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Effectively Leveraging Your Organization's Advanced Practice Providers

Advanced practice providers (APPs) are a rapidly growing presence within the clinical workforce. Consider these statistics:

- The *British Medical Journal* reported that one-fourth of U.S. healthcare visits are now delivered by non-physician clinical staff.[1]
- The U.S. Bureau of Labor Statistics estimates that between 2022 and 2032, employment of nurse anesthetists, nurse midwives, and nurse practitioners in the U.S. will grow by 38% and employment of physician assistants by 27%. In contrast, the employment growth rate for physicians over the next decade is estimated at 3%.[2]
- Kaufman Hall's *Physician Flash Report* shows that, as of the end of 2023, APPs made up almost 40% of total provider FTEs.[3]

With median salary and fringe benefits for APPs approaching $200,000 a year, health system leaders can no longer afford to think of APPs as extenders or expensive scribes. They must work to effectively integrate APPs across clinical settings and develop the operational and financial data points needed to monitor the efficacy and efficiency of that integration. The key question management must answer is, "How do we know that we are effectively and efficiently leveraging APPs within our health system?"

APPs and access in ambulatory settings

Ambulatory settings, including both primary care and specialty practices, now serve as the main "front door" for most health systems. The ambulatory space has also been an area of intensifying competition, and ensuring easy and prompt patient access to ambulatory settings is essential for health systems to maintain their competitive edge.

Bonnie Proulx
Senior Vice President

Patient access statistics provide some of the best insights into whether APPs are being effectively leveraged within the ambulatory setting. One example is the percentage of patients requesting appointments who are able to be seen on a same- or next-day basis. If the health system has recruited a sufficient number of APPs (we recommend, for example, that at least 50% of clinical FTEs in the primary care space should be APPs) and these APPs are being deployed as an access point of care for both new and current patients, this percentage should be higher. If APPs are being used mainly in older models—shared clinic models, for example, or scribe models—these percentage will likely be lower. And this percentage is critical: Patients have many alternative sites of care available, and if they are unable to quickly and easily obtain an appointment, they are likely to look elsewhere.

The goal here is not to usurp the physician's role, but to build care team models that enable patients to get through the door, have their immediate needs addressed, and be referred on to a physician if the patient's needs require a higher level of care. The results of these efforts should also appear in metrics such as patient satisfaction and appointment cancellations/no shows. These efforts will also help the health system fulfill the mantra to provide the right care, at the right place, at the right time (and at the right cost).

[1] Miller, J.: "A Fourth of U.S. Health Visits Now Delivered by Non-Physicians." Harvard Medical School, News & Research, Sept. 14, 2023. https://hms.harvard.edu/news/fourth-us-health-visits-now-delivered-non-physicians

[2] U.S. Bureau of Labor Statistics. *Occupational Outlook Handbook*. Updated as of Sept. 6, 2023. https://www.bls.gov/ooh/healthcare/home.htm

[3] Kaufman Hall: *Physician Flash Report: 2023 Year-in-Review*. Jan. 30, 2024. https://www.kaufmanhall.com/insights/research-report/physician-flash-report-2023-year-review

APPs in the inpatient setting

As volumes recover and resident shortages grow in the inpatient setting, APPs are playing a more important role. With the heightened role of APPs in inpatient care, health systems should ensure that the physician/APP teams are functioning effectively and efficiently. In the era of split/shared billing, the proper division of labor within these teams will have impacts on both patient care and revenue.

When analyzing the efficiency of inpatient care teams, a good place to start is with volume, and whether existing care teams are able to effectively meet the demand for inpatient services. If not, relevant questions include:

- Are the physicians seeing every patient, and if so, why?
- Are there services the physicians are providing that could be provided by APPs?
- How much additional volume could be generated if the care teams were able to meet current demand?
- Even if the care teams are meeting current demand, are there opportunities for the physicians to generate additional volume?

Another important metric—and one that again speaks to capacity and revenue—is patient throughput and average length of stay. Many health systems are struggling with length of stay issues; could APPs be better deployed to improve this metric? And if so, what would be the revenue implications?

Compensation and productivity

Regardless of care setting, health systems must also look at questions of compensation and productivity. As noted above, these questions are even more relevant in the era of split/shared billing; with APPs paid at 85% of physician compensation under the Medicare program, for example, deciding which clinician will spending the majority of time with each patient has bottom-line implications. These implications can be negative, but they can also be positive if

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APPs are being deployed in a way that improves access and throughput and enables the system to grow patient volume.

A good starting question here is whether your organization looks at APPs as an added expense line on its profit and loss statement. If so, there is a likelihood that your organization is missing opportunities to leverage APPs in revenue-generating functions. This will not be the case across all practice areas; appropriate care models and benchmarking metrics will vary and the targets for different practice areas must reflect the realities of the appropriate model. There may also be value provided that is not captured in the P&L: for example, physician or patient satisfaction. At the same time, it is worth asking the question, how do we know that we are using the appropriate care model for this practice area? Are we paying APPs to perform tasks that could be performed by someone at a lower pay grade?

There are several resources available for benchmarking physician and APP productivity, including Kaufman Hall's *Physician Flash Report* and the MGMA physician productivity benchmarks. And there are several ways of looking at productivity: Is the team productive? Is the physician productive? Is the APP productive? But these resources also should provoke additional questions. For example, if physician productivity is benchmarked at the MGMA 65th percentile, should that benchmark increase if the physician is paired with an APP to add the cost of the APP into the physician's overall productivity? Should we benchmark APPs to ensure that they cover their cost? Should the productivity of the APP mirror that of their physician colleague?

APPs as part of your executive team

The questions posed in this article need solutions, but the solutions must be devised by someone within the organization who understands physician/APP care models, productivity benchmarking, and growth and financial strategy. If that position does not exist within your organization, who would be available to fill it? If you have not elevated an APP leader to a C-suite position, now is the time to consider doing so. An APP leader can help with strategy and bring an understanding of APP capabilities that will help ensure that your health system is deploying highly effective team-based models of care.

Given the cost of inefficient APP models, organizations must look at their investment per APP as well as their investment per physician. They also must have someone in a leadership role who can understand the evolution of the APP from an extender to a critical component in team-based care models set up for today's needs, and who can guide the finance team in identifying metrics to assure the efficient and effective leveraging of APPs.

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Elevating and more effectively leveraging the role of APPs in your organization is bound to cause some discomfort. The end result, however, should be enhanced patient access, more effective patient throughput, and improved productivity for APPs and their physician colleagues alike.

Questions? Please contact Bonnie Proulx at bproulx@kaufmanhall.com.