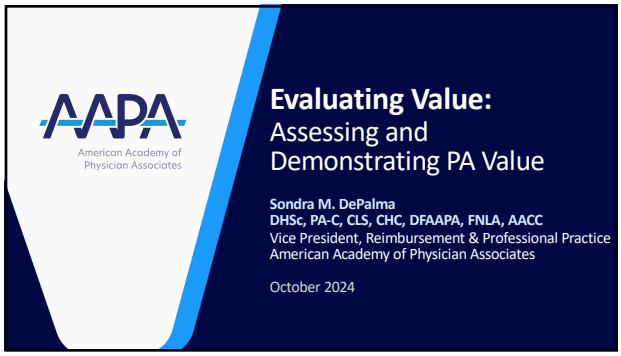
AAPA
American Academy of Physician Associates
Evaluating Value:
Assessing and Demonstrating PA Value
Sondra M. DePalma
DHSc, PA-C, CLS, CHC, DFAAPA, FNLA, AACC
Vice President, Reimbursement & Professional Practice
American Academy of Physician Associates
October 2024

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No disclosures or conflicts of interest

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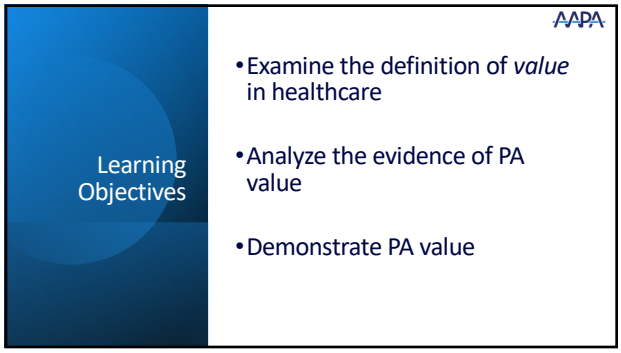
AAPA
Learning Objectives
•Examine the definition of *value* in healthcare
•Analyze the evidence of PA value
•Demonstrate PA value

3

Value

4

Why be Concerned About Value?

- Increased interest in value in healthcare
- Concern of employers and health systems
- Determinations for public health policy and funding

5

What is Value?

- Relative importance, usefulness, or desirability of something or someone
- The monetary worth of something

"Nowadays people know the price of everything and the value of nothing."
Oscar Wilde

6

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Traditional Value Equation

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

7

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"Value is a composite of patient experience, quality and cost, delivered with complete transparency."

"It is about the quality of services consumers receive, how they appreciate what they receive, whether it met their satisfaction and whether it was delivered at a price they could afford."

Yele Aluko, MD, MBA

8

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Updated Value Equation

$$\text{Value} = \frac{\text{Benefits}}{\text{Costs}}$$

(financial & otherwise)

- Productivity & Revenue
- Quality & Outcomes
- Access to Care
- Patient Satisfaction
- Provider & Staff Satisfaction
- Efficiency & Care Coordination

9

What is Productivity?

- Efficiency of production or provision of services
- Units of output over time
- A proxy of value

10

Measurements of Productivity

Charges
- what a practice charges for the service

Collections
- what a practice receives from the payer

RVU (Relative Value Unit)
- work effort, practice expense, and malpractice

wRVU
- relative value of work performed by a provider

11

RVU

Standardized measure used to determine payment for services

Work RVU	←	Provider time, effort & skill
+		
Practice Expense RVU	←	Labor, equipment & supplies
+		
Malpractice RVU	←	Malpractice premium
=		
Total RVU	× Conversion Factor =	Payment Rate

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wRVU

- Provider-based relative value measure
  - Accounts for work product and effort of the practitioner
  - Eliminates variation in charges and payments for services
- Commonly used by employers to measure and incentivize productivity and as a proxy of value

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wRVU – Limitations for PAs

Methods of measuring productivity may be inaccurate, particularly depending on:

- Variations in practice settings, patient complexity, acuity of care, healthcare resources, workflow, and care services provided
- Billing mechanisms and policies
- Contribution to global surgical billing and bundled payments

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wRVU – Limitations for PAs

Methods of measuring productivity may be inaccurate, particularly depending on:

- Variations in practice settings, patient complexity, acuity of care, healthcare resources, workflow, and care services provided
- **Billing mechanisms and policies**
- Contributions to global surgical billing and bundled payments

15

Billing Mechanisms/Policies that Limit APP Productivity Measurement

- Optional Medicare billing mechanisms (i.e., "Incident To" and Split (or Shared) Billing) and/or commercial payer policies that instruct APPs to "Bill Under a Physician"
- Claims data will attribute all such work/encounters to billing physician

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Billing Mechanisms/Policies that Limit PA Productivity Measurement

17

Potential Work-Arounds to the Problem

'Dummy' codes

Percentage of physician work

Documentation and other metrics

18

wRVU – Limitations for PAs

Methods of measuring productivity may be inaccurate, particularly depending on:

- Variations in practice settings, patient complexity, acuity of care, healthcare resources, workflow, and care services provided
- Billing mechanisms and policies
- **Contributions to global surgical billing and bundled payments**

19

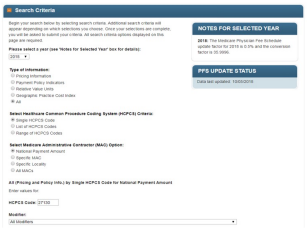
Measuring Productivity as Part of Global Surgical Package

- Bundled payment for all usual and necessary pre-, intra- and post- operative care for a procedure or surgery
- PA contribution thought to be hidden

20

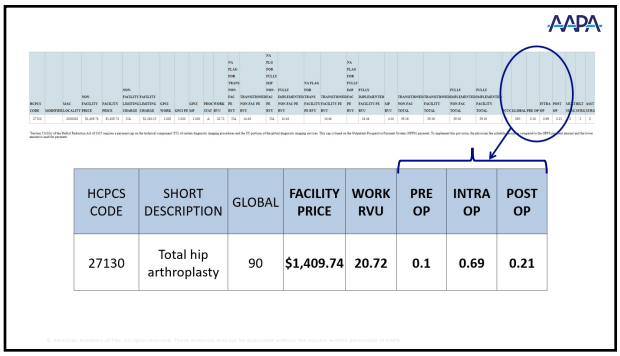
Physician Fee Schedule Search

https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx



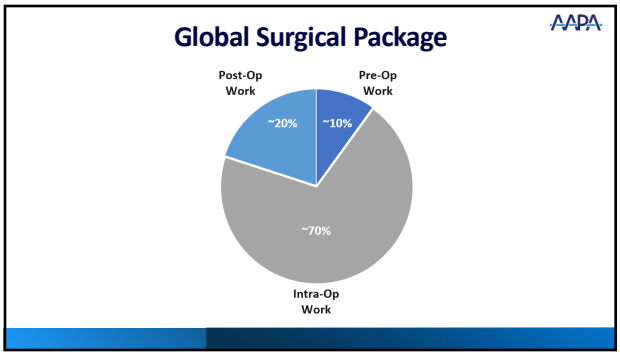
- ✓ Type of information: All
- ✓ Single HCPCS Code
- ✓ Select MAC/Locality option
- ✓ Modifier: All Modifiers

21



HCPCS CODE	SHORT DESCRIPTION	GLOBAL	FACILITY PRICE	WORK RVU	PRE OP	INTRA OP	POST OP
27130	Total hip arthroplasty	90	$1,409.74	20.72	0.1	0.69	0.21

22



23

Hypothetical Work Attribution for THA

27130	Global Surgical Package	Physician	PA/NP
Pre-operative (0.1)	$140.97 2.07 wRVU		$140.97 2.07 wRVU
Intra-operative (0.69)	$972.72 14.30 wRVU	$972.72 14.30 wRVU	
Post-operative (0.21)	$296.05 4.35 wRVU		$296.05 4.35 wRVU
Total	$1,409.74 20.72 wRVU	**$972.72 14.30 wRVU**	**$437.02 6.42 wRVU**

24

CPT Code 99024

- *Postoperative follow-up visit, normally included in the surgical package*
- No fee, no RVUs
- Captures services normally included in the surgical package

Captures post-op work provided in Global Surgical Package

25

Measures of Productivity

Productivity Component	Examples of Measurement
Direct Measures of Reimbursable Services	wRVU, RVU, total charges/collections
Indirect Measures of Reimbursable Services	Number of scheduled patients, number of documentations in the EHR, portion of global payments/RVUs, total practice revenue or RVUs
Measures of Indirect Clinical Services	Hours worked, hours on-call, time spent providing patient education
Measures of Non-Clinical Services	Participation in quality improvement or system processes, contribution to research

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Pitfalls of Measuring Productivity

In addition to the risk of inaccuracy, measuring value by productivity may:

- Cause colleagues to compete for patients
- Lead to unnecessary tests or procedures
- Decrease professional satisfaction and perceived clinical contribution
- Devalue other, non-revenue-generating contributions

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Measures of Value (other than productivity)	
Value Component	**Examples of Measurement**
Quality & Outcomes	Rates of attaining quality measures (e.g. BP or Hgb AIC), % of patients receiving guideline-recommended screenings, post-op infection rates
Access to Care	% of patients seen within timeframe of requesting appt, average time to first-available appt
Care Coordination	Timely responses to patient enquiries, ordering of RXs, reviews of diagnostic tests
Patient Satisfaction	Average patient satisfaction scores
Resource Utilization	Adherence to Appropriate Use Criteria, Cost/Outcomes Ratios

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Evidence of Value

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Value Equation

$$\text{Value} = \frac{\text{Benefits}}{\text{Costs}}$$

(financial & otherwise)

- **Productivity & Revenue**
- Quality & Outcomes
- Access to Care
- Patient Satisfaction
- Provider & Staff Satisfaction
- Efficiency & Care Coordination

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HEALTHCARE FINANCE

July 25, 2018
Beth Jones Sanborn

Non-physician providers boost revenue, practice productivity, MGMA data shows

Practices with higher ratios of NPPs to physicians made more money, despite a rise in operating costs, data shows.

31

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Advanced Practice Providers Optimize Efficiency and Improve Financial Performance

By Zachary Hartsell, Mark Rumans, MD, Julie Bowman, RN, and Jared T. Muenzer, MD

For the past six years, more than 60 percent of healthcare organizations surveyed have increased their advanced practice provider population.

32

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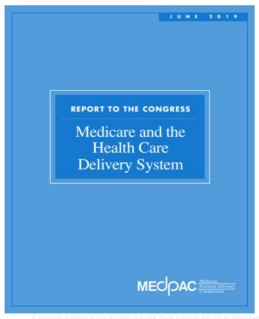

"NPs & PAs nearly always lower costs (and increase profits) for their employers because their salaries are less than half of physician salaries, on average, but their services can be billed at the full physician rate or at a modest discount ."

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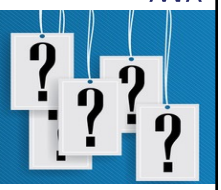
What about the "lost" 15%



More than made up for in increased efficiency, decreased burden, and contribution margin.

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Reimbursement & Profit

- PA (and NP) reimbursement is at 85% of physician fee schedule
- PA (and NP) salary is 30% - 50% that of physician salary
- Contribution margin for PA is greater than that for physician

Contribution Margin
Revenue minus wages/costs

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Personnel Costs

Salary	PA/NP < physician
Benefits (PTO, CME allotment, etc.)	PA/NP ≤ physician
Recruitment/Onboarding	PA/NP ≤ physician
Malpractice Premiums	PA/NP < physician
Overhead (building, staff, supplies)	PA/NP = physician

Overall cost to employ PA (or NP) ↓↓↓ physician

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Cost Effectiveness of PAs

A hypothetical day In the hospital	Physician	PA
Revenue with physician and PA providing the same 99232 service	$1080 ($72 X 15 visits)	$915 ($61 X 15 visits) [85% of $72 = $61]
Wages per day	$960 ($120/hour x 8 hours)	$440 ($55/hour x 8 hours)
"Contribution margin" (revenue minus wages)	**$120**	**$475**

Example does not include personnel costs and other expenses.

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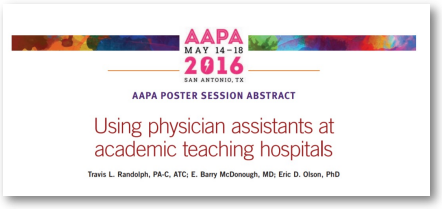

https://journals.lww.com/jaapa/citation/2016/10000/using_physician_assistants_at_academic_teaching.47.aspx

38

6-Month Pilot Study

Compared "shared clinic" to "split clinic model"

- **Shared clinic model** – PA functions like a medical resident or scribe, services billed under the name/NPI of physician, risk of fraud/abuse/compliance violations
- **Split-clinic model** – PA functions autonomously while physician is in clinic or operating room, services billed under the name/NPI of the rendering provider

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6-Month Pilot Study

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PA Results

- 700% ↑ in PA's total patient volume
- 600% ↑ in PA's payments
- 500% ↑ in PA's RVUs

40

6-Month Pilot Study

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Physician Results

- 5% ↓ in total payments and RVUs for physician during 6-month pilot
- 33% ↑ in physician's operating projections for first month following pilot study

41

6-Month Pilot Study

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Practice Results

- 17% ↑ in total patient volume
- 41% ↑ in New Patients
- 16% ↑ in Return Patients
- 66% ↓ in patient wait times
- 14% ↓ in patient no-shows for physician
- 95% of patients rated PA as good or excellent
- Medical residents reported improved learning experience

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AAPA 2020 POSTER SESSION ABSTRACTS

Four-year follow-up study on the use of PAs at academic teaching hospitals

Travis L. Randolph, PA-C, ATC

4 years follow-up compared to 6 years prior to pilot

175% ↑ # of PAs/NPs

100% ↑ collections per PA/NP

125% ↑ wRVUs per PA/NP

https://pubmed.ncbi.nlm.nih.gov/33496501/

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ORIGINAL RESEARCH

Demonstrating advanced practice provider value: Implementing a new advanced practice provider billing algorithm

Paula B. Brooks, DNP, FNP-BC, MBA, RNFA; Megan E. Fulton, MSPAS, PA-C

https://journals.lww.com/jaapa/fulltext/2019/02000/demonstrating_advanced_practice_provider_value_.17.aspx

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Billing Optimization

- Utilization of PAs and NPs was optimized
  - Allowing practitioners to practice to the full extent of their education, experience, and licensure
  - Transferring "supportive" work performed for physicians to other staff
- A standardized billing algorithm was developed with more autonomous PA/NP billing

https://pubmed.ncbi.nlm.nih.gov/30694959/

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Billing Optimization

Results - ↑ wRVUs and collections for
- PAs/NPs
- Group Practice
- Physicians

https://pubmed.ncbi.nlm.nih.gov/30694959/

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Physician & APP wRVUs and Collections for General Internal Medicine Group (Without Change in Staffing)				
		FY 2017	FY 2018	% Variance
Physician Total	wRVUs	35,924	37,086	3%
	Collections	$1,637,975	$1,715,268	5%
APP Total	wRVUs	1,274	9,019	608%
	Collections	$52,612	$457,178	769%
Group Total	wRVUs	37,198	46,105	24%
	Collections	$1,690,586	$2,172,446	29%

Implementation of more autonomous APP billing

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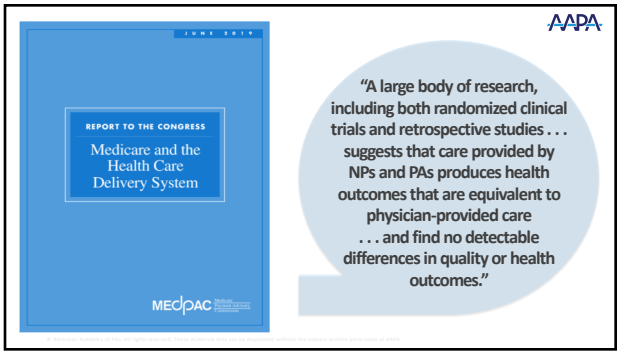
Value Equation

$$\text{Value} = \frac{\text{Benefits}}{\text{Costs}}$$

(financial & otherwise)

- Productivity & Revenue
- Quality & Outcomes
- Access to Care
- Patient Satisfaction
- Provider & Staff Satisfaction
- Efficiency & Care Coordination

48



49

"No statistically significant differences were detected in NP or PA care compared with primary care physician care."

ORIGINAL ARTICLES

A Comparison of Nurse Practitioners, Physician Assistants, and Primary Care Physicians' Patterns of Practice and Quality of Care in Health Centers

Kurtzman, Ellen T. PhD, MPH, RN, FAAN*; Barnow, Burt S. PhD† Author Information

Medical Care: June 2017 - Volume 55 - Issue 6 - p 615-622
doi: 10.1097/MLR.0000000000000689

https://pubmed.ncbi.nlm.nih.gov/28234756/

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HealthLeaders

ANALYSIS

NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS EQUIVALENT TO DOCTORS IN CHRONIC ILLNESS CARE

BY CHRISTOPHER CHENEY | DECEMBER 14, 2018

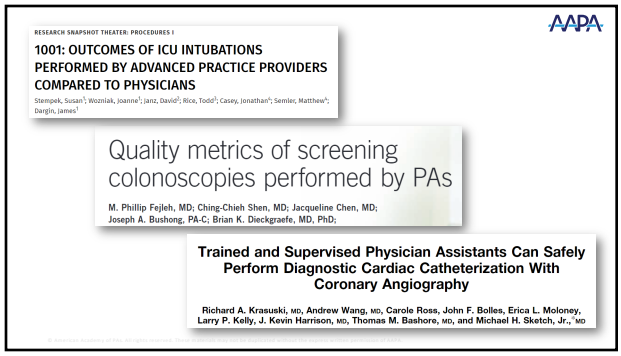
In NP, PA, and physician treatment of diabetes patients, no significant difference is found in three clinical measures.

https://www.healthleadersmedia.com/clinical-care/nurse-practitioners-and-physician-assistants-equivalent-doctors-chronic-illness-care

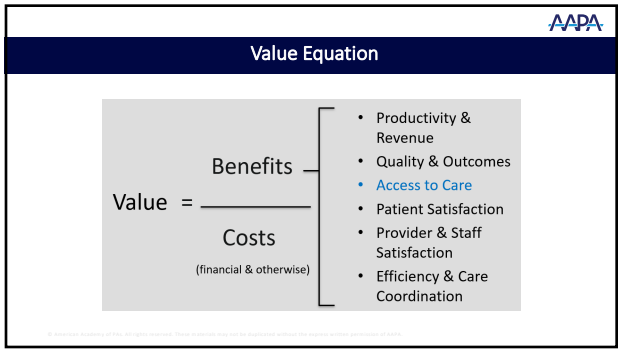
51


CONCISE DEFINITIVE REVIEW
Nurse Practitioners and Physician Assistants in Acute and Critical Care: A Concise Review of the Literature and Data 2008–2018
Kleinpell, Ruth M. PhD, RN, FCCM[1,2]; Grabenkort, W. Robert PA, MMSc, FCCM[3]; Kapu, April N. DNP, RN, ACNP-BC, FAANP, FCCM[3,4,5]; Constantine, Roy PhD, MPH, PA-C, DFAAPA, FCCM[6,7]; Sicoutris, Corinna MSN, ACNP, FAANP, FCCM[8] Author Information
Critical Care Medicine: October 2019 - Volume 47 - Issue 10 - p 1442-1449
doi: 10.1097/CCM.0000000000003925
https://pubmed.ncbi.nlm.nih.gov/31414993/
Provide value in "care management, continuity of care, decreasing costs of care, decreasing resource use, improving quality and safety metrics, patient and staff satisfaction."

52


AAPA
RESEARCH SNAPSHOT THEATER: PROCEDURES I
1001: OUTCOMES OF ICU INTUBATIONS PERFORMED BY ADVANCED PRACTICE PROVIDERS COMPARED TO PHYSICIANS
Stempek, Susan[1]; Wozniak, Joanne[1]; Janz, David[2]; Rice, Todd[3]; Casey, Jonathan[4]; Semler, Matthew[4]; Dargin, James[1]
Quality metrics of screening colonoscopies performed by PAs
M. Phillip Fejleh, MD; Ching-Chieh Shen, MD; Jacqueline Chen, MD; Joseph A. Bushong, PA-C; Brian K. Dieckgraefe, MD, PhD;
Trained and Supervised Physician Assistants Can Safely Perform Diagnostic Cardiac Catheterization With Coronary Angiography
Richard A. Krasuski, MD, Andrew Wang, MD, Carole Ross, John F. Bolles, Erica L. Moloney, Larry P. Kelly, J. Kevin Harrison, MD, Thomas M. Bashore, MD, and Michael H. Sketch, Jr., MD

53


AAPA
Value Equation
Value = Benefits / Costs
(financial & otherwise)
• Productivity & Revenue
• Quality & Outcomes
• Access to Care
• Patient Satisfaction
• Provider & Staff Satisfaction
• Efficiency & Care Coordination

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Increased Access

Utilization of PAs can result in

- ↓ patient wait-time-to-appointment
- ↓ cost of care
- ↑ clinic hours and/or locations
- ↑ types of services
- ↑ face-to-face time

https://journals.lww.com/jaapa/fulltext/2019/02000/demonstrating_advanced_practice_provider_value_.17.aspx
https://journals.lww.com/jaapa/citation/2016/10000/using_physician_assistants_at_academic_teaching.47.aspx
https://www.hamiltonproject.org/assets/files/AdamsandMarkowitz_20180611.pdf
https://lawecommons.luc.edu/annals/vol33/iss1/3

55

Increased Access & Equity

Utilization of PAs has been shown to improve health equity through ↑ care to:

- Rural and other medically underserved areas
- Lower income
- Disabled
- Elderly

https://www.bmj.com/content/382/bmj-2022-073933
https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf

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Increased Access

"I'm able to see [PAs] very quickly as opposed to my doctor. The access is really good. [They are] **attentive, thorough, friendly,** and **accessible**."

Woman, age 65+

95% of PA patients felt valued by the care they received.

91% agree PAs a solution to provider shortages

90% agree that PAs increase access.

https://www.aapa.org/research/patient-experience/pdf

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Value Equation

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- Efficiency & Care Coordination

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Patient Satisfaction

- Medicare beneficiaries "do not distinguish preferences based on provider type" and "in all indices of satisfaction PAs (and NPs) were rated as favorably as physicians"
- A plurality (41.2%) of people aged 18 to 34 years prefer to receive care from a PA (or NP) compared with a physician (27.7%)

https://pdfs.semanticscholar.org/90eb/eaee6f919185f7e96e79d585f8703307d1ac.pdf
https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2012.1150

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What Patients Say

- "The PA explained things to me in a way I understood."
- "The PA spent time with me."
- "The PA listened to me."

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Value Equation

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- Productivity & Revenue
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Critical Care Medicine: October 2019 - Volume 47 - Issue 10 - p 1442-1449
doi: 10.1097/CCM.0000000000003925

https://pubmed.ncbi.nlm.nih.gov/31414993/

Provide value in "care management, continuity of care, decreasing costs of care, decreasing resource use, improving quality and safety metrics, patient and staff satisfaction."

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Implementing Optimal Team-Based Care to Reduce Clinician Burnout

By Cynthia D. Smith, Celynne Balatbat, Susan Corbridge, Anna Legreid Dopp, Jessica Fried, Ron Harter, Seth Landefeld, Christina Y. Martin, Frank Opelka, Lew Sandy, Luke Sato, and Christine Sinsky

https://nam.edu/wp-content/uploads/2018/09/Implementing-Optimal-Team-Based-Care-to-Reduce-Clinician-Burnout.pdf

63

Value Equation

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CONCISE DEFINITIVE REVIEW

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Critical Care Medicine: October 2019 - Volume 47 - Issue 10 - p 1442-1449
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https://pubmed.ncbi.nlm.nih.gov/31414993/

Provide value in "**care management, continuity of care**, decreasing costs of care, decreasing resource use, improving quality and safety metrics, patient and staff satisfaction."

65

Optimal Use of Advanced Practice Providers at an Academic Medical Center: A First-Year Retrospective Review

Vasco Deon Kidd [1], Alpesh Amin [2], Nitin Bhatia [1], Denise Healey [2], Courtney Fisher [3], Mojgan Rafiq [3], Mary Jo Angelica E. Gallegos [4], Kathrina Munoz [2]

1. Orthopaedic Surgery, University of California Irv... Orange, USA 2. Clinical Affairs, University of Calif... of California Irvine, Orange, USA 3. Urology, Unive...

Corresponding author: Vasco Deon Kidd, deon60...

ORIGINAL ARTICLE

An evaluation of the impact of advanced nurse practitioner triage and clinical intervention for medically expected patients referred to an acute National Health Service hospital

Lucy Moxham BSc Hons, MS, Kate McMahon-Parkes RGN, BSc Hons, PGDipHE, MA

First published: 20 June 2020 | https://doi.org/10.1111/jocn.15392 | Citations: 8

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9889205/pdf/cureus-0015-00000034475.pdf
https://onlinelibrary.wiley.com/doi/epdf/10.1111/jocn.15392

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Importance of Value in Value-Based Payment

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In FFS, $ ↑ with	In VBP, $ ↑ with
• Provision of Services	• Patient Outcomes • Patient Satisfaction • Access to Care • Care Coordination • Cost Containment

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PAs and Value-Based Payments

PAs

- Quality
- Patient Satisfaction
- Access
- Care Coordination
- Cost Containment

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Value Considerations

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Value Considerations

- PAs need to be able to practice to top-of-license to realize optimal value
  - PAs are not scribes
- Risk of fraud and abuse by not utilizing PAs appropriately

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PAs are NOT Scribes

"scribes are not providers of items or services"

CMS

- NOT cost-effective
  - PA/APRN ~$130,000 annually
  - Scribe ~40,000 annually
- Risk of fraud and abuse

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R713PI.pdf

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Value Considerations – Remove Practice Barriers

- Call for states to remove practice barriers and allow PAs to practice to the full extent of their education, training, and experience
- Recommended by
  - Policy experts, government agencies (including Departments of Health and Human Services, Treasury, and Labor), economists, researchers, and other experts

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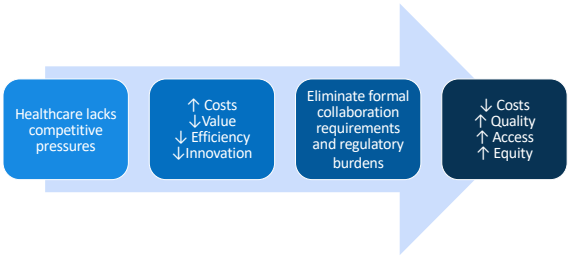
Value Considerations – Remove Practice Barriers



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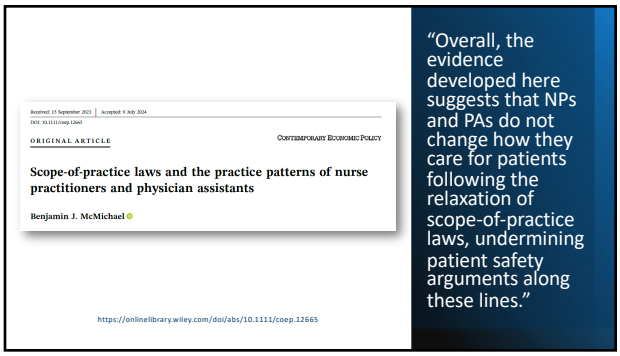
Value Considerations – Remove Practice Barriers

States should "consider eliminating requirements for rigid collaborative practice and supervision agreements . . . that are not justified by legitimate health and safety concerns."

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. DEPARTMENT OF THE TREASURY
U.S. DEPARTMENT OF LABOR

https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf

75



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3 Independent Research Articles Published in 2023 found NO EVIDENCE of Patient Harm by Removing Collaboration/Supervision Requirements from State Law

1. Relaxing practice laws for PAs and NPs decreased "healthcare amenable deaths"
2. Permissive compared to restrictive practice laws for PAs are NOT associated with increased malpractice payments
3. Full Practice Authority for NPs is NOT associated with increased malpractice payments

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Original Research Article

Medical Malpractice Payment Reports of Physician Assistants/Associates Related to State Practice Laws and Regulations

Analyzed PA State Laws & Regulations and MMPRs from the National Practitioner Data Bank Public Use Data File from 2010-2019

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Results

No significant difference in MMPRs for PAs ($p = 0.588$) or physicians ($p = 0.154$) between permissive versus restrictive states

- Permissive practice environments (with 4 or more permissive SOP elements)
- Restrictive states (with 3 or fewer permissive SOP elements)

https://meridian.allenpress.com/jmr/article/109/4/27/498933/Medical-Malpractice-Payment-Reports-of-Physician

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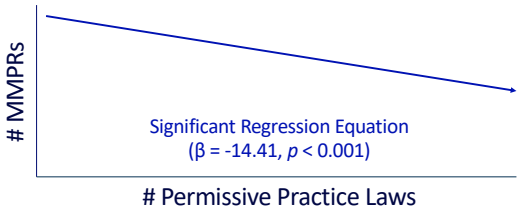
Results



https://meridian.allenpress.com/jmr/article/109/4/27/498933/Medical-Malpractice-Payment-Reports-of-Physician

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State Elements and Associated Risk of MMPRs for PAs and Physicians
Highly significant decrease in MMPRS for PAs and physicians
Allowing PAs to practice consistent with their training and experience (PAs β = -0.875, $p = 0.000$; physicians $p = 0.002$)

https://meridian.allenpress.com/jmr/article/109/4/27/498933/Medical-Malpractice-Payment-Reports-of-Physician

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State Elements and Associated Risk of MMPRs for PAs and Physicians
A significant decrease in MMPRs for physicians with no effect on MMPRs for PAs
Allowing PAs to practice in collaboration with physicians or have no formal statutory relationship with a physician (physicians β = -0.29, *p* = 0.017; PAs *p* = 0.112)
Authorizing physicians to collaborate with an unlimited number of PAs (physicians β = -0.16, *p* = 0.036; PAs *p* = 0.659)

https://meridian.allenpress.com/jmr/article/109/4/27/498933/Medical-Malpractice-Payment-Reports-of-Physician

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State Elements and Associated Risk of MMPRs for PAs and Physicians
No significant effect on MMPRs for PAs or physicians
Allowing PA SOP to be determined at the practice site (PAs *p* = 0.463; physicians *p* = 0.520)
Not requiring a physician to be onsite or in proximity to a practicing PA (PAs *p* = 0.949; physicians *p* = 0.783)

https://meridian.allenpress.com/jmr/article/109/4/27/498933/Medical-Malpractice-Payment-Reports-of-Physician

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State Elements and Associated Risk of MMPRs for PAs and Physicians
Significant increase in MMPRs for PAs & a trend toward decreased MMPRs for physicians
Physician co-signature requirements (PAs β = 0.150, *p* = 0.048; physician *p* = 0.058)

https://meridian.allenpress.com/jmr/article/109/4/27/498933/Medical-Malpractice-Payment-Reports-of-Physician

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Conclusions

- Restrictive PA scope of practice elements can be eliminated from state laws and regulations without adversely affecting MMPRs or patient safety
- More permissive PA practice environment leads to a reduction in MMPRs for PAs and physicians.
- Allowing PAs and physicians to have flexible collaboration determined at the practice site may result in more meaningful collaboration, optimized practice, and efficiency of care that improves healthcare and reduces risk

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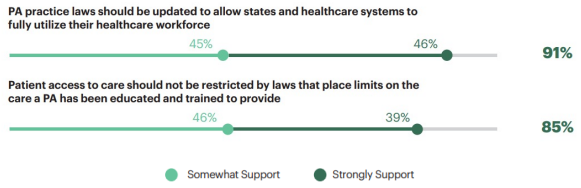
Patient Perception of SOP Laws



https://www.aapa.org/download/113513/?tmstv=1684243672

86

# of PAs (and APRNs)
# of encounters with PAs (and APRNs)

# of physicians
# of encounters with physicians

https://www.bmj.com/contet/382/bmj-2022-073933

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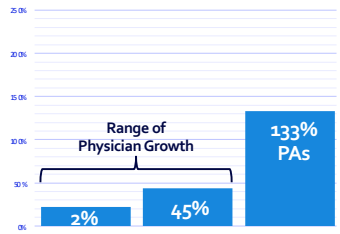
Increase in Practitioners from 2010 to 2024



https://www.iqvia.com/locations/united-states/library/insight-brief/the-increasingly-important-role-of-nps-and-pas-in-healthcare-sales-targeting

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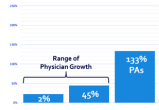
Increase in Practitioners from 2010 to 2024

"This growth is not arbitrary but stems from the pivotal contributions these professionals make to our healthcare system."



https://www.iqvia.com/locations/united-states/library/insight-brief/the-increasingly-important-role-of-nps-and-pas-in-healthcare-sales-targeting

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Billing Practitioners per 1,000 Medicare Beneficiaries

2017-2022

PAs & APRNs	Primary Care Physicians	Specialist Physicians
↑ 4.1 to 5.2	↓ 2.6 to 2.2	↓ 8.5 to 8.0

https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf

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Billing Practitioners per 1,000 Medicare Beneficiaries

2017-2022

"The composition of the clinician workforce continues to change, with a rapid increase in the number of APRNs and PAs."

https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf

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PA and APRN Services

2021-2022

↑ 11.2% E&M Services	↑ 16.3% Imaging	↑ 11.2% Non-Imaging Tests	↑ 10.6% Treatment Services	↑ 13.1% Procedures

https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf

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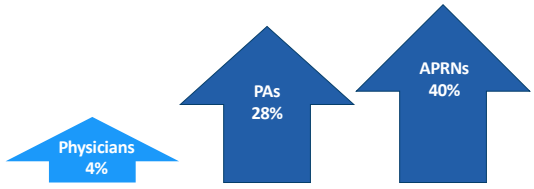
Expected Growth of Professions

Percent Change in Employment from 2023 to 2032



US Bureau Labor and Statistics

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Expected Growth of Professions

Employment in 2032

Approximately 1.3 Million Practitioners

US Bureau Labor and Statistics

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"Although Americans have historically seen a physician as their usual clinician, increasingly that usual clinician will now be a nurse practitioner or physician assistant."

https://www.bmj.com/content/382/bmj-2022-073933

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Key Takeaways

- PAs are valuable members of the healthcare team!
- Value should not be measured by productivity alone.
- Accurate evaluation of value is important to demonstrate contribution.

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