Do You Ask Yourself These Questions?

Do I need an NPP?

How do we transition the patients?

How do we use them?

How do I pay them?

How do I find NPPs?

Where do I find NPPs?

How do I get reimbursed for their work?

What’s the difference?

Who should I hire? NP or PA?

What’s the appropriate staffing amount?

Should I hire full time, part time, or contract?

How do we recruit & retain them?

Will they fit the culture?

©MGMA. All rights reserved.
NPP utilization in the future of US healthcare

Healthcare organizations use nonphysician providers (NPPs) to extend the therapeutic reach of physicians, increase patient satisfaction and add clinical revenue to the bottom line. Roles for these skilled individuals are expanding as the number of physicians shrinks (especially in primary care), the population of seniors expands and the Affordable Care Act (ACA) makes healthcare accessible to more than 10 million more Americans¹. **NPPs are assuming a pivotal place in the future of healthcare.**

NPPs are trained and licensed practitioners who provide clinical care. The majority of which have a master’s degree level of education, but this is dependent on the practitioner specialty². Some — such as certified registered nurse anesthetists, physician assistants or surgeon’s assistants (first assists) — function under the direct supervision of a physician. Others may work more independently, such as nurse practitioners, optometrists and physical therapists.³ All NPPs can bill insurers for their services, either incident-to⁴ the care provided by an overseeing physician or as independent practitioners when permitted by their state licensure.

MGMA developed this content based on the analysis of both internal as well as external data. It is intended to reflect findings that are indicative of the results of this research.
In clinical medical practice, NPPs typically:

- Provide patient counseling, education and coordination of care
- Provide on-call and hospital care
- Assist physicians with in-office and hospital surgical procedures
- Obtain patient histories and perform physical exams
- Order and/or perform diagnostic and therapeutic procedures and tests
- Develop working diagnoses
- Chart all pertinent clinical findings
- Assist scheduling staff with patient triage
- Make appropriate patient referrals to practice physicians and other healthcare providers
- Participate in clinical meetings
- Develop, implement and monitor the effectiveness of treatment plans

NPPs=Nonphysician providers, midlevels and/or nonphysician practitioner
They handle administrative duties in the practice, as well. NPPs may:

- Report to the practice administrator for personnel matters;
- Coordinate operational issues with the clinical manager, such as patient scheduling, tasks performed by medical assistants and nurses, and patient flow matters;
- Complete the provider section of managed care referral forms for specialty care and/or diagnostic testing;
- Complete the clinical portion of third-party payer inquiries and disability forms as required; and
- Help order medical supplies and equipment.

Similar to other positions, NPPs provide important teamwork functions in the practice. They:

- Work with whomever and wherever necessary to get a job done;
- Proactively support company policies, philosophies and decisions;
- Take opportunities to positively influence support staff;
- Facilitate a shared expectation of success within the support staff team, setting an example when circumstances warrant it;
- Accept constructive suggestions from management team; and
- Actively participate in solving problems.
Data from at least the last 15 years indicate that medical practices in the United States have been increasing their use of NPPs. The 2004 MGMA Cost Survey Report showed that the number of full-time-equivalent (FTE) NPPs per FTE physician increased in virtually every type of single-specialty group, and that more practices altogether were using NPPs. A look at the MGMA DataDive 2013: Cost and Revenue Module shows that Cardiology, Family Medicine, and Orthopedic Surgery practices have still seen an increase in NPPs per FTE physician over the last 5 years.

The reason is clear: **Practices with NPPs typically perform better financially, generating higher physician income.** MGMA data from 2004 show that “except for family practice, physicians in the single specialties studied had higher compensation when their practices had NPPs.” Eight years later, the MGMA DataDive 2013: Physician Compensation and Production Module shows physician compensation is still higher for practices with NPPs, including those in Family Medicine.
Settings for NPPs

As Becker’s Hospital Review noted in 2010, “Over the last 30 years, roles of midlevel providers have expanded well beyond the primary care environment. Today, midlevel providers work in hospitals, emergency departments, inpatient and outpatient surgical facilities and in specialty practices such as cardiology and oncology, as part of the team that serves patients receiving ongoing treatment. It is often a midlevel provider who monitors fragile diabetics, sees cancer patients between treatments, sets bones in the ED or closes for the doctor after surgery.”

9
Urgent care centers

Urgent care centers, where walk-in patients can receive ambulatory medical care outside of a hospital emergency room, provide another significant source of NPP employment. Urgent care centers continue to proliferate, with 9,000 across the nation at the start of 2013.10, 11 As employers of NPPs, urgent care centers offer flexible schedules and competitive pay. Urgent care centers focus on primary acute medical problems at the lower end of the severity spectrum12 and share characteristics of emergency and primary-care facilities.

“Retail” clinics

So-called “retail clinics” located in grocery stores, Walmarts and other shopping hubs have opened a new market to NPPs. These facilities, catering to walk-in patients with nonemergent conditions, are almost exclusively staffed by NPPs and offer inexpensive, convenient care for many routine medical situations. According to the ConvUrgentCare Report, the country had 1,603 retail clinics at the end of 2013 compared with 1,417 at the end of 2012. This growth rate of 13 percent is a significant jump over the 4.6 percent increase in 2012.13
Where NPPs are the only practitioners, facilities see significantly lower operating and staff costs, although revenue also drops. This may be because of fewer ancillaries, procedures, and shorter office visits than typically seen in the office with physicians.

NPP Retail Clinics vs. Physician Primary Care Practices

Per NPP
Custom Analysis — Retail Clinics: Only Nonphysician Providers, No Physicians

Per FTE physician
Reported in Primary Care Report: All Primary Care Practices, Hospital/IDS Owned

Source: MGMA Cost and Revenue: Special Analysis: 2013 Report Based on 2012 Data
Some health systems are partnering with retail clinic operators, thereby boosting retail clinics’ profile in the public eye. For example, in late 2013, Henry Ford Health System, based in Detroit, signed an agreement with MinuteClinic, part of CVS Caremark Corp., to “to meet an expected increase in patient demand” from the ACA. Henry Ford is providing physician medical directors to 14 MinuteClinics in metro Detroit to oversee clinical work and supervise NPs. Health system patients can visit the MinuteClinics as they would any other approved provider. Patients — and the health system — benefit from increased access to care from Henry Ford caregivers.

In a variant of the retail clinic theme, CoxHealth, a health system based in Springfield, Mo., has opened its own NP-staffed clinics in WalMart stores as part of its response to the expected surge of patients created by the ACA.

“Retail health clinics are turning into a boon for physician assistants who prefer to work in primary care but do not necessarily want to be involved with a private practice or hospital setting. At this point, there is so much work available they really have quite a few choices when searching for employment.” The same holds true for nurse practitioners.
Nurse-managed medical centers

Some healthcare analysts suggest that nurse-managed medical centers, usually affiliated with academic health centers, could help meet the nation’s increased demand for primary care services in the face of a shortage of primary care physicians, an influx of newly insured patients under the ACA and the aging baby boom population. “Nurse-managed health centers, also known as nursing centers or nurse-led clinics, provide a full range of primary care and some specialty services. They are managed and operated by nurses, with nurse practitioners (many of whom are or will become doctors of nursing practice) functioning as the primary providers.”18
Does our practice need NPPs?

NPPs allow practices to care for more patients and free physicians to perform work that only physicians can do. Because NPPs spend more time with patients than physicians for routine visits, they can increase the depth of the provider-patient relationship and enhance patient satisfaction.

How do you decide whether your practice needs NPPs?

Consider where your organization stands in relation to the U.S. physician shortage, the influx of senior patients as the baby boom generation ages and the millions of Americans who have gained health insurance through the Affordable Care Act.
Particularly worrisome is the projected shortage of primary care physicians as demand for those services increases. By 2015, the Association of American Medical Colleges forecasts the United States will have 29,800 fewer primary care physicians than it needs. This translates into a shortfall of about 135 million ambulatory visits annually (right).

NPPs offer one way to accommodate the demand, as they can handle many types of routine primary care visits on their own. The graph (left) compares productivity for NPs and PAs in primary care settings. **Most recently in the 2013 report, ambulatory encounters for nurse practitioners increased to 2,242 while primary care physician assistant encounters decreased to 2,763.**
As Laura Palmer, FACMPE, an MGMA senior industry analyst notes, “Perhaps the most important thing you can do before you hire an NPP is to thoroughly research what your state allows them to do. State laws governing NPPs’ scope of practice can vary significantly. As an example, APNs [advanced practice nurses] in 17 states can diagnose and treat patients without physician supervision, whereas physician assistants work under the supervision of physicians in all settings.”

“The state guidelines will usually be outlined in the occupations code, medical practice acts, advisory boards and the rules for delegation of prescriptive authority,” Palmer notes.

<table>
<thead>
<tr>
<th>Regardless of state law, physician supervision should depend on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>An NPP’s training, education and experience;</td>
</tr>
<tr>
<td>The nature of your practice;</td>
</tr>
<tr>
<td>The complexity of your patient population; and</td>
</tr>
<tr>
<td>The supervisory style of particular physicians.</td>
</tr>
</tbody>
</table>
How do we use NPPs?

Getting optimal use out of your NPPs can boost revenue, increase efficiency and free your physicians to focus on other patients. The MGMA Performance and Practices of Successful Medical Groups: 2010 Report Based on 2009 Data, showed that 61 percent of better-performing practices employ NPPs. Most recently the 2013 report reported an increase to nearly 68 percent. David Gans, MSHA, FACMPE, senior fellow, MGMA Industry Affairs, notes that “In primary care practices, they can provide 80 percent or more of services with equal or better patient satisfaction at a lower cost than a physician. Many times, NPPs have fewer demands than physicians and are more readily available to patients.”

To use your NPPs to their greatest advantage:

- Work with your physicians to determine their needs for these colleagues (within NPPs’ scope of practice) — some physicians may want more collaboration than others;
- Establish benchmarks to measure NPP performance, including productivity, utilization and patient satisfaction; and
- Know the optimal number of NPPs for your practice — the right number can increase productivity, lower overhead and boost physician compensation, but too many NPPs per physician can have the opposite effect.
Whom should I hire, an NP or PA? What’s the difference?

Physician assistants (PAs) and nurse practitioners (NPs) are perhaps the best-known NPPs. However, the designation includes but is not limited to:

- Certified registered nurse anesthetists
- Certified nurse midwives
- Clinical psychologists
- Clinical nurse specialists
- Clinical social workers
- Occupational therapists
- Speech pathologists
- Nonclinical psychologists
- Physical therapists

NPPs work under a physician’s direct supervision or in collaboration with physicians. Some, such as NPs, PAs, optometrists and physical therapists, may function more independently. They fulfill roles in acute care, ambulatory care, hospital care, urgent care clinics, quick-access clinics at retail sites, home care, surgical care and others across the healthcare continuum. Where physicians are in short supply, such as rural areas, NPPs often provide services autonomously.
In medical practices, the NPPs patients are most likely to interact with are NPs and PAs. Typically, NPs and PAs:

- Are practitioners certified to diagnose and treat acute and chronic conditions.
- Prescribe medications.
- Manage patients’ overall care and counsel patients without physician supervision.
- Perform physical exams.
- Diagnose and treat illnesses.
- Order and interpret lab tests.
- Perform procedures.
- Assist in surgery.
- Provide patient education and counseling.
- Make rounds in hospitals and nursing homes.
- And are trained to coordinate patient care.

**NPPs’ scope of practice varies by state.** For example, in Colorado, NPs can evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments and prescribe medications under the authority of the state’s board of nursing. Florida requires that NPs provide patient care under the supervision of an outside health discipline. In Michigan, PAs are permitted to prescribe all DEA* Schedule II-V drugs, but Georgia restricts PAs prescribing to a set formulary of Schedule III-V medications.

*Drug Enforcement Agency*
What are some tips for getting started?

An administrator may be concerned that both physicians and patients may be unwilling to accept NPPs as primary care-givers. Without an environment of collegial respect and cooperation — an accepting and flexible organizational culture — your new NPPs may be reluctant to stay long at the practice.

To overcome reluctance on the part of physicians and facilitate NPP integration, consider working with clinical leaders to:

- Define clear roles for physicians and NPPs;
- Identify care gaps and delineate where and how NPPs can fill them;
- Develop a thorough orientation program for NPPs, including shadowing physicians for every type of patient they see;
- Document standing orders, protocols, collaborative agreements, delegation and supervision agreements;
- Ensure that physicians understand the importance of delegating to NPPs and that having these practitioners will allow physicians to see more patients, not fewer; and
- Help physicians see NPPs as partners, not competitors.32

To help patients accept NPPs in the practice:

- Have physicians send letters to their patients announcing the NPPs’ hire and collaborative role in the practice. (As with physicians, this is an opportunity to educate patients on NPPs’ roles and the increase in patient satisfaction they can bring);
- Have physicians introduce the NPPs to their patients at appointments, describing the NPPs as essential members of the care team; and
- Ensure that all interactions that patients witness between NPPs and other practice staff are professional and collegial.33

The necessity for these measures will wane as NPPs become integral players in all aspects of healthcare. Therefore, you may have no need to employ persuasive tactics with patients or colleagues when you hire NPPs.
What’s the NPP employment situation?

NPPs face an optimistic employment market. HEALThHeCAREERS, a major U.S. job resource for healthcare professions, reported for the third quarter of 2013 that eight of the top 10 most in-demand nonphysician positions include family medicine NP, general PA, psychiatric/mental health NP, general NP and emergency medicine PA. Consider posting your practice’s NPP openings at HEALThHeCAREERS (healthecareers.com), a leading site for healthcare job recruitment.

U.S. government statistics, too, support the strength of NPP employment opportunities.

For nurse practitioners (as of May 2012):

- 105,780 were employed at a mean annual salary of $91,450.
- Jobs for NPs, nurse anesthetists and nurse midwives are projected to grow 31 percent between 2012 and 2022.
- The states with the highest employment level for NPs are California, New York, Florida, Texas and Massachusetts.
- The top-paying states for NPs are Alaska, Hawaii, Oregon, Massachusetts and New Jersey.
- Physician offices, hospitals and outpatient care centers make up the majority of employment sites.
Government statistics for physician assistants state that:

- 86,700 PAs were employed in the United States at a median annual salary of $90,930.
- 120,000 positions for PAs are projected for 2022.
- 58 percent of PAs work in health practitioner offices, 23 percent work in hospitals, 7 percent work in outpatient care centers, 4 percent work in government and 3 percent work in educational capacities.
- New York, California, Texas, Pennsylvania and North Carolina are the states that employ the most PAs.
- Top-paying states for NPs are Rhode Island, Connecticut, Washington, Oregon and Nevada.\(^3\)

Clearly, a career as an NPP offers promise.

You can learn more about the job outlook for physician assistants and nurse practitioners at:

BLS.gov, PA job outlook
BLS.gov, NP job outlook
How do I pay NPPs?

NPPs cost significantly less than physicians to employ. For example, in 2012, the median total compensation for an NP in primary care was $94,062; the cost that year to employ a family medicine physician was $207,117. Annual compensation for a surgical PA in 2012 was $112,689 vs. $367,885 for a general surgeon.\(^{37}\)

Not surprisingly, however, NPPs are commanding higher pay as demand for their services rises. From 2008 to 2012, their median total compensation increased 10 percent to nearly 17 percent, depending on specialty.\(^{38}\)
The American Academy of Physician Assistants and the American Association of Nurse Practitioners offer salary guidelines for these professionals.

Medical groups take a variety of approaches to paying NPPs. An online discussion among members of the MGMA Financial Management Society on paying nurse practitioners indicated that some:

- Pay NPs an annual salary based on their specialty and their full-time equivalent;
- Pay full-time NPs on salary and part-time NPs hourly; or
- Provide an annual base salary with a production incentive.39

Medical practice leaders should balance NPPs’ revenue contributions against the salaries and benefits they cost the organization — more on this below.
What's appropriate staffing for NPPs in my practice?

MGMA’s Cost Survey Report contains a wealth of information about staffing levels for NPPs in both multispecialty and single-specialty practices. Use this resource to learn best-practices in staffing and compare your employee levels to those of peer organizations.

Impact of increased numbers of nonphysician providers on support staff per FTE physician in physician-owned multispecialty groups

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Zero FTE non-physician providers</th>
<th>.25 or fewer FTE non-physician providers per FTE physician</th>
<th>.26 to .5 FTE non-physician providers per FTE physician</th>
<th>Greater than .5 FTE non-physician providers per FTE physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median total business operating staff per FTE physician</td>
<td>1.00</td>
<td>1.19</td>
<td>1.28</td>
<td>1.37</td>
</tr>
<tr>
<td>Median total front office support staff per FTE physician</td>
<td>1.29</td>
<td>1.56</td>
<td>1.58</td>
<td>1.75</td>
</tr>
<tr>
<td>Median total clinical support staff per FTE physician</td>
<td>1.42</td>
<td>1.56</td>
<td>1.65</td>
<td>2.60</td>
</tr>
<tr>
<td>Median total ancillary support staff per FTE physician</td>
<td>0.22</td>
<td>0.75</td>
<td>0.87</td>
<td>1.01</td>
</tr>
</tbody>
</table>
Keep in mind that you need to balance NPPs’ revenue contributions against the salaries and benefits they cost the organization. Gans notes that practices may not always reap economies of scale by employing NPPs. When the ratio of NPPs per full-time-equivalent (FTE) physician increases above 0.5 FTE in physician-owned multispecialty groups, median FTE clinical support staff per FTE physician can rise by almost a full-time staff member. This may happen because NPPs must be properly supported with staff too.40

When deciding whether to hire NPPs on a full-time, part-time or contract basis, review your practice’s expenses and determine whether you can afford the extra cost per FTE physician, understanding that practices with higher revenue tend to have higher staff and costs.
How does the practice get paid for NPPs’ work?

Unlike nurses, NPPs can bill insurers directly for their services, providing reimbursement at the physician rate. Federal and private health plans set their own rules for NPP billing. Under Medicare, NPPs can bill “incident to” a physician’s care, using the physician’s National Provider Identifier (NPI). After an initial visit by the physician, NPPs must perform these services under the physician’s direct supervision or while the physician is present in the same office suite to immediately assist. Moreover, “incident to” services must be furnished in the physician’s office or clinic as an integral part of a Medicare patient’s normal course of treatment.

Physicians must see new Medicare patients and evaluate new problems for Medicare patients. NPPs may address new problems and see new Medicare patients if the NPP is billing under his or her own NPI. In order to bill subsequent visits with the NPP as “incident to”, the physician must have continued active participation and management of the patient’s treatment with appropriate documentation in the patient’s medical record.
Alternatively, NPPs can bill Medicare directly after obtaining Medicare credentialing, using their own NPIs. Unless all services fall under the “incident to” definition, NPPs must complete appropriate Medicare enrollment forms to be paid for providing care to Medicare beneficiaries. Note that practices credentialing their NPPs through Medicare receive lower reimbursement than from “incident-to” billing — 85 percent of the physician fee schedule rate for office visits. Laboratory and immunizations are reimbursed at 100% of the physician fee schedule.

Commercial payers usually require their own credentialing of NPPs, and also reimburse NPP services at a lower rate than those provided by physicians. Be sure you understand the requirements when payers do not cover NPPs and do not enroll them as credentialed providers. An article by an MGMA authority points out that “Most payers will cover NPP services, but they may not enroll them. In this situation, a practice would bill under a physician’s NPI and follow the billing guidelines in the payer’s provider manual. Commercial payers will follow state laws and often require modifiers to correctly identify the provider and supervising physician providing care.”

Unless all services fall under the “incident to” definition, NPPs must complete appropriate Medicare enrollment forms to be paid for providing care to Medicare beneficiaries.
Many medical practices take both approaches to garner NPP revenue. However, failure to comply with any insurer’s NPPs billing rules can put organizations at risk for noncompliance.

Coding specialist Laurie Desjardins, CPC, PCS, delineates the pitfalls of NPP “incident-to” billing, noting that “Nurses, medical assistants or other trained personnel may also perform incident-to services such as immunizations, injections or brief evaluation and management (E&M) services such as those associated with blood pressure checks” using CPT* code 99211. “Remember, a physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife or clinical psychologist may provide direct supervision for ancillary personnel.” CPT 99211 is the only E&M code that does not mandate the presence of a physician in the exam room, so it’s mainly applied to visits with ancillary personnel for doctor-requested measurements, education and follow-up. The code should not be used, Desjardins cautions, in place of one that is more accurate or appropriate.

Be sure to check with the Centers for Medicare & Medicaid Services (CMS) Web site, as well as with your group’s commercial payers to stay in compliance with NPP billing rules.

---

*Current procedural terminology

Payers will have their own web links and/or live representatives for this purpose. The American Academy of Physician Assistants has extensive billing resources for members, as does the American Association of Nurse Practitioners.
How do we recruit and retain NPPs in our practice?

Once you’ve decided to add NPPs to your organization’s staff, you need to hire the best and keep them. Deborah Hosilyk, PAHM, an MGMA member and administrator, Advancements in Dermatology, Edina, Minn., described her group’s proven tactics to hire and retain NPPs.

“Keep in mind,” Hosilyk says, “that it’s not the number of responses you get but the quality of the applicants. You can train new graduates and those with experience in other areas of medicine, but they won’t succeed without a passion for your group’s specialty.”

To find candidates:

- Post ads on the websites of local NP and PA associations and allied health schools;
- Purchase mailing lists from these associations and advertise your openings via direct mail;
- Ask your staff, pharmaceutical representatives and other vendors to spread the word and provide recommendations.
Keeping good NPPs involves building a workplace and culture attractive to all employees. In addition to offering NPPs a competitive salary with good benefits, Hosylik recommends:

- **Providing an allowance for continuing medical education — with time off;**
- **Paying for NPP licenses, malpractice coverage, association memberships, etc.;**
- **Giving NPPs some autonomy and responsibility for clinical operations or staff; and**
- **Using an incentive plan to motivate production.**

Experienced providers receive the benefit immediately; new graduates have to work a year before becoming eligible for the incentive. Hosylik’s practice pays NPPs a small percentage of net collections that each generates monthly — which increases the number of patients seen per day.
Hosylik notes that an excellent working environment also includes a no-tolerance policy for negativity, social events that include all staff and significant others, and monthly meetings with providers and support staff to ensure open communications. In addition, sharing financial and performance data is an important piece to share with nonphysician providers as well.

She recommends asking NPP candidates certain questions to determine their suitability for employment in your practice (right).

Questions to include in NPP interviews

What experience do you have with our specialty, personally or professionally?

Has your clinical judgment ever been questioned? If so, by whom and why? What was the outcome?

What are your clinical strengths? Would others agree?

How would your patients describe you? What would they say you do best?

What would your patients say you could do better?

How many patients can you see a day? How many do you prefer to see a day?

Have you ever been reported to the medical board? Do you have any claims against you now or in the past?

Have you had any malpractice suits?
Looking to the future

The nation’s changing healthcare landscape is giving NPPs unprecedented opportunities. The ACA, the U.S. physician shortage and new models of healthcare delivery are reshaping the way Americans deliver, receive and regard healthcare.

Affordable Care Act and shortage of primary care physicians

The ACA is generating myriad job opportunities for NPPs as millions of previously uninsured Americans gain access to healthcare services. NPPs offer a skilled alternative to physicians for healthcare organizations seeking to treat more patients, balance provider workloads and sustain their clinical viability while combating administrative, regulatory and financial pressures.

Because many newly insured individuals seek primary care, NPPs can help cover for a serious U.S. shortfall in general-medicine physicians: a gap estimated from 9,000-45,000 for practitioners of general internal medicine, family medicine, geriatric and general pediatrics.49
**Patient-centered medical home**

New models of healthcare delivery, such as the patient-centered medical home (PCMH), call for more clinical roles that NPPs can fill. The PCMH is primary care that is “patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.”

Both government and private insurers are turning to the PCMH as an outcomes-based, value-driven model where payments can be based on results. Insurers increasingly expect practices to coordinate patients’ care with other providers and facilities to avoid duplicating services, ensure appropriateness of care and reduce error.

Population health forms another key pillar of the PCMH and generates opportunities for NPPs. Forty-five percent of healthcare leaders polled by the HealthLeaders 2013 Media Population Health Survey say they plan to improve access to NPPs as part of an investment in population health management.

Although groups may choose to hire nonclinical staff for care coordination, NPPs are well suited for this responsibility. In addition, they increase patients’ access to care by offering clinical alternatives to physicians, serve as key members of the patient’s healthcare team and overall managers of PCMH principles and goals.

**Careful consideration of NPPs’ clinical abilities, expenses, revenue generation and appropriateness for your facility should give you a deeper appreciation of these versatile professionals.**
Sources


5. Dunn C. The basics of nonphysician providers (NPPs). Medical Group Management Association blog, July 30, 2010. www.mgma.com/blog/the-basics-of-nonphysician-providers-(NPPs).]

6. Ibid.

7. Ibid.


13. Grider R.


15. Ibid.

Sources (cont’d)


21. Ibid.


23. Ibid.

24. Dunn C.

25. Ibid.

26. Ibid.


33. Ibid.


36. Ibid.

37. Ibid.
Sources (cont’d)

38. Ibid.
42. Ibid.
43. Ibid.
44. Ibid.
46. Ibid.
48. Ibid.