Adding Nurse Practitioners to Inpatient Teams: *Making the Financial Case for Success*

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Nurse practitioners (NPs) are increasingly being added to inpatient care teams to meet demands for cost-effective, high quality, and safe patient care. NPs have been shown to increase adherence to evidence-based processes of care, decrease unnecessary resource utilization, enhance positive patient experience, and improve patient care outcomes such as ideal length of stay, reduced unexpected readmissions, and reduced hospital-acquired complications.[1-14] National reports have emphasized the evidence supporting the use of this unique provider type and have emphasized the need to expand this workforce and continue to explore their impact within the health care team, on cost effectiveness and on quality outcomes.[15-17] Despite evidence supporting the case for NPs, organizational economic and financial drivers demand a comprehensive business case before implementation of an NP team. This article reviews an academic medical center's experience with advanced practice proposals and the development of a standardized mechanism for submission and evaluation.

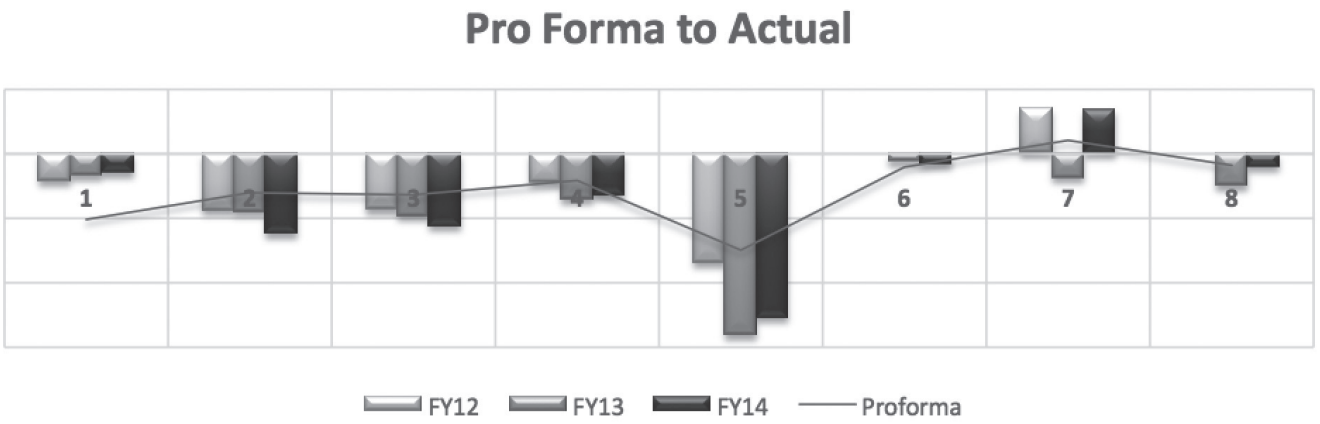
BACKGROUND

Nursing leaders are frequently asked to develop or weigh in on the development of NP practice models. Given the shared nursing philosophical and educational foundations for advanced practice, it makes sense for the nursing leader to provide insight on strategy and development of NP practice groups. NP practice is unique in that NPs, in addition to being providers that diagnose and treat, are often billing professional fees and are integral to organizational strategies to optimize hospital reimbursement. Failure to structure NP practice models in such a way that their contributions are maximized to achieve organizational goals can be costly, inefficient, and often disappointing. Likewise, failure to empower NPs in their role, providing appropriate resources and opportunities for professional growth and development, can lead to job dissatisfaction and turnover.

SIGNIFICANCE

Knowing that careful planning of these programs and empowerment of NPs would lead to greater success, we sought to

Figure 1. Pro Forma to Actual



understand the components of planning, development, implementation, and evaluation. This would allow a better understanding of the NP role and whether an NP, practicing to the top of his or her license, would best meet the needs of a practice, and serve as a solution in many ways to the problems legitimized by our current health care climate, as well as those experienced by the individual practice. We had seen programs succeed, and we had seen programs fail. Interestingly, what we never thought would lead a practice to failure, did; and what we never thought would lead to success, happened. It was curious that seemingly solvable issues, such as who is responsible for what, staffing disagreements, and scheduling, could create large barriers in team dynamics and role construct. And yet, it was a strong affirmation when the downstream financial impact related to length of stay, increased access, and consistency in patient care defined success far greater than day-to-day revenue generation.

FINANCIAL PLANNING FOR SUCCESS

Quality and revenue are both essential components in the provision of cost-effective health care. With quality comes cost savings associated with consistency in evidence-based standards of care and thoughtful use of resources, but also cost avoidance with proactive care and prevention of complications. Revenue, on the other hand, is a direct, immediate measure of productivity and considered heavily when establishing a provider, physician, and nurse practitioner alike practice.

As we began to launch inpatient practices several years ago, the coverage and quality imperatives were at the forefront of the initial decision; however, our pro formas were based on expenses and direct productivity. As the practices grew, the direct productivity was the apparent measure of success; however, there were the quality measures that were more difficult to firmly attribute to the addition of the NP providers. And this made for difficulty in the development of a business case going forward. In other words, without solid evidence within our own organization of the improved patient care outcomes associated as an impact of adding NPs to inpatient teams, we were left with productivity markers alone. Some areas were quite productive whereas other areas, such as surgical areas where fees were included in the global cost of the surgical procedure and areas where physicians remained the primary billing provider, were immediately less productive; but there was a supposed impact to the overall practice by achieving a higher volume of patients seen, better quality outcomes, and leveraging physician time. We wanted to be able to measure the quality impact and utilize these measures as a key metric in our business proposals going forward.

To better understand our history and achievement level of our past proposals, we reviewed NP practice pro formas and compared the initial projections with current productivity. We also reviewed published quality outcomes associated with several of these teams and overall strategies for successful integration and retention. Our goal was review and discuss our findings with senior financial, medical, and nursing leaders in order to develop a standardized format for proposing new nurse practitioner teams.

First, we analyzed the pro formas of 8 NP practices and compared these with current state. Figure 1 represents the pro forma to actual for 8 NP teams or groups for fiscal years (FY) 12, 13, and 14. For group 1, there was a 284% variance from the initial pro forma, group 2 (60%), group 3 (60%), group 4 (64%), group 5 (69%), group 6 (64%), group 7 (141%), and group 8 (50%). For all of these teams, there was a variance in full time equivalents (FTEs) from original pro forma. Groups 6 and 8 both began in FY13, so there is no data for FY12 for them.

The pro forma to actual comparison of productivity showed that the teams varied from the original pro forma, with a range of achieving 50% of initial pro forma to achieving 284% above initial pro forma; however, there was also a variance in NP FTEs from year to year. Original expectations for performance may have been diluted when the FTEs increased, or in some cases, exceeded with a lower number of FTEs. Furthermore, longitudinal studies may reveal FTE-associated patterns and indicate whether productivity projections stabilize or increase with time.

A known limitation is that there were probable variances in the methods for delivery of care, billing, and documentation responsibilities between physicians and NPs in those