WHITE PAPER

Modernizing the Role of the Advanced Practice Clinicians in Surgical Specialties

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Modernizing the Role of the Advanced Practice Clinicians in Surgical Specialties

By Jim Cavallero, PA-C, and Beth Pittman, MBA

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Historically, the role of the advanced practice clinician (APC) in surgical subspecialties has focused primarily on first assisting in the operating room, managing postoperative patients in clinic and hospital settings, placing orders, and taking call. This limited scope has often resulted in APC job dissatisfaction, underutilization of clinical skills, and missed revenue opportunities for hospitals, clinics, individual surgeons, and APCs.

In this white paper, AMGA Consulting will explore APC models in surgical specialties that enable groups to maximize provider productivity and patient access. We partnered with Jim Cavallaro, a seasoned APC leader, after seeing the levels of productivity the orthopedic APCs were achieving in his organization.

Effectively Using APCs

In our experience, we see broad use of APCs in the primary care specialty, with a median work RVU (wRVU) productivity of 4,719. It has become common for APCs in primary care to practice with an independent schedule and bill those encounters as the rendering provider. However, the surgical specialties' median wRVU productivity is 33% of primary care specialties, at 1,557 wRVUs. It is understood that APCs in surgical specialties can work in a care team model that ultimately makes the surgeon more efficient, but APCs can succeed beyond this approach. Here, we will evaluate clinical role design and complementary compensation strategies for APCs in surgical practices that incentivize individual production levels and drive program growth.

Just as the training and capabilities of physician assistants and nurse practitioners have expanded, we are seeing similar expansion of APC utilization and compensation in surgical subspecialties. When APCs are trained and deployed to work at the top of their license, organizations benefit from improved job satisfaction, higher-quality team-based care, and increased operational and financial performance.

Effective utilization begins with the intentional hiring of APCs who are motivated to pursue advanced clinical training, similar to a medical/surgical fellowship model. Equally important are surgeons who are willing to invest in that development and adopt a long-term, team-based approach to care delivery.

Defining Clinical Roles

Designing the clinical role around a patient-centered approach is the essential first step, one that prioritizes patient access, and, in turn, drives growth of specialty programs. This approach requires a high degree of collaboration with surgeons to ensue their needs served by the traditional "extender" model continue to be met. Consideration for when an APC is the clinically appropriate resource should be scrutinized with other clinical team members participating in the redistribution of tasks. An example would be operating room (OR)

first assisting, evaluating when an APC provides meaningful value—such as surgeons operating in a swing-room environment or procedures requiring graft harvesting or true co-surgeon functionality. Cases that do not meet this higher-level criteria may be clinically appropriate to staff with surgical technicians.

When APCs run an independent parallel vs. duplicative office schedule, there is a greater number of patient visits in total, as depicted in this example:

Scenario 1: Parallel clinics for APC and surgeon. Each provider will see their own full schedule of visits.

	APC	Surgeon	Total
Visits	35	35	70

Scenario 2: Duplicative clinic with APC extending. The APC will assist the surgeon in their office schedule so the surgeon can complete 25% more visits than they could alone.

	APC	Surgeon	Total
Visits	0	44	44

In scenario 1 with parallel clinics, the APC and surgeon collectively complete 26 additional visits, a 59% volume increase. Beyond the gains for patient access and office visit revenue, surgical yield is an opportunity. To be conservative, we will assume a 10% surgical yield, and the additional 26 visits could drive an additional two-to-three surgical cases to the surgeon.

In this example, utilizing orthopedics as the surgical specialty, the surgeon will see an estimated loss of office visit wRVUs, approximately 14.40 wRVUs from a nine-visit reduction at 1.6 wRVUs per visit. The increased surgical yield, however, would drive an additional 34.5 wRVUs from three additional surgeries, at 11.5 wRVUs per case. Ultimately, from one day in the clinic, a surgeon could see an increase of 20.1 wRVUs, and at median compensation per wRVU for an orthopedic surgeon of $78.25, this model could drive an incremental $1,573 in clinical compensation to the surgeon. While a surgeon may initially hesitate to embrace a new APC model, they will quickly see their practice grow with an ultimately positive impact on their income.

Aligning the Compensation Model

With a clearly defined clinical role in place, the next step is designing an aligned compensation model to ensure successful implementation. A compensation model should not drive the clinical role; it is critical to do the difficult work of role definition first. Compensation models that drive growth and ownership of practice are not traditional staff-level salary models. The three compensation models below have proven effective in supporting top-of-license APC practice while maintaining flexibility for surgical departments and maximizing efficiency and profitability.

1. Pure Productivity Model

In the pure productivity model, APCs are compensated entirely on a productivity basis (e.g., compensation per wRVU). This model is best suited for APCs practicing independently in clinic or hospital-based settings.

Under this approach, APCs primarily evaluate new and follow-up patients, with limited postoperative visits. Surgical candidates are appropriately triaged to surgeons, while APCs manage nonsurgical conditions referred by surgical colleagues. This model ensures that the right provider performs the right work at the right time, improving access to care, increasing clinic throughput, allowing surgeons to focus on operative cases, and driving growth in surgical and nonsurgical volumes. A well-trained APC can also be utilized to see patients who are likely to be surgical; have the same discussions regarding risks, benefits, and anticipated recovery time that they would have with surgeon; and then pass on to the appropriate surgeon in the practice. This approach allows the patient to hear this critical discussion multiple times, prior to consenting for surgery.

2. Mixed Salary/Productivity Model

In the mixed model, APCs spend the majority of their time in the clinic, with one to two days per week dedicated to first assisting in the operating room. While it is generally more cost-effective to staff first-assist

roles with noncredentialed providers, such as surgical technicians, there are select scenarios in which APC involvement adds meaningful value.

In this model, APCs can be compensated based on wRVU productivity for clinical work, supplemented by a fixed daily stipend for operating room time. Any wRVUs from first assisting would not be credited to the APC for productivity incentive in this model. Another option is a salary with a wRVU threshold, with an incentive for wRVUs achieved beyond the threshold. Although the incremental efficiency gains to the surgeon may be difficult to quantify, this model can be effective when applied strategically and aligned with procedural complexity and operational needs.

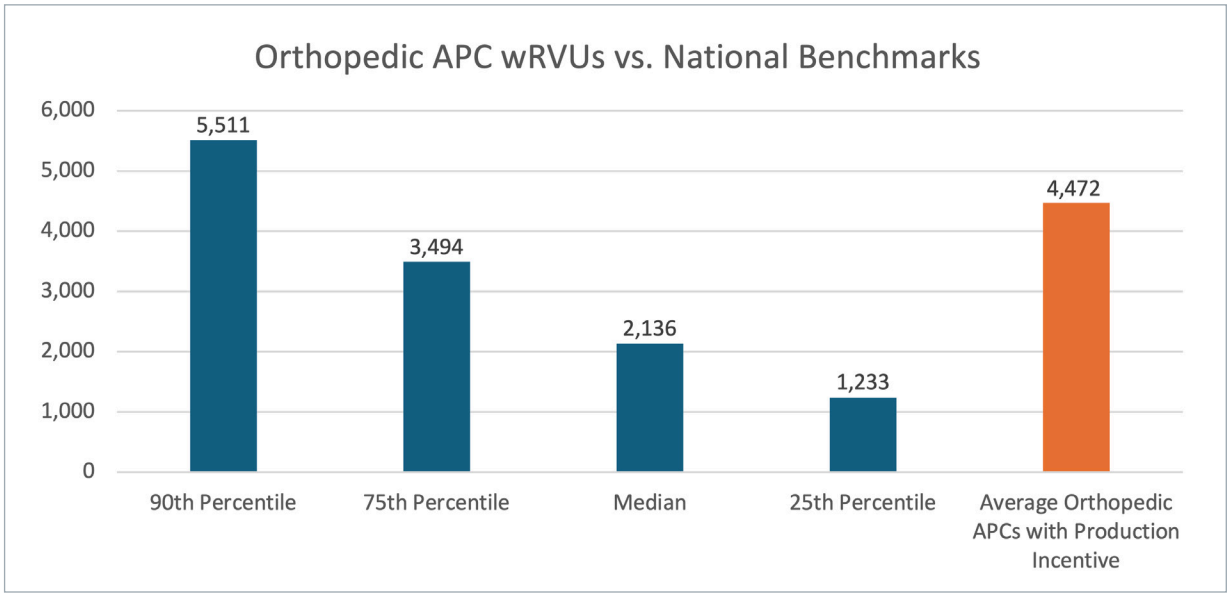
3. Pure Salary Model

The pure salary model should be used sparingly, but it is appropriate in situations where APCs have limited control over their schedules and primarily support surgeon and departmental efficiency, rather than individual productivity.

This model is most commonly required in large inpatient surgical services with high census and consultation volume, such as orthopedic trauma units. In these settings, teams of APCs manage inpatient rounding, postoperative care, and floor consultations. Compensation should be benchmarked to ensure it is market competitive and reflects call responsibilities, shift length, and overnight or weekend coverage requirements.

Productivity Impact

The results of mapping APCs to a defined clinical role, and thus a compensation model that maximizes patient access and productivity in an orthopedic practice, are demonstrated in the chart below.



This graph demonstrates the growth potential of surgical APCs. In this example, APCs are outperforming the national median by 2,336 wRVUs, driving incremental revenue for office visits and growth of specialty programs with surgical yield capture.

Multiple compensation models have a place in surgical specialties, and the right approach will depend on the unique structure and goals of each program. We recommend working alongside your team to tailor

a strategy that will maximize program growth and designing a provider compensation plan to support it—one that ultimately aligns incentives for both surgeons and APCs. The provider landscape continues to evolve; per the *AMGA 2025 Medical Group Clinic Staffing Survey*, APCs now comprise 44% of the providers nationally. As APCs move from a minority to a substantial share of the workforce, it is a strategic imperative to evaluate the roles of APCs and how compensation design impacts the outcomes.

Next Steps

If your organization is navigating questions about how to structure, deploy, or compensate surgical APCs—whether you're building a program from the ground up or rethinking an existing model—we welcome the conversation. AMGA Consulting works alongside medical groups and health systems to develop customized strategies that reflect your unique culture, specialty mix, and operational goals. Reach out to us at info@amgaconsulting.com to learn how we can help you find the way forward.

Jim Cavallaro, PA-C, is medical director, Orthopedic Advanced Practice Clinicians, TRIA Orthopedics, Orthopedic APC Fellowship Director, TRIA, HealthPartners & Park Nicollet.

Beth Pittman, MBA, is a senior director with AMGA Consulting, bringing over 20 years of healthcare leadership experience spanning hospital systems and integrated medical groups. Most recently, she served as the Chief Operating Officer of a multispecialty medical group where she led initiatives in operations optimization, daily management systems, provider alignment, and process improvement.

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AMGA | One Prince Street, Alexandria, VA 22314-3318
Phone: 703.838.0033 | Fax: 703.548.1890 | amgaconsulting.com