

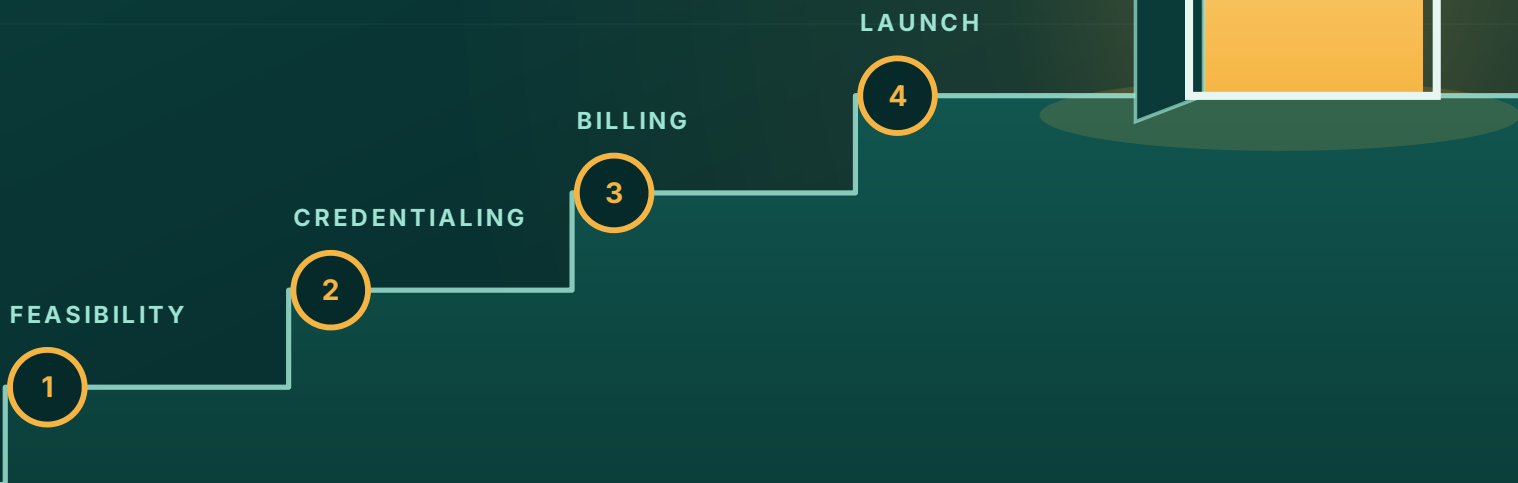
2026 EDITION

A FIELD GUIDE FOR LAUNCH CONSULTANTS

The Nurse Practitioner

Practice Launch Consultancy Playbook

How to build, run and grow a consulting business that helps NPs start and manage their own practices



The Credentik Team

CREDENTIK

2026 EDITION

The Nurse Practitioner Practice Launch *Consultancy* Playbook

How to Build, Run, and Grow a Consulting Business That Helps
NPs Start and Manage Their Own Practices

The Credentik Team

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The Nurse Practitioner Practice Launch Consultancy Playbook

How to Build, Run, and Grow a Consulting Business That Helps NPs Start and Manage Their Own Practices

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CHAPTER 5

Discovery and Launch-Readiness Assessment

How to interview an NP client, inspect the evidence behind every claim of “done,” separate blockers from warnings and deliver a readiness report the client can act on.

Every engagement starts with the same question: how close is this nurse practitioner to seeing patients and getting paid? Clients usually answer it with optimism. “My license is done, I have my NPI, and I applied to the insurance companies.” Each of those statements may be true and the practice may still be months from a billable visit. Discovery is the work of replacing statements with evidence.

This chapter gives you a repeatable discovery process: a structured interview, an evidence inspection, a way to classify findings as blockers or warnings, a simple scoring method and a report structure the client can use as a to-do list. It is also the first paid deliverable in most consultancies (see Chapter 6), so it has to be good enough to stand on its own.

I NOTE

In this chapter you will:

- Run a structured discovery interview that covers every readiness domain
- Learn which documents prove which facts, and which “proof” proves nothing
- Classify findings as blockers or warnings using a consistent rule
- Score readiness without hiding blockers behind an average
- Build a readiness report with findings, evidence, owners and repair actions

Why discovery is separate from doing

It is tempting to start fixing problems on the first call. Resist it. Discovery is a snapshot; its value comes from being complete and neutral. If you start filing applications before you have seen the whole picture, you will fix the visible problem and miss the one that actually blocks launch, such as a practice location that the client has not secured or an entity whose ownership rules nobody has checked.

Keep three roles distinct from the first conversation:

- **You (the consultant)** gather facts, inspect evidence, identify gaps and propose repair actions.
- **The NP decides** what to do: which payers, which location, which services, how much to spend, when to open.
- **Qualified professionals** answer questions outside your lane: an attorney on entity, scope-of-practice and contract questions; a CPA or tax professional on tax; an insurance broker on coverage; a clinical professional on clinical protocols.

Your report should name the owner of each item using exactly those categories.

The discovery interview

Schedule 60–90 minutes and send the document request list beforehand (see the evidence table below). Use the same interview guide every time so you can compare clients and so nothing is skipped because the conversation drifted. Templates 1 and 3 in Appendix A give you a ready-made questionnaire, document checklist and readiness assessment.

Domain	Questions to ask	What you are listening for
Vision and services	What services, for which patients, in what setting (in person, telehealth, both)? Which states?	Services that may need extra authority, settings that may need a facility license, out-of-state patients
Practice authority	Which state licenses do you hold? What does your state require for your practice model? Have you confirmed that with the board or counsel?	Assumptions about independence; practice environments differ by state [S01] [S02]
Entity and ownership	Have you formed an entity? Who owns it? Who advised you?	Ownership structures that need legal review; no EIN yet
Location	Do you have a signed lease or a written commitment for the service address?	A “location” that exists only as a plan
Identifiers and enrollment	NPI type(s)? CAQH status? Which payers, applied when, and what did they say?	Confusing “applied” with “approved” or “contracted”
Systems	EHR, practice management, clearinghouse, phone, scheduling?	Systems chosen but not configured
Finances	Startup budget, cash reserves, expected payer mix, owner pay expectations?	No working capital for the enrollment and claims lag (Chapter 8)
Insurance and risk	Malpractice, general liability, cyber, workers’ compensation?	Coverage assumed rather than bound

Domain	Questions to ask	What you are listening for
Timeline	What date have you told people you will open? What is that date based on?	Dates promised to patients, landlords or lenders before enrollment is effective

**TIP**

Ask “How do you know?” after every “yes.” The answer tells you which document to request.

Evidence inspection: what documents prove what

The core skill in discovery is knowing which document proves which fact. A license, an NPI, a CAQH profile, a payer credentialing approval, a signed payer contract, an effective date, a roster or location listing, EFT/ERA setup and claim-transaction readiness are separate facts. Each needs its own evidence. CMS itself lists getting an NPI and enrolling in Medicare as different steps [S05].

Fact to establish	Evidence that proves it	What does not prove it
Active APRN/NP license in the state of practice	Current board license verification record showing status and expiration	A wallet card, an RN license or an RN multistate compact privilege
Authority for the intended practice model	State statute/rule, board registration where the state requires one (for example, Florida’s autonomous APRN registration [S03][S04]) and counsel’s written view when the model is unclear	“My state is full practice” from a website summary
NPI exists and is accurate	NPPES record showing type, taxonomy and practice location	An NPI number on a business card
CAQH profile is usable	Current attestation date, complete sections, payer access granted	“I set up CAQH”
Payer credentialing approved	Written approval from the payer	Application submission confirmation
Network participation	Fully executed payer contract or agreement	Approval letter alone, unsigned contract
Effective date	Payer letter or portal record stating the effective date for this NP, entity and location	The date the application was sent
Listed at the right location	Roster or directory confirmation for the service address	A contract that names a different address
Medicare billing privileges	Enrollment approval stating the effective date; Medicare sets the effective date by rule, generally the later of the approved application’s filing date and the date services began at a new location [S00-12]	PECOS “submitted” status
Payments can arrive	EFT enrollment confirmation and ERA enrollment confirmation	Bank account opened
Claims can transmit	Clearinghouse enrollment for each payer and an accepted test or first claim acknowledgement	“The EHR can bill”

Fact to establish	Evidence that proves it	What does not prove it
Coverage in force	Certificate or declarations page with dates, limits and named insured	A quote

! WATCH OUT

Never mark an item complete based on a screenshot of a submission screen. Submitted means only that someone has the application. Record the submission date, but keep the item open until you hold the approval, contract or confirmation that actually proves the fact.

Blockers versus warnings

Classify every finding with one rule:

- **Blocker:** the practice cannot lawfully see patients, or cannot bill for or be paid for a planned service line, until this is fixed. Examples: no active license in the patient's state, no authority for the intended model, no executed contract or effective date for a payer whose patients are already booked, no service location.
- **Warning:** launch is possible, but the finding creates financial, compliance or operational risk. Examples: CAQH attestation due in three weeks, no cyber coverage, a malpractice limit that may not meet a payer's requirement, no written collection policy.

Two refinements keep the rule honest. First, a finding can be a blocker for one service line and not another. Missing commercial payer effective dates block in-network visits for that payer but not a cash-pay visit (subject to state law and the No Surprises Act good-faith-estimate rules for uninsured and self-pay patients [S10]). Write the finding that way. Second, legal and authority questions you cannot resolve are blockers until an attorney or the board resolves them. Do not downgrade them because the client is confident.

Scoring without hiding problems

A score helps clients see progress across repeated assessments. It must never average away a blocker.

Domain score: 2 = evidence complete; 1 = in progress with evidence of progress; 0 = not started or no evidence.

Readiness score = sum of domain scores ÷ (number of domains × 2) × 100

Readiness status = "Not ready" if any open blocker exists, regardless of score. Otherwise "Ready with warnings" or "Ready."

★ WORKED EXAMPLE: SCORING COASTAL BEND NP CARE (FICTIONAL PRACTICE)

Nine domains are scored: authority 2, entity 2, location 1, identifiers 2, payer enrollment 1, systems 1, finances 1, insurance 1, timeline 0.

Sum = $2 + 2 + 1 + 2 + 1 + 1 + 1 + 1 + 0 = 11$. Maximum = $9 \times 2 = 18$. Score = $11 \div 18 \times 100 = 61.1$, reported as 61%.

Check: $18 \times 0.611 = 11.0$. Correct.

Because two blockers are open (no executed lease and no payer effective dates while patients are booked), status is **Not ready** even though the score is above half.

The readiness report

Deliver a written report within an agreed number of business days after you receive the documents. Use the same sections every time:

- 1. Summary.** Status (Not ready / Ready with warnings / Ready), score, number of blockers and warnings, and the three actions that matter most.
- 2. Scope and limits.** What you reviewed, what you did not, the date of the snapshot, and a statement that the report is operational, not legal, tax or clinical advice.
- 3. Findings table.** One row per finding (format below).
- 4. Domain detail.** Short narrative for each domain with the evidence inspected.
- 5. Questions for professionals.** A list of questions to take to the attorney, CPA, broker or clinical adviser.
- 6. Dependencies and sequence.** Which repairs must happen first (a location before a location-specific enrollment, an entity and EIN before a group enrollment).
- 7. Evidence index.** Every document received, with date and source.

★ WORKED EXAMPLE: FINDINGS TABLE FOR COASTAL BEND NP CARE (FICTIONAL PRACTICE)

#	Finding	Type	Evidence inspected	Owner	Repair action
1	Service address not secured; lease unsigned	Blocker	Draft lease, unsigned	NP decides; attorney reviews lease	Execute lease or written commitment; then update NPPES and applications
2	Two commercial payers show "application received" only; patients booked from next month	Blocker (in-network visits for those payers)	Portal screenshots dated last week	Consultant follows up; NP decides on rescheduling	Obtain approval, executed contract and effective date; do not book in-network visits until held
3	Practice model may need state-specific registration	Blocker until resolved	Board website printout; no counsel opinion	Attorney	Obtain written legal view; file any required registration

#	Finding	Type	Evidence inspected	Owner	Repair action
4	CAQH attestation expires in 21 days	Warning	CAQH profile summary	Consultant prepares; NP attests	Re-attest before expiration
5	ERA enrollment not done for Medicare	Warning	EFT confirmation only	Consultant	Submit ERA enrollment; confirm receipt
6	No cyber coverage quote	Warning	Insurance summary from client	Insurance broker	Request quote; NP decides
7	Startup budget has no working capital line	Warning	Client spreadsheet	NP with CPA	Build cash-flow model (Chapter 8)

Consultant workflow

1. Send the engagement letter, document request list and interview guide.
2. Hold the interview using the domain table; record “how do you know” answers.
3. Log every document received in the evidence index, with date and source.
4. Verify what can be verified from primary sources (board license lookup, NPPES record, payer portals with the client’s authorization).
5. Classify each finding as blocker or warning and assign an owner category.
6. Score each domain; apply the blocker override.
7. Draft the report, including questions for professionals.
8. Review the report with the NP; confirm the NP’s decisions in writing.
9. Agree whether the next step is launch management (Chapter 6) or a re-assessment after the client completes repairs.

Evidence and deliverables

Step	Proof it is done
Interview	Completed interview guide with date and attendees
Evidence inspection	Evidence index with each document’s date and source
Classification	Findings table with type and owner for every row
Report delivery	Report sent, with delivery date
Client decision	Written confirmation of the NP’s decisions and next step

Common mistakes

- Treating “applied” as “approved,” or “approved” as “contracted and effective.”
- Accepting an RN compact privilege as evidence of APRN authority.

- Averaging scores so that a blocker disappears into a respectable percentage.
- Giving a legal opinion on practice authority instead of routing it to counsel.
- Promising an opening date in the report. Report dependencies, not dates.
- Leaving the owner column vague (“TBD”). Every finding has an owner category.

Closing checklist

- ☐ Interview guide completed for every domain
- ☐ Every “yes” backed by a named document in the evidence index
- ☐ License, NPI, CAQH, approval, contract, effective date, location, EFT/ERA and claim readiness recorded as separate facts
- ☐ Each finding classified as blocker or warning, by service line where relevant
- ☐ Unresolved legal or authority questions treated as blockers and routed to counsel
- ☐ Score calculated and checked; blocker override applied
- ☐ Report includes scope, limits and the non-advice statement
- ☐ NP’s decisions confirmed in writing

➔ KEY TAKEAWAYS

- Discovery replaces statements with evidence. Ask “How do you know?” after every yes.
- Each launch fact has its own proof. A submission is not an approval, an approval is not a contract and a contract is not an effective date.
- A blocker overrides any score.
- Every finding needs an owner: consultant, NP, attorney, CPA, broker or clinical professional.
- Report dependencies and repair actions, never guaranteed dates.

END OF SAMPLE

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You have just read Chapter 5 of 22. The complete 2026 Edition runs to 259 pages and gives you the whole engagement, from the first discovery call to the monthly support retainer.

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The toolkit

12 templates in Appendices A–D, also delivered as editable Markdown and CSV files: questionnaire, readiness assessment, pricing calculator, cash-flow model, enrollment tracker, risk register and more.

Checked sources

A glossary, an index and a references appendix (Appendix E) listing the primary sources behind every reference tag, checked as of October 2026.

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