Non-Physician Providers 2018: What You Need to Know

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What’s in a Name?

- Mid-Level Provider
- Physician Extender
- Advanced Practitioner
- Advanced Practice Provider
- Non-Physician Provider
- Non-Physician Clinician
Objectives:

1. Do I need an NPP in my practice?
2. PA? NP? What’s the difference?
3. How to Determine Cost Effectiveness
4. What Regulatory Changes Do I Need to Consider?
Do I need a Non-Physician Provider in My Practice?
Institute for Healthcare Improvement

Triple Aim

Improve the patient experience
Improving the health of populations
Reducing the per-capita cost of healthcare

...and a fourth...

Prevent physician burnout
## NPP Contributions

<table>
<thead>
<tr>
<th>Key Metrics</th>
<th>Outpatient/Autonomous</th>
<th>Inpatient/Outpatient Shared Service</th>
<th>Inpatient Service line</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost</strong></td>
<td>➪ Billable revenue ➪ Physician productivity ➪ Physician satisfaction</td>
<td>➪ Physician productivity ➪ Physician satisfaction</td>
<td>➪ Physician productivity ➪ Physician satisfaction</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>➪ Patient safety ➪ Patient satisfaction</td>
<td>➪ Patient safety ➪ Patient satisfaction</td>
<td>➪ Patient safety ➪ Patient satisfaction</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td>➪ Patient access ➪ Patient wait times</td>
<td>➪ Inpatient management and throughput</td>
<td>➪ Inpatient management and throughput</td>
</tr>
</tbody>
</table>
Does Our Practice Need NPP’s?

• Allow practices to care for more patients and free physicians to perform work that only physicians can do.

• Because NPP’s spend more time with patients than physicians on routine visits, they can increase the depth of the patient-provider relationship and enhance patient satisfaction.
How Can We Best Use our NPPs?

• Type of care provided
  • Primary care
  • Specialty care

• Patient acuity level
  • Single or multiple well-managed conditions
  • Patients triaged according to severity of their condition

• Patient Choice
  • Potential to decrease wait times and increase patient satisfaction
  • Better positioned to win patient loyalty
  • Differentiation from competition
How to Deploy NPPs in Various Settings

<table>
<thead>
<tr>
<th>Caregiver</th>
<th>Type of Care Provided</th>
<th>Patient Acuity Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>NPP</td>
<td>Returning patients</td>
</tr>
<tr>
<td></td>
<td>MD/DO</td>
<td>New patients</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>NPP</td>
<td>Continuing care</td>
</tr>
<tr>
<td></td>
<td>MD/DO</td>
<td>Diagnosis</td>
</tr>
</tbody>
</table>
# Influencing Factors

<table>
<thead>
<tr>
<th>Successful Utilization of Non-Physician Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance by Medical Staff</td>
</tr>
<tr>
<td>Acceptance by Administration</td>
</tr>
<tr>
<td>Acceptance by Patients (including family)</td>
</tr>
<tr>
<td>Acceptance by Nursing Staff</td>
</tr>
<tr>
<td>Understanding of Billing Process</td>
</tr>
<tr>
<td>Bylaws that are “User Friendly”</td>
</tr>
<tr>
<td>Credentialing and Privileging Driven by Physician Managers</td>
</tr>
</tbody>
</table>
Key Point

78% of better performing practices employ NPPs

MGMA Performance and Practices of Successful Medical Groups: 2016 Report Based on 2015 Data
PA? NP? What’s the difference?
Nurse Practitioner

Definition:

• A registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law

• Be certified as a nurse practitioner by a recognized national certifying body that has established standards for NPs

• Possess a master’s degree in nursing
Nurse Practitioner

Covered Services:
• Physician services if covered by a MD/DO
• Performed by a person who meets all NP qualifications
• Legally authorized to perform the services in the state in which they’re performed
• Performed in collaboration with an MD/DO
• Not otherwise precluded from coverage because of one of the statutory exclusions
Physician Assistant

Qualifications:

• Has graduated from a physician assistant educational program that is accredited by Accreditation Review Commission on Education for the Physician Assistant (ARC-PA)

• Has passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA)

• Licensed by the state to practice as a PA
Physician Assistant

Covered Services:

- Physician services if covered by a MD/DO
- Performed by a person who meets all PA qualifications
- Legally authorized to perform the services in the state in which they’re performed
- Performed under the *general supervision* of an MD/DO
- Not otherwise precluded from coverage because of one of the statutory exclusions
Non-Physician Providers

NPs
- Educated in nursing model to “independently assume responsibility and accountability for the care of patients (clients)”
- Nationally certified in specialty (adult, pediatrics, etc.)
- Function under collaboration agreement

PAs
- Educated in medical model as a generalist in medicine in a team based model
- 1 of 4 professions licensed to practice medicine (MD, DO, DPM, PA)
- Certification by one organization (NCCPA)
- Practices with physician supervision (direct, indirect, off-site)
Collaboration vs. Supervision

<table>
<thead>
<tr>
<th>Collaboration</th>
<th>Physician Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration is a process in which an NP works with one or more physicians (MDs/DOs) to deliver healthcare services, with medical direction and appropriate supervision as required by the law of the state in which the services are furnished. In the absence of state law governing collaboration, collaboration is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice. The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP.</td>
<td>The PA’s physician supervisor (or a physician designated by the supervising physician or employer as provided under state law or regulations) is primarily responsible for the overall direction and management of the PA’s professional activities and for assuring that the services provided are medically appropriate for the patient. The physician supervisor (or physician designee) need not be physically present with the PA when a service is being furnished to a patient and may be contacted by telephone, if necessary, unless state law or regulations require otherwise.</td>
</tr>
</tbody>
</table>

Rising Trend of Nonphysician Provider Utilization in Healthcare, MGMA, Dec 2016.
Key Point

"Know the CULTURE of your facility..."
How to Determine Cost Effectiveness

- Charges vs. collections
- Productivity
- Maximizing value
- Billing
## Charges vs. Collection

<table>
<thead>
<tr>
<th>MGMA</th>
<th>Specialty</th>
<th>Median Gross Charges</th>
<th>Median Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>Primary Care</td>
<td>$352,596</td>
<td>$246,001</td>
</tr>
<tr>
<td>PA</td>
<td>Orth.</td>
<td>$422,744</td>
<td>$180,174</td>
</tr>
<tr>
<td>PA</td>
<td>Surgical</td>
<td>$428,515</td>
<td>$152,814</td>
</tr>
<tr>
<td>NP</td>
<td>Primary Care</td>
<td>$261,191</td>
<td>$204,422</td>
</tr>
<tr>
<td>NP</td>
<td>Surgical</td>
<td>$181,751</td>
<td>$83,299</td>
</tr>
</tbody>
</table>

# Collection Ratios

<table>
<thead>
<tr>
<th></th>
<th>25&lt;sup&gt;th&lt;/sup&gt; %tile</th>
<th>Median</th>
<th>90&lt;sup&gt;th&lt;/sup&gt; %tile</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA – Primary Care</td>
<td>69%</td>
<td>69%</td>
<td>65%</td>
</tr>
<tr>
<td>PA – Ortho</td>
<td>32%</td>
<td>42%</td>
<td>30%</td>
</tr>
<tr>
<td>PA-Surgical</td>
<td>46%</td>
<td>35%</td>
<td>29%</td>
</tr>
<tr>
<td>NP-Primary Care</td>
<td>93%</td>
<td>78%</td>
<td>60%</td>
</tr>
<tr>
<td>NP-Surgical</td>
<td>60%</td>
<td>45%</td>
<td>58%</td>
</tr>
</tbody>
</table>


Collections / Gross Charges = Collection Ratio
Employment-Surgery

• Example: A surgeon employs a PA who first assists in the OR. The PA then does daily post-op rounds, changes dressings, pulls drains, writes orders, dictates discharge summaries, and writes discharge prescriptions.
• Can the surgeon’s practice bill for these services provided by the PA?
• PA overhead/bottom line/bean counting
Employment-Surgery

Medicare fee breakdown:

• 11% for pre-op work (H&P)
• 76% for intra-operative (surgical procedure)
• 13% for post-op care (10/90 days)

*24% of global payment is for non-OR services
Productivity

• Example: Total knee       $1769 Global

  • Pre-op              $  194.59
  • Intra-op            $ 1344.44 (surgeon)
  • Post-op             $  229.97
  • plus
  • First Assist        $  240.58
  • If PA performs pre- and post-op work and First Assists, the measure of PA “value” would be $665.14.
Productivity

If PA didn't’t perform the pre- and post-op work, the physician would have to.

While the NPP delivers non-billable services, the surgeon/physician is able to provide new, revenue generating services such as E/M in the office or more surgery.
## Physician/PA Productivity

### ASSUMPTIONS:
- Calculations 250 average TSA’s resulting in procedures/day x 20 working days.
- Calculations 12 procedures/week x $35/procedure.
- Calculations 440 preoperative H&P x $125/each, currently bundled in Surgical fee.
- Calculations 880 post operative visits x $45/each, currently bundled in Surgical fee.
- Calculations 3 additional consults/week @ $1500 x 48.
- Calculations 3 additional consults/week @ $150 x 48.

### ADDITIONAL ASSUMPTIONS:
- Conservative estimates based on gross billings in a surgical practice.
- Physician Assistant spends majority of time in a hospital setting.
- Physician increased patient time. However, may also allow for more physician time off which would reduce total numbers.
- Physician Assistant spends 57% of FTE on direct clinical services (31% billable/26% reduction).
- Allow 23% of FTE increased time for productivity or other activities for Physician.

### Physician Assistant Productivity:

<table>
<thead>
<tr>
<th>Description</th>
<th>$ Amount</th>
<th>Hours</th>
<th>%FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. TSA (Technical Surgical Assist)</td>
<td>$110,000</td>
<td>375</td>
<td></td>
</tr>
<tr>
<td>2. Procedures</td>
<td>$20,000</td>
<td>264</td>
<td></td>
</tr>
<tr>
<td><strong>Total Billable</strong></td>
<td>$130,000</td>
<td>639</td>
<td>31%</td>
</tr>
</tbody>
</table>

### Physician Overhead Reduction:

<table>
<thead>
<tr>
<th>Description</th>
<th>$ Amount</th>
<th>Hours</th>
<th>%FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Pre-op (bundled)</td>
<td>$55,000</td>
<td>288</td>
<td></td>
</tr>
<tr>
<td>Follow-up Care (bundled)</td>
<td>$39,600</td>
<td>180</td>
<td></td>
</tr>
<tr>
<td><strong>Total Value</strong></td>
<td>$94,600</td>
<td>468</td>
<td>26%</td>
</tr>
</tbody>
</table>

### Increased Physician Productivity:

<table>
<thead>
<tr>
<th>Description</th>
<th>$ Amount</th>
<th>Hours</th>
<th>%FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Cases</td>
<td>$216,000</td>
<td>375</td>
<td></td>
</tr>
<tr>
<td>Additional Consults</td>
<td>$16,000</td>
<td>264</td>
<td></td>
</tr>
<tr>
<td><strong>Total Increased Productivity</strong></td>
<td>$237,600</td>
<td>639</td>
<td>23%</td>
</tr>
</tbody>
</table>

### Total Productivity:

<table>
<thead>
<tr>
<th>Description</th>
<th>$ Amount</th>
<th>Hours</th>
<th>%FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$462,200</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How Do We Maximize Value?

• Train providers in coding how to maximize revenue.
• Know charges—what do you charge for services?
• Become familiar with major payor policies regarding non-physician providers.
• Insight on data (production/cost) for your practice
NPP Billing

• Medicare: two options
  • “incident to”
  • National Provider Identifier

• Private Payers
  • Third party payers generally require their own credentialing of NPP’s
  • Most payers will cover NPP services, but they may not enroll them
Two points

**Point 1**

Your text here. Your text here.
Your text here. Your text here.
Your text here. Your text here.

**Point 2**

Your text here. Your text here.
Your text here. Your text here.
Your text here. Your text here.
“Incident To” Billing

• Allows NPP to bill under physician’s NPI
• Must be performed under direct supervision or while physician is physically present in same office suite

“Services must be commonly furnished in the physician’s office or clinic, and must be an integral part of a Medicare patient’s normal course of treatment, during which a physician personally performed the initial service and remains actively involved in the course of treatment.”
Submit all NPP claims under their own NPI and accept 85% reimbursement, or make sure your NPPs and coding staff are fully educated regarding incident-to guidelines.
Analytic Assumptions

- Physician visit times, rates, remain constant across time
- Administrative work independent of clinical work for MD/DO and AP
- Recommend collections as % of charges reflecting weighted average of all payers’ reimbursement patterns
- AP costs only
# Expected Advanced Practice Provider (AP) Costs

The following page will help shed light on expected costs for APs. Please enter costs associated with the expected AP hires. The model considers four major drivers of cost: staffing, overhead, recruitment/onboarding, and lost productivity due to managing and training the APs. As with the previous page, we have pre-populated many of the values in the grey cells below; however, you can easily override the numbers by typing over them if you have values that more accurately represent your organization. A summary of the total AP costs will be displayed at the base of the page.

Please enter the number of AP FTE(s) you are considering hiring below:

Number of AP FTEs you are considering hiring to your practice

<table>
<thead>
<tr>
<th>AP Staffing (per AP FTE)</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary</td>
<td>$80,000</td>
<td>$80,962</td>
<td>$81,976</td>
<td>$82,982</td>
<td>$84,000</td>
</tr>
<tr>
<td>Benefits</td>
<td>$20,000</td>
<td>$20,245</td>
<td>$20,494</td>
<td>$20,745</td>
<td>$21,000</td>
</tr>
<tr>
<td>Annual bonus</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Compensation growth rate</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Practice Cost (all AP FTEs considered)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overhead (per AP FTE)</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office equipment and supplies</td>
<td>$5,000</td>
<td>$2,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>CME, licensing, registration</td>
<td>$10,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Incidents</td>
<td>$5,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Practice Cost (all AP FTEs considered)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recruitment &amp; Onboarding (per AP FTE)</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment</td>
<td>$10,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Incremental management and training</td>
<td>$5,000</td>
<td>$2,500</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Practice Cost (all AP FTEs considered)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Lost Productivity</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training and management of AP (hours per week)</td>
<td>8.3</td>
<td>4.0</td>
<td>2.0</td>
<td>1.6</td>
<td>0.5</td>
</tr>
<tr>
<td>Practice Cost (all AP FTEs considered)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

Total AP Cost Per Year

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
### Expected Advanced Practice Provider (AP) Visits

The following page will help quantify expected workload for the AP(s). Please enter details on the expected AP workload for years 1 through 5. We have pre-populated many of the values in the grey cells below based on our research into volumes and administrative workload for a new AP; however, you can easily modify the values by typing over them if you would like to model different scenarios.

**Number of AP FTEs you are considering hiring to your practice:** 0

**Practice Characteristics with AP(s) (per AP FTE)**

<table>
<thead>
<tr>
<th>Days worked per week</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours worked per day (excluding breaks)</td>
<td>8</td>
</tr>
<tr>
<td>Weeks worked per year</td>
<td>48</td>
</tr>
</tbody>
</table>

**Expected AP Consult Characteristics (per AP FTE)**

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute visit time (average minutes)</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Chronic visit time (average minutes)</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Volume of acute visits expected (average per day)</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Volume of chronic visits expected (average per day)</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Proportion of time dedicated for administrative work</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Expected percentage of available consult time utilized</td>
<td>85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**AP reimbursement rate (as a % of physician rate):** 85%

**Total Expected Revenue from AP Consults:**

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
## Estimated AP Net Revenue Impact

This sheet summarizes changes, costs, and revenues from the previous sheets for Years 1 through 5. The base of the page shows estimated practice net revenue with and without the newly hired AP(s). A positive dollar amount shown in red indicates a net revenue increase while a negative dollar amount shown in green indicates a revenue decrease.

### Practice without AP(s)

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Summary</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Acute visit charges</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Chronic visit charges</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Physician Revenue</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Expected Impact of AP Hire

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>AP Summary</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Acute visit charges</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Chronic visit charges</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Discount for charges billed independently from physician</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>AP Revenue</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>AP Cost</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Expected Net Revenue Impact

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected Practice Revenue with AP(s)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Practice Revenue without AP(s)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Net Difference</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Net Revenue Impact

```
$1
$1
$1
$1
$1
$1
$1
$1
$0
$0
$0
$0
$0

Year 1 Year 2 Year 3 Year 4 Year 5
```
Billing isn’t the #1 challenge when using NPP’s, how you use them is more critical...

Laura Palmer, FACMPE, MGMA senior industry analyst.
MGMA e-Source, March 12, 2013
Regulatory Changes
Nurse Practitioner State Practice Environment

- **Full Practice**: State practice and licensure law provides for all nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments — including prescribe medications — under the exclusive licensure authority of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing.

- **Reduced Practice**: State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. State law requires a regulated collaborative agreement with an outside health discipline in order for the NP to provide patient care or limits the setting or scope of one or more elements of NP practice.

- **Restricted Practice**: State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State requires supervision, delegation, or team-management by an outside health discipline in order for the NP to provide patient care.
Physician Assistant State Practice Environment

1. "Licensure" as the regulatory term
2. Full prescriptive authority
3. Scope of practice determined at the practice level
4. Adaptable supervision requirements
5. Chart co-signature requirements determined at the practice level
6. Number of PAs whom a physician may supervise determined at the practice level
## Optimal Team Practice

<table>
<thead>
<tr>
<th>Policy component</th>
<th>Anticipated Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emphasize PAs’ commitment to team practice.</td>
<td>Empowers teams to make decisions about team practice, which PAs are fiercely committed to, where the care is taking place rather than in state laws and regulations.</td>
</tr>
<tr>
<td><strong>Authorize PAs to practice without an agreement</strong> with a specific physician—enabling practice-level decisions about collaboration</td>
<td>Expands access to care, reduces administrative burdens, and eliminates physician liability for care provided by the PA.</td>
</tr>
<tr>
<td><strong>Create separate majority-PA boards</strong> to regulate PAs, or give that authority to healing arts or medical boards that have as members both PAs and physicians who practice with PAs</td>
<td>Assures PAs will have meaningful and consistent input into the regulation of the profession just as physicians and nurses do.</td>
</tr>
<tr>
<td>Authorize PAs to be directly reimbursed by all public and private insurers.</td>
<td>PAs are the only health professionals who bill Medicare that are not entitled to direct reimbursement. This often leads to increased administrative arrangements and documentation burden for organizations hiring and utilizing PAs and to less flexible employment arrangements for PAs (e.g., difficulty in working with staffing companies or in certain group structures). Direct reimbursement levels the playing field so PAs can compete with other health professionals on the basis of their clinical competence and skill sets.</td>
</tr>
</tbody>
</table>
Regardless of State Law...

• Physician supervision should depend upon
  • An NPP’s training, education, experience
  • The nature of your practice
  • The complexity of your patient population
  • Supervisory style of particular physicians
Growing Pains

• Lack of a well-defined, controlled process for recruiting, selecting, and onboarding NPPs

• Physician resistance to treating NPPs as productive clinicians
  • Highly productive vs. restricted roles vs. refusal to use them altogether

• Inadequate structure for assessing NPP performance
  • Practice managers not effectively evaluating clinical performance
Should NPPs have their own panels?

• Primary care vs. specialty care
• State and payer regulations
• Concerns that primary care physicians will see their NPP colleagues as competitors, particularly in organizations that use productivity-based compensation models
• Room for diversity in scope of practice
  • Some NPPs may thrive as independent providers, while others may prefer or be better suited to supporting an MD/DO in managing his/her panel
  • Even empaneled NPPs benefit from regular collaboration with MD/DOs and the ability to refer more challenging patients to a physician’s care
Main challenge to maximizing AP impact

- Agreeing on the role NPPs play in the clinic and in the organization
- Physician buy-in
- Incentivizing APs to be aligned with medical group goals
- AP fit in expansion strategies for specialty care

Realizing Full Value of the Care Team

Study in Eight Conclusions

1. Advanced Practitioners (APs) an Increasingly Important Strategic Asset
   Medical groups in all markets face intensifying pressure to expand patient access and improve care affordability, but a looming physician shortage makes meeting these goals challenging. As a result, groups increasingly rely on APs to deliver high-value care.

2. AP Employment Often Yielding Unsatisfactory Returns
   Many groups employing APs have found that these providers’ clinical and financial contribution lags behind expectations. Most also lack a consistent strategy for managing APs as a cohort; as a result, medical groups see below-par engagement levels and high turnover rates.

3. Groups Must Recalibrate Expectations for AP Clinical, Organizational Roles
   The challenges of AP employment are due in large part to lack of consensus concerning the AP role. Medical groups must cut through internal disagreements to set clear expectations for top-of-license AP utilization, and establish structures for clinician collaboration and AP management that support this goal.

4. Greater AP Clinical Autonomy Will Increase Patient Access, Physician Efficiency
   In all specialties, best-practice models allow APs to conduct patient visits independently, rather than merely supporting a physician’s workflow. Physicians, in turn, focus on patients requiring a higher level of clinical expertise. This approach is key to expanding access in a cost-effective manner.

5. Principled Deployment, Provider Education Initiatives Help Maximize AP Clinical Contribution
   Accurate, consistent assessment of AP staffing requests prevents situations in which APs are asked to perform lower-level tasks. Management skills training for physicians and clinical training for APs further support top-of-license AP utilization.

6. Effective AP, Physician Compensation Incentives Reward Team Collaboration
   Incentives reinforce AP and physician cooperation. APs must be rewarded for both individual performance and effective support of physician performance goals. Physician incentives must be designed to eliminate physician-AP competition and promote maximal AP productivity.

7. AP Management Structures Must Support AP Role as Provider
   APs, like physicians, inflict care quality, productivity, and patient satisfaction outcomes. Accordingly, APs should be hired, managed, and evaluated similarly to physicians. Dedicated AP leaders can further these goals, as well as advocate for and support this constituency’s needs.

8. Progressive Systems Include APs in Medical Group Leadership
   Lack of AP representation in group governance and leadership can lead to disengagement and conflict among APs, while the medical group misses out on key insights from these frontline clinicians. APs should be included in group-level discussions of issues affecting providers, with AP leaders holding both committee positions and executive roles.
Recommendations

Things we should stop doing

Things we should keep doing

Things we should do more of
Work with Clinical Leaders to...

• Define clear roles for physicians and NPP’s
• Identify care gaps and delineate how NPP’s can fill them
• Develop a thorough orientation program for NPP’s
• Document standing orders, protocols, delegation, collaborative agreements
• Help physicians see NPP’s as partners, not competitors
Integrating NPP’s into the Practice

• Work with physicians to determine their needs for these colleagues
• Establish benchmarks to measure NPP performance
  • Productivity
  • Utilization
  • Patient satisfaction
• Know the optimal number of NPPs for your practice
Collaboration

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In Summary, NPP’s...

- Extend therapeutic reach of physicians
- Increase patient satisfaction
- Add clinical revenue to the bottom line
THANK YOU

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