# MANITOBA INTRODUCING PHYSICIAN ASSISTANTS INTO PRIMARY CARE
## PHASE 2 EVALUATION REPORT: AUGUST 2013

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**APPENDICES**

*Appendix A: Baseline Evaluation Report*

*Appendix B: Summary of Symposium/Research Planning Day*

*Appendix C: Focus Group/Interview Guide*
KEY POINTS

- This phase of evaluation focused on implementation evaluation in three primary care pilot sites for Physician Assistant introduction in Winnipeg, Manitoba.

- In general, implementation at the initial sites was reported to have gone extremely well, much more smoothly and with fewer challenges to implementation than expected.

- Site level implementation experienced few difficulties, and these difficulties were addressed fairly easily. It was generally agreed that the pilot sites were well prepared for PA introduction, and the time and resources provided for this preparation was appreciated.

- However, a number of challenges were identified related to perceived lack of system preparation for PA primary care introduction. Many of these challenges continue to impact the effectiveness of the PA role.

- Sites reported a number of positive, and sometimes dramatic, impacts of PA introduction, even within the short assessment period. These included a) greater number of patients attached, b) increased access, c) improved patient-related communication, and d) system efficiencies. However, more in depth assessment is required to assess the magnitude of reported impacts.

- This phase of evaluation also suggested a number of unique characteristics of PAs that may result in greater impact on patient attachment and access, compared to other roles. Further research is needed in this area.

- A number of recommendations for broader implementation are suggested: many of these suggestions focus on addressing system (regional and provincial) challenges. As additional sites are slated for PA introduction in the near future, timely action to address these challenges is a priority if optimal impacts are to be obtained.
INTRODUCTION

Purpose of Report

This report builds on the initial baseline report prepared for the Manitoba *Introducing Physician Assistants into Primary Care Steering Committee*, (IPAPCSC) in fall of 2012. That previous report was intended to provide direction for planning and supporting implementation of the Physician Assistants into Primary Care program. Background on both the program and the evaluation plan can be found in this initial report (Appendix A).

The purpose of this Phase 2 Evaluation Report is to summarize findings from the implementation of the three initial pilot sites: 601 Aikins (a direct funded site of the Winnipeg Regional Health Authority), a community fee-for-service family practice, and a hospital-based primary care role within the Concordia Hospital. *The focus of this phase of the evaluation was to identify facilitators and barriers to effective implementation, and develop specific guidelines that could be incorporated into a draft Implementation Handbook to support implementation of Physician Assistants (PAs) in other sites in Manitoba.*

Summary of Pilot Sites

**601 Aikins** is a direct funded primary care site operated by the Winnipeg Regional Health Authority. Located in an inner city neighbourhood, the clinic provides primary care from birth to death; a teen clinic; a methadone clinic; a public health well-baby clinic; a wound care clinic; a diabetes education program; as well as connections with mental health services. The patient population is primarily low-income residents at all ages and stages of life. A large proportion of the patients served are Aboriginal, refugees and immigrants, or those without a permanent residence.

Although the first site selected to be funded for a PA, 601 Aikins was not successful in its recruitment efforts in 2011. This setting has a long experience of inter-professional practice, with a current staff complement of four physicians, one nurse practitioner, one shared care mental health counselor, one primary care nurse, four administrative support staff, one coordinator, and (since January 2013) one Physician Assistant. Primary expectations of the PA were to focus on chronic disease care, and take on new patients. The PA carries an independent panel of patients: roles include providing primary care services to this panel, connecting with mental health services (including provision of home care visits with mental health workers) and an active role in the methadone clinic.
The Concordia Hospital, a community hospital in Northeast Winnipeg, has had experience with PAs in surgical roles, but also identified the potential of PAs to support their family medicine program. The PA was hired in December 2012: she began with a residency-type training program. This was expanded to rotations with graduated independence and gradually increasing workloads. While initially the PA was placed with different family practitioners, on a two-week rotation, the role has evolved to placement with one primary physician, while providing back up coverage for vacation and other high-demand situations.

The initial objectives of the role focused on helping family physicians bridge their in-hospital and community responsibilities, acting as a liaison and communicator between the physician and hospital staff; and – through greater hours of availability – supporting patient family care in hospital. While not a primary goal, there was also interest in exploring the capacity of physicians to take on a greater number of patients. The PA provides patient coverage on behalf of the Family Practitioner for 40 hours per week.

Community – based fee-for-service site. This is a traditional solo physician practice, offering birth to death care. Additional staffing includes an office administrator, Shared Care mental health staff (a counselor and psychiatrist), a laboratory technician, and since November 2012, one PA. The practice has a 50/50 male female patient ratio, with many patients having been with the practice for over 30 years. Like most family practices, mental health and chronic diseases are significant areas of care. The physician provides in hospital service, includes a 40-bed nursing home unit as part of his enrolled practice population, and is part of a call group. The PA performs hospital rounds and home visits, either independently or together with the physician: he also carries a panel of frail elderly that are seen at home. Other areas of PA focus are prevention (diet, lifestyle, obesity, smoking, immunization), chronic disease reports, and management of same-day patients.

Related Activities in this Evaluation Period

The Implementation and Evaluation Sub-committee to the Introducing Physician Assistants into Primary Care Steering Committee was formed in February 2013 to provide direct oversight to implementation and evaluation activities: it met six times between February and the end of August 2013. A specific Data Collection Working Group was also established within the subcommittee to address issues related to data collection. As recommended in the Baseline report, planning for both MPAN evaluation activities and provincial data collection initiatives were coordinated. Coordination of activities, to avoid duplication and promote integration, was viewed as critical in a context where many practices/sites were involved in more than one initiative (e.g., chronic disease tariffs as part of fee-for-service billing, Primary Care Networks evaluation, and - as an accountability measure for Interprofessional teams in fee-for-service programs – data abstract of primary care quality indicators).
The Implementation and Evaluation Sub-Committee refocused evaluation activities, with the intent of a) focusing Phase 2 evaluation activities towards developing concrete guidance for future implementation at additional sites, and b) development of a strategy to investigate, with a view to continual improvement, the current PA Education program. This report focuses on the first activity. An ethics amendment was submitted and approved for the second activity, and plans for a student/graduate survey are underway. In addition, the Steering Committee has been active in pursuing research opportunities to support expanded evaluation research activities.

Since the beginning of the implementation of PAs into primary care, the policy and practice environment within primary care in Manitoba has been rapidly evolving, with both development of existing initiatives, and introduction of new programs. Some of these strategic actions to support primary care renewal include: a) the government election promise of a family physician for every Manitoban who wants one by 2015; b) the EMR adoption program – supporting 1000 practices to implement Electronic Medical Records; c) the Interprofessional Team in Fee-for-Service Program; d) Primary Care Networks; and e) the Enhanced Family Physician Connection Program (matching patients and primary care homes). These activities are all linked strategically – with the intent of enhancing access to quality primary care.

It should also be noted that as the PAs being placed in primary care settings are “new roles”, there was a lack of established processes at many levels, (e.g. recruitment, hiring, resourcing): one of the reasons that implementation evaluation was felt to be so important. In addition, this unique role is being implemented in a complex context where it is necessary to facilitate decision-making and coordinate processes among multiple stakeholders (e.g. Health Workforce at the policy level, the University of Manitoba, regional programs, and individual sites – both fee-for-service and alternate care models). In addition, all pilot sites were located within the Winnipeg Regional Health Authority: an RHA which is undergoing rapid change (e.g. greater accountability to Manitoba Health, integration of community/hospital activities). During the time period of the evaluation there were also reports of increased challenges related to the matrix management structure and increased tensions between sites and programs.

Another important event was the Canadian Institutes of Health Research (CIHR) funded day-long symposium (The Potential of Physician Assistants in Interprofessional Primary Care) and follow up research planning day (held June 10 and 11, 2013). The symposium attracted over 55 provincial and regional decision-makers, physicians, and PAs: 11 decision makers and researchers (along with the resource persons) attended the planning day. Four national and international experts in physician assistant primary care attended as speakers/resource persons. Appendix B contains an outline of this event.

In addition to providing a province-wide opportunity for stakeholders to become current on the evidence related to physician assistants in primary care, the symposium also provided an opportunity to assess current support for, and concerns regarding, PA
implementation in primary care. The research day facilitated initial planning for a collaborative program of research to evaluate the role and impacts of PAs in primary care. As a result, a proposal is currently being developed for submission to the CIHR Partnerships for Health System Improvement November 2013 competition.

Methods

A summary of the overall evaluation plan can be found in the Baseline Evaluation report (Appendix A). This second evaluation phase integrated findings from four methods: a) focus groups conducted with affected staff at each of the three pilot sites; b) individual key informant interviews with Physician Assistants and others; c) analysis of a documents (including a process log maintained throughout the implementation process); and d) participant observation of Steering Committee, Implementation and Evaluation sub-committee meetings and other activities (such as the Symposium The Potential of Physician Assistants in Interprofessional Primary Care). A total of 24 individuals (closely associated with the implementation of one of the three sites – including supervising physicians, program managers, and other members of the staff/interprofessional teams) participated in focus groups and individual semi-structured telephone interviews. Written consent was obtained from all participants. A copy of the interview/focus group guide can be found in Appendix C. Focus groups took place in June 2013, and interviews between late June and early August July 2013. A larger number of individuals provided direct or indirect input through participation in meetings or the symposium/planning day.

KEY FINDINGS

Overall Assessment of Implementation Activities

Overall, participants’ evaluation of implementation at all three sites was overwhelmingly positive. The anxieties and concerns about introduction of PAs that were identified in the Baseline evaluation report appeared to have largely been addressed, and although sites continued to face challenges, participants expressed a high level of confidence in the PA initiative. Many participants felt reassured that attention was being given to the implementation, and felt that prior concerns, and many initial challenges, had been addressed. Some found the ease of implementation “a nice surprise” compared to the concerns initially expressed. For some, anxieties and concerns began to be addressed when they “met the candidates”: others – who had had reservations about hiring a ‘new grad’ – expressed more confidence in doing so in the future.

Somewhat surprisingly, as this was not anticipated based on the results of the baseline interviews, participants reported early significant observed impacts of the PA role. This
appeared to greatly contribute to overall support for the initiative, described by one participant as “an answer to our prayers”.

Participants noted the high level of acceptance of PAs by both patients and staff, and while there were initial difficulties in communicating the role and scope of PA practice, participants felt that this was getting better. However, it was also noted that this acceptance, particularly by staff was in part due to the “orientation and attitude of key players”.

However, there was still, as of summer 2013, significant frustration about some aspects of implementation, and some regional and provincial processes. As was observed in one focus group: “the evaluation was exceptional but implementation (of findings) just sort of dropped”. It was observed that preplanning attention had focused on site level preparation, but that system level preparation appeared to have been neglected, and that this is where most of the difficulties were experienced. It was observed by one that the challenges were largely “red tape issues”, rather than practice issues. The specific challenges are discussed in more detail in the section “Areas of Implementation Challenge”, page 7).

**Specific Findings**

**PA readiness/preparation for Primary Care Roles**

This phase of the evaluation did not directly address the extent to which PAs found that they were prepared for their role in primary care. A few comments indicated that PAs were open to, and interested in, providing primary care: one person observed that “PAs do not need convincing”. Some participants noted that their original anxieties about PA capabilities had been addressed, or expressed surprise that PAs without a previous clinical background could learn so much from a two-year program. It was observed that PA recognition of personal “responsibility to (the physicians) license” was taught well. A consistent theme was the importance of interpersonal/communication skills: and examples were given of selection of PAs with these skills over those with equal or greater clinical experience.

At the same time, there was some indication of gaps in the training provided as it related to the practice of family medicine itself – ‘practical things’ that should have been known and are specific to family medicine. Both PAs and sites identified such lacks. More in depth exploration is needed of this topic.

**Areas where implementation had gone well**

Participants were asked for information on what areas of implementation had gone well. Overall there was enthusiastic support for the early implementation process, which many felt had gone much better than anticipated. Two main areas success were noted.
Key among these appears to be patient acceptance. While it must be noted that there is not yet a strategy for assessing patient input in place, anecdotal reporting ("patients love X"; "only one patient has refused to see Y") from all sites indicates a high level of patient acceptance and satisfaction. Patient complaints were observed at one site when the PA was removed from service with some physicians. There were also observations of patients being more ‘comfortable’ talking to a PA than with the supervising physician.

The PAs selected for the pilot sites. Although there were some concerns about the recruitment and hiring process, the end result – the selection of individuals who were a match to the practice – appears to have been positive. At this point in the initiative, high levels of confidence were expressed in the individual PAs, their style, commitment, ability – and importantly at this stage of development of the initiative – willingness to experiment and try new things.

**Contributors to successful implementation**

Critical factors associated with effective implementation were similar across sites, providing additional support for principles adopted to support pilot site implementation planning. These included:

a) the individual skills and attitudes of the PAs
b) readiness of, and support from, the staff teams
c) prior exposure (in the training program) to a primary care site
d) adequate preparation, time, and orientation for all involved
e) clear communication of roles and processes
f) mechanisms for early identification and resolution of problems
g) “fit” between the PA and the practice setting
h) confidence in working relationship and communication between PA and supervising physician
i) a flexible environment supportive of experimentation
j) willingness to ‘invest’ time in PA orientation, training and supervision for long term benefit, and
k) individual willingness to take initiative and innovate.

In one setting, appropriate use of technology for communication purposes was also highlighted.

**Areas of implementation challenge**

In spite of the overall positive assessment in all three pilot sites, a number of challenges were experienced, some of which continue to create frustration and perceived inefficiencies. It was also noted that, in the community setting, there were a number of changes all occurring at the same time, and that this also created additional work and stress.

Many evaluation participants felt that there was inadequate preparation in terms of senior level (regional and provincial) administrative supports and decision-making. Concern was also expressed about some aspects of decision-making and
communication. These challenges were also perceived as affecting the efficiency and potential contribution of the PA role.

The day I started, still didn’t know if I could write my own prescriptions....

- The interview and hiring process created challenges for some sites. It was felt that the interview questions were not specific enough to be useful for site-level hiring. Another issue was the wait time after selecting a PA – the process of multiple sites interviewing the same candidates caused unexpected delays, which was experienced as stressful on the part of the sites. The process was experienced as ‘odd’ by some, who felt there was a lack of transparency in how the hiring was to be handled. The wait times and complexities of ‘sign offs’ also created frustrating delays.

Unusually long wait... didn’t hear for weeks – weren’t made aware, it just didn’t feel right.

Strong concerns were also identified with the processes used for making information on the positions available to new graduates, and the process used for interview and selection. Participants’ comments reflected perceptions of non-transparency, and a desire to have greater engagement of stakeholders in design of interview processes. Some were concerned about fairness to new graduates. While perhaps to be expected in a rapidly evolving context (where there were no pre-existing processes), this feedback points to the urgent need to engage stakeholders in developing processes that will transparent and effective.

- Confusion about provincial and regional processes was commonly reported (What cost centre is this charged to?, Who is the org chief? Should PAs shadow bill?). Sites described a general sense of confusion, and much time needed to get answers to basic questions.
  - HR processes to finalize hiring, and ensure payment were experienced as a major difficulty, though it was sometimes unclear how much of this was due to provincial, and how much to regional processes.
  - At the time of evaluation activities, the issue of whether PAs were to receive billing numbers continued to create confusion. Failure to have such numbers was viewed as contributing to inefficiencies ("double checking" and “manually transferring”) and additional workload by administrative staff, physicians and the PAs.
  - Responsibility for administration. Lack of clarity on what costs were to be covered by the program and which were to borne by the site, as well as for administrative processes was observed (e.g. who pays PAs? Who is getting computer set up?) It was noted that “bare basics are never addressed”. Consequently sites reported delays in receiving equipment.
  - Lack of clarity on what data is to be recorded.

- Another issue contributing to participant frustration was perceived as lack of region-wide (or province-wide) processes to communicate with stakeholders about the
initiative, and to provide information on the authority of the PA to order tests (lab, imaging), or write prescriptions. This often resulted in the need for the physician signature, denial of request, and inefficiencies (time wasted by administrative staff, MD, and PA). Also, in some case this forced the PA to do advocacy and negotiation on their own behalf, which was not perceived as an ideal situation.

- **Site level challenges:** There were also challenges noted at the site level, although the majority of these appear to have been addressed.
  - Key among these was **workload**, although this issue was not experienced equally at all sites. Administrative staff in clinic sites appeared to most affected: in large part due to challenges in document management. Some of the additional workload was felt to be avoidable, resulting from lack of clear processes or failure to address identified barriers to efficient operation.
  - **Lack of specific information** on the PA role, hours, and availability caused some initial difficulty. Front line staff, in particular found they were lacking information on the PA role and the related practical logistics (*what can PA do? Can I book her for X? How do I contact him/her? When are they available?*). Although these issues appear to have been largely addressed, they did contribute to confusion (and in some cases PA stress).
  - Perhaps related to inadequate preparation of other team members, **inappropriate requests of PAs** were also reported.
  - **EMR** issues also were reported as presenting challenges.

The combination of lack of clarity on system level processes (or failure to respond to issues of concern to sites), and “battles” to have the PA role accepted (e.g. by pharmacy and lab), was described as not only frustrating (having to chase for a physician signature for something a PA is authorized to do), but also contributing to inefficiencies, and even potentially patient safety (as results may not be seen and responded to as quickly as they should be). Sites reported having to develop “workarounds” in a number of areas, and observed that the reported barriers are preventing professionals from working to the full scope of their practice.

While some of these challenges were experienced only in the first weeks or months after the PA joined the pilot sites, others are reported as ongoing. Lack of identification numbers for PAs continues to create problems; there is still lack of clarity in data collection requirements; and issues with lab, pharmacy and imaging continue to create challenges for some sites. Issues of equipment purchase have not all been addressed. As the international literature indicates that one of the factors associated with failing to achieve expected economic benefits of PAs has been identified as barriers to full practice effectiveness of PAs,¹ addressing such challenges should be a priority.

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**Reported Impacts**

Stakeholders participating in Phase 1 (Baseline) evaluation activities highlighted the importance of realistic expectations of system benefits. They advised that due to a combination of factors (PAs in primary care a new role for the province; lack of site experience with PAs; recruitment focus on new graduates; and the adaptation needed in any organizational change) it would likely take several months before benefits were achieved. In fact, some predicted that there could be an initial decrease in efficiencies as all involved went through a required ‘learning curve’. This does not seem to be the case: somewhat surprisingly, participants are reporting early and sometimes significant impacts. Some of the initial reported impacts (not all reported at all sites) include:

- Ability to take on new patients, including high needs patients. In hospital taking on more unassigned patients.
  - *Have taken on 120 new patients in 5 months*
- Decreased wait times for existing patients
  - *Has decreased wait time by as much as 2/3*
- Greater provision of preventive care
- Patient satisfaction – wait time for appointments, availability (particularly hospital-based), information-sharing with physician, time for explanations. Several case examples were shared regarding positive patient responses.
- Improved communication within the health care team, and between the health care team and physician. Development of personal relationships between physicians and other team members. More efficient communication between hospital staff and physician (through one person).
- Improved communication between health care team and family. More proactive communication with patients.
- Improved patient flow – e.g. clinic processes or expedited discharge (affecting length of stay)
- Decreased interruptions in physicians work day
  - *Phone calls during the day cut by 90%.*
- Improved documentation
- Improved job satisfaction of other team members
- Change in confidence/willingness to take on new graduates.

It is however important to recognize that these impacts are reported observations that have not been confirmed by objective measurement. Nor can it be assumed that all sites could achieve the reported impacts in this time frame: the three pilot sites were specifically chosen, and there are many “personal factors” that could explain these results. These reports do, however, provide guidance as to areas of focus for data collection.

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Advice for future implementation

A number of suggestions were made for implementation of PAs in primary care sites based on the initial experience of the pilot sites: these are consistent with many of the recommendations made in the Baseline Evaluation Report (Appendix A), and other guidelines for implementing interprofessional roles.

- **Ensure adequate time and resources for preparation**
  Much of the success of the implementation at the pilot sites was attributed to ensuring appropriate preparation. Details of needed preparation are outlined in more detail in the Baseline Report: in addition to the points raised at that time, participants added the importance of assessing the needs of the practice, and clarifying practice style.

- **Recognize the importance of selecting the appropriate PA for the site**
  The skills and attitude of the PAs, the characteristics of the site, and the match between the PA, the site, the team and (particularly) the supervising physician were seen as essential to effectiveness of the intervention. It was felt to be necessary to address concerns about current interview and selection processes; to pay particular attention to the process of selection of family practice sites; and ensure appropriate and transparent communication about hiring processes.

  All sites emphasized the importance of the match between supervising physician and PA; in fact the match with the appropriate physician was more important than the position for some PAs. The importance of including the PA in designing the role was also emphasized. Given the importance of fit with the practice, and ‘matching’ with the supervising physician, more than a one hour interview was felt to be necessary.

  *The longer I am here the more I realize the importance of the relationship between PA and physician.*

  Some participants felt it was important to place PAs with physicians who demonstrate high quality care. It was also suggested that more flexibility was needed in negotiating contracts.

- **Address administrative logistics**
  As earlier identified, the majority of participants found greater implementation challenges at the system than at the site level. While some adjustment is needed in any change management process, results of this evaluation highlight the importance of proactively addressing system issues that appear to be leading to inefficiencies and confusion. Changes were identified as needed at the regional (WRHA) and provincial level. It was noted that there had been learning from implementation of other new roles in the province (e.g. NPs), but that some of this learning had not been applied to roll out of the PA roles (e.g. provincial communication with pharmacy or lab). It is advised that these areas of concern are addressed before new sites begin implementation.
- **Communicate specifics of PA role**
  
  There was strong consensus on the importance of clear and specific communication about the details of the PA roles: not only general information, but specifics related to the particular PA at a particular site (e.g. contact information, hours) were also felt to be needed. It was recommended that this communication be directed at staff at all levels, patients and families, and related health services. New sites were advised that they would “need to do more than they thought they had to” for communication to be effective, and that plans for publicizing the arrival of the PA should begin before he/she arrives.

  The importance of providing detailed and specific information for administrative staff – often the ‘sharp end’ of patient, community, and consultant relationships – was stressed.

- **Provide peer support opportunities**
  
  While the facilitation supports provided to date were appreciated, it was believed that physician leadership was required to lead medical change and facilitate physician buy in. Providing physicians who could model, mentor and coach was recommended. There was also a suggestion of providing opportunities for PA support and shared learning.

- **Promote an attitude of experimentation and adaptability**
  
  A key characteristic associated with success was identified as flexibility – on the part of the PA, the supervising physician, and the staff team. It was recognized that initial plans may not work out, and that all on the team would have a learning curve. Several warned about the dangers of rigidity. Participants stressed the importance of having realistic expectations, and advised that sites should expect “growing pains”.

- **Ensure appropriate internal processes for monitoring and evaluation.**
  
  The importance of providing mechanisms to identify problems in the early stages and ensuring a quick response was also highlighted. This monitoring should focus both on the PA/physician relationship, and the overall practice.

- **Ensure appropriate time for orientation, mentoring, teaching.**
  
  Given some concerns about the adequacy of educational preparation related to primary care, and the variation in practice styles, some kind of ‘mini-residency’ or up-front training before the PA was given full responsibilities was also suggested. In addition, it was felt to be critical that the physician had time to set aside for orientation and teaching. There was recognition that different forms of supervision may be effective depending on the setting, but also that the physician would have to be available to the PA when s/he was working. The importance of knowing the background, knowledge and skill of a PA before they were assigned unsupervised tasks was stressed.
Unique characteristics of PAs

One issue explored directly in the focus groups, and indirectly through analysis of meeting discussions and interviews was the question of the specific and unique aspects of the PA role. In general, the first response of participants when asked about the unique contribution of PAs was to state that there were little differences between and Nurse Practitioner (NP) and PA role: and that both were important

However, a more in depth analysis identified some important differences that indicate that more systematic research is called for as the potential of PA roles is more fully explored. Some of the themes that appear to make PAs potentially unique are summarized below:

- **Physician extender vs. Independent practitioner**: This category appeared to be the most significant. While NPs were seen as colleagues, and mutual consultation acknowledged, the fact that they were independent, and physicians could not delegate to them was seen to limit their ability to address pressing needs. Closely related to this was the understanding that as PAs were prepared in the ‘culture of medicine’ there was less to negotiate and work through. It was also noted that because PAs were an extension of the physician, they could “make things happen”. While not all would agree that is appropriate to have this authority nested only in physicians, the current reality of our health system functioning requires that we acknowledge this dynamic.

- **Flexibility**. What was referred to as the ‘pluri-potent’ or ‘stem cell’ nature of PAs also emerged as another strength: whatever the physician could do/teach/supervise could be done within the scope of practice of a PA.

- **Liaison role**. PAs were described as providing a level of interprofessional contact/negotiation, that physicians did not have time, or perhaps interest in doing. This role appeared most apparent in the hospital setting.

- **Ability to facilitate physician communication with patients, families, staff**. PAs were acknowledged, by nature of their contract with the physician, to have facilitated access to physicians and be able to ensure faster response to patient needs compared to other interprofessional roles. It was observed that no other staff member had this authority to act on behalf of the physician.

- **Availability**. An advantage stressed at the hospital pilot site was the increased availability of the PA (as the physician representative). “The ultimate physician because s/he is available”. These extended hours meant that s/he could be available to meet with families; monitor progress and discharge planning; and facilitate physician communication when off-site.

These early and preliminary findings, while suggesting some areas for more rigorous research investigation, should not be used to guide planning.
CONCLUSION AND RECOMMENDATIONS

Conclusion

The appreciation expressed for both the site level implementation supports and the attention to implementation evaluation, reinforces the need to provide such supports to system change initiatives.

In general, implementation at the pilot sites was described as having gone extremely well, enthusiasm remains high and concrete and sometimes dramatic impacts of PA introduction were reported. As baseline evaluation activities suggested that early impacts should not be expected, this finding is very encouraging.

It is important to note, however, that these impacts differed by site. Impacts reported in the hospital-based pilot were distinct in some ways from those in community-based sites. For example, the ‘on-site’ availability of the PAs in the hospital setting appears to explain many of the reported impacts. The site-specific nature of impacts should be kept in mind in strategies to measure impacts: research to explore the range of impacts related to sites should be prioritized.

A number of suggestions emerged for planning a larger scale roll out of the initiative. In addition to continuing the strategies that had been effective in introduction of PAs at the site level, participants stressed the importance of addressing several system level issues that presented – and in some cases continue to present – challenges to effective implementation. As it is unclear what resources will be available to support and monitor future implementation, timely intervention to remediate identified issues will be required if the potential of the “Introducing Physician Assistants into Primary Care” initiative is to be optimized. While it is not surprising that the implementation of the “new role” of a PA in primary care would identify the need for new and redesigned processes, addressing these challenges is necessary both to maintain the positive response to the initiative, and to remove any barriers to effectiveness.

It is also important to maintain a focus on both a) implementation support, and b) implementation and impact evaluation. It is not unusual to find that the promising results of well supervised pilots, which often attract individuals with a great deal of commitment and enthusiasm, may not be realized as these initiatives are more generally adopted. Cautions were also identified by evaluation participants: there was some concern that, in spite of their success to date, PAs could be simply “the flavor of the month”, and ongoing interest in ensuring that there were strategies in place to prevent inappropriate deployment of PAs (e.g. funded positions that could increase physician revenue – “double-dipping” rather than improve patient access and care).
**Recommendations:**

Based on these findings it is recommended that:

1. Immediate attention be directed to addressing identified system challenges to effective implementation, and to ensure evaluation findings are acted upon.
   a. Establishment by the Steering Committee of a clear and transparent process for delegating timely action on system level concerns identified by participating sites; development of accountability processes for follow up action.
   b. Clear communication of funding models, including specifics of what costs are covered by the Manitoba Health program, and which must borne by the site.
   c. Review, in collaboration with stakeholders, of senior level provincial and regional processes for prioritizing criteria for selection of PA sites and roles.
   d. Clarification and simplification of the processes for recruitment, selection, hiring and compensation. Relevant Manitoba Health and regional human resources staff, along with the College, should be involved in addressing identified problems
   e. Creative and timely collaboration among relevant departments to address the other system level factors creating stress and inefficiencies at the sites.
   f. Development and implementation by Manitoba Health, in collaboration with the regions, of a province wide communication plan, directed to key stakeholder groups about the roles, responsibilities and authorized powers of PAs. Pharmacy and laboratory/imaging services should be prioritized.

2. The previously approved plan to assess the experience and training needs related to primary care of graduates of the University of Manitoba Physician Assistant Education program are implemented as soon as possible.

3. Findings from this phase of the evaluation, along with revised processes resulting from Recommendation 2, are integrated into an Implementation Handbook to guide the next phase of PA implementation. This resource should be evaluated and updated on a regular schedule.

4. Strategies for promoting peer-to-peer orientation and support for practices working with, or considering introduction of, PAs in primary care be developed.

5. There be continued collaboration in development of data collection strategies that will support evaluation and research initiatives. This should include a plan for assessing patient experience with PAs in primary care.

6. Strategies for review and evaluation of the specific roles and functions of PAs in each site are developed and implemented.

This phase of evaluation has focused on the implementation of roles at three sites: it has not addressed the next stage of evaluation: a focus on whether and how each of the initiatives could be improved (improvement-oriented evaluation). This strategy must include mechanisms for including confidential input from PAs themselves, and address the longer term issues of PA job satisfaction, retention, and professional development.
APPENDICES

APPENDIX A: Baseline Evaluation Report: Introduction of Physician Assistants into Primary Care: Baseline Assessment and Evaluation Recommendations

APPENDIX B: Summary of Symposium/Research Planning Day

APPENDIX C: Focus Group/Interview Guide
APPENDIX A

Introduction of Physician Assistants into Primary Care: Baseline Assessment and Evaluation Recommendations

Baseline report prepared for the
Introducing Physician Assistants into Primary Care Steering Committee

By Sarah Bowen, PhD
November, 2012
# Introduction of Physician Assistants into Primary Care: Baseline Assessment and Evaluation Recommendations

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Introduction of Physician Assistants into Primary Care: Baseline Assessment and Evaluation Recommendations

KEY POINTS

- This phase of evaluation focused on baseline data collected from key stakeholders in the Introduction of Physician Assistants into Primary Care initiative. The purpose of this phase of evaluation is to inform ongoing implementation planning.

- There is a high level of enthusiasm, both for the initiative and for thoughtful evaluation of both implementation of the initiative and the eventual outcome evaluation.

- A number of potential challenges and risks to the project were identified related to a) planning, management, and resourcing; b) the Physician Assistant role; c) patient/community acceptance; d) provider acceptance; and e) risks to organizations and professional associations. These challenges were felt to be manageable with appropriate leadership and resourcing.

- Participants highlighted the importance of ensuring appropriate time, resources, and effective leadership to support implementation. They highlighted the importance of viewing the initiative within the larger context of primary health system development. A number of suggestions were made that should be used to inform further development.

- Cautions were raised regarding premature attempts to measure outcome, especially given the context of implementing a new role with recent graduates. Participants stressed the need for broad consultation, and adequate time to ensure that the PA initiative was appropriately implemented.

- A broader issue affecting the initiative was identified requiring additional exploration: the need to understand factors affecting PA interest in, and preparation for, roles in primary care.

- Evolving events require that the original evaluation plan be reviewed and updated in a timely fashion. Several recommendations are made to guide future development.
INTRODUCTION

Purpose of Report
This report summarizes the results of analysis of a) baseline interviews conducted with members of the *Introducing Physician Assistants into Primary Care Steering Committee*, (IPAPCSC). The purpose of the report is to provide direction for further planning, and ongoing implementation of the Physician Assistants into Primary Care program by the Steering Committee. Although this report will inform the final report of the Evaluation of Physician Assistants into primary care, it is meant as an internal planning document to support program development: it is not summative in nature.

It should also be noted that the initiative has evolved significantly since it was launched: issues emerging from these changes are addressed in the summary section of the report.

How report is organized
Following a short summary of the project and the proposed evaluation (Background), the main section of the report summarizes findings from stakeholder interviews. The final section outlines the evaluator’s recommendations for next steps, and adaptation of the original evaluation plan.

Background
Two critical challenges facing the Canadian health system are a) current, and projected increasing, health human resources shortages, and b) need for effective primary health care responses to provide timely access to quality and appropriate patient-centred care. An effective system of primary care is the essential foundation of health care sustainability. In order to ensure continuous and comprehensive care in the community, development of primary care homes, primary care networks, and integration of inter-professional teams developed to respond to the needs of local communities is needed. Manitoba has made a commitment that by 2015 all Manitobans who wish to have a family physician will have access to one. This commitment creates an environment of urgency, which requires both innovation and timely evaluation of alternatives.

A potential strategy to address both of these challenges that has not yet been explored in Canada is the introduction of Physician Assistants (PAs) into inter-professional primary care teams. Manitoba Health has taken the step of approving funding for implementation of PA roles into primary care settings across Manitoba. While Manitoba has emerged as a leader in training, education and employment of PAs, roles to date
have been limited to acute care settings. It is unclear to what extent the generally positive experience of PAs in primary care in the United States or in the Canadian Armed Forces would be applicable to system planning by Canadian provinces and health authorities. While the international research indicates that appropriately resourced PAs pose no risks to patient care, and can actually contribute to quality care, the system impacts (e.g. whether PAs are a cost-effective response, or conversely, may even lead to overall cost increases) has not been determined.

The government of Manitoba has initiated funding of PAs in Primary Care as part of its Primary Health Care Renewal Strategy, with the priority of enhancing access to quality primary care. The Manitoba Patient Access Network (MPAN) has funded the IPAPCSC to support implementation of two such roles; one with a private practice family physician; and the other within a primary care team of providers at a primary care clinic operated by the Winnipeg RHA at 601 Aikins, Winnipeg. This funding is also supporting the evaluation described here.

**Evaluation of Physician Assistants into Primary Care**

In recognition of the importance of evaluating the innovation of introducing PAs into primary care, the IPAPCSC committed to comprehensive evaluation of the initiative. A half-day meeting of the committee was held with Dr. Sarah Bowen from the University of Alberta, who was engaged as evaluation consultant for this project. As a result of planning undertaken at that meeting, the consultant drafted an overall evaluation plan, which was circulated for input and approval to members of the committee. This plan emphasized, as the first phase, evaluation of the implementation of the Physician Assistant(s) roles. This implementation evaluation plan was comprised of several elements: a) baseline key informant interviews with members of the Steering Committee, b) baseline interviews/focus groups with members of the inter-professional care team, c) a review of the relevant literature on PAs in primary care, d) review of existing data sources and selection of indicators that would be used for subsequent outcome evaluation, and e) development of a strategy for patient input and evaluation. (See Draft Evaluation Plan, Appendix A).

The evaluation plan was submitted for review to the Health Research Ethics Board, University of Manitoba and approval received on July 9, 2012. Dr. Ingrid Botting, on behalf of the initiative, acted as Principal Investigator for this project: she sent potential interviewees a letter of invitation (Appendix B) along with an information and consent form (Appendix C). Those interested in participating were asked to return the signed consent to Dr. Botting’s office. Contact information for those who had agreed to participate was forwarded to the evaluation consultant who then contacted participants directly to set up telephone interviews. All 16 participants invited to participate returned the consent form and completed an interview. A copy of the interview guide can be found in Appendix D.
Because of the rapidly changing decision-making landscape, and the need for timely support for ongoing decision-making this report summarizes only the data gathered from these baseline interviews.

Current Context
At the time the evaluation plan was drafted in May, one site was identified as the focus of evaluation activities; subsequently two additional Winnipeg sites were approved for introduction of physician assistants (this was in addition to sites approved in other RHAs). This situation was the context at the time when most of the interviews took place. However, by the time the interviews were completed, only one site: a fee-for-service site, not the originally approved site, had been successful in recruiting a PA. In December it was announced that the original site had subsequently been successful in recruitment.

Some participants who were interviewed later in the process were aware of the challenges of hiring at the initial approved site and asked the question of whether, given the small number of graduates, recruitment would be successful for all positions. This meant that participants in earlier interviews had less information than those interviewed later: they may have responded differently if interviewed at a later point in time.

The WRHA Research and Evaluation Unit was requested to develop a rapid evidence scan on Physician Assistants in Primary Care focusing on where PAs were most effective; the organizational changes needed to support the introduction of PAs; recommendations for a PAs job description and role in primary care; and needed training; this was completed and circulated in October 2012.

Preliminary results from the evaluation were shared with the Introducing Physician Assistants into Primary Care Steering Committee, at their October 12, 2012 meeting.

KEY FINDINGS

Key findings from the interviews are organized as follows: a) response to the baseline survey; b) suggested sources of evidence for planning; c) perspectives on roles for PAs in primary care; d) perspectives on needed characteristics and qualifications of PAs working in primary care; e) hoped for impact of introduction of PAs into P; f) potential challenges and risks in PA introduction; g) advice for implementation; and h) perspectives on evaluation.

Response to Baseline Survey
Response to the request to participate in the baseline survey was extremely positive, and many participants expressed both interest and appreciation for opportunity to participate. Many also expressed a high level of excitement about, and openness to,
implementation of PA roles in primary care. As the next sections indicate, there was also thoughtful consideration of the potential challenges and risks of such introduction. However, while many cautions and concerns were raised, these were raised in the spirit of issues to be aware of going forward.

**Suggested Sources of Evidence for Planning**

Many different sources to guide planning were identified. Most frequently mentioned were:

- *The inter-professional planning literature*. Many participants highlighted the need to place PA implementation within the larger literature of inter-professional practice.
- *The literature on Physician Assistants in primary care roles from other jurisdictions* (e.g. the U.S.)
- *Local experience* in implementing both a) PA roles (e.g. in acute care) and b) other-providers (e.g. midwives, NPs).
- *Information on local populations & needs, patterns of use, gaps in service*. A number of participants stressed the need to fully understand the local context and current needs to direct planning.

Other information sources suggested including the experience of the Canadian Forces, system change objectives, EMR data the MCHP Profile of Métis health, the PA toolkit (CMA) and information emerging from ongoing evaluation of individual PAs and the implementation process.

**Role of the Physician Assistant in Primary Care**

One group of interview questions focused on participant perspectives on the role of the PA in Primary Care.

There was good consensus among participants on specific issues that might impact PA roles based on the types of sites in which they were placed (i.e. direct funded, community agency, or fee-for-service). Differences were identified related to funding models, management structure, PA supervision, and previous experience with inter-professional practice. In general, participants anticipated greater openness to the introduction of PAs in direct-funded sites where there was already a commitment to Interprofessional practice, and where fewer issues related to funding incentives were expected. There was the greatest uncertainty about acceptance and fit of such roles in private fee for service offices.

There was also good consensus on the unique contributions a physician assistant could make to an inter-professional team, many emphasized the contributions of PA as “physician extender”, and the potential this role had to link more patients, in a timely way, to a primary care home

- *Their ability to do almost anything, because tied to a physician don’t have the same kind of boundaries as (some other practitioners); Broad training in all areas of medicine*
• **Their relationship with physician, it’s legislated and contractual, docs like it.**

Most participants highlighted the potential of PAs in roles that would respond to current system pressures (e.g. chronic disease management; linking/integration between clinic, home and hospital; providing care for complex or high needs patients; mental health issues; providing advanced access). Some also suggested that PAs could help with specific procedures that are time consuming (e.g. ear syringing), hospital/home visiting, and after hours access.

At the same time, a number expressed concern that planning might be reactive (“knee jerk“) based on current stresses felt by the system and suggested that thoughtfulness was needed in planning PA placement. Some expressed concern about the common assumption that there should be a focus on chronic disease, and the need to be open to the potential contributions of other professional roles in this regard were highlighted. It was noted that plans appeared to be provider defined vs. patient defined. The need for more planning was identified:

- **We need to work this out... Think we agree but we don’t**
- **There are.... very different agendas....**

At the time many of the interviews were conducted, some “tension & anxiety around position development” was identified. This appeared in large part to reflect a tension between overall role definition and the need to specify permitted tasks.

There was more diversity in response to the question of what participants hoped would be achieved by introduction of PA roles in primary care. Some said they were unsure of what the actual role should be. Several emphasized the need to respond to the needs of both the specific primary care practice, and the community served.

As expected, most hoped that PAs would be a cost effective and efficient way of getting more people linked to family practice and primary care teams (i.e. provide more residents with a primary care home) while improving continuity of care. There was hope that the introduction would help strengthen and improve primary care in general. The potential of increasing health equity was also referenced.

Others stressed the learning opportunity that was presented by introduction of PAs to help achieve broader system goals related to inter-professional care. Some participants hoped that this introduction might help clarify roles for all team members, and provide an opportunity not only to gain greater understanding of the PA role in primary care, but also to explore different ways of delivering services in primary care. It was hoped that PA introduction would demonstrate the value of another professional role within an inter-professional team.

A few participants also commented on the potential contribution that the introduction of PAs could make to the profession of family medicine as well as to growing the PA
profession. It was suggested, for example, that by making continuity of care more possible, PA introduction could make delivery of “real” family practice more attractive. It was also hoped that this introduction would increase the demand for PAs, and therefore support for the PA education program.

**P.A. Characteristics and Qualifications**

Another set of questions explored the characteristics and qualifications felt to be important in a physician assistant working in Primary care. There was strong consensus on importance of ‘interpersonal’ characteristics: these were the qualifications most frequently mentioned by participants. It was felt important that a P.A. be

- Eager to be part of a team, a team player, **collaborative**
- A good communicator, ability to work through tension and different perspectives
- Sensitive to the community, with an ability to develop rapport with patients, families (patient centred)
- Open minded, willingness to learn, with a positive attitude, and ability to problem solve
- Mature and adaptable, but at the same time, confident about own scope of practice
- Enthusiastic, with a “pioneering” attitude, comfortable with an innovation role

There was also strong consensus on the need of Physician Assistants to have a commitment (“a passion”) to the values of Primary Care, and an ability to “fit” with the primary care environment; to have a community as well as an individual care focus.

- **Understanding the context of PC within community engagement and primary health care, understanding continuity vs. discrete events, understanding of fundamental philosophic difference**

While it was expected that a PA bring strong clinical skills, previous experience was less important to most. However, some felt that it was important that a PA be comfortable with mental health and social issues. Proficiency with the world of EMR and a solid understanding of confidentiality were also mentioned.

**Challenges and Risks Facing the Initiative**

While supportive and enthusiastic about the potential of PAs in primary care, the majority of participants also identified a number of potential challenges and risks to their introduction. There was also a high level of interest in adopting strategies to minimize or mitigate identified risks, and of addressing known challenges.

Challenges and risks identified can be grouped into the following categories:

- Issues related to expectations
- Issues related to planning, management, resourcing, including financial issues
- Issues related to the PA role
- Issues related to patient/community acceptance
- Issues related to provider acceptance
• Risks to organizations and professional associations

**Issues related to expectations**
There were common concerns about managing expectations of all stakeholders, and the risks inherent to attempting to do so. Some participants felt that the while the political commitment to providing Manitoban’s with a primary care home by 2015 had been helpful, it also created an environment where there was an expectation of quick results: … results that realistically could not be expected, but would require – initially – additional resources, and a ‘ramp up’ time to show benefit. There was some concern that there would be attention to “immediate vs. long term impacts”, and “pressure to show you have saved money.”

**Issues related to planning, management and resourcing**
By far the greatest number of risks and challenges identified, and the strongest concerns expressed, were those related to adequate preparation and support for PA introduction. Many participants expressed strong appreciation for the attention and supports that had been given to preparing for introduction at 601 Aikins: some, however, were concerned that resources may be stretched too thinly to support the quality implementation in what were then anticipated to be three different sites.

Participants expressed a profound appreciation for the complexity of implementation of new initiatives, and some were concerned that this complexity may not be fully understood by all in leadership positions. A number discussed the implementation of PAs in terms of the larger issue of change management; the challenges of developing and supporting development of inter-professional teams, as well as addressing unwillingness to change that was expected in some quarters. Time, leadership and facilitation resources were felt to be needed to address the anticipated challenges of role confusion/misunderstanding and lack clarity, and to “work out” the roles of interprofessional team members.

Within this large category of concerns a number of themes were identified:

**Need for adequate resourcing**
Because of the support (including time to prepare) given to support introduction at the 601 Aikins site, there was high level of confidence that this site was well positioned to address anticipated challenges. There was, however, concern about whether other sites would have the opportunity to undertake what was felt to be necessary and time-consuming preparation.

There was also a common anxiety about whether there would be ongoing support and understanding of the time, resources, and skill needed to get this initiative “up and running”. There were commonly expression of concern regarding the current context of health care, particularly primary care, which was described as highly stressed, and not well positioned to take on what were understood to be complex and time-consuming
initiatives. There were concerns about being able to retain current staff, and to fill the PA positions. It is important to emphasize that participants were supporting change and innovation, but that they wanted to ensure that the fragility of many components of the primary care system were understood ("people in the community are overwhelmed right now").

There was some concern expressed about whether the needed leadership, at both the regional and provincial level would continue to be provided. It was noted that ‘often there is a kick off and then its neglected, the presence is not there’ resulting in a ‘leadership vacuum’. Some wondered whether there was a shared vision for the initiative (Not sure we are all on the same page). There was a concern that the focus may be on a “stop gap” measure to respond to provider or site needs; creating a new role rather than looking at the need for overall system change (e.g. physician retention, or moving resources upstream beyond episodic care). Concern that the driver might be cost saving rather than improved care was also raised.

*Uncertainty around financial implications and funding models*
At the time the interviews were conducted there was also significant uncertainty around the funding models, although many saw this as a question to be answered through evaluation activities. There were concerns about identifying funding models that were cost effective, as well as developing strategies to ensure that the models were both fair to physicians, but at the same time could not be ‘gamed’ by those who might be looking to take advantage of a new funding source. Some were concerned about whether there would be adequate coverage of all costs associated with PA introduction: fears that PAs could be ‘drain on budgets’ were also acknowledged.

There were also a number of questions about reporting and supervisory arrangements for the PAs.

*Overall gaps in knowledge*
Concerns around knowledge gaps included lack of information on communities and their needs; lack of staff education on potential of PAs and interprofessional care; and inadequate information on the perspectives of physicians in general.

*Issues related to the PA role*
A number of different issues were raised related to challenges around the Physician Assistant role.

*Risks to patients*
Little concern was identified about potential risks to patients of Physician Assistants related to the role in general: in fact a number explicitly referred the larger literature and to the Manitoba experience in acute care as indicating that patient safety was not a concern ("being tied to a physician, there are enough checks and balances...I don’t worry about quality). Some, in fact, viewed introduction of PAs as potentially increasing
patient quality of care. However, some did see risks based on the process of implementation and lack of clarity in key areas: e.g. lack of clarity about goals and supervision.

- I don’t see risks to patients, we have evidence it doesn’t, more that we introduce them without adequate preparation, so it ‘sours the system’ or generates conflict.

**Preparation of PAs for primary care role**

Many participants, did however, question whether the preparation of PAs through their education program was adequate in the areas of importance to primary care, and saw potential risks related to inadequate supports and site preparation. Many were not aware of the content of the PA Education Program. Concerns were expressed around potential gaps in such areas as knowledge of, and general orientation to, primary/community care, the social determinants of health, patient engagement, etc. (“they are not being prepared in that way”). Others provided specific examples of potential gaps (e.g. harm reduction) or ‘language’ appropriate in a primary care setting (e.g. the language of patient ‘compliance’).

- I’m quite worried about what they come with
- ...feel there is a big chunk missing

However, others, felt that there were ‘unfair assumptions’ that physician assistants were not prepared for primary care roles.

Some of these concerns reflected common concern about the academic/practice divide:

- There is definitely a tension between the university and the system... they are in a time warp and don’t know what they need in terms of training... they need to be more aware of the way of the world.

There was also concern about unrealistic expectations of new graduates, reflecting a high level of awareness that the PAs would not be “ready on day one”, and recognition of the need for continual mentoring and evaluation. Some specifically noted as a risk the assumption that “fresh graduates can function at the same level as those that are experienced”. Many also commented on the fact that the PAs to be recruited were most likely to be new graduates, so the ‘greenness’ of those selected to the new roles was seen a potentially a major challenge. There were some concerns about the additional time that would be required for any new graduate to become proficient, and the potential impacts of this need for “ramp up time” on evaluation metrics.

In this context one participant observed that there could be patient safety risks if the PAs were not properly trained, or if physicians did not understand the level of supervision and evaluation needed.
Newness of PA role in primary care
Another, independent, risk identified was not related to the specifics of the PA role, but to introduction of any new, untested initiative. Some of these risks were related to understanding and acceptance of an alternative role and the need to ‘get the word out that one practitioner alone’ cannot meet needs.

There were also concerns about the potential burden placed on the newly hired PAs. Participants identified a need for adequate support and a welcoming environment for these ‘pioneers’, who they hoped would not be thrown ‘in the deep end’. There was also concern whether PAs would be supported and satisfied with their role, and the system would be able to retain them. Others were worried about whether these primary care roles would even attract candidates.

The fact that there were only 12 graduates from this year’s class was also highlighted a potential risk, both in terms of sustainability, and community response to decisions related to distribution of scarce resources (“Why some are getting a PA and others not”).

Issues related to Community/Patient Acceptance
Many participants expressed anxiety about whether the PA role would be accepted by patients, noting that the PA role in primary care was new and not understood by either patients or providers. It should be noted, however, that this concern was the motivation for an emphasis on patient preparation, and related to concerns that adequate planning and resourcing for patient communication were provided. Several commented on the need to address the barrier of ‘getting the word out to patients” and made specific and practical suggestions as to how patients should be informed.

There were also some concerns about community acceptance, and the need to ensure that introduction of PAs into disadvantaged communities did not give the message that “we’re not good enough for a physician”.

Issues related to Provider Acceptance
While ensuring patient understanding and acceptance of the role was highlighted as a challenge, more risk was seen in provider acceptance: a number of participants identified not only lack of experience and understanding of the role among providers, but even the potential of active resistance (on the part of some physicians) and turf protection (by other health providers).

Physician acceptance
There was concern that many physicians lacked understanding and experience of the PA role, and identified need for greater physician engagement around this issue. Uncertainties about liability issues of sponsoring physicians were also expressed. The potential of active resistance – i.e. PAs being viewed as a threat – was also identified:

• “people will find out that others can do 89% of what a physician does”
There was also some lack of confidence in the response of physicians to the availability of PAs. There were concerns that fee-for-service physicians, in particular, may view the provision of PAs in primary care as a potential source of increased revenue, rather than a strategy for improving patient care. Some expressed concern that it could lead to physicians ‘offloading’ unwelcome roles (e.g. after hours coverage); or that the reimbursement system might encourage them to ‘hang on to’ simple procedures that could be more appropriately performed by PAs. The common interest by participants in having PAs take on complex chronic disease patients suggests another area for concern.

Acceptance by other health care providers

The potential of “turf war politics” was identified as a major challenge by many participants: this challenge was understood to be embedded with the larger challenges of creating inter-professional teams. The “physician/nurse” dynamic, particularly the potential for tension between NPs and PAs was highlighted as of particular concern, and some acknowledged that there was not full acceptance within nursing of the PA role within primary care:

- its better than 5 years ago, but tension is still there
- (I’m) terrified about an us vs. them environment
- Leadership team is well beyond that but at the front line…. I am not sure. There are still NPs who are quite concerned.

Some feared that PAs were particularly vulnerable, not only because the PA role in primary care was a new profession, but because of fear that PAs “will be beaten up because they are outnumbered”. Several identified concerns about whether the first primary care sites would be able to create enough of a ‘welcoming environment’ to attract and retain PAs in primary care.

One person observed that “we have been dodging this role” (because of this turf dynamic). It was stressed that it was important to learn from the experience of introduction of other new health care professions. One person suggested that all needed to be familiar with the Canadian Association of Physician Assistants: Scope of Practice and National Competency Profile.

Risks to organizations and professional associations

The fact that PA roles in primary care were new was identified as an independent risk, with potential impacts not only on individual PAs, but also on the PA profession, the medical profession, individual sites and the health regions(s).

There was some concern that “if (the implementation) not done well could set the (PA) profession back significantly”. A related concern was the level of expectations placed on the first PAs hired, if the first few selected ‘didn’t work out’.

A few commented on potential risks to region and its relationship with both sponsoring sites and with physicians if implementation did not go well.
• **It may ‘blow’ the relationship if things don’t go well**
Sponsoring sites were also seen as taking on additional risks... specifically those who were working well: there were fears of potentially “ruin(ing) a good thing” or “blowing apart the great thing that we have:.

**Advice for Implementation**
While participants were asked directly about what advice they would give the implementation team, many integrated their thoughts on this issue within the context of discussing potential risks and challenges. Many stated that they were impressed by the support and actions taken to date.

In general, participants felt that all the risks and challenges were manageable if sufficient resources (e.g. time, funds, executive attention) were allocated. The primary strategies suggested were to:

- **“Communicate, communicate, communicate”**.
- Ensure that mechanisms for monitoring, trouble-shooting and ongoing dialogue were in place, and that there were regular and proactive efforts to assess how implementation is proceeding. Deal with problems as they arise. Ensure that PAs are integral to these activities.
- Recognize that fundamental challenges relate to change management, and education of the entire system, not simply teams at specific sites. Ensure that the initiative is presented within the context of primary care renewal, and the overall strategy rather than being treated as a ‘project’.
  - *If we do it right, can help all the strategic directions.. ability to help others do their implementation*
- Focus on inter-professional team development, not only on PAs. Prioritize the clarification of expectations and roles. Help all professionals work to the full scope of their practice. Creatively explore strategies that will be effective in turning ‘overlapping roles’ into an opportunity rather than a threat.
- Use evidence; including the knowledge that comes from fully exploring community needs, experiences of other jurisdictions and implementation activities, and hearing the perspectives of professional organizations.
- Allow sufficient time/preparation/support for implementation (including engagement of physicians, staff, patients and community), and support facilitation roles. This preparation should also acknowledge and equip individuals to deal with potential resistance.
  - *Slow down a bit... in terms of operationalizing it, so much going on, a lot to implement with small number of people.*
  - *You can’t just have a couple of meetings and plop a PA in.*
  - *If you don’t spend time thinking things through in the end, its more work than if we had that planning ahead of time.*
- **Provide needed education**: More information was felt to needed on “**what PAs can do**”, their training, and the curriculum.
- Ensure adequate supports and mentoring for both PAs and for family physicians. Engage these professionals fully in planning and problem solving.
- Ensure leadership involvement and presence.
- Address, in a timely fashion the issues related to logistics, governance, structures and mentorship that come with introduction of any initiative. There was felt to be need to clarify funding for, and address resource needs for overhead expenses, administrative support and data collection; support for physicians, including help in evaluating competencies and providing feedback to new hires.
- Ensure clear and realistic expectations. For example it was stressed that there needed to be a recognition that initially “things may go backward”, because any change required a readjustment period.
- Pay particular attention to selection of initial sites, and hiring for initial positions.
- Provide a welcoming environment, adequate supports, and useful feedback to PAs.
- Work with the university to ensure graduates have needed skills, and to market the option of a primary care career with PAs.
- Ensure appropriate evaluation.

**Perspectives on Evaluation Planning**

The initial evaluation plan was to focus on only one site. However, the majority of respondents felt that having additional sites, which were recognized as having very different characteristics and opportunities for preparation, offered an important opportunity to learn more about the potential role of PAs in primary care and there was awareness that this kind of comparison was necessary as the intervention may work better in one setting than another (“exciting”, “an opportunity you can’t pass up”). Participants noted the limited transferability of an evaluation based on only one site: the risk of drawing conclusions that may have been impacted by the particular skills, motivation, personality or approach of key individuals in only one site. It was also noted that the planned site, 601 Aikins, was unique in a number of respects, including the motivation and experience of the interprofessional team and the time and supports they had received to prepare for implementation; factors that could not be assumed in all locations. However, there was some concern expressed about whether there were adequate resources to undertake an expanded evaluation, and whether a broader focus might detract from the learning that would result from a more intensive focus at one site.

**Perspectives on evaluation approach and priority questions**

There was strong support expressed through the interviews for the developmental evaluation approach proposed at the initial planning meeting (particularly given the “continually evolving landscape”) and for initially focusing on implementation evaluation in order to ensure that the interventions were “ready” to evaluate. Several participants articulated the need for flexible, iterative evaluation models that would meet the needs of the sites and implementers.
Participants reinforced previous planning in terms of evaluation questions: several participants highlighted the need to understand the impact of the role introduction on other team members, and the need for evaluation to focus on system learning: to identify what works, what doesn’t and help guide implementation of other initiatives in the future.

There was, however, recognition of the importance assessing patient outcomes and impacts, as discussed further below. Perhaps due to events that were occurring over the summer and fall, participants also raised questions regarding assessment of overall sustainability, including economic viability. There was some concern about the adequacy of resources for the evaluation needed.

There was also recognition that MB Health was undertaking its own evaluation. While seen as different in focus than the WRHA evaluation, it was stated by several that they hoped that the two were coordinated and informed each other.

**Perspectives on outcome evaluation**

The importance of outcome evaluation was clearly recognized, and there was strong interest on the part of many participants in clarifying outcome measures and ensuring that these were appropriate and complete. Suggested outcome measures were consistent with the objectives of the initiative and focused on both access and quality. There was a belief by many that more work needed to be done in this area, (“if it is about access, what is the definition? Roster size bigger? Quicker access? Extended hours?”). Many participants felt that the EMR would be a key source of data for outcome evaluation, and that there was a need to determine the potential of the EMR in this regard. This perspective was not shared by all, however, and some had concerns about whether appropriate data was available for primary care (**data all over the place... (question is) how do we turn it into useable information?**)

A number of participants also expressed concern about expectations, particularly from Manitoba Health, for early impact and outcome measures. There was concern that a focus simply on objective measurable outcomes, particularly in the early stages, could have potentially negative consequences:

a) There was concern that the combination of new graduates being hired into sites without an established PA program would require a steep learning / adaptation curve (not only on the part of the PA, but also in adapting clinic processes) that could potentially have a negative impact on patient volume/care indicators over the first several months. Caution was urged in delaying any conclusions about impacts until after the **“bugs had been ironed out”** of the implementation.

b) Some also identified potential tension between access/volume vs. quality of care indicators (and the need to ensure that pressure to increase throughput does not negatively impact quality of care).
c) There were also concerns that any evaluation must be open to the possibility that there may be unintended consequences (positive or negative) of PA introduction, and that care must be taken to identify these.

There was also strong interest in getting early and broad patient and community response to the PA introduction and it was recognized that such data would not be easily available. Several stressed that it was not enough to “count numbers” to understand the patient experience.

SUMMARY AND EVALUATOR RECOMMENDATIONS

Implications for Evaluation Plan
The initial evaluation plan was developed with the objective of evaluating the implementation of a Physician Assistant at one site. However, data from baseline interviews reflected a rapidly changing environment: where both the potential sites, and the plans for recruitment were rapidly evolving. At time of writing one PA has been hired into a fee-for-service site, ongoing work is underway to recruit to the site originally part of evaluation planning. There are several implications for the evaluation plan:

- Reinforcement of the need for a flexible, developmental plan that can adapt to potentially many and unanticipated changes
- Confirmation of need for an initial focus on implementation evaluation
- Suggestion that there is a need to explore broader issues of facilitators and barriers to PA interest in primary care roles, an issue not identified in the original evaluation plan
- Need to clarify the resources needed to expand implementation and evaluation support beyond one site.

Evaluator Recommendations:
1. That the evaluation approach (developmental, with initial focus on implementation evaluation) is maintained.
2. That findings included in the report are shared widely to inform ongoing planning; and that perspectives and suggestions of stakeholders are integrated, as appropriate, into future work.
3. That the evaluation plan is reviewed at the next IPAPCSC meeting, and revised based on information available at that time
   a. That there is continued support for the process data collection now being conducted by the interprofessional facilitator.
   b. That strategies for monitoring evaluation at PA introduction sites are finalized, including reviewing lists of key stakeholders to be included in the evaluation, and finalizing specific evaluation activities.
4. That specific consideration be given to the following:
   - Including a larger number (perhaps all) of funded sites that are successful in recruiting a PA into the initial evaluation.
• Revisiting the implementation plan to assess the feasibility of providing more than one site with implementation facilitation support. This may require negotiation with MPAN and redistribution of the planned budget.
• More formally aligning the implementation evaluation plan with the outcome evaluation planning conducted by Manitoba Health
• Ensuring broad stakeholder input into selection of outcome measures
• Broadening the evaluation focus to investigate factors influencing the interest of PAs in primary care positions, including pre-training understanding of scope of PA roles, curriculum, experience with rotations, and other barriers and facilitators to PAs pursuing careers in primary care.
• Immediate action to develop a patient input/evaluation strategy.

5. Given the uniqueness of the Manitoba initiative and preparatory work undertaken consideration be given to exploring additional research support for in depth investigation of the potential of PAs to support and promote primary care renewal.
LIST OF APPENDICES

APPENDIX A: DRAFT EVALUATION PLAN
APPENDIX B: LETTER OF INVITATION
APPENDIX C: INFORMATION AND CONSENT FORM
APPENDIX D: INTERVIEW GUIDE
APPENDIX A: EVALUATION PLANNING MATRIX

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<td><strong>PLANNING/ASSESSMENT</strong></td>
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<td>• What evidence is there for the most appropriate role for PAs in PC? How should this inform our planning? The position description?</td>
<td>Is this evidence relevant for the Winnipeg context? How does makeup of current team affect role selection?</td>
<td>Critical review of PA and Interprofessional PC literature, baseline interviews</td>
<td>Peer – reviewed and grey literature, key stakeholders</td>
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<td>• What challenges to successful implementation can be anticipated? What strategies can be put in place during the pre-implementation phase to minimize these challenges?</td>
<td>Baseline interviews</td>
<td>Key stakeholders</td>
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<td><strong>IMPLEMENTATION EVALUATION</strong></td>
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| • What are the resources needed to support introduction and effective integration of an effective PA role in an inter-professional primary care setting? | - What is the training/orientation time investment needed to make the role effective?  
- What are the education needs of practicing physicians in order to support PA integration into PC?  
- What are the admin, other resources needed?  
- Concerns about simple metrics (e.g. physicians see more patients) | Time series interviews  
Focus groups  
Process documentation  
Time logs |                |                       |                            |
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<td>- What data collection systems are needed to adequately measure intervention outcomes?</td>
<td>- What is in place? What adaptations or new systems need to be implemented? What are the most useful indicators of PA impact?</td>
<td>Data collection working group</td>
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<td>- What barriers to implementation of a PA role in primary care are experienced? What are the perspectives of various stakeholders on these barriers? How can they best be addressed?</td>
<td>- Perspectives of all providers and clients Is training/preparation adequate? What additional training/experience may be needed?</td>
<td>Time series interviews Focus groups</td>
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<td>- What strategies are most effective in integrating a PA into an existing team? Promoting role adaptability?</td>
<td>- How can expectations of PA introduction best be managed?</td>
<td>Time series interviews Focus groups</td>
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**IMPACT EVALUATION**

What are the impacts of introduction of the PA role into an interprofessional PC team, from patient, provider perspectives?
- Does introduction of PA improve access? CD management? *(goals based)*
- What unanticipated impacts does the introduction have *(goals free)*

- Benefits? Improve accessibility to PC? To which populations? Decrease service utilization? Increase out of hospital care? What are patient perspectives on advantages and disadvantages of the role? What are the impacts of PAs on patient satisfaction? What differences in experience and

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<th>Time series interviews Focus groups</th>
<th>Time logs? Analysis of patient utilization data Patient experience assessment tool</th>
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<td>satisfaction do patients experience? What information and educational strategies are required to introduce the PA role to clients?</td>
<td>- Are there negative impacts? Increased number of referrals? Workload for physicians? Other providers? Liability? Role confusion? - What are the impacts on overall team functioning? - What is the impact of the requirement of supervisor change to Tx plan designed by PA?</td>
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<td>DEVELOPMENTAL EVALUATION</td>
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<td>- What is the unique contribution that PAs can make in an inter-professional Primary Care team?</td>
<td>- Clinic? Home care? Phone follow up? CD management? - How is contribution different than that of NP? - What should a PA position description in PC look like?</td>
<td>Time series interviews Focus groups</td>
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<td>- What are the most useful roles that a PA can adopt in a PC setting? What is</td>
<td>- What is the best contribution PAs can play in CD</td>
<td>Time series interviews Focus groups</td>
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<td>the best use of their time?</td>
<td>management?</td>
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<td>- What hours (shifts) are most useful?</td>
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<td>- To what extent, and in what ways, is the training provided to PAs adequate to prepare them for an effective role in PC? What changes would be needed (in pre-requisites, training, or placement)?</td>
<td>Time series interviews Focus groups</td>
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<td>- What is the impact and/or importance of a) pre-PA training b) professional experience and c) previous education, and d) personal skills and attitudes on effectiveness in a PA role?</td>
<td>Time series interviews Focus groups</td>
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<td>- What strategies are effective in promoting comfort and confidence in interprofessional/collaborative practice? What contextual factors need to be taken into account?</td>
<td>Time series interviews Focus groups</td>
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<td>- What can feasibly be done to increase the capacity of Family Practice and PA faculty in preparing students for interprofessional practice?</td>
<td>Key informant interviews</td>
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<td>- What insights does introduction of PAs in this role give us on roles of other practitioners?</td>
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<td>Analysis of all data</td>
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**OUTCOME EVALUATION**

- What is the best, most effective and efficient model for use of PAs in primary care?
  - What are the characteristics of a practice that is supportive/predictive of successful PA integration?

- What are the health outcomes of an effective PA role within primary care?
  - Need to develop list to inform data collection
Appendix B: LETTER OF INVITATION

As a participant in the MPAN project, which is one of the first to integrate Physician Assistants into Primary Care in Canada, I know you are aware of the plans to conduct a comprehensive developmental evaluation of this initiative.

One aspect of the evaluation will be confidential interviews with all key stakeholders conducted by Dr. Sarah Bowen from the University of Alberta; a researcher with experience in evaluating these kinds of initiatives. I am writing to ask for your permission to be contacted by her.

I am enclosing, for your information, an Information and Consent form. This provides details of the evaluation project, the activities you will be asked to participate in, and your rights as a participant.

If you are in agreement with having Dr. Bowen contact you, could you please return the Information and Consent form (initialed on each page, and signed) to me at 496 Hargrave Street, 5th Floor Winnipeg, MB R3A 0X7 Fax: 204.940.8575 or Email: spelletier@wrha.mb.ca.

If you provide this consent, Dr. Bowen will be contacting you over the next few weeks to set a time for the interview that is convenient for you. If you would like to contact her at any time, she can be reached at sbowen@ualberta.ca.

If you have any questions about the study, please contact Dr. Ingrid Botting (the Principal Investigator) at the information provided below. You may also contact Dr. Bowen (sbowen@ualberta.ca) directly to indicate whether or not you are interested in participating. Your participation in the evaluation is entirely voluntary: information on whether you choose to participate will not be shared with any other person.

Kind regards,

Sylvie Pelletier

on Behalf of
Ingrid Botting, PhD
Director, Health Services Integration
WRHA Family Medicine/Primary Care Program
496 Hargrave Street, 5th Floor
Winnipeg, MB R3A 0X7

tel: (204) 940-8572 fax: (204) 940-8575
email: ibotting@wrha.mb.ca
RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

Title of Study: Evaluation of Introduction of Physician Assistants into Primary Care

Principal Investigator: Dr. Ingrid Botting
Director, Health Services Integration
WRHA Family Medicine/Primary Care Program
496 Hargrave Street, 5th Floor
Winnipeg, MB R3A 0X7

Sponsor: Manitoba Patient Access Network

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the study staff. You may take your time to make your decision about participating in this study and you may discuss it with your friends, family and colleagues before you make your decision. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of Study
This research study is being conducted to study the process and impact of the introduction of Physician Assistants into an Interprofessional Primary Care team.

A total of 15-20 participants will participate in this phase of the study.

Study procedures
You are being asked to participate in a series of individual interviews that will be evaluating the implementation and impacts of the introduction of Physician Assistants into a Primary Health Care team. Your decision about whether to participate will be kept completely confidential: no one in your organization will be told whether or not you decided to participate.
If you take part in this study: You will be contacted by an external evaluator, Dr. Sarah Bowen of the University of Alberta, who will invite you to participate in a confidential telephone interview at the beginning of the project, and in follow up interviews at regular points throughout the 2 year project (3-5 interviews). The interviews will focus on your perspectives of the introduction of Physician Assistants into primary care, resource needs, benefits, challenges, and suggestions for changes. Interviews are anticipated to take from 20-30 minutes. Interviews will be scheduled at a time convenient for you.

Participation in the study will be for 2 years.

The researcher may decide to take you off this study if you move to another position.

You can stop participating at any time: you may decline to participate in any follow up interview.
Individual comments and perspectives will not be identified: all information that may identify your responses will be removed from summary reports. If any quotes are used, you will be asked for your permission to include them in reports.

Results of each phase of interviews will be made available to all participants, and the MPAN Steering Committee.

Benefits
There may or may not be direct benefit to you or to your program from participating in this study. We hope the information learned from this study will help inform guide further planning to integrate Physician Assistants into Primary Care programs.

Risks or Discomforts
You may feel uncomfortable sharing information about your perspectives on the implementation of this project. You may, however, decline to respond to any question that causes you discomfort.

Costs
You will receive no payment or reimbursement for any expenses related to taking part in this study. However, you will be able to participate in the interview on work time.

Confidentiality
Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. The transcript of your interview will be identified by a code, not your name. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All records will be kept in a locked secure area and only those persons identified will have access to these records. No information revealing any personal information such as your name, address or telephone number will leave the private office of the Evaluation Consultant, University of Alberta.

Voluntary Participation/Withdrawal from the Study
Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from the study will not affect your role or performance evaluation at the WRHA. No one at your place of employment will be informed about whether you chose to participate in this study.

You are not waiving any of your legal rights by signing this consent form nor releasing the investigator(s) or the sponsor(s) from their legal and professional responsibilities.

Questions
For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.
Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research study with Dr. Ingrid Botting and/or her study staff. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member) I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board, for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I agree to be contacted for future follow-up in relation to this study,

Yes ____   No ____

I agree that the telephone interviews may be audiotaped.

Yes ____   No ____

Participant signature _______________________________ Date ___________________ (day/month/year)

Participant printed name: ____________________________

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent

Printed Name: _______________________________ Date ___________________ (day/month/year)

Signature: _______________________________

“Role in the study: ____________________________

Relationship (if any) to study team members: ____________________________
APPENDIX D: DRAFT INTERVIEW GUIDES
BASELINE VERSION: INDIVIDUAL INTERVIEWS

1. There are now plans to introduce 3 PAs into different settings. What implications does this have for the evaluation? What are some of the factors that may affect the success of the placement in each location?
2. What evidence should the initiative be looking at in order to design the most effective role for a PA in an inter-professional primary care team?
   a. What, from your perspective is the unique contribution a PA can make to a PC team?
   b. What would you advise in terms of a position description?
      i. Probe: roles, focus, hours
   c. What are the key characteristics you would hope the selected PA would bring?
      i. Probe: interpersonal, education, experience
3. What do you hope will be accomplished by introduction of PAs into primary care?
4. What might be some of the risks to introduction of PAs in PC? How can these risks be minimized?
5. What advice would you have for the implementation team, including the Inter-professional coordinator?
   a. Probes: What are the most important things he/she be aware of? What should he/she be focusing on?
   b. What resources do you think will be required?
      i. Probe: new resources, additional resources? Training and supports for physicians?
   c. What are some of the factors that will facilitate and support this introduction?
   d. What are some of the potential barriers to effective implementation? From your perspective, how can these barriers best be addressed?
6. What do you think are appropriate impact and outcome measures of PA introduction in PC?
   a. Probes where appropriate: how can this best be measured? What data is available in your program?

PHYSICIAN ASSISTANT INTERVIEW GUIDE: BASELINE VERSION

1. What, from your perspective is the unique contribution a PA can make to a PC team?
1. What do you hope will be accomplished by the introduction of PAs into primary care?

2. In your opinion, what are the key characteristics of an effective PA?
   a. Probe: interpersonal, education, experience
   b. How well prepared do you feel you are for this role?
      i. Probe: strengths, weaknesses, adequacy of training

3. What are you hoping your role will be in this setting?
   i. Probe: roles, focus, hours

4. What concerns or anxieties do you have about your role as a PA in this setting? About the implementation of the role?

5. What advice would you have for the implementation team, including the inter-professional coordinator?
   a. Probes: What are the most important things he/she be aware of?
      What should he/she be focusing on?
   b. What resources do you think will be required to support the integration of a PA role in the PC setting?
   c. What are some of the potential barriers to effective implementation?
      From your perspective, how can these barriers best be addressed?

6. What do you think are appropriate impact and outcome measures of PA introduction in PC?
THE POTENTIAL OF PHYSICIAN ASSISTANTS IN INTERPROFESSIONAL PRIMARY CARE

A Symposium sponsored by the Introducing Physician Assistants into Primary Care Steering Committee.

Funding for the symposium has been received through a Canadian Institutes of Health Research Planning Grant, with additional support from the University of Manitoba Faculty of Medicine, Office of Physician Assistant Studies.

*There is no fee for attending, but pre-registration is required*

Date: Monday, June 10, 2013
Time: 10:00 a.m. – 3:30 p.m.
Location: Theater C, Basic Medical Science Building
730 William Avenue
Bannatyne Campus, University of Manitoba

AGENDA

10:00 a.m. Welcome and Greetings
Beth Beaupre, Head, Health Workforce Secretariat and ADM, Manitoba Health

Objectives of the day
Sarah Bowen, Associate Professor, School of Public Health, University of Alberta

10:15 a.m. Plenary Presentation: Integrating Physician Assistants into Primary Care: Implications for System Planning
Ruth Ballweg, MPA, PA-C, Associate Professor, Program Director University of Washington MEDEX-Northwest School of Medicine; International Liaison for the National Commission Certification of Physician Assistants.
Roderick S. Hooker, PhD, MBA, PA is a Physician Assistant and health services researcher who specializes in organizational efficiency.
Questions/Discussion

12:30 p.m. Lunch
1:00 p.m.  **Afternoon Opening Remarks**  
Dr. Brock Wright, Senior VP, Clinical Services & Chief Medical Officer, Winnipeg Regional Health Authority

1:15 p.m.  **Plenary Presentation: Integrating Physician Assistants into Primary Care: Potential for Optimizing Primary Care Practice**

*Christine Everett*, PhD, MPH, PA-C Health Innovation Program, University of Wisconsin-Madison.  
*Angela Cassell* MPAS, CCPA was among the first Physician Assistants employed in a Canadian Community Health Clinic, the Somerset West Community Health Centre in Ottawa, Ontario.  

Questions/Discussion

3:30 p.m.  **Wrap-up**

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**SPECIAL EVENING WORKSHOP FOR PHYSICIANS**

6:30-8:00 p.m.  **Myths and Realities: Working with a Physician Assistant in Inter-Professional Primary Care Practice**

Location: WRHA Offices - 650 Main Street, room 411

This participatory workshop is designed for physicians who would like to learn more about introducing a physician assistant into a family practice setting. Led by physicians and PAs with experience in working together in the Manitoba context, and using an inter-professional practice lens, this workshop will provide an opportunity to explore both the potential of the PA role, and practical issues related to implementation.

Dr. Sheldon Permack, MD, FCFP - *Family Physician and Medical Director, Family Medicine/Primary Care, WRHA*

Dr. Kerrie Wyant, BSc, MD, CCFP - *Family Physician and Site Medical Lead*

Dr. Ainslie Mihalchuk, MD, CCFP - *Family Physician and Medical Director, Family Medicine Concordia Hospital*

Susan Paul, BSc PA, CCPA – *Physician Assistant, Family Medicine/Primary Care Community Clinic*

Scott Naherniak, MPAS, BSc, DC - *Physician Assistant, Family Medicine/Primary Care and Long Term Care*

Brooke Osis CCPA, MPAS, BSc, MLS(ASCP) – *Physician Assistant, Family Medicine/Primary Care and Concordia Hospital*

(a light dinner will be provided)
**PRESENTER BIOS**

**Ruth Ballweg** MPA, PA-C, is a Professor in the Department of Family Medicine at the University of Washington School of Medicine where she is the leader of the MEDEX Northwest Physician Assistant Program. She also serves as International Liaison for the National Commission Certification of Physician Assistants. She is the recipient of American Academy of Physician Assistants’ Eugene A. Stead Jr. Award of Achievement — the highest award in the PA profession. Author of *Physician Assistant: A Guide to Clinical Practice*. Ms. Ballweg is recognized as a leading physician assistant educator and policy leader in the US.

**Roderick S. Hooker** is a health policy analyst and a health workforce scholar. A graduate of the University of Missouri in Biology, he spent two years in the Peace Corps in the Kingdom of Tonga in the South Pacific. After graduating in 1978 from the St. Louis University PA program, he spent 35 years in the medical field in rheumatology and as a health services researcher. He obtained his PhD in health policy from the Mark O. Hatfield School of Government at Portland State University in 1999. Rod has an extensive list of publications (200, of which 150 are peer-reviewed) on workforce and economic issues. Many of his studies have contributed to the advancement of team-based medical care. Rod has worked for Kaiser Permanente, The Department of Veterans Affairs and The Lewin Group. He is an adjunct professor at The George Washington University School of Public Health and Health Services, and works as an independent consultant for associations and universities.

**Christine Everett**, PhD, MPH, PA-C, has over 10 years of experience with the federal government in the US and is currently with the Health Innovation Program at the University of Wisconsin-Madison. Formerly the Director of Research, Physician Assistant program at the University of Wisconsin-Madison, her research focuses on understanding the design of healthcare team and their impact on quality outcomes. She has developed a novel conceptual model for physician assistant (PA) and nurse practitioner (NP) patient care roles in the delivery of primary care and has used it to compare the effectiveness of different PA/NP roles.

**Angela Cassell**, MPAS, CCPA was among the first Physician Assistants employed in a Canadian Community Health Clinic, the Somerset West Community Health Centre in Ottawa, Ontario. A member of an inner-city multi-disciplinary team, Ms. Cassell is part of the Chronic Disease Prevention and Management Collaborative. Her duties include managing a multidisciplinary team diabetes clinic which provides care for over 125 of the centre’s diabetics.
OUTLINE FOR DAY 2
Location: Meeting room 518- 496 Hargrave Street

PROPOSED AGENDA
(9:00 a.m. – 4:00 p.m.)

Attendees:  Core research/decision-maker team (full day)
Core research/decision-maker team, guest speakers (a.m.)

1. Approval of agenda
2. Debrief of Day 1
3. Confirming/refining the research questions
4. Confirming outcome measures- primary measures of impact (quantitative but also qualitative indicators); secondary measures; and potential predictor variables that will need to be collected
5. Final decision on study design/methods issues

LUNCH

6. Preparation for the grant proposal submission
   - Roles and responsibilities of team members
   - Organizing for letters of support
   - CCV
7. Timelines for developing proposal
8. Governance model for the team; data ownership and stewardship; authorship criteria; structure and processes of the integrated KT approach
9. Other Business
10. Evaluation and Closing
# APPENDIX C

## FOCUS GROUP/INTERVIEW GUIDE
Summer 2013

<table>
<thead>
<tr>
<th>Question</th>
<th>Possible Probes</th>
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| Thinking back to the time before the Physician Assistant arrived at (name of site/practice), what were your thoughts about the initiative at that time? *(e.g. roles he or she would play, the preparation you got for the introduction of the new role, any concerns you may have had at that time).* | • What roles were you expecting/hoping he/she would play?  
• What kind of preparation did you get for the introduction of this new role? Was it adequate? Appropriate?  
• What concerns did you have about the introduction of the PA role before he/she arrived?  
• Were these concerns addressed before the PA arrived? |
| **Intro:** Now that *(the PA)* has been with *(site/practice)* for x weeks/months, I am wondering about how the introduction of this new role has gone. First I would like to ask about the process of implementation itself. We know that any implementation can have challenges, even if people are happy with an initiative.  
1. To start with, in terms of the implementation process, I am wondering what has worked and is now working well?  
2. In what areas has implementation been more difficult?  
3. What issues continue to create difficulties?  
4. Knowing what you know now, what could have been done prior to implementation to avoid these difficulties? What should be done now? | 1. Probe, for details examples  
2. Probe for a) where responsibility for this activity resides, b) who should have done it |
| Now I’m wondering what you can tell me about any changes you have experienced at this site/practice because of the introduction of the PA. *(these changes could have been positive, or negative, or simply unexpected)* | • What positive changes, if any, have occurred?  
• Were any of these positive changes a surprise to you?  
  o If yes, why do you think this was?  
• Have there been any changes that concern you?  
  o Probe for clarity  
• Do you think something needs to be done to address this? |
| Now that the PA has been in his/her role X months, I am wondering how your thoughts and expectations about the role of PAs in primary care may have changed? |  |
| What advice would you have for other PC sites that are thinking about, or planning for introduction of a PA? | • Before the PA arrives?  
• When the PA arrives?  
• On an ongoing basis?  
• What should be incorporated into a handbook for staff like yourself? |
| Is there anything else you would like to say to contribute to the evaluation | Other questions you may have asked if you were leading this group? |