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Resetting Enterprise Strategy: Making Choices and Following Through

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The highly publicized challenges that Walmart, Walgreens, and other businesses with narrowing healthcare aspirations have recently faced underscore the inherent difficulty of long-term success in an unforgiving industry.

From a business economics lens, this isn't a surprising revelation.

Healthcare is capital intensive, with highly skilled, high-cost labor requirements and regulatory restrictions, and health systems often don't control the pricing for the very complex services they offer. And inflationary environments, including the current era, exacerbate further the economic model. When economics don't align with their value propositions, for-profit businesses can always exit or scale back their healthcare presence. As organizations with a mission to care for their communities, not-for-profit health systems don't have this option.

We posit that these recent retreats from generalized healthcare delivery provide us with two core ideas:

1. If healthcare "disruptors" are stepping away from the market, we know the model itself requires tremendous rethinking to determine how to deliver these services in today and tomorrow's environments, and
2. Health systems must step up to the plate and be willing to approach these opportunities differently if they wish to see a different outcome.

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Given these parameters, hospital and health system leaders must be willing to make difficult strategic choices and execute accordingly. In the wake of the pandemic and the macroeconomic and operational challenges that followed, though, enterprise strategy took a back seat to crisis management and operations for several years.

The case for enterprise strategy

Strategy is a method for making a cohesive set of choices to support the future of a given enterprise. Given the mission-based nature of not-for-profit healthcare, hospitals and health systems are often tempted to take the opposite course and attempt to be everything to everyone.

In this context, making choices is critical. Culturally, this may feel to be at odds with the roles our health systems play. Healthcare is inextricably linked to our communities, and for many it is a herculean effort to even ask whether and to what extent an organization needs to be differentiated, or focused in the services they offer (and how they offer them). Defining a distinctive value proposition is a difficult, but essential, task.

Healthcare leaders that can define where they need to go and align their organizations accordingly will always have a substantial leg up on the competition—and a better ability to fulfill their not-for-profit mission. Indeed, pursuing strategy as a decision-making exercise is the only way to execute priorities and deliver on the organization's brand, given that very few organizations are pursuing this path. In decades past, many organizations could survive and even thrive without defining a unique strategy, but the existential threats of the 2020s have erased that option.

Given the current challenges, health systems must be prepared to decide how to differentiate their organizations from their competitors moving forward, which requires asking difficult questions about the future direction of the enterprise. Organizations must then realign themselves to enable their future direction, an exercise that necessitates evolving their operating model, governance, scale capabilities, portfolio management, and other key elements accordingly.

Designing a value proposition and setting priorities

In our experience, few healthcare organizations have been incentivized historically to commit fully to declaring a strategic direction and executing on it, especially if they have thrived in their markets. As a result, most health systems don't possess the muscle memory of making meaningful strategic changes or taking risks. Instead, most providers have leaned on incremental initiatives designed to gain marginal market share, but without the potential to differentiate their organizations from their competitors.

In decades past, many organizations could survive and even thrive without defining a unique strategy, but the existential threats of the 2020s have erased that option.

However, given the current imbalance between the cost of healthcare services and the resources to provide them, organizations that are essential, well-regarded players in their markets today may not be in the future. Organizations that don't define and pursue a value proposition can face significant peril over time. Many observers argue that Boeing gradually lost sight of its historic value proposition of high-quality, safety-focused aviation design, leading to an inattention to detail that culminated in highly publicized safety lapses.

To sustain their competitive advantage, organizations must be willing to identify their value proposition and then align the organization to implement. We are observing that more executive leaders and boards are embarking on difficult conversations about who they are to their patients, employees, and communities. We are also starting to see leading organizations embrace a strategic direction and answering the hard questions necessary to achieve it at the expense of an "all of the above" approach:

- Will we provide better services to our consumers?
- Will we provide the highest value to our consumers?
- Will we be the easiest healthcare provider for consumers to use?

Every aspect of current operations must be on the table during the strategic planning process. Otherwise, organizations run the risk of including so many elements that they cannot realistically execute, and the plan becomes

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an inventory of unrealized goals. Leaders should inform their decisions by several key factors as they decide what to prioritize, including:

- The state of play of the local healthcare market, including any difference in financial positioning and the strength of relationships between payers and providers
- An understanding of any cost imbalances between delivering services and payment under existing reimbursement models, and an analysis of future cost structures for the businesses and services that health systems intend to offer
- The current operating model (governance, organization structure, how decisions get made) and its alignment to strategy
- The alignment of the organization's physician enterprise, and potential forward-looking strategies
- An understanding of the benefits of scale, as well as future competitive requirements
- An understanding of consumer needs and demands, as well as their potential evolution over time

Pivoting from planning to execution

While no organization is identical, we believe the health system of the future must consider the following strategic requirements for sustained success, designed to amplify and enable a specific, differentiated strategic vision:

- A platform capable of implementing its strategic plan, which will include an effective operating model, governance structure, and effective leadership
- An optimized portfolio of services and technology investments that align with the platform for differentiation
- Partnership capabilities to advance the organization's vision
- A strategy for physician alignment and a care model that guides how consumers interact with each facet of the health system
- Other activities to support transformation, which might include strategic pricing initiatives, managed care strategy and payer-provider partnerships

Conclusion: Key questions for guiding long-term strategy

After several years of grappling with one existential challenge after another, many organizations may find the task of resetting their strategy overwhelming. In our experience, most health systems have not asked or answered the difficult questions required to chart a new path.

And identifying the requirements that can amplify the organization's strategic direction is just the first step in the journey. Importantly, organizations must be able to determine whether they have the capital and cultural capacities to reach their goals and, after identifying any shortfalls, decide how to move forward.

From there, organizations need to be able to measure progress against their implementation plan—or run the risk of reverting back to previous modes of doing business. All too often, organizations fall short of implementing their strategic plans precisely because of the difficulties involved in changing direction. Over time, organizations that commit to a new strategic direction must continually ask:

- Do our actions match our value proposition and strategic priorities?
- Do our markets and consumers value what we are trying to achieve?
- Are we designed to implement our priorities?
- Can we execute – financially, culturally, and strategically, against our goals?
- *If not, what needs to be reset to achieve strategic alignment?*

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Optimizing 340B Participation Compliantly While "Waiting and Watching" New Developments

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Hospitals and health systems that participate in the federal 340B Drug Pricing Program are currently facing challenges on multiple fronts, including manufacturer restrictions and program audits, legal challenges, and constantly-evolving federal and state requirements for participation.

Since 1992, the 340B program has required drug manufacturers to provide drugs used for the outpatients of eligible health care organizations and other covered entities at significantly reduced prices, with the intent of helping safety net organizations improve their financial stability. In turn, hospitals are expected to demonstrate that the savings they receive from the program benefit their patients.

Presently, many hospitals are "waiting and watching" regulatory and legal developments that may impact their future 340B participation. In the interim, however, there are steps organizations can take to optimize their 340B programs compliantly, with the intent of improving financial outcomes, increasing revenue, and benefitting patients, employees, and the communities they serve.

Consider creating an internal pharmacy

Many 340B hospitals are moving in the direction of opening their own in-house retail or specialty pharmacies as part of their strategy to address restrictions from drug manufacturers. These pharmacies can serve patients, employees, or the general public, depending on how they are structured.

Key benefits of creating an internal pharmacy include:

- Increased revenue
- Potential alignment with managing patient care, including greater insight over patient prescription adherence and the overall cost of care
- Opportunities to provide easier access to prescriptions for patients
- Opportunities to align employee benefits programs with 340B to achieve additional cost savings
- Positive community perception by partnering with locally owned pharmacy businesses

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The primary benefits for patients can include:

- Direct patient discounts, copays, and other financial assistance in the event of hardship
- Tailored services and convenient and timely services, including delivery, medication therapy management, care management, and expanded hours
- Hands-on clinical care, including direct access to both clinicians and pharmacy staff
- Ongoing monitoring for drug safety, side effects, and efficacy
- Prior authorizations of medications

Strategically utilize contract pharmacy networks

Covered entities can also contract with retail pharmacies (whether they are owned, community-based, or specialty pharmacies) and extend their 340B discounts for their patients who fill scripts at these locations. These "contract pharmacies" must be registered on the Health Resources & Services Administration (HRSA) website once a contract is established.

Contract pharmacy networks can play a particularly important role with regards to specialty drugs, which, according to our analyses, comprise more than half of all hospital spending on drugs despite comprising only 2% of volume. Even organizations that have an in-house pharmacy may not be best positioned to distribute oncology drugs, given their limited distribution.

These high-cost medications treat rare, complex, chronic health conditions. Key therapies for specialty drugs include oncology, multiple sclerosis, HIV/AIDS, Crohn's Disease, blood/bleeding disorders, and inflammatory diseases, among others.

There are steps organizations can take to optimize their 340B programs compliantly, with the intent of improving financial outcomes, increasing revenue, and benefitting patients, employees, and the communities they serve.

As a result, organizations need to carefully select the pharmacy partners that are best aligned with their 340B services, which vary depending on the health conditions and medication needs of the patient populations they serve.

Closing thoughts

As hospitals await further legal, regulatory, and manufacturer-related shifts in the administration of 340B, the steps outlined in this article offer an interim path forward. Given the promise of the 340B program to help stabilize hospital finances, optimizing the program's benefits while remaining compliant with its rules and regulations should be top of mind for any participating organization.

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Embracing Financial Planning After a Pause: Key Considerations

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In recent years, many healthcare organizations have invested less effort in long-range financial planning to confront more immediate challenges to their margins and balance sheets. The unprecedented operating environment of the pandemic and its inflationary aftermath gave way to tight capital markets and limited capital investment in the non-profit healthcare sector. Healthcare leaders focused their attention on the immediate needs of their organizations, given continued uncertainty and a less favorable funding outlook.

In early 2024, signs are emerging of an improving outlook. Median U.S. hospital margins were at 2.3% at the end of 2023, according to Kaufman Hall's National Hospital Flash Report, and there is the possibility the Federal Reserve Board might begin to lower interest rates later in 2024. As a result, many healthcare organizations are beginning to plan for significant capital expenditures for the first time in several years.

However, pursuing reinvestment and growth strategies after extended turbulence is easier said than done. The operating environment for hospitals in 2024—which includes persistent volatility and a weakened financial position for most providers—is materially harder to navigate than the pre-pandemic era. Not-for-profit, mission-based healthcare organizations also have evolving needs and expanding demands in areas including workforce, technology, and progress toward value-based capabilities. In addition, many organizations have deferred brick-and-mortar investments in their facilities to consider.

In light of that landscape, leaders must carefully vet traditional planning metrics and targets to ensure they still provide accurate insight into the requirements for long-term sustainability. Organizations will have to carefully distribute their resources to high-priority needs—first carefully defining their investment capabilities given financial and sustainability goals. In turn, managing organizational resources within those guardrails requires a focus on long-term planning over short-term forecasting.

Organizations that are not positioned to sufficiently invest in their operations will face hard decisions about their future direction--including significant cost adjustments, limiting or terminating certain services, or seeking broader partnerships to ensure continued, appropriate investment in key community assets.

A Reinvigorated Approach to Financial Planning

The core principles of integrated strategic financial planning can help not-for-profit healthcare leaders guide their organizations through the current highly dynamic and constrained environment. Given limited overall growth, organizations must be able to reinvigorate their process, analytics, and evaluative criteria to ensure an appropriate return on constrained resources.

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A decade ago, many healthcare organizations relied on the traditional "heads in beds" approach to quantify the financial impact of a potential capital expenditure. Today, healthcare leaders might take the opposite path: for instance, determining how an investment in physician capacity might keep patients out of the hospital and cared for at home or in their community. A planned investment in an ambulatory surgery center might lead to evaluations of its impact across a broader variety of interconnected dimensions: existing operating rooms, reimbursement, cost structure, and physician alignment, just to name a few.

This shift in approach may require organizations to use more sophisticated planning resources – including staff, planning tools, and enhanced data. Ideally, the planning process is integrated with the organization's strategic decision-making, is transparent and understandable for stakeholders, and is designed with accountability for execution.

Organizational financial performance must be sufficient to meet the cash flow requirements of the strategic plan and maintain or improve the financial integrity of the organization, within an appropriate credit-and-risk context.

Key strategic needs for consideration will include:

- Supporting growth in clinical, academic, and/or research endeavors
- Maintaining a competitive market/facility presence
- Retaining or enhancing credit strength
- Creating capacity for additional investment
- Enhancing access to strategic capital

Key elements of a well-organized financial plan will include:

- Sensitivity analyses to identify key drivers of organizational success and areas of risk
- Scenario analyses and simulations to identify how specific actions and investments might shift in different operating environments
- Capital prioritization and funding requirements for strategic initiatives
- Decision-making frameworks for the operational expectations of the enterprise
- Comprehensive service line planning
- Appropriate credit targets to maintain optimal access to credit markets
- Applying data science techniques to define sustainability

Getting Started: Asking the Right Questions

Healthcare leaders must be able to both identify the resources their organization needs to sustain its enterprise and mission in the future—and evaluate whether they are positioned to deliver those resources. Key questions for consideration include:

- Can our organization meet the long-term financial requirements necessary for a sustainable operating path?
- If we cannot meet these requirements, what are the implications for our strategy?
- How do we stress-test our organization's future strategic and financial trajectory in light of changing market conditions?
- What are the financial and operational implications of our potential capital investments across our entire enterprise?
- How do these investment decisions compare to other demands on our resources?
- Are we moving toward building up the resources in workforce, technology, data, and other critical needs that will position our organization for resiliency and long-term success?

Closing thoughts

After a sustained pause in capital investment, most not-for-profit, mission-based hospitals and health systems have a long, growing list of capital needs and constrained resources to devote to them. And the capital planning metrics and processes that many organizations relied on before the pandemic are no longer sufficient, given the increasingly challenged operating environment.

An integrated strategic financial planning process can help healthcare leaders assess the long-term impact of potential capital investments on their mission and enterprise, quantify whether or not they currently have the wherewithal to pursue them, and guide their organizations accordingly.

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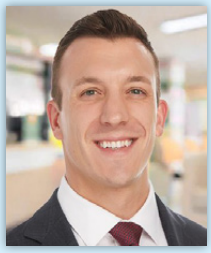
Hospital Conversion Foundations: Keeping the Community Promise After a Transaction Closes



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When a not-for-profit health system decides to pursue a sale to a larger organization, board members are often concerned that they will be giving up the ability to influence community health at the local level. This need not be the case, however: structuring the deal to create a resulting community foundation can ensure that community health will be supported into the future. Resulting community foundations are governed by an independent and local board of directors, separate from the health system, and are endowed with funds that can address local health needs and other issues that the health system may not have otherwise had the means to take on – unlocking new, incremental value for the community.

Creating a community foundation

Resulting community foundations are most commonly created in one of two transaction scenarios:

- A for-profit organization acquires the smaller not-for-profit health system and the net purchase price is used to fund the foundation.
- A larger not-for-profit health system acquires a smaller system that is a position of financial strength, with significant excess cash that does not need to come along with the transaction.

Regardless of the source of funding, the funds are put to a common use: they create an independent, not-for-profit foundation with its own identity and governance structure able to define its own mission, vision, and grant-making priorities.

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Key Questions

When determining the identity, scope, and governance structure of the foundation, key focus areas and questions include:

- **Activities:** To best fulfill our community promise, should our ongoing activities include grant-making, operating, and/or fundraising?
- **Geography:** Which communities should our foundation support?
- **Impact:** Should our foundation exist to create maximum impact in a time-limited period or sustainable ongoing impacts in perpetuity?
- **Board Composition:** What skills and experience are needed to fulfill our mission and purpose?]

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If funds for a foundation are available, there are several decision points that will affect the foundation's structure, duration, and activities and operations.

Life of the foundation. This is a decision that may be influenced by the amount of money available to fund the foundation. A smaller foundation may want to use its funds to make a big impact in a few areas of focus and spend down the foundation's funding within a matter of years. A foundation with more significant funds may be able to continue "into perpetuity," meeting the requirements for annual spending on grants and qualified operating expenses required by the Internal Revenue Service while continuing to maintain or grow its asset base.

Scope of foundation activities. There are several options to consider. The foundation might be focused solely on grant-making. It might have both grant-making and operating programs (e.g., funding and operating its own community food bank). Or it may want to include fundraising activities to support and grow the foundation's assets. These choices will have implications for both legal structure and operational requirements.

Identity of the foundation. This includes the foundation's mission, vision, and grant-making priorities. Community foundations can be narrowly focused on a few priorities or have wide-ranging interests that address multiple social determinants of health in the community (e.g., housing, transportation, economic stability, food access and security, and education). Community needs assessments conducted by the health system or a community health organization are often used to identify grant-making priorities when the foundation is created.

Generally speaking, the broader the scope of the foundation's activities, the more resources and staff will be required to support its mission. Foundations may have a staff of just a few people or a staff of 50 or more individuals.

Foundation governance. The size and complexity of the foundation and its operations will affect the composition of the board and its committees. There is often some continuity between pre-transaction membership of the board of the health system that is being acquired and membership of the newly created foundation, enabling health system board members to continue their community service with the resulting foundation. Given the community foundation's focus on local needs, the governance model is typically structured to include voices of community leaders involved in or affected by the foundation's mission and activities. Options include designating seats on the board for these community leaders or creating a community advisory council to provide information and insights to board members.

If funds for a foundation are available, there are several decision points that will affect the foundation's structure, duration, and activities and operations.

Typical committees include a finance or investment committee, a committee that oversees the foundation's grant-making activities, a nominating committee, and a committee that oversees compliance with and amendments to the foundation's bylaws and covenants. Boards of larger foundations may also have committees focused on human resources, for example, or foundation communications.

Community foundation boards can have some unique oversight functions related to the transaction that created the resulting foundation. The acquiring health system may make commitments to the local hospital to fund certain capital projects, for example, or maintain certain service lines for a period of years following the transaction. In this case, the community foundation board will often have the authority to monitor and enforce compliance with these commitments.

These decisions will form the framework for the community foundation and its identity, structure, and governance model. As part of the pre-closing process, workstreams can be established to have the foundation ready to

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begin operating once the transaction closes so that the foundation may begin making positive impacts in the community as quickly as possible. A summary of the typical workstreams and objectives for creation of a community foundation are shown in Figure 1.

The decision to partner with another organization through an acquisition process is always a high-stakes decision for a board. But for organizations that decide to make this move from a position of strength, the creation of a community foundation is one way to ensure that the health system's focus on its community not only remains intact, but also unlocks new potential to improve the lives of community residents. A transaction that creates a community foundation can both mitigate the financial risk that smaller health systems increasingly face in today's difficult operating environment and create an entity able to address community health issues with resources the health system may not have had access to. And for board members, creation of a foundation can offer opportunities to continue their service to the community through dedication to and expansion of the charitable community promise originally fulfilled by the health system.

Figure 1: Creating a Community Foundation – Workstreams and Objectives

Workstream	Objectives
Establish the foundation's identity	• Draft, refine, and establish the mission, vision, and grant-making priorities of the foundation
Design the governance model	• Determine the desired role, committee structure, composition, and meeting cadence of the foundation board • Establish post-closing enforcement oversight, if applicable
Hire administrative leadership and staff	• Hire, orient, and onboard lead executive and support staff complement to operate the foundation • Develop initial HR infrastructure (e.g., employee handbook, conflict of interest statement)
Select ongoing third-party vendors	• Conduct RFP process to evaluate and select third-party vendor services for key "day 1" functions (e.g., investment management, tax, accounting, audit, banking, legal, insurance)
Complete operational requirements	• Establish operational infrastructure required for "day 1" and "year 1" operations (e.g., payroll, branding, website, office space)
Legal	• Determine legal and tax structure • Develop articles and bylaws • Complete legal structure transition for pre-close vs. post-close operations
Wind down (if applicable)	• Evaluate and select consultant to successfully manage the wind down of relevant legacy assets and liabilities, if any

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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.

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.

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Senior Vice President

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).

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.

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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

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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 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.

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.

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