Optimizing Use of Advanced Practitioners
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OPTIMIZING USE OF ADVANCED PRACTITIONERS

The jury is no longer out on whether use of advanced practitioners (APs) will continue to grow. From 2012 to 2016 their ranks increased nearly 35%, and thousands more enter the workforce each year. As their numbers climb, so does their influence. Conservative estimates show that APs will deliver nearly one-third of all primary care by 2020. However, if barriers to their full deployment are overcome and APs are able to work top of license, reality could far exceed that forecast. Sg2 believes this shouldn’t be viewed as a lofty goal but rather a strategic imperative for long-term sustainability.

While APs will be pivotal for a more accessible, efficient US health care system, questions remain. How can they be best deployed across the full care continuum? Can their incremental value be adequately demonstrated to measure their impact on organizations’ performance improvement and growth goals?

Provider systems are increasingly leveraging APs to boost physician panel sizes, augment hospitalist services, succeed in new care models, become more consumer-centric or position for alternative payment structures. Data, in fact, show a financial advantage for specialty practices that employ APs. And specialties at the forefront of bundled payment, such as cardiology and orthopedics, will benefit from further AP innovation as an important means of smoothing care transitions and reducing total spend.

Without a sound deployment strategy, however, there’s risk that hiring APs will only raise workforce costs, which—in a time of belt tightening and mounting pressure to decrease costs—is unsustainable. APs can spur redundant utilization rather than care efficiency if they are not integrated effectively. And cultural barriers as well as misaligned incentives too frequently derail optimal deployment. Revenue recognition also remains challenging.

The industry, though, has made headway. Challenges posed by scope of practice laws and turf wars are subsiding. A broader embrace of team-based care and advances in virtual health have helped clarify and expand APs’ roles.

Further expansion will require innovative organizational structures, sound billing practices and effective onboarding. A commitment to comprehensive workforce planning that enables all clinicians to work top of license is crucial. Approaches to unleash the untapped potential of the growing cadre of APs must quickly become a strategic priority for health systems.

Sg2’s report Optimizing Use of Advanced Practitioners presents:

- The current state of the AP workforce
- Six strategies to optimize deployment:
  1. Pursue data-driven workforce planning.
  2. Standardize management approach.
  3. Navigate complex licensing.
  4. Scale through complementary innovation.
  5. Build the financial case.
  6. Implement through team building.
- Case studies of successful AP programs
Provider systems seeking to curtail costs without compromising quality—a likely goal of every organization—should view APs as essential to their workforce strategies. No longer considered midlevel providers, they are particularly well-positioned to help strengthen primary care through both ancillary and autonomous roles. Yet their potential impact across the full System of CARE and on an organization’s overall market position and bottom line should not be overlooked.

Advanced practitioners generally include nurse practitioners (NPs), physician assistants (PAs), clinical nurse specialists, nurse anesthetists and certified nurse midwives. This publication focuses on nurse practitioners and physician assistants.

**Well-Executed AP Deployment Can Curb Historic Practice Losses**

As trends such as population health and value-based reimbursement started to take hold, hospitals went on buying sprees to acquire independent physician groups. Many organizations were content to allow those independent practices to serve as loss leaders in exchange for downstream access but were reluctant to make substantial investments in care redesign. Now, as economic pressures mount and physician shortages persist, the losses hospitals face per employed physician—$176,463 in 2012—grow annually and are becoming unsustainable for already strapped health systems. Conversely, a strong AP presence has been attributed to higher practice revenue.

**TOTAL MEDICAL REVENUE PER PHYSICIAN FTE**

By Ratio of Nonphysician Provider FTEs to Physician FTEs

<table>
<thead>
<tr>
<th>Physicians or NPs Only</th>
<th>0.20 or Fewer</th>
<th>0.21 to 0.40</th>
<th>0.41 or More</th>
</tr>
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<tbody>
<tr>
<td>Primary Care Single Specialties</td>
<td>$1,200,000</td>
<td>$1,000,000</td>
<td>$800,000</td>
</tr>
<tr>
<td>Nonsurgical Single Specialties</td>
<td>$1,000,000</td>
<td>$800,000</td>
<td>$600,000</td>
</tr>
<tr>
<td>Surgical Single Specialties</td>
<td>$800,000</td>
<td>$600,000</td>
<td>$400,000</td>
</tr>
<tr>
<td>Multispecialty</td>
<td>$600,000</td>
<td>$400,000</td>
<td>$200,000</td>
</tr>
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**Diverse AP Roles Can Lead to Higher Value**

Many services traditionally offered by physicians can be performed by NPs or PAs. Although scope of practice varies between the 2 professions, as well as by state, standard roles include obtaining medical histories; conducting exams; ordering, performing and interpreting diagnostic tests; diagnosing and treating conditions; prescribing medications; and educating patients and families. PAs also participate in surgical services, providing pre- and postoperative care and assisting physicians during procedures. Strategically deployed, APs can optimize physician caseloads in both inpatient and outpatient settings while enhancing elements of care delivery essential to superior outcomes.

BUT DEMAND COULD OUTSTRIP SUPPLY

Consumerism and accelerating technological breakthroughs are converging trends that both increase demand for APs and heighten the competition for talent. At the same time, they highlight opportunities to utilize APs across the continuum.

Numbers Continue to Grow

The combined NP and PA workforce grew by nearly 35% from 2012 to 2016. This growth trend is expected to continue, especially as the number of graduates joining the workforce has also experienced a significant incline. The number of new NP graduates more than doubled in 2016 to 20,000 from 12,785 in 2012. In 2015, there were 7,888 new PA graduates, up from 5,928 in 2012. But efforts to expand and accelerate the training and deployment of new APs may not be enough.

AP GROWTH BY THE NUMBERS

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of NPs</td>
<td>157,000</td>
<td>222,000</td>
</tr>
<tr>
<td>Total Number of PAs</td>
<td>90,000</td>
<td>108,000</td>
</tr>
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AP WORKFORCE BY SPECIALTY

<table>
<thead>
<tr>
<th>NP Primary Specialty</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Family</td>
<td>55%</td>
</tr>
<tr>
<td>Adult</td>
<td>17%</td>
</tr>
<tr>
<td>Acute Care</td>
<td>8%</td>
</tr>
<tr>
<td>Women's Health</td>
<td>6%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>6%</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>5%</td>
</tr>
<tr>
<td>Gerontology</td>
<td>3%</td>
</tr>
<tr>
<td>Neonatal</td>
<td>2%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PA Primary Specialty</th>
<th></th>
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<tbody>
<tr>
<td>Family Medicine/General Practice</td>
<td>21%</td>
</tr>
<tr>
<td>Surgical Subspecialties</td>
<td>19%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>13%</td>
</tr>
<tr>
<td>Internal Medicine Subspecialties</td>
<td>9%</td>
</tr>
<tr>
<td>Internal Medicine General Practice</td>
<td>5%</td>
</tr>
<tr>
<td>Hospital Medicine</td>
<td>3%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>3%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>2%</td>
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Competition for APs Is on the Rise

Year-over-year growth in requests for nonphysician providers is approximately 160%, according to AMN Healthcare, a recruiting firm for clinicians. Competition for talent between private sector organizations is high in some markets, and in others, the federal government also is becoming a major competitor for talent. In 2016, the US Department of Veterans Affairs granted full practice authority to APs, regardless of state laws. The 5,700 advanced practice nurses (APNs) it currently employs already comprise more than 6% of its total nurse workforce. Retail clinics, which grew more than 5-fold over the past decade, also represent a major player for APN talent. Clinics’ expanding scope of services make them an attractive employer to NPs, who are responsible for both directing and delivering care at these clinics. Efforts to bridge potential care gaps created by physician shortages will also increase demand for APs. Trends suggest that by 2025, demand for physicians will exceed supply by a range of 46,000 to 90,000.

Sources:
### Pursue Strategies to Optimize Use of APs

<table>
<thead>
<tr>
<th>Focus on Workforce Planning</th>
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<tbody>
<tr>
<td>• Allow clinicians to forge new frontiers.</td>
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<tr>
<td>• Recruit, retain and train to secure necessary staff.</td>
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<tr>
<td>• Address experience gaps.</td>
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<table>
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<tr>
<th>Standardize Management Approach</th>
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<tbody>
<tr>
<td>• Instill a unified voice.</td>
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<tr>
<td>• Weigh options for governance structure.</td>
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<table>
<thead>
<tr>
<th>Navigate Complex Licensing, Credentialing, Privileging</th>
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<tr>
<td>• Plan with an eye toward applicable state laws.</td>
<td></td>
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<tr>
<td>• Scrutinize bylaws to determine if they are a barrier or boon to full deployment.</td>
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<table>
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<tr>
<th>Scale AP Strategy Through Complementary Innovation</th>
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<tbody>
<tr>
<td>• Consider innovative options for maximizing impact.</td>
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<thead>
<tr>
<th>Build the Financial Case for Deployment</th>
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<tbody>
<tr>
<td>• Maximize compensation/collections ratio.</td>
<td></td>
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<tr>
<td>• Consider the contribution margin.</td>
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<tr>
<td>• Understand billing models and requirements.</td>
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<table>
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<tr>
<th>Implement Through Team Building</th>
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<tr>
<td>• Recognize the importance of culture.</td>
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</table>
1 FOCUS ON WORKFORCE PLANNING
The changing health care landscape is forcing many organizations to develop workforce strategies that are responsive to emerging mandates to control costs while increasing value. It is imperative that provider systems look for opportunities across the continuum to enhance the value of their workforce, which represents their largest line item.

Allow Clinicians to Forge New Frontiers

Because APs can deliver as much as 85% of the care delivered by primary care physicians (PCPs), the ambulatory setting has been the logical starting point for AP deployment in many systems. Organizations have begun to expand the IP role of their APs to support system-wide efforts to reduce LOS, smooth transitions and enhance patient engagement. Rural hospitals in particular increasingly rely on inpatient APs to help them overcome physician recruitment challenges.

APs will continue to gain stature in both supervised and independent roles to support provider system strategy for unscheduled visits (eg, urgent, retail and after-hours care), medical homes, transitions to post-acute settings and improved performance (eg, LOS and readmission reductions).

WHERE ADVANCED PRACTITIONERS WORK ACROSS THE SYSTEM OF CARE

Note: Not all practice sites are included. CARE = Clinical Alignment and Resource Effectiveness.
Deploy APs in Step With Enterprise-Wide Workforce Plans

AP hiring decisions have typically been made at the business unit or service line level. Growth initiatives that target “how much more can be done” and care redesign efforts aimed at enhancing value by focusing on “who does what” can be facilitated with this approach. However, effective AP deployment depends on organizations’ ability to pursue hiring in concert with a system-wide strategy. Begin by determining which roles are needed to drive the strategy, and then identify the types of clinicians most appropriate to fill those roles.

### DATA-DRIVEN WORKFORCE PLANNING

<table>
<thead>
<tr>
<th>STEPS</th>
<th>REQUIRED INFORMATION</th>
<th>CONSIDERATIONS</th>
</tr>
</thead>
</table>
| 1. Identify physician WF gaps. | • Service line forecasts  
• Provider supply and demand  
• Expected physician turnover/attrition | • % of physicians approaching retirement  
• Work expectations of new physician workforce |
| 2. Segment current provider mix. | • Physician and AP deployment mix across care settings and service lines  
• Current scope of practice | • Degree to which clinicians currently fulfill assigned duties  
• Proportion of APs performing duties more appropriate to top-of-license RNs |
| 3. Define best practice utilization. | • Services APs can be credentialed to perform in targeted clinical areas; opportunities for best practice utilization  
• Service utilization and AP time requirements to complete services | • Extent to which planned roles meet consumer expectations for care delivery  
• Likelihood new roles will gain support given the current physician and organizational culture |
| 4. Define future AP and physician FTEs. | • AP FTE requirements to achieve best practice use, fill identified physician gaps  
• Provider costs to determine ROI | • Governing, credentialing and privileging requirements  
• Quality and efficiency savings  
• Ability to bill for AP services |
| 5. Estimate training time. | • Average work experience of existing APs  
• Current AP skill mix | • Practice in specific clinical areas  
• Current vs expected privileging/credentialing  
• Physician supervision/support requirements |
| 6. Develop a 5-year hiring road map. | • SWOT analyses  
• Data from steps 1–5  
• Incremental value analysis | • Internal strengths (eg, exec team support, WF supply)  
• Internal weaknesses (eg, lack of standardized onboarding approach, inexperience of WF, no fellowship/residency program)  
• External opportunities (eg, heavily saturated AP applicant pool, partnership with local university)  
• External threats (eg, competing hospital’s successful fellowship program, better pay/benefits at competitor) |

**ROOM TO GROW**

Across several service lines, AP-to-physician ratios show opportunities for growth outside of primary care. One stark comparison is primary care and cardiology.

<table>
<thead>
<tr>
<th>Service Line</th>
<th>AP:MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>1:2</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1:50</td>
</tr>
</tbody>
</table>

ROI = return on investment; SWOT = strengths, weaknesses, opportunities, threats; WF = workforce.
When the outpatient cardiology department of this 7-hospital health system in northeast South Carolina made the strategic decision to revamp its workforce, available appointments for existing patients in its electrophysiology (EP) clinic were typically 8 weeks out, with no new patient slots available. The sole physician in the EP lab was scheduling 45 to 50 patients per day; wait times averaged an hour or more; and patient satisfaction was taking a hit. On the back end, incomplete documentation from time-pressed physicians led to annual losses topping $200,000.

**Initiatives**
- A care team model was implemented.
- An existing physician assistant received disease-specific training to expand skills beyond device checks.
- A PA performs pre- and postprocedure visits and patient follow-up in the atrial fibrillation clinic.
- Physician time was freed up to devote 2 to 3 days per week in the EP clinic.
- All providers were included in revenue sharing.

**Results**
- Physicians’ daily patient loads reduced to 35 from approximately 50
- Average new patients increased from 0 to 5 daily
- Follow-up appointments scheduled within 14 days
- Wait times reduced from 60 to 30 minutes
- Physician contributed to 28% increase in revenue; PA contributed to 85% increase
- New EP clinic opening as a result of increased demand
- Plans to expand care team model across other clinical modalities

**Sources:** Sg2 Interview With McLeod Health, February 2017; Bodenheimer T, and Sinsky C. Ann Fam Med. 2014;12:573–576.
Recruit, Retain, Train to Secure Necessary Staff

As organizations find themselves competing for an experienced workforce, aggressive recruitment and retention plans are becoming increasingly necessary. Approximately 28,000 new NP and PA graduates enter the workforce annually. The quadruple aim speaks to providing a positive clinician experience that includes well-grounded onboarding and training programs in strategic plans to ensure members of the workforce are adequately prepared to assume—and retain—their new roles.

Expand Interview Panel for New Hires
Human resources departments coordinate the hiring and recruitment of APs in 41% of ambulatory care organizations; only 5% have an AP recruitment team. Peer-to-peer interviewing can help ensure a better match between candidate and position, as administrators often don’t have a full understanding of each AP role. Some organizations also have changed their interviewing processes to include physicians with whom the AP will be working.

Invest Time for Onboarding
Organizations must ensure APs are ready to hit the ground running and that physician partners are prepared for the inevitable workflow changes. Allowing time for APs and physicians to develop their own rhythm will create clarity around roles, competencies and preferences. However, a system-wide definition of roles, responsibilities and standard operating procedures is key to consistent deployment. Proper onboarding takes time and should be factored into the timeline of a strategic plan.

EXAMPLE STAFFING PLAN TIMELINE FOR NEW AMBULATORY CLINICS

Physicians develop partnership/workflow, build up patient panel
Hire minimum of 2 physicians
1 year
Hire NP
NPs fold into existing workflow; cooperative dynamic formed between all providers
Achieve optimal division of labor, working toward AP-to-physician ratio of 2:1

Note: Example provided by Memorial Hermann Medical Group.

Sources: Center for Provider Practices (CAP2) website. Accessed June 2017; Sg2 Interview With Memorial Hermann, February 2017.
Address Experience Gaps by Promoting a Culture of Professional Development

Studies have found a significant percentage of the NP workforce is nearing retirement age. Lack of a succession plan, especially for NPs in the near-term (PAs have a younger workforce and aren’t facing an immediate crisis), could lead to future underuse if the necessary competencies are lacking within the active workforce.

Offer Role-Specific Residency/Fellowship or Immersion Programs

Academic programs too often do not arm APs with the skills needed to practice in specialized settings. Progressive organizations have turned to fellowship programs that combine didactic lectures and hands-on clinical training as a way of preparing APs for these crucial roles.

Some organizations have partnered with local schools and universities to create an employment pipeline. Others, such as the rural hospitals contracted with the University of Mississippi Medical Center’s tele-emergency program, send their APs through an immersion program where they gain hands-on experience performing a variety of procedures and services under the watchful eye of a physician.

Use of preceptors is another proven approach to prepare APs to enter new roles and rapidly increase their autonomy. Organizations must proactively address any barriers, such as inadequate skills or time to devote to training, to providing the best possible educational experience to their mentees. Mentors must have the capacity to maintain a constant teaching presence, even when the clinical pace turns chaotic.

Create a Culture of Engagement and Collaboration

Employees who feel they have a voice are more likely to be engaged and invested in their work. Some organizations have achieved this within their AP workforces by creating AP councils and a governance structure that has APs from every department reporting up through the same channels. (See page 17 for more on management approach.)

In 2010, this health care system based in Charlotte, NC, which operates more than 900 locations, including 39 hospitals, across North and South Carolina and Georgia, began looking at APs as a growing part of the workforce. It brought together physician, nurse and administrative leaders to discuss how APs were currently deployed and how they could be further leveraged in the future.

**Challenges**

- There were no local programs graduating acute care NPs, resulting in recruitment challenges for IP roles.
- Transition to practice time for new graduates was too long.
- Seasoned APs lacked the role-specific experience needed for specialized job openings.
- The turnover rate was higher than the national average.
- Job vacancies were growing even while expanded insurance coverage was significantly increasing demand for care.

**Results**

- The Center for Advanced Practice was established to grow and develop an AP workforce, develop a transition-to-practice program for new grads and create a structure that would support APs once they became employed at Carolinas.
- A 1-year AP fellowship program was created to teach role-based skills and enhance and augment their specialty-specific education.
- Eligible fellowship candidates are fully licensed and credentialed graduates of an NP or PA school and are able to bill for their services. Both new graduates and current midcareer APs qualify.
- Exceeding preliminary goals, the initial launch was 10 tracks that included urgent care and primary care for 30 fellows. As of 2017, the program offered 24 clinical tracks for 70 fellows.
- Participants receive a stipend that is less than the standard pay for a full-time new graduate. If they stay on after 1 year, they are paid a retention bonus equal to the difference.
- Fellows are asked for a 2-year postfellowship commitment.
- A collaboration was established with the Carolinas College of Health Sciences and the University of North Carolina at Charlotte to initiate an adult gerontology acute care nurse practitioner program.
- The center has played a major role in supplying an AP workforce for the system as well as supporting, recognizing and enhancing AP practice. The turnover rate among APs has decreased significantly.

**Source:** Sg2 Interview With Carolinas HealthCare System, January 2017.
Effective implementation of an AP workforce must start with a strong organizational structure that places an enlightened champion at the top who understands the AP role and can advocate for them. Formal AP leadership roles and structures can significantly enhance an organization’s ability to effectively implement an AP workforce. Some organizations initially may want to work within the existing unit-based nursing structure but evolve toward a top-down approach that takes a degree-neutral stance on the full cadre of advanced clinicians.

PROPORTION OF ORGANIZATIONS WITH AP LEADERSHIP AND MANAGEMENT ROLES

![Graph showing the proportion of organizations with AP leadership and management roles from 2013 to 2015.]

2013: 31%
2014: 54%
2015: 73%

Instill a Unified Voice

Advanced practice committees have proven to be a pivotal factor in maximizing the use and efficiency of APs. Although originally conceived primarily as a vehicle for communication and professional development, some leading systems now charge such committees with:

- Proposing and advising system executives on an organization-wide AP plan that aligns with the system’s overall strategy
- Modeling NP and PA utilization to account for varied service line needs
- Guiding, reviewing and ruling on service line requests for NPs or PAs
- Standardizing, to the extent possible, compensation, credentialing and scope of practice
- Assuming prime responsibility for ongoing education, mentoring, advocacy and policy for APs
- Elevating a member to the credentialing board (see page 23 on bylaws)

Weigh Options for Governance Structure

As the complexity of advanced practice increases, the management matrix can get muddled with a number of dotted-line reporting relationships. Clarifying accountability and responsibility is essential to advancing new models of care delivery based on shared decision making. Appointing a director of advanced practice not only enables APs to have a voice in the organization but also asserts clear goals and aligned incentives that are well-communicated up, down and across the structure.

An institution-wide chief NP or PA, or chief of AP clinicians, is an emerging leadership role. According to the Center for Advancing Provider Practices, 63% of reporting organizations have an AP on staff with the title of director. Such individuals may be the prime liaison to the medical staff or nursing leadership, take the lead in quality and productivity measurement, optimize billing practices, and spearhead orientation and training. (See page 23 for more on how AP leadership influences the credentialing process.)

SAMPLE GOVERNANCE STRUCTURE WITH STRONG AP LEADERSHIP

This health system—the largest in Illinois, with 450 sites of care including 12 acute care hospitals—began rolling out its advanced practice strategy in both its medical group and acute care sites in 2015. Because of the different roles advanced practice clinicians (APCs) play in each setting—APCs operate much more independently in the ambulatory setting—the governance models differ between the 2. Both were already using APCs; therefore, leadership from both the medical group and acute care sites saw an opportunity to learn from each other as they developed new organizational and care model structures to ensure APCs were being used efficiently.

Initiatives

**Acute Care Sites**

- Administrators worked with chief nursing executives (CNEs) at each site to assess current use of APCs. They then determined the optimal roles that would drive operational effectiveness and ensure all APCs were working top of license.
- APRNs report up to the CNEs, with dotted-line reporting to the medical directors or service line directors of the specific specialty in which each works.
- An ad hoc approach to educating physicians about APC roles bolsters team building (eg, the CNE may offer a correction when APCs are referred to as “midlevel providers” and provide information on the breadth of top-of-license practice).
- APCs are credentialed and given privileges allowed under the state’s collaborative/supervisory agreement requirements.
- Services are billed under physicians; therefore, APC value is not measured in direct productivity.

**Ambulatory/Clinic Sites**

- All APCs enter the organization as providers.
- A director of APC role was created to assist with further development of the APC role and infrastructure.
- Recruitment, onboarding and credentialing processes are the same for APCs and physicians.
- APCs report to their site operational managers and the medical director who, together, work as a dyad to manage each practice. The supervising physician provides guidance, but no reporting structure exists.
- A seat on the medical group’s 8-member governing council is reserved for an APC.
- APCs are only brought on board after a site ensures sufficient patient volumes to support them without undercutting existing physician volumes.
- APCs bill for all services they provide.
- To promote top-of-license practice, work that doesn’t require APC preparation was shifted back to appropriate staff.

Source: Sg2 Interview With Advocate Health Care, February 2017.
NAVIGATE COMPLEX LICENSING, CREDENTIALING, PRIVILEGING
Numerous aspects of AP practice are dictated by law. Recognizing the regulatory boundaries established for oversight and prescribing authority is an essential first step in formulating a strategy that enables all clinicians to work at the top of their licenses. Although PAs do not practice independently, NPs’ independence varies from full autonomy to state requirements for formal collaboration with a physician or even direct supervision.

The Institute of Medicine and other leading health advocacy groups have called for breaking down scope of practice barriers to maximize APs’ roles. Bills to expand their responsibilities or independence are frequently debated in state legislatures and remain politically charged. A patchwork of regulatory approaches exists across the country, but lingering restrictions are being dissolved thanks to persistent workforce pressure.

States are increasingly moving to expand the role of NPs in primary care. In 2013 alone, more than 20 states took legislative or regulatory action expanding NPs’ practice authority or making reimbursement more favorable to them. Oregon, for example, became the first state to pass legislation mandating private insurers pay NPs in private practice the same rates as physicians for the same services. Eight states expanded NPs’ prescribing authority.

**NP SCOPE OF PRACTICE, BY STATE**

- **Autonomous Practice**: Nurse practitioners can independently diagnose and treat patients without physician involvement.
- **Primary Care Provider**: State statute and/or administrative code recognizes nurse practitioners as primary care providers.
- **Independent Prescribing**: Nurse practitioners have authority to prescribe without physician or Board of Medicine involvement, after completing specific state requirements.
- **Order Physical Therapy**: Nurse practitioners can make referrals for physical therapy, or a referral is not required.
- **Sign Death Certificate**: Nurse practitioners can sign death certificates.
- **Sign Handicap Parking Permits**: Nurse practitioners can sign handicap placard forms.
- **Sign Workers’ Comp Claims**: Nurse practitioners can sign workers’ compensation forms.

**Note:** Due to ongoing legislative activity, check with state officials for current status.

The physician assistant version of this scope of practice guide is available in the online version of this report, which can be accessed at Sg2.com.

Plan With an Eye Toward Applicable State Laws

Over two-thirds of states with a shortage of primary care physicians also have restrictive NP scope of practice laws, which may be a barrier to increasing access to primary care services through NPs. Of critical note, there are organizational variations on top of the predicated state laws that are a result of culture. By recognizing the value of AP top-of-license practice, organizations can define or reshape their culture to support AP expansion, despite state laws.

Determine Whether Bylaws Are a Barrier or Boon to Full Deployment

Hospital medical staff bylaws governing AP credentialing and privileging must adhere to applicable state laws. However, many AP advocacy groups contend it’s often those bylaws—not state scope of practice laws—that constrain APs’ ability to practice to the full extent of their training. The Joint Commission requires hospitals to follow the same privileging process for APs that they use for physicians, but how those processes are carried out varies. Some trade groups have established databases documenting institution-specific credentialing and privileging requirements to help guide the process for hospitals. In recent years there has been a 175% increase in AP representation on medical staff credentialing committees. This is vital to promote top-of-license practice among APs. Chief nursing officers are also taking on more active roles in the credentialing process, typically as representatives on the core medical staff credentialing panels or by directly reviewing applications. Overall, for example:

- 79% are members of the Medical Executive Committee
- 41% review all APRN applications and files
- 19% review all PA applications and files

Progressive organizations reduce barriers to full AP deployment by:

- Adopting peer review processes
- Conducting regular competency assessments (in accordance with state law)
- Implementing quality and efficiency dashboards

**VARIATIONS IN AP PRIVILEGING**

<table>
<thead>
<tr>
<th>Provider Privileges</th>
<th>APRN</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain History and Physical</td>
<td>91%</td>
<td>82%</td>
</tr>
<tr>
<td>Order and Interpret Diagnostic Testing and Therapeutic Modalities</td>
<td>94%</td>
<td>85%</td>
</tr>
<tr>
<td>Order and Perform Referrals and Consults</td>
<td>82%</td>
<td>74%</td>
</tr>
<tr>
<td>Order Blood and Blood Products</td>
<td>78%</td>
<td>71%</td>
</tr>
<tr>
<td>Order Conscious Sedation</td>
<td>37%</td>
<td>29%</td>
</tr>
<tr>
<td>Order Inpatient Nonscheduled Medications</td>
<td>84%</td>
<td>76%</td>
</tr>
<tr>
<td>Order Inpatient Scheduled (II–V) Medications</td>
<td>74%</td>
<td>66%</td>
</tr>
<tr>
<td>Order Topical Anesthesia</td>
<td>72%</td>
<td>65%</td>
</tr>
<tr>
<td>Perform Incision and Drainage With or Without Packing</td>
<td>65%</td>
<td>62%</td>
</tr>
<tr>
<td>Prescribe Outpatient Nonscheduled Medications</td>
<td>77%</td>
<td>72%</td>
</tr>
<tr>
<td>Prescribe Outpatient Scheduled (II–V) Medications</td>
<td>67%</td>
<td>61%</td>
</tr>
<tr>
<td>Write Admission Orders</td>
<td>73%</td>
<td>64%</td>
</tr>
<tr>
<td>Write Discharge Orders</td>
<td>77%</td>
<td>68%</td>
</tr>
<tr>
<td>Write Transfer Orders</td>
<td>72%</td>
<td>65%</td>
</tr>
</tbody>
</table>

SCALE AP STRATEGY THROUGH COMPLEMENTARY INNOVATION
Without an unlimited supply, provider systems must consider creative options for maximizing the impact of the APs they enlist. Numerous technologies enable better leverage of appropriately trained care teams. They can significantly enhance both efficiency and autonomy. Some technologies enable clinicians to zero in on patients most in need of their services. Others, such as virtual health, position APs to work independently while still having ready access to collaborate with other clinicians as needed. Organizations should assess the virtual health modalities already in existence and those they plan to adopt to determine which can be scaled and aligned to their AP deployment strategies.

**VIRTUAL HEALTH CONTINUUM**

- Telepathology
- Telepharmacy
- Teleradiology
- Virtual Multidisciplinary Conference
- Geo-Tagged Devices (eg, Kinsa, Propeller)
- mHealth Apps
- Online Support Groups
- Patient Web Portal
- Social Media
- Remote Patient Monitoring
- Telehealth Kiosks
- Virtual Medication Management
- Virtual Urgent Care
- Patient Scheduling Apps
- Personal Activity Monitors (eg, Fitbit)

Health systems assessing expansion of technology for use by AP providers should consider the following:

- **Determine market fit.** Understand the market’s appetite for technology-enabled services. Determine opportunities to expand access and quality, lower costs, and improve margins by matching APs with technology. Without the benefit of a strong market assessment, launching technology-driven care models can add extra cost with limited return.

- **Weigh technology investments and partnerships.** Technology partnerships may yield the best bang-for-the-investment buck as third-party organizations begin directing more artificial intelligence (AI) investments to tools that augment the AP workforce. Consider piloting new virtual tools that drive efficiency and empower consumers to enter information up front, as well as future AI tools that help APs screen for potential diagnoses.

- **Assess where technology can help meet consumer expectations.** Consider piloting efforts in areas where there is a mismatch between consumer needs and providers’ skill sets, where telehealth can bridge gaps in care, or where acute care cost and coverage are a challenge.

- **Pursue care delivery innovation.** Assess care process opportunities, model an optimal staffing/technology mix and develop workforce strategies to ensure sustainability. Populations with a high penetration of value-based care and markets with high-deductible health plan penetration may be an optimal starting point to insert efficient, technology-driven services. APs armed with real-time monitoring and virtual access can focus on chronic populations and/or deliver low-cost virtual care.
This 5-hospital academic medical center (AMC) in Jackson, MS, includes more than 700 beds and the state’s only Level 1 trauma center. That distinction provided the University of Mississippi Medical Center (UMMC) an opportunity to extend its brand, reach and referral channels into rural areas via innovative use of telehealth, coupled with progressive use of advanced practitioners.

**Initiative**
A tele-emergency program increases patient access to emergency care and boosts care quality in critical access hospitals (CAHs) unable to recruit emergency physicians. The average daily census is less than 30 patients at each hospital.

- Some hospital EDs run entirely with NPs; others have a limited number of emergency physicians with NPs supplementing coverage. All NPs practice under a collaborative agreement with UMMC physicians.
- NPs are hired by the participating hospitals but undergo a 3- to 6-month training program at UMMC that includes didactic lectures and immersive, procedural-based training.
- NPs independently treat low-acuity patients who present to participating facilities (about 56% of cases). Emergency physicians located at a UMMC-based contact center intervene via secure video monitoring in real time for emergent cases. For complex, nonemergent cases, NPs begin the patient workup and then consult with UMMC specialists on a care plan.
- Participating hospitals pay a monthly subscription fee for a fixed number of hours.

**Results**
- The number of participating hospitals has grown to about 20.
- ED volumes for participating critical access hospitals increased as patients gained confidence in their quality of care.
- The appropriateness of emergency transfers to UMMC improved, enabling more patients to remain in their communities for less complex care.
- The transfer process from the CAHs to UMMC was streamlined and expedited.
- Innovative staffing and technology enabled a financially sustainable model. Emergency coverage was achieved at half the hourly cost to employ specialists.
- Program prompted well-trained ED nurses to pursue higher education to become NPs.
This health system, the third-largest nonprofit system in the US, which operates 50 hospitals and employs more than 7,000 providers across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington, was facing a primary care physician shortage and the threat of new patients leaving the system due to lack of access. It also had an urgent care business filled to capacity. This led to a multifaceted workforce strategy that leveraged both technology and advanced practitioners and an access strategy to direct patients to the most appropriate sites of care.

**Initiatives**

- Providence Express Care provides 4 access points to the system: telehealth, urgent care centers, retail clinics and home visits; APs provide a large percentage of the care at those sites.
- A mobile application described as the “Uber for on-demand health care” summons a family practice NP or physician to the patient’s home, office or hotel.
- Retail clinic–based NPs conduct virtual visits during clinic downtime.
- Training of retail clinic–based NPs includes shadowing physicians before practicing autonomously.

**Results**

- Providence sees 40,000 new patients every month.
- In 2016, more telehealth visits were conducted than the prior 7 years combined.
- 70% of the visits to the Providence Express Care venues are done by advanced registered nurse practitioners.
- Providing APs with a variety of settings (virtual vs in-person) in which to practice gives Providence a recruiting edge.

**Sources:** Sg2 Interview With University of Mississippi Medical Center, March 2017; Sg2 Interview With Providence St Joseph Health, March 2017.
5
BUILD THE
FINANCIAL CASE
FOR DEPLOYMENT
Enhanced cost-efficiency and productivity are not a given with increased use of APs. In fact, APs could be viewed as a nonvalue added expense if not deployed strategically and if their value is measured by margin alone. Demonstrating ROI can be complex, and scenarios vary with specific roles. In certain clinical settings, modeling the impact is relatively straightforward, and studies consistently suggest an achievable upside. Few benchmarks exist for the more complicated calculus of system-wide deployment, however. Elements of any analysis must include:

- Billing potential
- Improved performance on value-based programs and related incremental value
- Impact of expanded access on revenue
- Incremental physician productivity due to AP activities

### Sample Analyses of Hospitalist Compensation vs Reimbursement per Visit

<table>
<thead>
<tr>
<th></th>
<th>Physician</th>
<th>PA/NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per-Visit Salary</td>
<td>$114</td>
<td>$48</td>
</tr>
<tr>
<td>Visit Reimbursement</td>
<td>$138</td>
<td>$117</td>
</tr>
<tr>
<td>Profit</td>
<td>$24</td>
<td>$69</td>
</tr>
<tr>
<td>Incremental Profit</td>
<td></td>
<td>$45</td>
</tr>
</tbody>
</table>

**Note:** Reflects visit reimbursement for Level 2 hospital admission H&P (E/M Code 99222).

### Maximize Compensation/Collections Ratios

### Median Compensation/Collections Ratio

<table>
<thead>
<tr>
<th>Nurse Practitioners</th>
<th>Physician Assistants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>0.42</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>0.39</td>
</tr>
<tr>
<td>Oncology</td>
<td>1.16</td>
</tr>
<tr>
<td>Surgical</td>
<td>0.97</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1.30</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>0.56</td>
</tr>
<tr>
<td>Nonsurgical/Non–Primary Care</td>
<td>0.60</td>
</tr>
<tr>
<td></td>
<td>0.44</td>
</tr>
<tr>
<td></td>
<td>0.35</td>
</tr>
<tr>
<td></td>
<td>0.74</td>
</tr>
<tr>
<td></td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>2.22</td>
</tr>
<tr>
<td></td>
<td>0.60</td>
</tr>
<tr>
<td></td>
<td>0.94</td>
</tr>
</tbody>
</table>

Utilization of APs can lead to higher operating margins compared with physicians, even with a reimbursement rate 15% lower than physicians’. Not only are their salaries, on average, half that of a physician, APs are able to perform tasks that are beyond a physician’s typical reach and provide access in settings not typically staffed by physicians.

Many outpatient settings have built the economic rationale for APs by allowing them to make up the majority of the provider mix and bill for their services directly. On the inpatient side, many systems have rationalized use of APs through avenues other than direct revenue generation, such as care coordination and case management. But shifting the IP provider mix to heavily rely on APs and increasing opportunities for direct billing could be an economic boon to hospitals struggling to surpass the breakeven point. For many rural organizations, APs are making the difference between shuttering programs and keeping them open.

When this critical access hospital serving an approximate population of 18,000 in and around Ladysmith, WI, started to see a major independent primary care group referring patients to a competing facility 45 miles away, leaders realized significant reengineering of its workforce was essential. Dissatisfaction with call requirements already had undercut the physician group’s recruiting efforts, and the hospital was feeling the impact. It was forced to suspend its obstetrics program in 2013 after 6 physicians left the medical group. The hospital started its own primary care clinic to address the problems but also faced recruitment challenges. In 2014, it decided to pursue an NP-led hospitalist program.

Initiatives

- The hospital hired 3 NPs to provide 24/7 coverage.
- Each NP works around the clock for 7 days, sleeping at the hospital, then takes 2 weeks off.
- NPs work independently with a collaborating physician available by phone. (Wisconsin grants full practice authority to NPs.)
- Emergency physicians are available for support in urgent cases (eg, patient codes).
- Collaborating physicians under contract with Rusk:
  - Sign all discharge orders, attesting care was appropriate
  - Conduct quality review of 10 charts per month
  - Receive NPs’ summary notes daily
  - Consult with NPs over transfer decisions

Financials

- $20,000 in recruitment costs
- $410,000 in 2014 salary and benefits for 3 hospitalists
- $290,000 in revenue from billed hospitalist services
- Inpatient volumes earn the hospital $3,500 per day.

Results

- Fewer patients transferred to tertiary facilities resulting in year-over-year gain of 57 admissions in 2016
- Improved success recruiting primary care physicians; 4 recruited to the community from 2014 to 2016
- 23% increase in admissions between 2014 and 2016
- Increase in percentage of patients willing to recommend Rusk from 61% to 85% within 2 years
- 13% drop in ED transfers, as emergency physicians gained confidence in the care delivered by the hospitalist program

Net Program Cost:

$140,000

Source: Butcher L. Case Study: Rusk County Memorial Hospital’s Nurse Practitioner Hospitalist Program. H&HN. April 11, 2017.
Consider Contribution Margin

Studies have found practices and health systems are more productive with APs. But the math will likely never add up for those measuring ROI solely by the number of AP-generated relative value units (RVUs). In fact, that metric in isolation often suggests an increase in labor costs without an increase in revenue that can be directly attributed to APs. This is because AP work is often “masked” by procedures and services billed under the physician’s provider ID.

In reality, incremental increases in annual collections typically accrue via expanded capacity (eg, additional new patient visits and return visits), increased case complexity handled by physicians or other clinicians, decreased time to fill appointments, and spikes in ancillary service on the ambulatory side. As the shift to value takes hold, financial gains will also be found in reduced ALOS, ICU use and 30-day readmissions, as well as gains tied to better throughput. Ensure, however, that any loss in physician productivity that may result from nonbillable supervisory time is taken into consideration.

Understand Billing Models, Requirements

Organizations that have a comprehensive knowledge of billing models—direct billing, incident to, shared visit—and properly educate providers on appropriate billing practices will be better positioned to assign tasks and workflows. Some organizations are incorporating such education and best practices into their onboarding processes.

**CASE EXAMPLE: University of Chicago Medicine**

As part of its onboarding process, all new attending physicians and advanced practitioners at University of Chicago Medicine are required to attend billing competency training. The hospital and affiliated medical group utilize different billing procedures based on the department and procedures performed. The training includes scenarios for which the clinicians must choose the appropriate billing method. In addition, attendings and APs jointly attend training sessions where they are encouraged to ask questions, making it a collaborative learning environment. After onboarding, AP billing competency sessions occur twice a year to meet the ongoing billing and fraud awareness training requirements.

**ANNUAL PATIENT LOAD PER HEMATOLOGY/ONCOLOGY FTE**

<table>
<thead>
<tr>
<th>Without AP</th>
<th>With AP</th>
<th>% Difference in New Patient Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>293</td>
<td>371</td>
</tr>
<tr>
<td>Median</td>
<td>263</td>
<td>354</td>
</tr>
</tbody>
</table>

# AP Billing Models and Requirements

<table>
<thead>
<tr>
<th>Model</th>
<th>Rules</th>
<th>Key Considerations</th>
</tr>
</thead>
</table>
| **Direct Billing** | • Under Medicare, “direct billing” refers to whom the payment is directed, not whose NPI is on the claim.   
• Professional services provided by PAs and NPs may always be billed under the NPI of the PA/NP.   
• Claims billed under the PA's NPI can only be directed to the employer of the PA. (PAs are not allowed to receive direct payments from the Medicare program.)   
• NPs may receive direct payment. Most NPs reassign payment to their employer as a condition of employment. | • When NP/PA services are billed under the NPI of the NP/PA, Medicare pays 85% of physicians’ rate. |
| **Incident To** | • The physician must be first to see the patient for the new problem, establish a diagnosis and initiate a care plan.   
• The AP conducts a follow-up visit for the same problem with a physician (does not need to be the same physician) on-site in the suite of offices.   
• Care provided by an AP must follow the physician’s initial care plan; if care deviates from the original plan (even in cases of a secondary diagnosis), or the patient presents with a new problem, incident to is no longer an option—the AP direct bills at 85%. | • Applies only to non-HOPD medical office setting (place of service 2)   
• Allows practices to capture 100% of physician rate   
• Has been a target of audits   
• Has been known to cause unnecessary delays in care   
• AP productivity “hidden” under physician billing |
| **Shared Visit** | • In an IP setting, the NP/PA and physician from the same group practice see the patient in the same calendar day and bill under the physician’s NPI at 100%.   
• In the OP hospital setting, shared visits can be utilized when the physician’s input is necessary but can lead to duplication of efforts and inefficiencies for routine visits. | • Applies only to follow-up visits in the office setting   
• Physician and AP must have same employer; only 1 bill per patient per day may be submitted   
• Physician must provide a face-to-face encounter with the patient and document it   
• AP productivity “hidden” under physician billing |

HOPD = hospital outpatient department; NPI = National Provider Identifier.  
Source: Sg2 Interview With American Academy of Physician Assistants, March 2017.
6 IMPLEMENT THROUGH TEAM BUILDING
A heightened focus on consumerism, value and quality has led to a wider acceptance of APs, particularly in the primary care setting. But it can still be difficult to sway some physicians to delegate a large percentage of their patient caseload to APs. Much of the challenge lies in a lack of clarity into the breadth of APs’ top of license/credentialing reach and in some organizations’ inability to clear up ambiguities related to individual roles in a team-based environment. As deployment further extends to specialty and inpatient settings, the roles and division of labor may not be as clear-cut. This could lead to added cost without incremental value or unnecessary conflicts if not managed effectively.

Recognize the Importance of Culture

Gaining physician buy-in is important to widespread AP deployment and should be considered a first step. Building a truly team-centered approach requires active collaboration between physician champions, nurse leaders and system administrators—not just on the clinical side, but on the financial and administrative sides as well.

Mutual understanding of each provider’s role is imperative and can be achieved through the coordinated efforts of this multidisciplinary team. Areas of focus for this group include:

• **Augmenting core and specialty privileging lists.** Avoid wasted time and resources granting clinical privileges for tasks that can be performed by lower-level team members (eg, RNs, medical assistants, technicians); focus on highest credentialing and privileges allowed. Refer to state scope of practice laws and local and national privilege data for guidance.

• **Clearly delineating roles and setting clear expectations.** Coordinate employment criteria and credentialing/privileging processes and requirements.

• **Ensuring everyone, including physicians, is working top of license and credentialing.** Regular internal audits of case mix will help organizations ensure an appropriate and efficient division of labor.

• **Developing fair compensation plans.** Consider implementing a bonus program that would incent team productivity and negate doctors’ personal loss of RVUs. Measure and disseminate quality and performance scores that demonstrate and reinforce value.

51% of NPs lead care teams in patient-centered care models.

On average, NPs see 17 patients per day.

On average, 25% of an NP’s day is spent on nonclinical paperwork.

PUTTING IT ALL TOGETHER
Employing multiple strategies indicative of best practice AP utilization, this member of the Henry Ford Health System serves as a sound example of how APs can be deployed in a sustainable, strategic way.

Strategic Imperatives

Focus on Workforce Planning
- The onboarding process for surgeons was changed to include meetings with the AP surgical team before the first surgery for standardizing “order sets” and surgeon preferences.
- Physicians participate in interviews and yearly evaluations for APs with whom they will work.
- Required experience and competency levels vary by position; specialized roles require more experience.
- Training/credentialing processes for procedural-focused APs were streamlined to mirror the resident teaching model.
- AP educator role was created to standardize all AP onboarding, skills validation and university training for all employed APs.

Navigate Complex Licensing
- Both the credentialing and quality committees have AP members.
- An AP credentialing oversight committee was created to incorporate new state law changes to ensure APs are utilized to the maximum extent of their licenses as defined by state law.

Build the Financial Case for Deployment
- A “facilitative care” model took the focus away from RVUs and focused on metrics with trackable, observable data.
- APs, who are on-site 24/7, take the lead answering documentation and coding queries and coordinating and expediting admissions, transfers and discharges.

Implement Through Team Building
- Implemented data-driven staffing model
- Standardized communications (ie, a daily report sent out to every hospital leader showing potential and anticipated discharges for the day and each department’s census with plans for patient movement) to ensure cross-continuum collaboration and team building

There are so many things my APs can do when the focus is no longer on RVUs but instead on trackable, measurable data. APs can impact every quality metric and dashboard out there. So what I do is put real-time data metrics to it and report that instead of RVUs.

—Todd Roark, Director of APP and Case Management Services, Henry Ford West Bloomfield Hospital
Results

- Improved job satisfaction. APs went from the 16th percentile in engagement (mean score: 4.83) in 2014 to the 96th percentile (mean score: 5.38) in 2016.
- Improved hospital billing by standardizing AP query response time. In 2 weeks, they went from 100 unanswered queries to zero, which was maintained for an entire year. Those answered queries earned the hospital $98,000.
- Improved throughput, thus creating access, by eliminating departmental silos.
- A hospital-wide throughput initiative launched in December 2014 led to the reduction of ED hold times to zero by the end of 2016.*
- Phase 2 post-acute care unit (PACU) hold times due to unavailability of IP beds were reduced from more than 1,000 total minutes per month in January 2016 to zero in March 2016. Savings were realized in nurse staff time needed to care for patients in PACU. Patient satisfaction scores also increased.
- Hold times remained at zero, allowing the hospital to repurpose the Phase 2 PACU space for extended recovery surgery patients.

WEST BLOOMFIELD HOSPITAL AVERAGE DAILY CENSUS AND ED HOLD DATA

TOTAL OF PACU PHASE 2 HOLD MINUTES

*ED Hold = When a patient waits 4 or more hours after an order has been written to admit them to an inpatient bed or to place them in observation.

Source: Sg2 Interview With Henry Ford West Bloomfield Hospital, March 2017.
ACTION PLAN
for Optimizing Use of Advanced Practitioners

1. Focus on Workforce Planning
   - Scan the care continuum to identify new opportunities to address care gaps and to lower the cost of care through strategic AP deployment.
   - Recruit, retain and train to secure necessary staff by including onboarding and development programs in strategic planning efforts.
   - Address experience gaps by building a culture of professional growth and mentoring.

2. Standardize Management Approach
   - Institute an organizational leadership position that includes AP representation on medical staff and credentialing committees.
   - Consider various governance structure options to ensure system-wide AP effectiveness.

3. Navigate Complex Licensing
   - Incorporate state NP and PA scope of practice laws into workforce role definitions.
   - Scrutinize bylaws to determine if they are a barrier or boon to full deployment and consider including an advocate to message the value of APs to the organization.
Scale AP Strategy Through Complementary Innovation

✓ Evaluate opportunities to further expand access and increase effectiveness through a combination of AP deployment, technology and care redesign.

✓ Consider the following deployment opportunities:
  • Pilot development
  • Service partnerships

Build the Financial Case for Deployment

✓ Maximize finances by utilizing APs in areas with high volumes, favorable compensation to collections ratios and where APs can significantly improve physician productivity.

✓ Consider the contribution margin advantage for services where physician access is constrained or hourly AP contribution margin outpaces physicians’.

✓ Hard-wire provider understanding of billing models, develop billing processes that meet regulatory requirements and establish reporting to monitor performance.

Implement Through Team Building

✓ Recognize the importance of organizational culture, delineate roles and align incentives to ensure a smooth transition.
APPENDIX

SCOPE OF PRACTICE AND EDUCATION VARY BY AP TYPE

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>PRACTICE</th>
<th>EDUCATION AND TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Assistants</td>
<td>• Scope of practice varies across states but typically includes a broad range of diagnostic and therapeutic work.</td>
<td>• PAs are typically licensed under state medical boards.</td>
</tr>
<tr>
<td></td>
<td>• PAs must work under a supervising physician and can prescribe certain medications under a physician’s direction.</td>
<td>• Most students have health care experience and a bachelor’s degree before entering a PA program, but applicants with an associate degree also can be accepted.</td>
</tr>
<tr>
<td></td>
<td>• Services are covered by all public and most private payers, though not all allow independent billing. Those that do typically pay 85% of the physician fee schedule (though Medicare’s “incident to” provisions for office services and “shared visit” provisions for hospital services enable 100% reimbursement under the supervising physician’s provider number).</td>
<td>• They must complete training through an accredited program, which averages 26 months (3 academic years), including more than 2,000 hours of clinical rotations.</td>
</tr>
<tr>
<td></td>
<td>• PAs are typically licensed under state medical boards.</td>
<td>• Postgraduate fellowships or residencies for a specific medical or surgical specialty are optional and typically take 12 to 24 months.</td>
</tr>
<tr>
<td></td>
<td>• Most students have health care experience and a bachelor’s degree before entering a PA program, but applicants with an associate degree also can be accepted.</td>
<td>• PAs earn certification through a national exam, with mandatory recertification every 10 years.</td>
</tr>
<tr>
<td></td>
<td>• They must complete 100 hours of CME every 2 years to maintain certification.</td>
<td>• They must complete 100 hours of CME every 2 years to maintain certification.</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>• Scope of practice varies across states but typically includes a broad range of diagnostic and therapeutic work with an added emphasis on disease prevention and health management.</td>
<td>• Typically licensed under state boards of nursing, making a current RN license mandatory; most organizations also require a master’s degree and national certification, but some clinicians are grandfathered in.</td>
</tr>
<tr>
<td></td>
<td>• NPs can practice and bill independently in many states. Most, however, require some degree of formal collaboration with a physician; some mandate practice under direct physician supervision.</td>
<td>• Admission to an accredited training program typically requires a BSN and active license, though direct-entry NP programs enable students to earn their RN midway through the program.</td>
</tr>
<tr>
<td></td>
<td>• NPs have prescribing authority in all states; restrictions vary.</td>
<td>• The master’s program takes 2 to 4 years and includes didactic as well as supervised clinical experience.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CME requirements vary by state.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• National specialty and subspecialty certification is available but optional.</td>
</tr>
</tbody>
</table>

CME = continuing medical education.

Sources: AAPA website; American Association of Colleges of Nursing website; AANP website. All websites accessed June 2017.
PA SCOPE OF PRACTICE, BY STATE

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**Note:** Due to ongoing legislative activity, check with state officials for current status.

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