# 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***

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## 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.

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## 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 of 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 scare 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 r 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: EVALUATION PLANNING MATRIX

| 1.Proposed Evaluation Questions | 2.Comments/Notes Sub questions | 3.Possible Methods | 4.Data Sources | 5.Potential Indicators | 6.Responsibility Resources |
|---|---|---|---|---|---|
| **PLANNING/ASSESSMENT** | | | | | |
| • What evidence is there for the most appropriate role for PAs in PC? How should this inform our planning? The position description? | Is this evidence relevant for the Winnipeg context? How does makeup of current team affect role selection? | *Critical review of PA and Interprofessional PC literature, baseline interviews* | *Peer – reviewed and grey literature, key stakeholders* | | |
| • What challenges to successful implementation can be anticipated? What strategies can be put in place during the pre-implementation phase to minimize these challenges? | | *Baseline interviews* | *Key stakeholders* | | |
| **IMPLEMENTATION EVALUATION** | | | | | |
| • 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?<br>- What are the education needs of practicing physicians in order to support PA integration into PC?<br>- What are the admin, other resources needed?<br>- Concerns about simple metrics (e.g. physicians see more patients) | *Time series interviews*<br>*Focus groups*<br>*Process documentation*<br>*Time logs* | | | |

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|---|---|---|---|---|---|
| - What data collection systems are needed to adequately measure intervention outcomes? | - What is in place? What adaptations or new systems need to be implemented? What are the most useful indicators of PA impact? | *Data collection working group* | | | |
| - 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? | - Perspectives of all providers and clients<br>- Is training/preparation adequate? What additional training/experience may be needed? | *Time series interviews*<br>*Focus groups* | | | |
| - What strategies are most effective in integrating a PA into an existing team? Promoting role adaptability? | - How can expectations of PA introduction best be managed? | *Time series interviews*<br>*Focus groups* | | | |
| **IMPACT EVALUATION** | | | | | |
| What are the impacts of introduction of the PA role into an interprofessional PC team, from patient, provider perspectives?<br>• Does introduction of PA improve access? CD management? (*goals based*)<br>• 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?<br>- 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 | Time series interviews<br>Focus groups<br>*Time logs?*<br>*Analysis of patient utilization data*<br>*Patient experience assessment tool* | | | |

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|---|---|---|---|---|---|
| | satisfaction do patients experience? What information and educational strategies are required to introduce the PA role to clients?<br>- Are there negative impacts? Increased number of referrals? Workload for physicians? Other providers? Liability? Role confusion?<br>- What are the impacts on overall team functioning?<br>- What is the impact of the requirement of supervisor change to Tx plan designed by PA? | | | | |
| **DEVELOPMENTAL EVALUATION** | | | | | |
| - What is the *unique* contribution that PAs can make in an inter-professional Primary Care team? | - Clinic? Home care? Phone follow up? CD management?<br>- How is contribution different than that of NP?<br>- What should a PA position description in PC look like? | *Time series interviews*<br>*Focus groups* | | | |
| - What are the most useful roles that a PA can adopt in a PC setting? What is | - What is the best contribution PAs can play in CD | *Time series interviews*<br>*Focus groups* | | | |

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|---|---|---|---|---|---|
| the best use of their time? | management?<br>- What hours (shifts) are most useful? | | | | |
| - 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)? | | *Time series interviews*<br>*Focus groups* | | | |
| - 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? | | *Time series interviews*<br>*Focus groups* | | | |
| - What strategies are effective in promoting comfort and confidence in interprofessional/ collaborative practice? What contextual factors need to be taken into account? | | *Time series interviews*<br>*Focus groups* | | | |
| - What can feasibly be done to increase the capacity of Family Practice and PA faculty in preparing students for interprofessional practice? | | *Key informant interviews* | | | |

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|---|---|---|---|---|---|
| - What insights does introduction of PAs in this role give us on roles of other practitioners? | | *Analysis of all data* | | | |
| **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 | | | | |

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,

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*
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## 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?

    a. 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?