University of Wisconsin- Madison Department of Family Medicine and Community Health

Clinical Care Taskforce Proposal

"Physician assistant and nurse practitioner role optimization"

June 23, 2016

Taskforce Members

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Taskforce development:

The Clinical Care Task Force was developed as part of the Department of Family Medicine and Community Health (DFMCH) ReCHARGED strategic planning initiative. Activities conducted by the DFMCH ReCHARGED Steering Group have included planning, data gathering and conferences to gain perspectives to expand the department's knowledge of best practices and innovation. In September 2015 a Vision Conference was held to problem-solve around the core areas of DFMCH. Vision statements in several key areas emerged from this conference. The Clinical Care task force was formed following that conference to develop a proposal addressing potential improvements in clinical care models for the DFMCH ReCHARGED strategic planning initiative.

Description of the issue:

The Clinical Care Task Force of the DFMCH aspires to assist our clinics in achieving the Quadruple Aim of:

1. Improved patient experience
2. Improved patient and population health
3. Lower per capita cost
4. Improved clinician and staff experience

We have chosen to focus on **access** as one of the most pressing issues facing our clinical system. Access is a cornerstone of strong primary care and population health management and key to the benefits (better quality, better health, greater equity at a lower cost) that primary care adds to a highly functional health system(Starfield 2005). Many argue that access is the most important cornerstone of any health system in that if patients cannot enter the system in the way the want and need they cannot benefit from high value quality care.

Access in DFMCH clinics has been declining as measured by:

- Patient satisfaction surveys: this data has been difficult to obtain due to recent problems with the survey instrument (Avatar). Data in Figure 1 shows that in January 2013 the range of top box scores at the clinic level was between 65% and 92.98% strongly agreeing with the statement, "An appointment was available when needed" By Feb of 2015 this range had fallen to between 56.52% and 86.79%.
- Panel size per 1.0 physician FTE: this number has increased from an average of 1402 in the community clinics and 1650 in the residency clinics in January of 2012 to 2031 in the community clinics and 2034 in the residency clinics in January 2016.
- Clinic panel size: Of our 18 Dane county and regional clinics, 12 are at 90% or greater to capacity based on target panel sizes; 8 of those 12 are at greater than 100% capacity.

Access has become such a problem in our system that UW Health had to approach our affiliated health plan, Unity, to hold on selling new policies until we improve our access by hiring more clinicians.

We believe that the current problem with access in our clinics is a long term rather than short term problem. According to data released by the Association of American Medical Colleges in 2015, there is a shortage of primary care physicians which is projected to be as high as 31,000 by 2025. Contributors to this shortage include projected population growth, an aging population and increased patient access to the health care system via the Affordable Care Act. Overall, physician demand is projected to be increase by 17%. Locally, Dane County is expected to grow by 1% annually with a projected 61% growth in people over 65 years old. Additionally, the role of primary care as deliverers of population health in addition to individual patient care means that new work is being added to our plates, further stressing the current system. Health systems will need to meet these demands in the setting of physician shortages.

Poor access to primary care in our system not only impacts patients and primary care clinics but UW Health as a whole. From a business perspective, in excess of 50% of net operating revenues for an integrated health care system (IHS) like UW Health are generated in the outpatient settings, including provider professional services (Zismer, 2014). High-functioning IHS's fully open "front doors" to the system to provide direct access the care system, prevent 'leak' of patient to other systems and improve health outcomes. Increased outpatient access also prevents unnecessary emergency room visits and hospitalizations, issues becoming more prominent in population health management and capitation reimbursement models. Additionally, as the competitiveness of the healthcare market rises, access will be the defining feature that will attract and retain patient loyalty to the UW Health system.

While others in our department are doing critical work to address the training and recruitment of medical students and residents to address this primary care physician shortage, a more immediate solution on which our task force chose to focus is consideration of the role and numbers of physician assistants (PAs) and nurse practitioners (NPs), (referred to in the rest of this document as "Advanced Practice Providers" or APPs) in our clinics.

We recognize that each clinic in our system has unique features with regard to patient population served and areas of physician, APP and staff expertise and personal fulfillment. As such we seek to give guidance where there is a reasonable certainty that all clinics can benefit from a particular recommendation while also intentionally leaving room for customization of roles that may be unique to each clinic.

Best and Current Practices regarding the role of APPs in helping to achieve the Quadruple Aim

Information sources for this report include

- Literature review
- Key informant interviews – DFMCH faculty, residents, PAs, NPs, managers, Ginny Snyder, PA, Christine Everett, PA
- A survey of all faculty, residents and APPs in the DFMCH

Improved patient experience:

Current state: UW Health data as well as published data in peer reviewed literature (Newhouse 2011, Hooker 2005) show that patients have equivalent satisfaction with care provided by APPs compared to care provided by physicians. Patient satisfaction as measured by "an appointment was available when needed" is one of the areas of lowest satisfaction in our organization.

Best practices: Improving access to our clinics via optimizing APP roles and increasing numbers of APPs in our clinics is likely to improve overall patient satisfaction with our clinics.

Representative comments from DFMCH survey:

"We are well accepted and respected by staff and patients"

"Excellent quality of care provided by APPs. Patients who may be unhappy that they are not seeing their primary physician are consistently pleased with the care they receive from APPs. Good communication and interaction about patient care."

Improved patient care and population health:

Quality of care:

Current state: There is no way for us to link APPs to patients in a way that allows us to easily assess quality of APP care in our current practices. The literature was reviewed regarding quality of care for patients seen by physicians as compared to those seen by APPs. Everett et. al. (2014) looked at diabetic outcomes and the involvement of the APP. They found that the involvement of an APP improved or did not change most outcomes. Newhouse et. al. (2011) performed a systematic review of 37 studies showing cost effective outcomes in regards to APNP. Their findings showed there was equivalent level of patient satisfaction, perception of health, functional status, glucose control, blood pressure control, emergency department visits, and hospitalizations when comparing APNP care to physician care. A similar review by Hooker and Everett regarding roles of PAs in primary care found similar or better outcomes for conditions such as back pain, HIV care, geriatric care and metabolic diseases. A 2015 paper by Hughes et. al.(2015) shows one area in which APPs may differ from physicians is in regards to ordering of imaging. The authors found higher rates of imaging for APPs compared to physicians. Lohr et. al. found in their 2013 study evidence that referral quality was judged to be higher for physicians than for APPs in one health system.

Best practices: Abundant evidence from the literature suggests that APPs can and do deliver high quality care. In our system we envision strong linkages between APPs and supervising physicians to ensure high quality care delivery with appropriate utilization of ancillary services and consultants.

APP roles:

Current state: We met with many clinicians and clinic managers throughout DFMCH as well as solicited input via paper and an electronically administered survey. APPs have varying roles in our current clinics. Some APPs who have been with the organization for many years still function in a PCP role though this is no longer the care model we are using moving forward. APPs all provide some amount of same day access for patients. Many also provide well adult and child visits and follow up for acute and chronic conditions. APPs vary in the type and frequency of procedures performed. At least one APP has a specific role in partnering with maternity care providers in her clinic to provide prenatal care. Many APPs participate in clear team structures in the clinics but 20% of respondents in our survey reported not having a clear group of patients for whom they were a team member. Most APPs cover their own in-basket and do not work out of physician in-baskets unless that physician is away on vacation. Many physicians voiced interest in getting assistance from APPs in this work; several APPs voiced reluctance to take on this work without dedicated time built into their schedule.

Best practices: We were unable to identify any published literature comparing physician and APPs roles to define a "best practice" in primary care. Descriptive studies included such varied APP roles as PCP, provider of urgent care only, provider of chronic disease management and patient education only, and provider of well care. Though the exact role varied tremendously, what these studies did have in common was that PA and NP roles were clearly defined with team-based care being an overarching theme. See appendix for two examples of well-defined APPs roles in our clinics in Deforest-Windsor and Northeast.

Representative comments from DFMCH survey:

"There should be a clear linkage between APP roles and the role of individual primary care clinicians. This should be a team, not independent players."

"Provide continuity of care for patients when faculty and resident providers are unavailable. / Offer access to appts for urgent care, well child and well adult care as we have the most patient care sessions available."

"PAs are exceptional. They are some of the best continuity providers and are a core of clinical practice"

"The majority of our MD's trust our clinical judgment and allow us to work to the highest level of our certification. They also allow us to see the types of patients that suit our individual interests. They are always willing to teach so that we can learn new skills (eg ob care). I feel like a colleague with my MD's."

"team based approach to care, particularly maternity/prenatal care"

"APP work generates a lot of extra work that still all goes to the MD/DO. Clinical staff are not skilled at navigating how to involve the APPs in in basket help. For example, protocols dictate ordering certain labs, which are nearly always ordered under PCP name even if patient seeing the APP. Many followup questions after an APP visit tend to go to the PCP instead of to the APP."

APP ratios:

Current state: Currently UW Health has a target ratio of 3 physician FTE to 1 APP FTE in our family medicine clinics. If we engage in team based care for this grouping of clinicians the target weighted panel size for this group would be 6300 (1800 x 3 physicians + 900 per APP). This large number of patients is impossible for a single APP to get to know on any sort of a personal level which often leads to decreased satisfaction for the APP as well as for patients.

Best practices: No clear evidence exists around best practices in this area. An informal survey administered via Email by the Group Practice Improvement Network in 2015 queried members regarding how many physicians and APPs comprise their primary care teams. Fifteen respondents from around the country reported physician:APP ratios varying from 4:1 to 1:2.

Representative comments from DFMCH survey:

"more closely align one PA to 1-2 physicians to have a smaller patient panel that is managed by that group"

Lower per capita cost:

Current state: Data shared by Michelle Riley for FY14 in DFMCH included revenue and expenses for 37 APPs who worked in Community, Residency, and Regional clinics. Of those 37 people, 36 had net positive income for the department based on the departmental collection rate.

Best practices: Appropriate and efficient care delivered by APPs can be a means of decreasing overall healthcare costs. Roblin et. al. (2004) found primary care practices that used APPs had lower overall healthcare costs. Eibner et. al. estimated using economic modeling that increasing APP using in Massachusetts 4.8 % to 18.1 % would have a cumulative health care cost savings of 4.2-8.4 billion dollars over 10 years.

Improved clinician and staff satisfaction:

Current state: Informal conversations with DFMCH physicians and APPs suggests a high rate of burnout in our clinics. We understand that UW Health plans to survey clinicians in the regard later this year. Physician satisfaction in Wisconsin as measured by the State Medical Society in 2014 showed forty-seven percent of Wisconsin physicians report being moderately or significantly burned out. (Coleman 2015) This is

nearly identical to national norms reported in a 2012 Mayo-AMA study (Shanafeldt 2012).

Best practices: We could find no data either in the literature or in our current clinics to suggest that a specific APP role or ratio resulted in improved clinician and staff satisfaction. It is our opinion that optimizing role the physician-APP team holds promise for improving burnout and joy in practice.

Representative comments from DFMCH survey:

"My job satisfaction would decrease considerably if I did not have APP colleagues in my clinic."

"I have an incredibly bright, thoughtful and compassionate PA"

Our proposal in three tiers:

Tier 1: Optimize current and future APP roles:

Goal: To work towards the Quadruple Aim via clarification of roles and responsibilities for current and future APPs in our clinics with an emphasis on understanding and addressing the unique needs of each clinic and utilizing a well-defined team structure.

We have identified several opportunities for optimizing physician/APP collaboration and partnership. In considering these opportunities, it is important to recognize that each clinic has unique patient populations, varying levels of current functioning partnership, and that APPs and physicians have varying skill-sets and interests (e.g., maternity care, procedures). Each clinic needs to independently identify the needs of its patients with regards to direct and non-direct patient care to assure high quality of care, patient satisfaction, and clinician and staff satisfaction. This first tier provides a guide for optimizing current and future APP roles. Recommended activities include:

- Perform a clinic needs assessment regarding what types of patient care services are needed and which clinician type is best poised to offer that service. For example if a clinic is having difficulty getting patients in for hospital follow ups with a physician, what visits on the physician schedule could be moved to an APP schedule to allow for this?
- Create clear team structures and roles for physicians and APPs
- Share the visit types between APPs and physicians that pose the greatest barriers to access
    - For example, establish templates with an intentional balance of acute care/chronic care/preventive visits, where appropriate for APPs.
- Share in-basket patient responsibilities between APPs and physicians with allocated time

- Develop patient education material regarding roles for team members
- Support co-location of teams to assist with partnerships, handoffs and mentorship
- Establish regular team and chronic care huddles that incorporate physician/APP partners.
- Establish regular team complex case review with APP, RNCC, MD and other team members a minimum of quarterly
- Assess team-based quality of care metrics that highlight outcome measures and care gaps/"missed opportunities."
- Offer brief, periodic education topics in clinician meetings that are appropriate for shared patients.
- Include time for physician/APP consultation regarding difficult cases into templates.
- Identify APPs in HealthLink as part of the care team for patients.

Tier 2: Increasing the numbers of APPs in DFMCH clinics – a pilot study

Goal: To improve access in our DFMCH clinics by adding APP FTE to our clinics with a goal of 1 physician FTE:1 APP FTE per 2700 patients.

This pilot would involve implementation of all of the approaches recommended in Tier 1 with the addition of more APP FTE at 1-2 pilot clinic sites. Adding more APPs makes for easier collaboration and teamwork between APPs and physicians. With a 1:1 ratio, physicians and APPs could each attach onto the other's inbasket and jointly take responsibility for addressing all items in a timely fashion. Patients could more clearly get to know a pair of clinicians who could take responsibility for improving team continuity.

Tier 3: Training APPs for team based care in the DFMCH

Goal: Offer a one year post-graduate training program (similar to "residency" for physicians) for PAs and NPs in team-based care in our family medicine clinics in order to overcome a tendency for our clinics to be reluctant to hire new graduates with less experience.

- Match APP trainee candidates to sites with patient populations of their interest – considerations would include volume of pediatric patients, maternity care, urgent care, sports medicine, chronic disease management.
- Assign APP and MD mentors to trainees with similar interest, practice and/or background.
- Assure a balance of clinical work, educational programming and opportunities for scholarship for trainees.

* See appendix for further curricular and financial details of a similar program piloted in DFMCH in 2012

Challenges to be addressed which require working with partners outside of our department:

1. **APP work hours requirement** :

Currently 32 hours of face to face patient care required per week in DFMCH v. 30 in general internal medicine (GIM). This issue must be resolved between leadership of the two departments.

Representative comments from DFMCH survey:

"We too have inbasket responsibilities and I think expecting us to see 32 patient hours while expecting the MD's to see 27 patient hours needs looking at. Reducing us to 30 patient hours (equal to internal medicine) APP's seems more reasonable. This is especially important due to the increasing time it takes to respond to My Chart messages in addition to refill requests and phone calls. Of note, when I stated above that I don't think we should be expected to cover MD's inbaskets, this sentiment doesn't include when they are on vacation. I am happy to cover when they are on vacation, but don't feel that we need to cover their inbaskets when they are in clinic."

Proposed action: Refer to departmental leadership to work with GIM on this issue. We recommend adopting GIM's hours rather than asking GIM to increase theirs (see #2 below).

2. **APP burnout:**

Representative comments from DFMCH survey:

"I do believe that as an APP, I am a valuable member of the team/clinic and provide a wide range of competent, compassionate care to our patients. That being said, the workload is on the verge of unmanageable given the full schedules of patients, charting, inbasket coverage, MyChart, teaching, etc. / I find that I work 1-2 hours nearly every night from home in order to stay on top of things. Also spend that amount of time on my day off each week managing my inbasket and other pt-related issues as they arise. / Most days are nearly frenzied in pace trying to keep up with 7 half days of patient care. Although I love my work, and have been in practice 20+ years, I have considered making a change as this pace is nearly impossible to maintain. Several of our APPs are reducing their percent appointment which reflects exactly this."

"Provide time during the day to call family members of frail patients for updates, advanced directives discussion and goals of care. / This is currently done after hours by me and contributes to my burnout because it takes away my private time."

Proposed action: Assess APP burnout with upcoming UW Health clinician survey and consider re-allocating weekly work hours from face to face to non-face to face patient care time.

3. **APP compensation coming out of MD compensation**

A theme we heard at many clinic site visits is that the way in which APP salaries are paid for out of physician salaries creates tension and is a disincentive to hire APPs. We heard several times that physicians are comfortable with a 2-3 year ramp up time for new physicians but the fact that APPs affect physician salaries immediately is a problem. It has also been discussed that APPs may need to be thought of as more of a care team member per panel member similar to RNs and MAs and supported in the same way (physicians don't "pay for" RNs and Mas).

Representative comments from DFMCH survey:

"comp system does not seem to work - APP at clinic does not allow larger panel (same in-basket work) and should not be tied to physician salary / organization should compensate APP if they wish to expand their roles to improve clinic access"

"I do not want more APP if the patient panel # would increase."

Proposed action: Request that the DFMCH Compensation Committee respond to these concerns and work with the Primary Care Compensation Governance Group as needed to recommend changes to address these concerns.

Financial requirement

Tier 1 – Requires no financial investment outside of the time it takes for clinicians and APPs to sit together and work through the suggestions regarding role clarity, task distribution and mentorship.

Tier 2 – Requires up front investment in the amount of a PA or NP salary. Most PAs and NPs recoup their salary costs via billing and charges within the first year of employment (personal communication, Michelle Riley). The pilot site(s) would need to be chosen based on need to expand capacity to see current and new patients.

Tier 3 – Requires the biggest investment without clear cost recoupment. A prior pilot of

a similar program estimated 1 year costs to be $78,000 (data available upon request), taking into account revenue from charges generated by the trainee in clinic, paying a trainee salary and assigning some portion of clinic overhead costs to the program. It is difficult to assign further value to the program – it may be that graduates of such a program are better prepared to enter primary care medicine in our clinical system, it may help with recruitment.

Short and long term plan

Recommended roadmap for implementation:

1. Tier 1
    a. This recommendation could be the focus of a DFMCH Dyad meeting and much of that work could be completed in a 4-6 month time frame.
2. Tier 2:
    a. Month 1: Choose pilot clinic(s) based on
        i. Need to expand access based on panel size for the clinic
        ii. Interest expressed by current physicians and APPs
    b. Month 2: Complete the Tier 1 assessment to create a clearly focused job description for the new APP(s)
    c. Month 3: Work with HR to create budget justifications and post positions
    d. Month 6: Interview and select candidates
    e. Month 12: APPs begin work in clinics
    f. Ongoing: monitoring outcomes including patient satisfaction, quality, cost, clinician satisfaction
3. Tier 3:
    a. Month 1: Work with John Beasley and Ginny Snyder to better understand prior pilot work in this area.
    b. Month 3: Rework the position description and educational plans for the program
    c. Month 6: Work with clinics to determine possible sites for the APP "resident".
    d. Month 9: Recruit, interview, select candidates
    e. Month 18: Begin training program
    f. Ongoing: monitor outcomes: participant feedback, clinic feedback, cost data, where do graduates go? What value do they find from the program?

How will we know we have succeeded?

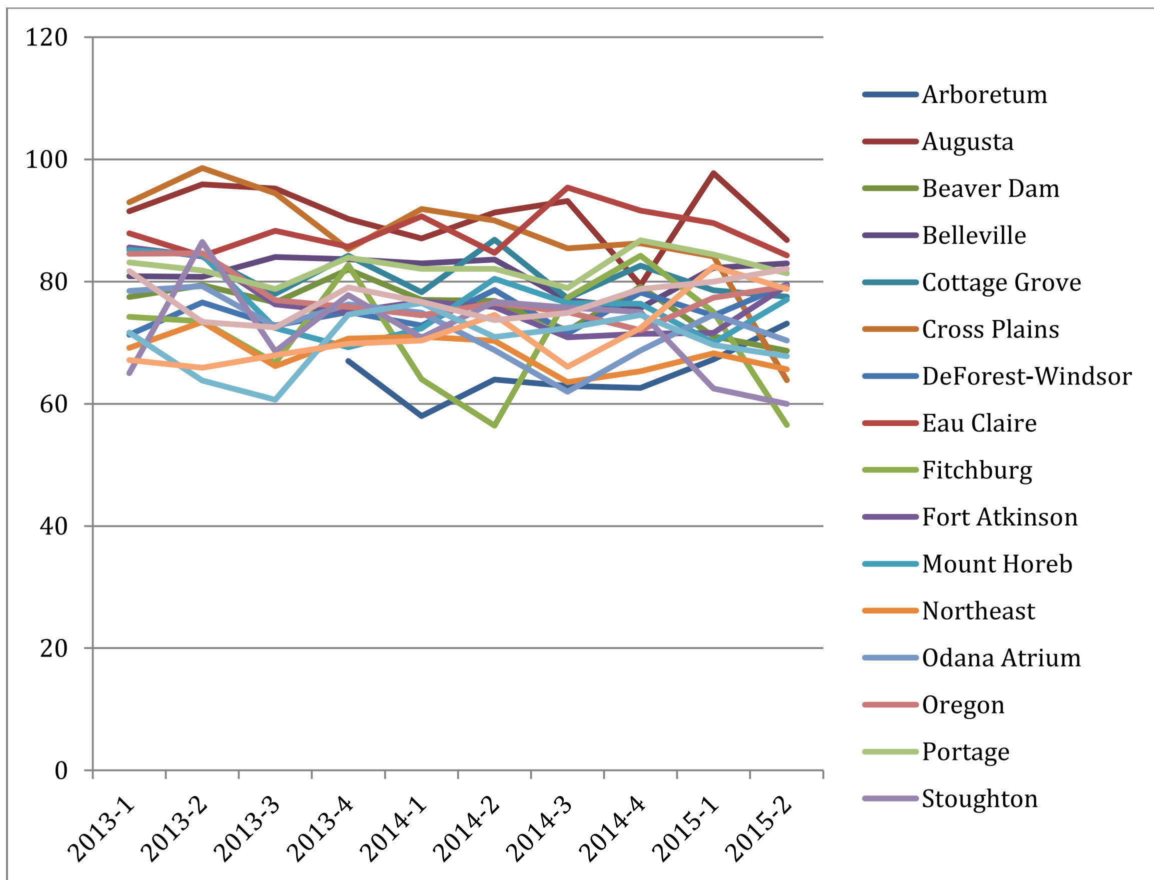
1. Improved access
    a. Patient satisfaction with access and other metrics
    b. 3rd next available appointment
    c. Panel sizes

2. Quality indicators stable or improved
3. Improved team continuity – percent of patients who see their personal physician or a team member
4. Improved clinician satisfaction as measured by soon to be administered UWMF survey
5. Improved financial bottom line for the clinic by year two

Specific targets for the above metrics will need to be based the baseline data for the clinics selected for the interventions.

Figure 1:

Top box scores for Avatar question "An appointment was available when needed"



Appendix:

DFMCH Clinician and staff survey results:

Summary:

- 82 people completed the survey, including 39 faculty physicians, 7 residents, 24

APPs, 8 RNs and 4 other staff.

- Overall, the respondents believed that APPs should handle well-adult exams, well-child checks, same day appointments, disease management and in-basket work. Respondents did not have particular preference about whether APPs should perform maternity care.
- The respondents overall did not feel that APPs provided enough assistance on in-basket work, chronic disease management and maternity care, comparing with other task types.
- The majority of respondents were satisfied about their clinic work. More than 18% were not satisfied with their work.
- About 18% of the respondents were not satisfied with the effectiveness level of their APPs.
- 65% of the respondents were satisfied with their MD/DO colleagues.
- Almost 20% of the respondents did not feel having a clear group of patients for whom they were a team member.

Positive comments that were noted:

- Many many people remarked on what valued colleagues and care team members APPs are
- Some APPs have special interests that add value to their site – examples include providing prenatal care, doing certain procedures, managing depression – and it would be a loss to take these roles away from folks in the interest of a fully standardized role for APPs
- APPs who work with clear team structure and guidance report high satisfaction

Areas where respondents felt there is room for improvement:

- Sometimes APPs see the most complex patients as urgent visits or hospital followups. This is not always the best role for an APP.
- Some APPs are not clearly aligned with teams in their clinics and have minimal continuity with patients and physicians
- Physicians requested APP assistance with inbasket management. APPs are concerned about being asked to take on this role without being given time to do so .
- Desire for role clarity – some clinics need more same day access, others requested help with well exams or chronic disease management.

Other comments:
Several folks thought APPs should be PCPs in our system
Examples of current highly functional APP roles in DFMCH –

Case study 1:
Northeast clinic - example of a well-defined team structure in a residency teaching setting:

Northeast Clinic is an example of a family medicine clinic with a clear team structure of faculty physicians, resident physicians and APPs. Northeast is a training site for 12-14 family medicine residents in which faculty physicians and residents act as primary care providers (PCPs). Due to the nature of academic practice and residency training all faculty and residents work in clinic on a part-time basis (0.2-0.7 FTE). APPs typically work more full-time and therefore play a crucial role in anchoring the team and caring for patients when their PCP is unavailable. All patients at Northeast are assigned to one of four patient care teams. Each team consists of 2 faculty physicians, 3 resident physicians, 1 APP and 2 RNs, LPNs or MAs. APPs mostly see patients assigned to their team, so they get to know their team's patients well. Being part of a team facilitates communication between physicians and APPs about mutual patients. APPs provide urgent care, well exams and chronic disease management. They are also encouraged to pursue personal areas of interest or expertise. For example, one of the PAs at Northeast has previous urgent care and procedural experience. She not only provides these services, but also teaches residents procedural skills. In the past APPs have offered specialized services such as ADHD evaluations and nutrition education. While APPs are not designated as PCPs, many patients know their team's APP very well and feel comfortable seeing both their PCP and APP for visits. This team-based care model improves both access and continuity in a clinic with a large number of part-time physicians who often have limited availability for clinic appointments.

Case study 2:
Deforest-Windsor – example of a clinic that performed a needs assessment and trained an interested APP to perform a specific role: that of alternating prenatal visits with a physician in the practice. The following outline was prepared by the involved physician, Jackie Gerhart, MD, regarding the positives outcomes of this team role:

1. Scheduling
    a. Patient satisfaction increased with better access (this includes non-OB patients having better access to my schedule and OB patients having more scheduling options by being able to pick between multiple practitioner schedules.)
    b. Better MD satisfaction with not having to "squeeze in" OB appointments that are urgent.
    c. Better patient and MD satisfaction when a MD calls in to cancel their clinic schedule for a delivery-- the OB patients that were on the MD's clinic schedule can be transitioned to the PA schedule

2. Volume
    a. With someone to share the workload we can potentially see more patients - do more deliveries per month if wanted Or the opposite - it's a great way to continue to do a set number of deliveries per month but not to be overwhelmed by the amount of prenatal visits - you can unload some of them to prevent burnout.

3. Financial
    a. PAs get a salary, while prenatal care is bundled into a global payment for prenatal care plus delivery. It is therefore financially beneficial for MDs to not perform every prenatal visit in order, creating opportunities to perform other billable office visits.
4. Patient Satisfaction
    a. Patients love the team approach. Jackie is sometimes asked if the PA gets to be at the delivery too!! They feel like there are more people invested in their pregnancy and have a true team that they can rely on. And as stated above, patients love the flexibility for scheduling and the ease of rescheduling if necessary
5. Quality Improvement of patient care
    a. Having two sets of eyes and hands can be helpful - less likely to miss something
    b. Consistency of use of problem list and note style and documentation because you are sharing the episode of care with another provider and need to set up a standard way of communicating in the chart to each other.
6. PA satisfaction
    a. With all the urgent care and chronic care that gets put on the PA's schedule, PAs see OB visits as an opportunity for:
        i. a break in their day to see someone "young and healthy"
        ii. fun to do the actual visit (listening to heart tones, enjoyable conversation)
        iii. a sense of continuity in their practice (in which they don't have a patient panel)
        iv. an opportunity to increase pediatrics in their practice (many parents are more comfortable seeing PAs for well child visits or sick kid visits if they met the PA during pregnancy
        v. an opportunity to have a "mini-panel" of OB patients they help follow with the PCP/OB Provider - helps them gain a sense of ownership and responsibility

Example of Tier 3 program: 2012 Pilot for PA trainee program – from John Beasley, MD:

PA PROGRAM TRAINEESHIP

Goal: To increase the numbers of PAs entering primary care careers by creating a PA Post-Graduate Family Medicine Traineeship Program at Family Medicine clinics in Wisconsin

Rationale: Although we are selecting students based on interest in primary care careers and have made curricular modifications to develop appropriate skills and maintain this interest, we have not made the progress we want in terms of placement of our graduates in primary care positions. Part of the issue is that there are simply not enough requests for newly graduated PAs in primary care practices. In discussions with both recruiters and the WAFP BOD, it is apparent that many practices, while wanting to have PAs as part of the practice, want ones who have experience, thus creating a "catch-22" as then the PA student takes a sub-specialty job and is at risk for getting siphoned off into a subspecialty career.

Proposal: We propose to address this problem by creating one-year PA Family Medicine Training programs within the UW DFM's statewide system of clinical settings.
These training programs will:

- Make it possible for PA Program graduates to get outstanding experiences in Family Medicine prior to entering practice.
- Promote interdisciplinary education by having PA students work directly with FM residents and faculty physicians who may be providing job opportunities in the future.
- Help us develop more effective models of PAs working in close concert with physician colleagues in teams in a way that goes beyond just increasing clinic productivity.

Structure: Starting in July, 2014, we propose that we hire 3-5 post graduate trainees to work in the Madison area at one of the UW Health family medicine sites. Each trainee would be employed as a 1.0 FTE through UWMF. Within the 1.0 FTE, .75 FTE will be at the clinical site with the remaining .25 FTE in structured educational activities, coordinated through the PA Program. The salary for the trainees would still need to be determined but would be in the ballpark of $50,000. In order to receive benefits, we would need to hire at a 1.0 FTE permanent with a clear explanation (written in the offer letter) that the employment will end after 1 year of completion of the program. This would allow full benefits and would add an additional cost of 34.9%. UWMF will not guarantee employment after the traineeship is complete.

Timeline: Most graduating PA students will begin their job search in the spring. Decisions regarding this program will need to be made in early 2014 so all of the details can be worked out and students can apply in the spring. They would begin their program in July, 2014.

Structured Learning Activities (.25 FTE):

- Attending, as appropriate, lectures of UW DFM PG-1 Family Medicine residents (1/2 day per week)

- A weekly seminar of 1 hour which will address issues of PA roles, team functions and such clinical topics as may not be covered in the residency lectures.
- Self-study as assigned by mentors or chosen by the trainees.
- Electives in specific clinical areas not to exceed .10 FTE
- A project comparable to a Master's Capstone which will demonstrate their ability for independent work and analysis

Objectives of the Clinical Portion (.75 FTE):

- Obtain additional clinical experience in a range of primary care services including acute, chronic, preventive, and mental health services to increase individual capacity for the delivery of comprehensive care.
- Enhance clinical decision-making skills through didactic and practical training in evidence-based medicine.
- Develop skills to participate in developing and analyzing systems that focus on the delivery of quality, patient-centered care that efficiently utilize resources.
- Develop teamwork skills such as communication and coordination.
- Enhance competencies in community-based medicine.
- Develop the attitudes and skills needed to practice patient-oriented medicine.

Evaluation: Clinical experiences will be documented using the OASIS system to assure adequate numbers of patient encounters with diverse patients and adequate numbers of procedures. In addition there will be ongoing monitoring of the trainees' progress by his/her on-site mentors. There will be no additional exams. The capstone project must be acceptable to Dr. Beasley.

Outcomes: The PA trainee will receive experience which has generally been considered to be comparable to three years of practice experience in the usual primary care setting. They will be prepared to function both independently (under the usual supervision) and as part of a Highly Functioning Care Team. They will show competence at an appropriate level in all cix ACGME Competencies.

Potential Questions/Considerations:

1. Does a site need to have a PA in order to be considered? *We feel that a site does not need to have a PA to house a PA Trainee. They would need to have a designated supervisor/mentor to oversee their work.*
2. Since fair employment practices will need to be followed, how will the trainees be chosen? *We would like to limit this to the UW PA Program Graduates for the first couple of years. Once the program is established, other PA graduates may be able to be considered. A process to determine the best candidates will need to be established and should include assessing personal stake in primary care, academic excellence and match with the sites.*

3. What are the benefits to the clinical sites that have a trainee (especially since recruiting experienced PAs is not a current issue)? *This would give sites an opportunity to support the educational mission of the department and a chance to select and train a PA for clinical situation specific to their site.*

Sample cost accounting in the Access clinical system from 2012:

PA Traineeship Analysis

1 Year Program

Revenue	
Charges	$ 230,845
Collection Rate- Dept	53%
Net Payments	$ 121,424
Assessments 20.41%	$ 24,783
Net Patient Revenue Dept Coll Rate	**$ 96,642**
Expenses	
Salary (clinic FTE only)	$ 50,000
Fringes (clinic FTE only)	$ 18,750
Other Expenses[1]	$ 1,000
Dept Facility Overhead[2]	$ 48,507
Support Staff[3]	$ 56,418
Total Expenses	$ 174,674
Net Income/(Loss)	**$ (78,033)**

[1] Other Expenses include licenses, business cards, lab coats, start-up costs, journals, exams

[2] Dept Facility Overhead rate multiplied by PA Clinical FTE

[3] 1.0 FTE MA, 1.0 FTE Receptionist Salary/Fringes prorated to clinical PA FTE

FY13 PA Family Medicine Benchmarks	
Benchmark Production	$ 461,690
Clinical FTE	0.75
Benchmark Production w/FTE rate @ 2/3	$ 230,845
Benchmark wRVUs	3,554
Benchmark wRVUs w/FTE rate @ 2/3	1,777

Facility/Telecom Overhead per 1.0 FTE Rate	MA Sal/Fringes 1.0 FTE entry level	Receptionist Sal/Fringes 1.0 FTE entry level	PA Traineeship Sal/Fringes 1.0 FTE entry level	Collection Rate
$ 64,676	$ 40,891	$ 34,333	$ 68,750	52.6%

Facility/Telecom includes utilities, waste removal, snow removal, lawn care, real estate taxes, personal property taxes, adjustments, janitorial, rent, local & long distance phone bills, cable found through PeopleSoft GL

Assumptions:
- PA Traineeship 1 year program, production at two-thirds of benchmark, at 0.75 clinic FTE
-PA trainee salary and benefits at UWMF 37.5% benefit rate and $50k salary
-0.75 FTE MA and 0.75 Receptionist UWMF salary/benefit(42.6%) expenses allocated for support staff needs
-Dept average of Facility overhead allocated to clinic FTE for use of clinic space
-Dept average collection rate
-FY13 Assessment Rate 20.41% on clinical revenue

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