

Advanced Practice Providers Can Help Physicians Reach Their Peak Potential

By Bonnie Proulx, Senior Vice President, *Kaufman Hall*

Advanced practice providers (APPs) now comprise about 40 percent of the clinical workforce in the United States.

APPs are clinicians with a master's or doctoral degrees and include nurse practitioners, physician assistants, certified registered nurse anesthetists, and anesthesiologist assistants.

APPs are a rapidly growing component of the clinical workforce. The Bureau of Labor Statistics predicts that employment of nurse practitioners will grow by 40 percent between 2023 and 2033,¹ and that employment of physician assistants will grow by 28 percent over the same period.² In contrast, employment of physicians is expected to grow by just 4 percent.³

With median salaries and fringe benefits for APPs now approaching \$200,000 a year, health systems can no longer afford to think of APPs as "physician 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. Most importantly, they must ensure that APPs are being deployed in ways that enable the physicians they work with to operate at the top of their potential.

Evolution of the APP Model

The emergence of APPs in the clinical workforce coincides with passage of the Medicare Act of 1965, which substantially increased the demand for primary and acute care and increased pressure on the physician-led care model.⁴ The first nurse practitioner program

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- 1 U.S. Bureau of Labor Statistics, "Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners."
 - 2 U.S. Bureau of Labor Statistics, "Physician Assistants."
 - 3 U.S. Bureau of Labor Statistics, "Physicians and Surgeons."
 - 4 Cate Brennan, "Tracing the History of the Nurse Practitioner Profession in 2020, the Year of the Nurse," *Journal of Pediatric Health Care*, March–April 2020.

was started at the University of Colorado in 1965, and in the same year, the first physician assistant program was started at Duke University Medical Center.⁵

The world of APPs today is quite complicated. State laws vary considerably with respect to the authority APPs have to practice independently (i.e., without direct physician supervision), and organizations' bylaws, rules, and processes can further complicate the scope of practice for APPs. All these factors will affect how APPs can be deployed within your health system (to the extent organizational barriers are a factor, these can be a focus for reform to enhance APPs' contributions to the organization's performance).

Despite these complications, it is helpful to think of four basic archetypes for APPs today:

- 1. Primary care:** This is the most straightforward of the archetypes. Primary care APPs should be mostly autonomous within the scope of their license and have 36 patient-facing hours per 40-hour week.
- 2. Ambulatory medical specialty:** APPs in this archetype work with physician specialists and share a group of disease-based patients as part of a care team. APPs can help significantly with patient access, particularly when physicians have long wait times or it is unclear what the patient is coming in with. APPs should be focused on revenue-generating activity, not on managing the physician's inbox or serving as a scribe (actual scribes are far less expensive than APPs). APPs in this archetype should have 32–36 patient-facing hours per 40-hour week.
- 3. Inpatient medical/surgical:** APPs in the inpatient medical setting should run the patient list with the physician, but each provider should see what is appropriate based on patient acuity (i.e., two providers *do not* need to see every patient). In surgery, the APP can be responsible for patient throughput to the OR, post-operative patient management on the floor, and discharge.
- 4. Hospital-based:** These APPs work on a shift-based model in the ED, hospital medicine, and the ICU.

As health systems recruit and deploy APPs across the enterprise, they must ask what need the APP will address, which APP archetype best aligns with that need, and what are the appropriate productivity and compensation structures for the APP individually and members of the care team (including physicians) that the APP is joining.

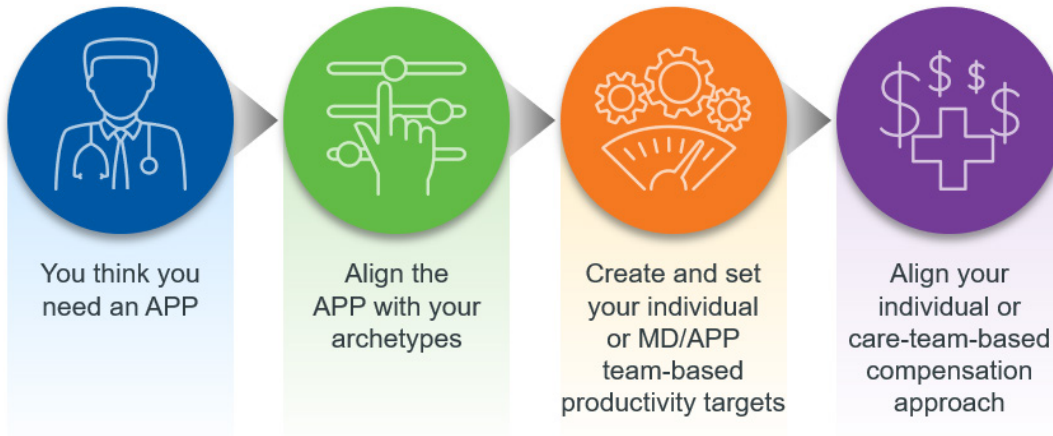
Implications of APP Deployment for Patient Access, Compensation, and Financial Performance

For years, discussions of APP deployment have focused on ensuring that APPs are able to operate at the top of their license. This is important, but more important is to ask: are

5 AAPA, "History of AAPA & the PA Profession."

our APPs being deployed in a way that improves patient access and ensures that our physicians can perform at their peak potential?

Effectively Deploying APPs across the Enterprise



Patient Access

One pain point for virtually every hospital and health system today is patient access. As noted earlier, APPs emerged at a time of significant increased demand for healthcare services; as the population ages and clinical workforce shortages have emerged, that demand remains strong today.

It is a fallacy to think that every patient wants to be seen by a physician; they want to be seen by someone who can address their issue and do so as quickly as possible. APPs can help retain established patients and bring new patients into the system. This is true across the primary care, ambulatory medical specialty, and inpatient medical/surgery archetypes. The key in all cases is to appropriately sort patients between APPs and physicians according to the urgency and acuity of the patient's needs. Doing so will speed the time between scheduling and the actual appointment date—helping reduce the number of cancellations and no-shows when frustrated patients turn elsewhere for care—and ensure that physicians are spending their time with patients who most need an advanced level of care. Just one or two more patients seen each day can drive material improvement in a practice's financial performance and in patient satisfaction.

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Compensation

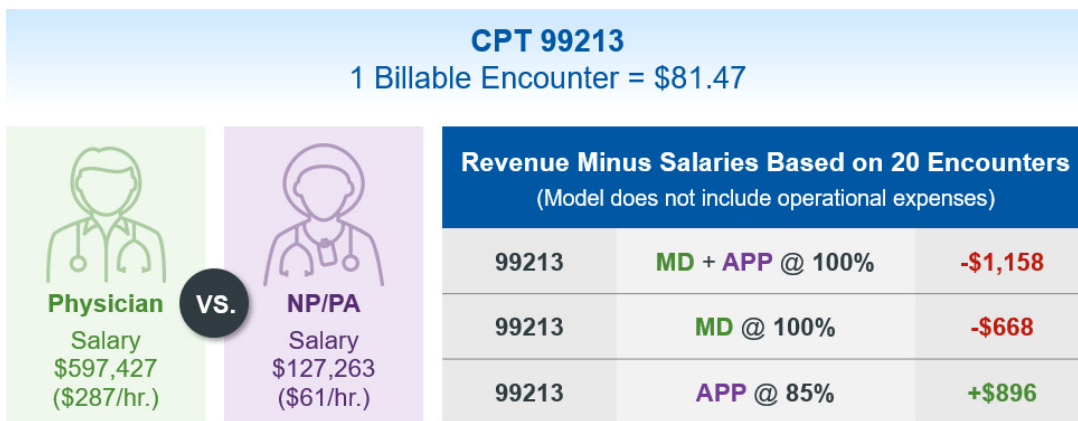
Physician productivity and compensation targets should reflect their use of APPs. If two physicians are operating at the 65th percentile of productivity but one of those physicians is achieving this benchmark with no APP support and the second is supported by two

APPs, the second physician’s actual productivity is probably significantly below the 65 percent benchmark. The second physician also is achieving the productivity benchmark at a much higher cost (the expense of two APPs) than the first physician. This should result in either a raising of the productivity benchmark for the second physician to reflect the APP support or a lowering of that physician’s compensation to align with the physician’s actual productivity after APP contributions to that productivity have been backed out.

Financial Performance

Focusing APPs on covering lower-acuity patient visits can also drive material financial improvement for the organization. Let us look at two licensed billing providers—one a physician and one an APP—providing a relatively low-acuity service (the CPT 99213 billing code, which covers an established patient visit of 20–29 minutes for a stable chronic condition or an acute uncomplicated injury). Only one provider can bill for this service, and it is true that payment will be 15 percent less if the APP is the billing provider. But it is also true that the physician’s salary costs almost \$300/hour while the APP’s salary costs just above \$60/hour. The financial outcomes are significantly better in this case if the APP is the sole billing provider versus the physician. The worst-case scenario involves having both providers see the same patient. If the APP has not been aligned with the appropriate archetype, and physician productivity has not been adjusted to include the cost of the APP on the physician’s care team, the health system will lose every time by paying the salary or expense of the APP and the physician who is providing redundant care, even if the physician is billing at a higher rate.

Revenue Outcomes for a Sample Low-Acuity Service



Sources: CMS 2023 Fee Schedule, 99213

*Salary is an estimated number, based on 2080 hrs., 8 hr shifts; MGMA Median GI Specialty 2023 Survey
 Estimated as \$62.67 /wRVU Net Revenue from actual healthcare system example

Conclusion

APPs have become an essential part of care delivery in most hospitals and health systems, but if they are not appropriately deployed within the system, they can add unnecessary expense. They should be able to expand patient access, generate revenue, and enable physicians to provide care to the patients most in need of higher-acuity services. Careful consideration of their appropriate role, the productivity targets that both they and the physicians they work with should meet, and compensation that is aligned with care team structures and productivity targets will help ensure that APPs truly add value to the system.

Key Questions for Board Members

A better understanding of the role of APPs within today's healthcare environment can help board members assess whether APPs are being appropriately deployed to enhance patient access, properly compensate clinicians, and drive improved financial performance. If APPs are not effectively deployed, they will represent a significant added cost. Key questions include:

- How is management determining whether APPs are being effectively deployed?
- Are APPs being deployed in a way that enables physicians to practice at the top of their license?
- Have we designed comprehensive, system-wide, standardized archetypes for APPs to allow for individual or team-based productivity target settings?
- Are we aligning physician compensation target benchmarks to incorporate the support of APPs?
- How do we justify the expense of APPs if they do not generate revenue?

TGI thanks Bonnie Proulx, Senior Vice President in the Physician Enterprise practice at Kaufman Hall, a Vizient company, for contributing this article. She can be reached at bonnie.proulx@kaufmanhall.com.

