The Calculus of **Addition**

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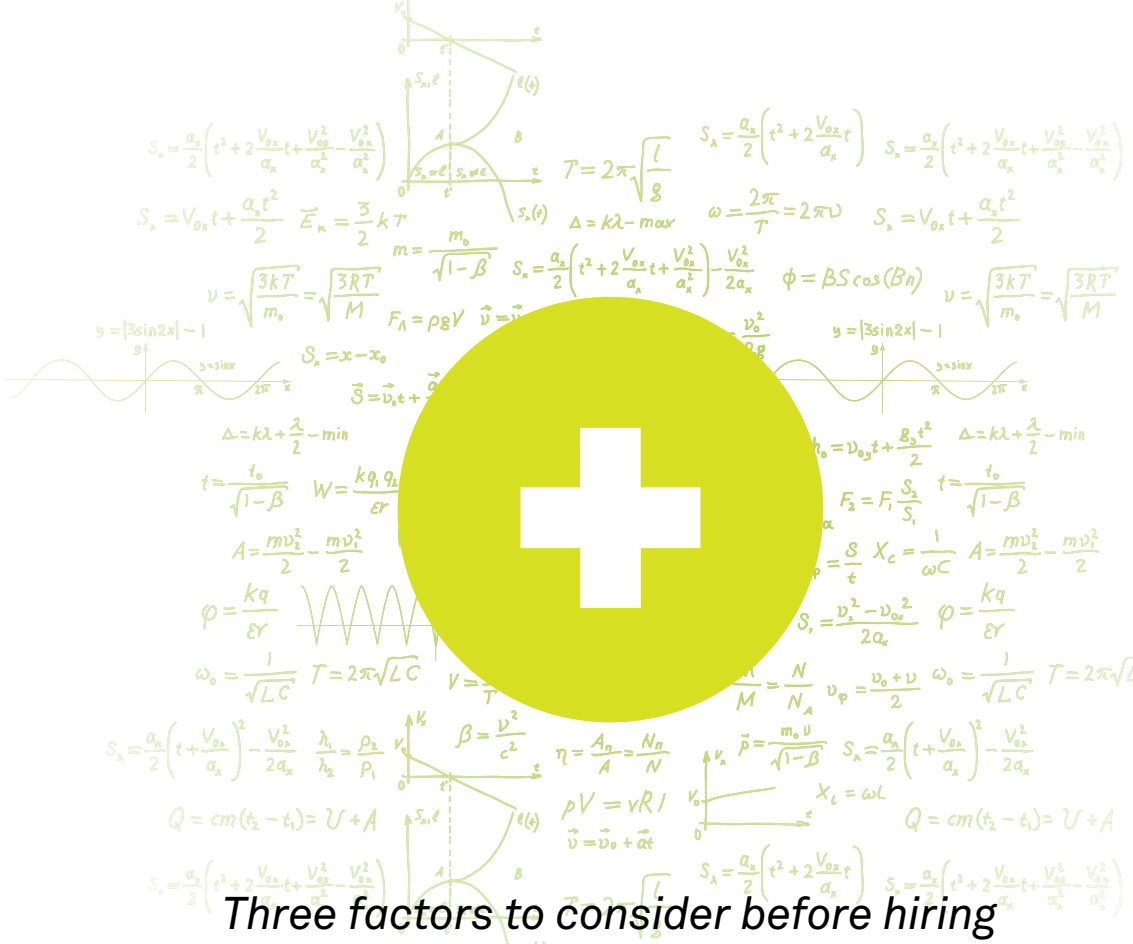


Three factors to consider before hiring more APCs for your medical group

By Rose Wagner, RN, M.H.S., FACMPE, and Fred Horton, M.H.A.

In recent years, medical groups have made the strategic decision to add more advanced practice clinicians (APCs) into their provider complement. In fact, according to data from the *AMGA 2020 Medical Group Operations and Finance Survey*, over the past four years, the median APC-to-physician ratio has increased by an average of 27% across all specialty types.

On the surface, adding APCs seems purely beneficial. From a salary and benefits perspective, APCs are less expensive than physicians, and for some specialties APCs are easier to recruit than physicians. Additionally, APCs can augment physicians by delivering preventative care in primary care settings and follow-up care in medical or surgical settings, thus freeing up physicians to see new patients, referrals, or patients with more complex medical issues.

However, all that glitters is not gold.

If you do not have the right approaches, processes, and recruitment criteria in place, APCs could end up producing a negative, rather than a positive, financial impact.

In our experience as executive leaders in medical groups and strategic advisors, we have found that there are three important factors to look at and consider before hiring more APCs in your practice.

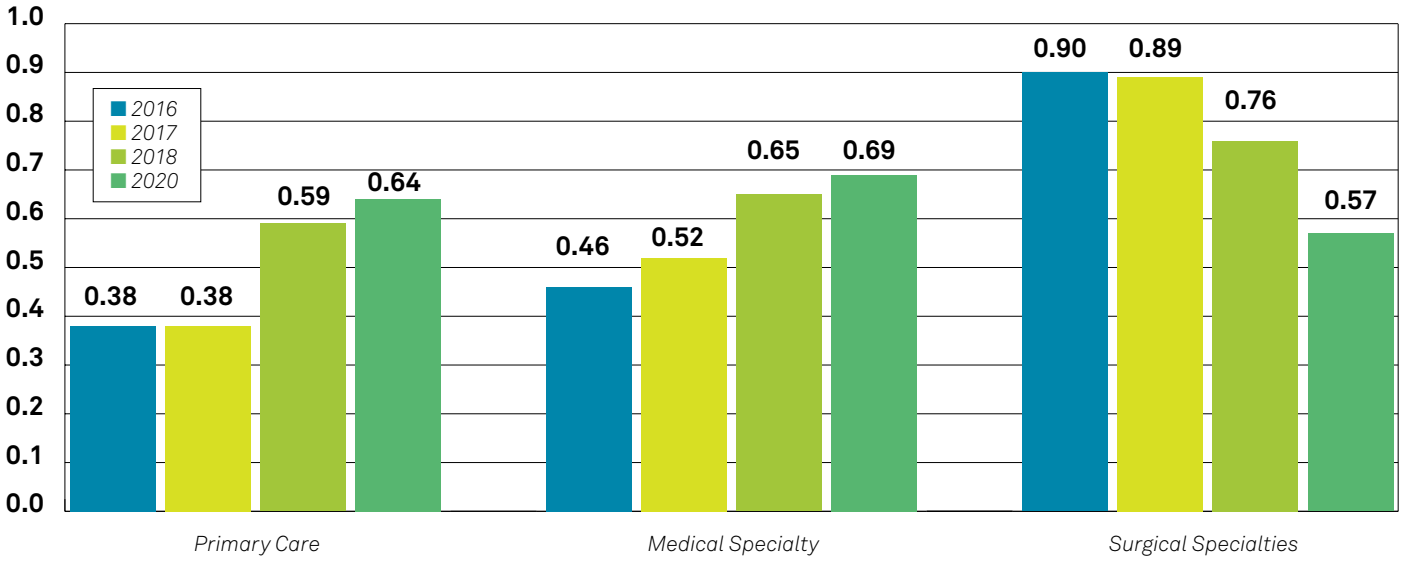
Start with Productivity

One of the first steps you should take is to determine the average productivity levels of the existing APCs and physicians to have a high-level view of your group's overall productivity. Figure 2 is an example of a quartile analysis of this data at a medical group. As you can see, when compared against national benchmark data, 73% of the group's physicians and 56% of the group's APCs are producing below the median.

It's important to remember that an APC typically consumes the same *amount* of resources (support staff, facilities, and infrastructure) as a physician, so as part of the planning process, we would suggest working with administration and physician leadership on defining the care model up front, including the ratio of APCs to physicians, the types of patients the APCs will be seeing, the billing methodology for APCs, and the productivity targets of both physicians and APCs, as some examples.

In the example shown in Figure 2, the majority of the physicians (and APCs) are producing below the median, so we could question the provider mix needed. Until a majority of the providers reach median or greater levels of production, you

Figure 1
APC-to-Physician Ratio – Change Over Four Years



could exacerbate financial and operational issues by hiring more providers—physicians or APCs.

Particularly now, in the age of COVID, medical groups need to be on their A game when it comes to provider staffing and efficiency, so it's important to consider productivity and other factors in your decision-making process.

Determine Provider Supply Needed

Provider staffing and efficiency in a medical group are more critical than ever before, particularly as medical groups navigate changing reimbursement, evaluation and management (E/M) coding changes, and market pressures.

In addition to analyzing physician and APC productivity, we suggest groups also look at a productivity-adjusted provider complement. This calculation estimates the number of providers a medical group would need in order to achieve adequate productivity (assuming all providers were producing at median).

In Figure 3, we combine the total work RVUs (wRVUs) for the group (648,561) and divide by the market median production by specialty. The resulting sum equates to the total number of providers needed for the current production if all were at median, which in this case suggests a potential surplus of 27 providers for the group. Note that this analysis can be adjusted to match an organization's target levels of production. For example, if the target productivity is the 60th percentile, then the total wRVUs would be divided by the 60th percentile, and the result would show the number of providers needed to produce the current total wRVUs.

Although the example given uses wRVUs as the measure of production, an organization could utilize panel size or other volume metrics, such as patient visits.

As previously discussed, each provider has resources attributed to them (staffing, facilities, overhead, IT, etc.). Therefore, a provider surplus, such as that shown in Figure 3, results in significant excess costs to a medical group, which are in addition to the provider salary and benefits expenses.

Further, with both APCs and physicians producing below the median, the answer may not be more APCs, but instead, a deeper dive into what can be done to increase productivity overall, starting with a focus on the physicians and the design of the care model.

Establish Productivity Targets and Align Incentives

Another unintended consequence of adding APCs to a provider complement without the right approaches or criteria in place is the potential to create competition between the APCs and physicians if the incentives aren't aligned.

In our experience, we've seen that competition of this nature is most common when physicians are on a productivity-based compensation plan, but lack the production levels necessary to achieve desired

Figure 2

Example Quartile Analysis of Physicians and APCs

Physicians wRVU Production			APCs wRVU Production		
Productivity Range	Count	Percent of Physicians	Productivity Range	Count	Percent of APCs
<25th	57	45.2%	<25th	44	31.2%
25th–49th	35	27.8%	25th–49th	35	24.8%
50th–74th	22	17.5%	50th–74th	32	22.7%
75th–100th	12	9.5%	75th–100th	30	21.3%
	126	100.0%		141	100.0%

Figure 3

Actual Providers vs. Needed Providers at Median Productivity

Productivity Adjusted Provider Complement Analysis	
Measure	Providers
FTEs	172.97
Total wRVUs	648,561
FTEs needed if all providers were producing at median	145.62
Difference in FTEs	27.36
Percentage difference	15.8%

levels of compensation. (Note that productivity in this instance can be either wRVUs or panel size in a value-based practice.)

If productivity criteria and aligned incentives aren't established upfront, or if physicians lack the ability to produce at appropriate levels, they may not be willing to share patients with APCs, thereby limiting the scope of practice of the APC.

It is important to align incentives and ensure operational processes support appropriate levels of production so that both physicians and APCs are adequately rewarded for seeing patients, delivering quality care, and providing patient access.

One Last Look Before You Leap

After you analyze productivity, define the structure, and implement the appropriate care model strategy, it may be necessary and the prudent strategic decision to hire more APCs for your practice.

With that in mind, there is one last item we recommend you consider before you pull the trigger. It's important to look at and consider, for each specialty, what the right APC-to-physician ratio is for your organization. The example analysis in Figure 4 uses data from the *AMGA 2020 Medical Group Operations and Finance Survey* to identify the market metrics of APCs to physicians for each specialty. This analysis can also identify key areas where you may be at a surplus or able to add APCs to your practice that could add tremendous value to your organization. Figure 4 shows that the organization has a surplus or 50 APCs greater than median when compared to benchmarks. Of note, this analysis assumes median provider productivity and results could be overstated or understated if productivity of existing providers is above or below median.

Although the example given uses wRVUs as the measure of production, an organization could utilize panel size or other volume metrics, such as patient visits.

Final Thoughts

Adding APCs to a medical group's provider complement can be a cost-effective approach to the provision of clinical care. This strategy can significantly improve patient satisfaction, ensure proper preventive services are provided

Figure 4

APC-to-Physician Ratio Example

Medical Group Care Model Analysis (APC to Physician FTE Ratio)			
Department	Department APC to Physician FTE Ratio	AMGA Median Benchmark	Variance From Benchmark
Family Medicine	1.56:1	0.61:1	17.23
FM/IM Blend	1.31:1	0.48:1	7.61
Cardiothoracic Surgery	2.38:1	0.50:1	5.64
Internal Medicine	2.73:1	0.38:1	4.98
Pediatrics	1.38:1	0.24:1	2.43
Multispecialty	0.91:1	0.50:1	2.19
Vascular Surgery	1.20:1	0.50:1	2.09
Surgical Oncology	0.95:1	0.50:1	1.36
Behavioral Health	1.90:1	0.67:1	1.23
Bariatric	0.90:1	0.50:1	1.22
Orthopedics	0.99:1	0.75:1	1.16
Pain Clinic	1.00:1	0.50:1	1.00
OB/GYN	0.58:1	0.32:1	0.75
Neurosurgery	1.11:1	1.00:1	0.55
Palliative Care	0.80:1	0.50:1	0.30
Breast Surgery	0.70:1	0.50:1	0.24
Pulmonology	0.44:1	0.59:1	-0.36
Urology	0.41:1	0.49:1	-0.45
PMR	0.33:1	0.50:1	-0.53
Trauma Surgery	0.37:1	0.50:1	-0.98
General Surgery	0.08:1	0.45:1	-2.99
Cardiology	0.58:1	0.91:1	-4.84
		Greater than Market Median Number of APCs:	50.00

to patients, improve quality, ease physicians' burdens, and provide greater patient access.

We urge groups to define the care model upfront, analyze provider productivity, examine provider supply, and align incentives between physicians and APCs to ensure they do not create competition. By having the proper recruitment criteria and aligned incentives in place, you can add APCs in a well-thought-out manner.

If these steps aren't taken, APCs can serve as a costly drain on a medical group's resources. However, with the right foundation, APCs can become an integral and valuable part of any medical group's provider complement. GPJ

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