orientation, provided that will help to introduce the new employee to the hospital policies and various aspects of employment. Set a schedule to check in frequently, and ensure the new hire is being properly acclimated to the group and solicit feedback. Take this time to arrange one-on-one meetings with the billing/coding department and clinical documentation contacts as well as check-in time with leadership.

Set a tempo to the days ahead with a mix of clinical observation, limited caseload days and time to shadow colleagues outside your specific department. Provide two to three days of shadowing and working side by side with an NP/PA colleague from other disciplines such as transplant medicine, infectious disease and interventional cardiology. Your new NP/PA colleague will be consulting with them in the very near future. It is more than nice to get to know them — it will enhance quality patient care.

Provide some free time for review of online resources during the new hire's day. Required learning modules are best taken in small portions. Depending on the candidate's background, they may be eager to find clinical resources and guidelines. Many departments utilize the Society of Hospital Medicine (SHM) Core Competencies as a framework for their learning. Invite them to join SHM and encourage them to get involved to broaden their scope of what other HMGs are doing. If resources and time allow, encourage them to attend a relevant conference such as the Hospital Medicine NP/PA Boot Camp at the next offering. Explore if there are departmental finances available to defray costs.

Remember, as a general rule, new NP and PA staff should be oriented differently than new physicians. Their scope of exposure to hospital medicine is likely to be significantly less than their physician counterparts. Take the time early on to invest in the new hire's integration into the practice and you are likely to reap the rewards of an engaged employee.

The following is an example orientation schedule:

Week 1:

☐ Corporate Orientation: Introduce new hire to other team members, to medical and nursing leadership on units, senior leadership (as able) and key C-Suite players.

☐ Distribute orientation manual and schedule.

☐ Provide list of important phone numbers and essential access materials (keys, access codes to patient care areas).

   If not done before start date and appropriate, obtain size information for lab coat(s) and place order.

☐ Complete needed documentation for medical expenses credit card (for CME and associated acceptable expenses reimbursed or paid for by organization).

☐ Coordinate needed hours with billing and coding staff.

☐ Introduce new hire to EMR — hours to be determined by IT staff and past experience of new employee.

☐ Shadow experienced NP/PA staff for remainder of Week 1 hours.

☐ Meet 1:1 with Medical Director-Collaborative Practice MD.

Weeks 2-3:

☐ Assign mentor(s) NP/PA and continue clinical shadowing.

☐ Continue EMR orientation – template review for H&P, progress note and discharge summaries.

☐ Start checklist completion – clearly outline patient number and documentation volumes before sign-off by Mentors.

☐ Schedule time with specialties frequently consulted by hospitalists in your facility (i.e., transplant surgery; cardiology; infectious disease; ear, nose and throat, etc.). The purpose is to provide basic insight into the hospitalist role in patient care from the specialist's point of view.

☐ Schedule time with PT and OT providers for insight into their roles in caring for hospitalized patients.

☐ Review and demonstrate the process for transition of care between hospital to home, hospital to SNF/TCU and the dynamics of transferring a patient to ICU-level care as appropriate to facility protocol.

☐ Schedule time with social worker staff and RN care coordinators for instruction and demonstration of discharge planning.

☐ Make attendance at organizational learning opportunities a priority (i.e., grand rounds, morbidity/mortality conferences).

Orientation schedule continued:

☐ Where established, introduce concepts of peer review/purpose and focus.

☐ Discuss and mentor new NP/PA staff in advanced directives and code status conversations.

☐ Review the role of the NP/PA in family conferences.

Weeks 4-5:

☐ Begin transition to NP/PA block schedule if progress on orientation checklist warrants.

☐ Evaluate timing of procedural orientation/competency for bedside interventions such as ultrasound for volume status assessment, paracentesis and thoracentesis (if relevant).

☐ Continue clinical orientation hours.

☐ Start to incorporate new employees in the actual care delivery process – notes to be reviewed and signed off by other APP mentor or physician collaborative colleagues. New employee sees each patient with a staff shadow until staff mentor and employee agree he or she is prepared to "fly solo."

☐ Learn the foundations of case presentation.

☐ Provide 1:1 feedback with each encounter – what went well and the opportunities for improvement in documentation, clinical exam and communication.

☐ Assure the new employee is increasingly comfortable with organizational protocols/procedures/process and patient flow.

Week 6:

☐ Review checklist progress.

    ☐ Continue clinical orientation hours.

    ☐ Continue procedural orientation.

    ☐ Encourage autonomy where appropriate with ongoing mentor shadow until checklist completion.

☐ Established staff members working with new NP/PA staff should expect and welcome more questions from their colleagues well into the first six months of start-up.

SECTION 3

Models of Care: Utilization of NPs and PAs

Models of Care: Utilization of NPs and PAs

NPs and PAs have proven to be integral members of the hospital medicine team. As hospitals aim to optimize efficiency and clinical outcomes in a cost-effective and value-based system, more emphasis is being placed on the role of NPs and PAs in the inpatient setting. A recent comparison of conventional and expanded PA hospitalist staffing models at a community hospital showed no statistically significant differences were found between the two groups for in-hospital mortality, length of stay or consultant use (Capstack TM, et al., 2016). Unfortunately, there is otherwise very limited data comparing the various models of care or details related to the level of support needed for NPs and PAs practicing in HMGs. Therefore, much of the information available is anecdotal and based on group experiences. It is important, however, to create a clear understanding of the proper roles for NPs and PAs to avoid the possibility of dissatisfaction or conflict among the group.

Troubleshooting: Conflict Management in NP/PA Practice

1. **Role definition** is often the initial source of conflict between NP/PA providers and physicians. The reasons for this are multi-faceted; lack of clear expectations, lack of clear communication and also a migration of the needs for which the initial NP/PA was hired can all lead to conflict. Often an NP/PA is hired without a clear understanding on the part of the medical group leader for how this new hire should be deployed, their scope of practice, their level of independence, etc. The NP/PA may be a new grad and lack the experience or confidence to definitively provide guidance in this arena, or they may be very experienced and have preconceived notions for how role development should

occur based on their previous work exposure. The most effective strategy for this type of conflict is often simply tincture of time. A steady hand from leadership, allowing that these "bumps in the road" are normal and expected, is helpful. Development of honest, respectful and professional dialogue is also 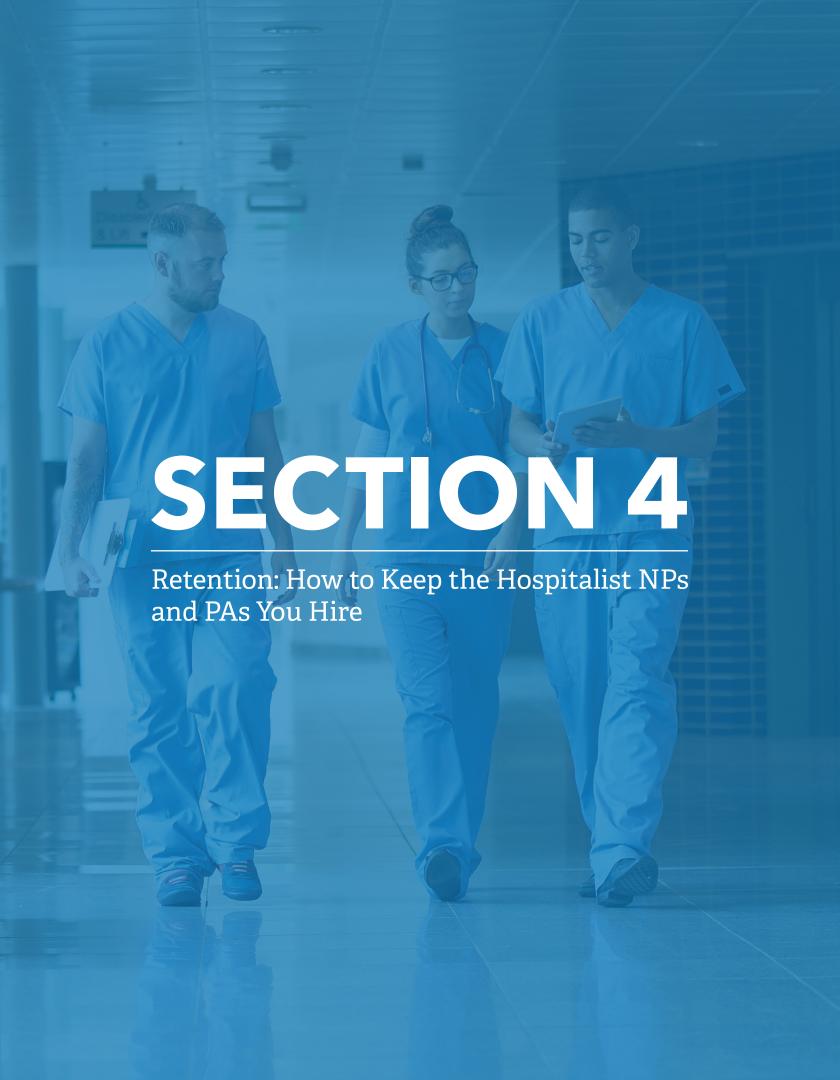a healthy tool in the arsenal to diffuse such conflicts. The expectation is best communicated that these types of conflicts are likely to develop, but that solutions are just as likely to develop over time. This allows all parties to begin the process of role reconciliation to their mutual benefit.

2. **Matching expectations** to the job description: Role development is paramount to successful NP/PA integration into a medical practice. A model of care should be chosen that best fits the practice needs. Examples of practice models follow (Furlong E, Smith R, 2005):

   - Integrated primary healthcare team providing full care to the patient or population group.
   - Consultancy: the NP/PA works independently and collaborates within a health system with other providers.
   - Specialty services/clinics: the NP/PA manages specialty clinical/services for a particular health specialty or population group.

   Ambiguous jurisdictions have been identified as common sources of conflict (Saltman DC, O'Dea NA, Kidd MR, 2006). Careful delineation of NP/PA expectations prior to onboarding will result in smoother integration and prevent the rapid turnover that leads to greater direct and indirect costs to the practice.

3. **Decision making** is also an area that can be problematic, depending on the type of role assigned to the NP/PA provider. For instance, if there are parallel roles (i.e., physician managing his/her patients and NP/PA managing his/her patients), who ultimately guides the decision making for patients? In medicine there are frequently multiple solutions or pathways for a single problem, without clear evidence that one choice or the other is superior. These decisions are often made based on experience, style and personal preference. So if there is no clearly superior method, who ultimately makes the decision? Often, physicians are taught that they "own" their patients and, therefore, the decisions in regards to patients. NP/PA providers may also feel this same level of commitment and bring their own expectations and experiences to their decisions. How does this conflict achieve resolution? The eminent Stephen Covey recommends parties think "win-win": rather than pushing for one side or the other to win every disagreement, work to see the other perspective and find the "third" alternative where both parties are respected and satisfied.

4. **Ethical challenges** - NPs and PAs may be asked to participate in activities that serve as "work-arounds" for practice guidelines and standards of ethical practice. Examples include the following:

   - An NP or PA is targeted by pharmaceutical representatives to be given samples and gifts because the practice does not allow the representatives to meet with physicians.

   - An NP or PA is asked by either the patient or physician to document inaccurate information for the purpose of insurance approval of medical therapy.

Medical practitioners advocate for patients while staying within legal and ethical boundaries of their practice. Advance practice providers may be prone to stretching these limits because of a strong sense of doing what is beneficial for the patient and because they are asked to do so by a supervising physician. Nearly half of NP and PA respondents (47%) to a 2006 survey reported they have been asked by a patient to mislead insurers to assist them in receiving care (Saltman DC, O'Dea NA, Kidd MR, 2006).

SECTION 4

Retention: How to Keep the Hospitalist NPs and PAs You Hire

Retention: How to Keep the Hospitalist NPs and PAs You Hire

Good medical talent is hard to find. That's no secret to anyone concerned with staffing hospitalist programs. Sourcing good providers, attracting and recruiting them, orienting and training them, and fitting them into an established team all take time, work and money. Thus, retention is a vital piece of the staffing puzzle, and one to which any successful program needs to pay close attention. Without retention, no staff plan will work, no program or team will be stable, and no additional efforts will serve the needs of patients, the hospital and the other providers.

First Impressions and Making a Good Start

Vital to retaining the best people is hiring them in the first place. A program staffed with happy, fulfilled providers will almost recruit to itself. If many of the current staff are disaffected or unhappy, it may be necessary to address that before looking for new personnel.

Once you have hired a new person, it is important to structure the situation to predict for and ensure their success. This usually means a well-organized and clearly structured onboarding process, a careful orientation and a deliberate investment in the training necessary to get new providers the skills and experience they need to be productive clinicians. As mentioned earlier, assigning a mentor who is invested in the new provider's success is a proven strategy. Having leadership check in frequently with new providers is another good idea. Additionally, a program of regular performance evaluations with a goal of recognizing and addressing problems early provides a source of feedback that any new staff member deserves.

Support

Never forget that for a new provider's professional life to be successful, it must be supported by a fulfilling private life. No provider with a spouse or partner who is unhappy with the community or not making the transition to a new life will stay. Worse, perhaps, is one who needs the group to support him or her through the crisis of a divorce or other personal upheaval. Thus, anything that will help the spouse of a new provider to make the transition, and will make available a new social circle for one or both, is likely to pay dividends. Frequently, new providers tend to gravitate to others in the group of like age or family status as they assemble a social network, and it is helpful to foster any activities that promote this.

A Program Structured for Retention:

Happy employees will tend to stay. That's simple enough, so focus on structural attributes that make employees happy. The major complaints heard in hospitalist programs invariably concern schedule and compensation.

- Schedule: People need and want flexibility built into their schedule. That is what is wrong with the traditional "seven on, seven off" schedule and why it makes most people locked into it unhappy. Instead, consider using a schedule that maximizes flex, adapting itself to the individual needs of various providers to the greatest extent possible. This involves proprietary software managed by dedicated, experienced schedulers. Schedulers should interview each new hire during the orientation process to ascertain the individual's schedule preferences and desires, then craft a schedule that, as much as possible, meets

the desires of each individual. Also, time-off requests should be able to be submitted up to a year in advance. The system accommodates swaps among providers, properly accommodates part-timers and is efficient in that it is considered the "source of truth" for payroll purposes.

- Compensation: Everybody wants to be fairly paid. Closely follow salary surveys (SHM, MGMA, Sullivan-Cotter, AAPA, etc.). These ranges should be adjusted to reflect the ease or difficulty of recruiting to a given site, the experience and length of service of the provider, and other factors, such as productivity, as desired. A clearly enunciated and commonly understood policy is crucial for fairness and defensibility.

Career Development

Ambitious professionals look to the future, and NPs and PAs are no different. They want to know that their employer will encourage their growth and career aspirations. Useful strategies may include:

- Including career development as part of an annual discussion or periodic performance evaluation.

- Offering PAs/NPs positions in management, leadership, administration, teaching, mentoring, hospital committee work or other directions in which their interests are inclined and that may be of substantial value to the group or employer.

- Broadening the clinical responsibilities of those who wish to learn procedures, to perform treadmill studies, or to involve themselves in ICU or other special unit care. This may require that the physicians in the group rethink their willingness to share clinical tasks with their non-physician colleagues, but discussing such realignment can, in and of itself,

provide understanding and closer working relationships, and confer value of its own.

Employee Empowerment

Tell your providers that, when there is clinical decision making to be done, the physician is the final authority. However, in any other sphere of practice life, value people's opinions as informed by their experience and expertise. Thus, NPs and PAs have opportunities to use non-medical skills, to have a voice and to influence the group and its culture. This is well accepted by physicians and can be a major source of satisfaction, even to PAs and NPs who do not seem interested in non-medical work issues.
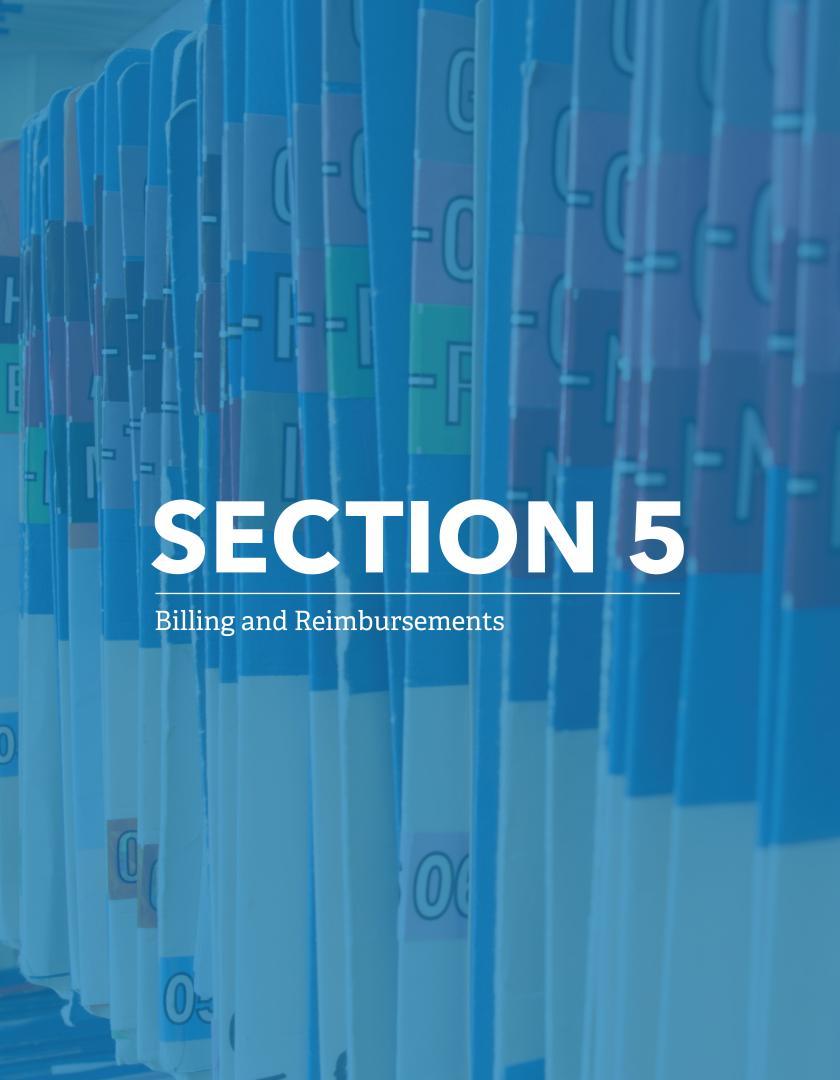
A Culture of Ownership

Confer on each clinician a sense that the practice they work in is theirs. Although individuals may take pride in the patient care they provide, it is essential to give everyone a sense that they contribute to the output of the group, that it is their group, and that they each contribute to the team effort. There are many ways to do this, from custom logo apparel to shared team recognition for various achievements to group social events. The point is that, as employees, this is their team, a group effort, their goals and their successes. Everyone contributes and supports each other in doing so.

Staffing a Program vs. Building a Team

Make it known that the goal is creating a highly functional, mutually supportive team, not just staffing to meet the load. The common analogy is that a busload of people will all arrive at the destination, but that if some seats are occupied by those who don't fit with the rest of the passengers, all will be unhappy with the journey. With this in mind, be prepared, and on occasion if necessary, consider the elimination of people who may be simply the "wrong person on the bus,"

or the wrong fit. Doing this can be painful, disruptive and expensive, but the cost of keeping such a person at the expense of the team is inevitably far greater.

To summarize, treat all employees as talented professionals functioning as part of a team dedicated to carrying out a clearly delineated mission. This comes from everyone having a role to play and making a valued contribution toward a shared goal. Working toward that end will also improve physician retention, job satisfaction, workplace cooperation, communication and willingness to serve the needs of the hospital as well as those of the patient. If that can be achieved, all hospitalist employees are happier and more efficient, the workplace is welcoming and highly functional, and patients, families, colleagues and hospital administrators and staff are pleased.

SECTION 5

Billing and Reimbursements

Billing and Reimbursements

As with every aspect of NP and PA practice, it is important to understand the proper method for billing and reimbursements. Despite possible misconceptions, both NPs and PAs can and should submit claims under their own National Provider Identification (NPI) number. Both NPs and PAs are able to bill for all levels of CPT evaluation and management codes under the general supervision/collaboration of a physician per the Medicare Policy Benefit Manual. Discussion between the supervising/collaborating physician and NP/PA related to the proper documentation requirements and billing provider should be decided at the practice level based on the services provided. For Medicare, the reimbursement for NPs and PAs will be at 85% of the physician rate (CMS IOM Publication 100-04).

Medicare:

Medicare reimbursement for services rendered by non-physician providers* (NPPs) is determined by federal Medicare policy, but Medicare defers to state law in defining scope of practice. There are two ways that practices can bill Medicare for inpatient services: under the PA's or NP's own name and NPI number, or as shared visits under the supervising physician's name and NPI. The NPI number can be obtained at https://nppes.cms.hhs.gov.

*This nomenclature is directly from Medicare policy

• Independent Billing:

NPPs are able to enroll and bill Medicare for services that they are licensed or certified to perform within the state. Normal billing under the NP's or PA's name and NPI number is reimbursed at 85% of the physician fee schedule.

• Shared/Split Billing:

NPPs who have their own billing number and provide shared visits with physicians in hospitals may bill for services at 100% as long as the physician has also seen the patient the same day in a "face-to-face" encounter (CMS IOM Publication 100-04). Billing will take place under the physician billing number.

The following criteria must be met for shared visit billing:

- Physician and the qualified NPP must be in the same group practice or be employed by the same employer

- The services provided must be E/M services. The split/shared E/M policy does not apply to critical care services or procedures.

- Both the NPP and physician must see the patient face-to-face on the same day and perform part of the E/M visit.

- Both must independently document their face-to-face visit with the patient.

For a split-shared visit, there must be documentation of the face-to-face portion of the E/M encounter between the patient and the physician. The medical record should also clearly identify the part(s) of the E/M service that were personally provided by the physician, and which were provided by the NPP. In the absence of such documentation, the service may only be billed under the NPP's provider number with reimbursement paid at the 85% rate. This applies to the initial history and physical examination, the discharge summary and subsequent hospital visits.

Non-Medicare claims:

Although Medicare policies are often used as blanket policy standards by physician practices and hospitals, organizations

should ideally apply Medicare policies only to Medicare patients, and research both state-specific Medicaid guidelines and payer-specific rules to see how they compare to Medicare's policies. Most third-party payers will cover NPP services, but they may not enroll them. In this situation, a practice would bill under a physician's NPI and follow the billing guidelines in the payer's provider manual.

Commercial payers will follow state laws and often require modifiers to correctly identify the provider and supervising physician providing care.

Employer site and impact on billing:

Incident-to services are for office-based services, and shared visits are for hospital inpatient/outpatient/emergency department services.

Hospitals that employ NPs and PAs must bill for their clinical services under Medicare Part B. However, if the hospital includes the NP or PA salary on the Medicare cost report (seeking payment under Medicare Part A) and if the hospital receives any reimbursement under that cost report, the hospital may not bill the NPP's services to Medicare under Medicare Part B (physician services).

Bylaws Impact on Billing:

State law dictates what medical services PAs and NPs can provide, how autonomously they can practice and what medications they can prescribe.

Supervision and Collaboration requirements:

Supervision Requirements for Physician Assistants

All physician assistants require physician supervision. The physician supervisor need not be present physically in the same location when the PA furnishes a service, unless state law provides otherwise. If the physician supervisor is not present, he or she must be

immediately available to the PA for telephone consultation. The laws and regulations governing PA practice vary state to state and change with each legislative session. For the most recent information regarding PA practice by state visit

https://www.aapa.org/threecolumnlanding. aspx?id=304.

Supervision Requirements for Nurse Practitioners

Currently, 21 states and the District of Columbia have approved "full practice" status for nurse practitioners, allowing them to practice independently, without physician oversight. Nurse practitioners who operate in these areas are free to establish and operate their own independent practices in the same way physicians do. NP laws and regulations are specific to each state and constantly changing. For an interactive map of up-to-date licensure and regulatory requirements visit

https://www.aanp.org/legislation-regulation/ state-legislation/state-practice-environment

Nurse practitioners have full practice authority in the District of Columbia and the following states: Alaska, Arizona, Colorado, Connecticut, Hawaii, Idaho, Iowa, Maine, Maryland, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, Vermont, Washington and Wyoming.

The remaining states continue to hold reduced or restricted practice regulations for nurse practitioners. In these states, NPs are required to have either a signed collaboration agreement with a physician or direct oversight of a physician. Not all states require the physician to be physically present or even in the same vicinity with the NP during patient care, but physicians should be available by phone or email.

Medicare Requirement for Collaboration

Federal law requires that NPs have a formal

collaborative or supervisory agreement with a physician or other healthcare provider "provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed" (CMS, 2005). In states with no supervisory requirement, an NP can practice without a collaborative relationship but cannot receive Medicare reimbursement for the services provided in that practice. Additionally, in every state, including those without a collaborative practice requirement, NPs must have physician collaboration in the care of hospitalized patients because under federal law governing hospitals, a hospital must require that "every patient be under the care of a physician."

Certification and Impact on Billing:

Medicare Qualifications for Nurse Practitioners

To qualify as an NP eligible to become a Medicare provider, an NP must:

- Be a graduate of Master's, Postmaster's, or DNP program
- Be a registered nurse authorized by the state to practice as a nurse practitioner
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners. The recognized NP national certifying bodies are:
  - o American Association of Nurse Practitioners (AANP)
  - o American Nurses Credentialing Center (ANCC)
  - o National Certification Corporation (NCC)
  - o National Certification Board of Pediatric Nurse Practitioners and Nurses (NCBPNPN)
  - o Oncology Nursing Certification Corporation (ONCC)
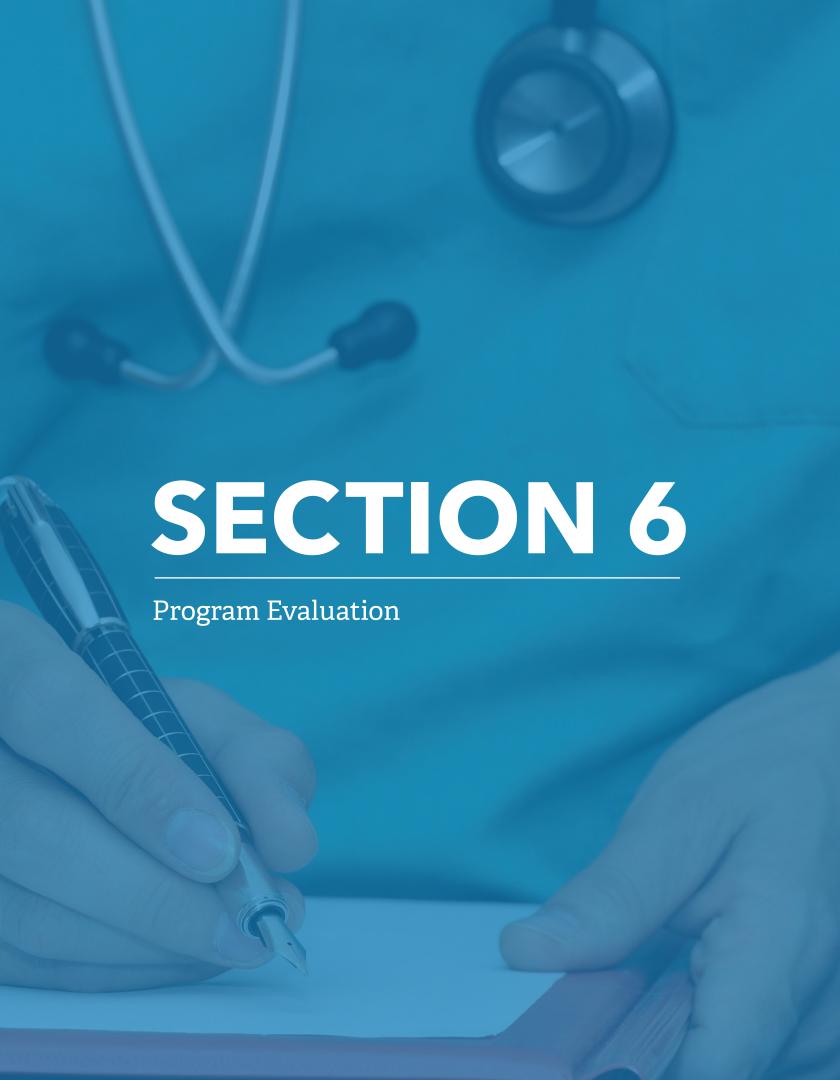 - o Critical Care Certification Corporation

Medicare Qualifications for Physician Assistants

To qualify as a PA eligible to become Medicare provider, a PA must:

- Be a graduate from a PA educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA); or
- Pass the national certification examination administered by the National Commission on Certification of Physician Assistants (NCCPA); and
- Hold a state license as a Physician Assistant

The following list of resources provides additional information on billing and reimbursements:

1. American Academy of Nurse Practitioners (AANP) Federal Legislation Medicare Update

   http://www.aanp.org/legislation-regulation/federal-legislation/medicare/68-articles/326-medicare-update

2. American Academy of Nurse Practitioners (AANP) State Practice Environment

   http://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment

3. American Academy of Physician Assistants (AAPA) Reimbursements

   https://www.aapa.org/reimbursement/

4. Centers for Medicare & Medicaid Services (CMS) IOM Publication 100-04, Chapter 12

   https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

5. Medscape Billing for Nurse Practitioner Services -- Update 2007: Guidelines for NPs, Physicians, Employers, and Insurers

   http://www.medscape.org/viewprogram/7767

SECTION 6

Program Evaluation

Program Evaluation

In this era of increasing awareness of practice costs and increased scrutiny of return on investment, it is critical for inpatient practices to develop a deliberate plan to perform ongoing, high-quality programmatic evaluation. Although the precise form and method of evaluation will vary per setting, every programmatic evaluation should include some common elements.

HMGs need high-quality data to make strategic decisions about their practice. Historically, groups/leaders have not had access to this data or have lacked insight into how to effectively use this information. Even when group leaders have data, it is often limited to professional fee collections, group costs and hospital/company support. While this information is important, it does not provide a comprehensive view of that program's contribution to the HMG or hospital at large.

An HMG leader needs to have access to information concerning mortality, case mix index, relative value units (RVU) earned, average daily census (ADC), encounters, length of stay, etc. Importantly, less easily obtained or defined data also requires attention. For example, if an NP or PA is providing administrative support (e.g., managing patient flow), then more costly physician time has been liberated to dedicate to purely clinical issues. If a physician is performing shared visits with an NP or PA, the contribution of the NP/PA must be extrapolated as this physician would have a lower ADC or potentially lower-quality encounter without this collaboration.

A special note should be made around shared visits versus independent visits. As mentioned earlier, Medicare and most other insurers pay 85% of the professional fees paid to a physician for an encounter. It is tempting look at an NP/PA seeing patients alone and billing independently as losing 15%. However, when the offset between NP/PA and physician salaries is accounted for, this 15% difference is more than covered. Moreover, most systems do not have the ability to flex physicians up and down in a way that maximizes efficiency (so the ADC for an HMG does not require a whole number of physicians in an efficient way), while the combination of NP/PA/MD models allows for much more efficient use of the combined providers.

As of 2015, readmission penalties accounted for 3% of Centers for Medicare & Medicaid Services (CMS) dollars paid to hospitals, and this percentage continues to grow. In addition, Value-Based Purchasing (VBP) will grow to 2% before the end of 2017 and hospital-acquired conditions will account for 1%. Although it may be difficult to attach hard data, such as is available on mortality, an important aspect of programmatic evaluation should capture any value that an NP/PA group adds in this arena. An HMG should aim to attribute when possible Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data to individual providers or at least provider models. For example, if communication with providers cannot be attributed to an individual provider, sometimes these data can be attributed to a physician-NP model as opposed to a physician-only team.
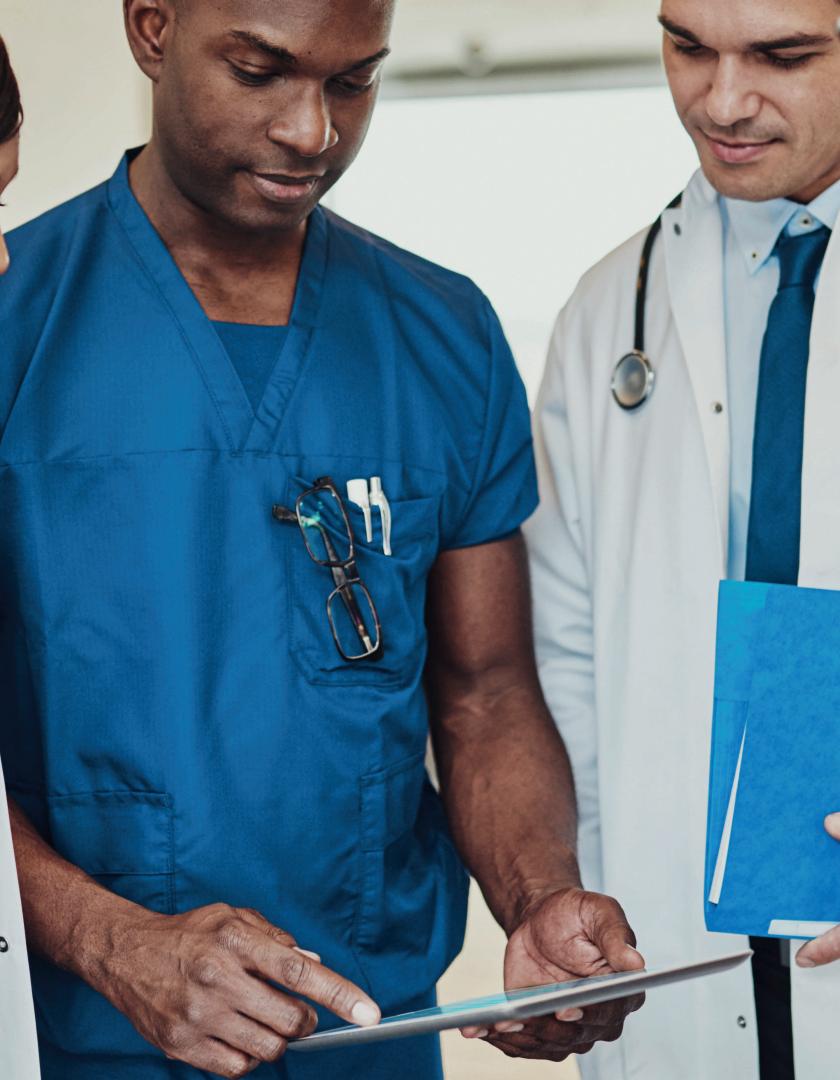
All HMGs need to have a strategic plan for improving patient experience, improving quality, improving outcomes and decreasing
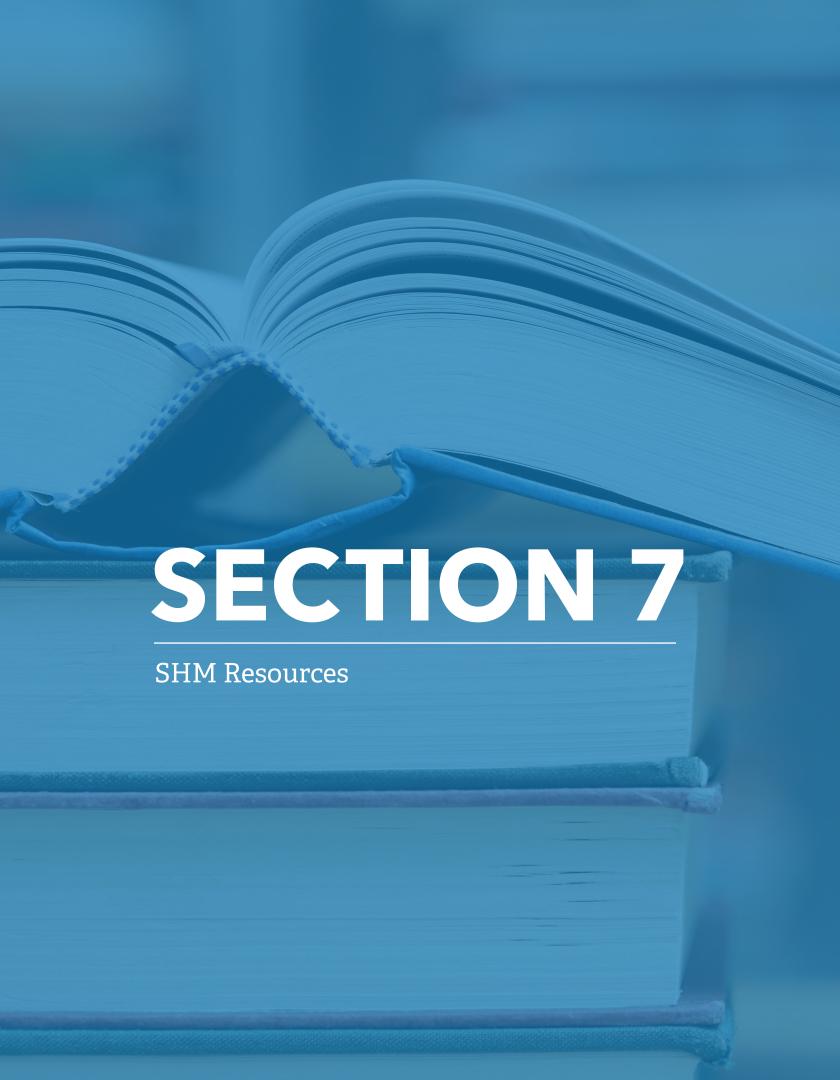
waste, as these represent the domains wherein hospitals will be penalized financially. Making use of NP/PA/MD collaborative models may be an excellent way to enhance the care of patients in these domains, but this has to be done thoughtfully as not to create undesirable positions for HMG NPs/PAs. For example, an NP or PA could lead an HMG's efforts to move toward checklists that have been shown to reduce readmissions and complications or have other positive outcomes. This might be perceived by NP/PA HMG members as a coveted leadership opportunity within the HMG. Another approach might involve an NP or PA managing the checklist and other measures that improve efficiency for a team's patients. While this may improve this important outcome measure, the NP or PA might perceive this as a clerical job, leading to job dissatisfaction and turnover.

A critical measure of an HMG's success is the turnover of its NP and PA members. Extrapolating from data describing the cost surrounding physician turnover, NP and PA turnover should be monitored closely. Turnover of these providers might even more impactful than physician turnover should an HMG's NP and PA providers be devoted to system roles that improve quality care or patient experience metrics. Should increases in turnover occur, well-designed root-cause analyses should be employed to uncover potential causes.

Most importantly, there must be a mechanism to use this evaluation to improve the programmatic design. For example, if an outcome is that a group's physician providers are happier because the NP/PA cohort dampens the impact of high admission days, this may not lead to financial stakeholders supporting the continuation of a program. However, if the NP/PA patients have better transitions to the community or decreased hospital-acquired infections, then value to these stakeholders is more easily shown.

SECTION 7

SHM Resources

SHM Resources

NP/PA Special Interest Group

A special interest member community on SHM's Hospital Medicine Exchange (hmxchange.org) designed to support and foster the role of nurse practitioners and physician assistants in hospital medicine and to provide collaborative opportunities with the SHM Nurse Practitioner/Physician Assistant Committee.

Adult Hospital Medicine Bootcamp

A joint meeting from the Society of Hospital Medicine and the American Academy of Physician Assistants, this annual program offers content on the most commonly encountered diagnoses and diseases of adult hospitalized patients.

SHM's Annual Conference

The largest national gathering of hospital medicine providers in the United States offering a comprehensive array of educational and networking opportunities for the hospital medicine professional.

References

Best Practices for Recruitment and Retention, http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Magazine/2011/Apr/0411HHN_FEA_gatefold

Capstack TM, Segujja C, Vollono LM, Moser JD, Meisenberg BR, Michtalik, HJ. A comparison of conventional and expanded physician assistant hospitalist staffing models at a community hospital. *JCOM*. 2016 Oct; 23(10):455.

Centers for Medicare & Medicaid Services (CMS) IOM Publication 100-04, Chapter 12, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Furlong E, Smith R. Advanced nursing practice: policy, education and role development. *J Clin Nurs*. 2005 Oct;14(9):1059–1066.

Lessons from an Industry Crisis: Solutions to Healthcare Worker Shortage Offer Lessons for All Businesses, http://www.employeeretentionstrategies.com/strategies/healthcare/

Saltman DC, O'Dea NA, Kidd MR. Conflict management: a primer for doctors in training. *Postgrad Med J*. 2006 Jan;82(963):9–12.

Strategies for Healthcare Retention: What Makes Employees Leave -- and What Makes Them Stay, http://www.inc.com/articles/2005/05/monster3.html

Ulrich CM, Danis M, Ratcliffe SJ, et al. Ethical conflict in nurse practitioners and physician assistants in managed care. *Nurs Res*. Nov-Dec 2006;55(6):391–401.

Empowering hospitalists. Transforming patient care.

shm
Society of Hospital Medicine