OUR TAKE
for Physician Executives

Deploying APPs Autonomously

Treat APPs more like physicians to maximize ROI

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While organizations are employing advanced practice providers (APPs) in growing numbers, many rely on physician-driven pilots that result in APPs practicing below top-of-license and turning over. To realize their full potential, organizations must deploy all APPs as autonomous providers.

To achieve this, organizations should align many aspects of APP deployment, training, compensation, and leadership more closely to that of physicians.

Advisory Board

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The conventional wisdom

The APP workforce is growing rapidly. According to data from the Bureau of Labor Statistics, APPs are projected to be one of the fastest growing health care roles across the next ten years, outpacing the average growth rate across health care occupations—even physicians.[1]

Despite this increase in hiring, most organizations fail to deploy APPs to their full potential. Physicians often dictate deployment models and determine their working relationship with the APPs on their care team. This physician-driven approach means that, while some practices or specialties may use APPs autonomously, more often than not APPs work below top-of-license, seeing overflow patients and being used in "extender" roles.

Overall, this approach causes two problems:

Missed profit and productivity: According to one Advisory Board member, medical groups lose about $50 for every primary care visit that's conducted by a physician that could've gone to an APP. Put differently, across the year, that's almost 1,500 lost wRVUs for every primary care physician who doesn't work with an APP.[2]

Increased turnover: At the same time, APP turnover is on the rise. Working below top-of-license is disengaging, which explains why almost 10% of APPs change jobs annually. And this turnover is costly. According to Advisory Board research, the cost to replace an APP is about $115,000 in primary care.[3]

Up to this point, fragmented, physician-driven APP deployment has limited the ROI of these care team members.

1. According to U.S. Bureau of Labor and Statistics projected growth rates for 2018-2028.
2. Lost wRVUs found by calculating the difference between the number of wRVUs generated by a physician who works with an APP and the number of wRVUs generated by a physician alone in family and internal medicine according to Advisory Board's Integrated Medical Group Benchmark Generator.
3. Advisory Board analysis suggests the cost to replace an employee that has turned over is 50% to 150% of annual salary. The cost of one APP turning over represents 100% of average APP salary in family and internal medicine according to Advisory Board's Integrated Medical Group Benchmark Generator.

Source: "Occupational Outlook Handbook," *U.S. Bureau of Labor Statistics;* Integrated Medical Group Benchmark Generator, Advisory Board; Advisory Board interviews and analysis.

Autonomy [aw-ton-uh-mee] *noun*

While autonomous APPs may co-manage a panel with a physician, they see and treat patients independently during the visit—acting as a provider in their own right.

Provider [pro-vid-] *noun*

In the following pages, we use the term "provider" to refer to both physicians and APPs who diagnose and treat patients, serving as a patient's primary caregiver.

Our take

Organizations must deploy APPs autonomously to fully capitalize on their value. APPs can perform many of the same tasks as physicians usually at less than half the salary[1]—making them an indispensable care team member for delivering high-value, cost-effective care. 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.

	Conventional wisdom: Physician-dependent APP roles	Our take: Autonomous APP roles within care team
		
Visit	Physician determines APP role in the visit	APP sees patient independently during the visit
Panel	Physician manages panel, offloads patients and tasks to APP	Physician and APP co-manage the panel

Regardless of state regulations, market dynamics, or specialty, all APPs can—and should—work autonomously. Not only does this increase productivity and top-of-license practice, but autonomous roles are also more engaging for APPs, thereby reducing turnover costs. How much autonomy organizations grant their APPs is directly linked to ROI. To lock in this autonomy, leaders should shift to a centralized strategy for APP hiring, deployment, and oversight, as opposed to the current physician-driven approach.

1. For example, average APP compensation is $116,133 compared to $258,777 for physicians in internal medicine according to Advisory Board's Integrated Medical Group Benchmark Generator.

Source: Integrated Medical Group Benchmark Generator, Advisory Board; Advisory Board interviews and analysis.

Terminology considerations

We use the more comprehensive term “APPs” throughout our work, but focused our research primarily on nurse practitioners (NPs) and physician assistants (PAs). However, many of the approaches discussed in the following pages can be applied across all types of APPs.

Regulatory considerations

Laws governing APP scope-of-practice and supervision requirements vary across the country. Though we do not comment on these regulatory considerations in our research, organizations should be able to implement the following best practices regardless of their state’s regulatory landscape.

Four components of an autonomous APP model

In order to maximize the ROI of their APPs, leaders must deploy them more like they do their physicians. In the following pages, we introduce a four-part model that promotes APP autonomy and discuss how APPs should be approached the same as—and different from—physicians.

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01 Standardized roles that advance strategic goals

First, design standard APP roles that support organizational—not individual physician—goals. This means moving from physician-driven pilots to more codified roles that align to the metrics that matter most to group success.

Align APP role with organizational goals

You won't use APPs the same way in every practice or specialty. But the decision about whether and how to deploy an APP should be removed from individual physicians and elevated to the practice-, specialty-, group-, or even system-level. Just as physician hiring, recruitment, and deployment is centralized to support the organization's larger strategy, the same should hold true for APPs.

Organizations predominantly deploy APPs to support three common goals:

Three goal-driven deployment models

Goal	 Access	 Population health	 New business
Deployment principle	Get patients into the practice faster	Encourage ongoing relationship with single provider	Minimize cost and risk for expansion into new market or service
Details	Patient sees physician or APP based on availability	Patients primarily assigned to one provider based on risk or condition	APPs manage their own panel in new markets or services

While organizations most commonly deploy APPs to expand access, these providers are often an untapped resource for advancing population health goals. Given their background in patient education, APPs are well-suited to manage more complex patients when provided with adequate care protocols and training.

In addition, while APPs building out their own panels is mostly limited to rural markets and primary care for now, we expect APP-only panels and practices to become more ubiquitous in the future, providing organizations who act now with a first mover advantage.

Clearly defining APP ROI

Beyond designing roles that advance strategic goals, teams must be held accountable for how they deploy their APPs. While some local variation is expected, wide variation in roles shouldn't exist across the organization.

Organizations should establish mechanisms that reinforce standard APP roles. One way to do this is by clearly defining metrics of success *prior* to hiring and deploying APPs—and holding teams accountable for meeting them. For example, some organizations set a baseline productivity target that the care team must meet. Others require that practices submit a full business case to justify hiring another APP. Setting a group standard like this reinforces the business objective for deploying APPs and ensures that leaders see ROI.

02 Centralized onboarding and clinical training

Most leaders would agree that there's a gap between the skills APPs graduate with and those they need to practice autonomously. While physicians receive additional training via residencies and fellowships following medical school, these programs are rare for APPs. To equip APPs to take on autonomous roles, organizations must provide this supplemental training themselves.

Organizations should take a centralized approach to prepare APPs for provider roles in two key areas: group onboarding and clinical training.

Combine physician and APP onboarding

Rather than develop two separate programs, onboard your physicians and APPs together. As APPs take on roles more similar to physicians, onboarding them together better sets expectations for your provider workforce as a whole on important topics such as group culture and workflow processes. To incorporate APPs into your existing program, use the same curriculum and timeline, but pair APPs with APP mentors and physicians with physician mentors.

Greater investment needed in clinical training

While organizations can incorporate APPs into existing physician onboarding programs, recently graduated APPs require additional training on clinical skills not needed by newly hired physicians. Often, this clinical training is left to individual physicians. While leaders often believe that physicians are best equipped to train APPs given their clinical expertise, physician-led training is often resource-intensive and inconsistent.

Instead, leaders should invest in an organization-wide approach for training APPs to streamline physician workload and ensure more consistent skill development. While the exact model varies by organization, there are four key components of any successful APP training program:

- **Scaled training program:** Train APPs in an organization-wide program, not by individual physicians.
- **Defined core and specialty competencies:** Determine the skills and knowledge APPs must demonstrate.
- **Personalized skill-gap analysis:** Tailor training to the areas where APPs need the most support.
- **Standardized signoff process:** Create an objective process for assessing APP readiness to practice autonomously.

03 Performance-based compensation

Most APPs today are paid on a flat salary—with little or no bonus potential. Not only does this compensation approach fail to reward APPs for their contributions to group success, but it doesn't incentivize them on key performance indicators like productivity, quality, or patient experience that's expected from providers.

Shift APPs towards physician-like compensation

Organizations must pay their APPs like they do their physicians: on a performance-based compensation model. At a minimum, APPs should be paid a base salary with bonus potential. While bonus size may vary, all APPs should have some compensation tied to non-productivity metrics and be evaluated on the same metrics as physicians (e.g., patient experience, quality).

We're starting to see some organizations shift APP compensation to more closely mirror physician compensation—for example, paying providers a base salary linked to productivity, tying APP compensation to *group* performance metrics, and distributing shared savings to APPs.

Regardless of your specific organization's compensation model, compensation for APPs should look more like how you pay your physicians, not other staff or care team members. Not only does this more appropriately incentivize APP performance, but it better sets expectations and shared goals for your entire provider workforce.

04 Involvement in group governance

Despite investments in standardized deployment, centralized training, and performance-based compensation models, organizations will fail to maximize APP autonomy without involving them in governance. Representation in leadership roles ensures that APPs feel valued—improving their engagement and reducing turnover.

APP councils commonplace at most organizations

Most organizations start by creating an APP council. Not only does this make APPs feel like they have a dedicated forum to provide input, but it also empowers them to address concerns that are specific to APPs, like credentialing and scope-of-practice. Invite APPs from across the organization to serve on the council to ensure that diverse perspectives are represented.

Hiring a senior APP leader is the new baseline

While forming a council is a good entry point, by now, most organizations should already employ a dedicated APP leader to spearhead their larger APP strategy. Though frontline APPs may not have a direct reporting line to the lead APP, this leader should oversee the organization's entire APP enterprise, including the components discussed in this report, such as deployment, training, and compensation. As APPs become a growing percentage of the workforce, a leader like this becomes even more essential to spearhead strategy moving forward. Just as important, however, elevating an APP in this way is engaging to those on the frontlines.

Integrating APPs into organizational leadership

But it isn't enough to just create separate APP leadership structures. To fully realize their potential, leaders must integrate APPs into existing governing bodies as well. Not only does this move convey important signal value, but APPs often bring a different, valuable perspective to strategic conversations.

Inviting APPs to sit on committees is a good starting point—especially in areas where they have a growing impact such as quality, patient experience, and referral strategy. But APP involvement can't stop here.

Just like physicians, leaders must give APPs a seat at the table, fully integrating them into strategic governing bodies and providing them with appropriate representation. We're starting to see organizations elevate APPs to positions on boards and executive teams. Progressive groups are even adjusting the composition of leadership bodies to better reflect the proportion of APPs and physicians in their provider workforce. Again, the signal value is key, but just as important is the APP perspective, especially as they become even more central to the organization's success.

Parting thoughts

Organizations should consistently leverage APPs as autonomous providers, aligning their deployment, training, compensation, and leadership more closely to that of physicians. Each organization is likely at a different point with each of these four components, depending on their investment in APPs to date.

Your next step is to determine where to begin implementing this model.

In our experience, there isn't a single order of operations that works best. While it often makes sense to start with standardizing deployment, some organizations begin by revamping training or hiring an APP leader to spearhead this work. Fill out the brief diagnostic below to help you determine where to begin. We recommend focusing your efforts in the areas with 1-2 checked boxes.

Deployment:

- ❑ Individual physicians decide when to hire APPs and how to deploy them.
- ❑ APPs mostly see overflow visits from physician schedules and don't manage a panel.

Training:

- ❑ APPs are onboarded with practice staff and/or non-physician team members.
- ❑ Physicians spend more than two hours per week training new APPs.

Compensation:

- ❑ APPs have lower patient experience and/or quality scores than physicians.
- ❑ APPs have less than 5% of compensation tied to non-productivity metrics.

Leadership:

- ❑ We don't employ a senior APP leader to oversee our APP workforce.
- ❑ We don't have at least one APP on all governing bodies (e.g., committees, boards, executive teams)

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