**FTE Request Evaluation Application for APP**

Office Use Only:

Application # \_\_\_\_\_\_

Date:       Requesting Department & Division:       *(Should be SOM, clinical Dept)*

TimeTrex designee/approver:       Practice manager/service line leader:

Key contact for questions:       email:       phone #:

APP type: [ ]  *NP* [ ]  *PA* [ ] *CPP* [ ] *CNM*

Type of request:  [ ]  *New* [ ]  *Vacancy* [ ]  *Status Change*

*If vacancy, credentialed name of APP vacating position:* Date of vacancy:

**Funding Source:**

Human Resources Payroll source? [ ]  *University (Faculty appt) OR* [ ]  *Health Care System*

Funding sources: SOM acct #:

Budget status: [ ]  *Budgeted &* *Approved which FY?*      [ ]  *Not Budgeted* [ ]  *Grant Funded*

FTE request: (count/number of APPs):       Department Suggested Level: 1 [ ]  2 [ ]  3 [ ]

**Clinical Activity & Billing**

**Describe roles/responsibilities.** Explain roles/responsibilities of this position. Include current work and any new patient volume. If work cannot be completed/absorbed by current staff/faculty, residents or expansion of residents please include why not.

**Funding:** How will this position be funded (Check all that apply):

|  |
| --- |
| [ ]  Independent APP wRVUs and billing  |
| Current wRVUs (annual):       | Projected wRVUs (annual):       | Revenue generated from wRVUs: $      |
| [ ]  Increase in physician wRVUs  |
| Current wRVUs (annual):       | Projected wRVUs (annual):       | Incremental revenue generated from wRVUs: $      |
| [ ]  Cost savings (*e.g.* *reduced readmissions*) |
| Describe metric affected:       |
| Current metric rating:       | Projected impact:       | Fiscal impact of change in metric: $      |
| [ ]  Grant/research funding: |  |  |
| Describe funding source:       | Length of funding guarantee:       | Amount of grant funding: $      |
| [ ]  Other (describe):       |

**Briefly describe the financial benefits to the HCS:**

**Associated units, clinics, or service lines:**       **Inpatient/outpatient/both**:       Supervising MD:

**Targeted clinical start date:**       **Targeted Med Staff Services (credentialing) application date:**

*(Based on orientation schedule)**(Must include all signed documents; minimum of 90 days prior to start date)*

**Projected breakdown of APP effort: Will the APP bill independently in their own name?** [ ]  **Yes** [ ]  **No**

|  |  |
| --- | --- |
| **Medicare Part A**Instruction and Supervision (Non-Patient Care) w/Residents       % Instruction of/Acting as Hospital Staffin Inpatient/Outpatient Setting       %Hospital Services in Hospital Based Clinic       %Case Mgmt/Pt Ed related to Hosp Activities       %Hospital Committees       % | **Medicare Part B**Direct Medical/Surgical Services toPatients (w/ or w/o residents)       %Clinical Admin (Department, ClinicSpecific and UNC P&A Committees)       %UNC School of Medicine and other University Activities       % **TOTAL\***       %  (\*both columns should add up to 100%)  |

**Key clinical performance metrics at specialty level** *i.e. how will you demonstrate success of this position* *(Check all that apply)*

|  |  |  |
| --- | --- | --- |
| **Metric** | **Current** | **Target** |
| [ ]  Improve patient access  |  |  |
| Time to third appointment |       |       |
| Patient wait time |       |       |
| Time to follow-up/discharge appointment |       |       |
| Improve throughput |       |       |
| Increase number/efficiency of discharge orders |       |       |
| [ ]  Quality and satisfaction |  |  |
| Decrease LOS |       |       |
| Readmission rate |       |       |
| Patient satisfaction |       |       |
| Other metrics (describe):       |       |       |
| [ ]  Financial |  |  |
| Increase physician productivity/revenue |       |       |
| Increase volumes/procedures (describe):       |       |       |
| Reduce cost/expense (describe):      (e.g. *reduce readmission penalty, replace higher cost provider*) |       |       |
| [ ]  Growth/strategic |  |  |
| New services (describe):       | --- | Expected Volume:       |
| New site (describe):       | --- | Expected Volume:       |
| [ ]  Provider workload/satisfaction |  |  |
| Productivity of providers |       |       |
| Provider workload |       |       |
| Provider turnover |       |       |
| Provider satisfaction |       |       |
| Time to full panel |       |       |
| Other metric (describe):       |       |       |

**Explain how/where metrics above were pulled:**

**Timeline for expected achievement of metric(s) listed above:**

**I have reviewed & approved this application, agreeing the position is clinically relevant & financially necessary.**

Chair/ACA: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

 Printed name:

Vice President**\***#1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:       **Hospital Acct #1**

 Printed name:

Vice President**\***#2: (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:       **Hospital Acct #2**

 Printed name:

**Application reviewed, approved and cleared to post position** *[ ]  Yes [ ]  No*

APP Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

*Submit Completed Application/Questions to the APP Center at:* *appcenter@unchealth.unc.edu*