

# HSG

THOUGHT LEADERSHIP



## INCORPORATING APPs INTO PATIENT CARE DELIVERY

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### INTRODUCTION

Most experts indicate that progressive utilization of Advanced Practice Providers (APPs) into clinical care delivery models is inevitable. The experts point to the continuing predictions of projected physician shortages (exacerbated by the aging current physician population), the continuing surge of APP numbers, and the steadily increasing healthcare demands of our aging population as the foundations for this belief.<sup>1,2,3</sup> APRN (Advanced Practice Registered Nurse) and PA (Physician Assistant) professional societies advocate strategic utilization of APPs to offset the physician shortage as APRNs are estimated to be able to perform approximately 85% of primary care physician tasks and PAs approximately 80%.<sup>4</sup>

In addition, APPs are increasingly being utilized by organizations shifting strategies toward value-based care and innovating their care models to reflect the changing demands of the market. APPs can perform significant roles to enhance preventive and wellness care, care management services, patient education initiatives, patient satisfaction enhancement, and favorable clinical outcomes achievement.<sup>4,5</sup> All of these functions contribute to success in a value-based market.

An additional impetus to incorporate APPs into practices come from financial data reports such as the following excerpt discussing evidence from the **2018 MGMA DataDive Cost and Revenue** data:

*“While primary care practices with a higher non-physician provider (NPP) to physician ratio (0.41 NPPs per physician or more) report greater expenses, they also report earning more in revenue after operating costs than practices with fewer NPPs (0.20 or fewer NPPs per physician), regardless of specialty. Physician-owned practices with 0.41 or more NPPs report earning \$100,748 more in revenue after operating expenses per physician than practices with 0.20 or fewer NPPs. In hospital-owned primary care practices, that difference is \$131,770 more in revenue after operating costs per physician.”<sup>3</sup>*

With these considerations in mind, utilizing APPs to meet healthcare demand while realizing increased profitability and provider productivity seem to be sound bases for incorporating APPs in care delivery models.

When contemplating incorporation of APPs, employed provider networks should consider the following points.

## INCORPORATING APPs

### Understand The Culture – of the practices, the medical community, and the public.

Introducing APPs represents a significant paradigm shift for many organizations and communities. Understanding, acknowledging, and addressing potential resistance prior to embarking on the APP recruitment process is key for acceptance. Recognize that many physicians may not have any prior experience with working directly with APPs and do not know what to expect. Others may harbor negative impressions that generate reluctance or defiance.

Similarly, utilizing APPs at their maximum capabilities can also represent a significant paradigm shift. Some physicians accept APPs as scribes or “helpers” but do not embrace the concept of maximizing their roles in direct care provision. If this limitation cannot be overcome, recruit scribes and clinical support staff instead of using APPs in this fashion. Scribes and clinical support staff will be professionally fulfilled in these roles and are much less expensive.

Finally, possessing a sound knowledge of state laws and regulations and the Medical Staff Bylaws is crucial to truly understanding the culture and identifying limitations and potential barriers.

**Knowing the culture is indispensable when formulating and proceeding with the planning and implementation processes.**

### Know And Communicate Why You Advocate Adding APPs To The Direct Care Provider Mix

Be transparent about the perceived benefits of assimilating APPs into network practices. Communicating the reasons for proposing APP introduction – or expansion – should be clear to the entire network and to the individual practices. Multiple discussions should occur and all staff should understand the reasoning and intent of proceeding – whether due to the inability to adequately recruit physicians or to expand services or to increase patient access to care or for other reasons. The communications should be bi-directional and address perceived or actual barriers.

### Customize Your Approach

Understanding the culture and knowing why you desire to proceed provides the ability to customize the approach to each individual situation. Although the literature contains various hub and spoke models consisting of desirable ratios, recognize that an ideal standard physician to APP ratio to strive toward does not truly exist. The “most desirable ratio” will vary by specialty and by circumstance.

For example, some future primary care models indicate an anticipated 1:4 physician to APP ratio in a hub and spoke model based on the predicted primary care physician shortfalls. This model designates the physician at the hub to render complex care, work closely with care managers to coordinate the care of complex patients, and consult and collaborate with the four associated APPs, who provide preventive and wellness services,

straightforward same day care, and chronic care for non-complex patients (stable single chronic condition managed by limited medications). This model may address physician shortage issues but may not be rewarding for the many physicians that relish a full spectrum of interactions with all patients – including the healthy. In addition, realizing this high ratio will not happen immediately in one fell swoop, but would likely need to be progressively worked toward.

On the other hand, a very efficient Orthopedic Surgery model utilizes a 1:2 orthopedist to APP ratio that can be leveraged to maximize the surgeon's time and expertise. In this model, the office schedule is attributed to the APPs and the orthopedist sees all patients after initial and continuing APP involvement. Simple casting and splinting are relegated to the APP. In this manner, the orthopedist manages a schedule that accommodates nearly twice as many patients as one that is solely orthopedist centered. On OR days, one APP assists with the surgical case while the other conducts the day of surgery clinical and administrative activities and serves as first call for problems or issues. At the conclusion of the case, the assisting APP completes closing, accompanies to patient to PACU, and enters post-operative orders – freeing the surgeon to talk with family and complete the Op Note. The 2nd APP accompanies the next patient to the OR (the one with whom the APP conducted the pre-op activities) and the APP roles reverse. This model predictably permits more cases per day to be accomplished as the workflow is streamlined considerably. The model can be professionally rewarding to all involved but requires a dedicated orthopedic surgeon, well-trained APPs, and mutual trust among team members.

### **Address Concerns Regarding APP Training and Skill Set Strengths and Weaknesses**

APPs are not physicians and should not be presumed to assume physician roles. Physicians complete a four-year medical degree and residency (and possibly fellowship) training – which many feel consolidates clinical skill sets. Even then, newly trained physicians are often gently introduced to “attending” roles and often closely mentored in early practice.

In contrast, APPs complete a two-year masters degree program and do not currently have options for post graduate training (acknowledging the tremendous nursing background that many NPs may have and DNP not withstanding). Yet, organizations often directly immerse newly trained APPs into full schedules expecting peak performance from the outset. This is unrealistic – especially outside of primary care roles.

Consider offering newly trained APPs an “internship” scenario to augment their formal education and training. This can be accomplished by pairing the new APP with established providers to co-evaluate and treat patients already scheduled for the paired provider – much like a student rotation. This can be accomplished while awaiting licensure. After several months of progressive independence and adding more patients to the paired provider's schedule, the APP, the established providers, and the staff become more comfortable and confident with each other and the path forward is much smoother.

Coaching and mentoring continues with the collaborating/supervising physician relationship. The requirements of this relationship should be well defined and monitored for compliance. Episodic individual interviews with both the APP and the collaborating/supervising physician should be conducted to ensure that interactions are beneficial and not perfunctory. Physician effort should be compensated with a stipend consistent with

external benchmarks.

Finally, consider funding additional formal training pertinent to the NPPs role, such as RNFA programs to allow APRNs or PAs to better function as surgical assistants.

### **Maximize APP Skill Set And Function**

Consider the above information when defining the role(s) and support required to promote success. For instance, NP curricula assume a primary care scope and emphasize preventive and wellness services and patient education. Designing NP utilization to reflect these areas – especially early on – predict smoother assimilation.

Similarly, minor acute care and stable chronic conditions are well within scope. Risk stratifying patients and including the risk stratification in the patients' EMR profile can assist the scheduling process and avoid mismatches in scope. Unfortunately, most practices do not define scope and expectations well and rely on schedulers "knowing" who to schedule with whom – which leads to frustration and inefficiencies for all ... the patients, APPs, physicians, and staff.

### **All Staff Must Embrace The Concept And Model**

Patient are now generally quite accepting of APPs' participation in healthcare delivery. We find that most patients who encounter APPs during their healthcare interactions accept them as they would any other provider – cautious of any new provider until they establish a trusting relationship. APPs who deliver empathetic, compassionate, "quality" care are readily accepted and embraced – and quickly develop a loyal following ... just like their physician counterparts.

However, to be truly successful, all staff must embrace APPs as primary members of the healthcare delivery team. The APP should not be offered as a secondary option that the patient is being asked to "settle for." The APP should be touted as a valued member of the care delivery team – as an important cog in "the way we provide the best care for you." The care delivery model should be explained during the scheduling process and featured in practice marketing efforts so that APP interactions are expected. When approached in this manner, patient acceptance is not an issue.

### **Organizational Commitment**

Restructuring the care delivery model to fully incorporate APPs requires more than hiring them. Although APPs are the mainstay of care in many communities, others require a significant cultural shift within the practice, the institution, the medical community, and the public during initial introduction or presence expansion. Organizations must be committed to the concept and the resulting reality.

Recognizing areas of resistance, objectively presenting the anticipated role(s) and expectations, prudently recruiting qualified candidates, and strategically progressing with implementation are required to be successful. Sometimes outside assistance is required to guide, mediate, and catalyze this change – a process with which we would be happy to assist.



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  - a. Advanced Practice Providers (APPs) are also referred to as Advanced Practice Professionals, Advanced Practitioners, or Non-Physician Providers (APPs) and traditionally include Advanced Practice Nurses (APRNs), such as Nurse Practitioners (NPs), Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse Midwives (CNMs), Clinical Nurse Specialists (CNSs), and Physician Assistants (PAs).