Realizing Full Value of the Care Team

Strategically Deploying Advanced Practitioners to Expand Access and Coordinate Care
Medical Group Strategy Council

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Available Within Your Medical Group Strategy Council Membership

Over the past year, the Medical Group Strategy Council has developed numerous resources to assist members in addressing physician strategy. The most relevant resources are outlined on the right. All of these resources are available in unlimited quantities through the Medical Group Strategy Council membership.

Strategic Guidance for Medical Group Leadership in an Era of Reform

- **Staffing for Population Management**
  Strategies for leveraging advanced practitioners to expand access to cost-effective care (Webconference)

- **Building the Integrated Clinical Enterprise**
  Six lessons for medical group executives seeking to lead service line transformation (Book)

- **Next Generation Physician Compensation: Defining an Enduring Model**
  Building compensation models amid market uncertainty (Whitepaper)

- **Analyzing Compensation at Fair Market Value**
  Guidance for structuring compliant physician compensation plans (Whitepaper)

- **Building Actionable Performance Dashboards**
  Lessons for creating medical group dashboards that demonstrate value and support management (Book)

Tools to Support Medical Group Strategic Planning and Performance Improvement

- **Medical Group Performance Benchmarks**
  Benchmarks for medical group financial performance, productivity, staffing levels, and management infrastructure

- **Stakeholder Perception and Alignment Audit Toolkit**
  Surveys and mapping exercises to ensure that medical group strategic goals are aligned with key stakeholder expectations

- **Change Readiness Assessment**
  Questionnaire for assessing medical group ability to execute change at scale

- **Performance Improvement Best Practice Crosswalk**
  “One-stop shop” for identifying industry-tested Advisory Board best practices for a wide range of performance opportunities.

- **Primary Care Volume Estimator**
  Tool for assessing primary care capacity based on primary care visit volumes at a county level

To access these and other Medical Group Strategy Council resources, visit our website: www.advisory.com/mgsc
Beyond the Medical Group Strategy Council: Crimson Practice Management

Elevating Medical Group Performance Through Technology, Proven Best Practice Solutions

Integrating siloed data into a single, comprehensive source…

...to enable a holistic, rigorous view into performance...

...and sophisticated analytics for actionable insight

Scheduling
Billing/Claims
wRVU Mapping
Encounter Detail
Patient Population Information
Provider Roster
Service Location
Quality

Medical Group Executives
Medical group CFO monitors per wRVU compensation and collection rate; reduces cardiologist pay rate: $125K

Practice Leadership
Practice administrator at two-provider site identifies opportunities for one provider to code more accurately: $34K

Administrative Team
Coding team targets audits and one-on-one education toward 11 physicians already identified as outliers: $215K

Frontline Medical Staff
Physicians monitor own productivity; two MDs reach threshold targets to earn incentive bonus: $45K

Support Beyond the Technology

Launching the Technology
Practice Management On-Line
Automated data extract from patient billing, registration, scheduling, roster; includes data mapping and validation

Advanced Training in Analytics
In-depth orientation for physicians and executives

Targeting the Opportunity
Customized Opportunity Assessment
Detailed assessment of member’s performance improvement opportunities

Dedicated Advisor
User training, opportunity identification, and results tracking for key stakeholders

Sharing Cohort Best Practices
Member Networking Opportunities
National performance summit, facilitated networking sessions

White Papers and Teleconferences
Case studies of Crimson partners realizing opportunities through the initiative
The Membership would like to express its gratitude to the individuals and organizations that shared their insights and experience with us. The research team would like to recognize the following members for being especially generous with their time and expertise.

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DeKalb Medical Group
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El Rio Community Health Center
Tucson, AZ
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Exeter Health Resources
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Robert Nordgren, MD

The Membership would like to express its gratitude to the individuals and organizations that shared their insights and experience with us. The research team would like to recognize the following members for being especially generous with their time and expertise.
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, inflect 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.
Essay: An Underleveraged Asset
Many medical groups are beginning to experience patient access challenges. Even for those that do not yet struggle to accommodate patients, future projections give cause for concern. Across the next few months, roughly 12 million people will gain access to the health system via Medicaid or state-level insurance exchanges. Previous experience suggests that the impact of this coverage expansion will be felt most directly in physician offices. After Massachusetts executed its version of coverage expansion, data revealed substantial latent demand for physician services. The number of patients who reported seeing a doctor once or more a year rose significantly in the two years after coverage expansion.

We can expect that many of the newly insured will seek primary care providers for routine care, and specialists to address conditions they may have ignored for years. This will put substantial pressure on physician groups to accommodate growing demand.

Coverage Expansion Exacerbates Access Challenge in Near Term

Percentage of Insured Non-elderly Americans

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<tr>
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<td>81%</td>
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2014 brings 12 million newly insured, largest increase in expansion over a single year

Health Care Utilization, Massachusetts Adults

Change Based on Self-Reported Data, 2006-2008

- One Annual Doctor Visit: 2006 79%, 2008 65%
- Multiple Doctor Visits: 2006 66%, 2008 62%

39% of exchange enrollees previously lacked usual source of care

New Consumers More Price Sensitive Than Ever

These new patients and their insurers are more sensitive to the value of care, and will be shopping for high-quality, affordable providers and services.

Commercial insurers and large employers are already experimenting with tiered networks designed to reduce total expenditures. Once state exchanges are implemented, participating insurers will offer more affordable coverage by steering patients to narrow-network coverage that promotes use of lowest-cost alternatives. In addition, both employers and insurers are increasingly shifting patients to consumer-driven health plans, which exchange higher premiums for higher deductibles, thus exposing patients more directly to the cost of their care.

To participate in narrow networks and attract new patients—many of whom will be personally responsible for upwards of 35% of costs—providers will need to increase their focus on delivering affordable care.

Purchasers Driving Newly Insured Toward Greater Cost Exposure

Likely Characteristics of Coverage for Newly Insured

<table>
<thead>
<tr>
<th>Value-Based Benefit Design</th>
<th>Lower Provider Reimbursement</th>
<th>Limited or Tiered Provider Network</th>
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<tbody>
<tr>
<td>• Enrollee deductibles, coinsurance, copayments</td>
<td>• Provider rate cut relative to existing contracts</td>
<td>• Evaluation of providers based upon efficiency, quality</td>
</tr>
<tr>
<td>• Rewards for wellness, patient engagement</td>
<td>• Value-based payment, performance incentives</td>
<td>• Patients steered to high-performing health systems</td>
</tr>
<tr>
<td>• Case and disease management programs</td>
<td>• Shared savings, delegated risk model</td>
<td>• Narrow network with select delivery systems</td>
</tr>
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Impacting Demand

Managing Supply

“Pulling All the Levers

“It’s about having the right products at the right cost structure—narrow networks, low-cost networks [on the exchange].”

Mark Bertolini, CEO of Aetna

These new cost pressures will affect the entire health system. Cost-conscious health care purchasers will be looking for value in two areas. First, they will seek out providers that can reduce inpatient utilization and overall costs through effective care management services—the so-called “medical perimeter.” Second, for patients who do require intensive acute care, payers will reward health systems that can provide the least expensive, best-coordinated acute care episodes.

This means that health systems are increasingly running two different businesses: An ambulatory network focused on coordinating care and patient activation, and a streamlined, cost-conscious, acute care business.

**Increasingly Running Two Businesses**

Health System Facing Dual Mandates of Access, Efficiency

**The Clinical Infrastructure of Accountable Care**

**“Medical Perimeter”**
- Broad network of primary care providers
- Chronic disease management tools
- Care coordination, IT interconnectivity
- Sustained focus on patient engagement

**Imperatives:**
- Expand access to primary care
- Deliver cost-effective, well-managed specialty care

**“Sustainable Acute Care Enterprise”**
- Strong procedural growth platform
- Standardized care processes
- Efficient use of labor
- Effective post-discharge care

**Imperatives:**
- Deliver high-quality, low-cost acute care
- Maximize coordination between inpatient and post-discharge settings

Source: Medical Group Strategy Council interviews and analysis.
New Ambitions Straining Core Clinical Workforce

What do these new purchaser and patient demands mean for the employed medical group?

To strengthen care management on the ambulatory side, groups will need to expand access to primary care, offer more education on chronic disease, and work with patients to increase care-plan compliance.

On the inpatient side, groups must work with physicians to develop and implement care standards, improve procedural efficiency, and reduce length of stay.

Both of these imperatives mean that medical groups will need more resources—specifically, more clinical staff. Responding to an Advisory Board survey, nine out of ten Chief Transformation Officers at progressive health systems said they foresee the need to hire more clinicians in the immediate future.

New Care Delivery Requires Additional Clinical Resources

New Responsibilities of the Integrated Medical Group

Bolstering Ambulatory Services
- Expand Primary Care Access
- Educate Patients about Chronic Disease
- Facilitate Care Plan Compliance

Transforming Inpatient Operations
- Standardize Treatment Pathways
- Maximize Procedural Efficiency
- Streamline Discharge Protocols


90%
Chief Transformation Officers who anticipate a need for new clinical staff across the next 18 months

Source: Medical Group Strategy Council interviews and analysis.
Betting on Team-Based Care

Expanding the clinical workforce is easier said than done. Over the next 10 years, demand for physicians is projected to significantly outpace supply. This also means that competition for physicians—both remaining independent physicians and new medical school graduates—will intensify, and the costs of physician employment will increase.

As a result, medical groups are turning to non-physician clinicians to alleviate physicians’ workloads and expand services in a cost-effective manner. Even four years ago, nearly half of both primary care and surgical practices were employing advanced practitioners—nurse practitioners and physician assistants. Since then, the numbers have continued to grow. This year, Medical Group Strategy Council researchers have heard from many member organizations that advanced practitioners already compose nearly 25% of their clinician staff—and they expect that proportion to grow to as much as 50% over the next few years.

Advanced Practitioners Poised to Expand Access, Boost Efficiency

Physician Workforce

Projected 2005-2025

AP Adoption Well Underway

Most Practices Employing Advanced Practitioners, 2009

<table>
<thead>
<tr>
<th>Primary Care Practices</th>
<th>Surgical Groups</th>
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<tr>
<td>Using APs</td>
<td>Not Using APs</td>
</tr>
<tr>
<td>45%</td>
<td>54%</td>
</tr>
<tr>
<td>55%</td>
<td>46%</td>
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Groups Facing Multiple Challenges to AP Utilization

Common Problems with Medical Group AP Workforce

Insufficient Clinical, Financial Contribution
- APs restricted to ancillary clinical roles
- AP productivity not justifying investment in compensation, added practice expense

Weak Management Infrastructure
- Groups lack structure, expertise, clear vision for managing AP workforce
- AP oversight may be housed within HR or nursing, rather than clinical leadership; AP organization may be fragmented across group

Dissatisfaction, Lack of Engagement
- APs feel underutilized, disenfranchised within medical group
- AP turnover close to double that of physician staff\(^1\) (11.5% to 6.8%)

1\(^{1}\) As reported for 2012 by the provider staffing firm Cejka Search.

Not Proceeding as Smoothly as We Had Hoped

However, working with these expanded clinician teams has proven challenging. Medical Group Strategy Council members have identified three primary concerns.

First and most basic is the fact that many groups employing advanced practitioners (APs) find that these providers’ financial contribution is lagging behind expectations. The Medical Group Strategy Council’s benchmarking survey suggests that AP profitability is highly variable (and variably accounted for), both within and across specialties. It is key to note that insufficient financial contribution is often linked to placing APs in overly narrow clinical roles.

Second, many groups lack a consistent strategy for managing APs as a cohort. Approaches vary from practice to practice, and even from physician to physician.

Finally, AP engagement and loyalty within organizations tends to be low. The provider staffing company Cejka Search reported that the 2012 turnover rate for both nurse practitioners and physician assistants was 11.5%—close to double the physician turnover rate of 6.8%.
The three problems medical groups experience in employing APs all stem from the same underlying issue: lack of consensus regarding the proper clinical and organizational role for APs.

The quotes presented on the right reflect this ambiguity. In response to questions about the ideal role of APs, different health system and medical group leaders offered very different opinions.

For example, a medical director offered the view that “APs will always be physician extenders,” while the CNO of another group opined that many APs are in every way qualified to treat patients without physician involvement.

On the issue of AP status within the group, some respondents said that APs must be treated just like physicians. Others expressed doubt as to APs’ readiness for that role.

These differences in opinion, seen both among and within organizations, create inconsistencies in the way APs are utilized and treated, which can lead to widespread frustration.

Source: Medical Group Strategy Council interviews and analysis.

Lack of Consensus Inhibiting Full Collaboration

Controversy Surrounding AP Role Underlies Deployment Challenges

Divergent Opinions on AP Issues

Appropriate Clinical Role?

“Our APs will always be physician extenders. That’s what our physicians want, and it’s in the best interest of patients.”

Medical director, MD
Employed faculty practice

“Experienced APs know what they are doing better than some physicians. Why should they be a physician’s lackey, instead of managing their own patient panels?”

Chief Nursing Officer, DNP
Large academic medical center

Right Organizational Status?

“APs need to be part of the medical group leadership. We are providers, and should be represented as such.”

AP Leader
Large employed medical group

“I’d be happy for APs to be just like physicians. Let’s make them shareholders! But I don’t think they really want the responsibility of being a provider and an owner.”

CMO
Independent medical group
In order to provide cost-effective access despite a shrinking physician workforce, medical groups must fully leverage and engage APs. This will require cutting through internal disagreements to set clear, consistent expectations among all stakeholders in three distinct areas.

First, groups must address AP clinical utilization. This requires understanding which clinical functions can be delegated to APs, in order to expand the capacity of all clinicians—both APs and physicians.

Second, groups must set clear ground rules for collaboration between physicians and APs. This includes hardwiring a principled approach to AP deployment; providing relevant clinical and leadership education; and restructuring compensation to encourage mutually supportive behavior.

Finally, groups should realign oversight structures to promote effective management of AP clinical performance, as well as address APs’ needs and strengthen their engagement with the organization.

Source: Medical Group Strategy Council interviews and analysis.
Realizing Full Value of the Care Team

Strategically Deploying Advanced Practitioners to Expand Access and Coordinate Care

I
Expand Clinician Roles Across the Care Team

1. Enable Autonomous AP Visits to Maximize Specialist Efficiency
2. Give AP Hospitalists Full Responsibility for Lower-Acuity Patients
3. Position AP as Comprehensive Caregiver, PCP as Diagnostic Expert

II
Strengthen AP-Physician Collaboration

4. Systematize Evaluation of AP Deployment
5. Support Physicians in Becoming Effective AP Managers
6. Ensure AP Clinical Preparedness
7. Incorporate Performance Incentives into AP Compensation
8. Structure Physician Incentives to Maximize AP Productivity

III
Align AP Management to Provider Status

9. Hire and Contract APs as Providers
10. Standardize Clinician-Driven Performance Evaluation
11. Develop Dedicated AP Oversight
12. Incorporate APs into Group Governance

The rest of this publication will address the three issues discussed on the previous page.

First, we examine specialty-specific models for expanding clinicians’ roles to get the most out of a multidisciplinary workforce.

Second, we look at strengthening inter-clinician collaboration by optimizing deployment, provider education, and compensation incentives.

Finally, we present best-practice approaches to organizing and managing APs across the medical group.

Source: Medical Group Strategy Council interviews and analysis.
Expand Clinician Roles Across the Care Team

- Lesson #1: Enable Autonomous AP Visits to Maximize Specialist Efficiency
- Lesson #2: Give AP Hospitalists Full Responsibility for Lower-Acuity Patients
- Lesson #3: Position AP as Comprehensive Caregiver, PCP as Diagnostic Expert
Most physician organizations are affected by the physician shortage. However, the impact manifests differently across specialties.

In specialty care, the primary effect of the shortage is long wait times for physician consultations and procedures. At best, this is an inconvenience to patients; at worst, it poses health risks.

In the hospital, the clinician shortage can create patient safety concerns due to excessive workloads for individual hospitalists.

Finally, in primary care, where shortages are most severe, physicians often cannot provide care for all the patients in a given area. Many PCP panels are stretched to their limits, even as the population—including soon-to-be newly insured patients—grows older and sicker.

A key part of resolving the physician shortage challenge is making sure that currently working physicians are performing at high capacity.

In a recent study published in *Health Affairs*, a team of economists modeled PCP panel growth using conventional estimates of physician schedule capacity, patient demand, and panel size. Contrary to most projections, they concluded that it is possible to meet demand with the existing supply of PCPs. According to the model, two changes to practice operations can make this possible.

The first is physician pooling: working in multi-PCP practices, with physicians available to cover each other’s patients when needed.

The second is outsourcing more care responsibilities to advanced practitioners. Even a solo PCP can increase his or her panel by a thousand patients by outsourcing a third of the visits to an AP. A pool of three PCPs can realize the same gains.

This study highlights the importance of using APs to maximize physician capacity—often by maximizing the AP’s own clinical purview.

**New Care Models Expand Physician Reach**

**Estimated Average Panel Size per PCP**

Assuming 20 Appointment Slots per Day, 50% Same-Day Access

<table>
<thead>
<tr>
<th></th>
<th>Solo PCP</th>
<th>Solo PCP Outsourcing 30% of Care to AP</th>
<th>3-PCP Pool</th>
<th>3-PCP Pool Outsourcing 30% of Care to AP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2,149</strong></td>
<td></td>
<td><strong>3,169</strong></td>
<td><strong>2,313</strong></td>
<td><strong>3,344</strong></td>
</tr>
</tbody>
</table>

Three PCPs at single practice site available to see each other’s patients

To realize the potential for greater access despite physician shortages, the traditional role of APs within medical group must evolve.

Today, many APs serve as physician extenders. They take care of routine needs and prepare patients to see the physician. Some APs may conduct patient visits, but the physician will most often still come by to check quality and confirm the care plan.

Under either scenario, the physician takes the time to see all patients, even those already seen by the AP. This means that the care team can only see as many patients as the physician can see alone.

To resolve this bottleneck and expand the care team’s capacity, organizations need to give APs more autonomous roles. APs can see patients independently, rather than supporting a physician’s workflow. This would enable physicians, in turn, to focus fully on patients who need a higher level of clinical expertise.

The next three lessons review specialty-specific ideas for distributing patient responsibilities between APs and physicians.
Lesson #1: Enable Autonomous AP Visits to Maximize Specialist Efficiency

Substantial Opportunity Cost in Specialty Backlog

In specialty care, access challenges manifest primarily as high wait times. This is not only distressing (and occasionally dangerous) for patients, but can also undermine medical group referral management efforts. When PCPs need to refer their patients to specialists, wait times can be the difference between an in-network and an out-of-network referral.

Autonomously functioning APs can make a significant difference in this area. Several models are examined on the following pages.

Long Wait Times Hampering Medical Group Referral Capture

**Average Appointment Wait Time**

In Days, 2009

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Wait Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB/GYN</td>
<td>27.5</td>
</tr>
<tr>
<td>Dermatology</td>
<td>22.1</td>
</tr>
<tr>
<td>Orthopedic</td>
<td>16.8</td>
</tr>
<tr>
<td>Cardiology</td>
<td>15.5</td>
</tr>
</tbody>
</table>

Boosting Surgeons’ OR Productivity

At The PolyClinic, an independent group in Washington state, physician assistants (PAs) see almost all patients that come through the orthopedic clinic. They conduct the majority of initial evaluations and follow-up care visits. Physicians are available to consult with the PAs by phone at any time.

This allows orthopedic surgeons to spend most of their time doing what they do best: surgery.

After this model was implemented, PolyClinic saw a dramatic reduction in wait times. Currently, the wait for a new patient visit with a physician orthopedist is at least one to two weeks. But a patient can see a PA for an evaluation within one day.

Moreover, patients who have already been seen by a PA are fast-tracked onto the surgery waitlist. For patients who have not seen the PA, it can take twice as long to get into the OR.

APs Conduct Office Visits Independently While Physician Operates

Orthopedics Patient Flow

Case in Brief: The PolyClinic

1. Provides post-operative evaluation, therapy
2. Performs orthopedic surgery
3. Evaluates, educates patients before surgery
4. Cares for minor injuries

1-2 Weeks
Wait time for first orthopedic visit with physician

1-2 Days
Wait time for first orthopedic visit with AP

1) Physician assistant.
PolyClinic’s model works well for specialties where the priority for physician time is surgeries. In other practices, physicians may have a different priority: new patients. Often, both patients and referring PCP may want the patient’s first visit to be with a physician rather than AP. In these situations, an ideal autonomous role for APs is focusing on returning patients. A great example of this model comes from the sleep lab at Illinois Neurological Institute (INI), part of the medical group at OSF Healthcare.

In the past, patients would wait nearly three months to see INI’s sleep specialist. However, now the specialist oversees as many as four APs, each of whom autonomously manages a panel of returning patients. This allows the physician to prioritize her time for new patients. The wait time now is only one day. Depending on a group’s approach to utilization management, greater access to sleep medicine may not always be the right choice. But the same model can be used in specialties where a higher level of access is strategically important.

### Autonomous APs Allow Physician to Focus on New Patients

#### Distribution of Patient Visits in Sleep Lab

<table>
<thead>
<tr>
<th>Patient</th>
<th>First Visit</th>
<th>Follow-Up Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physician Sleep Specialist</td>
<td>4 Neurology APs¹</td>
</tr>
</tbody>
</table>

- Sees new patients on first visit (joined by AP)
- Each AP manages follow-up care for own patient panel
- Physician may drop in on some visits to provide input

### Case in Brief: OSF Physician Enterprise

- 650+ physician group employed by eight-hospital health system based in Peoria, Illinois; includes Illinois Neurological Institute (INI)
- INI facing access challenges in sleep lab; hired 4 APs to support sleep specialist

¹) Two PAs and two nurse practitioners.

Wait time for sleep lab before APs hired: 90 Days
Current wait time for sleep lab: 1 Day

Source: OSF Medical Group, Peoria, IL; Medical Group Strategy Council interviews and analysis.
Another way to allocate responsibilities between APs and physicians is by patient acuity. Pseudonymed Lutz Medical Group has created a clinic to focus on complex cardiac disease, including heart failure. The clinic is based at a hospital facility, and receives both inpatient and ambulatory referrals from PCPs, hospitalists, and general cardiologists for cases that exceed these physicians’ expertise.

The clinic’s sole heart failure specialist sees a very high volume of extremely sick patients. Recognizing the need to maximize throughput, he brought in an APRN to serve as an autonomous provider. Each morning, the physician and APRN divide up the patient roster according to acuity, and then carry out their consults independently. The APRN plays a particularly important role in preventing unnecessary admissions by serving as a first responder for ER consults.

AP Responsible for Multiple Types of Lower-Acuity Care

Case Types
- Complex inpatient consults
- Post-discharge patients
- New outpatients referred by PCPs, cardiologists

High Acuity
Seen by Physician

- Lower-acuity inpatient consults
- ER consults
- Post-discharge follow-ups on inpatient consults
- Outpatient follow-up

Lower Acuity
Seen by APRN

Advanced Heart Failure Program
- Treating acute heart failure, other complex CV conditions
- Staffed by one specialist, one APRN; supported by four RN coordinators

Case in Brief: Lutz Medical Group
- 300-physician, 100-AP employed group based in the Southeast
- Launched hospital-based advanced heart failure program

Building True Expertise
“One-third of heart failure medicine is outside cardiology. A specialized APRN can provide better care than a general cardiologist.”

Heart Failure Specialist

1) E.g., pulmonary hypertension, mechanical support devices, hypertension.
2) Advanced practice registered nurse.
3) Pseudonym.
The case studies discussed on the previous three pages present different models for triaging patient encounters between APs and specialist physicians.

However, some practices are going so far as to deploy APs for all types of patient encounters, without triage and with only minimal physician involvement.

The faculty group at the University of Rochester has pursued this approach in their pediatric neurology practice. Facing long wait times for headache care, the specialty leadership decided to give patients a choice—see a nurse practitioner next week or a physician in approximately three months. Posing the choice directly to patients eliminated concerns about referral loss or patient dissatisfaction.

In fact, the vast majority of patients chose to see an AP. As a result, the nurse practitioner became the de facto primary specialist in headache. She sees all patients, with a physician available to consult as needed.
In specialty care, an AP’s potential for autonomous clinical work often correlates with degree of specialization. In both examples of highly independent AP roles presented earlier—Lutz Medical Group’s heart failure APRN and the University of Rochester’s headache specialist—the APs are not only experienced, but have extensive training in the health conditions for which they provide care. Usually, it is the physician specialist in the practice who invests time and effort in training APs.

This degree of specialization does not appeal to all APs. While some APs seek opportunities to become an expert in a specific area, others want a broader scope of expertise in order to protect their versatility and keep job prospects open.

The table to the right presents considerations for designing specialty AP roles that address the sometimes competing needs for autonomy and specialization.

### Types of AP Roles

<table>
<thead>
<tr>
<th>Broad Clinical Focus</th>
<th>Potential for AP Autonomy</th>
<th>Most Appropriate For</th>
<th>Role Design Options</th>
</tr>
</thead>
</table>
|                      | ![Circle Graph]           | • APs who prefer more diverse, more holistic patient care role  
|                      |                           | • Newer APs           | • Provide opportunity to rotate among multiple subspecialists |
| Narrow Specialization| ![Circle Graph]           | • APs who prefer managing patients independently  
|                      |                           | • Experienced APs     | • Assign AP to one physician when possible  
|                      |                           |                      | • Create opportunity to manage own patient panel |
|                      |                           |                      | • Support specialist in providing training |

Source: Medical Group Strategy Council interviews and analysis.
Lesson #2: Give AP Hospitalists Full Responsibility for Lower-Acuity Patients

Growing Inpatient Admissions a Threat to Safety

Our second lesson explores opportunities to maximize the capacity of hospitalist physicians by expanding AP autonomy in the inpatient setting.

Despite the aim to reduce hospital utilization, for now hospital admissions are still on the rise. Advisory Board forecasting tools predict more than 8% growth in inpatient volumes over the decade through 2019. Due to population aging and the growing prevalence of chronic disease, these patients will be older and sicker than before.

This is placing a significant burden on hospitalist physicians, whose numbers, like those of their colleagues in other specialties, are not increasing quickly enough to meet the new demand. A recent survey published in the Journal of the American Medical Association found that a significant proportion of hospitalists believe the size of their typical daily census poses a threat to patient safety.


1) Advisory Board Company forecast.
Using AP hospitalists to support physicians is hardly novel: Many medical groups have done so for years.

However, most of the staffing models commonly used allow APs to perform only individual elements of patient care—for example, intake, disease management, or portions of consults. This helps alleviate some of the pressure faced by physicians, but still leaves physicians responsible for the care of a facility’s entire daily census.

### APs Take on Tasks, Not Whole Cases

#### Common Hospitalist AP Utilization Models

<table>
<thead>
<tr>
<th>Model</th>
<th>AP Role</th>
<th>Physician Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offloading Intake Duties</td>
<td>Obtains history, physical during patient intake</td>
<td>Provides all patient care</td>
</tr>
<tr>
<td>Staffing “Swing Shift”</td>
<td>During hours between day and night shifts, admits patients who will later be seen by nocturnist</td>
<td>Provides all patient care except admission</td>
</tr>
<tr>
<td>Strengthening Disease Management</td>
<td>“Owns” specific clinical issue, such as glycemic control</td>
<td>Provides majority of each patient’s care not covered by AP</td>
</tr>
<tr>
<td>Joint Rounding</td>
<td>Sees patients first; shares findings, recommendations with physician</td>
<td>Sees each patient briefly after AP consult</td>
</tr>
</tbody>
</table>

Under all models, hospitalist physician sees every patient.

Source: Medical Group Strategy Council interviews and analysis.
The physician group at IU Health, a large academic medical center, recognized that the only way to truly relieve hospitalists—while managing larger patient volumes at a lower cost and with fewer complications—was to make APs fully independent.

IU was already using AP hospitalists for consults. However, physicians were coming in at the end of each visit to review the case. All visits were then billed in the physician’s name. IU Health has since made the decision to allow for independent AP consults. Similarly to the heart failure clinic discussed on p. 26, this requires triaging patients by acuity. Physicians and APs hold a consultation, or “huddle,” every morning to divide up the patient load. In general, hospitalist physicians focus on the ICU, while APs see less sick patients. Over time, this model is expected to raise hospitalist teams’ average daily census from 15 patients to 22. This will make up the loss in revenue due to direct AP billing. At the same time, physicians’ daily census is expected to decrease to 14 or fewer. This ensures that all clinicians have a safer workload, even as the team as a whole becomes more productive.

### Considerations
- APs have previous consult experience
- AP, physician, other care team members huddle daily to review all patients
- AP, physician assigned to same floor; communicate frequently

**Case in Brief: IU Health Physicians**
- 1,000-physician, 255-AP employed group based in Indianapolis, Indiana
- Changed hospitalist staffing to team model to reduce cost, LOS², readmissions
- APs now bill in own name for hospitalist consults

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Fully Accountable Hospitalist APs Relieve Physicians

Rural hospital facilities are confronting the access shortage sooner and more intensely than those based in other markets. As a result, rural organizations lead the way in exploring possibilities for autonomous AP inpatient care. For example, some have started to use APs as primary hospitalist staff.

Ministry Health Care in Wisconsin faced an acute shortage of PCPs, with only four physicians available to provide both ambulatory and inpatient care. In response, Ministry Medical Group’s physicians worked with hospital leadership to staff the facility full time with two NP hospitalists. These NPs are responsible for admitting, discharging, and managing all patients. Importantly, they are strongly supported by physicians: They have access to the community PCPs, an ER physician based at the hospital, and hospitalists at a sister facility 30 miles away (more about this on the next page).

Resolving a Rural Facility’s Physician Shortage

From Overworked PCPs…

- Four PCPs seeing both ambulatory and hospital patients
- Physicians working long hours, frustrated with lack of work-life balance

…to Independent APs

- Two NPs\(^1\) admit, manage, discharge majority of patients; send complex patients to sister facility
- Practice under collaborative agreement with hospitalist director at sister facility
- Available days, weekends; PCPs take night call

Case in Brief: Ministry Medical Group and Ministry Eagle River Memorial Hospital

- Employed medical group and 25-bed rural hospital owned by Ministry Health Care, based in Milwaukee, Wisconsin
- Family practice physicians historically rounded on inpatients; sister facility 30 miles away fully staffed by hospitalists
- With support from state nursing board, rural hospital obtained three-year waiver from state laws barring APs from admission, discharge privileges

\(^1\) Nurse practitioners.
Making the Case for Hospitalist AP Independence

In designing the new staffing model at Eagle River, Ministry faced a common barrier: Wisconsin state laws do not allow APs admitting privileges. Ministry’s response serves as a reminder that medical groups are not powerless in such situations: The group successfully pursued a waiver from state restrictions.

To obtain the waiver, Ministry needed to demonstrate that the APs at Eagle River would have adequate physician support. The group created three key resources, useful not only for obtaining the waiver, but also for overcoming internal skepticism and supporting AP development.

First, Ministry’s hospitalists developed a six-month training program for APs. For curriculum and assessment materials, see the Appendix.

Second, Ministry created telemedicine access to hospitalists at a sister facility. Conferences are required at each admission and discharge, and hospitalists are available for consultations at all times.

Finally, the group ensured that APs were using care protocols developed by hospitalist physicians.

Earning Exemption from State Restrictions on AP Privileges

Key Elements of Ministry’s Waiver Application

<table>
<thead>
<tr>
<th>Demonstrated AP Competency</th>
<th>Ensured Telemedicine Access</th>
<th>Bolstered Care Protocols</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prior to program launch, NPs¹ required to train with hospitalists at sister facility for six months</td>
<td>• Sister facility staffed 24/7; new part-time hospitalist hired to ensure telemedicine availability</td>
<td>• Hospitalist physicians developed evidence-based care protocols for rural hospital</td>
</tr>
<tr>
<td>• Hospitalist medical director developed training curriculum for APs</td>
<td>• Telemedicine conference at each patient’s admission and discharge, every third day of stay</td>
<td>• NPs to follow protocols when providing care</td>
</tr>
</tbody>
</table>

¹ Nurse practitioners.

For Ministry’s new AP hospitalist training curriculum and new hospital by-laws, see Appendix.

Source: Ministry Medical Group, Milwaukee, WI. Medical Group Strategy Council interviews and analysis.
Even more than in specialty and hospitalist practice, in primary care, the subject of APs can be highly controversial.

On the one hand, as the data on the right suggests, medical groups have an acute need to grow primary care panels. In many markets, this will not be possible without highly autonomous APs who can care for patients without placing demands on the physician’s time.

On the other hand, PCPs may perceive autonomous APs as a threat. In the specialties, the differences between AP and physician expertise and permitted activities are clear. In primary care, however, there is more room for debate about what APs can do and what level of supervision they require. This can foster competition between APs and PCPs, undermining the mutual support needed for both clinicians to work at top capacity.

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Prioritizing Physician Schedule Over AP Results in AP Underutilization

Some practices establish a clear hierarchy by ensuring that PCP appointment schedules are prioritized over those of APs. Under this arrangement, the APs role is manifestly defined as helping the physicians with overflow patients, rather than serving as independent providers. However, it can also mean that APs are often underscheduled. Given the non-negligible costs of AP employment, that reduces financial performance for the practice as a whole. It can also cause frustration and reduce engagement among APs.

Common Solution Proving Inadequate

Case in Brief: Girard Medical Group

1. 200-physician, 50-AP employed medical group based in the Northwest; includes 65 physicians, 20 APs in primary care
2. When scheduling primary care appointments, staff prioritize filling physicians’ schedules, then start filling APs

Scheduling Service

1. Physician Schedule
   - PCP workload unchanged
2. AP Schedule
   - AP not fully utilized, reducing ROI

An Underleveraged Resource

1. Average patients seen daily by AP: 10
2. Average patients seen daily by PCP: 20

AP spends only half as much time as PCP on patient care

Source: Medical Group Strategy Council interviews and analysis.

1) Pseudonym.
Confining APs to Acute Care No Better

Other primary care practices try to resolve the competitive PCP-AP dynamic by restricting APs to more basic patient encounters. This usually means that APs take care of simple acute illnesses, while the physician serves more complex patients. Unlike prioritizing physician schedules, this approach ensures that APs stay busy seeing patients.

However, it introduces other problems. First, it means that physicians are now responsible for all chronic patients, including those who have compliance issues. That makes PCPs’ days more tiring without a corresponding increase in compensation. Second, it still does not give APs the wide clinical exposure that many of them prefer.

APs, Physicians Both Dissatisfied When AP Only Sees Acute Cases

Allocating Tasks Based on Acuity

APs Provide Acute Care, PCPs Attend to Chronic Cases

Physician Dissatisfiers
• Chronic care visits demand more time and effort, with no superior reimbursement
• Missed opportunity to build patient relationship through acute visits

AP Dissatisfiers
• Limited, repetitive clinical role
• Unable to use chronic disease, education training

Source: Medical Group Strategy Council interviews and analysis.

1) Urinary tract infection.
Instead of delineating PCP vERSUS AP functions by type of problem—simple acute versus chronic—some organizations are drawing the distinction by type of care. In this model, diagnostic assessment is prioritized for physicians, while more routine, protocol-driven care—executing and adapting the care plan based on the patient's needs—is delegated to APs. This division of responsibility takes full advantage of the strengths of each provider's training. A PCP's medical education includes extensive training in differential diagnosis, ideal for assessing patients who present with unexplained problems—both acute and chronic. Many NPs, on the other hand, are focused on patient education and engagement. PAs, in turn, may be expert at individual procedures and acute care treatment. This distinction also aligns well with visit length. PCPs, whose time is more expensive, can see a large volume OF relatively quick diagnostic visits, while APs can spend more time with patients in follow-up care.
Several practice models can allow PCPs to focus on diagnostics while APs provide routine care. These models differ in the approach to assigning accountability for the patient panel. As with autonomous AP hospitalists, it is often rural groups that lead the way on implementing these models.

The first model, used in two rural practices at Wenatchee Valley Medical Center, may be termed “PCP as CEO.” In each practice, the PCP manages a team of two APs. The PCP evaluates all new patients and any new problems, and then “passes” the patients on to the APs, who provide the majority of care. The physician is accountable for performance for the entire patient panel.

This model works well when patients prefer having a PCP as their primary provider, as Wenatchee’s focus group analysis has shown to be the case in their market.

In addition, APs must be comfortable with physicians as team leaders. This might favor a practice where PAs are a significant presence, since PAs are used to closer physician supervision than many NPs.

**“PCP as CEO” Primary Care Model**

**Case in Brief: Wenatchee Valley Medical Center**

- 200-physician, 100-AP independent group practice based in Wenatchee, Washington
- Experiencing PCP shortage in rural area
- Developed two care teams, each with one PCP leading two APs

**Initial Assessment**

- Sees all new patients
- Assesses new problems for returning patients
- Accountable for quality for all patients

**Follow-up Care**

- Provide majority of care for returning patients
- Specialized in chronic disease management
- Accountable for quality for patients seen

**Considerations for Applicability**

- Patient preference for physician as primary provider
- State laws restricting independent AP practice
- PAs¹ a significant proportion of AP workforce

¹ Physician assistants.

Source: Wenatchee Valley Medical Center, Wenatchee, WA; Medical Group Strategy Council interviews and analysis.
Leveraging the PCP as Technical Consultant

In the second primary care model, the PCP serves as a consultant to APs. This approach is used at Slattery Medical Group, a pseudonym. One of their rural practices is staffed entirely by APs, who manage patient panels independently. The PCP consultant visits the site once a week to see more complex patients and mentor the APs.

This model can help organizations leverage APs who have a strong interest in managing their own patient panels. It is also well suited for markets where the PCP shortage prevents physicians from serving as primary providers for all patients.

APs Accountable for Panels, Rely on PCP for Support

“PCP as Consultant” Primary Care Model

Routine Care
Two APs

- Each AP provides all care for 2,500-patient panel
- Accountable for clinic’s productivity, quality

Complex Care, Review
Collaborating PCPs

- Visiting PCP sees complex patients, mentors APs; at clinic one day each week
- PCP supervisor2 onsite half-day each week; reviews charts

Considerations for Applicability

- Significant PCP shortage
- Experienced APs available, interested in independent practice
- State laws allow APs to serve as provider of record
- No strong patient preference for physician

Case in Brief: Slattery Medical Group1

- 150-physician, 80-AP medical group based in the Northwest
- Experiencing PCP shortage in rural area
- Created rural satellite clinic staffed with two APs

1) Pseudonym.
2) Physician responsible for AP collaborative agreement.
Moving Beyond Panel Ownership

At Wenatchee Valley Medical Center, the PCP is primarily responsible for the patient panel, with APs supporting the PCP. At Slattery, to the contrary, it is the APs who “own” patient panels, with support from the PCP. However, it may be possible to create a third model that makes these distinctions unnecessary.

In a potential future primary care model, the practice as a whole may take responsibility for patient relationships as well as financial and clinical performance. Rather than having assigned panels, providers would see patients based on their individual strengths.

Such a model would offer distinct advantages. Having all providers in the practice available to see all patients can ensure more timely access to care. This is particularly important in cases where a patient does not clearly articulate his need when booking the appointment, or has multiple needs. It also has the potential to end status disputes between PCPs and APs.

While this may seem far off, the quote to the right suggests that, as the payment environment evolves, some providers may be ready to consider it.

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**Model of the Future**

“The idea of panels is a function of the fee-for-service payment model. Once the team is really managing a population in a fee-for-value environment, we may be able to get away from ‘my panel, your panel.’”

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**Considerations for Applicability**

- Strong physician leader over each practice or region drives accountability for care quality, outcomes
- Practices include multiple PCPs, APs
- PCPs, APs willing to let go of panel “ownership”

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1) Nurse practitioner.
2) Physician assistant.

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Source: Medical Group Strategy Council interviews and analysis.
Expanding APs’ Role Across Care Continuum

Having discussed utilization models for APs in specialty, hospitalist, and primary care practice, let us note key opportunities to use APs beyond the physician practice.

The graphic on the right presents a range of clinical settings—from home visits to urgent care to post-discharge clinics—where APs are ideally positioned to provide lower-cost care. As health systems work to build out the “medical perimeter” and improve the quality of acute care, these new clinical services will only gain importance.

Case studies and guidance on cost-effective AP utilization in these settings are offered in a Medical Group Strategy Council webconference, Staffing for Population Management.

APs Well Positioned to Support Expansion of “Medical Perimeter”

Next Frontiers for AP Staffing

<table>
<thead>
<tr>
<th>Community</th>
<th>24-Hour</th>
<th>Primary Care Practice</th>
<th>Post-Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Outreach clinic</td>
<td>✓ Urgent care center</td>
<td>✓ Evidence-based panel management</td>
<td>✓ Post-discharge clinic</td>
</tr>
<tr>
<td>✓ Disease management clinic</td>
<td>✓ Evening, weekend practice hours</td>
<td></td>
<td>✓ SNF(^1), PACC(^2) rounding</td>
</tr>
<tr>
<td>✓ Home visits</td>
<td></td>
<td>✓ Advanced care planning</td>
<td></td>
</tr>
</tbody>
</table>

More information on these and other AP utilization case studies in the Medical Group Strategy Council webconference, Staffing for Population Management, available at www.advisory.com/mgsc

1) Skilled nursing facility.
2) Post-acute care center.

Source: Medical Group Strategy Council interviews and analysis.

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Expand Clinician Roles Across the Care Team

The questions on the right are designed to support medical group leaders and their teams in thinking through models for elevating AP autonomy and transforming the physician role to focus on more complex care.

<table>
<thead>
<tr>
<th>Key Questions for Medical Group Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Which specialties would most benefit from having APs see patients autonomously? In which areas are APs most prepared for this expanded role?</td>
</tr>
<tr>
<td>2. Are physicians in our medical group—specialists as well as PCPs—ready for a new clinical role, in which they spend most of their time on complex care and decision making? How can we support physicians in making this transition?</td>
</tr>
<tr>
<td>3. What objections might physicians, or other stakeholders, pose when considering team models that give APs a more autonomous role? How can we address their concerns?</td>
</tr>
<tr>
<td>4. How much flexibility should individual practices (within a given specialty) have in designing AP clinical roles? Which aspects of AP staffing should be standardized and required for all practices?</td>
</tr>
</tbody>
</table>

Source: Medical Group Strategy Council interviews and analysis.
Strengthen AP-Physician Collaboration

- Lesson #4: Systematize Evaluation of AP Deployment
- Lesson #5: Support Physicians in Becoming Effective AP Managers
- Lesson #6: Ensure AP Clinical Preparedness
- Lesson #7: Incorporate Performance Incentives into AP Compensation
- Lesson #8: Structure Physician Incentives to Maximize AP Productivity
APs, Physicians Often Not Ready for Roles to Evolve

**Change Is Hard**

For any model of AP utilization to succeed, medical groups must lay strong foundations for AP-physician collaboration.

As mentioned earlier, there are three key aspects to encouraging collaboration: ensuring that APs are deployed in appropriate practice settings; educating APs and physicians about working together; and adjusting incentives to ensure aligned interests.

All three of these can be challenging. Physician practice patterns have become established over a long time. In particular, physicians are used to having primary responsibility for the patient relationship, rather than sharing it with other team members. This mindset is slow to change even when physicians are confident of APs' skills—which they rarely are.

In addition, physicians often are unfamiliar with AP clinical abilities. As a result, they can struggle to design appropriate AP roles. For example, as one CNO noted, physicians often forget that new graduate APs need more guidance than physicians fresh out of residency.

---

**Not Ready to Let Go**

“Physicians too often just don’t want to delegate patient care to APs—they don’t understand what APs can contribute, and they don’t want to let go of the patient relationships they have built.”

*Medical director*

*Employed medical group*

---

**Mismanaging Expectations**

“Some physicians think APs are just like other physicians—ready to provide all aspects of patient care right out of school. They forget that APs don’t have a residency, and need some training first.”

*CNO*

*Large academic medical center*

---

Source: Medical Group Strategy Council interviews and analysis.
Lesson #4: Systematize Evaluation of AP Deployment

Lacking Rigor in Deployment Evaluation

Because physicians are not always familiar with an AP’s capabilities, physician staffing requests may not accurately reflect actual practice needs.

The two examples on this page demonstrate the disconnect between physician requests and actual needed roles at two employed practices with the University of Mississippi Medical Center.

In one instance, a cardiovascular clinic requested an AP to relieve access problems. However, when the Chief Advanced Practice Officer observed the clinic, she discovered that the real need was for someone to schedule appointments and follow up with patients—functions that are within the practice scope of an RN, and do not require an AP.

Similarly, a UM endocrinology practice requested an additional physician to relieve overburdened providers. After conversations with the Chief Advanced Practice Officer, the physicians recognized that they needed help managing follow-up visits for chronic patients. An AP, rather than a physician, was then brought in to help.

Physicians Don’t Know What Help They Need—So Neither Do We

Two Recent Provider Staffing Requests

<table>
<thead>
<tr>
<th>Requesting Practice</th>
<th>Perceived Need</th>
<th>Actual Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular clinic struggling with access</td>
<td>AP</td>
<td>Nurse or case manager to schedule appointments, follow up with patients</td>
</tr>
<tr>
<td>Endocrinology practice with physicians feeling overworked</td>
<td>Physician</td>
<td>AP to manage routine chronic care</td>
</tr>
</tbody>
</table>

First Step: Acknowledge the Problem

“Most of the time, physicians aren’t asking for the right staff. We can’t just throw people at problems—we want to be proactive and have an organized approach.”

Kristi Henderson, DNP
Chief Advanced Practice Officer
University of Mississippi Medical Center

Case in Brief: University of Mississippi Medical Center

- Academic medical center based in Jackson, Mississippi, employing 557 physicians, 212 APs
- CAP1 believes physicians requesting staff overestimate provider level needed at least half the time

Source: University of Mississippi Medical Center, Jackson, MS; Medical Group Strategy Council interviews and analysis.

1) Chief Advanced Practice Officer.
Supporting Informed Decision Making

As the examples on the previous page illustrate, the first step to ensuring appropriate AP utilization is placement. A well-placed AP will perform better, earn credibility with the physicians, and build a strong foundation for future collaboration. However, many medical groups do not have a robust evaluation system for assessing resource requests.

Indiana University (IU) Health Physicians requires any practice requesting additional staff to complete the employment evaluation diagnostic displayed on the right. This tool helps physicians identify a process or metric to target for improvement and then assess whether hiring an AP is the appropriate solution. In addition, the diagnostic forces physicians to assess the financial viability of the staffing request. To bolster this assessment, IU Health also helps the practice complete a detailed pro forma on AP employment.

Only after receiving a complete diagnostic and executive approval does the medical group create an AP job description and begin recruitment efforts to meet the practice’s identified needs.

Decision Support Tools Help Standardize AP Deployment

AP Employment Evaluation Tool

<table>
<thead>
<tr>
<th>Need</th>
<th>Fit</th>
<th>Value</th>
<th>Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the clinical and/or process issue?</td>
<td>Is the AP the only person able to resolve the issue?</td>
<td>How much will it cost? Who will pay? ROI?</td>
<td>Submit executive approval form</td>
</tr>
</tbody>
</table>

**Sample Considerations**
- **Need:**
  - Throughput
  - Increase volumes
  - Increase new services
  - Lost revenue

- **Fit:**
  - Core competencies:
    - Assess
    - Diagnose
    - Order
    - Prescribe
    - Procedures
    - Bill

- **Value:**
  - Complete analysis:
    - Payer mix
    - Salary support
    - Productivity measures
    - Pro forma
    - Biller/Non-biller

- **Approval:**
  - Submit executive approval form
  - Determine key functions
  - Determine funding
  - Develop MOU
  - Recruitment

Case in Brief: Indiana University Health Physicians

- 1,000-physician, 255-AP employed group based in Indianapolis, Indiana
- Developed decision tools for physicians considering employing an AP

Evaluation Tool Characteristics

- Available on system website
- Physicians expected to consult tool prior to requesting AP
- Used in conjunction with pro forma analysis
- Ensures consistent consideration of workflow, clinical, financial aspects of AP hiring decision

For detailed evaluation tools, including pro forma, see Appendix.

1) Memorandum of Understanding.

Source: Indiana University Health Physicians, Indianapolis, IN: Medical Group Strategy Council interviews and analysis.
In addition to tools for preparing AP requests, medical groups must be able to prioritize and respond to staffing requests in a consistent manner. University of Mississippi Medical Center (UMMC) created a two-step process to address this need.

First, the Chief Advanced Practice Officer (CAP) reviews each staffing request by observing the practice, assessing workflows, and developing a job description if appropriate. Having a single individual with extensive expertise concerning AP scope and utilization review requests from all practices helps ensure consistency in deployment decisions.

Second, an executive council at the system level reviews each request. This step balances the request with broader system priorities: Is the service line seeking an AP valuable enough to justify investment? Are there other practices or departments where the need is more pressing?

This two-step evaluation ensures that practices receive needed staff while the system is able to allocate resources according to explicit strategic priorities.

### Create Accountability, Process to Assess Requests for AP Support

**AP Hiring Request**

Specialty department identifies need, submits formal electronic request

**Chief Advanced Practice Officer**
- Assesses practice resources, workflows
- Evaluates practice needs, determines appropriate provider level
- Develops AP job description

**System Executive Council**
- Includes CFO, CEO, CAP
- Evaluates requests based on current service line priorities set by system
- Vice Chancellor may review denied requests

### Case in Brief: University of Mississippi Medical Center

- Academic medical center based in Jackson, Mississippi, employing 557 physicians, 212 APs
- Utilizes two-step process for assessing need for additional AP support
Once APs are deployed into appropriately staffed roles, medical groups need a mechanism to track APs’ effectiveness in their positions.

University of Mississippi Medical Center has developed a solution to this concern as well. The Chief Advanced Practice Officer works with clinicians in each department to create specialty-specific metrics for tracking the performance of new APs. Both APs and physicians sign off on the metrics, a sample of which is shown on the far right. The metric lists help hold both parties accountable when an AP is underperforming. Often, underperformance is due to inappropriate utilization—for example, an AP who is not allowed to see patients independently may struggle to meet productivity targets. The metrics are thus an essential tool for ensuring adherence to agreed-upon models of AP utilization.

### Jointly Developed Metrics Help Hold Physicians, APs Accountable for Role

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**Developing AP Performance Metrics**

<table>
<thead>
<tr>
<th>Solicit Specialty-Specific Performance Criteria</th>
<th>Monitor Metrics to Ensure Right Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>APs working within specialty department propose AP metrics</td>
<td>CAP&lt;sup&gt;1&lt;/sup&gt; uses dashboards to identify cases of poor AP performance</td>
</tr>
<tr>
<td>CAP&lt;sup&gt;1&lt;/sup&gt; meets with department chair to ensure metrics align with physician, department goals</td>
<td>Meets with physician, AP to identify barriers to AP meeting metrics, create corrective plan</td>
</tr>
</tbody>
</table>

---

**Sample AP Metrics**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Meets Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter associated infection rate</td>
<td>✔️</td>
</tr>
<tr>
<td>Ventilator associated pneumonia rate</td>
<td>✔️</td>
</tr>
<tr>
<td>Length of stay</td>
<td>✔️</td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>✔️</td>
</tr>
<tr>
<td>Foleys discontinued within 48 hours of surgical intervention</td>
<td>✔️</td>
</tr>
<tr>
<td>Documentation compliance</td>
<td>✗</td>
</tr>
</tbody>
</table>

---

Portion of AP compensation tied to metrics

For sample dashboard template, see Appendix.

---

<sup>1</sup> Chief Advanced Practice Officer.
Lesson #5: Support Physicians in Becoming Effective AP Managers

Good Clinicians Not Always Good Managers

Developing metrics to track AP performance is important, but it is equally critical to ensure an effective ongoing relationship between the AP and his physician collaborator.

This can present significant challenges. On the right, a physician describes a fundamental shortcoming in most medical school curricula: Not only are physicians rarely taught to work effectively in a team, but some curricula actively discourage the kind of mutual dependence necessary for team-based care.

Many physicians excel as team leaders despite these limitations. However, until management and teamwork skills are taught to all medical students, physician management abilities will remain unpredictable.

With growing employment of APs—as well as other care team members—medical groups need every physician to be able to lead a team. In the near term, that means the group will benefit from providing the necessary training to physicians.

Physicians Struggle with Overseeing APs

“Not Team Players

“There is a huge failing in curriculum, training, and expectations for physicians. Physicians are not trained as managers and team players; rather, they are trained as custom workers and independent thinkers. Teamwork is not taught, nor is it reinforced. On the contrary, independence is rewarded, while the mutual dependence appropriate to a team is looked down upon.”

James Rogers, MD
VP, Adult Primary Care
Mercy Clinics Springfield

Source: Medical Group Strategy Council interviews and analysis.
First Step: Understanding What They Do

The first thing physicians need in order to collaborate effectively is a solid understanding of team members’ training and capabilities.

Rush University Medical Center recognized that many physicians lacked clarity regarding APs’ clinical scope. In response, Rush created a scope of practice workshop, designed to teach physician leaders—medical directors and department chairs—how and when they should rely on their AP colleagues.

In the workshop, physicians learn about the concept of top-of-license tasks. They also discuss different clinical scenarios and identify which type of clinician—RN, AP, or other—would be needed in each.

While the material discussed may seem basic, this process helps ensure that all physicians share a baseline understanding of the AP role. In addition, physician leaders participating in the workshop have an opportunity to exchange best practices for managing APs and other team members.

Medical Directors Tapped to Communicate AP Clinical Scope to Peers

Scope of Practice Workshop

- Led by medical group executive director for 60 medical directors, department chairs
- Discuss training, scope, appropriate role of APs, other clinical staff, including scenarios when each staff type may be needed
- Medical directors share information with colleagues in each specialty department; encourage appropriate AP utilization

Case in Brief: Rush University Medical Group

- 500-physician, 100-AP employed faculty group based in Chicago, Illinois
- Looking to grow AP workforce
- Physicians have limited understanding of appropriate roles for APs versus other staff; struggle to manage APs

Source: Rush University Medical Group, Chicago, IL; Medical Group Strategy Council interviews and analysis.
Physician Dinners an Effective Forum for Best Practice Exchange

Physician Dinners
Hosted by Medical Group Leadership

Best-in-Class Physician Managers
- Physicians identified as strong AP managers based on panel size, productivity, patient satisfaction
- Three to four physicians per cohort

New Managers
- Physicians interested in adding new APs or improving AP utilization
- Five to seven physicians per cohort

Facilitating Knowledge-Sharing Among Peers

Another way to elevate physicians’ team leadership skills is pairing providers in management roles with mentors.

Piedmont Medical Care Corporation is working to partner physicians who are just beginning to work with APs with more experienced colleagues. The medical group is hosting dinners where small cohorts can come together to ask questions and exchange best practices. These cohorts usually consist of three to four experienced physician managers, and five to seven physicians considering AP employment.

The dinner setting allows physicians to learn from their peers, while also building a bench of experienced managerial talent that Piedmont will be able to refer to as AP utilization increases across the medical group.

Case in Brief: Piedmont Medical Care Corporation
- 250-provider employed group based in Atlanta, Georgia
- In response to access challenge, declining market share, looking to increase number of APs in practices
- Many physicians unsure how to use, manage APs

Source: Piedmont Medical Care Corporation, Atlanta, GA; Medical Group Strategy Council interviews and analysis.
To support physicians in managing APs and cement expectations for both types of clinicians, some organizations are drafting formal supervision arrangements. An excerpt from Wenatchee Valley Medical Center’s supervision agreement can be found to the right. In contrast to a collaborative practice agreement, which spells out the scope of the AP’s role, this document lays out commitments the physician makes not as a clinician, but as a manager.

For example, the agreement includes provisions about how frequently the physician will check in on the AP, offer practice tips, and provide feedback. The AP and physician collaborate to update the supervision agreement annually to ensure that supervision provisions continue to reflect the AP’s professional development.

**Case in Brief: Wenatchee Valley Medical Center**
- 200-physician, 100-AP independent group practice based in Wenatchee, Washington
- Concerned about common over-, under-supervision of APs
- Required PCPs, APs to jointly compose annual supervision agreement

**Supervision Agreement**
*Decided Jointly by PCP, AP:*
- Frequency of interaction expected during day or week
- Scenarios (e.g., specific diagnoses) when discussion with PCP will be expected
- Chart review expectations

**Written Agreement Facilitates Appropriate Supervision, Communication**

*Source: Wenatchee Valley Medical Center, Wenatchee, WA; Medical Group Strategy Council interviews and analysis.*
Supporting Clinicians in Building Management Skills

Teaching physicians management skills is key to successfully achieving team-based care. To support medical groups in this critical task, the Advisory Board’s Talent Development Services offers physician leadership development opportunities focused on team management skills.

This page shows a summary of the first-year curriculum, which focuses on physician leadership in a team setting.

Introducing the Advisory Board Physician Leadership Academy

Supporting Clinicians in Building Management Skills

Tailored Curriculum for Year 1

Four-Workshop Series

1. Problem Solving
   - Understanding core leadership imperatives
   - Honing critical thinking skills through problem framing and root cause analysis

2. Coaching to Full Potential
   - Setting clear expectations for staff
   - Evaluating staff performance
   - Conducting coaching conversations

3. Managing Disruptive Behavior
   - Conducting strategic, effective confrontations about behavior
   - Creating a self-correcting culture that refuses to accept disruption

4. Facilitating Effective Teamwork
   - Defining the outcomes of effective teamwork
   - Diagnosing and correcting dysfunctional team dynamics

Physician Leadership Academy develops and facilitates custom workshops to train physician leaders

8,000 Physician leaders participating
14,500+ Workshops taught worldwide
300+ Physician partner organizations

Source: Medical Group Strategy Council interviews and analysis.
Disparities in AP Clinical Skills Hinder Collaboration

While sometimes the primary barrier to physician utilization of APs is lack of knowledge about the AP role, often it is just the opposite. Many physicians are quite aware of the gap in formal clinical training between themselves and APs, and as a result, may not fully trust their AP colleagues.

The table on the right summarizes formal clinical training requirements for physicians and APs. It is key to note that some APs receive just the minimal hours of training outlined in the table, while others have significant prior clinical experience as nurses, EMTs, or combat medics. The clinical skill and experience of an individual AP can be hard to predict, which naturally breeds physician skepticism.

![Table showing clinical training requirements for physicians and APs.](source.png)

“A Major Concern

“When physicians come out of training, there’s some variability in their skill level. But for APs just out of PA⁴ or NP⁴ school, that variability is much greater. Physicians just don’t know what they’re getting.”

Stuart Freed, MD
Medical Director, Wenatchee Valley Medical Center

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1) Doctor of Nursing Practice.
2) Varies significantly by program.
3) Physician assistant.
4) Nurse practitioner.

http://www.aafp.org/online/etc/medialib/aafp_org/documents/press/np
Structured Peer Mentorships Help New APs Acquire Critical Skills

**Mentor Characteristics**
- APs with at least one year of experience, strong performance (high productivity, quality, patient satisfaction scores)
- Receives quality bonus for participation

**Mentor Role in AP Onboarding Process**
- First one to two weeks
  - Externship
    - Allows new AP to shadow practice
    - Reviews new AP's charts
- Indefinitely
  - Buddy System
    - Provides consult, advice to AP mentee
    - Networks with other mentor-mentee pairs

---

**Case in Brief: ProMedica Physician Group**
- 400+ physician, 150-AP employed group based in Toledo, Ohio
- Established peer mentoring program connecting newly hired APs to experienced APs

---

To enhance the predictability and quality of AP skills, medical groups can work to equalize clinical experience across the AP workforce. As with physicians, perhaps the simplest way to spread best practices across the AP workforce is through mentor relationships.

One example of a successful AP mentorship program comes from ProMedica Physician Group in Ohio. For the first two weeks of tenure, each new hire shadows an experienced AP within the latter's practice. This provides a safe learning environment for new APs to begin to see patients and become familiar with the organization. After this shadowing period, the AP continues to meet with his or her mentor, who can monitor the AP's progress and provide advice.

By connecting each new AP with an approachable colleague, the mentorship program helps cultivate broader engagement across the AP cohort.
As their AP workforce grows, some medical groups are moving to implement robust AP residency programs that help smooth APs’ transition to clinical practice and enhance their ability to collaborate with physicians.

Pseudonymed Cerie Medical Group struggled to find qualified AP candidates for specialty roles. Instead of hiring less qualified APs or more expensive physicians, this group—which is based at a large academic medical center—transformed the vacancies into one-year residency positions.

To minimize the cost of the program, AP residents join physician residency activities. To support them, Cerie hired two part-time directors, who offer the AP residents dedicated instruction and feedback.

This program offers three benefits. First, it creates an opportunity to evaluate candidates before hiring them full time. Second, it ensures that new AP hires are prepared for clinical practice. Last but not least, it helps physician residents prepare for collaborative practice by working side by side with APs in the residency program.

Formal Training Program for APs Prepares New Graduates for Employment

AP Residency

- **Specialties**: critical care, surgery, hospital medicine, neonatology
- **Duration**: One year; four six-week specialty rotations, each up to 80 hours per week
- **Curriculum**: Residents included in physician resident activities (including lectures, simulations, Grand Rounds)

Resources Required

- Surgical program director (hired at 0.2 FTE)
- Critical care program director (offered stipend)
- Entry-level salary for AP residents; vacant AP positions repurposed for residency

Benefits to Organization

- Residency provides opportunity to evaluate, select AP talent before hiring
- New AP hires prepared to provide care
- Physician residents gain skills in AP collaboration

Case in Brief: Cerie Medical Group

- 2,000-physician employed faculty group based in the Northeast
- Faced difficulty recruiting experienced APs for specialty positions
- Created one-year precepted, paid resident positions to train APs for specialty vacancies

1) Pseudonym.
Continuing Medical Education (CME) provides yet another opportunity to boost AP training.

CME is often perceived as little but a burdensome requirement. However, the AP director at Cerie sees it as an opportunity to provide focused training on topics relevant to both APs and the organization as a whole. To achieve this goal, he is building an in-house AP CME curriculum.

The director envisions two potential models for this program. With a more generous budget, the medical group could compensate physician faculty for presenting dinner lectures twice a month. Follow-up clinical workshops would then be offered in areas related to the week’s lecture, enabling APs to gain hands-on experience.

With fewer resources available, APs can present to their peers on topics where they have significant experience. The group would also still offer clinical workshops, but on a case-by-case basis, as opportunities become available.

“CME should be a continuous workshop, focused on a particular skill or management of a disease, rather than a bunch of random lectures. We lose so much money by not managing our CHF\(^2\) or COPD\(^3\) patients. If we’re going to pay for CME, why not use it to improve that?”

*Director of Advanced Practitioners*  
*Cerie Medical Group\(^1\)*

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**Investment in Custom AP CME Supports Strategy-Aligned Skill Development**

**Two Approaches to In-House AP CME**

<table>
<thead>
<tr>
<th>Resource-Intensive</th>
<th>Resource-Light</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lectures Related to Specialty Area</td>
<td></td>
</tr>
<tr>
<td>Clinical Training Opportunities</td>
<td></td>
</tr>
<tr>
<td>Physician faculty presents biweekly dinner lectures</td>
<td></td>
</tr>
<tr>
<td>Formal clinical workshop in area related to lecture (scheduled during off-hours)</td>
<td></td>
</tr>
<tr>
<td>AP volunteers offer lectures every two to three months</td>
<td></td>
</tr>
<tr>
<td>Clinical immersion offered when possible, on case-by-case basis</td>
<td></td>
</tr>
</tbody>
</table>

---

1. Pseudonym.  
2. Congestive heart failure.  
3. Chronic obstructive pulmonary disease.  

Source: Medical Group Strategy Council interviews and analysis.
Lesson #7: Incorporate Performance Incentives into AP Compensation

Not Putting Our Money Where Our Mouths Are

While education for physicians and APs is an essential first step toward effective collaboration, compensation incentives are often needed to hardwire cooperative clinician behaviors.

According to a recent survey by the consulting firm Sullivan Cotter, 68% of medical groups pay APs either straight salary or an hourly rate. Lower-level practice staff, such as nurses or medical assistants, are usually compensated according to these types of models.

However, these staff members generally have little influence on the quality of ambulatory patient care, and do not function autonomously. APs, on the other hand, see patients and directly impact practice productivity, patient satisfaction, and care quality.

These factors determine practice success, and physicians are accordingly incentivized for performance in these areas. This means that it is also in the interests of the group and the physicians—not to mention APs themselves—to reward AP performance on productivity, quality, and service.

Most APs Not Compensated Like Providers

AP Compensation Models

- **Straight Salary**
  - 52%

- **Salary plus Hourly Rate**
  - 26%

- **Salary plus Incentive**
  - 16%

- **Straight Incentive**
  - 1%

Majority of AP compensation models commonly used to pay non-provider practice staff (e.g., nurse, office manager)

Few organizations paying APs similarly to physician providers

Medical groups compensating APs as they compensate support staff

68%

Medical groups compensating APs either straight salary or an hourly rate.

1) As reported by organizations for a majority of their APs.


Medical Group Strategy Council interviews and analysis.
It is possible to create performance-based incentives for APs relatively easily, without overhauling all aspects of AP compensation.

At pseudonymed Hornberger Medical Group, APs are paid by the hour. However, the medical group has created a bonus scale that links AP compensation to improved performance. New APs begin with a 1%-2% bonus opportunity based on specialty-specific goals, which can include anything from RVU targets to patient safety. As APs gain experience, they qualify both for higher hourly pay and for increased bonus potential—up to 5%-8% of total compensation.

Performance Accountability an Essential First Step

Case in Brief: Hornberger Medical Group

1,000-physician, 700-AP employed faculty group based in the Southwest
APs paid by the hour; performance bonus incorporated into hourly pay
As with any type of employee compensation, poorly designed AP incentives can lead to unintended consequences.

Donaghy Medical Group had developed a generous AP incentive scheme based strictly on RVU production. Quite naturally, APs responded by seeking out “quick” acute cases to maximize their bonus.

Since APs were reluctant to focus on chronic care education and other care management activities, physicians were left spending most of their days with more time-consuming, complex patients.

It became clear that APs were the only stakeholders benefiting from the pay scheme. Physicians were working harder—with no added compensation—and at times struggled to hit their own productivity targets. The medical group was not seeing returns on the AP investment in terms of quality, patient satisfaction, and other non-RVU goals.

**Case in Brief: Donaghy Medical Group**

- 100-physician medical group based in the Northeast
- Primary care APs’ compensation includes potential to earn portion of revenue generated
- RVU-only compensation model leaves PCPs inadequately supported
Multiple Stakeholders Affected by AP Performance

The lesson of the Donaghy case study is that AP performance, perhaps even more than physician performance, affects multiple stakeholders. As a result, an ideal AP incentive model would not only reward individual success, but also encourage behavior that supports an AP’s collaborating physicians and the group as a whole.

AP Compensation Should Reflect Medical Group, Physician Goals

Attributes of Ideal AP Compensation Model

Rewards AP Performance
- Introduces performance accountability
- Recognizes APs for higher-quality work

Supports Physician Success
- Motivates AP to support physician in achieving productivity, quality goals
- Aligns incentives for AP, physician

Promotes Group Goals
- Rewards AP performance on strategic goals set by medical group leadership, such as quality, panel size

Source: Medical Group Strategy Council interviews and analysis.
Multi-Tiered Bonus Supports AP, Physician Collaboration

A great example of a balanced AP incentive structure comes from pseudonymed Rossitano Medical Group.

At Rossitano, APs can earn up to 20% of their total compensation based on performance. This incentive is divided between goals based on the AP’s individual performance and those contingent upon the supervising physician’s performance.

As the graph to the right demonstrates, a total of 60% of the incentive is based on the AP’s own visit volume and on patient satisfaction scores for those visits. The other 40% is based on whether the AP’s collaborating physician meets Meaningful Use targets and quality metrics. Those quality metrics, in turn, are set by the group.

This incentive model successfully aligns the goals of all key players—the AP, the physician, and the group.

Case in Brief: Rossitano Medical Group

- 300-physician employed medical group based in the West
- Incentivized APs on multiple performance measures, including but not limited to visit volume

---

1) Meaningful Use.
2) Pseudonym.
In building AP incentives, how can organizations accurately identify and assign credit for the ways in which APs support physician quality performance?

As noted on the previous page, at Rossitano, the physician’s quality performance automatically translates into a bonus for the AP. Wenatchee Valley Medical Center, where primary care APs provide the majority of follow-up patient care, chose to create a more detailed and accurate picture of how each provider individually contributes to care quality.

Wenatchee’s EMR automatically attributes to an AP quality data from patients listing that AP as their provider, and those who have visited the AP more than twice in 18 months. In addition, the quality team manually sorts through EMR records to attribute these quality metrics to the AP’s collaborating physician as well.

This information is synthesized into quality dashboards tailored to the physician and the AP. Soon, ten percent of both physician and AP income will be tied to quality performance.

### Collecting Quality Performance Data for Both APs and PCPs

#### Quality Data Attribution to Provider

- Patients seen by AP at least twice in past 18 months
- Patients identifying AP as primary provider

- All patients seen by PCP, APs
- Patients attributed to AP also attributed to PCP

#### Individual Provider Quality Dashboard

- Same metrics tracked for PCPs, APs
- Will be tied to 10% incentive for both providers

#### Case in Brief: Wenatchee Valley Medical Center

- 200-physician, 100-AP independent group practice based in Wenatchee, Washington
- Developed two care teams, each with two APs led by one PCP

1. Currently automating process of matching patients seen by AP to AP’s physician collaborator.

Source: Wenatchee Valley Medical Center, Wenatchee, WA; Medical Group Strategy Council interviews and analysis.
Lesson #8: Structure Physician Incentives to Maximize AP Productivity

Should We Incentivize Physicians for Collaboration?

If APs need to be incentivized to support physician goals, it is only fair to ask: Do physicians also need incentives for working with APs and supporting their needs?

The answer to this question looks very different for different physician specialties. As the quote on the left explains, specialists have a natural incentive to use APs: With APs available to perform simpler tasks, the physicians can focus on procedures and other activities that require significant expertise—and command the highest reimbursement.

For PCPs, the finances do not align as well. The quote on the right suggests that the tasks APs are best qualified to perform in primary care are no less lucrative than those requiring the physician. As a result, in PCPs lack motivation to maximize APs’ productivity and clinical contribution, and may even see them as competitors.

To eliminate this competition and promote maximal AP productivity, medical groups can work to align PCP incentives with the need to elevate AP utilization.

APs a Different Proposition for Specialists Than for PCPs

Natural Incentive for Specialists

“Specialists enjoy focusing on the highest-level decision-making and procedures, while NPs1 and PAs2 handle everything else. Those are also by far the best-reimbursed activities. If the physicians could do just that all day, they’d be thrilled.”

Bob Kwech
Executive Director, GI Associates

Source of Frustration for PCPs

“Having an AP and PCP both working at the top of their licenses creates some competition and leaves the physician seeing the “harder,” sicker patients—which is more tiring, and not necessarily better compensated. Without incentives, the PCP is not especially motivated to participate in that arrangement.”

Donna Littlepage
CFO, Carilion Clinic

Source: Medical Group Strategy Council interviews and analysis.

1) Nurse practitioners.
2) Physician assistants.
Multiple Ways to Reward PCPs for AP Productivity

This page offers an overview of the most common incentive models for PCP-AP collaboration. Note that the two models that most resemble private practice incentives—cost defrayment and profit sharing—are most effective for aligning AP, PCP, and medical group goals. However, even these two incentives structures are designed for, and are most effective in, the fee-for-service environment. In the future, medical groups will need to align incentives more clearly with the goals of value-based care.

<table>
<thead>
<tr>
<th>Description</th>
<th>Per-RVU Fee</th>
<th>Supervision Stipend</th>
<th>Cost Defrayment</th>
<th>Profit Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>PCP paid fee for each RVU generated by AP</td>
<td>PCP paid set annual amount to supervise AP</td>
<td>AP covers PCP practice costs in proportion to revenue</td>
<td>Portion of revenue generated by AP paid out to PCP</td>
</tr>
<tr>
<td>Advantages</td>
<td>• Lucrative for PCP • Rewards PCP for AP productivity</td>
<td>• Explicitly rewards supervision • Lower cost to group</td>
<td>• Motivates AP to raise productivity • Lower cost to group</td>
<td>• Can share profit among AP, PCP, group • Rewards PCP for AP productivity • Rewards practice (not just individual) success</td>
</tr>
<tr>
<td>Drawbacks</td>
<td>• May be expensive for medical group • Perceived by APs as unfair</td>
<td>• Reward not linked to AP productivity, performance • Often lower compensation potential for PCP</td>
<td>• Requires accurate assessment of AP-generated revenue • Limited incentive if PCP not fully exposed to costs</td>
<td>• Requires accurate assessment of AP-generated revenue</td>
</tr>
<tr>
<td>Potential to Align Group, PCP, AP Goals</td>
<td>![Diagram](Per-RVU Fee)</td>
<td>![Diagram](Supervision Stipend)</td>
<td>![Diagram](Cost Defrayment)</td>
<td>![Diagram](Profit Sharing)</td>
</tr>
</tbody>
</table>

Source: Medical Group Strategy Council interviews and analysis.
Incentivizing AP Utilization Through Net Income Compensation Model

Pseudonymed Rossitano Medical Group, noted earlier for its AP compensation model, provides an example of transitioning the incentives offered to PCPs for AP utilization from a profit to a value basis.

Historically, Rossitano has compensated physicians on net income, according to the model shown on the right. From the perspective of AP utilization, the approach functions as a profit sharing model: Since PCPs collect the revenues generated by APs and pay the costs of their employment, they have a clear financial stake in ensuring maximal AP productivity.

### Case in Brief: Rossitano Medical Group

- 300-physician employed medical group based in the West
- All physicians currently compensated on net income
- Organization in process of changing physician compensation model to account for panel size

---

1. If physicians are unable to reach consensus, allocation may be decided by specialty division head or group leadership; such cases are rare.
2. Includes $10,000 bonus potential based on patient satisfaction, quality, system revenue goals.
3. Adjusted through system funding to be within 0.5 standard deviations of mean market per-RVU rate for specialty.
4. Pseudonym.
Keeping Pace with System Strategy

However, Rossitano is about to adopt a new PCP compensation model focused on population management.

Under the new model, base compensation will be tied to both traditional per-RVU calculations and population management metrics. At the outset, the latter component will reward panel growth. However, as the organization takes on more risk contracts, it will incorporate risk-based payouts. This component will also grow in proportion to the RVU-based compensation.

In addition, PCPs will be eligible for a significant bonus. Notably, Rossitano chose to incorporate population management incentives as part of the base compensation, not part of the bonus. As a result, the more physicians increase their panels and effectively manage risk, the more they increase their bonus potential.

This model creates three incentives for extensive AP utilization. First, AP-generated RVUs count toward the RVU component of the PCP’s base pay. Second, APs can help grow PCP panels. Finally, the large bonus based on the entire patient panel promotes using APs to meet quality and safety goals.
Panel Size the Foundation of Future PCP Comp

While Rossitano is transitioning to population-based compensation gradually, pseudonymed Jordan Medical Center, a small rural hospital, completely overhauled its PCP compensation structure to promote panel growth.

Southwind, the Advisory Board’s practice management consulting division, helped Jordan design a model in which 85% of PCP compensation is based on panel size, rather than productivity. Jordan will also support PCPs in hiring up to four APs, with the expectation that total panel size for the care team will reach about 7,000 patients.

Under this model, effective use of APs to manage larger patient populations becomes the key to maximizing the PCP’s own income potential. At the same time, it directly incentivizes Jordan’s PCPs to meet growing market needs and support new contracting strategies—which, after all, is the ultimate goal of team-based care.

Making AP Utilization an Essential Part of PCP Role

Potential PCP Income

- 85% Panel Size
- 15% Bonus based on access, productivity, efficiency, quality

Base Compensation

- Base Pay
- PCP may hire up to four APs to expand panel
- Likely panel size limit

Panel Size the Foundation of Future PCP Comp

Case in Brief: Jordan Medical Center

- 50-physician medical group based in the rural Southeast
- Committed to medical home implementation for all owned primary care practices
- Redesigned PCP base salary in partnership with Southwind

Source: Southwind, Nashville, TN; Medical Group Strategy Council interviews and analysis.
Strengthen AP-Physician Collaboration

In conclusion to this section on enhancing physician-AP collaboration, the questions on the right probe into challenging issues related to AP deployment, physician and AP education, and compensation incentives for both types of clinicians.

Key Questions for Medical Group Leaders

1. What processes can our medical group develop that will support physicians, administrators, and practice leadership in making principled decisions regarding appropriate AP deployment?

2. What aspects of managing APs do our physicians find most difficult? How can we address their concerns?

3. Which specialties would most benefit from hands-on clinical training for APs? How can we target resources to help APs cultivate these skills?

4. How can we design AP compensation incentives that effectively support physicians in different specialties? What processes could we use to collect physician feedback on this issue?

5. What would it take for our medical group to move to substantial value-based compensation (e.g., based on panel size) as the primary incentive for PCP utilization of APs?

Source: Medical Group Strategy Council interviews and analysis.
Align AP Management to Provider Status

- Lesson #9: Hire and Contract APs as Providers
- Lesson #10: Standardize Clinician-Driven Performance Evaluation
- Lesson #11: Develop Dedicated AP Oversight
- Lesson #12: Incorporate APs into Group Governance
The previous pages have reviewed opportunities to increase care access, productivity, and quality by expanding AP roles and promoting clinician collaboration. To support these efforts, medical groups will need a robust set of processes for managing the AP workforce.

As noted earlier, APs function far more like physicians than any other type of clinical staff. But too often, existing management structures lump APs together with support staff. The quote to the right reflects the all-too-common disconnect between the clinical roles APs play and the common approach to managing this constituency.

**Are We Talking About the Same People?**

“Everyone knows that APs are critical care providers in our group and play a key role in our long-term strategy. But we’re realizing that the processes in place to hire and manage them are no different from those for our cafeteria workers—and it doesn’t make sense.”

*Medical group administrator*

**AP Role Closer to Physician Than Practice Staff**

**Assessment of AP Clinical Role**

**Typical AP Practice**

- Maintains provider relationship with patients
- Key role in care team, able to provide diagnostic, prescriptive services
- Strategic cohort growth a group goal
- Provides care that complements, elevates physician practice

Source: Medical Group Strategy Council interviews and analysis.
Lesson #9: Hire and Contract APs as Providers

Starting Off on the Wrong Foot?

Managing APs as providers has proven integral to maximizing APs’ clinical potential.

One key example is the hiring process. Medical groups have designed the physician recruitment and contracting functions to match the key role physicians play in attracting and retaining patients. However, APs—who increasingly play a similar role—are usually hired by system HR, outside this provider-centered process. This creates three troublesome differences between physician and AP employment.

First, physicians are usually hired by specialized recruiters, with input from physician colleagues. This allows for better candidate screening, which would benefit AP hiring as well.

Second, physicians are able to negotiate contract terms, and enjoy greater security due to explicit termination clauses. Denying APs these privileges can cause frustration.

Finally, contract terms that protect the group in case of a provider’s departure are rarely included in AP contracts. As a result, practices face greater exposure in the event of AP turnover.

AP Employment Conditions Leave AP, Medical Group Exposed

Common Characteristics of Physician, AP Hiring

<table>
<thead>
<tr>
<th>Recruitment Process</th>
<th>Physician</th>
<th>AP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conducted by provider recruitment specialists</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Clinicians involved in interviewing, selection</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>New hires able to negotiate terms, additional benefits</td>
<td>✓</td>
<td>✗</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Terms of Employment</th>
<th>Physician</th>
<th>AP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination clause creates job security, predictability</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Termination clause prevents provider from leaving on short notice</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Non-compete clause protects group’s market share if provider leaves</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Not eligible for overtime pay</td>
<td>✓</td>
<td>✗</td>
</tr>
</tbody>
</table>

Problem for Medical Group

1. Holding AP candidates to inadequate standards
2. Denying APs provider privileges
3. Shielding APs from provider responsibilities

Source: Medical Group Strategy Council interviews and analysis.
**Taking Ownership of AP Hiring**

To align AP recruitment and contracting with the processes used for physicians, the first step is centralizing oversight of AP hiring within the medical group.

St. Elizabeth Physicians, an employed medical group based in Kentucky, successfully lobbied its health system to shift AP hiring from the system human resources department to the group’s own HR.

In advocating for the transition, St. Elizabeth’s leadership positioned it as a boon for both the system and the group. System HR’s workload would decrease, while the group would be better able to prioritize AP hiring according to need and select APs for fit, reducing turnover and saving on hiring costs.

**Medical Group Better Equipped to Select, Set Terms for APs**

**Transfer of Accountability for AP Hiring**

AP hiring oversight moved from system HR to medical group

**Benefits to Group**
- Able to prioritize AP hiring as needed
- Recruiters accountable to group, understand needs
- Opportunity to employ APs under provider contracts
- APs integrated into physician hiring infrastructure; no new FTEs required

**Benefits to System HR**
- Reduced workload
- Fewer complaints from medical group
- No need to develop policies, procedures for AP hiring process
- Reduced turnover of APs
- Reduced hiring, training costs due to lower turnover

**Case in Brief: St. Elizabeth Physicians**
- 280-physician, 45-AP employed medical group based in Crestview Hills, Kentucky
- Growth of AP workforce a strategic priority for medical group; system AP hiring not meeting group needs
- Medical group CEO requested to move AP hiring accountability from system HR to medical group

---

1) St. Elizabeth Physicians refers to these clinicians as midlevel providers.

Source: St. Elizabeth Physicians, Crestview Hills, KY; Medical Group Strategy Council interviews and analysis.
Provider Status Has Upsides, Downsides

For St. Elizabeth, a key benefit of owning the AP hiring process was the chance to place these clinicians on provider contracts.

However, putting contracts into place was not a straightforward process. St. Elizabeth’s leadership recognized that, from the APs’ perspective, while there were drawbacks to being hired in the same way as staff, there were also benefits. First and foremost of these was the opportunity for overtime pay, available to non-contracted workers. St. Elizabeth’s APs were reluctant to relinquish this benefit.

To win support for the move to contracts, the CEO convened all the group’s APs for a conversation. In that setting, he laid out the pros and cons of becoming contracted employees. He made clear that APs had to choose between provider and staff status—they could not retain the benefits of both roles.

Swayed by the promise of greater job security and higher organizational status, APs chose unanimously to accept contracts.

A Cost-Benefit Analysis

“At first the midlevel providers said they wanted it both ways—why not take the best parts of being an employee and a provider? But once I made it clear that this was not an option, we had a constructive discussion. They ultimately made the choice to be treated like the physicians.”

Glenn Loomis, MD
CEO, St. Elizabeth Physicians

1) St. Elizabeth Physicians refers to these clinicians as midlevel providers.
Striking a Balance in AP Contracting

In addition to the benefits discussed a few pages ago, contracting APs can serve as a critical engagement lever.

Carolinas HealthCare System recently convened a taskforce to discuss AP engagement. One of the primary recommendations to emerge from this initiative focused on AP contracting. In response, Carolinas created AP contracts that closely match those used for physicians.

The table to the right details the contract terms Carolinas chose to use. These include a 90-day termination notice and a non-compete clause that help protect the group from patient backlogs and market share loss when an AP decides to leave the group.

<table>
<thead>
<tr>
<th>Provisions</th>
<th>AP Contract Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term</td>
<td>One year, automatic renewal</td>
</tr>
<tr>
<td>Weekly Patient Contact Hours</td>
<td>40</td>
</tr>
<tr>
<td>CME Time Allowance</td>
<td>5 days maximum</td>
</tr>
<tr>
<td>CME Allowance</td>
<td>$2,000 annual</td>
</tr>
<tr>
<td>Termination Notice</td>
<td>90 days</td>
</tr>
<tr>
<td>Non-Compete</td>
<td>Primary care: 15 miles, one year&lt;br&gt;Specialty care: 30 miles, one year</td>
</tr>
<tr>
<td>Base Compensation</td>
<td>Salary within established ranges</td>
</tr>
<tr>
<td>Bonus Compensation</td>
<td>Varies by practice</td>
</tr>
</tbody>
</table>

Case in Brief: Carolinas HealthCare System

- 1,400-physician, 460-AP health system based in Charlotte, North Carolina
- Assembled taskforce dedicated to improving AP engagement
- Medical group CEO proposed taskforce-recommended AP contracts to board

Source: Carolinas HealthCare System, Charlotte, NC; Medical Group Strategy Council interviews and analysis.
Lesson #10: Standardize Clinician-Driven Performance Evaluation

Calibrating Evaluation to Performance Expectations

Once APs are hired under the same terms as providers, the next step is to bring a higher level of accountability to AP performance evaluation.

As autonomous providers, APs, like physicians, inflect care quality, productivity, and patient satisfaction outcomes. It is only logical that AP performance expectations in these areas should be set and assessed similarly to physicians.

Typical AP performance evaluation processes are often lacking in two key ways. First, APs are often evaluated by office managers or other administrators rather than fellow clinicians. These professionals are not in a position to give APs actionable clinical feedback.

Second, most medical groups lack a standardized approach to AP evaluation. Some practices hold APs to unreasonably high standards, while others may not evaluate them at all.

This lesson outlines two models for AP evaluation that address these issues. In both, APs are evaluated by clinicians, and AP managers across the group share common standards when evaluating APs.

Current Approaches Disparate, Underinformed

Two Common Problems with AP Performance Evaluation

Prepared by Non-provider

- Office manager lacks clinical experience to provide relevant feedback
- Criticisms, delivery not as effective for engaging APs in performance improvement

Varied Across Medical Group

- Review differs in frequency, type of evaluation, source of performance feedback
- Variance can lead to inconsistent standards, AP dissatisfaction

Source: Medical Group Strategy Council interviews and analysis.
Using the Infrastructure We Have

Assessing AP Performance Through Existing Physician Evaluation Infrastructure

One way to include clinician feedback during the AP performance evaluation process is to incorporate AP evaluation into the existing physician performance evaluation structure.

At Wenatchee Valley Medical Center, APs receive feedback directly from their collaborating physicians. However, in addition, both APs and physicians are evaluated by a physician manager and the medical group quality committee.

An AP’s collaborating physician assesses the AP’s day-to-day performance and shares this feedback with the physician manager. The manager, who reviews both physicians and APs, examines a percentage of the AP’s charts, and works with the physician and AP to address any performance issues.

Similarly, the medical group’s quality committee is responsible for quality oversight of both physicians and APs. For APs specifically, the committee annually reviews a random selection of clinical charts, and flags issues for the physician manager to discuss with the AP and collaborating physician.

<table>
<thead>
<tr>
<th>Reviewed by</th>
<th>Collaborating Physician</th>
<th>Physician Manager¹</th>
<th>Medical Group Quality Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review process</td>
<td>1. Reviews at least 10% of AP charts</td>
<td>1. Reviews 10% of AP charts, quality data specific to AP</td>
<td>1. Reviews 10 randomly selected AP charts for clinical logic</td>
</tr>
<tr>
<td></td>
<td>2. Provides other review in accordance with collaborative agreement</td>
<td>2. Addresses issues directly with AP</td>
<td>2. Discusses problems with physician, AP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Annually</th>
</tr>
</thead>
</table>

**Case in Brief: Wenatchee Valley Medical Center**

- 200-physician, 100-AP independent group practice based in Wenatchee, Washington
- Uses physician managers, physician quality committee to evaluate AP performance

¹ Oversees eight physicians, collaborating APs.

Source: Wenatchee Valley Medical Center, Wenatchee, WA; Medical Group Strategy Council interviews and analysis.
Even with increasing clinical autonomy, AP roles will always be different from those of physicians. In addition, as discussed in previous lessons, physicians may not fully understand AP scope and skills. For this reason, some medical groups find it helpful to solicit input from an AP manager during the performance evaluation process, even when the process is led by physician managers. Among other things, an experienced AP can provide insight on scope of practice compliance and common workflow issues.

At GI Associates, an independent GI group in Milwaukee, a physician-AP dyad assesses AP performance. While the physician manager takes the lead in compiling and delivering each AP’s performance evaluation, the AP partner weighs in on role-specific responsibilities and skills.

For example, the physician’s feedback is often focused on performance aspects related to collaborating with the physician, such as communication skills. The AP partner can contribute feedback more specifically focused on the AP’s own performance.

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**Case in Brief: GI Associates**

- 24-physician, 26-AP independent single-specialty group practice based in Milwaukee, Wisconsin
- Created AP-physician management dyad within each of two divisions that oversees APs
- Team-based management structure captures feedback on all aspects of AP performance
As the AP workforce grows, AP performance evaluation may become a burden on physician managers. Some larger medical groups are choosing to invest in a dedicated leader to perform evaluations.

At ProMedica Physician Group, physicians were too busy to conduct AP performance evaluations. The responsibility fell to office managers, who were unable to give APs constructive clinical feedback. Realizing that the AP cohort was only going to grow, ProMedica hired an AP leader. Today, this leader performs many duties in overseeing over 150 APs—one of which is reviewing performance.

To ensure that APs receive thorough and detailed feedback, ProMedica’s AP leader solicits feedback from supervising physicians and office managers, benchmarks APs’ productivity and patient satisfaction data, and reviews charts through the EMR system.

This type of multidimensional performance management process can benefit from a strong evaluation tool. See the Appendix for a sample tool from the University of Rochester.

---

**Invest in Centralized Structure to Deliver Comprehensive AP Evaluation**

**Dedicated AP Performance Evaluation**

- AP leader compiles feedback, data on AP performance from across group
- Conducts individual follow-up, development conversations
- Can reassign APs across group as needed

**Data Included in AP Annual Review**

- Feedback from supervising physician, office manager on day-to-day activities, behaviors
- Benchmarks on patient satisfaction, productivity metrics from finance department
- EMR analysis, including chart audit, check on prescribing patterns, coding review by compliance team

**Case in Brief: ProMedica Physician Group**

- 400+ physician, 150-AP employed medical group based in Toledo, Ohio
- Physicians too busy, office managers not qualified to evaluate APs
- AP leader reviews performance for all group APs across 10 service lines

---

1) Press Ganey scores for APs must exceed 50th percentile.
2) Productivity metrics include number of visits, revenue per encounter.
3) Chart audit based on AMA standards of practice.

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**For NP performance evaluation tool from the University of Rochester, see Appendix.**

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Source: ProMedica Physician Group, Toledo, OH; University of Rochester Medical Center, Rochester, NY. Medical Group Strategy Council interviews and analysis.
Lesson #11: Develop Dedicated AP Oversight

No Clear Chain of Command for APs

An AP leader like the one at ProMedica fills many roles, perhaps none more important than providing dedicated oversight to APs.

The quote on the right captures a concern many APs have: they often feel “stuck in the middle.” APs frequently are placed within either the physician or the nursing management structure, though technically they belong in neither. As a result, APs feel they lack appropriate recourse if issues arise. In addition, the dearth of APs in leadership roles means that more experienced APs, who may be interested in leadership, struggle to see a forward career trajectory.

As APs come to play a more central role in employed practices, medical groups will benefit from providing explicit, dedicated oversight for this constituency.

APs' Unique Needs Often Unmet—or Even Unheard

"Physicians can go up the chain in medical leadership, and nurses can go up the chain of nursing leadership, but we’re these intermediate professionals who don’t have an advocate or space or role. Whomever you talk to, you’ll find NPs and PAs who feel very in-between, who don’t know whom to go to."

Sonya Green, PA
Director, Allied Health
DeKalb Medical Group

Neither Fish Nor Fowl

Source: Medical Group Strategy Council interviews and analysis.
One Leader, Many Benefits

A more complete list of the AP leader’s responsibilities at ProMedica Physician Group sheds light on the many important functions dedicated AP leaders can serve.

In addition to overseeing AP recruitment, orientation, deployment, and engagement, the AP leader supports physicians in using APs effectively.

The AP leader also plays an important role in advocating for APs within the group, and ensures that the organization stays up to date on regulatory changes concerning AP scope of practice.

AP Leader Lays Groundwork for Dedicated Management Infrastructure

Functions Served by AP Leader

- **AP Leader**
  - **Boost Recruitment**: Collaborates with local AP training programs to precept student interns, recruit top performers
  - **Standardize Deployment**: Applies financial tools, algorithms to ensure appropriate AP placement, use
  - **Tailor Care Models**: Promotes care models that maximize AP use, such as expanded after-hours care
  - **Promote Development**: Supports new hire orientation program, training resources to bolster AP clinical competency
  - **Educate Physicians**: Conducts one-on-one conversations with physicians to explain AP role, benefits
  - **Advocate for Constituency**: Encourages group consideration of issues specific to AP cohort, AP participation in committees

Case in Brief: ProMedica Physician Group

- 400+ physician, 150-AP employed medical group based in Toledo, Ohio
- Hired AP director to organize, manage APs across system entities

Source: ProMedica Physician Group, Toledo, OH. Medical Group Strategy Council interviews and analysis.
The Earlier, the Better

Large medical groups, often employing hundreds of APs, have the most obvious need for AP leadership. However, smaller organizations can reap significant benefits as well.

DeKalb Medical Group in Georgia currently employs only 17 APs for a 75-physician group. However, their goal for the next five years is to reach a ratio of one AP to every two physicians.

The AP leader is working with the medical staff and hospital administrators to expand AP inpatient privileges, with two goals in mind: first, to establish more effective AP utilization patterns; second, to elevate AP engagement in their role. In addition, the AP leader is developing and implementing a recruitment and hiring strategy for ambulatory practices.

On both fronts, the CEO believes there is significant benefit to having a dedicated leader, with the expertise and mandate to focus specifically on AP strategy.

Bringing AP Leader on Board Early Sets Stage for Growth

Benefits of Appointing AP Leader for Small AP Cohort

Poised to Grow

1:5
Current AP-physician ratio

1:2
Target AP-physician ratio

Expands Privileging

- Developed AP advisory council to identify regulatory barriers to AP practice
- Collaborating with medical staff directors at three system hospitals to align medical staff bylaws with state legislation

Structures Employment

- Implementing contracts to allow for performance-based AP compensation
- Altering physician compensation to incentivize AP utilization
- Writing AP job description to ensure appropriate scoping of role
- Working to gain AP, physician buy-in for employment changes

Case in Brief: DeKalb Medical Group

- 75-physician, 17-AP employed medical group based in Decatur, Georgia
- Planning to grow AP workforce
- Appointed PA with administrative experience to develop AP utilization strategy

1) APs currently paid hourly through system HR, goal to include productivity, quality, patient satisfaction metrics.

Source: DeKalb Medical Group, Decatur, GA; Medical Group Strategy Council interviews and analysis.
Finding the Right Person for the Job

The role of AP leader can be challenging to fill. The right individual must be able to work effectively with both physicians and group administrators, while also gaining the support of APs.

APs are clear candidates for this role, since they best understand their colleagues’ unique needs and are most likely to earn credibility among the AP constituency.

Perhaps surprisingly, some organizations place a physician in this role. Physicians more naturally obtain credibility among their peers, and physicians are an equally important constituency to sway when trying to change the nature of AP oversight.

Yet other organizations seek the best of both worlds by choosing an AP-physician dyad to fill the role.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Strengths</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>AP</td>
<td>• Understands AP needs&lt;br&gt;• Can communicate easily, effectively with other APs</td>
<td>• May further separate AP constituency from physicians&lt;br&gt;• May struggle to gain physician support, credibility</td>
</tr>
<tr>
<td>Physician</td>
<td>• Well positioned to communicate with physicians&lt;br&gt;• Helps integrate APs into existing physician leadership infrastructure</td>
<td>• May lack experiential understanding of AP needs&lt;br&gt;• Must make extra effort to gain AP buy-in, trust</td>
</tr>
<tr>
<td>AP-Physician Dyad</td>
<td>• Incorporates expertise of both providers&lt;br&gt;• Partnership requires less commitment from each leader</td>
<td>• Dyad’s success hinges on communication between AP, physician</td>
</tr>
</tbody>
</table>

Source: Medical Group Strategy Council interviews and analysis.
Evaluating Options to Delegate AP Management Responsibilities

### Three Possibilities for Organizing AP Sub-leadership

<table>
<thead>
<tr>
<th>Description</th>
<th>By Specialty</th>
<th>By Location</th>
<th>By AP Type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Appoint AP leads for different service lines or physician departments</td>
<td>Appoint AP leads for different system entities or geographic regions</td>
<td>Appoint AP leads to represent sub-groups within AP cohort</td>
</tr>
<tr>
<td><strong>Strengths</strong></td>
<td>• Enables AP leader to account for specialty differences in AP role</td>
<td>• Customizes oversight to distinct regulatory environments</td>
<td>• Accounts for unique regulatory needs, AP preferences where differences between sub-groups of APs is substantial</td>
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<td></td>
<td>• May allow for more cohesive relationship between AP leads, physicians</td>
<td>• Enables swift response to local changes, issues</td>
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<tr>
<td><strong>Considerations</strong></td>
<td>• Requires minimum number of APs in each specialty</td>
<td>• Does not allow for specialty-specific expertise</td>
<td>• Requires minimum number of each AP type</td>
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<td></td>
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<td>• Risks fragmenting AP cohort, creating hierarchies</td>
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*Group can matrix regional and specialty management if AP cohort is large enough*

Source: Medical Group Strategy Council interviews and analysis.
Establish Committee Support

In addition to building out a leadership team, some AP directors are also harnessing the power of committees to develop and share expertise on specific operational issues.

At pseudonymed Spurlock Medical Group, several committees support the AP leader. For example, the innovation committee serves as a kind of incubator, developing new utilization models and proposing new engagement strategies. The legislation committee monitors scope-of-practice regulations and coordinates the group’s efforts to appeal those that are too restrictive.

![Committees Supporting AP Leader](image)

**Committees Supporting AP Leader**

**Innovation**

Serves as think tank focused on improving AP utilization, retention

**Education**

Oversees AP CME, training, residency programs

**Communication**

Assists HR in recruitment, outreach

**Operations**

Proposes hospital policy reforms on AP scope of practice, privileges, credentials

**Legislation**

Monitors state, federal regulations, prepares group for changing legislation

---

**Case in Brief: Spurlock Medical Group**¹

- 1,000-physician, 700-AP employed faculty group based in the Southwest
- Created several multidisciplinary committees dedicated to addressing AP-specific issues; committees report to AP leader

¹ Pseudonym.

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Source: Medical Group Strategy Council interviews and analysis.
Lesson #12: Incorporate APs into Group Governance

Oversight Separate From Group Decision Making

AP committees can be an effective tool for addressing functional and operational issues that are specific to the AP cohort. However, there is an important distinction between these more functional matters and broader strategic concerns that affect the entire group.

For example, a separate AP committee is well equipped to work on AP privileging and scope-of-practice expansion. But on initiatives such as EMR roll-out or quality standard adoption, which are likely to transform workflows for all clinicians, it is critical to integrate APs into a broader, group-wide conversation.

Advocating AP Representation in Group Governance

Range of Issues Facing Medical Group Administrators

- **Functional**
  - Issues affecting APs, physicians differently
  - Credentialing, privileging

- **Strategic**
  - Issues affecting entire group
  - EMR roll-outs, optimization initiatives

**AP Oversight Focus**

Dedicate resources to manage key AP-related operational functions

**Strategic Integration Imperative**

Encourage AP involvement in medical group governance

Source: Medical Group Strategy Council interviews and analysis.
Separate AP Council Reinforces Workforce Divides

Some organizations have tried to incorporate AP views into strategic conversations by creating governance councils exclusively for APs. This strategy tends to deepen divides between APs and their physician colleagues. First, giving APs a separate governance council means their voice is missing from group-wide conversations that affect their roles. In one case, APs discovered that the group governing council discussed standardizing AP compensation across practices—without a single AP present for the conversation.

Second, in addition to APs feeling excluded, the medical group misses out on their contributions to conversations. APs have close contact with patients—in some cases, more than physicians. As a result, they have unique insight on issues affecting quality, efficiency, and patient satisfaction.

A Common Response to AP Requests for Representation

"When our medical group decided to integrate more closely, high-level decisions were made at board meetings to standardize AP compensation and benefits...APs were nowhere to be found in any of these conversations. That really rankled APs who had been happy for a long time."

AP Leader
Large employed medical group

"Some of the best practice models and standards of care are overseen and implemented by APs. APs play a huge role on quality committees...they are the ones looking at innovative practices, bringing them to the attention of physician colleagues, and operationalizing them."

Lisa Norsen
Director, Sovie Institute for Advanced Practice
University of Rochester

Depriving APs of a Voice

Missing Out on AP Contribution
Giving APs a Voice in Strategic Governance

Sensitive to the issues discussed on the previous page, Alegent-Creighton Clinic in Nebraska restructured its governance council to avoid siloes between physicians and APs and maximize each group’s contribution to strategic planning.

Alegent-Creighton’s governing council comprises several committees, each seating five clinicians. Alegent-Creighton reserves one seat on each of these committees for an AP representative, which roughly matches their overall ratio of APs to physicians. As the mix of clinical staff changes, committee composition will change too.

In selecting APs for group committee service, Alegent-Creighton looks for similar characteristics to those a physician leader possesses. The ideal candidate is respected by peers—both APs and physicians—and capable of taking a strategic, long-term view of medical group needs.

APs Incorporated into Group Governance Committees

Overview of Committee Structure

- One seat reserved for AP on each medical group committee
- Each elected representative holds seat for two years

Committees
- Executive
- Governance
- Finance
- Clinical quality
- Strategic planning
- Service excellence
- Informatics

Capture AP Contributions

“We wanted to avoid developing an unproductive ‘us versus them’ mentality. We didn’t want to silo APs—we wanted to bring them into the fold because they have a great deal to contribute to the group.”

Rick Rolston, MD
CEO
Alegent-Creighton Clinic

Case in Brief: Alegent-Creighton Clinic

- 554-physician, 128-AP employed medical group based in Omaha, Nebraska
- Added position for one elected AP to every committee in the medical group

Source: Alegent-Creighton Clinic, Omaha, NE; Medical Group Strategy Council interviews and analysis.
APs who have the leadership qualities described above are a great fit for governance committees. But these same qualities can also prepare them for executive leadership positions within the group. Progressive medical groups work to prepare high-potential APs, as well as physicians, for leadership roles.

Fairview Medical Group adopted this approach several years ago. Fairview has always offered physicians leadership training, which includes in-house lectures and opportunities to attend leadership conferences. Now, they offer the same training to APs.

When Fairview has an executive vacancy, they often open the position to both physician and AP applicants. In fact, Fairview’s current VP of quality is an AP. She works closely with the quality committee to improve quality assessment and performance across the entire group.

This open-minded approach means that Fairview can choose from a larger pool of leadership talent. It has also helped break down barriers between physicians and APs, allowing for better collaboration.
Align AP Management to Provider Status

The preceding four lessons are the beginning of a conversation about adjusting AP management and organizational status to maximize benefit to all constituencies involved—APs themselves, physicians, and the medical group. This dialogue will continue to grow in importance as medical groups begin to experience the impact of coverage expansion.

As with the two preceding sections, this slide offers some questions that can serve as a starting point for conversations among the medical group executive team about how to work with the APs as a cohort and incorporate them into medical group leadership.

Key Questions for Medical Group Leaders

1. How does our medical group structure AP management? What benefits and drawbacks do we anticipate from centralizing management?
2. How does AP employment parallel that of physicians, and how does it differ? How would APs and physicians react to contracting APs as providers, and how can we address their concerns?
3. Does our medical group have a provider-driven, standardized process for evaluating AP performance? Does this evaluation structure incorporate an AP perspective and AP-driven feedback?
4. What benefits would our medical group realize from appointing a leader to oversee AP operations? Where do we anticipate that leader requiring support from subleaders or committees?
5. How do we envision adapting our group’s governance structure to account for its growing population of APs? What steps can we take today to prepare for this shift in leadership composition, and how can we generate buy-in for this shift?
Coda: Capitalizing on Change
The 12 lessons discussed in the preceding pages are reviewed to the right.

This publication opened with best practices for elevating the clinical roles of all providers in order to maximize both AP and physician productivity and expand patient access. Since implementing these clinical models requires effective AP-physician collaboration, the following five lessons focused on strategies for strengthening collaboration. Finally, building on the recognition that the number and importance of APs in most medical groups is poised to increase, the final chapter highlighted the need to manage APs like providers—from the contracting process to representation in group governance.

The next four pages are devoted to concluding thoughts on the subject of AP utilization and management.

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<tr>
<th>1</th>
<th>Expand Clinician Roles Across the Care Team</th>
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<tbody>
<tr>
<td>1.</td>
<td>Enable Autonomous AP Visits to Maximize Specialist Efficiency</td>
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<td>2.</td>
<td>Give AP Hospitalists Full Responsibility for Lower-Acuity Patients</td>
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<td>3.</td>
<td>Position AP as Comprehensive Caregiver, PCP as Diagnostic Expert</td>
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<th>2</th>
<th>Strengthen AP-Physician Collaboration</th>
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<td>4.</td>
<td>Systematize Evaluation of AP Deployment</td>
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<td>5.</td>
<td>Support Physicians in Becoming Effective AP Managers</td>
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<td>6.</td>
<td>Ensure AP Clinical Preparedness</td>
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<td>7.</td>
<td>Incorporate Performance Incentives into AP Compensation</td>
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<td>8.</td>
<td>Structure Physician Incentives to Maximize AP Productivity</td>
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<th>3</th>
<th>Align AP Management to Provider Status</th>
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<td>9.</td>
<td>Hire and Contract APs as Providers</td>
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<td>10.</td>
<td>Standardize Clinician-Driven Performance Evaluation</td>
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<td>11.</td>
<td>Develop Dedicated AP Oversight</td>
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<tr>
<td>12.</td>
<td>Incorporate APs into Group Governance</td>
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</table>

1) An Underleveraged Asset.
First, as the health care market prepares for a larger and needier group of insured patients, the very concept of provider access is likely to change.

Given persistent physician shortages, growing the clinical workforce at the rate needed to serve patients will require extensive use of NPs and PAs. As pointed out in the graphic on the right, training a physician costs between three and 12 times more than training an NP, and takes substantially more time. Not surprisingly, the NP workforce is projected to more than double by 2025.
Second, physicians cannot continue to provide all needed services to all patients. With a changing clinical workforce comes the need to restructure physician roles, maximizing the time physicians spend working at the top of their license. This will require training all physicians to be better managers of a broad care team involving a variety of non-physician clinical professionals.

Thankfully, there is evidence that medical schools and teaching hospitals are likely to support them in this task by innovating clinical curricula. The University of Colorado School of Medicine is at the forefront of this effort. They have started incorporating care-team management into the curriculum for family medicine. At Colorado, medical students and residents learn not only how to diagnose and treat illness, but how to select and manage the other clinicians who provide care as part of the team.

**New Physician Responsibilities Span Staff, Settings**

**Case in Brief: University of Colorado School of Medicine**

- Medical school affiliated with the University of Colorado Denver
- Family medicine residency curriculum incorporates training on team-based care, collaboration with mental health, pharmacy
- Recently expanded focus on teaching residents to assemble care team, facilitate top-of-license practice


“Can’t Be Everything to Everyone”

“You as the doctor are in charge, but unless you allow other people to do what they do best, you can never be successful.”

Douglas Kelling, MD Internist
**Clinical Standardization Never More Important**

A final thought on the future of team-based care is that the ability to delegate some of the tasks traditionally reserved for physicians will depend on the quality of care protocols or standards.

Dr. Douglas Kelling, an independent internist in North Carolina, commented on the evolving role of the primary care physician in a recent article in the *New England Journal of Medicine*. Dr. Kelling believes that NPs and PAs can manage nearly all cases he sees—as long as the standards of care they consult are accurate and thorough. Many medical groups are already working with physicians to create explicit care standards for the use of APs.

Some groups are also beginning to recognize that this process creates a broader opportunity to improve care. As medical groups continue to employ more APs, and as more of these APs come to rely on clinical standards, the entire group will move toward a more consistent, standardized care workflow. As one CMO put it: “We’re going to roll out care standards to the APs. And when the doctors see how well they work… we’re going to roll them out to the doctors.”

---

**Sample Diabetes Assessment**

- Explore patient concerns
- Assess self-care ability
- Review metabolic control (HbA1c and blood glucose, etc.)
- Identify CV risk factors

**Narrowing the Skill Gap**

“We’ve found that 98% or 99% of all patients, with our systems and pathways, can be managed by the physician assistants and nurse practitioners.”

*Douglas Kelling, MD*
*Internist*

**Catalyzing Broader Change**

“No one can control how physicians meter their practice…. With APs, you have the ability to drive standardization through protocols, really have the same care and outcomes for the same diseases everywhere. We need to move that way.”

*AP Director*

---

Increased reliance on AP clinicians and acceptance of care standards constitute a new approach to delivering care. However, even as medical groups undertake these significant changes, they can take comfort in knowing that the essential goals have remained the same.

Health care organizations are still focused on the objectives that have motivated so many individuals’ decision to work in health care: expanding access to care, ensuring high care quality, and creating a seamless, supportive environment for patients. These have always been, and will remain, the bedrock of the industry and the principles guiding future change.

Team-Based Approach Provides Greater Value to Patients

Promise of Team-Based Care for Patients

- **Timely Access**
  - Convenient appointment schedules
  - Investment in new capacity, access points as needed

- **Cost-Effective Care**
  - Efforts to reduce costs, unneeded utilization
  - Use of low-cost care pathways

- **Top-Quality Care**
  - Use of evidence-based care standards
  - Availability of transparent performance data

- **Unified Care Experience**
  - Seamless care transitions
  - Information used as a system asset to streamline care experience

- **Open Communication**
  - Prompt response to patient inquiries
  - Proactive patient engagement in care management

Source: Medical Group Strategy Council interviews and analysis.
Appendix

1. Ministry Medical Group: AP Hospitalist Training Curriculum
2. Ministry Medical Group: AP Hospitalist Skills Self-Assessment
3. Ministry Medical Group: Additions to Eagle River Hospital By-Laws
4. Indiana University Health Physicians: AP Deployment Decision Tree
5. Indiana University Health Physicians: AP Intent to Recruit and Hire
6. Indiana University Health Physicians: AP Recruitment Approval Form
7. University of Mississippi Medical Center: AP Performance Dashboard Template
8. Wenatchee Valley Medical Center: Physician-AP Supervision Agreement
10. DeKalb Medical Group: Director of Allied Health Job Description
Ministry Medical Group

AP Hospitalist Training Curriculum

Six-Month Training Curriculum

1. Initial skills assessment. This is a self-assessment of what areas the NP feels they need additional training in (see next page).

2. Orient to Ministry hospitalist program and work routine.

3. Review templates for dictating H & Ps, discharge summaries, and writing progress notes.

4. Review billing and coding education and documentation requirements. Meet with the business office quarterly for review.

5. Learn to triage patients—including which patients require NP versus MD primary management starting from day one.

6. Co-manage a subset of patients to learn a hospitalist’s approach to problems.

7. Independently manage a subset of patients similar to what the NP will manage at Ministry Eagle River Memorial Hospital.

8. Do case presentations (formal and informal) to ensure that the NP can communicate important and relevant clinical information and create a differential diagnosis.

9. Complete a weekly reading list from UptoDate and Harrisons. Meet with the program director weekly to review and do a formal case presentation.

10. Antibiotic review, including judicious use.


12. ECG interpretation.

13. Orient with case managers at Ministry Eagle River Memorial Hospital to learn about nursing homes, CBRFs, and community services that are available in the Eagle River area.

14. BLS and ACLS certification/recertification as appropriate.

15. Attend "Hospital Medicine Boot Camp" sponsored by SHM, AAPA, and AANP.

16. Training in telemedicine use.

17. Final assessment by physician hospitalists.


Source: Ministry Medical Group, Milwaukee, WI; Medical Group Strategy Council interviews and analysis.
Ministry Medical Group

AP Hospitalist Skills Self-Assessment

**Advanced Practice Clinician Hospitalist Skill Self-Assessment**

The following diagnoses have been collected over the past year for the General Surgery department. Please rate your level of proficiency of each of the following skills on a scale of 0-4. Completed assessment can be returned to your assigned Provider Liaison. This assessment will be forwarded to your Clinic Operations Manager, Supervising Physician, and Medical Director for review to assist with development of your department specific orientation plan.

Please indicate your level of experience as a clinician:
- New graduate
- 1-2 years of experience
- 3-5 years of experience
- 5+ years of experience
- Transitioning into new specialty focus

Please indicate your areas of proficiency as it relates to the top diagnoses listed below for an NP Hospitalist:

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis</th>
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<th>1</th>
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<tbody>
<tr>
<td><strong>Pneumonia</strong></td>
<td>Community Acquired</td>
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<td></td>
<td>Community Acquired – ICU</td>
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<td></td>
<td>HAP/HCAP</td>
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<td><strong>Acute Exacerbation COPD</strong></td>
<td>Acute vs. Chronic Respiratory Acedosis</td>
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<td></td>
<td>Bronchitis</td>
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<td><strong>Urinary Tract Infection</strong></td>
<td>Obstructed</td>
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<td></td>
<td>Non-obstructed</td>
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<td><strong>Sepsis</strong></td>
<td>Septic Shock (with help from MD)</td>
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<td><strong>Atrial Fibrillation</strong></td>
<td>Rapid Ventricular Response</td>
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<td></td>
<td>Bradycardia</td>
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<td>Dehydration</td>
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<tr>
<td><strong>Chest Pain</strong></td>
<td>Rule Out MI (myocardial infarction)</td>
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<td></td>
<td>Acute Coronary Syndrome</td>
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<td>Non-Transmural MI</td>
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<td>Post-renal (obstruction)</td>
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<td></td>
<td>Renal</td>
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<td><strong>CVA (Stroke)</strong></td>
<td>Ischemic – No TPA</td>
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<td></td>
<td>Ischemic (Using TPA with help from MD)</td>
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<td></td>
<td>TIA (Transient Ischemic Attack)</td>
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<td>Necrotizing (with help from MD)</td>
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<td>Decubiti</td>
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<td></td>
<td>Leg ulcers</td>
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<td><strong>GI Bleeding</strong></td>
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<td><strong>Transfusion Therapy</strong></td>
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<td>Coagulation Factors</td>
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<td>Emergency (with help from MD)</td>
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Source: Ministry Medical Group, Milwaukee, WI; Medical Group Strategy Council interviews and analysis.
### Ministry Medical Group

#### AP Hospitalist Skills Self-Assessment (cont.)

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<td><strong>Deep Veinous Thrombosis</strong></td>
<td>Deep Veinous Thrombosis</td>
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<tr>
<td><strong>Bradycardia</strong></td>
<td>Bradycardia</td>
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<tr>
<td><strong>Chronic Renal Failure (not needing dialysis)</strong></td>
<td>Chronic Renal Failure (not needing dialysis)</td>
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<tr>
<td><strong>Asthma</strong></td>
<td>Asthma</td>
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<tr>
<td><strong>Diverticulitis</strong></td>
<td>Diverticulitis</td>
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<tr>
<td><strong>Recognize Acute Abdomen (surgery problem)</strong></td>
<td>Work-up</td>
<td></td>
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<td></td>
<td>Appropriate Consult</td>
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<tr>
<td><strong>Pre-op Evaluation and Clearance</strong></td>
<td>Pre-op Evaluation and Clearance</td>
<td></td>
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<tr>
<td><strong>Symptom Therapy</strong></td>
<td>Pain Management (oral, IV, topical, local)</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Nausea/Vomiting</td>
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<tr>
<td></td>
<td>Itching</td>
<td></td>
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</tr>
<tr>
<td><strong>Warfarin (Coumadin) Lovenax Use</strong></td>
<td>Bridging</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Diabetic Management</strong></td>
<td>New Onset</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Routine in Hospital (with help from MD)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>IV Insulin (with help from MD)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>DKA (with help from hospitalist)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Hypoglycemia</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Hyperkalemia/Hypokalemia</strong></td>
<td>Work-Up</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Treatment</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>TPN (Total Parenteral Nutrition)</strong></td>
<td>TPN (Total Parenteral Nutrition)</td>
<td></td>
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<tr>
<td><strong>Enteral Feeding</strong></td>
<td>Enteral Feeding</td>
<td></td>
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<tr>
<td><strong>Alcohol Detox</strong></td>
<td>Alcohol Detox</td>
<td></td>
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<tr>
<td><strong>Narcotic Detox</strong></td>
<td>Narcotic Detox</td>
<td></td>
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<tr>
<td><strong>Urinary Reduction</strong></td>
<td>Urinary Reduction</td>
<td></td>
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<tr>
<td><strong>Terminal Care/Symptom Relief</strong></td>
<td>Terminal Care/Symptom Relief</td>
<td></td>
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</tbody>
</table>

Source: Ministry Medical Group, Milwaukee, WI; Medical Group Strategy Council interviews and analysis.
Ministry Medical Group

Additions to Eagle River Hospital Bylaws (to Accommodate AP Hospitalists)

BYLAWS OF THE MEDICAL STAFF OF THE EAGLE RIVER MEMORIAL HOSPITAL EAGLE RIVER, WISCONSIN

Article I: Medical Staff Membership

[...]

Article VII: Review, Revision, Adoption, and Amendment

Section 1: Medical Staff Responsibility

Section 2: Methods of Adoption and Amendment

Section 3: Related Protocols and Manuals

The Medical Executive Committee will recommend to the Board a Credentials Policy, an Organization and Functions Manual, and such other rules as are necessary to further define the general policies contained in these Bylaws.

Definitions

1. The term “Medical Staff” is defined as all medical and osteopathic physicians, dentists, and podiatrists holding licenses who are privileged to attend patients at the Eagle River Memorial Hospital.

MEDICAL STAFF POLICY AND PROCEDURE: ALLIED HEALTH PROFESSIONALS

Part One: Authorization and Control Procedures

I. Qualifications of the Allied Health Professional Staff

[...]

XI. Special Conditions Applicable to APNPs Providing Services as Part of the Hospital’s APNP Hospitalist Pilot Program

APNPs who have the requisite qualifications and training to provide services as part of the Hospital’s APNP Hospitalist Pilot Program (“Pilot Program”) are permitted to provide services to Hospital inpatients in accordance with granted clinical privileges and subject to Pilot Program policies and procedures.

APNPs operating within the context of the Pilot Program will have a collaborating physician who is a member of the Medical Staff at ERMH, and be subject to the qualifications, prerogatives, and obligations contained herein.

As an independent-AHP member of the Allied Health Staff, APNPs within the Pilot Program may admit and treat inpatients without physician supervision and serve as the principal attending practitioner of record, but will seek physician consultation and collaboration as required by standards of medical and nursing practice and in accordance with Pilot Program policies and procedures.

[...]

Part Two: Application Procedure for Allied Health Professionals

[...]

Source: Ministry Medical Group, Milwaukee, WI; Medical Group Strategy Council interviews and analysis.
Indiana University Health Physicians

AP Deployment Decision Tree

Decision Tree for New Advanced Provider Need

1. **What is the clinical and/or process need?**
   - Examples:
     - Improve throughput
     - Increase volumes
     - Expand new services
     - Provide procedures
     - Declining revenue

2. **Is the NP the only non-physician provider that can fill this need?**
   - Core competencies:
     - Assess
     - Diagnose
     - Order
     - Prescribe
     - Perform procedures
     - Bill

3. **$**
   - How much will it cost?
   - Who will pay?
   - What is the ROI?
   - Complete analysis request:
     - Pro forma
     - Payer mix
     - Salary support
     - Productivity measures
     - Billing status (biller/non-biller)

4. **Acquire formal approval**
   - Submit IUHP Executive Approval form

5. **Approved—Next steps**
   - Create position
   - Examples:
     - Improve throughput
     - Increase volumes
     - Expand new services
     - Provide procedures
     - Declining revenue

Source: Indiana University Health Physicians, Indianapolis, IN; Medical Group Strategy Council interviews and analysis.
Indiana University Health Physicians

AP Intent to Recruit and Hire (Part 1: Instructions)

Intent to Recruit and Hire

Goals: Strategic Planning for Service Lines
Set Clear Expectations, Plan Capital Investments, Plan Expense Requirements, Manage Productivity Expectations

I. Description of Strategic Justification
   a) Why is the position being requested?
   b) Include financial and operational consequences if position is not approved.
   c) Capacity considerations including market need.

II. Business Plan
   a) Three-year business plan including production, revenue, and expense assumptions.
   b) Include necessary incremental ongoing support or operational expenses.
   c) System value to be calculated and added by IUH Decision Support.

III. Practice
   a) State intended practice locations including OR or surgery center locations.
   b) Note physician office location(s).
   c) Note practice capital requirements such as equipment, build-out, new space, etc.
   d) Note system capital requirements.

IV. Additional Considerations
   a) Note if position requires academic or research support or resources.
   b) Note any partnership or affiliate considerations such as partial VA appointment, IUH system need, etc.
Indiana University Health Physicians

AP Intent to Recruit and Hire (Part 2: New Hire Details)

REVENUE

A. 1. Payer distribution as follows:
   2. Fee schedule and collection process are based on IUHP approved fee schedule, IUH revenue cycle
      historical collections for this specialty
   3. Productivity for a FTE approx _____ wRVUS
      Anticipated productivity of new APP in this location is _____ work RVUs the first 6 months; _____ wRVUs the
      next 12 months, _____ wRVUs the next 12 months.

B. Based on historical experience concerning payer mix and procedure distribution, the Plan assumed a __% net
   collection rate based on ___________; (i.e., gross charges net of contractuals and bad debt).
   $_____ per wRVU based on IUHP fee schedule
   Gross charges were reduced to 90% of physician per wRVU based on Anthem and Medicare lower fee schedules
   for APPs

EXPENSES

A. APP Salary
   1. The APP will be a 1.0 clinical FTE and his/her salary will be . . . $ -
      a. IUHP Component 100%
      b. IU Component 0%

B. Support Staff
   a. X Medical Assistant to start with new APP
   b. X Clinical Service Specialist (front desk)

C. Benefits/Univ Fringe
   1. IUHP Benefit 25%
   2. IU Benefit %
   3. CME
      a. 2000 per year
   4. Malpractice
      a. APP annual amount estimated to be $XXXX

D. Medical Supplies are $X per wRVU based on service line budget; Office supplies based on service line budget

E. Billing Fees - 5% of net collections

F. Utilities, Rent and Maintenance - no additional material expenses as this is an add to an existing practice
### Incremental Loss for adding 1.0 FTE APP to IUH West Hospital

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
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<td></td>
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<tr>
<td>Gross Patient Revenue</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Less: Contractuals/Bad Debt</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Patient Revenue</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
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<td></td>
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<tr>
<td>APP Salary</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Physician Compensation</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Recruiting expenses</td>
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<tr>
<td>Medical support salaries</td>
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<td>Administrative staff</td>
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<tr>
<td>IUHP fringe</td>
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<tr>
<td>University fringe</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>Office supplies</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Medical supplies</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CME</td>
<td>1,000</td>
<td>2,000</td>
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</tr>
<tr>
<td>Malpractice insurance</td>
<td>-</td>
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<tr>
<td>Utilities, Rent, Maintenance</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>1,000</td>
<td>2,000</td>
<td>2,000</td>
</tr>
<tr>
<td><strong>(Deficiency) of Revenue over Expenses</strong></td>
<td>(1,000)</td>
<td>(2,000)</td>
<td>(2,000)</td>
</tr>
<tr>
<td>wRVUs</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
IUHP Executive Physician Recruitment Approval

I. Service Line Approval

Position/Specialty: _______________________
Department: _______________________
☐ This position has been approved under the IUHP physician manpower plan.
☐ This position has been approved under the Riley manpower plan.
Funding Approval: _______________________
(Attach approved pro forma.)
☐ This is a replacement (If replacement during same calendar year with same clinical effort and Service Line resides within IUHP, only need service line leader signature if currently meeting budget expectations.) SL Leader Signature:
☐ Outside entity funding: Funding Approval: _______________________
☐ Vice President/Service Line Chief/For Medical Director has presented a business plan request to IUHP leadership to initiate the physician recruitment process.

*If there are less than 90-120 days lead time for Provider Enrollment/Credentialing completion prior to this Physician’s billing start date, Service Line Leader and/or Department Chair acknowledges that the associated Practice billing revenue may be at risk for delayed reimbursement and/or complete forfeiture.*

II. Executive Approval

Advanced Provider Administrator, IU Health Physicians 
Date _______________________

COO, IU Health Physicians 
Date _______________________

CEO, IU Health Physicians 
Date _______________________

CME, IU Health Physicians 
Date _______________________

IUSOM Corporate Administration 
Date _______________________

III. Financial Approval

CFO, IU Health Physicians 
Date _______________________

Please note: IUHP will not begin the recruitment process or execute a contract without this signed and executed agreement.
### FY 2013 Scorecard

#### Pillars

<table>
<thead>
<tr>
<th>Metric</th>
<th>MIN</th>
<th>Target</th>
<th>MAX</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICU Metrics</td>
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<tr>
<td>SICU Admissions Rates</td>
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<tr>
<td>SICU Re-Intubation Rates</td>
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<tr>
<td>VAP Incidence</td>
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<tr>
<td>ED Metrics</td>
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<td></td>
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<tr>
<td>ICU Length of Stay</td>
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<tr>
<td>ICU Ventilator Days</td>
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<tr>
<td>Implementation of DVT Prophylaxis</td>
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<tr>
<td>ICU Metrics</td>
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<tr>
<td>Catheter-associated infections</td>
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<tr>
<td>Foley Discont. w/ 48h Surg Intervention</td>
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<tr>
<td>Handwashing Compliance</td>
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<tr>
<td>RVU Targets</td>
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<tr>
<td>Client Metrics</td>
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<tr>
<td>Chart Completion Compliance</td>
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<tr>
<td>Healthstream Education Compliance</td>
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<tr>
<td>Patient Satisfaction</td>
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</table>

Source: University of Mississippi Medical Center, Jackson, MS; Medical Group Strategy Council interviews and analysis.
Wenatchee Valley Medical Center

Physician-AP Supervision Agreement

ADVANCED PRACTICE CLINICIAN (APC) PRACTICE PLAN

All practice plans should be tailored to the education, training, experience, and expected duties of the APC.

Name:

1. Designation of Supervising Physician:
   Primary:_________________________Alternate(s):_________________________

2. Scope of Practice:
   Patient population in general:
   Specialty emphasis:
   Specific target patient population:
   Exclusions and limits:

3. Expected interactions between the APC and supervising physician:
   Please include these elements in the box below:
   Setting of APC practice and how it is related to that of the supervising physician.
   Frequency and intensity of interaction expected during the course of the working day or week. For APCs practicing remotely from supervising physician, specify methods of communication between the APC and supervising physician.

4. Please include these elements in the box below, as detailed as felt to be appropriate, of scenarios where discussion with the supervising physician will be expected and/or a physician visit required, such as:
   Specific problems or diagnoses, specific time intervals (e.g., physician visit or case review, for example), when in the time course of unsolved diagnostic problems or treatment failures.

5. Quality Assurance Plan. Please include these elements in the box below:
   Specifics of review: Who, how often, how many, how selected?
   Assessment of APN bedside and procedural skills: Who, how often?
   How will the above be recorded and tracked?

6. Please include these elements in the box below:
   Expected impact on department performance:
   Clinical and quality: Revenue, Overhead, and Productivity.

Advanced Practice Clinician’s Signature: ________________________________
Printed Name: ________________________________ Date: ________________

Manager Signature: ________________________________
Printed Name: ________________________________ Date: ________________

Physician Manager Signature: ________________________________
Date: ________________

Credentialed Committee Signature: ________________________________
Date: ________________

Source: Wenatchee Valley Medical Center, Wenatchee, WA; Medical Group Strategy Council interviews and analysis.
## NP Performance Evaluation Tool

**Name:**

**Title:**

**Date of Review:**

**Department:**

### PART 1 – PERFORMANCE EXPECTATIONS and MEASUREMENTS

Please assess staff competence against the performance factors below. Use the space provided at the end of each section to comment or explain your ratings. Performance factors < 2 need to be incorporated into Part 2, with agreed upon goals for improvement.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Excellent/Exceptional</td>
</tr>
<tr>
<td>4</td>
<td>Exceeds Standards</td>
</tr>
<tr>
<td>3</td>
<td>Meets Standards</td>
</tr>
<tr>
<td>2</td>
<td>Needs Improvement</td>
</tr>
<tr>
<td>1</td>
<td>Unsatisfactory/Does not meet</td>
</tr>
</tbody>
</table>

Consistently performs in an exceptional manner that far exceeds performance standards  
Performs in a manner that exceeds expected performance standards  
Consistently performs in a manner that meets expected performance standards  
Performs in a manner that needs improvement—identified area for growth  
Performs in a manner that does not meet expected performance standards

### Staff Expectations and Performance Measures

**Job Summary:** The Nurse Practitioner (NP) works in a collaborative relationship with a physician provider to oversee the care delivered to a patient population. The NP is responsible for direct patient care, documentation of care delivered, adherence to hospital and nursing policies, procedures and practice standards, education of patients and staff, assurance of service excellence, completion of state and hospital-required reviews of practice, and participation in performance improvement and other activities as required.

**Minimum Qualifications and Position Expectations:** Checking YES indicates that item is met and that copies of required documentation or proof of completion, are present in portfolio.

<table>
<thead>
<tr>
<th>Performance Expectations</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York State license as a Registered Nurse</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Updated CV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New York State license as a Nurse Practitioner</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Mandatory reporting timely and complete.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Certification as a Nurse Practitioner</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Self evaluation is complete and used as a basis for the development of professional goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attendance/Punctuality is at or above acceptable level.</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Self portfolio meets minimal requirements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual mandatory inservices are complete (University).</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>SON appointment letter (If applicable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPR BLS certification is current.</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Infection Control up to date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACLS/PALS/NRC/PEARS is current (if required in clinical area)</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Quarterly chart reviews submitted on time to Associate Director’s office.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual education record is complete, with tally of contact hours, and a printed copy is available</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Credentialing up to date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copy of last year’s goals in portfolio</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Practice agreement with collaborating physician updated as needed.</td>
<td></td>
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</tr>
<tr>
<td>Payer and regulatory documentation standards consistently met.</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
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</tbody>
</table>

### Overall Performance Rating

- 5 Excellent/Exceptional
- 4 Exceeds Standards
- 3 Meets Standards
- 2 Needs Improvement*
- 1 Unsatisfactory/Does not meet* (*Developmental Plan attached)

**Self Evaluation:**

**Overall Evaluator Comments:**

**Signatures:**

- **Staff:**
- **Associate Director:**

**Date:**

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Source: Office of Nursing Accreditation and Advancement, University of Rochester Medical Center, Rochester, NY; Medical Group Strategy Council interviews and analysis.
University of Rochester

NP Performance Evaluation Tool (Cont.)

**Evaluation process**
The evaluation process is a method for each nurse practitioner to provide supportive documentation. Since each nurse practitioner’s practice is so diverse, a variety of matrices are provided to utilize in the process. It is up to each nurse practitioner to submit the required documentation to the evaluator in order to complete the evaluation process. Each nurse practitioner will have a multidisciplinary 360 evaluation. **Additional items may be considered and should be discussed with the person doing your evaluation.**

**Clinical practice and service (60% of total evaluation score)**

For this section you must document a total of 4 elements; one clinical productivity, one quality/safety, and one patient/family centered care plus an element of your choice. This will qualify you for a score of 3 for this section of the evaluation. Documentation of 4 additional items from any section will qualify for a rating of exceeds (4). Documentation of 4 additional items from any section will qualify for a rating of exceptional (5).

Score:
- 3 (1 item from each of the 3 categories plus 1 item from any category)
- 4 (1 item from each of the 3 categories plus 3 items from any category)
- 5 (1 item from each of the 3 categories plus 5 items from any category)

Your portfolio needs to support the item you have chosen. Data from administrator on productivity/CMS measures.

**Clinical productivity (CP)**

1. Clinic productivity volume and/or revenue maintained or greater than previous year
2. Reduced LOS for patient population
3. Patient satisfaction scores improved or maintained at level of excellence
4. NP inpatient volume maintained or increased from previous year
5. Overall department volume increased by 3% for either inpatients or outpatients
6. Acuity/RVU assessment that suggests increasing acuity or workload
7. Other: as discussed with evaluator (free text in measure): *favorable billing audit, reducing day of surgery cancellations, increased admissions, increased number of procedures, increased discharges, etc.*

**Quality and safety/research (QS)**

1. Cite example of a solution for near miss episode
2. Cite example of improved access to care because of NP intervention
3. Cite example of improved access to medication because of NP intervention
4. Cite example of NP intervention that avoided a hospital admission
5. Cite example that NP supported achievement of core measures/meaningful use
6. Cite example of clinical activities that support service needs
7. Cite example of complex care coordination
8. Cite example of managing transitions in care across environments of care
9. Unit discharge before noon > 30%
10. Participates in the collection of data or initiating a program for a quality improvement or research study
11. Assists with the identification and enrollment of research subjects
12. Principal, co-investigator, or study coordinator in a research study
13. Attend the Patient Safety Course
14. Successful outcome of compliance review for documentation
15. Cite an example to demonstrate that you are recognized as an expert in your area of practice.
16. Other: as discussed with evaluator (free text in measure)

**Patient and family centered care (PFCC)**

1. Strong Stars, patient letters, emails, and cards
2. Unit Press Ganey scores > 90th percentile
3. Service Press Ganey scores > 90th percentile
4. Clinic Press Ganey scores > 90th percentile
5. An example of a situation where behavior was consistent with URMC ICARE Values
6. Participation in a URMC initiative to address PFCC
7. Attend the Crucial Conversations course
8. Other: as discussed with evaluator (free text in measure) *TEAM Steps, frequent attendance/participation in patient safety rounds*

Portfolio Score (Clinical Practice and Service) _________
University of Rochester
NP Performance Evaluation Tool (Cont.)

Professional development (30% of total evaluation score)
*Rating indicators

Previous year’s goals achieved:
1. no goals*.
2. partially met*.
3. met goals*.
4. exceeded goals.*
5. met own goals and mentored others to achieve theirs.*

Participation in providing continuing education.
1. no in-services.*
2. provided informal education *
3. 1 -- 2 in-services in-house or locally or present a lecture in SON/SOM (not supported by salary)*
4. 3 -- 4 in-services in-house or #3 plus 1 or 2 local presentations or precepted a student.*
5. 5 or greater in-services in-house or #3 plus 1 national presentation or publication in a journal.*

Membership in professional organization or active participation in Hospital/Service Committee.
1. none.*
2. this rating is not available for this measure*
3. member in at least 1 professional organization/hospital or service committee.*
4. #3 plus active locally or serve as a mentor or committee chair.*
5. #3 plus active nationally.*

Meets contact hour requirements .
1] < 20.*
2] 21 to 49.*
3] 50 to 55.*
4] 56 to 60.*
5] >61*

Portfolio Score (Professional Development) (10% of total evaluation score)

---

***Any other activity negotiated with evaluator

Scoring
Score for Clinical Practice and Quality/Safety/PFCC(Score1):____________ (60%)
Score for Professional Development (Score 2):_________________________(30%)
Score for strength of portfolio (Score3):_______________________________(10%)
Total Score:______________________________________________

Excellent/Exceptional (4.6 – 5.0) Consistently performs in an exceptional manner that far exceeds performance standards
Exceeds Standards (3.6 – 4.59) Performs in a manner that exceeds expected performance standards
Meets Standards (2.6 – 3.59) Consistently performs in a manner that meets expected performance standards
Needs Improvement* (1.6 – 2.59) Performs in a manner that needs improvement—identified area for growth
Unsatisfactory/Does not meet* (1 – 1.59) Performs in a manner that does not meet expected performance standards

Source: Office of Nursing Accreditation and Advancement, University of Rochester Medical Center, Rochester, NY; Medical Group Strategy Council interviews and analysis.
## PART 2 – PROFESSIONAL GROWTH

### Advanced Practice Nurse Expectations & Performance Measures

<table>
<thead>
<tr>
<th>Personal/Professional Goals and Collaborative Service Goals: (These become targets of measure for coming year evaluation)</th>
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### Discussion of Goals:

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### Career Planning

**Personal Growth /Career Planning**

**1** Interaction with Others/Communication: Flexible and willing to listen to ideas that are different from their own in order to promote understanding. Use effective listening, verbal, and written skills to provide necessary information clearly and in a timely fashion.

**2** Customer Service: Focuses on understanding, meeting, and exceeding customer expectations and includes attention to sensitivity and responsiveness to individual needs.

**3** Expertise/Continuous Learning: Demonstrates knowledge and skills related to the functional area and exhibits commitment to developing personal abilities.

**4** Resourcefulness/Results: Uses available resources to assist in day-to-day operations and to produce quality products/services.

**5** Personal Accountability: Takes responsibility for own work in completing tasks and maintaining a safe, clean environment.

*University of Rochester Medical Center Core Competencies/Standards for Customer Service*

### Strong Memorial Hospital
#### DEPARTMENT OF NURSING PRACTICE
##### Age-Specific Performance Evaluation

(Please check those patient populations that apply to your practice and evaluate performance of age-specific patient assessments)

<table>
<thead>
<tr>
<th>Neonatal / Infant  (Birth – 12 Months)</th>
<th>Toddler / Preschool  (13 months – 5 years)</th>
<th>School Age  (6 – 12 years)</th>
<th>Adolescent  (13 – 18 years)</th>
<th>Adult Patient Population  (19 – 64 years)</th>
<th>Geriatric  (65+ years)</th>
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<tr>
<td>1. Includes physical and psychological development characteristics in assessment and treatment plan.</td>
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<td>2. Assures that IV rate and medication doses are appropriate for weight/condition.</td>
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<td>5. Adheres to Pediatric Safety Standards.</td>
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- **Meets**
- **Does not meet**

* Requires comments/developmental plan

Source: Office of Nursing Accreditation and Advancement, University of Rochester

Medical Center, Rochester, NY; Medical Group Strategy Council interviews and analysis.
DeKalb Medical Group

Director of Allied Health Job Description

Job Summary: The Allied Health Professionals (AHP) Medical Director of Operations reports directly to the VP of DMPG. The role is to be part-time administrative and part time clinical. The administrative duties comprise the following:

Job Responsibilities:
1. Supervision of all DMPG employed AHP.
2. Recruitment and Retention making DMPG the preferred place for AHP to practice.
3. Responsible for making sure all AHP are complying with all federal and state laws.
4. Responsible for making sure all AHP are complying with all payer specific billing rules.
5. Mentoring both new AHP and physicians new to the use of AHP to ensure the highest quality and most efficient practice use.
6. Design and implement a new incentive based compensation and benefit plan for AHP.
7. Design and implement an incentive based compensation plan for supervising physicians to encourage the use of AHP.
8. Design and Implement a quality monitoring program to ensure the highest standards of care are being provided.
9. Performs other duties as assigned to meet the goals and objectives of DeKalb Medical.

Patient Population Served (check all that apply):
Infant________ Pediatric_________ Adolescent________ Adult_________ Geriatric________

Skills, Knowledge and Abilities: (examples only; update as needed)
1. Skill and ability to communicate verbally, including public-speaking, and in writing
2. Skill and ability to make decisions and solve problems by identifying creative options and/or solutions
3. Skill and ability to effectively manage multiple tasks and priorities within a fast-paced environment
4. Skill and ability to plan and organize and manage multiple projects
5. Skill and ability to anticipate, manage, and adapt to change
6. Skill and ability to operate independently and collaboratively as part of a team
7. Knowledge and skill to gather and summarize data from multiple sources and analyze using common statistical functions
8. Skill and ability to manage internal and external relationships
9. Skill and ability to lead and take initiative

Minimum Education, Experience and Licensure Required:
Currently licensed as a PA or NP in the state of Georgia
Minimum 5 years of experience

Reporting Relationships: The position reports to the VP of DMPG

DeKalb Medical job descriptions are used to complete annual performance evaluations