



Optimizing Advanced Practice Providers in Healthcare

DEEP DIVE -

QUALITY & PATIENT EXPERIENCE

SAVED TO MY DASHBOARD

The COVID-19 pandemic has amplified the previously growing importance of advanced practice providers (APPs) in care delivery and practice performance.

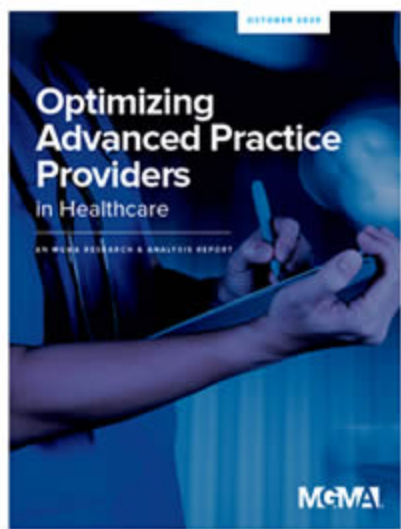
Increasing demands for healthcare point to a **projected physician shortage, estimated to reach between 54,100 and 139,000 physicians by 2033**. One strategy to address this shortage is to close gaps in primary care access through increased use of APPs. One estimate points to expanded **use of nurse practitioners (NPs) could reduce primary care physician (PCP) shortages by 70%**.

Many practices already recognize the substantial boost that APPs can provide to practice performance, with APP utilization growing. **MGMA data show that almost 67% of Better Performer practices employ APPs; for physician-owned practices, that rate jumps to almost 87%.**

Advanced Practice providers (APPs) are a crucial component for optimizing care delivery and practice performance during the COVID-19 pandemic and beyond.

This report is the most recent addition to MGMA's Deep Dive series, and includes:

- Guidelines and regulations for using APPs, including incident-to billing rules
- Expert advice for APP compensation and payment structures
- Specialty-specific insights and practical tips on APP staffing
- Details on state-by-state rules on APP scope of practice.



FREE REPORT



OPTIMIZING ADVANCED PRACTICE PROVIDERS

Optimizing Advanced Practice Providers in Healthcare, an MGMA Research & Analysis report, focuses on the projected physician shortage and the vital role of APPs, including: Guidelines and regulations for using APPs; expert advice for compensation; specialty-specific insights and tips; and details on state-by-state rules.

19 pages. PDF. Free to all.



OCTOBER 2020

Optimizing Advanced Practice Providers in Healthcare

AN MGMA RESEARCH & ANALYSIS REPORT

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Introduction

The COVID-19 pandemic has amplified the previously growing importance of advanced practice providers (APPs) in care delivery and practice performance.

Increasing demands for healthcare point to a projected physician shortage, estimated to reach between 54,100 and 139,000 physicians by 2033.¹ One strategy to address this shortage is to close gaps in primary care access through increased use of APPs. One estimate points to expanded use of nurse practitioners (NPs) could reduce primary care physician (PCP) shortages by 70%.²

Many practices already recognize the substantial boost that APPs can provide to practice performance, with APP utilization growing. MGMA data show that almost 67% of Better Performer practices employ APPs; for physician-owned practices, that rate jumps to almost 87%.³

Defining APPs

APPs — specially trained and licensed individuals who can provide medical care and billable services — have been called “advanced clinicians,” “nonphysician providers” and “midlevels.” These providers include:

- **Physician assistants (PAs)** are nationally certified and state-licensed medical professionals who practice medicine with physicians and other providers. They practice and prescribe medication in all 50 states, the District of Columbia, most of the U.S. territories and the uniformed services.⁴
- **Nurse practitioners (NPs)** are independently licensed healthcare professionals who possess a master’s or doctorate degree. They diagnose and treat medical conditions by prescribing medication, ordering and interpreting diagnostic tests, and performing invasive procedures.⁵
- **Advanced practice registered nurses (APRNs)** are nurses with at least a master’s degree in nursing.⁶ There are four types of APRNs:
 1. **Certified nurse-midwives (CNMs)** are registered nurses who have graduated from a nurse-midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME) and have passed a national certification examination.⁷
 2. **Clinical nurse specialists (CNSs)** are expert clinicians with advanced education and training in a specialized area of nursing practice who work in a wide variety of healthcare settings. A CNS’ specialty may be defined by patient population, care setting, disease or type of problem, or type of care.⁸
 3. **Clinical social workers (CSWs)** have a post-graduate degree in social work with an emphasis on clinical experience and provide mental health services for the prevention, diagnosis, and treatment of mental, behavioral, and emotional disorders in individuals, families, and groups.⁹
 4. **Certified registered nurse anesthetists (CRNAs)** are advanced practice registered nurses with graduate level education who provide anesthetics to patients in every practice setting, and for every type of surgery or procedure. They are the sole anesthesia providers in nearly all rural hospitals and the main provider of anesthesia to the men and women serving in the U.S. Armed Forces.¹⁰

An upward trajectory for APPs

Medical practices across the United States are increasing their use of APPs. MGMA data found that **the APP-to-physician ratio has increased from 0.42:1 in 2012 to 0.60:1 in 2019.**¹¹

A June 2020 report by the Association of American Medical Colleges (AAMC) estimated there were 131,200 certified PAs and 248,000 advanced practice registered nurses (APRNs) at the end of 2018. The same report also estimates **the supply of APRNs to grow by 276,000 full-time-equivalent (FTE) workers and the supply of PAs to grow by nearly 138,000 by 2033.**¹²

The COVID-19 pandemic has intensified this upward trajectory for APPs, as a 2020 Merritt Hawkins report finds that **NPs are the second-most in-demand healthcare worker**, behind only family medicine.¹³ With the projected physician shortage, it is clear APPs will play a large role in care delivery going forward, driving a need for more APPs to enter the field amid an optimistic job market.

As more doctors reach retirement age, the physician shortage will get worse, especially with the stress of the COVID-19 pandemic, according to MGMA consultant Alan J. Beason, MS, FACMPE. **“We need to push as much as we can to the next level of licensure and certification [to] take some of that burden off the doctors,”** Beason says.

Lower numbers of primary care/family medicine physicians could even lead to an increase in the business model of a nurse practitioner-owned and -operated practice in states that permit it, according to Lorri M. Phipps, DNP, CPNP-PC, pediatric nurse practitioner, president and co-owner, Mainstreet Pediatrics, Parker, Colo.

The demand for APPs is already reflected in the growth of the overall employment of these healthcare professionals, as well as rising compensation.

- **Median NP compensation reached \$111,238 in 2019**, according to 2020 MGMA DataDive Provider Compensation data.¹⁴ The U.S. Bureau of Labor Statistics (BLS) estimates overall employment will grow at a rate of 45% — much faster than the average for all occupations.¹⁵
- 2020 MGMA DataDive Provider Compensation data also show that **PAs earned a median salary of \$112,260 in 2019** — a 6.8% increase from 2015 levels.¹⁶ The PA field is growing at a rate of 31%, per BLS.¹⁷

The APP as outlined by CMS

CMS defines the qualifications, covered services and level of supervision for NPs and PAs for the Medicare program as outlined below.¹⁸

NP qualifications	PA qualifications
- Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner (NP) in accordance with state law; and - Be certified as an NP by a recognized national certifying body that has established standards for NPs; or - Be a registered professional who is authorized by the state in which the services are furnished to practice as an NP by Dec. 31, 2000.	- Have graduated from a PA educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs [CAAHEP] and the Committee on Allied Health Education and Accreditation [CAHEA]); or - Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and - Be licensed by the state to practice as a PA.
Covered services	Covered services
Coverage is limited to the services an NP is legally authorized to perform in accordance with state law (or state regulatory mechanism established by state law). Services may be covered under Part B if all of the following conditions are met: - They are the type that are considered physicians' services if furnished by a doctor of medicine or osteopathy (MD/DO); - They are performed by a person who meets all NP qualifications; - The NP is legally authorized to perform the services in the state in which they are performed; - They are performed in collaboration with an MD/DO; and - They are not otherwise precluded from coverage because of one of the statutory exclusions. Incident to: If covered NP services are furnished, services and supplies furnished incident to the NP may also be covered if they would have been covered when furnished incident to the services of an MD/DO.	Coverage is limited to the services a PA is legally authorized to perform in accordance with state law (or state regulatory mechanism established by state law). Services may be covered under Part B if all of the following conditions are met: - They are the type that are considered physicians' services if furnished by a doctor of medicine or osteopathy (MD/DO); - They are performed by a person who meets all PA qualifications; - The PA is legally authorized to perform the services in the state in which they are performed - They are performed under the general supervision of an MD/DO; and - They are not otherwise precluded from coverage because of one of the statutory exclusions. Incident to: If covered PA services are furnished, services and supplies furnished incident to the PA's services may also be covered if they would have been covered when furnished incident to the services of an MD/DO.
Direct billing and payment	Direct billing and payment
Direct billing and payment for NP services may be made to the NP. Reimbursement is 85% of the fee schedule amount for physicians.	Payment for the services of a PA may be made only to the actual qualified employer of the PA. Reimbursement is 85% of the fee schedule amount for physicians. Not eligible for direct reimbursement.
Collaboration	Physician supervision
Collaboration is a process in which an NP works with one or more physicians (MDs/DOs) to deliver healthcare services, with medical direction and appropriate supervision as required by the law of the state in which the services are furnished. In the absence of state law governing collaboration, collaboration is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice. The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP.	The PA's physician supervisor (or a physician designated by the supervising physician or employer as provided under state law or regulations) is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient. The physician supervisor (or physician designee) need not be physically present with the PA when a service is being furnished to a patient and may be contacted by telephone, if necessary, unless state law or regulations require otherwise.

The APP and incident-to billing

Medicare's rules on incident-to billing allow 100% reimbursement for services provided by APPs instead of the standard 85% for APP services — if certain requirements are met:

- The physician must initiate the care and remain actively involved and control the management of the patient's condition.
- The physician must be present in the office suite and be immediately available to provide assistance and direction when the APP is performing services. Incident-to can only be billed as outpatient office as place of service.
- If a new problem is introduced, the visit is not incident-to and cannot be billed as such.
- New patient visits, visits in a hospital or skilled nursing facility setting, and annual wellness visits are also services that do not qualify for incident-to billing.
- Documentation of the incident-to service must include the link to the physician's service to which the service is incidental.
- Referencing by date and location the initiating provider's service will support the active involvement of the physician.
- The APP's identity and credentials must be recorded in the medical record, as well as the name of the supervising physician for the encounter.
- The supervising physician does not need to be the same provider who ordered the incident-to service.
- The supervising provider's number should then be used for billing the service.

In summary, incident-to is defined as services or supplies that are:

- Furnished incident to a physician's professional services when the services or supplies are furnished as an integral — although incidental — part of the physician's personal professional services
- Part of the patient's course of treatment
- An expense to the physician.

If incident-to requirements are met, services may be reported under the physician's national provider identifier (NPI). If incident-to requirements are not met, services must be reported under the APP's NPI.

APP compensation and payment structures

It is clear that not only the number of APPs is growing but also the rate of compensation. This leads to the question of how are the compensation agreements structured for APPs, as there are many different options and methodologies.



APP compensation structures

There are many different types of compensation models for APPs. The typical compensation models are as follows:

- Salary
- Salary plus bonus (based on productivity and/or quality measures)
- Hourly
- Full production based
 - wRVU conversion rate
 - Percentage of fees billed/collected

APP compensation models can vary based on the individual circumstances of the practice. Generally, in situations in which an APP is consistently seeing non-billable visits, such as post-op follow-up visits or global OB visits, it makes sense for a straight salary to be paid versus compensation based on production. If the APP is providing billable visits, a model that incentivizes both productivity and quality makes sense. APPs who provide surgical assistance are generally compensated at higher levels than those who don't.

When putting together a bonus structure, it is important to know if the basis of the bonus will be cash net revenue, wRVUs and/or other quality-based metrics. If you will be offering a bonus above a salary, establish either a flat bonus rate, a percentage of cash net revenue or a wRVU conversion rate that will be used to calculate the bonus, which often begins after the base salary has been met.

An example of this is an APP who has a "greater of" -based contract with a base salary of \$90,000 per year and a bonus incentive based on wRVU production. The wRVU conversion rate in this example is \$32 per wRVU. If the APP achieved 3,500 wRVUs, that would equate to \$112,000. The APP would effectively receive the minimum base salary of \$90,000 plus the \$22,000 bonus based on production for a grand total of \$112,000, or more if productivity increases continue.

In addition to wages there are benefits that need to be considered as well. Health/dental insurance, malpractice insurance, CME expenses, dues/subscriptions, retirement matching/contributions [401(k)], vacation days, and cell phone expense reimbursement should all be considered. Know before posting the position whether it will be fulltime, parttime, or supplemental and which days/times the shift will cover. Fair market value (FMV) should also be taken into consideration when making an offer to an APP.

There is no doubt that as the demand for APP services continues to rise, so will the expectation for higher compensation.

PROVIDER COMPENSATION TOOLS

- [**MGMA RVU Calculator Tool Overview**](#) — To calculate work RVUs, practice experience RVUs and more
- [**Provider Production Overview**](#) — Details on total RVUs, work RVUs and other elements of MGMA's Compensation and Production Survey
- [**Sample Compensation Model Tables**](#) — PDF download for wRVU, tiered wRVU, net revenue and partnership compensation models for physicians
- [**MGMA DataDive Provider Compensation**](#) — Industry-leading benchmarking data for APP specialties based on your organization's profile (size, region, ownership)
- [**MGMA DataDive Cost and Revenue**](#) — Dig deeper into expenses, charges and revenue to find the right staffing ratio for your organization



DECISION-MAKING TOOLS

A pro forma is an excellent tool to help calculate best- and worst-case scenarios and decide if your proposal will be financially viable.

- [Developing a pro forma financial statement](#)
- [MGMA member tool: Medical Practice Pro Forma Template](#)

When does hiring an APP make sense?

Some of the reasons physicians and administrators cite for not hiring APPs include:

- “I can’t afford an APP.”
- “APPs don’t bring any revenue into the practice.”
- “APPs are the competition.”

MGMA data show that practices that utilize APPs continually perform better financially than practices that do not. Physician shortages will limit the availability of PCPs, thus a resistance to utilizing APPs will cause practices to struggle to meet patient care demands.

Hiring an APP is substantially less expensive than hiring a physician. Lower salaries, overhead, liability insurance costs and other costs of care — along with the benefits of increased patient volume and improved patient satisfaction — are all major benefits for practices utilizing APPs.¹⁹

MGMA recommends that you estimate the average amount of cash net revenue or wRVUs and use that data to calculate a break-even point. For example: If you had an APP with a salary/benefits of \$120,000 per year and your average reimbursement per visit was \$100, the practice would break even after 1,200 visits, which is based on 260 business days per year. That’s 4.62 visits per day to break even and shift into profitability.

In surgery clinics, APPs often provide postoperative patient care or work as surgical assistants. When an APP provides post-op care instead of a physician, they free the surgeon to perform more surgeries. If a practice’s APPs are doing the work that is included in the global surgical package of a major procedure, physicians often don’t see the financial benefit.

MGMA recommends conducting an ROI analysis to compare the increased revenue from adding surgeries and/or billing surgical assist fees as compared to the APP expense.

If the APP wasn’t there to provide care of the postoperative patient, this role would fall to the surgeon.

In rural areas, APP utilization is essential. The Rural Health Clinic Services Act of 1977 made freestanding rural clinics staffed by NPs and PAs eligible for government payments without meeting physician supervision requirements. To qualify as a rural health clinic (RHC) with Medicare, the RHC must employ one APP (NP or PA) who is working at the clinic at least 50% of the time the clinic is open as an RHC. RHCs are reimbursed at the same encounter rate for physicians and APPs.²⁰

According to Miku Sodhi, MBBS (MD), PCMH-CCE, FACMPE, deputy CEO, Shasta Cascade Health Centers in California, equal reimbursement is the same whether the patient is seen by a doctor, NP or PA, and also applies to federally qualified health centers (FQHCs).

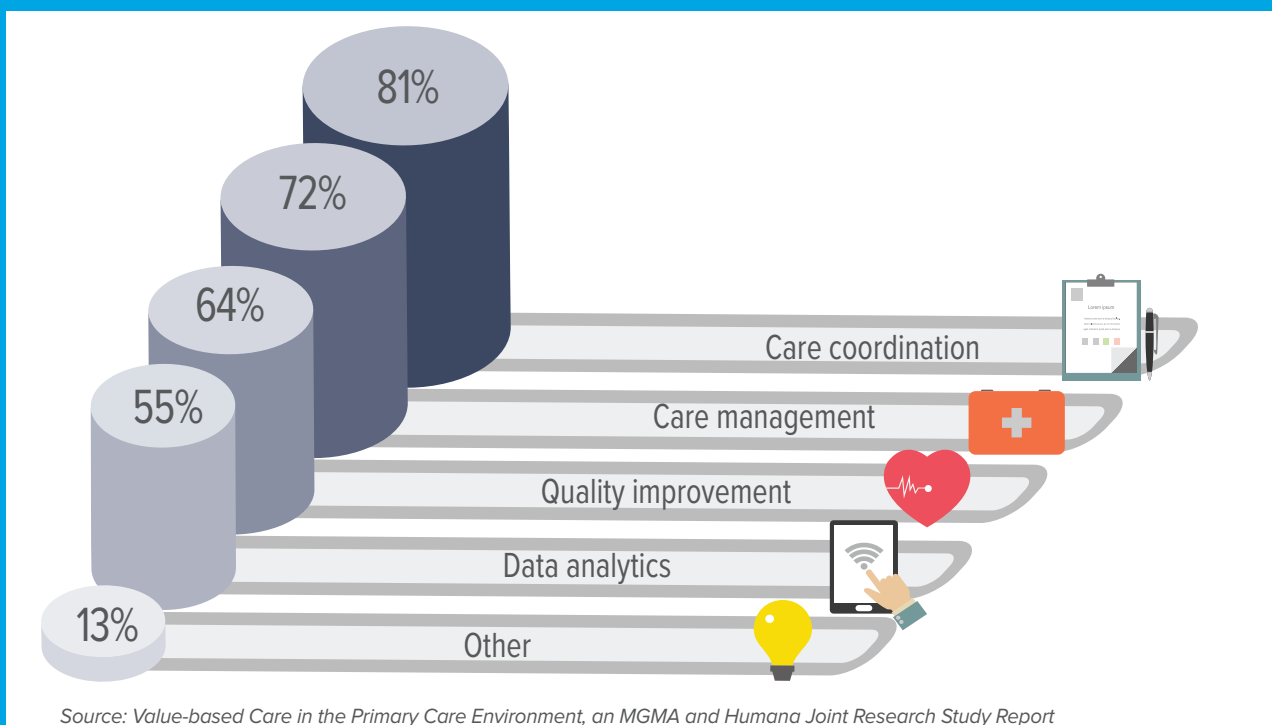
APPs and value-based care

With the ongoing shift to value-based care it is becoming even more important to have a team-based approach to care that takes into consideration quality, efficiency and cost. APPs will play a critical role in the future of value-based care, especially as Medicare continues to penalize providers with readmissions of patients for heart failure, for example.

With one Louisiana practice Beason helped lead, he noted that “the cost of implementing an NP to coordinate this transition of care once the patient leaves the hospital, instead of just being discharged to home,” was justified given the follow-up work the NP performed. This helped prevent readmissions due to patients not taking their medications or other preventable reasons.

When APPs see patients with lower-acuity issues, physicians can spend more time on patients with complex health concerns, which helps yield better care outcomes and supports quality metrics that dictate value-based reimbursement.

Figure 1. Which type of staff has been added to accommodate your shift to value-based care?

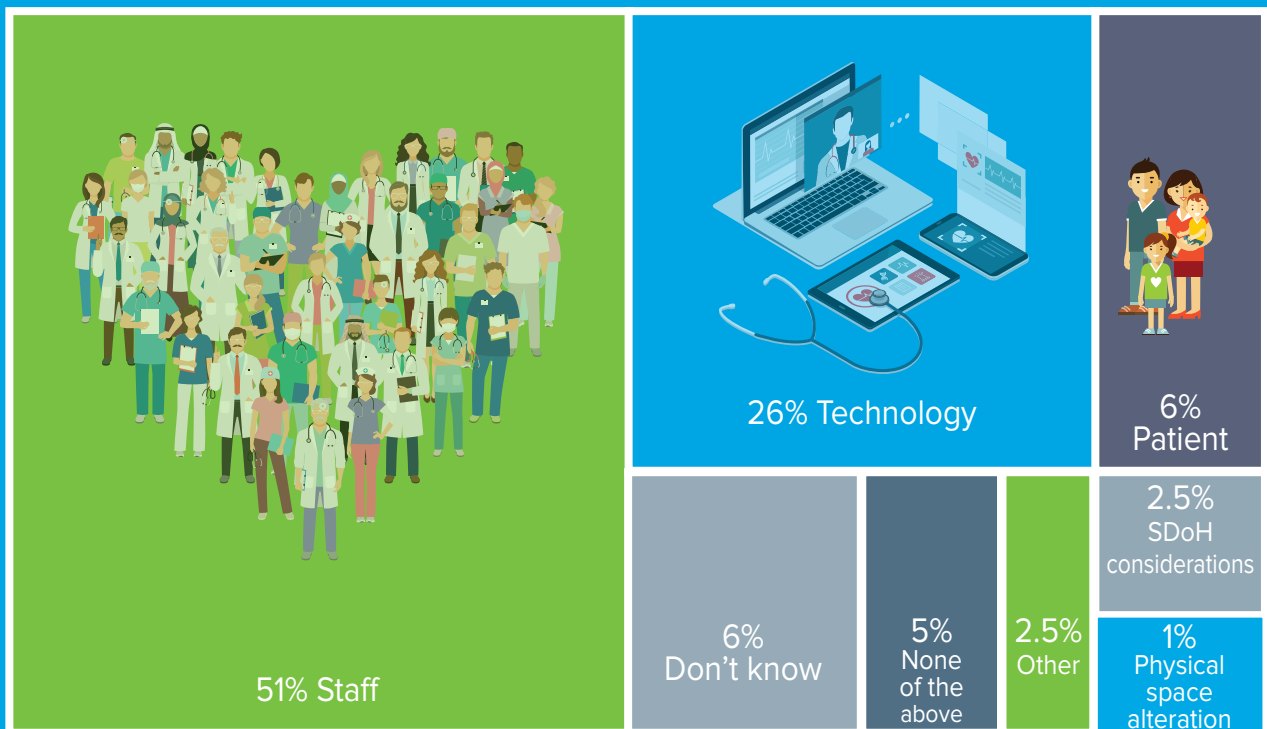


Recent joint research by Humana and MGMA also found that practice employees (such as APPs) focused on care coordination and management are frequently the top additions to staff in the transition to value-based care.²¹

This greater emphasis on patient outcomes translates to more resources devoted to evaluating quality of care, increased points of contact with patients and fosters deeper assessment of relevant metrics. While adding staff represented “big hoops to jump through,” as one practice manager characterized it, the steps resulted in a stronger overall practice.²²

Primary care practices that transitioned into value also cited these staff as having **the most positive impact on the financial performance of the practice in terms of profitability.**

Figure 2. Of the paid resources added, which provides the greatest positive impact on the financial performance in terms for profitability of the practice?



Source: *Value-based Care in the Primary Care Environment, an MGMA and Humana Joint Research Study Report*

Value-based care programs by CMS and commercial payers will be heavily influenced by APPs both today and well into the future with the continued end goal of cost reduction while maintaining and improving upon the care provided.

Specialty-specific insights into APP use

Anesthesiology and CRNAs

MGMA consultant Frank F. Brabec, MBA, CMPE, works extensively in anesthesia groups and knows the supply of anesthesiologists from medical schools is not keeping pace with demand, which has made salaries for these physicians — and CRNAs — very competitive. “CRNAs and anesthesiologists will move around based on getting a higher salary somewhere else and, perhaps, a job that isn’t so intense,” Brabec says.

Faced with mounting cost concerns amid the COVID-19 pandemic, more hospitals may reconsider which anesthesia group they partner with to seek the lowest-cost option, which often involves moving from an all-anesthesiologist group to one that embraces CRNAs in their model.

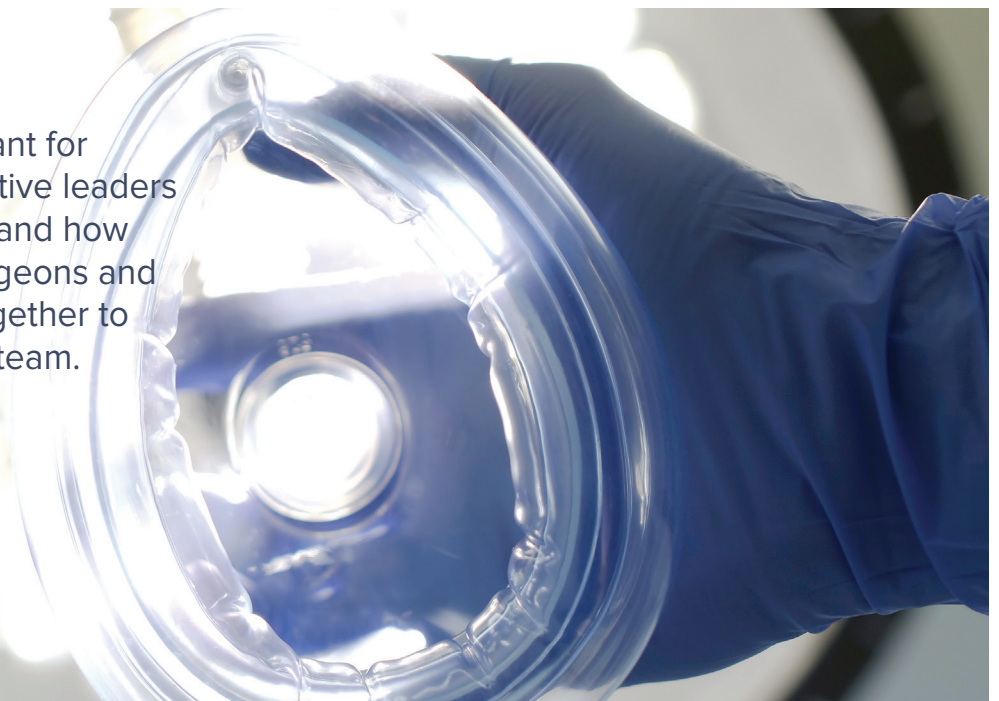
“It’s roughly half the cost for a CRNA versus an anesthesiologist, and CRNAs can do just about any case,” Brabec says. “They can do traumas, they can do hearts. They’re highly useful.” While many all-anesthesiologist groups have a culture of avoiding CRNAs, Brabec adds, CRNAs are not a threat to physicians.

Brabec says some surgeons he’s worked with ultimately warm to a CRNA after having the experience. “They tend to like it,” Brabec adds.

It’s important for administrative leaders to understand how to pair surgeons and CRNAs together to work as a team, and to not simply add APPs into the practice staffing model. Physicians still need to set the bar and serve as role models. **“The APPs will tend to mimic whatever attitudes and work ethic that the physician will have,”** Brabec says.



It’s important for administrative leaders to understand how to pair surgeons and CRNAs together to work as a team.



Credentialing and consumerism in pediatrics

The paradigm shift of reining in total cost of care is going to affect every practice regardless of ownership, according to Phipps, but it's complicated by increasing levels of consumerism among patients and their families.

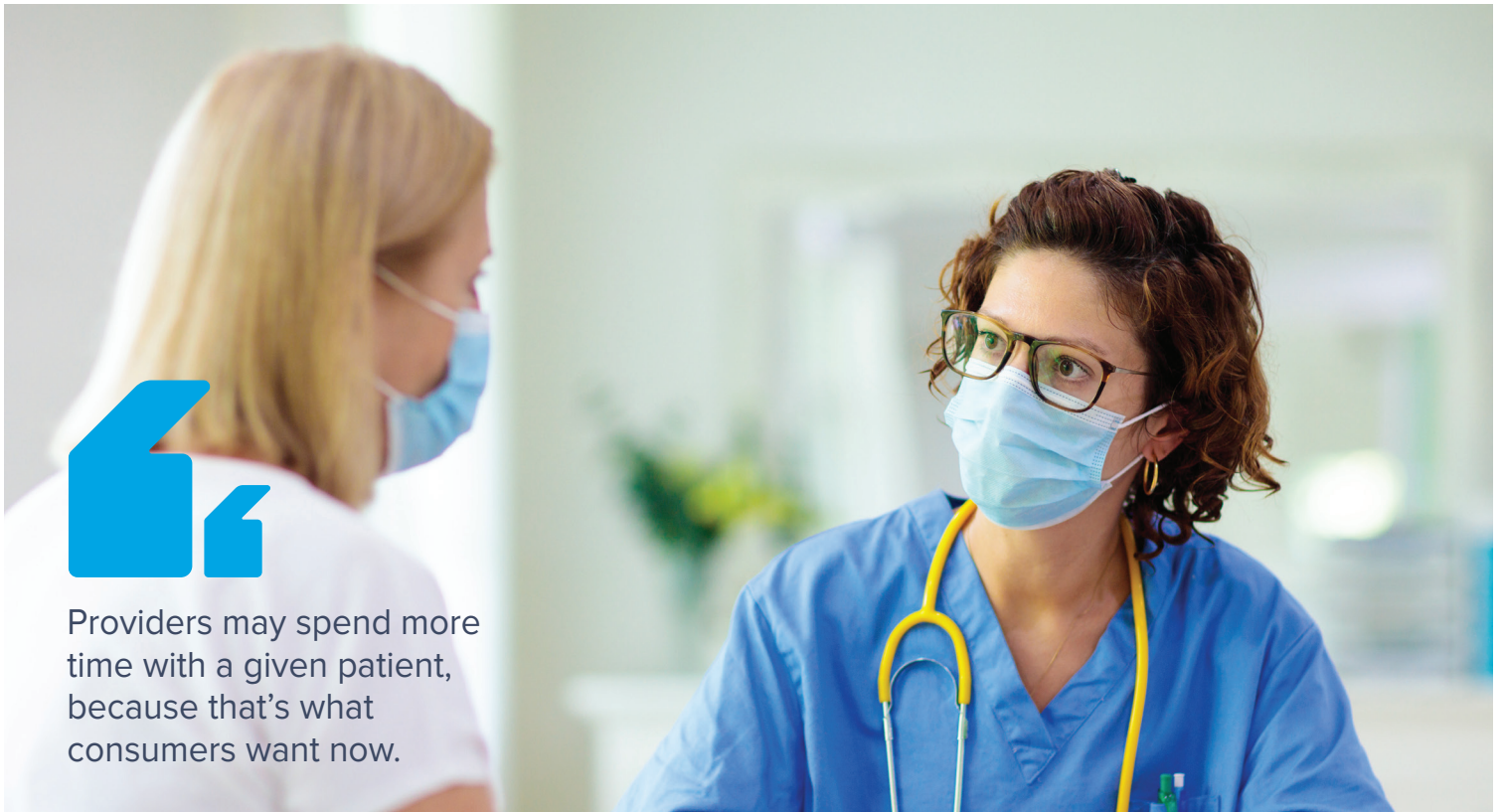
Providers may spend more time with a given patient, “because that’s what consumers want now,” Phipps notes. If relying exclusively on physicians to meet those needs, “you can’t stay in business with that type of a model.”

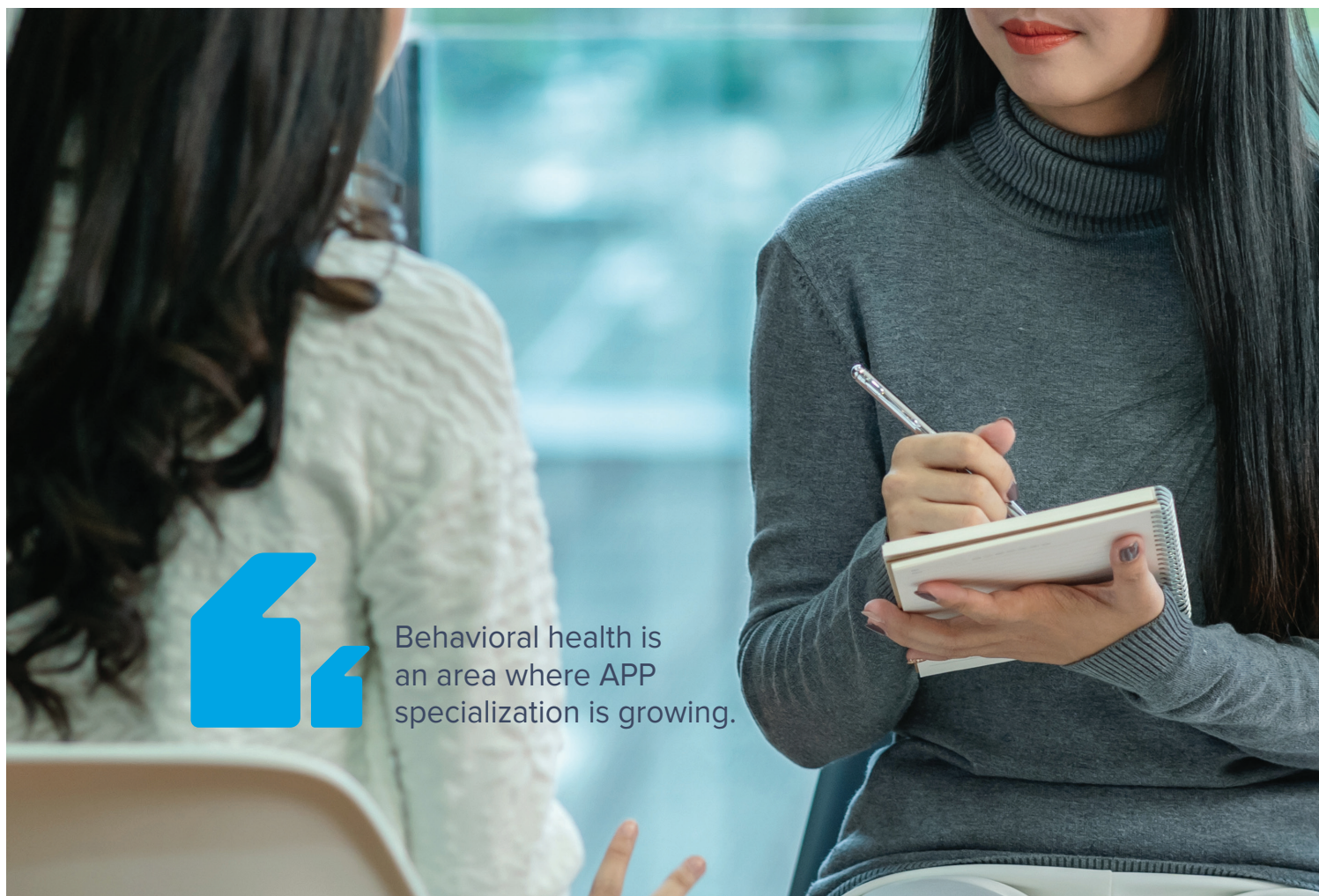
While adding APPs as a lower-cost alternative makes plenty of sense, Phipps cautions that not credentialing those team members will be a risk to reimbursement as more health plans and insurance companies crack down on that type of billing.

Ultimately, that consumerism also will influence some medical groups that operate from a physician-focused mindset, Phipps says. “I don’t think it makes a difference [to patients and families]. ... **If you go to a practice that has physicians, NPs and PAs, most families don’t know who they’re seeing. ... They just want to have good care, they want someone who listens, they want someone who cares,**” Phipps said. **“And that’s what makes a difference.”**



Providers may spend more time with a given patient, because that’s what consumers want now.





Behavioral health is an area where APP specialization is growing.

The APP and behavioral health

Behavioral health is an area where APP specialization is growing. Medicare recognizes the following APPs as eligible under Part B to furnish diagnostic and/or behavioral health treatment:

- **Clinical social workers (CSWs)**
- **Clinical nurse specialists (CNSs)**
- **Nurse practitioners (NPs)**
- **Physician assistants (PAs)**
- **Certified nurse-midwives (CNMs).**²³

For details on required qualifications, coverage and payment for each type of APP in furnishing diagnostic and/or behavioral health treatment, consult the MLN booklet on Medicare mental health: go.cms.gov/3kkFDuP.

Services and supplies furnished by CSWs, CNSs, NPs, PAs and CNMs can be covered when furnished as incident to the professional services of a physician or other specified APP if all incident-to rules are followed (see above). CMS coverage rules for CSWs follow state law, meaning that CMS will only reimburse for CSW services when allowed by the state when provided by a CSW.²⁴

Staffing in urgent care

As urgent care volumes grow as patients return for in-person care amid COVID-19, practice managers will have to be able to identify when to change staffing models.

As Jacquelin Houze, FACMPE, practice manager, St. Elizabeth Physicians, noted in *MGMA Connection* magazine, the staffing model chosen for an urgent care clinic “directly correlates to the clinic’s success and the contentment of providers and staff,” which can drive clinical support staff retention rates.²⁵

Figure 3. Top reported staffing models

		Top reported staffing models
1	       	1 physician, 1 physician assistant (PA), 2 medical assistants (MA), 1 radiologic technician (RT), 1 center manager, 2 receptionists
2	       	1 physician, 1 nurse practitioner, 1 medical assistant (MA), 1 licensed practical nurse, 1 radiologic technician (RT), 1 center manager, 1 receptionist
3	    	1 physician, 1 nurse practitioner, 1 medical assistant (MA), 1 radiologic technician (RT), 1 receptionist

Source: Urgent Care Association, ucaoa.org

For a multispecialty group based in Northern Kentucky with five urgent care locations, success was found with a staffing model that always included two of the following:

- Physician
- APRN
- PA.

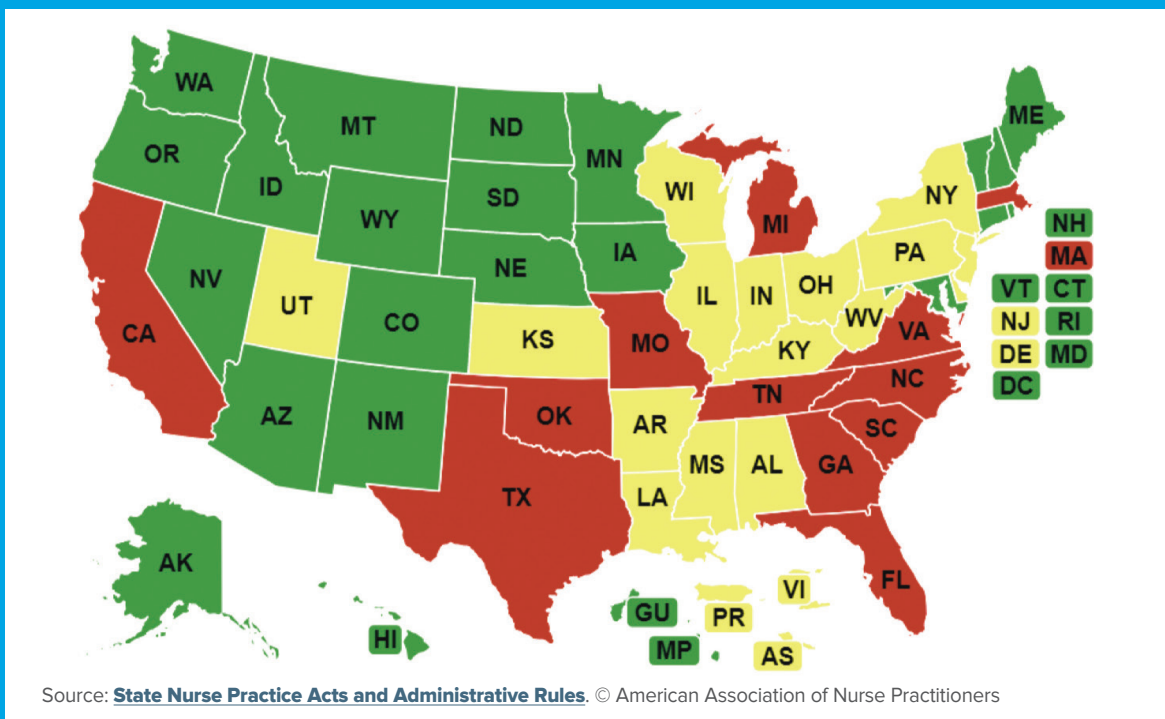
By maintaining two licensed providers in the office, the practice will be prepared for the need to perform advanced cardiac life support (ACLS) at any time, as those clinics will need two medical professionals who can run code if required. This model also benefitted from using medical assistants (MAs) at top of licensure, providing direct patient care, including obtaining essential health histories, administering medications and assisting with minor surgery. However, MAs are not trained for patient assessments.

As Houze writes, it is crucial to provide additional training to all clinical staff members to support them in their jobs. Additional training such as casting and splinting, suture removal and ear irrigation will free up providers and help maintain steady patient flow.²⁶

The APPs, state by state

The key to covered services for APPs lies in their state's scope of practice as well as facility policy and privileges: What is allowed in one state may be reduced or restricted in another. This leads to confusion for practices utilizing APPs. Because of variance in state regulation of APPs, it is essential to understand the environment in which you practice.

Figure 4. NP rules across the United States (as of October 2020)

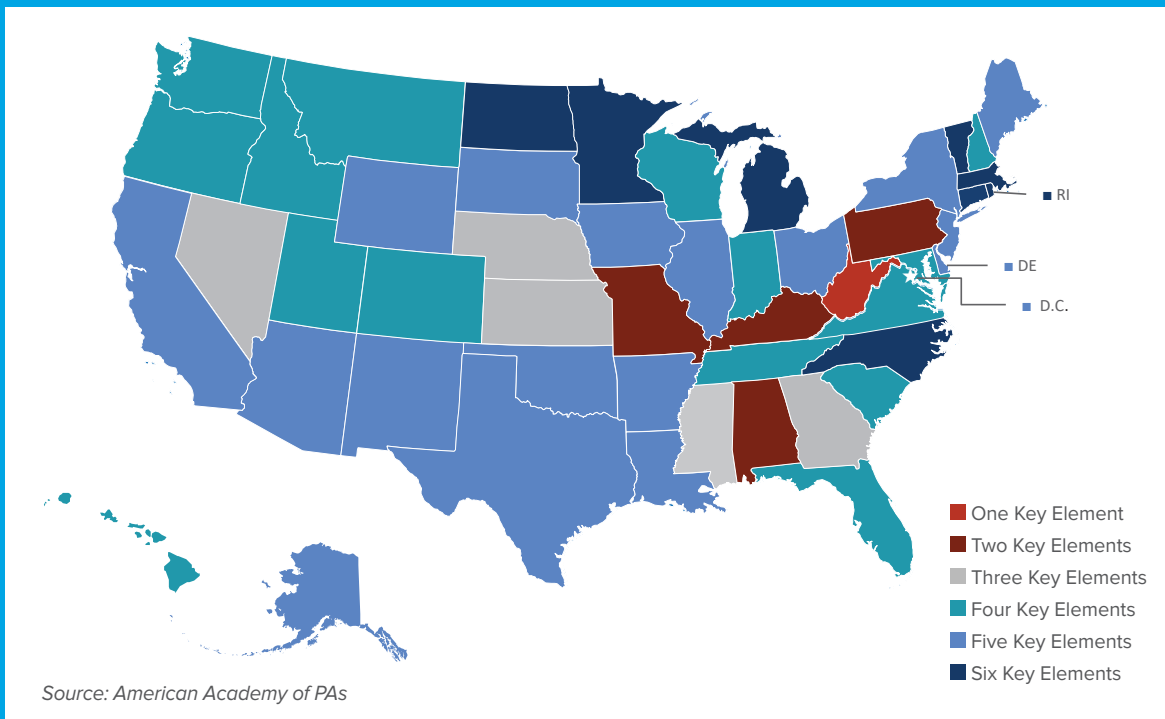


Green — Full practice: State practice and licensure laws permit all NPs to evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing.

Yellow — Reduced practice: State practice and licensure laws reduce the ability of NPs to engage in at least one element of NP practice. State law requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care, or it limits the setting of one or more elements of NP practice.

Red — Restricted practice: State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team management by another health provider in order for the NP to provide patient care.

Figure 5. PA rules across the United States (as of October 2020)



PA rules across the United States (as of October 2020)

The American Academy of Physician Assistants (AAPA) has identified six key elements that should be part of every state's PA practice act:

1. **“Licensure” as the regulatory term:** “Licensed” is now the preferred term, as opposed to “certified” or “registered” PAs.
2. **Full prescriptive authority:** AAPA contends that laws restricting PAs’ prescriptive authority may interrupt care delivery.
3. **Scope of practice determined at the practice level:** State laws limiting the list of services that PAs can provide can lead to inefficiencies or limited access to care.
4. **Adaptable collaboration requirements:** Imposing proximity requirements that require physicians to be on site with a PA can be cumbersome.
5. **Chart cosignature requirements determined at the practice:** Physician and PA collaboration on charts is sufficient and ought not require physician cosignature.
6. **Number of PAs whom a physician may supervise determined at the practice level:** Legal limits on physician-to-PA ratios may not account for unique differences in various specialties or practice settings.²⁷

Conclusion

With a looming physician shortage and the numerous impacts of expanded telehealth, new technology, the shift to value-based care models and the ongoing effects of the COVID-19 pandemic, the healthcare industry is headed toward a future in which APPs continue to play an increasingly vital role.

Notes

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A close-up, low-angle shot of a medical professional, likely a nurse or doctor, wearing blue scrubs. They are holding a blue pen in their right hand and writing on a clipboard held in their left hand. A stethoscope is visible around their neck. The background is dark and out of focus, showing some medical equipment and a bright light source, possibly an operating room or a clinical examination room. The overall lighting is dim, with a strong blue tint.

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