




# Overview of APP deployment models

## Design APP roles to advance organizational goals

Organizations should deploy all APPs autonomously to support group business goals. This means moving away from physician-driven deployment to a centralized model where APPs practice as providers alongside physicians. While they may co-manage a panel with a physician, APPs should see and treat patients independently, acting as a provider in their own right. Below we've outlined three common models for deploying APPs to support access, population health, and new business goals. While you will likely deploy APPs in all three models below, the decision about whether and how to deploy APPs should be standardized at the group, specialty, or practice level—not determined by individual physicians.

## Deployment models in brief

Goal	 <i>Model 1: Access</i>	 <i>Model 2: Population Health</i>	 <i>Model 3: New Business</i>
Details	<ul style="list-style-type: none"> <li>Gets patients into the practice faster to access care</li> <li>Patient sees physician or APP based on time and availability</li> </ul>	<ul style="list-style-type: none"> <li>Encourages an ongoing relationship with single provider</li> <li>Patients are primarily assigned to one provider based on risk or condition</li> </ul>	<ul style="list-style-type: none"> <li>Minimizes cost and risk for entry into new market or service</li> <li>APPs manage their own patient panel in new markets or specialties</li> </ul>
Good for groups with	<ul style="list-style-type: none"> <li>Long wait times</li> <li>APPs with excess capacity</li> </ul>	<ul style="list-style-type: none"> <li>High volume of chronic or complex patients</li> <li>Large percentage of revenue tied to value-based contracts</li> </ul>	<ul style="list-style-type: none"> <li>Growing geographic footprints</li> <li>Large growth targets</li> </ul>
Implementation guidance	<ul style="list-style-type: none"> <li>Allow patients to select primary care provider</li> <li>Position APPs to do intake visits for low-acuity specialty conditions</li> <li>Establish process to transfer patient to physician when clinically necessary</li> <li>Educate patients about care team model and APP's role</li> </ul>	<ul style="list-style-type: none"> <li>Use risk score or condition to assign patients to a single provider</li> <li>Establish parameters for when change in providers is warranted</li> <li>Deploy APPs with coaching, care management expertise, and niche experience</li> <li>Consider investing in supplemental training</li> </ul>	<ul style="list-style-type: none"> <li>Determine whether there is a business case for entry into a new market</li> <li>Deploy experienced APPs who require minimal supervision</li> <li>Make sure that deployment and supervisory arrangements comply with state regulations</li> </ul>
Expected results	<ul style="list-style-type: none"> <li>Increased productivity</li> <li>Decreased time to next available appointment</li> </ul>	<ul style="list-style-type: none"> <li>Higher patient experience scores</li> <li>Improved chronic disease management</li> </ul>	<ul style="list-style-type: none"> <li>Increased growth in new markets and/or services</li> <li>Higher APP job satisfaction</li> </ul>

Source: Advisory Board interviews and analysis.

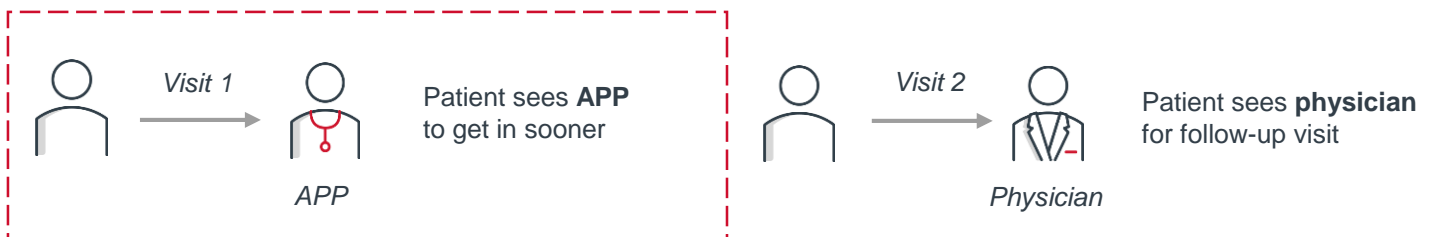
# Access: Get patients into the practice faster

Deploying APPs to maximize access means proactively scheduling visits with the APP based on availability and patient preference—not positioning APPs to just take overflow from the physician’s schedule. APPs and physicians share the panel and either provider can see patients for their care, often prioritizing the flexibility of the APP’s schedule to get patients in as quickly as possible. We see APPs deployed to improve access in both primary and specialty care.

## Primary care: Empower APPs to see all patients and let patients pick their provider for each visit

### CASE EXAMPLE

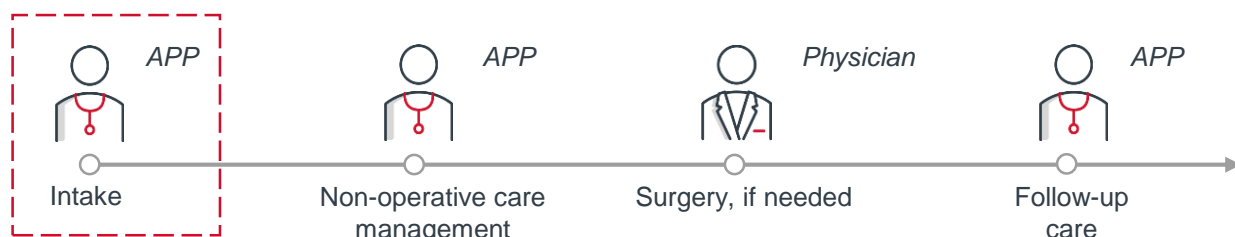
At **Metro Health**, PCPs work in teams with one or more APP. APPs are positioned to see and treat all patients in primary care so it’s up to the patient to pick the provider they want to see based on their availability and personal preferences. Oftentimes, patients schedule with the APP when they want to be seen quickly due to more availability in APP schedules. To ensure that more complex patients have some touchpoints with the physician, Metro Health put a few safeguards in place. First, APPs can escalate any visit to the physician if necessary. Second, nurses mine registries to identify patients with multiple chronic conditions who haven’t seen the physician in 12-18 months. Then, they proactively schedule a well visit with the physician.



## Specialty care: Position APPs to perform intake visits for low-acuity specialty conditions

### CASE EXAMPLE

At **Syracuse Orthopedics Specialists**, spine patients were waiting a long time to see a physician. Once these patients got in, physicians ended up sending most to the APP for ongoing management because they didn’t need surgery right away. Instead of making patients wait to see a physician, Syracuse Orthopedics positioned APPs to take all initial consults for spine patients. After an assessment, APPs either keep the patient for symptom management or refer them to the physician for surgery. In this model, patients get in sooner, APPs are more satisfied in their roles, and physicians aren’t wasting time on patients who aren’t yet ready for surgery.



Source: Metro Health/University of Michigan Health, Wyoming, MI; Syracuse Orthopedic Specialists, Dewitt, NY; Advisory Board interviews and analysis.

# Population health: Encourage relationship with one provider

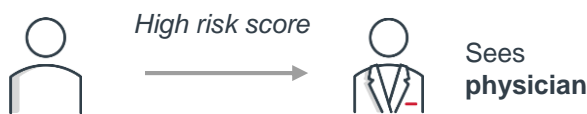
Similar to the access model, APPs and physicians share the panel in the population health model. However, rather than seeing both providers for their care, patients are primarily assigned to either the APP or physician. This encourages an ongoing relationship with a single provider that can be helpful for care planning and management. Organizations can assign patients to their primary provider based on either risk or condition.

**Risk:** Assign patients to see either the physician or APP based on risk score

## CASE EXAMPLE



**Penn Medicine Clinical Care Associates** uses a risk score calculated after the patient's initial visit to triage patients to a single provider—either the APP or physician—for ongoing care. They also take into account patient preferences and provider discretion when assigning patients. In this model, physicians typically provide care for patients with high risk scores, while APPs continue seeing patients with low risk scores. Patients largely stay with the same provider for the duration of their care, creating a long-term relationship with a single provider. However, if there's a significant, sustained change in risk score, patients may switch providers.

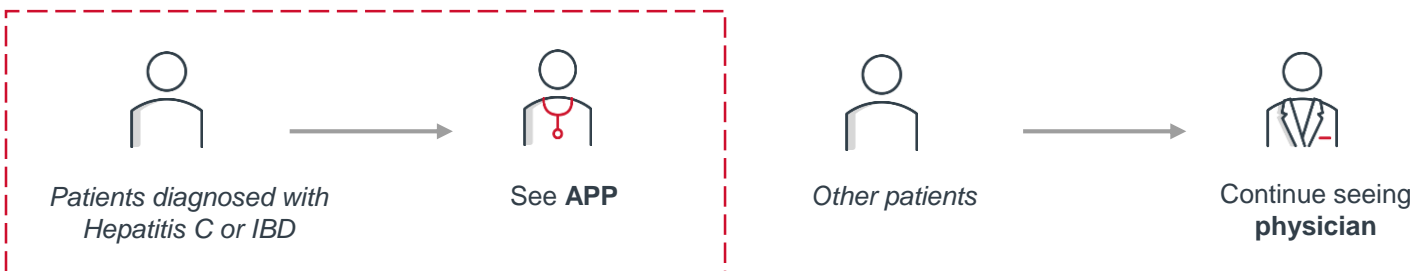


**Condition:** Position APPs to provide ongoing care for patients with certain conditions

## CASE EXAMPLE



All patients at **GI Associates** see a physician for their initial visit to establish a diagnosis and treatment plan. Then, those diagnosed with IBD<sup>1</sup> and Hepatitis C are assigned to an APP for ongoing care management. To make this work, physicians chose diseases that require a lot of patient education, and where ongoing management is largely protocol-driven. Leaders found that these ongoing patient education roles appealed to APPs and allowed them to work autonomously while better managing these patient populations.



1. Inflammatory Bowel Disease.

Source: Penn Medicine Clinical Care Associates, Philadelphia, PA; GI Associates, Milwaukee, WI; Advisory Board interviews and analysis.

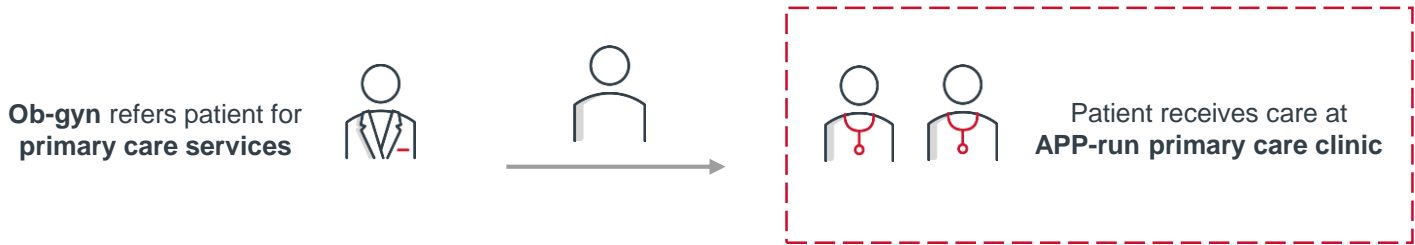
# New business: Expand into new markets and services

In the new business model, organizations can deploy APPs to test out a new market or service line and ramp up capacity in a more cost-effective manner. Unlike the previous two models, APPs manage their own panel instead of sharing one with a physician. APPs in this model are usually very experienced in their roles so that they can see patients autonomously with minimal supervision from physicians.

**New services:** Leverage APPs as a lower cost, lower risk provider to pilot new services

## CASE EXAMPLE

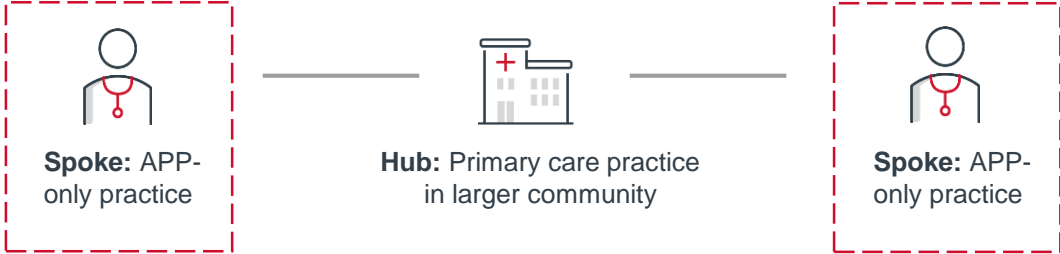
**Women’s Health CT** found that many patients were using their ob-gyn as their PCP and looking for additional services from their practice. To support these patients, they opened an APP-run primary care clinic across the hall from one of their ob-gyn practices. Two APPs run the clinic which takes walk-ins and referrals from Women’s Health CT’s ob-gyns. This arrangement allowed the group to move into the primary care space and based on early success they plan to scale the model to other specialties that they currently don’t offer such as behavioral health.



**New markets:** Deploy APPs in new markets to expand organization’s footprint at lower cost

## CASE EXAMPLE

**OSF Medical Group** expanded their geographic footprint by deploying APPs in new, rural markets using a hub-and-spoke model. In this model, hub practices serve larger communities with multiple physicians and APPs, and spokes serve rural communities with a dedicated APP. APPs at the spoke clinics can connect with PCPs at the hub for necessary support but these practices are primarily run by APPs with significant clinical experience. OSF has found that it’s often easier to hire APPs in these markets and it allows them to expand into new regions at a lower cost. Depending on state regulations, organizations can adapt this model by having a physician rotate through each spoke site for supervision once a week.



Source: OSF Medical Group, Peoria, IL; Women’s Health CT, Avon, CN; Advisory Board interviews and analysis.