

Physician Assistants in Urgent Care: A Qualitative and Quantitative Approach to Practicing
PAs in Urgent Cares in Winnipeg

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Abstract

Despite being a relatively new profession in Canada, physician assistants (PAs) have been successfully integrated into urgent care (UC) departments in Winnipeg, Manitoba, Canada. The recent closure of emergency rooms (ERs) within the Winnipeg Regional Health Authority (WRHA) has led to a re-distribution of less emergent services into new UC departments in Winnipeg. At present, eight PAs have been integrated into two Winnipeg UCs and are an integral part of the interprofessional health care team.

PAs and UCs are a part of the solution to the increasing demands for efficient and cost-effective health care delivery. This capstone project focuses on understanding the scope of PAs within the UC departments in Winnipeg by analyzing quantitative de-identified patient data from the two Winnipeg UCs who employ PAs. This data was then compared to quantitative data gathered through an international literature review of UC PAs (mostly in the United States). This was in order to determine if there are discrepancies or similarities between the use of PAs in Winnipeg compared to other countries or regions. Finally, this capstone project qualitatively identifies what PAs do in Winnipeg UCs, via a questionnaire filled out by Winnipeg employed urgent care PAs. Seven out of eight PAs working in UCs in Winnipeg responded to the questionnaire, three of which were recent graduates. Questions were focused on perceptions of their own skill sets and competencies, physician collaboration, types of presenting complaints seen, severity of patients, and opportunities for growth. The main goal of this questionnaire was to determine what PAs feel their role is within Winnipeg UCs and to recognize areas of opportunity for growth and development.

The quantitative analysis of the Winnipeg UC data and the literature review revealed that PAs in Winnipeg UCs have a broad scope of practice, similar to PAs in American UCs. The quantitative analysis also suggests that PAs in Winnipeg UCs see mostly CTAS 3 patients, and most commonly manage orthopedic (20%), gastrointestinal (15%) and skin (13%) complaints. The results of the questionnaire suggest that PAs in Winnipeg UCs self-identify as being experts at most CanMEDs-PA competencies for procedures/treatment skills as well as airway management and cardiac resuscitation. Identified areas of future growth and development was in the management of CTAS 1 and CTAS 2 patients.

The data collected for this capstone project suggests that PAs have been successfully integrated into UCs and continue to require support in gaining appropriate skills and breadth of scope. There are still relatively few PAs in UCs across Manitoba, and as such it is important to not only identify current roles, but also identify future expansion opportunities and areas of growth. The information from this research could serve as a guide to inform our own utilization of PAs in Manitoba UCs as well as help direct future research in this area.

Introduction

The scope of practice, complexity of patients seen, CTAS scores of patients, and procedures and treatments are of interest in this research because they are important aspects of a PAs work. There has been a recent integration of PAs into Winnipeg UCs and there is benefit in understanding these roles further. Identification of what PAs do in Winnipeg UCs as well as determining areas of growth are both key in fully utilizing PAs.

First established in the 1970's in the United States, and in 2017 in Winnipeg, Manitoba, UCs have gained popularity and become an important venue for patients to receive appropriate emergent and urgent care (1). Urgent care medicine is a provision of immediate medical services that addresses urgent management of patients, often requiring same-day treatment, management of injury, chronic illness, and/or acute illness (2). The ways in which we meet healthcare needs are changing and UCs have evolved from a need to efficiently and appropriately manage a variety of patients (3). It is important to first establish what types of care can be expected from UCs, including treatment/management, severity of illness, and common complaints, which can be found through a deeper look into the literature.

It is of equal importance to understand the roles of PAs in UC centres. PAs were initially shaped and born from a military background, and after extensive professional development, the first formally recognized civilian PA began work in Manitoba in 2003 (4). The PA profession has deeper roots than the newer urgent care centres in which they work. Thus, PA roles have been well established in many specialties/areas of medicine, but not as thoroughly in UCs in Winnipeg, which date back to 2017 (1). Currently, there are three Winnipeg urgent care centres employing eight PAs. Both of these numbers will likely grow, considering the amount of PAs in American UCs has doubled in the last ten plus years (2). Patient encounter data was obtained from the two UCs in Winnipeg that employ PAs: Seven Oaks General Hospital and Victoria General Hospital. It was of interest to isolate the types of encounters and Canadian Triage and Acuity Scale (CTAS) scores of patients seen by PAs. It is of further value to gather qualitative data from Winnipeg PAs in UCs to identify breadth of scope and opportunity for growth and development.

PAs are known to increase the capacity of a team, decrease wait times, improve throughput, efficiently redirect physician care, provide appropriate management, and help with continuity of care (5, 3). Like PAs, UCs also were formed from a demand to increase the quality of our healthcare system. Valuable to both are appropriate management of patients with the right care, by the right person, at the right time/environment (6). A qualitative look at how PAs influence and benefit UCs through their work was done through a questionnaire interview. A deeper and investigative look at PAs in Winnipeg UCs can be helpful for furthering this profession in the urgent care setting, which can help inform future integration/development of future PAs in UCs.

Methods

This research was founded on three different types of information: (1) a literature review of PAs in UCs, (2) a de-identified data set, and (3) a questionnaire interview distributed to working PAs in Winnipeg UCs.

To properly conduct this study, a thorough search of the literature was done. Articles addressing the research question were found by searching keywords in the following electronic databases: PubMed, Medline (Ovid), University of Manitoba Libraries, and Google Scholar. The keywords and phrases used include the following: physician assistant, urgent care, physician assistant in urgent care settings. Parameters included full article availability, English language, and peer reviewed. Inclusion criteria: relevant studies to the research question, printed in English, addressing either American or Canadian physician assistants, addressing either American or Canadian urgent care centres/emergency departments. I was the sole decision maker for the exclusion and inclusion of articles. Nine scholarly articles were obtained and used for a baseline knowledge of physician assistants in urgent care settings. Very few journal articles were Canadian based research, thus all literature in this study was based on PAs in UCs/ERs in the United States.

Additionally, a data set of patient visits from three Winnipeg UC/ER sites that employ PAs was obtained, including the Victoria General Hospital (VGH), Seven Oaks General Hospital (SOGH), and The Grace Hospital (GH). The administrative data included information from March 2019 to February 2020 (one year). The data ERs (The Grace Hospital). Additionally, data from before July 22nd, 2019 was excluded for SOGH, as before this date SOGH was not yet an UC, but still operating as an ER. Ethical approval was not required to obtain and use this de-identified data set. Excel was used to help manage/quantify the data sets.

To further investigate the role of PAs in UCs in Winnipeg, a qualitative interview questionnaire was conducted. There are eight PAs working in Winnipeg UCs, all of which were contacted. Seven of the eight responded and were e-mailed a Word document interview questionnaire, which was filled out and returned. Three of these seven were recent graduates. A copy of the interview questionnaire is included in this report.

Results

As evidenced by the data physician assistants manage a wide variety of patients in UCs. Figure 1 shows the percentage of different patient diagnoses seen by PAs at an American UC over a one-year span (7).

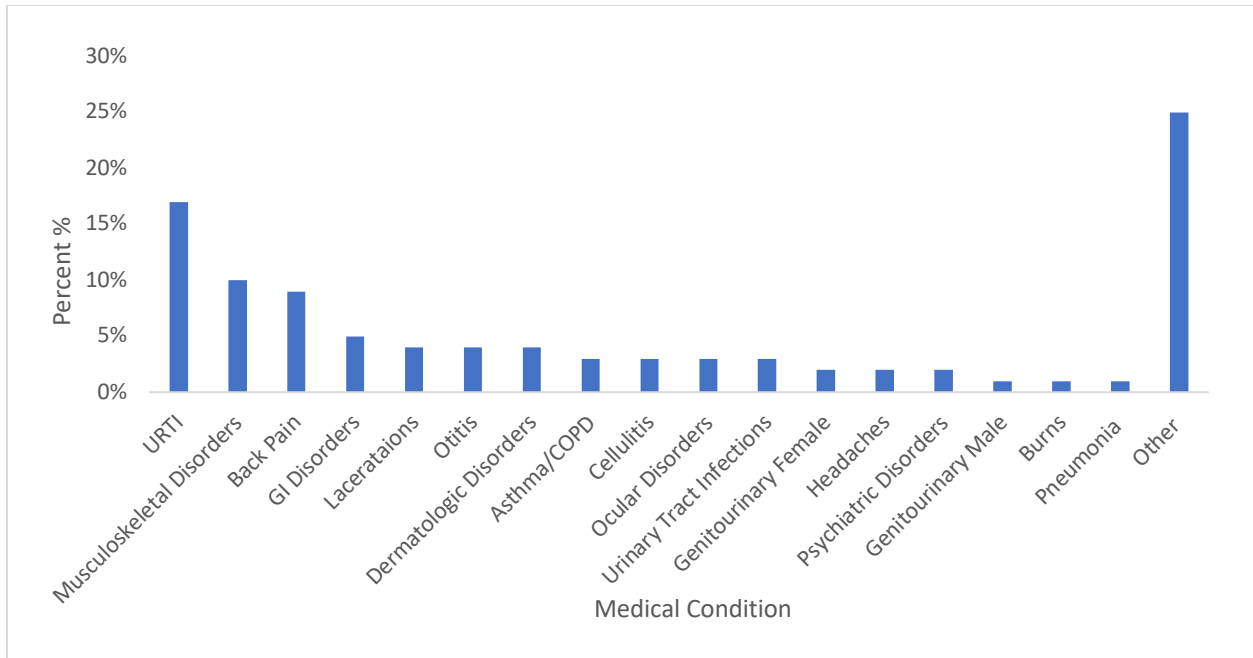


Figure 1. Distribution of patients by diagnosis seen by PAs in American ERs/UCs, original data from the literature search. Data was obtained from documented patient encounters seen by PAs at an American UC over one year. N = 9 061. (7).

Physician assistants are seeing a varied distribution of patients in Winnipeg urgent cares, demonstrating a broad scope of practice which is shown in Figure 2.

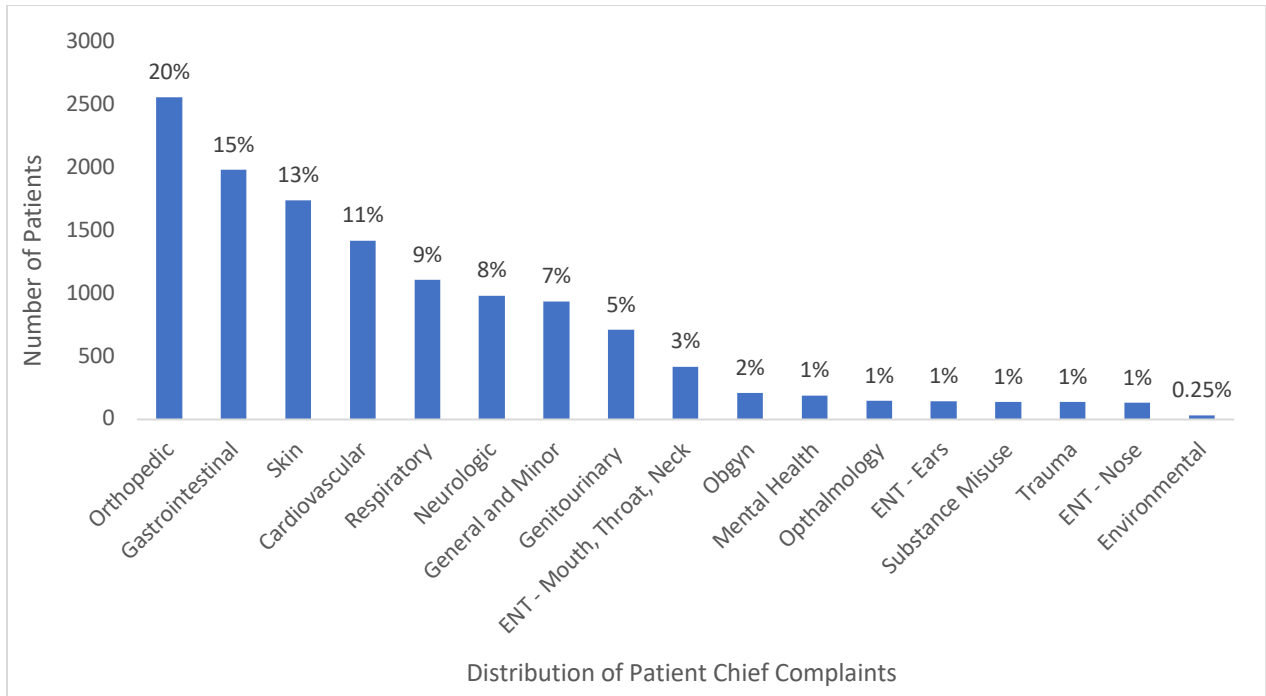


Figure 2. Distribution of patient diagnoses/categories seen by physician assistants in Winnipeg urgent care centres in 2019-2020, inclusive of Seven Oaks General Hospital* and Victoria General Hospital. N = 13 011 patient visits.

*Data from Seven Oaks General Hospital was collected from July 22, 2019 to February 29th, 2020, reflecting the transition from emergency department to urgent care. Data from Victoria General Hospital was collected from March 1, 2019 to February 29, 2020.

Additionally, the CTAS scores of patients seen by Winnipeg PAs in UCs is demonstrated in Figure 3.

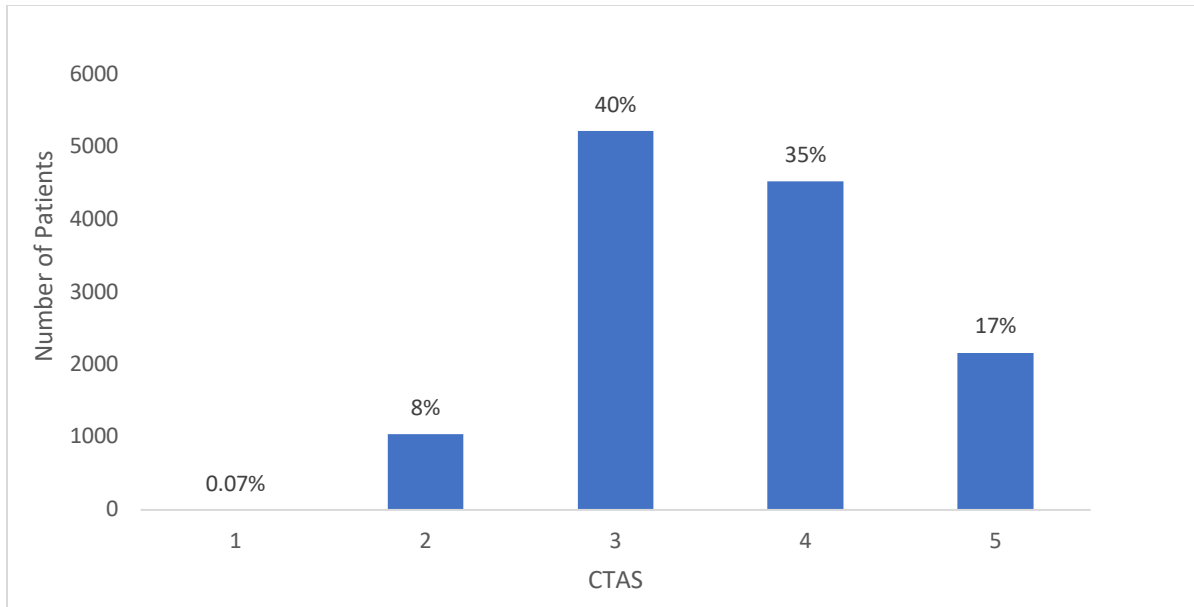


Figure 3. Distribution of CTAS levels seen by physician assistants in Winnipeg urgent care centres in 2019-2020, inclusive of Seven Oaks General Hospital* and Victoria General Hospital. N = 13 011 patient visits.

*Data from Seven Oaks General Hospital was collected from July 22, 2019 to February 29th, 2020, reflecting the transition from emergency department to urgent care. Data from Victoria General Hospital was collected from March 1, 2019 to February 29, 2020.

Table 1 below includes the Can-MEDS procedures/skills competencies expected of a Canadian PA, as dictated by “CAPA and supported by CPSM and CMA” by the College of Physicians and Surgeons of Manitoba (8). These are compared to the perceived and self-reported competencies of seven Winnipeg PAs working in UCs collected via the Questionnaire Interview.

Table 1. Can-MED-PA procedural skills expected of a physician assistant (column A) and physician assistants in urgent cares who self-identify as performing the named procedure (s) or skill(s) expertly in Winnipeg UCs (Seven Oaks General Hospital and Victoria General Hospital, 2019-2020) (column B). N = 7. Questionnaire question posed was: “The CanMEDS-PA states that PAs are expected to demonstrate “effective, appropriate and timely performance of diagnostic and therapeutic procedures relevant to patient care” (8). In your experience, which procedures do PAs in UCs manage expertly. Please select all/any that apply.” (Can-MEDS PA).

A PA Can-MED Competency – Expert Skill	B Number (and Percent) of PAs Interviewed in Wpg UCs that Identify as Expertly Performing these Procedures/Skills
Abscess incision and drainage	7 (100%)
Insertion of simple suturing	7 (100%)
Laceration (simple) repair; suture and gluing	7 (100%)
Cryotherapy of skin lesions, skin scraping for fungus determination	4 (57%)
Release subungual hematoma	4 (57%)
Removal of a foreign body from skin e.g. Fish hook, splinter, or glass	7 (100%)
Superficial and partial-thickness burn care	7 (100%)
Minor surgical procedure to include excision biopsy (elliptical and cyst removal)	5 (71%)
Local anesthetic to include topical, local infiltration, eye and digital nerve block	7 (100%)
Instillation of Fluorescein	7 (100%)
Removal of corneal or conjunctival foreign body	7 (100%)
Application of eye patch	7 (100%)
Removal of cerumen	6 (86%)
Removal of foreign body from ear	7 (100%)
Anterior nasal packing	7 (100%)
Removal of foreign body from nose	7 (100%)
Nasogastric tube insertion	4 (57%)
Performing pap smear	4 (57%)
Conducting bi-manual pelvic exam	6 (86%)
Provide assistance in normal vaginal delivery	3 (43%)
Splinting of injured extremities	7 (100%)
Application of sling – upper extremity	7 (100%)
Assist in the application of simple casts	7 (100%)
Airway management to include basic and advanced techniques	5 (71%)
Cardiac resuscitation to include cardiac pacing and defibrillation	5 (71%)
Prepare and perform an intramuscular injection	5 (71%)
Prepare and perform a subcutaneous injection	5 (71%)
Prepare and perform an intradermal injection	5 (71%)
Perform a venipuncture	4 (57%)
Prepare and obtain a peripheral intravenous line	4 (57%)
Perform a finger stick blood glucose test	4 (57%)
Obtain nasopharyngeal swab	7 (100%)
Manage nebulizer treatment	4 (57%)
Perform peak flow	2 (29%)

Table 2 demonstrates areas of improvement/suggestions for growth that Winnipeg PAs in UCs have identified throughout their experiences.

Table 2. Self-identified areas of growth for PAs working in Winnipeg UCs via questionnaire interview (Seven Oaks General Hospital and Victoria General Hospital). N=7. Interview question posed was, “In your experience, what areas of growth/opportunities do you think there could be for PAs in UCs? Please select all/any that apply.”

Areas of Growth	Number (and Percentage) of PAs Interviewed in Wpg UCs that Identified Need for Growth/Opportunities
More autonomy/less review with physicians	4 (57%)
More expertise/learning with POCUS	5 (71%)
Casting	4 (57%)
Minor treatments	3 (43%)
Involvement/leadership in invasive airway management	4 (57%)
Involvement/leadership of acute ACS management, including Mis*	4 (57%)
Management of CTAS 1 and CTAS 2 patients	6 (86%)
Suturing skills	3 (43%)
CPR, ACLS, ATLS learning/leadership and implementation of skills in UCs	5 (71%)
Chronic disease exacerbation management	3 (43%)
Other	2 (29%)

*Due to error in question, response may not be accurate.

Questionnaire Results Summary:

A full questionnaire with results is included in the appendix. In this summary, only the most relevant questions/answers were included, with lesser relevant questions omitted (but included in the appendix).

In the experience of the seven PAs in Winnipeg UCs who completed the questionnaire, the following results were found (of note, three of the seven interviewed PAs were new graduates):

Question 1: What CTAS scores can PAs most effectively manage in Urgent Cares?

43% responded that CTAS 3 and below were the CTAS levels that PAs can most effectively manage in UCs. 29% responded CTAS 2 and below, and another 29% responded CTAS 1 and below.

Question 2: What types of patients do you think PAs can best manage?

71% responded that PAs can best manage all patients, including acutely ill requiring emergent intervention.

Question 3: How many patients can be seen on average per hour by a PA?

86% responded that PAs can see equal to or less than three patients per hour.

Question 4: Are PAs able to see similar numbers of patients in the same time frame (hourly) as other team members (physicians, nurse practitioners if applicable)?

57% responded yes, while 43% responded unsure.

Question 5: Why might PAs see less patients than other care providers in the same time period (physicians, nurse practitioners)? (Numbers are low as only answers of “No” and “Unsure” from Question 4 were asked to respond to Question 5, with one “Yes” participant incorrectly responding as well):

100% of PAs who responded “No” or “Unsure” to Question 4 reported PAs have to review with a physician after the assessment, adding time. (One respondent who replied “Yes” to Question 4 also responded to Question 5).

One respondent answered this question twice and added that PAs take a more thorough approach to history and physical, adding time.

Question 6: How often do PAs interact/review with their collaborating physicians for support/guidance with treatment and management decisions?

43% reported every patient encounter, while another 43% reported multiple times per shift (less than every second patient). *Of note, three PAs included in this study are new graduates.

all of which reported reviewing with a collaborating physician for every patient encounter. More experienced PAs reported multiple times per shift (less frequent than every second patient).

Question 11: In the United States, there are many Post-Graduate Physician Assistant Residency Programs, including those in Emergency medicine, Primary Care, Critical Care and Trauma etc. Would similar programs be of benefit to PAs in UCs in Winnipeg?

83% of PAs responded yes.

Question 12: If “Yes” or “Unsure” to the above, in your experience which Post Graduate Physician Assistant Residency Program(s) would be most beneficial for PAs working in Urgent Cares? All of the below are actual residency programs offered in the United States. Please select any/all that apply.

57% responded that an Emergency Residency program would be beneficial, while 43% responded that all/any residency programs would be beneficial to the work of PAs in UCs.

Discussion

American UCs are recommended by the Urgent Care Association of America to meet the following criteria/services: evaluation of a broad range of illnesses, delivery of care to all ages, walk-in basis care, open seven days a week, having x-ray and phlebotomy services on site, at least two exam rooms, and offer EKG, oral, intravenous, and/or intramuscular medicine delivery, and minor procedures including suturing for minor lacerations, incision and drainage of abscess and splinting (6). Further, the literature shows the roles and ways in which PAs have

been incorporated into UCs, particularly in American UCs. There is variation between sites, however, in general, PAs are expected to perform physical assessments, order and interpret diagnostic studies, do minor treatments/procedures, and appropriately manage patients while collaborating with an interdisciplinary team (6). One study shows the distribution of patients by diagnosis seen by American PAs in UCs, as shown in Figure 1 (7). The article includes data showing the following top five distribution percentages: upper respiratory tract infections (17%), musculoskeletal disorders (10%), back pain (9%), GI disorders (5%), and lacerations (4%) (7). These data show that American PAs manage a spectrum of patient complaints, which directly speaks to the ability and skill of PAs to properly manage and work up a multitude of complaints. Comparatively, the data in Figure 2 show the distribution of patients seen by PAs in UCs in Winnipeg. Although direct comparisons cannot be accurately made to the American data in Figure 1, it is worthwhile to note similarities and differences. The Winnipeg UC data (Figure 2) shows that PAs in UCs see orthopedic complaints most commonly (20%), then gastrointestinal (15%), skin (13%), cardiovascular (11%), and respiratory complaints were the fifth most common complaint seen by PAs (9%). Upper respiratory tract infection complaints were the number one presenting complaint that PAs in the American UC saw at 17%, while it was orthopedic complaints at 20% in Winnipeg UC. There are many reasons why this may be the case, including location of UC, proximity to an ER, ambulance service, and imaging/diagnostic capabilities – all which may influence a patient's decision to present to care at a particular centre. Considering the distribution of complaints listed in the American data, it seems some UCs in the United States may use PAs for less severely ill patients, minor treatments/procedures, and more common complaints (7). Though, the literature is limited, and this may not be the case. It is of note that it appears Winnipeg based PAs are being used to the same capacity as American PAs, and perhaps even more.

Additionally, Figure 3 shows PAs in Winnipeg UCs see majority of patients with CTAS scores of 3 (40%), 4 (35%), 5 (17%) and rarely 1 (0.07%) and 2 (8%). In the Questionnaire Interview, it was reported in Question 1 that 43% of PAs in UCs believe PAs can most effectively manage CTAS level 3 and below, 29% responded CTAS 2 and below, and another 29% responded CTAS 1 and below. It is important to note that included in the study were three newly graduated PAs, and 4 experienced PAs. This may be reflected in the results; however, these numbers align with the Winnipeg data set as CTAS level 3 being the majority of who a PA will manage. CTAS 3 patients are common in EDs and UCs, so perhaps this also contributes to the distribution seen by a PA (8).

As UCs develop into a specialty of its own in Canada, PAs continue to effectively integrate their skillsets and scopes into these departments (6). Table 1 and Table 2 show questionnaire interview results from the seven PAs in UCs in Winnipeg who responded out of a total of eight PAs who work in Winnipeg UCs, all of whom were contacted. The sample size is small, introducing concern for accurate representation of PAs in UCs in general, however the results represent 87.5% of all PAs working in Winnipeg UCs. Although it appears that despite being a relatively new profession in an equally new specialty in Manitoba, PAs in UCs are being

used effectively, and their scope is broad. However, it is important to name the areas of desired growth and expansion. Table 1 demonstrates which skills PAs identify as experts in as outlined by the Can-MEDS PA competencies (supported by the Canadian Association of Physician Assistants and the College of Physicians and Surgeons of Manitoba) (9). The noteworthy areas where fewer PAs expressed confidence in expert management (after omitting the procedures/skills that were less relevant to UCs/PAs) were: cryotherapy (57%), release subungual hematoma (57%), minor surgical procedure to include excision biopsy (elliptical and cyst removal) (71%), airway management to include basic and advanced techniques (71%), cardiac resuscitation to include cardiac pacing and defibrillation (71%), prepare and perform intramuscular, subcutaneous, and intradermal injections (71%), manage nebulizer treatment (57%), and perform peak flow (29%). When further asked about areas of improvement/growth, management of CTAS 1 and CTAS 2 patients was identified as the number one area of potential growth (86%). CPR, ACLS, ATLS learning/leadership and implementation of skills in UCs was identified by 71% of PAs involved in the questionnaire, and more expertise/learning with point of care ultrasound (71%). It is clear that the scope of PAs in urgent cares is vast, and also has room for growth.

This research does not extensively look at the methods in which PA integration into UCs can be facilitated. However, Post-Graduate PA residency programs are offered in the United States, which are not available in Manitoba. Question 11 results show that 86% of the PAs interviewed would view residency opportunities as beneficial for PAs to improve their practice in Winnipeg UCs. Question 12 shows that in specific, emergency residency programs (57%) may be most beneficial, with 43% of PAs replying that all/any residency programs mentioned could be of benefit to the work of PAs in UCs.

Lastly, despite the limitations of the anecdotal and qualitative nature of the questionnaire interview data, respondents noted ways to help integrate and expand the role of PAs in UCs. A clinical resource PA in UC and ERs on a regional or hospital level may help implement residency programs, organize and facilitate continuing education, regulate and review the practice of PAs in certain specialities, and provide a closed loop feedback system in which concerns/opportunities could be addressed.

Conclusion

As physician assistants continue to be integrated into Canadian healthcare, both the specialties in which they serve and the patients they care for benefit from the PA role (10).

As is shown in the literature, it's important to first understand the scope of an urgent care, and subsequently the scope of a PA before they can be successfully integrated (11). UCs improve accessibility to quality and timely care. This is especially true if they are staffed with PAs whose scope of practice is congruent with the services UCs offer (7). PAs in UCs provide a multitude of benefits from many perspectives, including quality management of a variety of

health conditions and a broad scope of procedures/treatment skills (5). This study focused on what types of services/care PAs provide UCs. It can also be concluded that despite the successful integration of PAs in both Canadian and American UCs, there are significant areas of growth for this profession in this specialty, which perhaps can be mediated by incorporating furthered learning opportunities/programs. In addition, there is little Canadian research on PAs in UCs, making it an area for future study. PAs are key to the future of healthcare in Manitoba when it comes to providing efficient, economical and accessible health care services, especially in specialties such as urgent care. This profession continues to integrate well into the evolving health care system, and it is of immense value to understand the value and scope of practice of PAs so that we can identify areas of growth to better serve our healthcare system, communities, and economy.

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Appendix

Capstone Questionnaire – PAs in Urgent Care

PA Student: Jana Charlo

Mentor: Chris Barnes, PA

1. In your experience, what CTAS scores can PAs most effectively manage in Urgent Cares?

- a) CTAS 1 and below - **2**
- b) CTAS 2 and below - **2**
- c) CTAS 3 and below - **3**
- d) CTAS 4 and below
- e) CTAS 5

Comments:

2. In your experience, what types of patients do you think PAs can best manage?

- a) All - **5**
- b) Acutely ill, requiring emergent intervention - **1**
- c) Moderately ill, requiring urgent intervention - **3**
- d) Mildly ill, requiring elective intervention - **2**
- e) Chronic disease management - **1**
- f) Minor treatments/procedures - **2**
- g) Other, please specify: _____

Comments:

3. In your experience, how many patients can be seen on average per hour by a PA?

- a) 1
- b) < or equal to 3 - **6**
- c) < or equal to 4
- d) < or equal to 5 - **1**
- e) < or equal to 6
- f) >6

Comments:

4. In your experience, are PAs able to see similar numbers of patients in the same time frame (hourly) as other team members (physicians, nurse practitioners if applicable)?
- a) Yes - **4**
 - b) No
 - c) Unsure - **3**

Comments:

5. If you answered “No” or “Unsure” to the above question, why might PAs see less patients than other care providers in the same time period (physicians, nurse practitioners)?
- a) PAs often see more time intensive patients, (i.e. chronic disease management)
 - b) PAs take a more thorough approach to history and physical, adding time - **1**
 - c) PAs have to review with a physician after the assessment, adding time - **3**
 - d) PAs do not have the same skills/knowledge as other care providers, adding time
 - e) PAs are a relatively new profession and are not yet integrated efficiently
 - f) Other (please explain): _____

Comments:

6. In your experience, how often do PAs interact/review with their collaborating physicians for support/guidance with treatment and management decisions?
- a) Every patient encounter - **3**
 - b) Every second patient encounter
 - c) Multiple times per shift (less frequent than every second patient) - **3**
 - d) Once per shift - **1**
 - e) Do not interact/review with a physician during an average shift
 - f) Other: _____

Comments:

7. In your experience, how many collaborating physicians do PAs in UCs generally work with?
- a) 1
 - b) 2

- c) 3
- d) 4
- e) 5 or more - **7**

Comments:

8. In your experience, what areas of growth/opportunities do you think there could be for PAs in UCs? Please select all/any that apply:
- a) More autonomy/less review with physicians - **4**
 - b) More expertise/learning with POCUS - **5**
 - c) Casting - **4**
 - d) Minor treatments - **3**
 - e) Involvement/leadership in invasive airway management - **4**
 - f) Involvement/leadership of acute ACS management, including Mis - **4**
 - g) Management of CTAS 1 and CTAS 2 patients - **6**
 - h) Suturing skills – **3**
 - i) CPR, ACLS, ATLS learning/leadership and implementation of skills in UCs - **5**
 - j) Chronic disease exacerbation management - **3**
 - k) Other, please specify: _____ - **3**

Comments:

Other: The biggest and most important area for growth and opportunity is the development of a clinical resource PA either for the individual regions or hospitals to help coordinate and facilitate continuing education and learner experience.

9. The CanMEDS-PA states that PAs are expected to demonstrate “effective, appropriate and timely performance of diagnostic and therapeutic procedures relevant to patient care” (CanMEDS-PA Medical Expert 5 – 5.1.12). In your experience, which procedures do PAs in UCs manage expertly. Please select all/any that apply:
- a) Abscess incision and drainage - **7**
 - b) Insertion of simple suturing - **7**
 - c) Laceration (simple) repair; suture and gluing - **7**
 - d) Cryotherapy of skin lesions, skin scraping for fungus determination - **4**
 - e) Release subungual hematoma - **4**
 - f) Removal of a foreign body from skin e.g. Fish hook, splinter, or glass - **7**
 - g) Superficial and partial-thickness burn care - **7**
 - h) Minor surgical procedure to include excision biopsy (elliptical and cyst removal) - **5**
 - i) Local anesthetic to include topical, local infiltration, eye and digital nerve block - **7**

- j) Instillation of Fluorescein - **7**
- k) Removal of corneal or conjunctival foreign body - **7**
- l) Application of eye patch - **7**
- m) Removal of cerumen - **6**
- n) Removal of foreign body from ear - **7**
- o) Anterior nasal packing - **7**
- p) Removal of foreign body from nose - **7**
- q) Nasogastric tube insertion - **4**
- r) Performing pap smear - **4**
- s) Conducting bi-manual pelvic exam - **6**
- t) Provide assistance in normal vaginal delivery - **3**
- u) Splinting of injured extremities - **7**
- v) Application of sling – upper extremity - **7**
- w) Assist in the application of simple casts - **7**
- x) Airway management to include basic and advanced techniques - **5**
- y) Cardiac resuscitation to include cardiac pacing and defibrillation - **5**
- z) Prepare and perform an intramuscular injection - **5**
- aa) Prepare and perform a subcutaneous injection - **5**
- bb) Prepare and perform an intradermal injection - **5**
- cc) Perform a venipuncture - **4**
- dd) Prepare and obtain a peripheral intravenous line - **4**
- ee) Perform a finger stick blood glucose test - **4**
- ff) Obtain nasopharyngeal swab - **7**
- gg) Manage nebulizer treatment - **4**
- hh) Perform peak flow - **2**
- ii) Other (please specify): _____ - **2**

Comments:

Other: suturing complexes lacerations, joints dislocations, casting, fracture reduction, chest tubes, pleura and thoracentesis

10. Can you identify any current obstacles or limitations to more fully incorporating PAs into UCs? If so, please explain. Examples might be: limited opportunities for specialized training (POCUS, casting, suturing skills, etc.), limited support of the PA role, etc.

Comments: need ability to qualify to participate in ATLS, cost barriers to ultrasound courses/advanced educational opportunities. Need the time off to have time for learning, seldom do with current rotations and department obligations.

Comments: Physician compliance/approval and supervision

Comments: Emerg program would benefit integration

Comments: Current obstacles is not all hospitals have Pas in their emergency departments, and some emergency departments PAs more so at the Grace hospital they are only to used in MTA area, which is totally different than Seven Oaks where we are used to more of our potential, example managing any case that comes in the door, and we are not only their to see patients of low acuity. Something that I think if ER docs have never worked with PAs they do not the extent our or knowledge base or capabilities.

Comments: The biggest limiting factor is the will of the regions or individual ERs having a desire or seeing the value in having PAs as part of their teams. The second biggest are financial/funding barriers. Skills are not an obstacle or barrier to fully incorporating PAs into UCs. Clinical resource PAs would help with this.

11. In the United States, there are many Post-Graduate Physician Assistant Residency Programs, including those in Emergency medicine, Primary Care, Critical Care and Trauma etc. Would similar programs be of benefit to PAs in UCs in Winnipeg?

- a) Yes - **6**
- b) No
- c) Unsure - **1**

Comments:

12. If “Yes” or “Unsure” to the above, in your experience which Post Graduate Physician Assistant Residency Program(s) would be most beneficial for PAs working in Urgent Cares? All of the below are actual residency programs offered in the United States. Please select any/all that apply.

- a) Urgent Care Residency - **1**
- b) Emergency Residency - **4**
- c) Family Practice Residency
- d) Acute Care and Trauma Residency - **2**
- e) Psychiatry Residency
- f) Internal Medicine Residency
- g) Cardiology Residency - **1**
- h) All/any of the above would be beneficial to the work of PAs in UCs - **3**

Comments:

13. In your experience, are PAs adequately trained/prepared to handle the current demands in Urgent Cares during this Covid19 Pandemic?

a) Yes - 7

b) No

c) Other (please specify): _____

Comments:

14. Do you have any other comments, concerns, or feedback regarding the role of physician assistants in urgent care facilities in Winnipeg?

Comments:

Comments: need leadership and better cohesiveness for PAs working within this discipline. Spread out and not often communicated together as a group from anyone within WRHA. Networking sparse as well.

Comments: There is a lot of potential for us in this setting. With the proper supervision PA's can be autonomous and greatly aid in patient flow and benefit the medical system as a whole. 7 oaks where I work has 7 PA's and from what I have seen has very promising statistics (please verify the wait times vs patient encounter numbers)

Comments: UC do limit the experience and skills sets for a newly graduated Pa.

Comments: I think as there becomes more of us in the profession and now even at Seven Oaks we have 7 full time Pas, the ER Docs really appreciate having us on. We also do overnights at the urgent care and I believe we are the only Pas that do so.

Comments: As mentioned earlier, I think that the creation of a clinical resource PA in Urgent Care and ER, either on a regional level or individual hospital level is the most pressing issue in the ER program. The second would be having a trial of PAs at St. B and HSC to determine if their teams have a gap that could be filled with a PA. Also, an ER/UC residency program is an excellent Idea and could be administered by the Regional Clinical Resource PA, supported by a Clinical Resource PA at the individual Hospitals.

Thank you very much for your time and input!