APCs: an important primary care resource for value-based care

Advanced practice clinicians offer an important solution to the looming challenge facing health systems from a growing demand for primary care physicians amid a waning supply.

AT A GLANCE

> The numbers of advanced practice clinicians (APCs) have grown exponentially in recent years, adding to an important resource for health systems pursuing population health and value-based care strategies.
> Health systems are beginning to incorporate APCs into their clinically integrated networks to fill the primary care gap emerging from a growing shortage of primary care physicians.
> Although many have questioned the ability of APCs to deliver the same high quality of care as is expected of primary care physicians, studies have shown that a primary care practice’s quality of care can be improved by the inclusion of APCs.

Value-based contracting and population health programs require a combination of access, choice, efficiency, and reasonable price. These are essential business requirements for the more than 750 clinically integrated networks (CINs) and the accountable care organizations (ACOs) in the nation, which have been created to lead the transition from volume to value from government and commercial payers. Having an adequate supply of primary care providers, therefore, is essential to ensure CINs and ACOs can provide convenient access to care and effectively provide in-network care coordination with specialists, hospitals, post-acute care facilities, urgent care centers, and other points along the continuum of care.

The supply of primary care physicians, however, is stressed—particularly in rural and medically underserved urban areas.

Key findings in a 2016 American Association of Medical Colleges (AAMC) report on physician supply and demand indicate that the demand for physicians, driven mainly by population growth and aging, will grow faster than its supply over the next several years. The AAMC report concludes

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that, by 2025, the overall demand for physicians will exceed the supply by 46,000 to nearly 90,000 physicians, with the shortage of primary care physicians (excluding primary care trained hospitalists) amounting to about 15,000 to 36,000. This shortfall is concerning, because primary care providers are the lynchpin to success in population health and value-based care contracting.

The AAMC also concludes that the physician shortage will persist "under every combination of scenarios modeled," creating the need for "innovation in delivery, greater use of technology, improved efficient use of all health professionals on the care team, as well as increased federal support for residency training."

A Key Resource for Filling the Primary Care Gap

A potentially cost-effective means for provider organizations to improve the effectiveness and efficiency of their CINs in the delivery of value-based care is to integrate advanced practice clinicians (APCs) into their care delivery models. For organizations pursuing a population health approach, APCs practicing to the full extent of their licenses represent a potential solution to the primary care shortage, in that they can provide the additional clinical resources and support services required for success under such a value-based care approach.

As defined here, APCs include all specially trained and licensed individuals who can provide medical care and billable services, but mainly nurse practitioners (NPs), advanced practice nurses (APNs), and physician assistants (PAs). APCs first emerged in the U.S. healthcare environment in the 1960s, and their numbers have grown exponentially since the late 1990s.

The proliferation of licensed NPs has been particularly noteworthy and is projected to continue. In 1999, they numbered 68,300, according to the American Association of Nurse Practitioners (AANP), and a recent study projects their numbers will increase to about 244,000 by 2025. Moreover, the AANP reports that there currently are more than 210,000 credentialed NPs with graduate degrees in the United States, and 83.4 percent of NPs are certified to deliver primary care.

Meanwhile, there are 115,500 PAs licensed to practice, according to the American Academy of PAs (AAPA), and the top specialties for these practitioners are as follows:

> Primary care, including family medicine, general internal medicine, and general pediatrics (24.4 percent)
> Surgical subspecialties (26.3 percent)
> Emergency medicine (10.5 percent)
> Internal medicine subspecialties (10.8 percent)

Together, primary care NPs and PAs constitute the fastest growing portion of the primary care workforce, according to the Health Resources & Services Administration.

Support for Inclusion of APCs in Team-Based Care

Both NPs and PAs can have full practice authority to diagnose and manage acute and chronic conditions; they can submit orders, conduct interpretative and diagnostic tests, and prescribe and dispense medications. They also can practice in team-based environment or autonomously.

Nonetheless, there have been only a few recent studies of their quality and cost effectiveness within a practice setting (although the use of APCs has been endorsed by the American Congress of Obstetricians and Gynecologists [ACOG]). The following are a few examples of

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d. HRSA, Projecting the Supply and Demand for Primary Care Practitioners Through 2020, October 2016.

e. ACOG Task Force on Collaborative Practice, Collaboration in Practice: Implementing Team-Based Care Executive Summary, Obstetrics & Gynecology, March 2016.
recent studies of the quality and cost effectiveness of APCs in hospital and primary care settings.

Comparison of expanded staffing using PA hospitalists with conventional staffing. A study published in the Journal of Clinical Outcomes Management found that, over a period from January 2012 to June 2013, a community hospital with a high PA-to-physician ratio delivered outcomes of similar quality in terms of in-hospital mortality, readmissions, length of stay, and consultant use at a lower cost of care compared with another community hospital using a conventional staffing model with more physicians and fewer PAs.

Inclusion of APCs in high-performing primary care practices. A 2017 report by the Peterson Center on Healthcare and Stanford University’s Clinical Excellence Research Center (CERC) identified 11 primary care practices, drawn from a national sample, as “positive outliers” for the value—higher quality at significantly lower cost—of the care they provide.” Notably, all these practices use a team approach with APCs—NPs, PAs, nurses, and/or medical assistants working at the top of their license.

Comparison of the quality of outpatient care with and without APCs on the care team. A study published in the October 2015 Journal of American College of Cardiology found that the quality of outpatient care provided by healthcare teams that included NPs or PAs was equal to or better than care provided in a physician-only model across several levels of comparison.

Assessment of the impact of integrating APCs into the workforce on the physician shortage. An analysis by the U.S. Department of Health and Human Services (HHS), which projects a shortage of 20,400 physicians by 2020, also projects that this number could be reduced to 6,400 by if APCs were integrated into the workforce.

In addition to the value of APCs implicit in the findings of such studies, various other factors are creating new opportunities for APC employment, such as coverage expansions under the ACA and telehealth, which are expanding health care to new and often underserved areas, and new team-centered delivery models such as patient-centered medical homes and medical neighborhoods.

Team-Based Care and the Structure of CINs

Both the AANP and the AAPA have strongly endorsed the Institute of Medicine’s concept of team-based care to provide high-quality and patient-centered care, which fits well with the structure of CINs. The team concept is based on the notion that APCs should have authority to practice independently to the fullest extent of their educational training. In a recent white paper, the AAPA notes that team-based care is likely to become standard, given the increasing complexity of medical care driven by innovation in technology and advancing drug treatments. AAPA bases this assertion of the premise that “no single provider, including PAs, will be able to master the growing medical knowledge-base.”

The team-based approach can allow APCs to furnish acute, chronic, and preventive care across the continuum of care in all settings. The team goals for APCs—which are closely aligned with the core set of primary care functions the Centers for Medicare & Medicaid Services outlines in its Comprehensive Primary Care Initiative—include the following:

> Long-term partnerships between clinicians
Case Study: North Mississippi Health System

The effective use of advanced practice clinicians (APCs) to provide primary care in a clinically integrated network (CIN) is exemplified by North Mississippi Health Services (NMHS) system, a health system based in Tupelo, Miss., that serves 24 mostly rural counties in the northeast corner of Mississippi and a few neighboring counties in Alabama. NMHS’s experience may anticipate the future for CINS nationwide. Ranking last among states in primary care physicians per capita, Mississippi has much of its primary care delivered by APCs, many of whom are in practices numbering one to three providers. In other words, the primary care provider mix in Mississippi today is likely a preview of tomorrow’s mix for the rest of the United States.

During its CIN planning stage, NMHS quickly realized it was not well aligned with APCs in the region because, like most health systems, it had been focusing its outreach efforts on primary care physicians in the market. Its rationale for doing so was based largely on two premises. First, APCs in Mississippi are required to have a supervising physician, so to some degree, these supervising physicians would logically be the optimal point of engagement for a health system.

But the primary factor that had prevented NMHS from reaching out to APCs was its largely unspoken assumption that APCs deliver care that is inferior to the care delivered by primary care physicians. In other words, looking to be associated with the “highest-quality” providers in the region, the health system had focused its alignment efforts on primary care physicians to the exclusion of APCs. In contrast, independent specialist physicians in the region were well aware of the importance of APCs as primary care providers, because APC referrals represented a high percentage of their referral business (30 to 50 percent, based on interviews).

The Decision to Include APCs

The concerns raised about the quality of care provided by APCs, although unverified, posed a very real obstacle in NMHS’s decision about whether to include APCs in the formation of its CIN. In a few instances, primary care physicians saw APCs as competition and did not want them included in the network.

In the end, however, NMHS acknowledged the importance of APCs in delivering primary care in the region, and it determined that if the CIN’s mission was truly to elevate the quality of care in the region, it not only needed to include APCs in the network, but also required APC representation in the CIN design process. Thus, the name of the entity charged with developing the CIN was changed from Physician Steering Committee to the more-inclusive Provider Steering Committee, and a community-based independent nurse practitioner was elected to the CIN board.

Engaging APCs

With the framework for strengthening NMHS’s historically weak alignment with APCs in place, the steering committee embarked on an effort to actively engage APCs to integrate them into the network. The CIN’s articulated goal was to become the “preferred partner for APCs” in the region. The initiatives and activities developed to achieve this goal formed the foundation of the CIN’s APC recruitment strategy.

For an independent APC to join a health-system-sponsored CIN, trust is required. Having an independent NP on the CIN board provided this important credibility. NMHS also engaged APCs working within its network to participate in recruitment meetings and phone calls as a means of building relationships.

To establish a single standard for high-value primary care across the CIN’s network, the CIN board created a committee charged with promoting and supporting such a standard in both physician and APC offices. This committee, called the Primary Care Collaborative (PCC),

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Expanded access and continuity
Planned care for chronic conditions
Risk-stratified care management
Patient and caregiver engagement
Clinician-led teams to coordinate care and community support

In many rural areas, APCs practice individually, with NPs and midwives practicing independently or in groups. Effective CINs require targeted patient care coordination supported by committed primary care team leadership. All clinicians in the CIN organization, including APCs, should receive training to fill roles as population health coordinators.

A Key to Financial Viability in Value-Based Contracts
In a pure fee-for-service environment, before the advent of team-based care, aligning APCs with the hospital medical staff could be difficult. APCs typically were not well connected to hospitals, often were practicing independently in the community, and were frequently seen as competition by primary care physicians.
Although a few physicians still view APCs as either too expensive to hire or a poor source of revenue to the practice, recent MGMA data suggest that practices that use APCs as an integral part of their workforce financially outperform those that do not.¹

Moreover, new team-based delivery models in which care teams are wholly responsible for their patients’ physical and mental health needs will be challenged in their ability to meet this charge without the use of APCs. As “population care managers” and “clinical integration specialists” in various types of care teams in CINs, APCs can play an indispensable role in:

- Ensuring the transfer of patient information between care teams and delivery sites
- Ensuring a care coordinator manages the continuity of acute and post-care acute care
- Ensuring patients transition between settings
- Ensuring patients have access to services with reasonable waiting times and 24/7 care
- Providing electronic or telephone access for patients
- Focusing on patient preference and involvement in decision making
- Ensuring patients with chronic health conditions have individual care plans and community linkages

Employing APCs in a CIN or medical group also brings the added benefits of boosting productivity and volume and helping meet new metrics for patient satisfaction and quality of care. Compensation for APCs commonly involves a salary plus a bonus for meeting patient satisfaction goals, although many family medicine practices still compensate APCs primarily using straight salaries.

APCs also can help eliminate inefficiencies in a group’s delivery system by helping a group shift from an individual-practice focus to a clinical-team approach. This shift requires a change in orientation from a focus on one patient at a time to a more population-based


**State Variation in APC Practice Authority and Billing**

Generally, commercial and government payers pay APCs for the same services that would be considered physician services if they were delivered by a medical doctor or an osteopathic physician. Payment for APCs differs by carrier, just as it does with physicians. The scope of an APC’s practice authority varies by state, and both the AAPA and the AANP strongly advocate for their member APCs to have full authority to practice at the limit of their educational credentialing.

For example, 14 states provide full practice authority to NPs, which means they can evaluate, diagnose, and prescribe the model recommended by the National Council of State Boards of Nursing. Others restrict the scope of NPs’ authority to practice, and some mandate that NPs not be authorized to deliver full patient care without the supervision of a physician or other qualified party. Such supervision, however, may be limited to timed chart reviews by a physician, leaving APCs to practice with broad independence. In terms of billings, NPs and PAs can bill Medicare directly under their own National Provider Identifier, and they generally are paid at 85 percent of the amount of physician fees.

**From Physician-Centric to Team-Centric**

Historically, health systems have been physician-centric when developing CINs, ACOs, or other networks. This tendency is not surprising, given that physicians provide most of the primary care in United States (except in staff-model HMOs, such as Kaiser Permanente and Harvard Community Health Care). However, with the supply of primary care physicians dropping, and an increasing number of newly trained APCs entering primary care fields, health systems must be able to more effectively align...
with APCs and adjust care models to incorporate these providers if they are to effectively deliver high-quality care.

The considerations involved with recruiting APCs are much like those with respect to physicians. To be able to recruit APCs into a CIN and engage them in quality improvement activities, a health system must understand the unique elements of an APC’s practice environment, including the state regulations delineating the parameters of independent practice.

Given the annual decline in the ranks of practicing primary care physicians in the United States, and the continuing surge of APCs entering the primary care market each year, CINs, ACOs, and other organizations will likely need to integrate not just primary care physicians but also APCs into their networks if they are to effectively deliver population health across a broad geography.

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