KATY REED / JASON PETERSON
ECG Management Consultants, Inc.

Rethinking the Role of Advanced Care Practitioners

Is the right person performing the right tasks at the right time in your cardiology practice? Undoubtedly, your practice is striving to improve patient access, throughput, and outcomes, all while simultaneously reducing costs. Unless you have the right care delivery model in place, gains in efficiency and access will be hard to attain. So it may be time to ask yourself: Is your care delivery model helping or hindering your ability to provide efficient, cost-effective care? If performance is being hindered, what changes can be made?

Advanced care practitioners (ACPs), such as physician assistants (PAs) and nurse practitioners (NPs), have long supported the delivery of cardiac care. In many of the physician practices and hospitals I work with, however, ACPs are simply not being leveraged as effectively as they could be. Instead, lingering assumptions about the role of ACPs and long-held practice models are restricting their true capacity to improve productivity and enhance patient access. The use of PAs and NPs is not new or novel, yet ACPs continue to be untapped resources for improving the delivery of cardiac care.

ACP Utilization and Responsibilities

While the benchmark ratio of ACPs to physicians has grown over the past five years, increased employment does not necessarily reflect optimal usage. Consider how you are using these ACPs. Most PAs and NPs assume the following responsibilities within a cardiology practice:

- Providing follow-up care for the easiest cases (e.g., lipid checks for stable patients)
- Documenting exam findings and treatment plans
- Educating patients
- Refilling prescriptions and initiating new medications

This holds true across the majority of the organizations I work with and seems to be accepted as the appropriate level of work for ACPs. That said, there is often an opportunity to safely increase the scope of work for PAs and NPs, from providing follow-up care for more complex patients to administering stress tests and even diagnostic cardiac catheterizations (primarily in select academic settings). Various studies confirm this, including a Duke University study showing that trained and supervised PAs performed diagnostic caths on par with cardiology fellows.

While helpful in freeing up your time for additional procedural work and more difficult cases, ACPs can also help provide patients with a cohesive, seamless experience. Assigning PAs/NPs to a particular physician can help ensure that patients see a familiar face during each visit.

Care Teams

Those attempting to expand the role of ACPs may have experienced difficulty in "selling" a visit with a PA/NP to patients. This challenge can often be overcome by emphasizing the benefits of a "care team" approach.

"Care teams" consist of two physicians and an ACP. The team is assigned a panel of patients, who will always see one of the three team providers, allowing for more efficient follow-up scheduling and a greater sense of continuity. This approach also elevates the role of an ACP. Independently, an ACP may focus on treating simple follow-up patients, while an ACP on a care team may treat more complex follow-up patients based on physician care plans, work with triage RNs to coordinate patient scheduling, and manage licensed practicing nurses/medical assistants. With their enhanced role, ACPs must be equipped with the experience, listening skills, bedside manner, and confidence (among other attributes) to overcome any potential reticence about not having physician credentials. This increase in responsibility allows team physicians to increase their focus on more complex patients and the development of treatment plans. As the initial operational challenges of team practice are identified and addressed, the teams I work with are often able to handle a panel size greater than would have been possible as independent providers, thereby increasing patient access. As an aside, care team models are often cited as a way to improve physician work/life balance.

Shared Visits

Many high-performing cardiology practices use "shared visits" or "double schedules" as another way to increase the integration of ACPs into their practices. In these types of appointments, the PA/NP gathers the majority of information from the patient and conducts most of the appointment, with a brief visit from the physician at the end. This allows the PA/NP to run a full schedule, side-by-side with the physician, significantly enhancing patient access. One client I have worked with found that this approach allowed physicians and ACPs to see up to a combined 35 to 38 patients in a day. This approach can also help improve patient satisfaction, as patients may prefer a timely appointment with an ACP and brief visit with their physician over lengthy waits for a physician-only visit. Organizations using shared visits often develop standards to make sure that patients are still seen by physicians when appropriate (e.g., new patients must see a physician, patients have to see a physician at least once per year) and that referring physicians are satisfied with the care their patients receive.

Becoming more effective, efficient, and cost-conscious requires physicians and physician practices to think innovatively about care delivery, however, it doesn't necessarily mean you have to reinvent the wheel. With ACPs continuing to be available but underutilized resources, it's time to rethink their involvement in advancing care and not just supporting it. ■

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Jason Peterson is a manager at ECG Management Consultants, Inc. **Katy Reed, MBA**, is a senior manager at ECG Management Consultants, Inc.