Health Centers in Trenton and Newark:
Building New Jersey's Primary Care Safety Net

Assessing Feasibility of Nurse Practitioner Practices: A Toolkit for New Jersey Communities

Submitted by:

Nurse Practitioner Healthcare Foundation

New Jersey Health Care Quality Institute

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INTRODUCTION

The establishment of a nurse practitioner (NP) practice in the community deserves careful thought. In most cases, NP practices have been found to be highly responsive to patients' needs, and a welcome addition to the mix of services available in the community. Abundant literature exists that demonstrates the effectiveness and quality of nurse practitioner care to meet primary care needs.[1] NP outcomes have been shown to be equivalent to, or better than, those of physicians. NPs are known to focus on their relationship with the patient as well as the provision of healthcare, paying attention to the medical, psychosocial, and social determinants of an individual's health.

Yet, a careful assessment of the community will yield important information to consider in determining the advisability of an NP practice. Identifying the strengths, resources, unmet service needs, and capacities of the community is key to understanding the unique features that must be addressed by a new practice. Similarly, researching the demographics of the community, health status indicators, legal and regulatory issues affecting practice, and the financial options are important as well. Information from key stakeholders – providers, community leaders, and patients – can provide important insight into the decision to initiate an NP practice. The political environment and degree of support of the business and philanthropic community must be understood. Finally, an assessment of the potential barriers to the establishment of a successful nurse-led practice is part of a comprehensive evaluation of feasibility of a nurse-led practice. This *Toolkit for New Jersey Communities* was developed as a guide for communities in New Jersey to use in assessing the feasibility of a nurse practitioner practice in their community. The Toolkit provides an overview of each assessment area, gives examples of key questions to ask, and lists resources to refer to for further information. The Toolkit outlines a methodical way to evaluate the feasibility of establishing a new nurse practitioner-led practice in the community.

[1] See the American Association of Nurse Practitioners for extensive resources and research. Web. https://www.aanp.org/research/reports

COMMUNITY ASSESSMENT

It is essential to understand the demographics of the community in which a nurse practitioner-led practice would be opened. A careful review of the demographic makeup of the local population will help identify not only the health status of the intended clients, but their cultures, language, and importantly, their specific health needs.

Community and County Demographics

It is important to have a good sense of the population in the targeted area because it will impact where and how to deliver care to underserved populations. Some questions to ask:

- Are the underserved unemployed or employed? This may affect the hours the clinic is open and it will certainly have ramifications as to what type of insurance, if any, the clients have (Commercial, Self-funded, Marketplace, Medicaid, Medicare, etc.).
- What is the education level of the clients? This will affect communication issues such as health literacy, and the ability to reach younger populations in the school systems.
- Are there cultural considerations that might impact the way healthcare is delivered? Will women healthcare professionals be preferred? Will women healthcare professionals be accepted? Who are the decision-makers in the family? All of these issues may affect how the clinic is marketed and operated.
- What is the average income? How many single mother households are there? This will impact the health dollars that may impact affordability and access for potential clients.
- What are the primary languages spoken in the community? Communication is important in healthcare; translators or healthcare professionals who speak the most common languages will be essential.

Resources:

- Population Demographics: U.S. Census http://www.census.gov/quickfacts/table/PST045215/34
- City Profiles: http://www.city-data.com
- Unemployment statistics: US Bureau of Labor Statistics http://www.bls.gov/

Community Segmentation

Consider how the community is divided. Do residents identify with particular neighborhoods? Are there pockets of ethnic communities? Consider whether there is adequate transportation that allows those without cars to move through communities. It is important to assess whether individuals will seek to obtain care outside of their local neighborhood. Understanding a community's living habits and ties to its neighborhood will impact both where to locate the practice site, and the reach of the clinic based on its location.

Community-wide Challenges

Certain community factors should also be considered, such as:

- Food Desert: assess the availability of healthy food options.
- Education: assess the levels of education for the local population to adapt health literacy materials for clients.
- Crime: evaluate the issue of safety of within the target community to understand the challenges for both patients and future employees of the clinic. http://www.neighborhoodscout.com
- Homeless: understand the numbers of homeless individuals and available shelters as this will influence the location of services, if this population is a potential client base. http://www.homelessshelterdirectory.org/cgi-bin/id/city.cgi?city=Newark&state=NJ

Community Health Status

It is important to comprehend the most prevalent health challenges of the community to be served. Identify the common chronic diseases for each population segment and age group. Some important health status information can be obtained from Chartbooks of each county. These are epidemiological studies done by the State.
http://www.state.nj.us/humanservices/dmhas/publications/epidemiological/

Conduct a wide search to identify disease-specific studies completed in the region by various health professional groups, nonprofits and/or government agencies. Sources of these studies may include city, county and state health departments, disease-related nonprofits such as the American Heart Association, and others.

Emerging Community Trends

Evaluate any relevant past and ongoing work in the area of healthcare delivery and payment to identify key stakeholders, funding sources, pilot programs, availability of health clinics, and other initiatives that might impact the opening of a new nurse practitioner-led practice. Failed attempts to collaborate or to provide health services to the underserved should not be ignored as important lessons can be learned and mistakes avoided from past unsuccessful efforts.

Overview of Health Services in the Community

Assess the Current Status of Care in the Community

- Availability of primary care providers. *NJ Physician Workforce Task Force Report*. http://www.njcth.org/NJCTH/media/NJCTH-Media/pdfs/FINAL-NJ-Physician-Workforce-Report--w-appendices-012910.pdf
- Availability and location of hospitals, Federally Qualified Health Centers (FQHCs), mobile clinics, and other sources of primary and urgent care in the region.
- Determine if any Accountable Care Organizations exist or are forming.
- Identify any pilot projects or grant-funded projects providing health services in the area.
- Determine if the community is designated as a Medically Underserved Area (which may make the practice eligible for federal grants) http://www.hrsa.gov/shortage/mua/

- Map out the available clinics and hospitals to understand the accessibility in terms of transportation.
- Collect information about the availability of primary care appointments beyond the normal workday. Is the community using emergency rooms for primary care? If so, why?

Consider the Politics of Healthcare in the Community

Because healthcare delivery is closely tied to funding, and the source of that funding is often based in government, it is essential to understand the political power structure both locally and in the state and federal arenas that may impact the funding sources that will support the NP-led practice. Questions to consider:

- What political parties lead the community? Has that leadership been stable or has it fluctuated between the parties?
- Has healthcare been a political issue; if so, how?
- Are there any health professionals or health policy experts in the political power structure? If so, meet with these individuals to gain insight into their openness to support, or at a minimum remain neutral, to the establishment of a new, nurse-led practice.

Hospitals and medical groups are often entwined in the political structure, usually through business groups such as the Chamber of Commerce, Kiwanis Club or similar civic organizations. Meet with individual leaders of these groups and discern their thoughts on this new venture. They usually will be quite helpful and, even if they are not supportive, can be a source of valuable information.

STAKEHOLDER ASSESSMENT

Community Leaders, Policy Makers, Healthcare Professionals, and Others

In any community, there are business, political, and local dynamics that may support or impede the success of a new program or service. Understanding those dynamics and the individuals and organizations involved, as well as the interests and positions they represent, might make or break a new endeavor. Thus, it is important to gather baseline information on and from those whose interests might be impacted either favorably or unfavorably by a new service. An effort should be made to formally or informally gather data on the perspectives of those with a perceived interest in the project. Develop prepared questions to begin the conversation when meeting with stakeholders.

Sample Questions:

- What are your concerns about healthcare delivery and health status in your community?
- Do you perceive your community as over-, under- or adequately served in primary care? (Ask about preventive care, illness care, and mental health/behavioral health services and any other health concerns you identified in your demographic research.)
- How familiar are you with the role of nurse practitioners and their role in delivering primary care?
- What barriers do you see to establishing a new primary care practice? A nurse-led practice?

- Would you be willing to support this practice publicly? Financially? Politically?

Follow up on any other issues raised during these discussions to get maximum feedback.

Because healthcare touches everyone, conduct stakeholder interviews with a broad range of individuals and groups, including but not limited to the following:

- Business leaders, including CEOs from local chambers of commerce as well as local shop owners. See the section in this Toolkit entitled "Assessment of Community Support" specifically relating to soliciting feedback from these stakeholders.
- Nursing and healthcare professional leadership in the area. This might include academic leaders, existing providers or key opinion leaders in the field. Be sure to include outreach to the existing clinics, FQHCs, FQHC Look-Alikes, and community mental health agencies to understand their perspectives on establishing a nurse-led practice.
- Religious leaders who are influential in the broader community and in specific ethnic or cultural populations.
- Labor organizations, unions and cooperatives may offer a patient-oriented perspective of healthcare needs.
- Appropriate municipal, county and state officials whose regulations may need to be addressed to open a practice or service.
- Local political leaders such as council members from the service area.
- Leadership from social service and community agencies that would likely interface with a nurse-led practice.
- Foundation staff to explore future funding. See the section entitled "Philanthropic Appraisal" for more details about how to solicit feedback and support from this type of stakeholder.
- Health plan representatives with an eye toward promoting contract discussions and conversations about new models of healthcare delivery.
- Hospital leadership to explore partnering opportunities on support services, referral arrangements, and other activities to meet patient needs.
- Accountable Care Organizations (ACOs), if any, established in the targeted community.
- Representatives from various cultural and ethnic groups to promote inclusion and understanding of their particular needs.

Being engaged in the broader community will provide information and guidance that will help to anticipate business, political and policy trends that could impact the success of the practice.

Business Community Support

The business community is a potential source of patient referrals and valuable health information. As the ultimate payer of healthcare, employers may wield significant influence over how care and services are provided. Therefore, new providers should make an effort to introduce themselves to key employers who may offer insights into the influence of certain health plans and suggest partnership opportunities and linkages to influential local leaders. Since many employers believe that good health is good for business, having a working relationship

with the business community may foster a collaboration that promotes primary care and a healthier community.

When speaking with business executives, it would be helpful to meet with a company's chief medical officer or director of health services as well as leaders from local chambers of commerce, business coalitions, insurance brokers, and other business trade associations. Consider discussing the following concepts and opportunities:

- It is important to know and understand the healthcare issues of an employer and the needs of its employees.
- While most employers are seeking to reduce their overall healthcare costs, many are also focused on improving the health and productivity of their workforce. This creates an opportunity for a nurse-led practice to partner with employers on wellness and prevention programs.
- Addressing chronic conditions such as hypertension, diabetes and cardiovascular disease, and developing/addressing medication adherence issues could be very attractive to certain employers. Towards that end, a nurse-led practice that provides on-site screenings or office-based assessments could be helpful to employers.
- Many large employers are looking to develop a "culture of health" in their organization to promote prevention and wellness. Working through either the human resource department or medical affairs, a nurse-led practice may offer opportunities to partner with or support health fairs, screening programs, flu vaccine efforts, or employee education initiatives.
- Smaller employers in the community may be interested in supporting an occupational medicine program that promotes return-to-work interventions.
- Getting to know the large employers in the service area may have ancillary benefits, as they may be willing to fund local health efforts through their foundations or community affairs departments.
- Leaders from the business community often sit on the boards of local hospitals, and community agencies. Thus, having a relationship with the business leaders could bring broader benefits to a nurse-led enterprise, especially in developing a doctor-NP collaborative relationship as required by New Jersey statutes.

Resources:

- New Jersey Chamber of Commerce – www.chamber.com
- Employers Association of New Jersey – www.canj.org
- New Jersey Business and Industry Association – www.njbia.org

Employer/Corporate Assessment

To better understand the needs of employers, it may be worthwhile to conduct a brief survey to assess their perspective on the needs for and value of a nurse-led primary care practice. Use of a tool, such as Survey Monkey, can be helpful to obtain data to assess both the feasibility of opening a new practice as well as unmet needs identified by employers. The survey could include the following questions:

Evaluate perceptions of access to primary care/need for additional primary care services:

- Do you believe there is a need for additional primary care services in your community?
- Do you believe that employees have access to conveniently located primary care services that are comprehensive? That are affordable? That meet the needs of employees?
- Do you agree that a healthier population is good for business and for the community as a whole?

Identify employee health needs:

- How would you describe optimal health services for your employees?
- How important are each of the following conditions to your employees' health? (List smoking, obesity, stress, depression, chronic medical conditions, or other health issues identified in your search of the community's health demographics.)
- How important are each of the following health services to your employees? (List same day care, preventive care, treatment of common minor conditions, treatment of chronic conditions [give examples], prenatal care, treatment of emotional/mental health conditions)

Ascertain where employees seek care to identify how to structure services:

- If your employees need primary care, where do they usually go? (Allow the respondent to check all that apply: company-sponsored clinic, convenient care clinic, urgent care center, community clinic, physician office, nurse practitioner practice, emergency room)

Rate employer's expectations of outcomes of care to develop useful metrics for future services:

- Please rank the outcomes that you would expect from using a primary care center (reduced emergency room visits, reduced hospital readmissions, reduced healthcare costs, better managed chronic conditions and health risks, coordinated care, reduced employee absenteeism).

Assess familiarity with and value of NP services to yield information about potential barriers and facilitators of an NP-led practice:

- Describe the level of experience you have with NP primary care practices.
- If a new NP-led health center providing a full range of services opened in your community, would it be helpful to your company/your employees? If yes, how might you support it?

Be aware that although it may be difficult to get an adequate response from an email survey, there could be value in this method; certain issues and ideas may be raised in this more anonymous survey that are not identified during personal interviews and conversations.

Healthcare Colleagues and Competitive Assessment

A thorough evaluation of existing healthcare providers, institutions, and clinics in the targeted community is essential in assessing the feasibility of establishing an NP-led practice. It should be understood that not all may react positively to the opening of a new primary care practice in the community. Getting a sense of the healthcare providers who would be potential competitors or collaborators is an important element in measuring the likelihood of success of a new nurse-led primary care practice. Ask:

- Are providers accepting of nurse practitioners, and of nurse-led practices?
- Are resources tight? This could result in a perception by healthcare colleagues that a new practice is a financial threat for the existing practices.

Determine the number and types of entities who are providing similar services in the community. Are these facilities underutilized? Do they have long wait times? What is their reputation for care and service? How will the NP-led practice differentiate itself? Although it may seem difficult, in most cases, it is possible to approach similar practices directly and ask for their input. The goal is to assess their view of the proposed practice and whether or not it will be welcomed. It is an opportunity to establish a congenial relationship with an entity that may be a competitor. Additionally, it is important to evaluate the new practice's potential access to specialists for consultation, referral, and hospital admitting privileges. Experience indicates that most practice startups do not sufficiently assess their competitive environment, which can be a serious oversight.

Philanthropic Appraisal

Foundations can be a valuable resource to a community seeking to support an NP-led primary care practice. Some foundations may have access to health data and other information that can inform decision-making required to initiate a new health service. Additionally, foundations may be a source of funding for community-based projects that meet a specific need and may be willing to partner with a nurse-led practice to meet those needs. Every foundation has its own criteria for evaluating requests. Each has distinct processes and time frames that govern their programs.

Consider:

- Large employers often have foundations that support programs in the communities where their employees reside and customers are located. These foundations often are located within the public affairs department.
- Foundations may fund a specific need such as women’s health, health and wellness, or programs for seniors. It is important to review a foundation’s funding criteria before seeking support.
- Foundations may support health screening programs, wellness programs, medication adherence programs, and provide start-up funds that address a compelling need.
- In some instances, hospital foundations have resources that may be available to support new providers.

- Most foundations do not fund for-profit entities. Thus, it may be necessary to partner with a non-profit organization that would meet the eligibility criteria.
- Another source of financial support might be the Small Business Administration. It provides loans, grants, and business advice for businesses and services that meet its criteria.

Some tips when seeking grant funding:

1. Know that grants vary in the amount of funding that is available to each project. Stay within the foundation's parameters.
2. Before submitting any grant application, know the mandate and mission of the foundation to which an application will be submitted. Ensure the request aligns with the foundation's areas of interest.
3. If a letter of inquiry is requested initially, it should speak to the applicant's credibility and the soundness of the project, but not provide more details than requested.
4. Completing the full proposal should reflect the guidelines outlined and cover the following: goals, objectives, methods, other support, budget, sustainability, and resumes of key staff members.
5. There may be a need to support the request through a meeting with the foundation's staff. Be prepared and concise in supporting the request.
6. Depending on the size and scope of the grant being requested and the complexity of the application, it may be helpful to use a grant writer.

Resources:

- Community Foundation of New Jersey: http://cfnj.org/
- The Nicholson Foundation: https://thenicholsonfoundation.org
- Foundation Center: http://foundationcenter.org/
- Council of New Jersey Grantmakers: https://www.cnjg.org/

The Patient Experience of Healthcare

In 2008 Don Berwick, Tom Nolan, and John Whittington first described the "Triple Aim" of simultaneously improving population health, reducing per capita cost of care, and improving the patient experience of care.[2] Since then, there has been growing acknowledgment that the patient's experience of healthcare is a valuable component of healthcare delivery. Patients' perception of the care they receive, the interactions they have with providers, the continuum of care, and the various systems of care delivery all define the patient experience of healthcare. Understanding patients' perception of care delivery and needs can be valuable information as new care services are designed.

[2] Stiefel, M, Nolan, K. A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement, 2012.

Focus Groups as a Method of Appraisal

Patient focus groups can be a valuable tool to understanding the strengths and weaknesses of services currently available. An effective focus group will provide the potential users of the proposed new services an opportunity to share their experiences, their likes and dislikes, and most importantly, what they believe is needed to improve the experience of care. Note that both the language used and word choice may be important. Allowing users to communicate in their primary language allows more complete feedback. Consider the health literacy level of the group and adjust the questions to meet the lowest common level. Additionally, use of culturally-appropriate terms to match the speech patterns and understanding of the cultural background of the group may be helpful.

Focus groups should be held at convenient times, and in locations that are near to where people live and/or work. Patients should be given information about the purpose of the focus group, whether their names will be identified in any reports, and how the information will be used. It is important to seek a signed consent form from participants disclosing uses of the information derived from the session(s), and whether the results will be treated as confidential or confidential as to source.

Steps in the Selection/Recruitment of Focus Group Members

1. From the needs assessment and stakeholder interviews, identify the healthcare need you hope to address.
2. Determine what population group(s) will be served - this determines what age, gender, and cultural identification will be important to represent in the focus group.
3. Identify a way to "access" people who are representative of the population you wish to serve and determine how you will invite them to a focus group. Often, it is helpful if people are approached by a familiar, trusted individual, such as their pastor, a leader in the community, or an organization they know. Other methods for selecting participants in a focus group include a flyer or poster indicating the reason for the focus group, requirements to participate, and how to sign up.
4. The number of participants in the focus group is flexible, but keep in mind that you want participation, so if the group becomes too large, it is often difficult for all participants to have an opportunity to speak.

Conducting a Focus Group

It is often helpful to develop a set of key questions that you want the focus group to address. The conversation will often lead you in a variety of directions. The list of key questions will ensure that information you think is most crucial is addressed. Taking notes during the session ensures that you correctly recall the information and that key points of agreement – or disagreement – are noted. Often, audiotaping is used so that the focus group convener is able to pay attention to the dialogue; the audiotape provides an accurate record of what was said. If an audiotape is used, it should be with the written consent of each attendee.

For detailed information about conducting a focus group, go to:
https://assessment.trinity.duke.edu/documents/How_to_Conduct_a_Focus_Group.pdf

Understand the Patient Experience

The experience of healthcare is highly dependent on age, heritage and/or cultural values, whether the individual has healthcare insurance, whether the patient has access to care, has transportation, and a host of other variables. Understanding the experience of receiving care from the perspective of the types of populations the new practice hopes to serve can be a highly productive exercise. Collect some basic demographic information so as to better interpret the results:

- Gender
- Age
- Insured or Not Insured

Sample Focus Group Questions

Start with some questions that will elicit specific answers:

- How would you rate your general health? (Use a descriptive scale or a number scale)
- Have you seen a primary care provider in the last three months? If yes, where?
- How do you usually receive care?
- Do you need help in getting healthcare services? Does someone help you with appointments, referrals, or coordinating your care? Who helps you?

Then move to open-ended questions that yield rich information:

- Talk about your experience getting healthcare in (*insert community name*).
- What is "GOOD" about healthcare in (*insert community name*)? What do you like?
- What is "BAD" about healthcare in (*insert community name*)? What isn't working well?

Explore System Challenges for Patients:

It's helpful to ask questions about the system(s) of care to identify some of the challenges facing patients. It is likely that some identified problems will require major effort, time, or money to "fix." Other system challenges will be more easily rectified. By identifying challenges, it is more likely that the new practice can offer the improvements sought by the targeted patient population as well as improve patient outcomes and satisfaction.

Specific areas to explore include:

- Transportation options to care sites
- Safety of care sites, neighborhoods, transportation options
- Clinic hours, including after-hours primary care availability
- Cost of care, co-pays, pharmacotherapeutics or other treatments
- Language
- Wait times for primary care and specialty care appointments
- Availability of "care when you are sick" – same day care, urgent care, emergency room care, hospital care.
- Availability of mental/behavioral health care, dental care, prenatal/maternal care.

Solicit Patient Recommendations to Improve Care:

Health professionals and policy makers often assume that "they know best," but, patients have the best understanding of what they need and can offer suggestions for how to get it. Start with open-ended questions to encourage the generation of general ideas or areas of concern, then use focused questions to "drill down" to identify specific examples and suggestions that patients might have for changes in healthcare delivery.

An Example of an Open-Ended Question Might Be:

- How would you make healthcare here better or easier to use?

Follow-up Questions Might Be:

- Can you describe that idea a little more? Tell me how that would work? How would that help?

Resources:

- Berwick, DM, Nolan, TW, and Whittington, J. (May, 2008). The Triple Aim: Care, Health and Cost. *The Journal of Health Affairs*, 27(3), 759-769. Access at: http://content.healthaffairs.org/content/27/3/759.long
- Patient Experience Collaborative of the California Quality Collaborative. *"A Quick Reference Guide: Improving the Patient Experience."* Access at: http://www.mtchealth.com/content/CQCIntervention.pdf
- Mayberry, D and Hanson, M. (May, 2013). *"Let's Talk: A Guide for Transforming the Patient Experience Through Improved Communication."* MN Community Measurement. Access at: http://mncm.org/wp-content/uploads/2013/04/MNCM_LetsTalk_FNL_LoRes.pdf

PAYER ASSESSMENT

For financial sustainability of a nurse-led practice, support from the key payer segments is critical. Horizon Blue Cross Blue Shield of New Jersey ("Horizon") and Aetna hold significant market share as insurers in New Jersey followed by Anthem, Cigna, Qualcare, AmeriHealth, and Oxford Health Plans/UnitedHealthcare. These seven entities are active in fully insured, Medicare and self-funded commercial business but only Aetna, Horizon and UnitedHealthcare are key players in Managed Medicaid.

Consider:

- **Payer Mix:** What payers are available and willing to cover services offered by the new nurse-led practice? See Payer Stakeholder Section below for more about how to evaluate this issue. See also Appendix A for further information about additional programs that reimburse APN practice.
- **Nurse Practitioner Reimbursement:** Understand the varying levels of reimbursement for services based on the payer. Medicaid and Medicare pay NPs 15% less than what is paid

to other healthcare providers. Some, but not all, commercial health plans follow the same payment structure. This requires checking with each payer to obtain their reimbursement policy for nurse practitioner services. Often, however, the State Nurses Association, a nurse practitioner organization, or even local nurse practitioners can provide this information.

- **Ability to influence Medicare 5 Star Ratings:** Some payers make provider choices based upon their ability to improve a health plan's 5 Star Rating. Medicare reports on the performance of a variety of sectors using 5 Star Ratings. These ratings currently apply to hospitals, home health, longterm care, and Medicare Advantage plans, although CMS has been gradually expanding their application. Ratings can spell the difference between success and failure of any of these entities. In the case of Medicare Advantage Plans, Star Ratings not only impact levels of compensation to the plans but can determine how the plan can market their services. When designing a new NP-led practice, it can be critical to align practice strategies with Star Rating enhancement in order to best position the practice with payers seeking to improve their overall ratings. A nurse-led primary care practice of sufficient size can have a significant and positive impact on a Medicare Advantage's Star Ratings in a region. Of course the NP practice might also help improve other entities' ratings such as hospitals, home health, and long term care, but the payer relations impact is most visible in the Medicare Advantage sector. Review the summary of the 5 Star Rating for Medicare Advantage plans and examine the elements set forth here: https://www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx Consider a strategy that the NP-led practice might employ to assist health plans with their star ratings.
- **Start-up costs:** Understand the costs of establishing a practice in the targeted community. What added city costs must be considered for this clinic? For example, are there added security costs for a practice located in a high-risk area? Are there local, state and federal fees for zoning, licensing, or inspections that should be factored in a budget for starting up the practice?
- **Practice Design:** Is there a service component of the NP practice that can address the various concerns raised by payers? Is the scale of that opportunity large enough to make a difference for the practice and the payer?
- **Funding Unmet Needs:** Is the proposed clinic addressing a significant need in the community that will create an independent source of funding for this clinic?

Payer Stakeholder Interviews

In order to evaluate the financial feasibility of a new nurse-led practice, key payer segments should be interviewed. The goal of these interviews is to discern opportunities to address payer needs so as to pave the way for a favorable contract for meeting those needs. These stakeholder interviews should be conducted with the following types of payers covering lives in the targeted community: fully insured commercial, self-funded administrative services only, Medicare Advantage, and Medicaid Managed Care programs. In addition, conversations with the local hospital(s) human resources departments (or the group that handles benefits administration), key large local employers, and any trade union funds in the community may uncover an appropriate niche for the new practice. The final group of stakeholders for an adequate payer

assessment includes the main benefit consultants (also called "brokers") for commercial and governmental healthcare business lines.
Questions to consider in evaluating potential payer mix:

- What is the percentage distribution of the various payers (also called "payer mix") of the population intended to be served in the targeted community?
- In addition to the payer mix, who are the Top 25 employers in the region. Include public and private sector payers and do not overlook the healthcare industry itself. Consider not only the employers' business sites but also where most employees reside. (*NJBiz,* a local business magazine, compiles a "book of lists" online and as a hard-copy which contains much of this information.)
- How many employers have 1,000 or more employees? Are they self-funded, and if so, who administers their plan? Resources: *NJBiz* or the New Jersey Business and Industry Association (NJBIA).
- Are there self-funded public sector employers in the region, and if yes, how many, how are they covered and by whom?
- Are there trade unions representing members locally? Of what size? Are they self-funded?
- For all plans, self-funded or not, identify the issues of most cost and concern? Consider in what ways a nurse-led practice may solve or mitigate those issues.
- Will the practice provide care for undocumented immigrants, for whom there is little to no reimbursement? Is there a resource that can provide coverage for that care such as a foundation or a religious organization?

Specific Questions for Payers:

- Can you outline your three biggest challenges in revenue, administrative expense, medical expense management, and/or quality improvement that this nurse-led practice might be able to positively impact?
- Can we work together to construct a contractual and/or strategic relationship that would focus on meeting these challenges? If so, who should we meet with to accomplish this?

Resources:

- ERISA: https://en.wikipedia.org/wiki/Employee_Retirement_Income_Security_Act
- Horizon Blue Cross/Blue Shield of New Jersey: www.horizonbcbsnj.com
- Aetna: www.aetna.com
- Cigna: www.cigna.com
- QualCare™ Inc.: www.qualcareinc.com
- Anthem BlueCross BlueShield: https://www.anthem.com
- UnitedHealthcare: www.uhc.com
- UnitedHealthcare Oxford: https://www.oxhp.com

NURSE PRACTITIONER PRACTICE

Nurse Practitioner Profession and Practice Capabilities

When considering implementation of a nurse practitioner-led practice, it is helpful to understand the NP profession, the NP's practice capabilities, and the NP scope of practice. Nurse practitioners are advanced practice nurses who are educated at the graduate level to provide healthcare services that are distinguished by their patient-centered focus on health promotion and prevention, health education, and patient advocacy. They receive extensive education and "hands on" training in advanced clinical skills (health history, physical exam, procedures, etc.). NPs are educated in health promotion as well as the diagnosis and management of common acute and chronic illnesses/conditions. Care provided by NPs is noted to be relationship-based, high quality, and cost effective. In addition, NPs have the needed nursing background to provide care coordination, patient education, and assistance with care transitions across settings. APNs hold prescriptive authority in all 50 states and practice in all settings where quality care is provided.

NPs practice in both rural and urban settings. NPs practice in primary care, acute care and specialty settings providing healthcare to patients of all ages and walks of life. NPs assess patients, order and interpret diagnostic tests, make diagnoses, and initiate treatment (including writing prescriptions). NPs also provide lifestyle counseling, care coordination and education for patients and their families. Patient satisfaction with NP care is exceptionally high. Numerous studies have demonstrated that NPs provide equivalent care or improved care at a lower total cost than physicians. In fact, government studies have determined that NP-provided care decreases cost by as much as one third, particularly when NPs see patients in an independent manner.[1]

NP Certification and Scope of Practice

NPs are nationally certified in their specialty areas, and practice under the rules and regulations of the state in which they are licensed. NP specialty areas are: family practice, adult/geriatric health, pediatrics, women's health, psych/mental health, neonatal health, and acute care. In addition, many NPs practice in subspecialty areas. The scope of practice is related to the area of certification.

In determining the feasibility of an NP practice, the following steps are helpful:

1. Identify the services that are needed in the community and the population(s) to be served. Thorough preparatory research and community interviews as outlined above will be the source for determining the service and population targets for a nurse-led practice.
2. Determine if a nurse practitioner is able to provide the services needed.
3. Identify the qualifications needed to provide the services. Does the NP need to be certified in a particular specialty area? For example, if the practice will be a practice that only sees children, a Pediatric Nurse Practitioner (PNP) or a Family Nurse Practitioner (FNP) would be the appropriate specialties to offer care. If, however, the practice also will provide care for adults, keep in mind that a PNP may only see patients up to age 21. If the patient is older than 21, a Family Nurse Practitioner or an Adult Nurse Practitioner

must be part of the mix of providers in the practice. For information about certification, licensure and state regulations, go to: https://nursinglicensemap.com/advanced-practice-nursing/

4. Determine if a focus group of NPs would be helpful in determining the scope of services to be offered, and the model of service delivery. It may be helpful to ask NPs what support they feel is necessary in order to initiate and manage the practice being envisioned.

Resources:

- American Association of Nurse Practitioners: www.aanp.org
- New Jersey Collaborating Center for Nursing : www.njccn.org
- New Jersey Nurses Association: www.njsna.org

Barriers to Nurse Practitioner–Led Practices

When weighing the feasibility of initiating a nurse practitioner-led practice, it is important to consider the impact of certain barriers that could impact the success of the endeavor. Understanding the likely challenges is essential to ensure proper planning and outreach before opening a clinic. Be sure to evaluate the import of:

- **Legal/Regulatory Restrictions on APN Practice.** Nurse practitioners are designated as Advanced Practice Nurses (APNs) in the State of New Jersey. Appendix A provides an expanded analysis of legal and regulatory issues of NP practice in New Jersey, including a discussion of physician practice proscriptions on APN ownership.
- **Collaborating Physicians:** Although NPs are permitted to provide full-scope primary care, they cannot do so without a collaborating physician. The state requires a joint protocol for these independent nurse practitioners that is developed with the physician collaborator and outlines the agreement with regard to the ability to prescribe medications and/or devices. The collaborating physician must also review some patient cases for quality assurance. Many physicians charge a monthly fee to serve as the collaborating physician even though the actual time commitment is minimal.
- **Admitting Privileges:** Although New Jersey law permits healthcare facilities to allow NPs to admit patients, such privileges can be denied by the hospital review board, which is controlled by the institution's medical staff. Without the ability to get patients admitted into hospitals, nursing homes, psychiatric institutions, rehabilitation centers, and other facilities, a primary care practice may not be practical or prudent. Certainly, this situation would require a "work around" strategy to ensure needed services are provided. The most common "work around" is developing a relationship with a physician who has admitting privileges to the facility, supports the NP-led practice, and is willing to admit the patient.

Resources for further details on legal and regulatory issues include:

- "Developing Your Own NP Practice: Are You Crazy or What?" http://www.npcentral.net/talks/dev.own.np.practice.shtml

- 10 Steps to Starting Your Independent Nurse Practitioner Practice. A Business Blog for Advanced Practice Clinicians. http://npbusiness.org/10-steps-to-starting-your-independent-nurse-practitioner-practice/
- Podcasts by NPBusiness.org http://www.sageclinician.com

PRACTICE IMPLEMENTATION

The feasibility of a nurse practitioner-led practice is not complete without consideration of the actual practice implementation itself. The following factors must be considered:

Determine the Best Model of Care

A number of care delivery models operate today with varying degrees of maturity. Some models are focused on redesign of specific delivery for a group of services, and some are intended to redesign healthcare across the full spectrum of healthcare delivery. Finally, some models build on the current open system using fee-for-service payments with small adjustments; others were set up to create an entirely new concept in healthcare delivery. Most new models are designed to effect an increase in the quality and efficiency of care delivery for the patient's benefit. These efforts have expanded the notion of who might provide care as well as how care might be delivered outside the traditional face-to-face visit. Team-based care and non-face-to-face modalities for ensuring patient engagement and care coordination have become prominent components of these redesign efforts.

Ask:

- What is the best model of care delivery for the services that will be offered?
- Will an existing model serve the needs identified, or will some sort of hybrid model be required?

Appendix B provides an overview of existing models of care that might be considered in the establishment of a nurse-led practice.

Technology Needs

The two critical software packages needed to run a practice are the electronic health record and billing/practice management. Without technology, a practice will be disadvantaged in terms of patient perception of the clinic's effectiveness and ability to meet their needs. Additionally, certain government funding requires technology to be in place.

Tips for meeting technology needs:

- Purchase cloud-based software; this is becoming standard and allows for frequent updates as needs and systems change.
- Perform due diligence in evaluating both software and hardware. Review at least three systems and compare them for costs, maintenance, ability to meet meaningful use standards, reporting capabilities, and ease of use. Invest in products just above the middle of the road.
- Select a communication system that will meet the multiple needs of external and internal communication.
- Consider obtaining a picture archiving system.

- Include an IT specialist to assist in the software and hardware evaluation process.

Questions to ask when evaluating technology:

- How long has the technology/software been on the market?
- How is it ranked nationally in comparison to other systems?
- Is the product certified?
- What is the ease of use?
- What support is available?
- Is there online or in-person training available?
- Are there interconnectivity capabilities?
- Is a patient portal available?
- Does the system have e-prescribing capability?
- How often are system upgrades performed and introduced?
- What are the costs and advantages of outright purchase versus leasing or monthly charges?

Resources:

- Business software reviews http://www.softwareadvice.com/
- Selecting electronic health record system www.aafp.org/fpm/201510100/p13html

Financing

When starting a practice, it's helpful to secure funding upfront. A wide variety of funding sources are possible, such as bank loans, venture capital or an "angel investor", foundation grant funding or state/federal government grants or special initiatives/pilot projects.

Steps to take:

1. Develop a start-up budget that includes consulting, legal, accounting, capital needs, and general start-up costs.
2. After determining start-up costs, increase that amount by 25-50 percent to cover unanticipated expenses.
3. Obtain Medicare and Medicaid Tax Identification Numbers prior to delivering service to any patients. https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf
4. Develop an operating budget to project revenue and expenses for the practice model and patient mix anticipated.
5. Select a qualified Certified Public Accountant (CPA) that specializes in medical practices. The CPA should be charged with the development of the fee schedule, capital/credit/banking, and development of accounts.
6. Hire a qualified attorney to form the entity and assist with the Tax Identification Number as well as the Medicare provider number. The attorney can also assist with negotiating and establishing payer contracts, which will be the lifeblood of the practice; each contract must be reviewed for its terms and reimbursement levels.

7. Determine which insurance plans with which the practice will contract. Apply early as this process may take three or more months to complete. Consider:
    - Medicare
    - Medicaid
    - Commercial
    - PPO/HMO
    - Insurance Trusts and Union Plans
    - Workman's Compensation Programs

Tips:

- Keep in mind the typical delay in payments when initiating billing even after payer contracts have been established. Expect a minimum of 90 days delay between billing date and receipt of payment for services rendered.
- The budgeting process should include consideration of cash flow issues associated with high and low patient volumes due to practice growth, credentialing requirements, payment delays, as well as sources of operating capital during low cash periods. Associated tasks in the budget formulation process include financial projections, income/revenue, and overhead/expense. Note that the Service Corps of Retired Executives (The SCORE Association) of the Small Business Administration can provide significant free assistance and advice on these budgeting tasks. https://www.sba.gov/tools/local-assistance/score

Financial Sustainability

Sustainability is highly dependent on productivity of the staff and determination of staff-to-patient ratio, practice management capability to proactively monitor billing cycles, reimbursement discounts, key payer sources, and overhead costs. Sustainability is also highly dependent on marketing and practice growth, networking, identification of practice administrators in the area, and membership in networking organizations such as Independent Practice Associations (IPAs), group purchasing cooperatives, and marketing collaboratives. Start-up costs and low cash flow times need to be projected. The availability of equipment for rent and space that does not require long-term commitment can drop start-up costs and drive more rapid achievement of sustainability.

FINANCIAL BARRIERS

A complete assessment of the feasibility of opening an NP-led practice must include an honest evaluation of significant financial barriers. These barriers can be overcome with smart planning, relationship development, strong marketing and adequate payer mix.

Payer Mix: Throughout the state, in communities at every level of the socioeconomic ladder, healthcare providers are forced to shift revenue shortfalls resulting from government-based payers. In some communities, the commercial payer footprint is very small and, therefore, the opportunity for cost shifting is severely mitigated. Be cautious with uncompensated care. A balanced payer mix is important to the financial health of the practice.

City Costs: Research the community's fees and charges for permitting and taxes. In some communities with high crime rates, there may be added costs to the practice for additional security measures to protect employees and reassure cautious patients.

Reimbursement Levels: NPs are reimbursed for care at a lower level than their physician colleagues. Both Medicare and Medicaid pay NPs 15% less than other healthcare providers. Commercial health plans often follow the strategy in their own payment structure. Ensure you have a good sense of what reimbursement levels can be expected from the commercial plans in the projected payer mix.

Workforce: Staffing is critical to the success of the practice and also represents a significant expense. Carefully consider the need for office staff. Initially one person will have to do multiple jobs and that person may well be the clinician. Some positions combine well and can be staffed by a single person in a small practice. Add staff overtime cautiously and know availability of potential staff in the marketplace by performing a market-specific analysis. Evaluate the need and timing of hiring the following:

- Nurse Practitioner
- Medical Assistant
- Coder/Biller
- Office Manager/Receptionist/scheduler
- Community outreach specialist /volunteer

Infrastructure: Facilities encompass not only the actual building space to the equipment and supplies needed to practice medicine, but also utilities, telecommunications, and office supplies. In addition, if laboratory capabilities are being considered for the practice, obtain and adhere to the Clinical Laboratory Improvement Amendments (CLIA). Additionally, consider the need for personnel policies and patient care policy and procedure manuals.

When obtaining basic equipment, buy only that equipment that is not likely to change over time, such as exam tables and blood pressure cuffs, and buy the best you can afford as you will not likely replace it in the near future. When possible, purchase used equipment. For technology/equipment that changes rapidly, opt to lease to take advantage of the opportunity to upgrade at the end of each lease period. Consider the experienced accountant and attorney, as well as a competent medical biller/coder as part of the essential infrastructure of a successful nurse-led practice.

Resources:

Clinical Laboratory Improvement Amendments (CLIA) https://wwwn.cdc.gov/CLIA/

Personnel policies and procedures. http://psqh.com/september-october-2014/policies-and-procedures-4-healthcare-organizations-a-risk-management-perspective

Legal/Regulatory Barriers: A key resource on this topic is: *Nurse Practitioner's Business Practice and Legal Guide*. http://amazon.com/exec/obidos/ASIN/0763733415/monstercom/ by Carolyn Buppert, a lawyer and certified registered NP.

CONCLUSION

There is clearly much to be considered in the establishment of a nurse practitioner directed primary care practice. It's easy to get "lost in the weeds" with the feasibility assessment process (as outlined herein) and lose sight of the fact that nurse practitioner-directed primary care practices have been highly successful across settings for many years. They have provided unique person-centric healthcare services that are greatly valued by patients and enrich the care that is offered in the community. The considerations and suggestions set forth in this Toolkit are intended to assist in the establishment of successful practices that are sustainable over time.

APPENDIX A:

LEGAL AND REGULATORY ANALYSIS OF APN PRACTICE IN NEW JERSEY

A review of legal and regulatory issues that affect initiating and sustaining a new Advanced Practice Nurse (APN)-led health center is an important part of evaluating the feasibility of establishing a nurse practitioner led practice. A threshold question faced is whether and how an APN-led entity can function within the legal and regulatory environment of New Jersey.

Entity Structure and the Corporate Practice of Medicine

New Jersey has a relatively strict view of the relationship between corporate structure and medical professionals, especially physicians. The New Jersey Board of Medical Examiners' restrictions on the ability of corporations to hire, and thus control physicians are designed to ensure the independence of medical decision-making. These restrictions on the so-called "corporate practice of medicine" ("CPM") are not shared by APNs. Conversely, APNs, who are regulated by the New Jersey Board of Nursing, may be freely employed by corporate entities, but their ability to practice is subject to the requirement that they collaborate with a physician. To reiterate, other than collaborative model restrictions, there are no professional practice structure restrictions (CPM) placed on APNs by the New Jersey Board of Nursing regulations.

Collaborative Practice

The APN's mandatory collaboration is expressed in the requirement that each APN enter into a joint protocol that has been cooperatively agreed upon and signed by the APN's designated collaborating physician. Pursuant to that document, each member of the healthcare team functions within her/his scope of practice using developed guidelines and established formularies where appropriate. The document contains guidelines for prescribing medications and devices for an APN in a specific practice setting. The document must be signed by the APN and her/his designated collaborating physician, and reviewed, updated and co-signed, at least annually. Though the particular language in the joint protocol may vary from practice to practice, each joint protocol must follow the outline defined by New Jersey State Board of Nursing regulations at 13:37-6.3.

Unlike many states, New Jersey does not require the physician to be physically present or within a certain geographic radius of the APN. Nor do physicians need to meet with their collaborating APNs, although periodic review of a number of charts is required. There is no specific number of chart reviews required, but as the agreement itself must be reviewed annually, the time period for chart review should be at least annually.

Collaborative Practice-Prescriptive Scope

The practical import of this protocol may be limited to a level which his or her collaborating physician deems fit. Assuming the broadest prescriptive scope within the protocol, a registered and licensed APN may prescribe non-controlled drugs and devices pursuant to the protocol. In order to prescribe Class II-V controlled substances as is allowed by law, the APN must first obtain a controlled and dangerous substances (NJ CDS) license number, followed by securing a Federal Drug Enforcement Agency (DEA) number. In addition, in the outpatient setting, APNs must have their own NPI number and their own uniform prescription blank pads, specifically designed for an individual APN prescriber. Prescriptions must

be printed on special paper as required in NJ. New Jersey law is unclear on electronic prescribing,[1] but usual and customary practice is that APNs are using electronic prescribing where it is available in their particular practice setting.

Impact of Physician Practice Proscriptions on APN Ownership

When it comes to operating a healthcare facility, APNs are less likely to face legal difficulty from their own professional restrictions (assuming a satisfactory collaborating physician may be found) than they are to feel the pinch of the restrictions placed on their collaborating physicians, psychiatrists, or psychologists. In New Jersey, an APN may not employ a physician. This is because a person with a broader scope of practice (a physician has the broadest scope possible) may not, in general, be employed by a person with a narrower scope, such as an APN. To state it in another way, a physician may not be employed by or serve as an independent contractor for an APN-owned company, because a physician cannot work for someone with a more limited scope of practice. This does not preclude co-ownership of an entity between allied health professions. Any practice, clinic, health center, or facility owned or otherwise controlled by an APN and enjoying the services of a physician, will have to be carefully structured, in order to ensure that the appropriate licensed healthcare professional is permitted to work there. For example, the APN and physician may have mutual ownership in the practice. As written in the Board of Medicine regulations, the corporate practice of medicine doctrine, coupled with the collaborative requirement, create a concern for the collaborating physician, if s/he accepts payment. Still, while this proscription is “on the books,” contracting and reimbursement of collaborating physicians is commonplace, perhaps more the rule than the exception. We could not find an instance when a contract for APN collaboration was considered by the BME as a prohibited relationship, nor has it been used as an argument by a payer or any third-party against a physician in any reported instance.

In general, where a physician’s participation is required for the provision of care, and where the physician expects to be hired by or contracted to the entity, the entity must either be a private practice owned or operated at least in part by the physician, or the corporate structure needs to fall within a regulatory exception. Licensure by the New Jersey Department of Health as a health maintenance organization, hospital, long or short-term care facility, ambulatory care facility, or other type of healthcare facility constitutes an exception to the practice proscription. Clearly the structuring of the APN/Physician relationship should be reviewed by an attorney specializing in representation of providers. There is no question that the corporate practice of medicine doctrine coupled with the collaborative requirement and the likelihood that a physician might wish to be remunerated for his or her collaboration services creates challenges for the creation of a solely APN-owned and operated entity, absent licensure.

Primary Care Center: An Example of an Allowable Permitted Practice Structure

Accordingly, an APN could own or operate a primary care center. The state defines "primary care" to mean “the provision by a healthcare facility of preventive, diagnostic, treatment, management, and reassessment services to individuals with acute or chronic illness.” The term is used in reference to facilities providing family practice, general internal medicine, general pediatrics, obstetrics, gynecology, and/or clinical preventive services, including community health centers providing comprehensive primary care. Comprehensive primary care may include the provision of sick and well care to all age groups, from

[1] APN regulations prohibit electronic prescribing yet other regulations specifically permit it for licensed professionals, “such as certified nurse midwives.” The two conflicting regulations can be found at NJAC § 13:37-7.9 and 45:14-57.

perinatal and pediatric care to geriatric care. Primary care is further characterized by the fact that it represents the initial point of contact between an individual and the healthcare system, by the assumption of responsibility for the person regardless of the presence or absence of disease, by the ongoing responsibility for coordination of medical care for the person, by its family-centeredness, and by its community orientation.

Should the APN wish to own or operate a center meeting the definition of a primary care center, that facility must be licensed as an ambulatory care center. The New Jersey Department of Health ("NJDOH") licenses "all healthcare facilities that provide ambulatory care services, including, but not limited to: primary care…family practice, family planning, outpatient drug abuse treatment, chronic dialysis, computerized tomography, magnetic resonance imaging, extracorporeal shock wave lithotripsy, and radiological services;" and defines an "ambulatory care facility" as a facility that provides preventive, diagnostic, and treatment services to persons who come to the facility to receive services and depart from the facility on the same day. Physicians may be employed by such a licensed entity without fear of violating corporate practice restrictions.

While there is no need for a Certificate of Need for a primary care center, there is significant other regulation surrounding, for example, the physical plant: Any ambulatory care facility that intends to undertake any alteration, renovation, or new construction of the physical plant must submit plans to the Health Plan Review Program of the Department of Community Affairs for review and approval or, in cases of existing construction where no Department of Community Affairs review is required, to the Office of Certificate of Need and Healthcare Facility Licensure for review to verify that the facility's physical plant is consistent with the licensure standards prior to the initiation of any work. See, N.J.A.C. 8:43A-2.4. These requirements may be seen as burdensome, and certainly involve costs. In some cases, the regulators' requirements may be counter-intuitive, such as the enforcement of standards that are interpreted to require separate entrances/waiting rooms for centers that provide both mental health and primary care services. These issues would not arise if the APN pursued a private practice structure, but again, the private practice structure might not allow for the full integration of the collaborating physician unless that physician were an owner.

An additional requirement for licensed ambulatory care facilities is that there must be a physician to serve as medical director, and the medical director or his or her designee must be available to the facility at all times. The medical director is responsible for the direction, provision, and quality of medical services provided to patients, including developing and maintaining written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for the medical service. This medical director could also, of course, serve as the collaborating physician of the APN. Again, a physician may be hired or contracted by a licensed facility to perform this role, but such hiring or contracting of a physician by a corporation or an APN would be prohibited for most un-licensed entities.

While we cannot identify issues specific to APN-run entities, other scope of practice issues need to be recognized in light of the challenges or opportunities they may pose for the needs of the patient population. For example, New Jersey hospitals may privilege or otherwise credential APNs, and permit them to admit or discharge patients. But they are not required to do so. As other aspects of this report reveal, an APN forming a new provider entity will need to be sensitive to the existing relationships and territories formed by other providers. *Note: The New Jersey Collaborating Center for Nursing is currently completing a survey of APNs' ability to admit to hospitals in New Jersey.*

In addition, and most importantly, APNs may be reimbursed in New Jersey from Medicare, New Jersey

Medicaid, and some insurance companies. According to the New Jersey State Nurses Association, the following payers credential APNs as providers of patient care: Horizon, Oxford, Qualcare, United Healthcare, Horizon Mercy and Magellan Behavioral Health. Direct reimbursement is granted when services are provided to members of the uniformed services and their families under the Civilian Health and Medical Program of the Uniformed Services Act and federal employees under the Federal Employee Health Benefit Plan. Medicare and Medicaid reimburse approved services at 85% of the rate paid to the physician for similar services.

APNs can also seek reimbursement "incident to" the physician and obtain reimbursement at a 100% rate. The qualifier "incident to" is strictly defined and may not be desirable in a collaborative practice health center setting, because there must be a physician service to which the "incident to" services are incidental. The physician must see the patient with sufficient frequency to demonstrate the physician's involvement in the patient's care. Some of these requirements may defeat the purpose of APN services in needy areas, where the ability to make frequent, lengthy visits is compromised, and where direct physician involvement may not be necessary. "Incident to" services performed by an APN would not be visible on the claim form. The service is submitted as if the physician rendered it.

Other Settings and Structures for the Provision of Care

As noted above, APNs may create private practices with other allied professionals, and/or on their own, and may provide services within each of their scopes of practice.

They may likewise, and within the restrictions noted above, form and lead Federally Qualified Health Centers (FQHCs), and look-like FQHCs, hybrid governmental agencies, and private practices located as retail clinics. FQHC's, as NJDOH-licensed facilities, allow for the hiring of a physician without falling afoul of the Corporate Practice of Medicine restrictions. They may form any of the above as a for-profit structure, or seek the tax advantages of non-profit status. They may also form Professional Corporations which are managed by larger corporate entities (Captive PCs) and which contract for services from that corporate entity, or Medical Services Organizations (MSOs).If the facility is a private practice, an MSO could be hired to take care of all administrative services, including providing the collaborating physician. The administrative services provided by an MSO do not include the provision of direct care to patients.

In summary, when evaluating the establishment of an APN-led practice, there will be regulatory, structural and operational challenges and opportunities. Given the complex web of relationships between providers with varying scopes of practice, and the corporate practice of medicine, legal advice should be sought before structuring a practice.

APPENDIX B

COMMON CARE DELIVERY MODELS

A range of care delivery models are in place across the US, the most common of which are described below. Consideration of these models and others may be useful in determining the delivery of care in a new practice.

The Chronic Care and PCMH Models

Alongside efforts to re-evaluate and reorganize healthcare and staff roles, efforts are being tested to incorporate new ways to deliver care such as round-the-clock primary and specialty care access, virtual care coordination support, home-based monitoring, and interactive voice-response surveillance. These innovations combined with the application of the multicomponent practice changes that formed the basis for the Chronic Care Model (CCM) developed more than a decade ago may well be informative to the development of new models of care that will improve care and impact health outcomes.

The aim of the CCM is to transform daily care for patients from acute and reactive to planned intervention provided by an effective care team. It is a model that provides directionality to care delivered in primary care practices and has application for special populations such as perinatal and well child practices. To be effective, the care team must be informed and skilled, patients must be engaged, and registry-based information systems must be utilized in combination with integrated decision support. These are the elements that have been incorporated into innovations such as the Geisinger Health Systems innovation strategy and are incorporated into elements of the Patient Centered Medical Home (PCMH).

Each redesign effort has focused on enhancing value by explicit care delivery system reform strategies and the associated organizational change strategies. Geisinger, as an example, suggests that sustainable healthcare value is created only when care process steps are eliminated, automated, appropriately delegated to lower-cost but capable staff or otherwise improved through innovation.[1]

As a widely adopted approach to ambulatory care improvement and as a guide to national quality improvement initiatives, the CCM model is an integral part of current patient-centered medical home models.[2] Patient-Centered Medical Homes (PCMHs) are transforming primary care practices into what patients want, focusing on patient themselves and all of their healthcare needs. This is a model that was adapted by pediatricians in response to the complex needs of children and is now being utilized in perinatal healthcare programs.

These practices are also seen as foundations for a healthcare system that gives more value by achieving the Triple Aim of better quality, experience and cost.[3] It is notable that these are primary care practices that have been in existence and therefore not in a start-up phase. Further, there is a vehicle for

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[2] Coleman, K., Austin, B.T., Brach, C. & Wagner, E.H. (2009) Evidence On The Chronic Care Model In The New Millennium, *Health Affairs,* 28 (1) 75 -85.

[3] Rich, E, Lipson, D, Libersky,J & Parchman, M. (2012) Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA29020090000191/HHSA29032005T) AHRQ Publication No. 12-0010-EF Rockville, MD; Agency for Healthcare Research and Quality. January 2012.

recognition of PCMHs by the National Committee for Quality Assurance (NCQA). To achieve recognition, practices must meet rigorous standards for addressing patient needs. The model is designed to support the primary care physician in taking the lead role in coordinating care for patients.[4] The core elements of PCMHs include the following:

- Comprehensive Care: meeting the large majority of each patient's physical and mental healthcare needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care means having a team of care providers.
- Patient-Centered: meeting the care coordination needs of each patient by partnering with the patient and the family, respecting their values and wishes.
- Coordinated Care: coordinating care across all segments of the broader health system.
- Accessible Services: delivering care with shorter wait times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication as requested by the patient or family.
- Quality and Safety: demonstration of a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based practice and clinical decision support tools. Measuring and reporting of the patient experience, patient outcomes, and population health management is integral to the demonstration of quality.[5]

There is broad support in both public and private sectors for PCMH. The Department of Defense is working to transform all of its primary care practices into PCMHs that meet the NCQA standards for recognition. The US Department of Health and Human Services is helping community health centers and FQHCs to also become PCMHs. As of 2014, there is an increasing emphasis on team-based care, integration of behavioral health, care management of high-need populations, and encouragement of patients and family involvement in practice management.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are another example of primary care delivery envisioned to transform care. Their primary focus is to provide access where primary care resources are constrained and population health outcomes have therefore been compromised. They are required to be community-centered and must emphasize care coordination. Furthermore, they rely on a range of staff to provide services.

Service sites include permanent sites, which are open year-round in a defined location, seasonal sites, mobile van sites, and intermittent sites operating in a van at locations during certain times of the year. Given their role as community-based safety net providers, FQHCs are subject to fairly extensive governance requirements. They are required to have a board of between 9 and 25 people, with the majority of the members being patients receiving services from the FQHC.[6] The core elements of the FQHCs include the following:

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[4] American Academy of Acturaries. (2014) Examining the Health Care Equation: Actuarial Perspectives on the cost and quality. *Issue Brief.* January available at www.actuary.org.

[5] Bielaszka-DuVernay, C (2011) Vermont's Blueprint for medical homes, community health teams, and better health at lower cost. *Health Affairs.*30 (3): 383-386.

[6] MedPac, (2011) Federally Qualified Health Centers, *Report to the Congress: Medicrae and Health Care Delivery System, Chapter 6.* (June): 145-160.

- Provide primary and supportive services that enable access to all, regardless of ability to pay, inclusive of preventive and enabling health services.
- Offer accessible locations and hours of operation including after-hours coverage.
- Hire culturally and linguistically appropriate physicians with admitting privileges at area hospitals.
- Develop and follow a quality improvement plan that is overseen by a clinical director whose focus of responsibility is to support quality improvement and who guides periodic assessment of appropriateness of utilization.
- Have established arrangements for hospitalization, discharge planning, and patient tracking to ensure continuity of care.
- Provide primary care services for all age groups; provide or arrange for dental services, mental health and substance abuse services, transportation services, and hospital and specialty care.
- Establish systems for data collection, reporting, and medical information recording.
- Maintain a core staff that can address the needs of the population being served inclusive of services delivered by physicians, nurse practitioners, physician assistants, and clinical nurse midwives. FQHCs run by a physician assistant or nurse practitioner must have an arrangement with a physician to supervise these staff.
- Offer an opportunity for medical residents and other healthcare providers to experience care delivery in an ambulatory setting.[7]

FQHC Look-Alikes

Federally Qualified Health Center Look-Alikes (FQHC-LAs) are health centers that have been certified by the federal government as meeting all of the Health Center Program requirements, but do not receive funding under the Health Center Program. They provide primary, preventive, healthcare services to all age groups and must have arrangements for dental health, mental health, enabling services, hospital, and specialty care. Grant reporting requirements are eliminated. The care models often reflect the lack of this funding and care is delivered through arrangements with other providers and service groups using a care coordination model. As of 2012, the average FQHC-LA caseload was about 10,000 patients per center compared to 18,000 in funded centers. They provided a total of 3.4 million visits, compared to the 83.8 million provided by funded centers. Medical visits, as opposed to mental health or dental visits, appear to make up a larger share of visits and there is often a limited capacity to provide certain types of care.[8]

The culture of both the FQHCs and the FQHC-LAs emphasizes cultural competence, team-work, and patient-centrism and is well aligned with the PCMH model. Furthermore, they have experience in collaborating on quality improvement initiatives. However, they would need substantive support to make the required fundamental changes in processes and practice culture most notably in the areas of operational efficiencies, delegation of work to other team members, and ability to meet the demand for all services needed by the patients they serve.

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[7] Katz, A.B., Felland, L.E., Hill, I & Stark, L.B. (2011) A Long and Winding Road: Federally Qualified Health Centers, Community Variation and Prospects Under Reform, *Center for Studying Health System Change*, *Research Brief.* N0.21, November 2011.

[8] Shin, P, Sharac, J, Rosenbuam, S.J (2014) Community Health Centers: A 2012 Profile and Spotlight on Implications of State Medicaid Expansion Decisions. *Geiger Gibson/RCHN Community Health Foundation Research Collaborative.* Paper 38. http://hsrc.himmelfarb.gwu.edu/spphs_ggrchn/38

Nurse-Managed Health Centers

Nurse-managed health centers (NMHC) as a model of service delivery have been present throughout the U.S. healthcare system for the past 22 years, delivering services to client groups in various sectors of American society. NMHCs accomplish this through a variety of unique arrangements that evolved out of the opportunities provided by academic environments for nursing education, or through partnerships with academic institutions. Using this model, the healthcare services provided may range from basic health promotion and disease prevention approaches, to full service primary care, inclusive of disease management programs. The essence of the NMHC is embodied in independent nursing practice, with NPs serving as primary care providers, managers, and administrators. Structurally, the NMHC model is led by an NP with educational and experiential qualifications in leadership and supervision. The nurse leader has overall responsibility for the design and implementation of the strategic plan, as well as for the operational and financial systems of the organization. A concomitant goal is that of providing for student clinical experiences.[9]

Changing reimbursements and dependency on academic institutions continue to pose financial challenges for this model. That situation is compounded by their dependency on grants and support from the Health Resources and Services Administration (HRSA), which can end at any time. Literature on NMHCs is still relatively sparse and thus evidence of quality, access, and cost are only beginning to be validated. The populations they serve are highly variable as is the care delivery model. Some centers provide a full range of primary care services while others provide basic health promotion or specialty services.

In an effort to retain a viable practice, some NHMCs have expanded their services. A number of the NMHCs have elected to integrate mental health into primary care to provide a holistic, comprehensive model. In some models studied, visits average 20 to 30 minutes and increased efficiency was noted when primary care visits for less complex patients were initiated by an RN followed by a few minutes with the NP, allowing the NP to focus on the more complex patients.[10] This type of study is foundational to the emerging literature on a new model for NP utilization in primary care to increase productivity and cost efficiency.

Accountable Care Organizations

Accountable Care Organizations, (ACOs) have the potential for delivering a high degree of integration of care, greater communication across the care continuum, and quality-based care delivery. ACOs are comprised of physicians, hospitals, and other healthcare providers which come together to demonstrate cost efficiency and quality care delivery. These “networks” share financial and medical responsibility for the patients served and primary care is at the heart of the care model. To date those ACOs which have been successful are those which have undergone entire system redesign and are employing many of the tenants of CCM. The staffing model and the care model are highly dependent on the population that the network is serving. At its core is a commitment to primary care, care coordination, and real-time information. It is a model currently under evaluation, focused on the ability to improve quality and costs

[9] Esperant, M.C. R., Hanson-Turton, T, Richardson, M , et al. (2011) Nurse-managed health centers: Safety-net care through advanced nursing practice, *American Academy of Nurse Practitioners,* 24 : 24-31

[10] Ely, L.T (2015) Nurse-Managed Clinics: Barriers and Benefits Toward Financial Sustainability when Integrating Primary Care and Mental Health. *Nursing Economics,* July-August 33:4, 193-202

for the Medicare population. The core elements must be demonstrated throughout the entire "system" of care.

Program of All-Inclusive Care for the Elderly (PACE®)

The Program of All-Inclusive Care for the Elderly (PACE®) provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. An interdisciplinary team of health professionals provides PACE® participants with coordinated care. For most participants, the comprehensive service package enables them to remain in the community, rather than receive care in a nursing home. Financing for the program is capped, which allows providers to deliver all services participants need rather than limit them to those reimbursed under Medicare and Medicaid fee-for-service. The PACE® model has traditionally been physician-led with the support of an array of both professionals and paraprofessionals. Social workers are an integral part of the team as are nurse practitioners. There does not, however, seem to be any direct impediment to this practice being NP-led.

Hospital at Home Model

An additional model that is important to mention is the Hospital at Home model that allows patients requiring admission to an acute care setting to consent to treatment at home. Physicians lead an interdisciplinary team in delivering care in the home setting using care pathways. Physicians and nurses are available 24 hours a day. This model allows for intensive care in the least costly, least intensive settings and the outcomes from such programs assist in informing care model development using a team approach with care guided by patient wishes and care pathways.

The Hospital at Home model has informed other care models through its demonstration of the use of interdisciplinary teams in the home setting that deliver intensive care. The Strong Start for Mothers and Newborns and enhanced perinatal care model is one example. This program is inclusive of comprehensive perinatal care and is providing enhanced care in maternity care homes. Care is delivered by a team of nurse practitioners and midwives that includes psychological support, education, peer counselors, and a broad array of health services.

Well Child Care Models

Lastly, there is a need to address well child care models and guidance on the care delivery elements of the National Health Promotion and Prevention initiative led by the American Academy of Pediatrics (AAP). The AAP provides guidance on the health screening and ongoing monitoring of the well child. The tools developed through this initiative are founded in the health home model devised and promoted by this organization and thus the care model demonstrates the application of core elements of the health home.

Chronic Care Model Advantages

All of the models discussed have some elements of the Chronic Care Model introduced earlier. Again note this framework and its adaptation has been well demonstrated over the years and provides guidance for emerging care models. Furthermore, it has been validated as having application when addressing even the most complex care issues such as diabetes, congestive heart failure, chronic obstructive lung disease, chronic pain, behavioral health issues, cancer, perinatal and well child care, as well as substance abuse. It is notable that the model supports the concepts being fostered today

regarding patient engagement and patient driven approaches. The graphic below identifies the elements of the model that can lead to improved outcomes.