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What's Inside:

Advanced Practice Providers Can Help Physicians Reach Their Peak Potential

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

Advanced practice providers (APPs) now comprise about 40 percent of the clinical workforce in the United States. APPs are clinicians with a master's or doctoral degrees and include nurse practitioners, physician assistants, certified registered nurse anesthetists, and anesthesiologist assistants.

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

With median salaries and fringe benefits for APPs now approaching $200,000 a year, health systems can no longer afford to think of APPs as "physician extenders" or expensive scribes. They must work to effectively integrate APPs across clinical settings and develop the operational and financial data points needed to monitor the efficacy and efficiency of that integration. Most importantly, they must ensure that APPs are being deployed in ways that enable the physicians they work with to operate at the top of their potential.

1 U.S. Bureau of Labor Statistics, "Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners."
2 U.S. Bureau of Labor Statistics, "Physician Assistants."
3 U.S. Bureau of Labor Statistics, "Physicians and Surgeons."

Evolution of the APP Model

The emergence of APPs in the clinical workforce coincides with passage of the Medicare Act of 1965, which substantially increased the demand for primary and acute care and increased pressure on the physician-led care model.[4] The first nurse practitioner program was started at the University of Colorado in 1965, and in the same year, the first physician assistant program was started at Duke University Medical Center.[5]

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

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

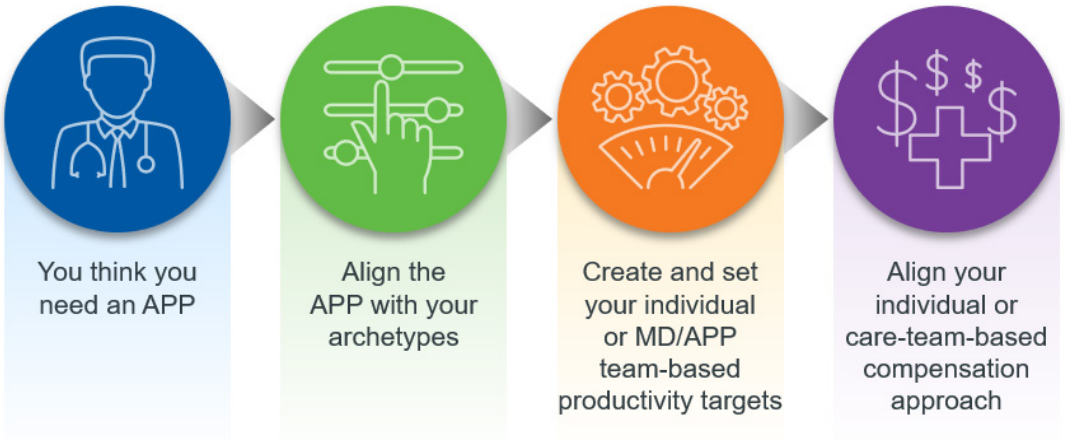
1. **Primary care:** This is the most straightforward of the archetypes. Primary care APPs should be mostly autonomous within the scope of their license and have 36 patient-facing hours per 40-hour week.
2. **Ambulatory medical specialty:** APPs in this archetype work with physician specialists and share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

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

4 Cate Brennan, "Tracing the History of the Nurse Practitioner Profession in 2020, the Year of the Nurse," *Journal of Pediatric Health Care*, March–April 2020.

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

Effectively Deploying APPs across the Enterprise



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

For years, discussions of APP deployment have focused on ensuring that APPs are able to operate at the top of their license. This is important, but more important is to ask: are our APPs being deployed in a way that improves patient access and ensures that our physicians can perform at their peak potential?

Patient Access

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

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

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Compensation

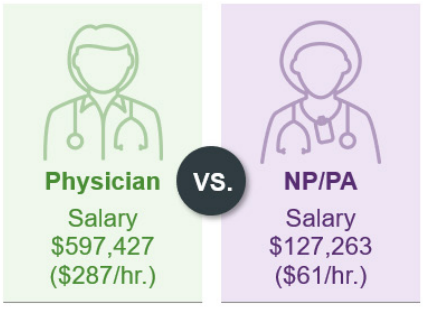
Physician productivity and compensation targets should reflect their use of APPs. If two physicians are operating at the 65th percentile of productivity but one of those physicians is achieving this benchmark with no APP support and the second is supported by two APPs, the second physician's actual productivity is probably significantly below the 65 percent benchmark. The second physician also is achieving the productivity benchmark at a much higher cost (the expense of two APPs) than the first physician. This should result in either a raising of the productivity benchmark for the second physician to reflect the APP support or a lowering of that physician's compensation to align with the physician's actual productivity after APP contributions to that productivity have been backed out.

Financial Performance

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

Revenue Outcomes for a Sample Low-Acuity Service

CPT 99213
1 Billable Encounter = $81.47



Revenue Minus Salaries Based on 20 Encounters (Model does not include operational expenses)		
99213	MD + APP @ 100%	-$1,158
99213	MD @ 100%	-$668
99213	APP @ 85%	+$896

Sources: CMS 2023 Fee Schedule, 99213
*Salary is an estimated number, based on 2080 hrs., 8 hr shifts; MGMA Median GI Specialty 2023 Survey
Estimated as $62.67 /wRVU Net Revenue from actual healthcare system example

Conclusion

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

Key Questions for Board Members

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

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

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

An Interview with Dr. G: Building Scalable Trust with Consumers and Physicians

Geeta Nayyar, M.D., M.B.A., Chief Medical Officer, *Technologist*, and Best-Selling Author

TGI: **Why is trust an issue that healthcare leaders should be talking about right now?**

Dr. G: The one person most healthcare consumers (93 percent) say they still trust is their doctor. But when you ask those same consumers if they trust the healthcare system, that number drops into the 50th percentile. What that means to me is that in a post-pandemic world, the consumer believes that the healthcare system is not set up for their success or their physician's success. The numbers were not this way in the past, but in today's era where information is 24/7 and everyone is an "expert" or can be an influencer, it's very hard for consumers to know fact from fiction. The other kicker is that those who have a doctor still trust them, but not everyone even has a doctor. That is the healthcare world we are living in today.

TGI: **How do you scale something like trust, and which leaders should be involved?**

Dr. G: This is where marketing comes in, with a paradigm called "know, like, trust."[1] Paul Matsen, Chief Marketing and Communications Officer at Cleveland Clinic, said that if customers are going to do business with you, they first must **know** who you are. Today, especially for providers, that means more than just a billboard or a Web site. It means having an omni-channel presence and meeting the consumer where they are.

Then, consumers need to **like** you. There has to be something about you that then makes them like you. For the healthcare space, that means personal commonalities. For example, if you're a woman, you might want to see a woman when you get your colonoscopy or deliver your baby. The Cleveland Clinic intentionally recruited doctors and nurses who look like the community because they understood the "like" part of that consumer strategy.

Last is **trust**, and this is the hardest part for the healthcare industry. Trust is believing that when I have a problem, I can call your number right away and you are going to answer and help me get through it. It is having history together and that bonded experience. When you look at healthcare, we don't have that for several reasons: 1) no one has their doctor on speed dial, and when you call you go through an answering service and then talk to someone who isn't the doctor; 2) you also have to have an established doctor to call, and plenty of Americans don't have doctors; and 3) we have to have history together, which means that patients should be seeing the same doctor every time.

1 For more information on this, see Geeta Nayyar, *Dead Wrong: Diagnosing and Treating Healthcare's Misinformation Illness*, John Wiley & Sons: New Jersey, 2024.

The "know, like, trust" methodology requires an enterprise strategy with the Chief Medical Officer, Chief Marketing Officer, and Chief Information Officer all working together. Cleveland Clinic has done this, and part of their strategy included creating short video content (30 seconds or less) with doctors who represented the community and were able to speak in simple language. The doctors shared their knowledge, and said "click here to make an appointment," with the launch of a telemedicine strategy. They made a marketing project into a revenue-generating project through YouTube, and they saw social media as an asset, not a detriment. Right now, very few hospitals and health systems are doing this, but this can be effective because you are not just competing with the hospital or doctor down the street anymore. You are competing with the podcaster selling supplements and the influencer selling an at-home genetic testing kit—and those things are more accessible than your doctor.

TGI: **In your work, you talk about how healthcare leaders don't do enough to link the consumer and patient experience with the physician experience. Why is that important and how does that idea connect with trust?**

Dr. G: When we talk to providers, there's a lot of focus on the consumer experience. But we don't talk about the physician experience as it relates to the consumer. In my opinion, the consumer experience *is* the physician experience. If you have a staff that is overworked, underpaid, and generally unhappy, there won't be a good consumer experience. We are ultimately a service and humanity business. As we discussed, consumers go back to the health system because they trust their doctor. With all the workforce issues we have—burnout, reimbursement, staffing—we need to make our doctors happy if we want to make our patients happy. They are very much on the same side of the conversation, and we often divorce those concepts.

How to make doctors happy and avoid burnout is the hard part. Hospitals and health systems need to be doing anything they can to help their doctors and nurses practice at the top of their license. We have also removed the joy of medicine by making our doctors and nurses data-entry clerks. They want to look patients in the eye and have a relationship. They don't want to be forced to spend seven of their 10 minutes with patients doing data entry. Technologies that were meant to innovate actually slowed down our staff, and we are now hoping to fix them with AI. Many ambient AI technologies are focused on documentation. Telemedicine also becomes very interesting for doctors who want to work from home.

Ultimately, we have to start bringing the joy of medicine back. And it's not about taking a yoga class or doing meditation. There are some significant workforce issues in today's environment, and we have to find strategies to address those, as well as retain good staff. One of the beauties of the era we are living in is that there is so much innovation.

TGI: **The elephant in the boardroom right now is money. Why should boards be focusing on trust right now when there are so many other pressing concerns that seem more directly related to the organization's financial health?**

Dr. G: There is no doubt that there are economic pressures across the board. Everyone is being asked to do $100 of work for $10, and so that's even more reason to innovate. How do you drive the inefficiencies out of the hospital? How do you make your workforce that much more stretchable and augmented in ways that they were not before? Some of these technologies can pay for themselves if done effectively. But the key is really bringing your staff along with you as you make these decisions. Every institution is looking at how they implement AI. Involving your clinicians and workforce is going to be really important to that conversation. Innovation is a way to save money right now, but determining which investments and when and how you deploy and implement them requires clinical leadership.

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> —*Dr. G.*

TGI: **What are some strategies that boards and senior leaders should be considering as they are working on building trust at scale all the way from consumers, communities, and patients to employees and physicians?**

Dr. G: One of the ways to do this is to have senior leadership (and board members if they are able) spend some time in the emergency room. Spend a day in the life of the staff or a patient. Have them go through your health system as though they were getting services and then help them understand firsthand what it's like to work there. The problems will be abundantly obvious from that perspective. Too often we shelter the board from the realities of what's happening, but if they can spend a couple hours in an emergency room, they will find out everything they need to know about their health system—how they refer patients, how they work within the community, what the staff looks like, what the patients look like, what is manual versus automated.

The board should also be hearing directly from management about what doctors and patients are experiencing. They need to ask management what they believe the top five consumer problems are, and then the top five physician problems. There will most likely be an overlap there. Patients might say, "I can't get an appointment." And physicians might say, "I'm overworked." Then what would be the strategies to consider? How do you get the low-acuity patients off your panel so that you can see the very sick patients and someone else can see the low-acuity patients? Telemedicine? Do you need to hire a physician assistant to see the simple upper respiratory infection cases or the patient who has a UTI and needs a prescription?

Another example would be patient complaints about bedside manner—"nobody communicates with me." The doctor's problem is that the electronic health record

doesn't allow them to look their patients in the eye and doesn't give them the time to call patients back. Then there needs to be a real evaluation: what can we do with a new innovation like AI to improve that? Again, alignment comes in here. Everything you do in the hospital is a doctor–patient relationship. How do you make that relationship better and stronger? That must be the focus of your strategy. But first you have to understand the existing problems with the doctor–patient relationship—from the doctor's view and from the patient's view.

Looking at these issues and bringing recommended solutions to the board helps to implement the strategies that pay it forward for both patients and staff, and ultimately builds trust at scale.