

## Population Health Management and Clinical Staffing



A resource provided by Staff Care, the nation's leading locum tenens staffing firm and a company of AMN Healthcare (NYSE: AHS), the largest healthcare workforce solutions company in the United States.

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## POPULATION HEALTH MANAGEMENT AND CLINICAL STAFFING

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### About Staff Care

Staff Care is the leading provider of locum tenens staffing services in the United States and is a company of AMN Healthcare (NYSE: AHS), the largest healthcare workforce solutions organization in the nation. As part of our role as industry leaders, Staff Care generates original survey data regarding trends in locum tenens staffing, presents educational seminars on physician staffing and related topics, and develops a series of white papers examining physician and advanced practitioner staffing issues.

Staff Care executives authored the book on locum tenens staffing. Entitled, *Have Stethoscope, Will Travel: Staff Care's Guide to Locum Tenens*, the book outlines locum tenens staffing principles, uses and procedures for both healthcare facilities and physicians. Staff Care is proud to sponsor the **Country Doctor of the Year Award**, a national honor that recognizes the spirit, skill and dedication of America's rural medical practitioners.

In this white paper, we examine the topic of population health management, including its definition, purpose and the staffing implications of this emerging healthcare delivery model.

### Overview

The advent of the Affordable Care Act (ACA) has been one of a number of influencers that are shifting the focus and delivery of healthcare, placing a premium on quality of care and the effective management of patient health.

While a fee-for-service approach that rewards providers for volume of service delivered has been the prevailing model, healthcare managers and clinicians are moving toward a different approach. The concept of population health management - a system in which a team-based group of providers works to improve healthcare coverage for large patient groups- is gaining momentum.

In this white paper, Staff Care examines the development of population health management, component elements, and how healthcare organizations are implementing and staffing this emerging delivery model.

## What is Population Health Management?

Population health management is generally understood as a healthcare delivery model in which an integrated healthcare organization provides care for defined population groups, managing care and assuming financial risk.

Though there may not be an absolute definition of the term, population health management generally is characterized by the following three elements:

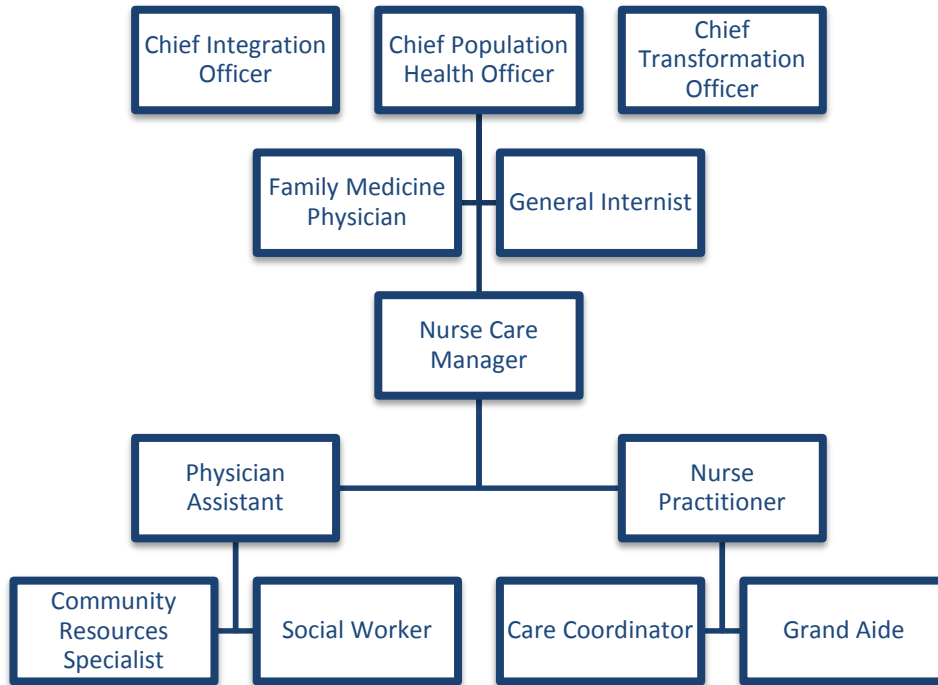
1. Information based clinical decision making
  - Robust patient data supports comprehensive, evidence-based care.
  - All clinicians/facilities share an integrated data network.
  - A position leader, typically a physician, merges data analytics with clinical care decision making.
2. Primary care-led clinical workforce
  - Primary care physicians are the “point guards,” managing the team and distributing care as needed.
  - Care team extends reach into the community to manage/direct outcomes.
3. Patient Engagement and Community Integration
  - Services are mapped to population need.
  - Non-clinical barriers to good outcomes addressed.
  - Patient values integrated into the care plan.
  - Community stakeholders connect patients to resources.

*Source: Three Key Elements for Successful Population Health Management.  
The Advisory Board Company*

In the future, implementation of this model will be driven through inter-professional education, in which collaborative practice techniques will replace the current approach that features clinicians training in silos and subsequently taking the “silo” approach into the workplace.

Today the model is being implemented through a growing number of accountable care organizations (ACOs) large medical groups, and hospital systems that have achieved staffing, management, and information technology integration.

Central to the delivery of population health management is the primary care-led team, which is on the front lines of patient care. The composition of this team is as follows:



*Source: Three Key Elements for Successful Population Health Management. The Advisory Board Company*

At the top of the pyramid is the executive leader responsible for designing and implementing the population health management model and staffing, managing and creating incentive programs for the primary care-led team. This executive may hold one of several comparatively new titles, including “Chief Population Health Officer,” “Chief Integration Officer,” or “Chief Transformation Officer.” He or she is the “change agent” responsible for directing the shift away from a volume based system to one based on value/quality. Often, this leader is a physician or other clinician with the management acumen to represent “administration” and the medical knowledge needed to achieve the trust and buy-in of care givers.

Within the framework set by the executive leader, primary care physicians such as family physicians and general internists are the (pick one) “point guards,” “quarterbacks,” or “CEOs” of the delivery team. Through the patient management and care coordination they provide, quality goals are achieved within an environment of defined (capitated) financial resources. Primary care physicians then are rewarded for the savings they realize within a global payment structure, the quality standards they achieve and for their managerial role.

Primary care physicians in this model practice to “the top of their training,” often managing the needs of patients with multiple chronic conditions while working with nurse case managers who help ensure that work is allocated to the appropriate clinician (including PAs and NPs) and that patient care is managed, even outside of the office. Patient outreach and care management is provided by social workers, community resource specialists, care coordinators and “grand aides,” who work directly with patients (often in their homes) to ensure treatment plans are followed and outcomes more closely controlled. These professionals also may work to ensure the improvement of social conditions that can affect the health of the covered population group, often through patient education

Medical specialists are integrated into the team when appropriate by the primary care physician. Certain medical specialties are particularly central to population health management, due primarily to the role these physicians play in chronic disease management. These specialties include:

- ❖ Obstetrics/Gynecology (OB/GYN):

- Important for women's health management, including preventive measures such as wellness visits and cancer screenings, OB/GYNs are seen as central to population health management by promoting positive behaviors that can affect the next generation of patients.
- ❖ Cardiology:
  - Vital for evaluation of heart conditions- including heart disease (the number one cause of death in the United States), hypertension, and other chronic issues. Heart-related conditions typically occur in older patients that have multiple chronic conditions, and thus it is essential that providers are on the same page in terms of medication management, diet and fitness regimen, and patient understanding and education of condition(s).
- ❖ Pulmonology:
  - Another key provider in management of chronic conditions- particularly COPD, the third leading cause of death in the United States and the only leading cause of death which has increased over the last 40 years. Patients under the care of a pulmonologist typically have many social determinants that lead to conditions, including long-term tobacco use and smoking, older age with low activity level/fitness, and high unemployment rate with low income level. Thus, patient education, understanding of care, and consistent management of condition is important to prevent life-threatening symptoms and ER admissions.
- ❖ Gastroenterology
  - Considerations for disease prevention are very important in the context of population health; gastroenterologists provide disease screenings through colonoscopies, an essential step to monitor for colon cancer.
- ❖ Psychiatry:
  - One in every five adults in America experiences some form of a mental illness, with the average delay between onset of mental health symptoms and intervention being 8-10 years. These conditions generally require management over time and coordination with other types of physicians.
- ❖ Hospitalist:
  - As a part of improving quality of care, hospitals and other healthcare systems are continually evaluating how to decrease the likelihood of readmission for patients- either for the same ailment/condition that caused admission, or a problem that develops as a result of the initial stay. Hospitalists may enhance quality, reduce errors and serve as key care coordinators during the stay.
- ❖ Neurologist
  - The management of chronic pain, stroke, Alzheimer's, Parkinson's, sleep apnea and related neurological disorders will become a greater priority as the population ages, increasing demand for neurologists.

All clinicians and facilities share an integrated data network and may use “big data” to implement evidence-based treatment protocols and coordinate care.

## Use of Locum Tenens

As the population health model proliferates, demand for primary care physicians, PAs, NPs and physicians who provide chronic care management is likely to increase. Both Staff Care and its sister company, Merritt, Hawkins, see client demand for services highest in the areas of family practice, internal medicine, psychiatry and hospitalists and anticipate increased demand for disease management specialists.

A comprehensive, strategic staffing plan needed to implement population health management may include the appropriate use of temporary (locum tenens) physicians, NPs, PAs and other clinicians. Temporary providers can be used to “test market” the need for certain types of providers within a population health context and to “right staff” as needed. The flexibility locum tenens providers offer allows organizations implementing population health to control costs within a defined budget by staffing up or down as appropriate.

## “Frequent Flyers”

Implementing population health management includes understanding patient population characteristics -- primarily through identifying and managing patient groups that utilize health services the most and are at risk for health complications. These patient groups are often referred to as “frequent flyers” or “hot-spotters” - a small subset of the patient population that utilizes a disproportionate amount of health services, and could be more efficiently cared for and managed through an integrated and coordinated health system.

As profiled in *Health Leaders* in May 2015, Intermountain Healthcare out of Salt Lake City, Utah found between 2008-2012, that this “hot-spotting” portion of their patient population (5% of the total) accounted for 51% of costs. Many of these patients shared similar profiles- multiple chronic conditions that required frequent physician specialist visits- without coordination through a primary care physician. (Source: *Health Leaders*, “Population Health Hot-Spotting”, May 2015).

Case studies such as these identify a persistent issue in current health care that population management attempts to address. Coordinating medical information, patient profiles and visits among primary care physicians and specialists reduces the need for extraneous health encounters- while reducing costs for the patient and allowing physicians increased capacity for care. This increased coordination also reduces the likelihood that patients with significant risk factors will develop emergent or life-threatening complications, saving patient lives and improving quality metrics in the process.

Population health management is seen as a promising delivery model because of the emphasis it places on quality patient outcomes- and continually improving those outcomes. Rather than treating symptoms through volume of services it seeks to address causes through care coordination and management, with quality/value as part of provider rewards.

## Accountable Care Organizations

The Affordable Care Act promotes the establishment of accountable care organizations (ACOs) which have the integrated structure to implement population health management. The ACO/population health management model falls in line with the Institute for Healthcare Improvement's Triple Aim. The goals of the Triple Aim include: 1) Improving patient experience of care; 2) Improving health of populations; and 3) Reducing per capita cost of care.

*Source: Institute for Healthcare Improvement;  
<http://www.ihl.org/Topics/TripleAim/Pages/Overview.aspx>*

An ACO is “a group of providers who are willing and able to take responsibility for improving the overall health status, care efficiency, and health care experience for a defined population”- a vital resource for the implementation of improved coordinated care (see “Driving Population Health Through Accountable Care Organizations”, *Health Affairs*). This “group of providers” jointly shares responsibility for the coordinated care of patients all while attempting to keep costs within a defined budget.

As of April 2014, 428 provider groups were operating as ACOs, servicing 14% of the United States' population and four million Medicare beneficiaries (see Kaiser Health News, “FAQ on ACOs, April 2014”). Global management consulting firm Oliver Wyman projects an even greater number of healthcare organizations operating as ACOs, with 522 ACOs in the United States, including 46-52 million patients serviced under these ACOs (see “ACO Update: Accountable Care at a Tipping Point”, Oliver Wyman, April 2014; Copyright © 2013, Oliver Wyman).

At present, ACOs, or systems acting as ACOs, are the primary implementers of population health management.

## ACO Programs

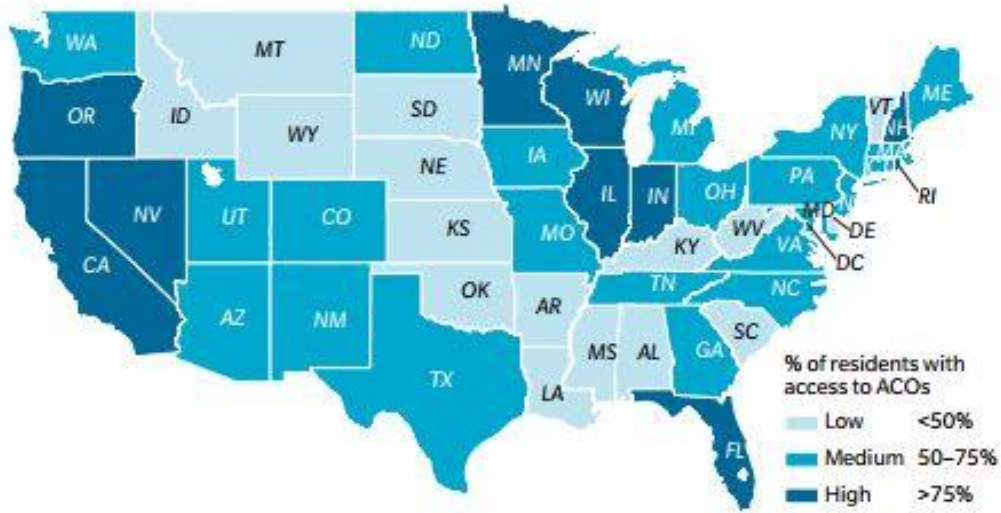
ACOs can fall into two distinct categories, as either participating in Centers for Medicaid and Medicare Services (CMS) programs or non-CMS programs. CMS ACOs service both Medicare and non-Medicare beneficiaries (although primarily Medicare beneficiaries), and receive financial incentives from CMS tied to improved quality-control and coordination of care. Models under CMS ACOs include:

- ❖ **Medicare Shared Savings Program:** Financial incentives provided to participating ACOs based on evaluation of quality-care metrics for Medicare patients (includes Advanced Payment ACO Model, where participating rural-based physician providers are provided upfront payments to invest in improved care)
- ❖ **Pioneer ACO Model:** designed for healthcare systems that already utilize effective coordinated care, with emphasis to shift to population management care.

According to CMS, there are currently 405 ACOs participating in the Medicare Shared Savings Program and 19 ACOs participating in the Pioneer ACO Model.

Non-CMS ACOs are those that participate in a shared-savings or risk agreement with an independent commercial payer not tied to the CMS. Oliver Wyman estimates there are 154 non-CMS ACOs as of April 2014.

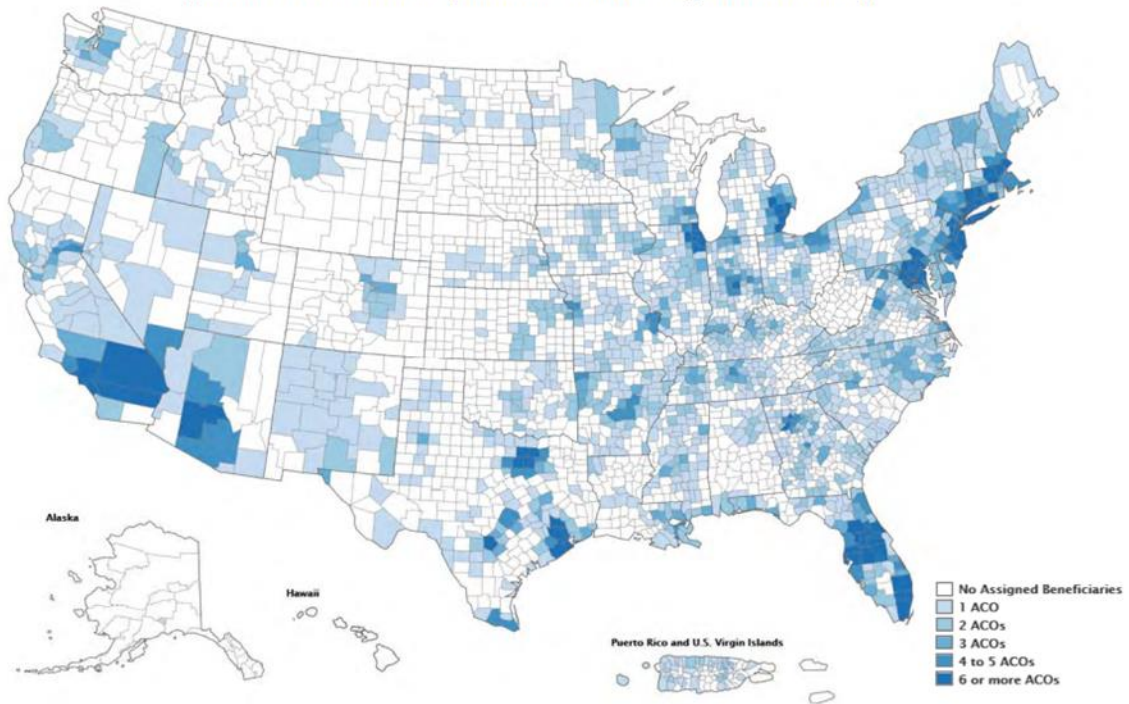




Source: Oliver Wyman, "ACO Update: Accountable Care at a Tipping Point";  
 Copyright © 2013, Oliver Wyman

## Medicare Shared Savings Program ACO Assigned Beneficiary Population by ACO by County

(counties with more than 1 percent of an ACO's assigned beneficiaries)



Source: Centers for Medicare and Medicaid Services (CMS)



## Medicare Shared Savings and Financial Incentives

The majority of healthcare organizations that are ACOs participate in the Medicare Shared Savings Program, as indicated by the 405 participating organizations referenced above. CMS evaluates the performance of participating ACOs each year based on 33 quality performance measures, with adequate performance in these areas resulting in the rewarding of financial incentives. The four key domains emphasized include:

- ❖ Patient/caregiver experience
- ❖ Care coordination/patient safety
- ❖ At-risk population, including patients with:
  - Diabetes
  - Hypertension
  - Ischemic Vascular Disease
  - Heart Failure
  - Coronary Artery Disease
- ❖ Preventive Care

*Source: Centers for Medicare and Medicaid Services (CMS);  
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf>*

In order to be accepted as an ACO under the Medicare Shared Savings Program, the organization in question must agree to accept at least 5,000 Medicare fee-for-service beneficiaries. The application process also includes detailing how the ACO plans to integrate improved quality of care and lower costs for beneficiaries. The term for participation in the Shared Savings Program with CMS is a minimum of three years.

Primary care physicians under an ACO are only considered to be those in internal Medicine (IM), general practice (GP), family practice (FP) or geriatric medicine. Although patients under an ACO may receive treatment from advanced practitioners including NPs and PAs, a physician in the appropriate specialty must be considered the patient's primary provider in order for the patient to fall under the 5,000 beneficiary requirement for ACOs.

## ACO Case Studies

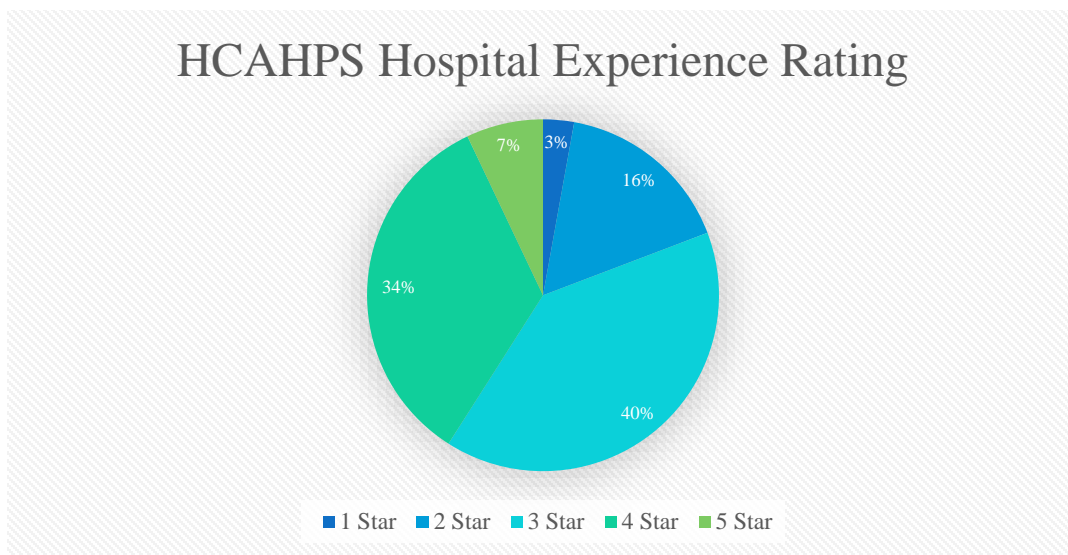
Although the integration of ACOs into the health system is still emerging, there have been case studies of encouraging returns and improvement in quality of care. Recently profiled in the March 2015 issue of *Health Leaders*, University Hospitals in Cleveland established the University Hospitals Accountable Care Organization (UHACO) in 2010 within their 15 hospital system. UHACO reported multiple integrated changes in their EMR and billing system over the past five years, with data collected in their system used to supplement inpatient care. This quantifiable data led to real changes in the way care was provided in their system; for example, a deficiency of mammogram and colorectal cancer screenings noticed within their employee EMR led to an increase of 11% in mammograms and 8% in colorectal screenings for employee medical plans.

Source: Health Leaders, "Population Health and the Revenue Cycle", March 2015

Other healthcare systems are focusing on areas of demand and growth within the populations they are servicing. Virtua Health System in New Jersey, featured in another Health Leaders profile, has established VirtuaCare and other ACOs under their system, servicing nearly 50,000 patients. As a part of their quality care evaluation, they plan to increase outpatient capacity to fit a growing need- including doubling their urgent care centers. This expansion marks an emerging trend in accessibility of care- with urgent care providers supplementing care for PCPs and emergency department physicians.

Source: Health Leaders, "These 4 Strategies Make Population Health Thrive", Health Leaders, June 2015

Despite these gains, the smooth integration of population health metrics still has some noted areas where improvement is indicated. In April of 2015, CMS released their first five-star rating system for patient experience in hospitals, with the returns revealing some shortcomings in patient satisfaction. Conducted by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for 3,553 hospitals, the majority of hospitals received either 3 star (40%) or 4 star (34%) ratings as given by patients. A breakdown below is provided:



Source: Health Leaders Media, "Medicare Issues its First Star Ratings for Patient Experience"; HCAHPS

Although patient-directed rating systems do not paint the full picture on quality of care and experience healthcare systems provide, they are an important indicator of the satisfaction level of those receiving care. As healthcare systems continue to evaluate the best methods for care improvement, it will be important to consider the opinion of the ones receiving care themselves - patients.

## Staffing Considerations

With the PCP serving as the "quarterback" of the care coordination team, it is natural to evaluate supply

of PCPs within the United States as a priority for population health management. Using the Medicare Shared Savings Program’s definition of a primary care physician- general practice, family practice, internal medicine, or geriatric medicine- there are currently 204,095 PCPs practicing actively in the United States. The top 5 states in terms of PCP supply- California, New York, Texas, Florida and Illinois- comprise 35.9% of the primary care physician workforce as defined by the Shared Savings Program. When evaluated on a per capita basis, however, the states with the most PCPs are as follows:

<b><u>State/Region</u></b>	<b><u>Total PCPs</u></b>	<b><u>PCPs per 100,000</u></b>
Washington, D.C.	768	116.6
Massachusetts	6,226	92.3
Maine	1,224	92.0
Rhode Island	912	86.4
Vermont	528	84.3
Maryland	4,829	80.8
Minnesota	4,235	77.6
Oregon	3,002	75.6
New York	14,894	75.4
New Hampshire	999	75.3
Connecticut	2,676	74.4
North Dakota	545	73.7
Hawaii	1,034	72.8
Illinois	9,339	72.5
South Dakota	609	71.4
Pennsylvania	9,125	71.4
Wisconsin	3,979	69.1
Alaska	509	69.1
Washington	4,854	68.7
New Jersey	6,008	67.2
Nebraska	1,253	66.6
West Virginia	1,231	66.5
Virginia	5,508	66.2
Colorado	3,514	65.6
Iowa	2,020	65.0
Michigan	6,411	64.7
Ohio	7,450	64.3
Kansas	1,864	64.2
Montana	645	63.0
California	24,233	62.5
New Mexico	1,295	62.1
Tennessee	3,977	60.7
North Carolina	6,006	60.4
Wyoming	349	59.7
Delaware	552	59.0
South Carolina	2,804	58.0

Florida	11,422	57.4
Indiana	3,774	57.2
Missouri	3,434	56.6
Arkansas	1,673	56.4
Louisiana	2,560	55.1
Georgia	5,548	54.9
Alabama	2,653	54.7
Idaho	888	54.3
Arizona	3,640	54.1
Kentucky	2,329	52.8
Nevada	1,463	51.5
Texas	13,290	49.3
Oklahoma	1,850	47.7
Utah	1,301	44.2
Mississippi	1,283	42.9
<b>United States</b>	<b>204,095</b>	<b>64.0</b>

*Source: AMA Master File/MMS List*

Below are suggested physician-to-population ratios as determined by Richard A. Cooper, M.D., a nationally known physician supply and utilization expert at the University of Pennsylvania/Wharton School and Director of the Center for the Future of the Healthcare Workforce at the New York Institute of Technology. These are demand-based ratios that suggest the number of physicians that can be economically supported by a given population. Calculated in 2013, they are the most recent such ratios of which Merritt Hawkins is aware; they are also the most “real world” ratios applicable, as they indicate not how many physicians a population may theoretically need, but how many it can sustain given economic and demographic considerations.

**Population Needed to Support One  
Physician by Specialty**

Family Medicine	3,100
Internal Medicine	3,378
Cardiology	14,084
Obstetrics/Gynecology	7,692
Psychiatry	6,802

**...per 5,000 population**

Family Medicine	1.61
Internal Medicine	1.48
Cardiology	0.36
Obstetrics/Gynecology	0.65
Psychiatry	0.74

**...per 50,000 population**

Family Medicine	16.1
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Internal Medicine	14.8
Cardiology	3.6
Obstetrics/Gynecology	6.5
Psychiatry	7.4

**...per 100,000 population**

Family Medicine	32.2
Internal Medicine	29.6
Cardiology	7.1
Obstetrics/Gynecology	13.0
Psychiatry	14.7

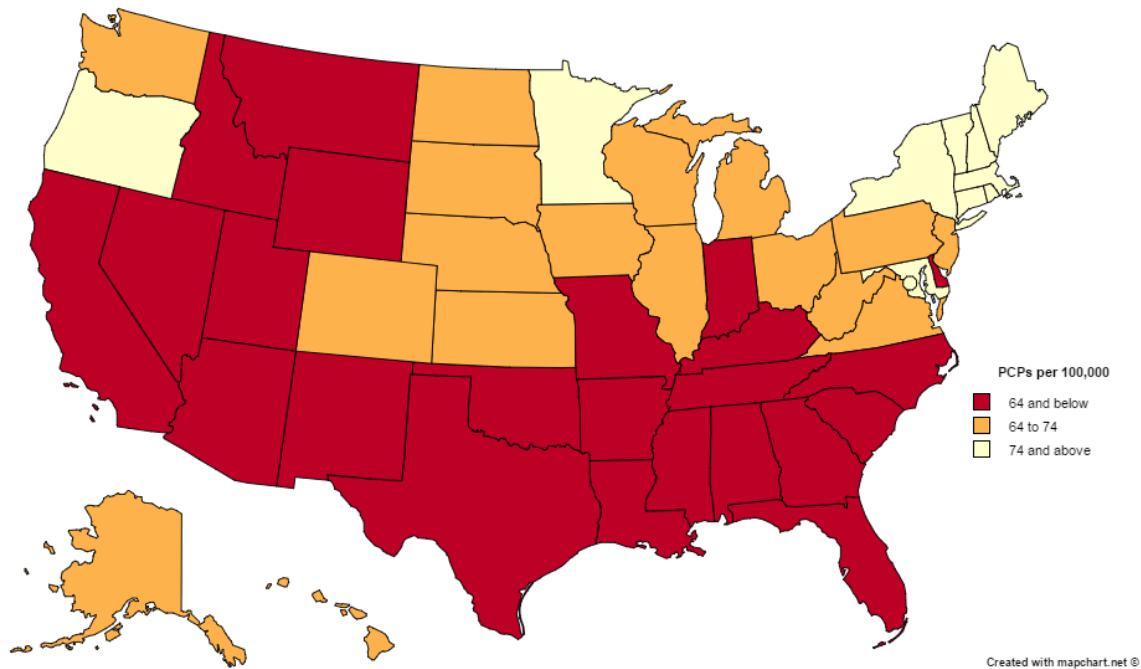
*Source: Richard A. Cooper, M.D./University of Pennsylvania/Wharton School*

These numbers are national ratios and may not reflect the needs of specific population groups which can vary widely by age and overall health. However, they do offer some guidelines for the number of physicians in various specialties needed to implement the population health management model.

With an aging United States' population, it is likely that the demand for PCPs and other specialty services may be even greater than indicated by these numbers. Current population composition reveals that 14.1% of the U.S. population is 65 years of age or older- the portion of the population that requires the most healthcare coverage. This includes nearly 50 million individuals that access Medicare for health insurance coverage (for more information on this topic, see the white paper *"The Aging Physician Workforce: A Demographic Dilemma"*, Merritt Hawkins, 2015).

Individuals aged 65 and older drive the greatest demand for healthcare services. Over 96% have a regular healthcare provider; nearly 94% of individuals in this age group have seen a provider in the last year; and 37.4% of in-patient procedures and 47.1% of diagnostic testing/treatments were undergone by individuals aged 65 and older, according to 2010 data from the CDC.

This demand is heightened by a stark reality- this portion of the population will continue to grow, while a retiring physician population will exit the workforce and join their peers in demand for healthcare services. Early Census Bureau projections estimate the U.S. population age 65 and older to be 56,441,000 by 2020, nearly 25.5% growth over that time period. With this in mind, healthcare leaders will have to evaluate provider and practitioner supply based on the looming demand, not necessarily just by the current landscape.



Overall, the national average for PCPs per 100,000 residents is 64, with populous states including Texas, Florida, and California falling below this number.

For other specialties particularly important to population health management, per capita supply numbers for each specialty are included below, including the top 10 and bottom 10 states/regions in physicians or advanced practitioners per capita:

<u>State/Region</u>	<u>Cardiologists per 100,000</u>	<u>State/Region</u>	<u>Pulmonologists per 100,000</u>
Washington, D.C.	14.7	Washington, D.C.	10.5
Massachusetts	12.3	Massachusetts	7.3
New York	10.8	Connecticut	7.0
Rhode Island	10.6	Rhode Island	6.1
New Jersey	10.6	Maryland	6.0
Connecticut	10.5	New York	5.8
Pennsylvania	9.9	New Jersey	5.4
Maryland	9.2	Vermont	5.3
Florida	8.2	Pennsylvania	5.2
Louisiana	8.0	Maine	4.9
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New Mexico	5.0	Mississippi	3.0
Washington	4.9	Texas	2.9
Montana	4.8	North Dakota	2.8
Hawaii	4.6	Iowa	2.8
Colorado	4.4	Oklahoma	2.7
Utah	4.3	Alaska	2.6
Alaska	3.7	Idaho	2.6
Idaho	3.1	Arkansas	2.3
Wyoming	2.9	Nevada	2.0



**National Average**

**7.1**

Wyoming

1.7

**National Average**

**4.1**

**State/Region**                      **Gastroenterologists**  
**Nephrologists per**  
**100,000**

Washington, D.C.                      16.5  
 Massachusetts                      12.5  
 Connecticut                      11.6  
 New York                      11.2  
 New Jersey                      10.7  
 Maryland                      10.2  
 Rhode Island                      10.2  
 Pennsylvania                      9.7  
 Florida                      8.0  
 Minnesota                      7.9

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Nebraska                      5.5  
 New Mexico                      5.5  
 Arkansas                      5.3  
 Nevada                      5.2  
 Oklahoma                      5.0  
 Utah                      4.5  
 Iowa                      4.3  
 Idaho                      4.2  
 Alaska                      4.1  
 Wyoming                      3.6  
 Montana                      3.5  
**National Average**                      **7.5**

**State/Region**                      **OBGYNs per**  
**100,000**

Washington, D.C.                      27.9  
 Connecticut                      19.2  
 Rhode Island                      19.1  
 Maryland                      18.3  
 Vermont                      17.9  
 New York                      16.4  
 New Jersey                      16.3  
 Massachusetts                      15.8  
 Hawaii                      15.2  
 Oregon                      14.2

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Kentucky                      10.3  
 West Virginia                      10.2  
 Idaho                      10.0  
 North Dakota                      10.0  
 Nevada                      9.9  
 South Dakota                      9.5  
 Arkansas                      9.4  
 Delaware                      9.3  
 Oklahoma                      9.1  
 Iowa                      8.7  
**National Average**                      **13.0**

**State/Region**                      **Hospitalists per**  
**100,000**

Maine                      7.8  
 Connecticut                      5.1  
 New Hampshire                      5.1  
 Washington, D.C.                      4.2  
 Massachusetts                      4.2  
 Hawaii                      4.2  
 North Carolina                      3.3

**State/Region**                      **Psychiatrists**  
**per 100,000**

Washington, D.C.                      24.0  
 Massachusetts                      17.9  
 Rhode Island                      17.2  
 Vermont                      16.3  
 Connecticut                      15.8  
 New York                      15.4  
 Maryland                      13.7

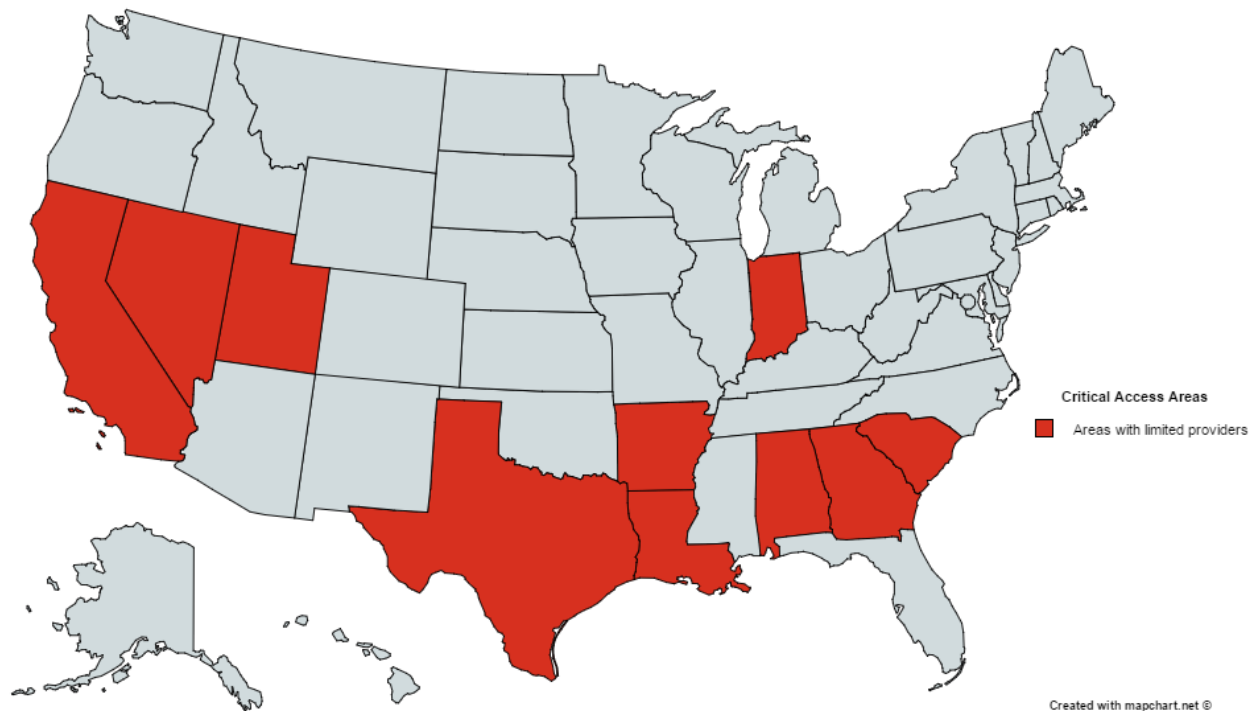
Delaware	3.2	Maine	11.5
Maryland	3.1	New Hampshire	10.8
Nevada	3.0	New Jersey	10.7
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West Virginia	1.7	Utah	6.3
Louisiana	1.6	Alabama	6.3
Iowa	1.6	Nebraska	6.2
New Jersey	1.6	Wyoming	5.8
Idaho	1.5	Texas	5.7
Oklahoma	1.4	Iowa	5.6
Alaska	1.2	Mississippi	5.3
North Dakota	1.2	Indiana	5.2
Arkansas	1.2	Nevada	5.1
Wyoming	1.0	Idaho	5.1
<b>National Average</b>	<b>2.4</b>	<b>National Average</b>	<b>13.0</b>

<u>State/Region</u>	<u>NPs per 100,000</u>	<u>State/Region</u>	<u>PAs per 100,000</u>
Massachusetts	107	Alaska	63
Tennessee	102	South Dakota	60
Connecticut	99	Maine	57
New Hampshire	96	New York	55
Delaware	96	Pennsylvania	52
Maine	92	Nebraska	52
Alaska	86	West Virginia	51
Vermont	84	North Carolina	50
Mississippi	82	Montana	50
Kentucky	82	Connecticut	49
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Wyoming	53	Tennessee	24
South Carolina	53	Nevada	24
Idaho	52	Illinois	21
Utah	51	Louisiana	19
Michigan	47	Indiana	16
California	44	Hawaii	16
Texas	41	Missouri	15
Oklahoma	37	Alabama	15
Nevada	34	Arkansas	10
Hawaii	29	Mississippi	5
<b>National Average</b>	<b>60</b>	<b>National Average</b>	<b>33</b>

## Critical Access Areas

Under population health management, primary care physicians serve as director of patient care and needs, facilitating further treatment for concentrated and chronic conditions as needed to specialists. Advanced practitioners such as PAs and NPs play a supplementary role for providing care to patients, filling gaps in PCP care as needed.

Based on per capita supply numbers of PCPs, PAs and NPs, we have identified several critical access areas under the scope of population health management. These states/regions all have physician and advanced practitioner per capita supply numbers that fall below the national average, one potential sign that a significant shift to population health management would prove difficult. These states/regions include: **Alabama, Arkansas, California, Georgia, Indiana, Louisiana, Nevada, South Carolina, Texas, and Utah.**



As these states move forward, and the demand for population-based healthcare coverage grows, it will be essential for these states to evaluate current supply of primary care physicians and advanced practitioners, evolving current policies as needed.

## Conclusion

As healthcare organizations continue to evaluate the best methods of care delivery, new models will be needed to ensure healthcare goals are achieved within an environment of fixed budgets. Population health management -- in which health outcomes of a population are monitored and improved through risk management, care coordination, investment in education and patient outreach- may be a promising model that currently is typically implemented by accountable care organizations (ACOs). There are many challenges that need to be addressed by healthcare systems in implementing population health management. Chief among these concerns is creating the right mix of physicians, advanced practitioners and other healthcare professionals needed to create primary-care led teams. A comprehensive, strategic staffing strategy may include the appropriate use of temporary (locum tenens) healthcare professionals.

For additional information on population health management and clinical staffing, contact:

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