THE ROLE OF ADVANCED PRACTICE NURSES (APN) IN PROVIDING STROKE CARE IN STROKE BELT

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What we know about APNs:

- No shortage of studies on APN’s Positive role in modern heath care
  - Over 50yrs of peer-reviewed data
- Key to accessible/cost effective care
- Decrease LOS (Increase Hospital profits)
- Decrease re-admissions
- Decrease mortality rates
- Comparable/better outcomes than MD: 30-60-90 days to 2yrs
What we know can help expand Regional/National Goals:

- APNs are Uniquely qualified to provide Holistic Care and provide strategies to Promote Health/Prevent disease, yet barriers remain blocking us from practicing to the fullest extent of our training/edu.
- Affordable Care Act (ACA) = Influx of new users into an already maxed system. More than a “Doc fix”
- APNs part of cost-containment of HC & “safety net”
- ACA will expand APN roles and utilization
- April 2015: Repeal of Sustainable Growth Rate (SGR) formula for Medicare part B (Improves HC delivery specific to NPs and ensure unobstructed care.)

Why this SGR Repeal is specifically important:

- Authorizes NPs to document evals for durable medical equipment
- Include NPs in first year of Merit-based Incentive Payment System (MIPS)
- Ensures NP-led pt centered Medical Homes are eligible to receive incentive pay for mgt of chronic diseases
- Extends Community Health Centers & NHS funding to NPs in vulnerable/underserved populations
Discrepancies in Distribution of Health Workforce:

- 2012 HRSA NSSNP: Complexities measuring “non-physician” supply of health professionals
- Drastic need to update methods for estimate demand for services: meet future of HC delivery
- IOM 2010 report outlines future direction of ANPs
- Address provider misidentification: verifications show magnitude of error due to lack of ANPs “visibility” in basic reports such as Area Resource Files (ARF) w/data variables used in Health Provider Shortage Areas= $$NP funding!

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Health Care Workforce:

**Table 1. U.S. primary care workforce by provider type, 2010**

<table>
<thead>
<tr>
<th>Primary care provider</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>208,807</td>
</tr>
<tr>
<td>Nurse practitioners</td>
<td>55,625</td>
</tr>
<tr>
<td>Physician assistants</td>
<td>30,402</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>294,834</td>
</tr>
</tbody>
</table>

Source: AHRQ Primary Care Workforce Facts and Stats #1 and #2.
Where you live matters!

Table 2. Geographic distribution of health care professionals, 2010

<table>
<thead>
<tr>
<th>Geography</th>
<th>All specialties</th>
<th>Primary care</th>
<th>U.S. population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NP</td>
<td>PA</td>
<td>Physicians</td>
</tr>
<tr>
<td>Urban</td>
<td>84.4%</td>
<td>84.4%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Large rural</td>
<td>8.8%</td>
<td>8.8%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Small rural</td>
<td>3.9%</td>
<td>3.8%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Remote rural/remote</td>
<td>2.8%</td>
<td>3.0%</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

Data derived from analysis of National Provider Identifier file, November, 2010; U. S. Census Bureau Population Estimate, 2008. Rural and urban designations are taken from the Rural Urban Commuting Areas Codes, a Census tract based classification scheme that uses standard Census Bureau definitions in combination with work commuting information to characterize rural and urban status and relationships of the nation’s Census tracts. Roughly, large rural populations = 10,000 - 60,000; small rural populations = 2,500 - 6,999; and remote rural frontier populations = less than 2,500 people. For more information see: http://depts.washington.edu/awruca/RUCodeDics2.pdf and http://depts.washington.edu/awruca/ruc-lists.php.

National Avg of PCPs w/APNs: 53%

Figure 3. Percentage of office-based primary care physicians with physician assistants or nurse practitioners in their practices: United States, 2012.
Need Improved Access to Care

Figure 2
Nurse Practitioner State Practice Environment, 2014

SOURCE: American Association of Nurse Practitioners, 2014

Where are the specialties?

Exhibit 3. Specialty of Practice/Facility for Nurse Practitioners Providing Patient Care

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of Nurse Practitioners</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>60,407 (48.1%)</td>
<td></td>
</tr>
<tr>
<td>Internal Medicine Subspecialties</td>
<td>16,675 (13.3%)</td>
<td></td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>11,047 (8.8%)</td>
<td></td>
</tr>
<tr>
<td>Pediatric Subspecialties</td>
<td>3,880 (3.1%)</td>
<td></td>
</tr>
<tr>
<td>Psychiatry/Mental Health</td>
<td>7,034 (5.6%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>25,079 (20.0%)</td>
<td></td>
</tr>
<tr>
<td>No specialty</td>
<td>1,586 (1.2%)</td>
<td></td>
</tr>
</tbody>
</table>

APN Era: Strategies to decrease rising costs

- 5/50 Rule in Health Care (Forbes, Jan 10, 2013)
- Enormous amount of money centered on a very small concentrated group.
- Not just newborns/elderly, but socioeconomic disparities with multiple co-morbidities with increase stroke risk, as we see concentrated in Stroke Belt.
- Serious/Chronically ill

APN role in stroke care begins at a community level

- Rural/Urban
  - Lg burden exceeds the capacity of caregivers
- Education/Prevention
  - Target changing behaviors/Lifestyle
- Accessibility for chronic/co-morbid pts
  - Decrease access leads to poor self-care -> Poor outcomes
- Improved Mgt of chronic/co-morbidities
  - Develop programs for Primary/Preventative HTN clinics
  - Decrease Hospitalization
  - Decrease serious events/Stroke
**APNs in Acute Care**

- Collaboration= Time to break old silo’s of practice!
- Expand role in Acute Stroke Care
  - Endovascular and Interventional Neuroradiology
  - Active part of academics/Research
- Few Educational courses available specific to Neuro/Stroke
- Need for Residency in specific specialties
- Need for Preceptors/Educators in specialty area of Stroke & Vascular neurology

**APNs in Specialty Care/Follow up clinics & Rehab:**

- Specialty roles for APNs are lacking in general
- NO Neurology NP data available, except for 70 ANVPs now certified. (Alexandrov, 2009)
- Vital role in Stroke care throughout the continuum. (AHA/ASA 2009)
  - Should expand APN lead Stroke and TIA clinics within the CSC’s: F/U Secondary Stroke prevention clinics
How will NP developments be funded?

- CMS & Pvt Ins, but currently collect data only on MD quality points, NPs not built into database for “Pay-for-Performance” initiative

- Need for Health Cost & Utilization Project (HCUP) to properly identify provider types (NP v MD) in order to provide money to fund underserved populations and geographical areas.
  - This provides access to health stats/info inpatient & ER utilization
  - Current assessment on Quality$ needs Drastic overhaul:
    - Household survey questions don’t include APNs, only MDs
    - Medical “provider”= MD, Hospitalist, Home Health and Rx only. NO APNS

The APN of the Future

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Future State:

- Transitional Care NP
- Expansion of bundled care
- NP led chronic disease clinics
- Integrated Practice Units
- NP specific quality data
- Full scope of practice

Data Source: Harvard Business Review
Integrated Practice Units (IPUs)

- Organized around a specific medical condition
- Multidisciplinary team dedicated to specific condition
- Full cycle of care
- Patient education, follow up, engagement
- Attributable outcomes leads to team accountability
- Regular meetings for process improvement
- Opportunity for NPs to lead IPUs

Bundled Payments

- Encourage team work
- Collaboration across the continuum
- Payment that is aligned with value and cost containment
- How about stroke care?
- APNs as a “Transitional Care Coach”
- Partnerships with Rehab/SNF/HHT to improve the transitions
- Empowerment of patients/families
- Reduction in 30,60,90 readmissions seen
Reimbursement

- 85% vs 100%
- NPs not allowed to certify Home Health services or DME
- Lack admission privileges at most acute care facilities
- Fee for service and RVU based -> little time for prevention!
- Equal payment for services rendered
- Remove barriers to ordering Home Health and DME
- Allow admission privileges -> rural communities
- Visits dedicated to prevention

10 years from now...

- All states will endorse top of license practice
- Reimbursement will equalize with more focus on preventative services
- NP led teams with focus on stroke Prevention and Care across the continuum
- Bundled payments for stroke care
- More NPs in rural and underserved areas
- Outcomes management with NP specific data specific to disease
How to get there?

- Must acknowledge the barriers and remove them (bylaws, educational gaps)
- Administrators must roll out the red carpet and ease the road of credentialing! (APP)

Important Terms to Know to Navigate Common Issues

- TERMS
  - Credentialing
  - Privileging
  - Onboarding
  - Professional Practice Evaluations

- COMMON ISSUES
  - New Grads
  - Lack of Relevant Experience
  - Poor Planning
  - Meeting NP where they are in specialty
Consider – Advance Practice Council

- Part of Interview
- Part of Credentialing and Privileging
- Part of On-Boarding
- Continuing Education
- Communication
- Monthly Meetings
- Mentorship

THANK YOU!!