New Podcast Episode! APP-Led Models of Care: Perspectives From a Nurse Practitioner and Physician

Podcast interview conducted by Jodie Elrod

In this episode of *the EP Edit*, we're featuring a conversation with Andrea Robinson, NP, and Anish K. Amin, MD, to discuss their Atrial Fibrillation (AFib) and Advanced Cardiac Therapeutics (ACT) Clinics, which are both led by advanced practice providers (APPs), as well as their pharmacist-led antiarrhythmic drug clinic. They offer the APP and physician perspective on this innovative model of care.

AR: My name is Andrea Robinson, I'm a nurse practitioner in electrophysiology at OhioHealth Riverside Methodist Hospital in Columbus, Ohio. I have been in electrophysiology for the past seven years. For the past three or four years, my focus has been helping to open and start our APP-run AFib clinic.

AA: My name is Anish Amin, I'm the section director for electrophysiology for the OhioHealth Heart and Vascular Physician Group in Columbus, Ohio. This is a great opportunity for me, and I'm excited to have a conversation with Andrea about the structural changes that we've made to our care model.

AR: So, as you know, over the last several years within our institution, we have had three new allied health or APP-run clinics: our atrial fibrillation clinic, our new ACT clinic, which is run by a heart failure and EP nurse practitioner looking at CRT response, and then most recently, our pharmacist-run Class III drug clinic. I think we've had a big culture change within our own institution across the past several years, which has allowed the opening and the support of these clinics looking at team-based models of care. Are you able to speak to what the culture changes were that helped to support these care models?

AA: Absolutely, I'd love to speak a little towards the culture change that has had to take place in our institution. As you're well aware, our mission has pushed us into new geographies and into new roles in caring for an ever-growing population of patients. We have also been tasked to deal with transition plans for many of our established positions. With these changes in mind, we've taken the approach to use this time to develop a new model of care. That really does mean that we have to manage the expectations of our patients, of our referring clinicians, and of the folks that we work day-to-day with, and helping everybody recognize what it means to be on a team. We have historically been a practice that has been physician centric. Allowing and empowering our APPs, device staff, and RNs to make decisions, and at the same time feel supported by more senior and/or specialty-specific docs, is important. This is certainly not easy to do. More days than not, I feel like a cheerleader encouraging everybody to reach for the stars and be their best self, but ultimately, I think it's been fruitful for everybody that is involved. What are your thoughts? It's been a dramatic transition, I think for the nurse practitioners, especially. You've taken on a large role in developing not only the concept of an atrial fibrillation clinic, but building the clinical process and working closely with many aspects of the hospital team that you probably didn't have much interaction with prior to this role. I think it's given you an opportunity to take on leadership that potentially you weren't exposed to prior to this model. Can you describe to me what you or some of your colleagues went through in developing the advanced cardiac therapeutics clinic and antiarrhythmic clinic?

AR: Initially, starting with our AFib clinic, I think the thought process really stemmed at looking at our current approach to AFib management and just thinking that we could do something better, not only from an access standpoint, as you mentioned, we have some physicians who are moving out and we have some others not as quickly moving in, but also a different model of care where we could offer these detailed, comprehensive visits, sort of an integrated care approach that we knew was probably a better model of care. We just didn't have it mapped out on how to do it. So, looking at using APPs seemed to make sense for this, not only from a resource perspective, but also driven by the desire from our APPs to do more. You mentioned there is somewhat of a culture shift within our institution. I think in many institutions, nurse practitioners or APPs largely started out doing tasks like histories & physicals, discharge summaries, and seeing stable follow-up patients. But we've really had this drive to be a more valuable member of the care team, particularly with a disease state such as AFib. So this really afforded us a nice opportunity to take on that approach in that role. In putting together that model, there were some resources for us to gain some perspective from to make our own changes with and make it our own. We've been very successful with our APP-led AFib clinic model. Three years later, we now have two other clinics: our antiarrhythmic pharmacist-led clinic, as well as our heart failure and EP-CRT clinic. I really think the success of the AFib model allowed those two things to happen. Largely, I think a lot of that came from support of our physicians and administrators. I think some of our initial challenges were having colleagues, other physicians, and referring partners accept that some of this autonomous care would be from an advanced practice provider. I think having the support of our physician leaders was key in being able to really gain that buy-in. Dr. Amin, you've been very publicly supportive in your role not only as system chief, but as our medical director of the AFib clinic. In regard to support of autonomous practice team-based models, how important do you think this has been in really gaining the buy-in of other colleagues or referring providers?

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AA: You know, I think that it's always helpful to lead by example. What I was describing earlier, where I sometimes feel like a cheerleader, there are so many people and pieces to corral together to get all of this to work. The best thing that I can do is to have everybody that is around me — my clinic nurse, the APPs, the device staff,

and the patients — see that I implicitly trust the process and the people who are working there. Beyond that, I think that another piece of this that makes this work is to see that the care is not delivered independently, it really is delivered together. So when we're on rounds, we round as a group of nurse practitioners, pharmacists, and residents, and the doctor, the patients, and the staff on the floor can see that we are a team. We respect everybody's opinion, we take on the challenges that team members bring up, and we do the same thing in the outpatient space. Having folks directly visualize that physicians have truly embraced this new model of care — there is an implicit trust that I think rubs off on people. For instance, in our AFib clinic with you, and in our antiarrhythmic clinic with Megan, our pharmacist, they see that there is buy-in from our own team internally, and they're much more supportive of it in their own programs, and we've seen that. I think we've seen that there has been a dramatic shift in the way that our partners in structural heart, interventional cardiology, and heart failure have looked at what we're doing and attempted to emulate it for their own practices. At the end of the day, folks will buy into what they see as being efficient and productive. We've shown that with close collaboration, data, and supporting our outcomes. Once you see it in action, there is nothing that will let you go back to the traditional model of care.

AR: I agree. I think part of getting our initial buy-in was knowing that there was already some baseline data out there about allied health or NP-led clinics. The paper that came out from Dr. Jeroen Hendriks' group about 10 years ago on nurse-led care versus standard of care for patients with AFib showed evidence for improved outcomes, decreased hospitalizations, and also cost reduction. We knew that those care models were functioning on almost like an algorithmic approach, these computerized models which were guiding their decisions. So I think, we had that data, but then we knew if we were going to show those same type of outcomes in our clinics, that would need to replicate that. So I think taking on the initial approach of having good clinical practice guidelines, heavily focused on evidence-based practice, was also helpful in showing that we had a desire to replicate those good outcomes and that we weren't going to be going rogue in clinic. We would be making sure we had an approach that was standardized so we could show those good outcomes as well.

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AA: We have eight docs at our primary site. What was it like trying to corral that group to consider and/or accept a single practice guideline?

AR: It's a battle we face every day! But no, I think that's one benefit of our clinic is that our APPs were pretty good at sticking to a standardized approach. I think that when we stick to that, and then we lightly sprinkle in the individual philosophy of our physicians on top of that, it's kind of what makes their clinic hum. We're not robots either — we're not just sticking to guideline medicine, because it's only a guideline, and so different people have different philosophies on when you offer ablation versus when you offer a drug, or who is appropriate or not for interventional therapy. That can't be standardized — we have to treat each patient encounter uniquely as well. I think we do a great job of having really open communication with our physicians. Our physicians are acutely available to us when needed, when we do need to reach out to collaborate for a patient. With that being said, if they're not acutely available, as you've mentioned, we have the trust and the backing to make those decisions independently, if we need to.

AA: I think you're right. We're not the only institution that has shifted towards an integrated care model for a number of diseases. Clearly, there are benefits, as you described, to these approaches. We're pushing forward, as you know, to have every one of our clinicians be performing at top of license. Most recently, we asked you guys to take part in helping us unload the labs, specifically asking for APPs to become proficient in the implanting ILRs (implantable loop recorders) and hopefully looking towards APPs performing cardioversions. What do you think the response has been from your team about taking on and increasing procedural workload?

We're excited to be a part of another space where we think we can add value, not only on hospital rounds in the clinic, but now in the lab as well. I really do think that there is a lot of opportunity in this area.

AR: We're excited. Initially, there was some apprehension — a lot of us have been away from any procedural area for a long time with just a clinical focus. So I think there was some apprehension, but we're excited to be a part of another space where we think we can add value, not only on hospital round or in the clinic, but now in the lab as well. I really do think that there is a lot of opportunity in this area. As these clinics grow and we continue to increase our lab volumes, there has got to be a give somewhere on the physicians. So if we can also help to offset some of that work by taking on some of the procedural workflow and maybe even move those things out of the lab, we're really happy to take part in that.

AA: Andrea, this has really been awesome. I love getting a chance to talk to you about the struggles that we faced in starting some of these spaces, and at the same time, getting an opportunity to reflect back on where we were, how far we've come, and where we think we want to be.

AR: I agree, and I want to formally thank you for all of your support and leadership throughout this. It was a lofty goal from the beginning to think we'd get buy-in for one APP-led clinic, and now we have three that are highly successful and valuable at our institution, and that has been under your leadership. So thank you! ■

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An upcoming discussion between two NPs on the role of the APP in the EP lab is also coming soon in another new podcast!