Building the Business Case: Demonstrating Return on Investment for APP Fellowship Program

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July 2026

Learning Objectives

1. Identify and quantify the direct, hidden, and opportunity costs associated with APP vacancies, turnover, and traditional onboarding.

2. Compare and contrast metrics and funding strategies across community health centers, private practice, and academic medical centers.

3. Estimate the financial return of an APP fellowship program by applying a break-even calculator with setting-specific inputs — including vacancy costs, revenue ramp, and retention savings.

4. Recognize the key principles that distinguish a system-level quality dashboard from an ROI financial dashboard and how each serves a different institutional audience.

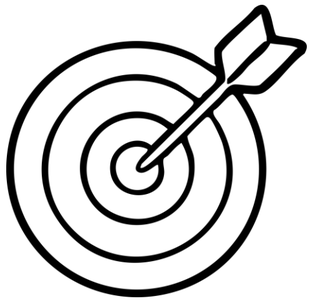
5. Recognize how competency-based training milestones and structured evaluation tools provide defensible evidence of practice readiness for institutional stakeholders.

Have you been involved in calculating the cost of an APP vacancy beyond just the recruitment line?

Have you been involved in calculating how much revenue your practice loses in the first 12 months of a new APP's ramp-up compared to a fully productive provider?

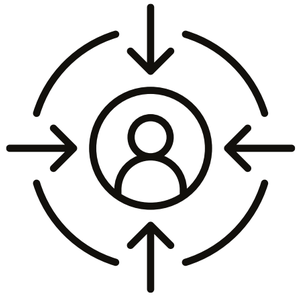
Can you tell me today what percentage of expected RVUs a new APP in your department generates in their first six months.

Not everyone in this room is working in an RVU-driven system. Everything we're going to talk about today can — and should — be adapted to reflect what value looks like in your environment.



Today’s Goal

Give you the financial concepts and tools to build YOUR ROI story.



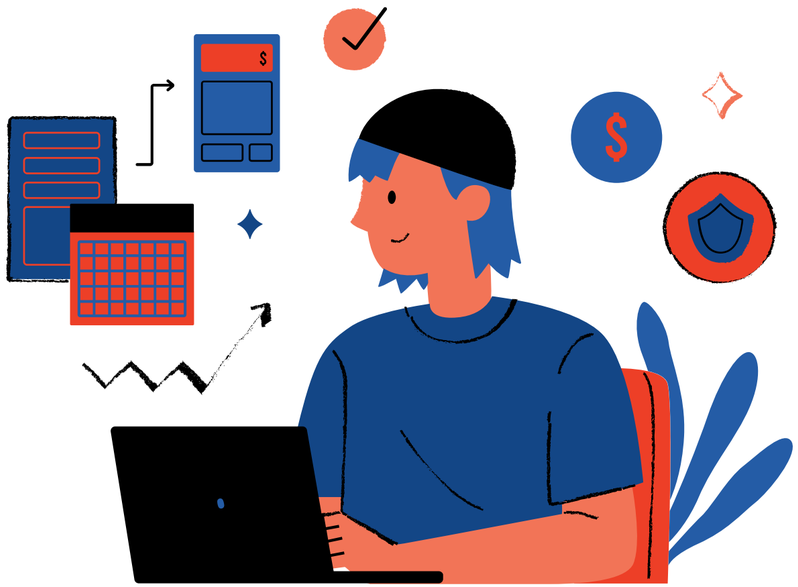
Our Approach

Two case studies, two models, different paths — same destination.

The Workforce Crisis

APP workforce is growing

NPs grew 49%, PAs grew 74% in just six years (2016-2022).



APP leaving

Nearly 1 in 3 early-career APPs leave their first practice within three years.

Turnover is unaffordable but avoidable

The direct cost of a single NP turnover episode is $86,000 to $115,000 on average.

DIMENSION	COMMUNITY HEALTH CENTER	PRIVATE PRACTICE	ACADEMIC MEDICAL CENTER
Primary mission	Access for underserved	Revenue + practice growth	Education, research, clinical excellence
Biggest pain point	Recruitment in shortage areas; turnover most disruptive	Overhead ratio; lost revenue from unfilled panels	Ramp-up time; physician time diverted to supervision
What "value" looks like	Visits/week, wait time, retention, locum avoidance	Collections, panel size, revenue/FTE	wRVUs, academic output, GME mission
Fellowship ROI language	Access + workforce stability + cost avoidance	Fastest financial ROI + billing offset	Pipeline + quality + mission alignment

Thinking like a CFO

Direct Costs

Fellows salary, benefits, liability

Why it is miscalculated

Institutions and practices ignore downstream return

See the INVESTMENT

Hidden Costs

Faculty/preceptor time, admin effort, reduced preceptor productivity

It will always look like an expense

The fellowship line item looks like an expense — until you compare it to the alternative

The True Cost of Vacant Positions

Lost revenue from unfilled panels, downstream referral loss

Cost of locum tenens
$150-250+/hr

Cost of limited clinic access
Unused capacity = unrealized revenue

Cost avoidance
The money you DON'T spend because you trained and retained

Setting specific impacts
CHC: Hundreds of patients without access
Private practice: $300k–$500k+ in lost annual collections
Academic: Physician faculty diverted from research/teaching/procedures to clinical coverage

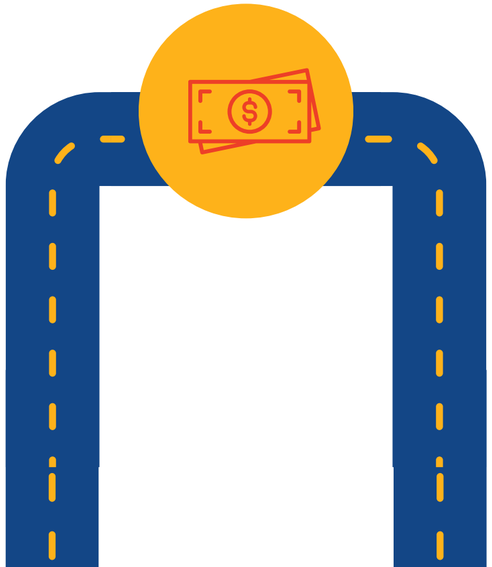
The Onboarding Data: The Strongest ROI Evidence

Without Fellowship

About 25.4 weeks to independent practice; cost ~$361,714 per APP

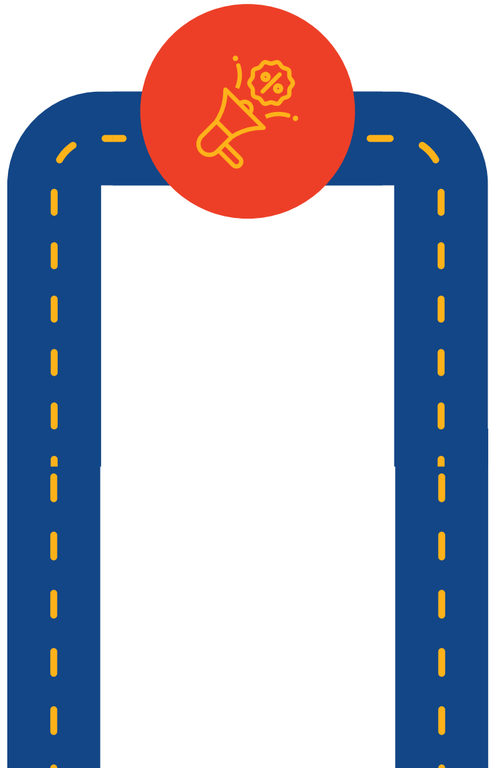
With Fellowship

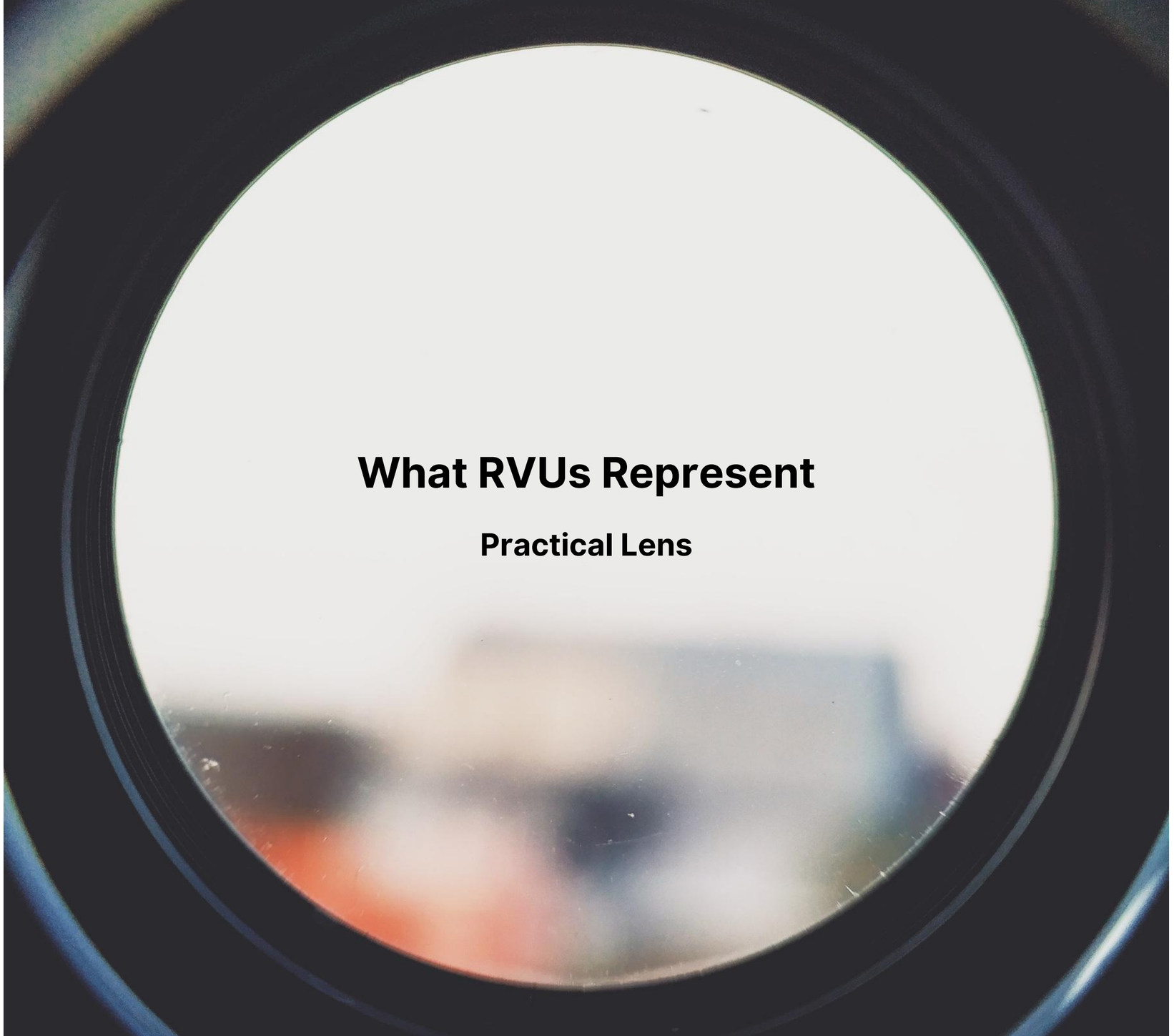
About 11 weeks to independence; cost $66-80k



Fellow Goals

Fellow reaches 100% template at 12 months vs. 18–24 months for traditional hire

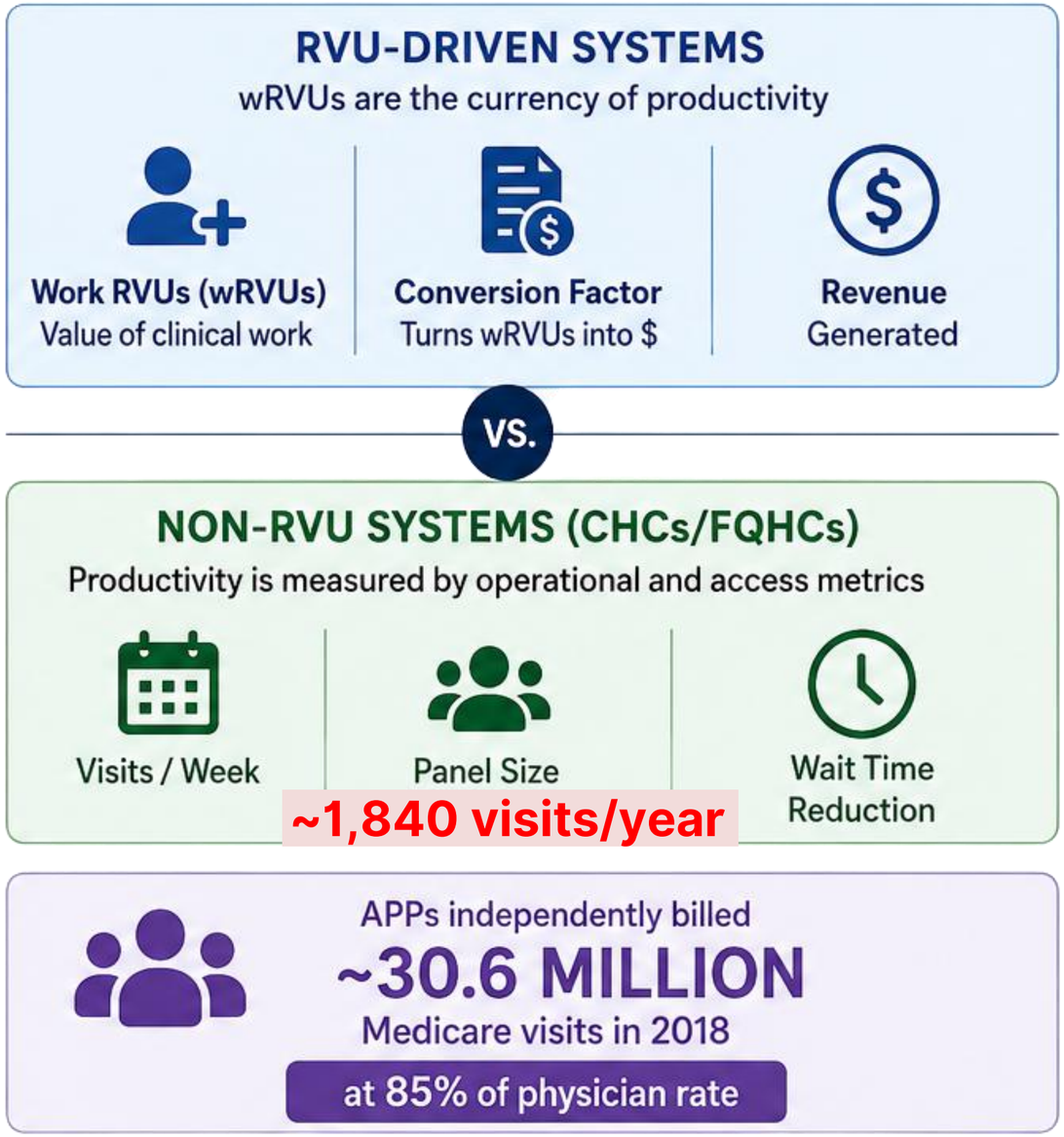




What RVUs Represent

Practical Lens

The Revenue



What separates high-performing CHCs?

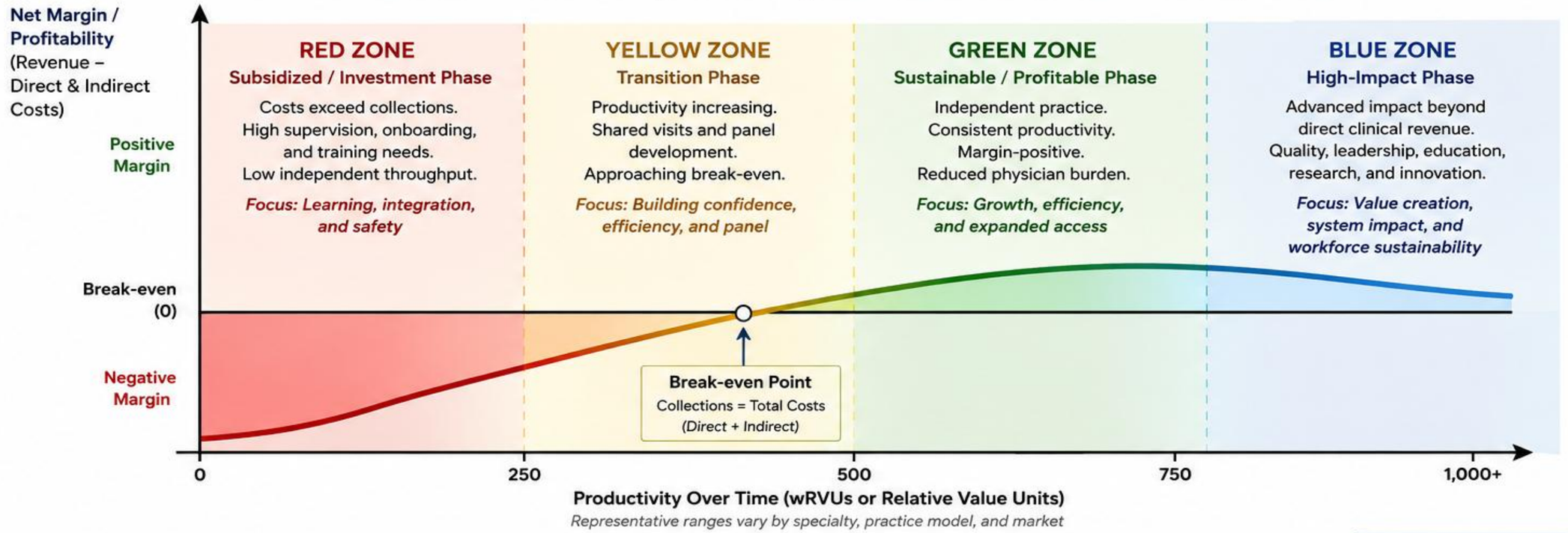
Scheduling parity

Financial incentive

Formal onboarding and training programs

The Clinician Productivity Continuum:
From Subsidized Care to Sustainable Impact

A Framework for Understanding Profitability, Value, and Impact for APPs and Physicians



Representative ranges vary by specialty, practice model, and market

RED ZONE
0 – ~250 wRVUs

- Orientation and training costs
- High supervision and support
- Lower visit volume/efficiency
- Collections < Costs

Goal: Safe onboarding and competency development

YELLOW ZONE
~250 – ~500 wRVUs

- Increasing independent visits
- Shared panels and procedures
- Improving efficiency and RVUs
- Approaching break-even

Goal: Reach productivity threshold and panel stability

GREEN ZONE
~500 – ~1,000 wRVUs

- Independent practice
- Consistent RVUs and collections
- Margin-positive
- Expanding access, reducing physician workload

Goal: Optimize care, access, and operational efficiency

BLUE ZONE
1,000+ wRVUs

- High-value activities
- Quality improvement
- Education & mentorship
- Research & innovation
- Strategic and system impact

Goal: Drive value beyond volume and sustain the workforce

KEY ENABLERS

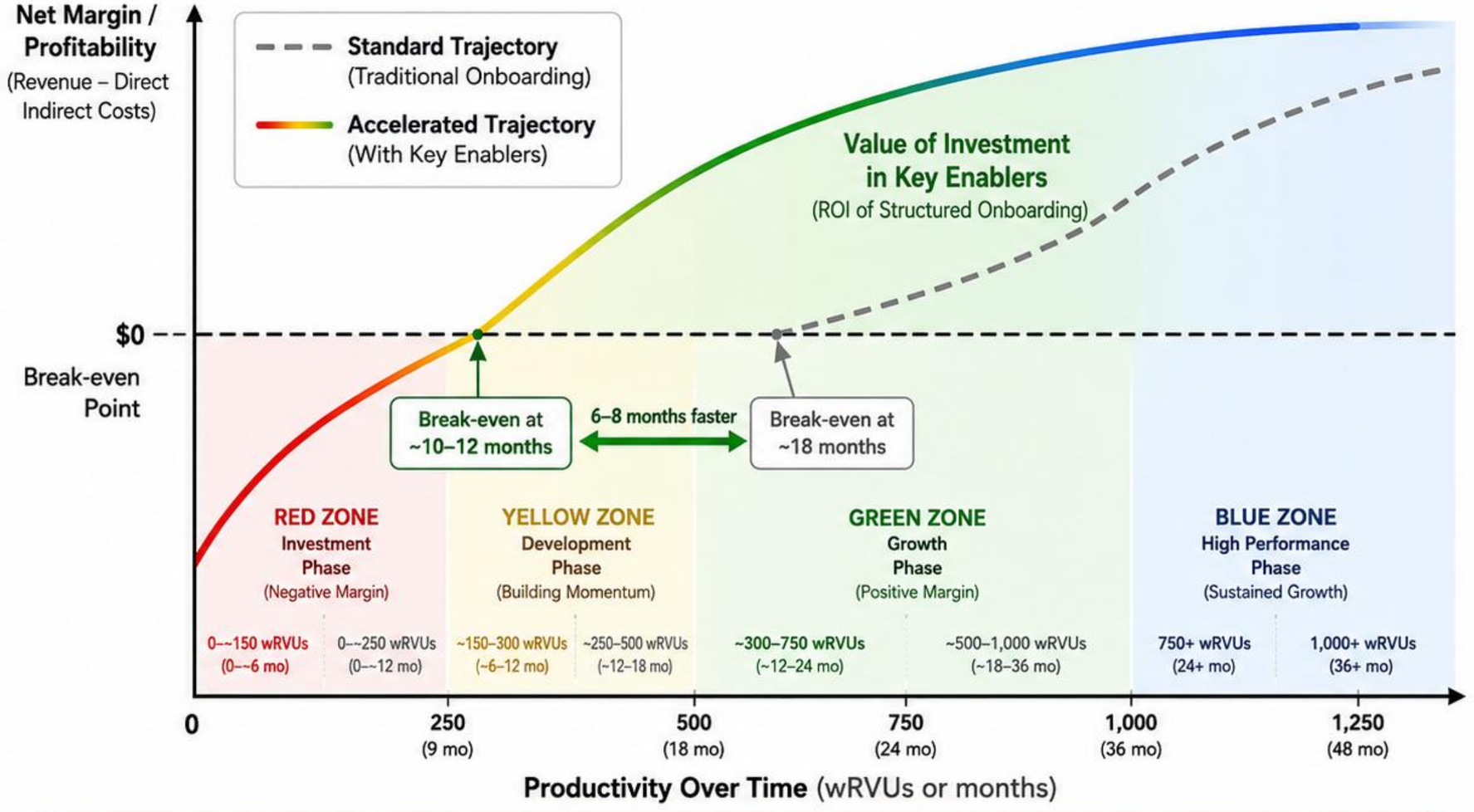
- Structured onboarding and mentorship
- Team-based care and workflow design
- Data-driven feedback and benchmarking
- Ongoing education and skill development
- Leadership support and alignment

This framework illustrates a typical trajectory. Individual performance will vary based on specialty, patient population, practice setting, and organizational factors.

APP = Advanced Practice Provider | wRVU = Work Relative Value Unit

The Impact of Key Enablers on the Clinician Productivity Continuum

Structured Investment Compresses the Red Zone and Accelerates Break-Even



KEY ENABLERS	OUTCOME / IMPACT
Structured onboarding and mentorship APP onboarding programs as short as 3–6 months have been shown to accelerate independent practice.	Accelerates ramp to independence by 6–8 months
Team-based care and workflow design Scheduling parity and workflow integration drive up to 2x productivity differences.	Up to 2x higher productivity potential
Data-driven feedback and benchmarking Real-time wRVU tracking allows early course correction.	Improves efficiency and prevents extended time in yellow zone
Ongoing education and skill development Phased competency milestones prevent stalling in the yellow zone.	Smoother progression and sustained momentum
Leadership support and alignment Internal hires who trained within the same system ramp up faster than external hires.	Faster time to break-even and higher retention

Organizations that invest in key enablers compress the red zone by up to 50%, reach break-even 6–8 months sooner, and reduce the risk of costly turnover — estimated at $500,000–$1,000,000 per physician.

Ramp-Up by Setting: Three Different Stories

COMMUNITY HEALTH CENTER / RURAL

Recruitment takes longer; onboarding is harder; turnover is most disruptive

One provider leaving can eliminate access for an entire community

Fellowship benefit:
Better retention + confidence managing complex patients without subspecialty backup

PRIVATE PRACTICE

External hire:
Recruitment fees (15–25% of salary), credentialing delays, lost revenue

Fellow:
Known entity,
most billing opportunity
during training

Redesigning APP clinics can shift daily financials from **-$1,342** to **+$1,310**

ACADEMIC MEDICAL CENTER

External hire also ramps (often underestimated), higher recruitment cost

Fellow:
Known entity,
faster cultural/clinical integration

Fellow at 100% template at **12 months** vs. **18–24 months** for external hire

APP FELLOWSHIP BREAK-EVEN TOOLKIT

Calculators & Documents for Program Directors

Calculator (Excel) | Input Sheet (PDF) | ROI Model (PDF)

1 BREAK-EVEN CALCULATOR: INPUTS

Cost Category	Your Program	Typical Range	Notes
A. Fellow stipend + benefits	$_____	$65,000 – $100,000	Varies by region and specialty
B. Program director time (FTE fraction)	$_____	$25,000 – $50,000	0.1–0.2 FTE typical
C. Preceptor productivity loss	$_____	$20,000 – $40,000	Reduced patient volume during teaching
D. Didactic/simulation/ materials	$_____	$5,000 – $15,000	Can leverage existing GME resources
E. Administrative support	$_____	$5,000 – $10,000	Coordinator time, credentialing
F. TOTAL FELLOWSHIP INVESTMENT (A+B+C+D+E)	**$_____**	**$120,000 – $215,000**	**Per fellow per year**

2 BREAK-EVEN CALCULATOR: OUTPUT

$$\text{Break-even} = \frac{\text{Total Fellowship Investment}}{\text{Total Annual Return}} \times 12 \text{ months}$$

Break-even = the point where benefits (Component 2) exceed imvestment (Component 1)

3 BREAK-EVEN: RETURNS (SAVINGS + REVENUE)

Return Category	Your Program	Typical Range	How to Calculate
G. Fellow billing revenue (during training)	$_____	$15,000 – $200,000	~50% of programs bill; track wRVUs or encounters
H. Vacancy cost avoided (per position filled)	$_____	$150,000 – $400,000	Monthly vacancy cost × months avoided
I. Locum tenens cost avoided	$_____	$50,000 – $150,000+	Locum rate × shifts that would have been covered
J. Recruitment cost avoided	$_____	$15,000 – $30,000	Recruiter fee (15–25% of salary) per hire
K. Accelerated ramp-up value	$_____	$50,000 – $150,000	Revenue difference: 11 wks vs. 25 wks to independence
L. Retention savings (avoided re-turnover)	$_____	$86,000 – $115,000	Per turnover episode avoided
M. TOTAL RETURN (G+H+I+J+K+L)	**$_____**	**$366,000 – $1,045,000+**	**Per fellow retained**

4 3-YEAR ROI MODEL (EXAMPLE)

Year	Investment	Cumulative Return (if fellow retained)	Net ROI
Year 0 (fellowship year)	-$150,000	+$40,000 (billing during training)	-$110,000
Year 1 (first year as staff)	$0	+$350,000 (avoided vacancy + full productivity)	+$240,000
Year 2	$0	+$350,000 (continued productivity + avoided re-turnover)	+$590,000
Year 3	$0	+$350,000 (continued productivity)	+$940,000

3-year net ROI: **+$940,000** per fellow retained (conservative estimate)

Each additional year of retention multiplies the return

Compare to: 3-year cost of serial external hires with 30% turnover rate


Retention Rate
Vacancy Avoidance
Billable Fellows

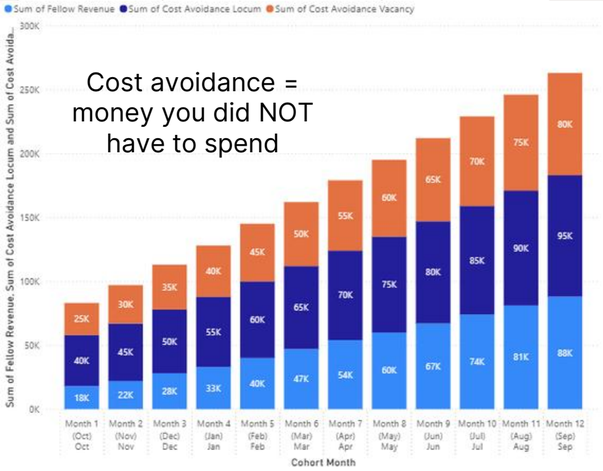

Retention Rate
Vacancy Avoidance
Billable Fellows

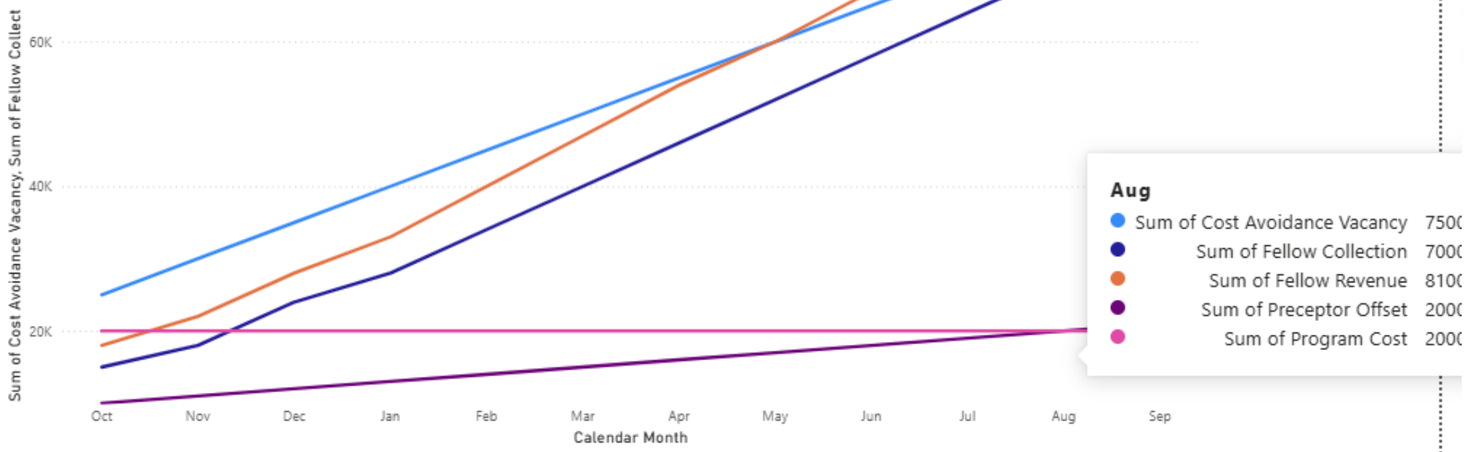
Make Yourself a Dashboard

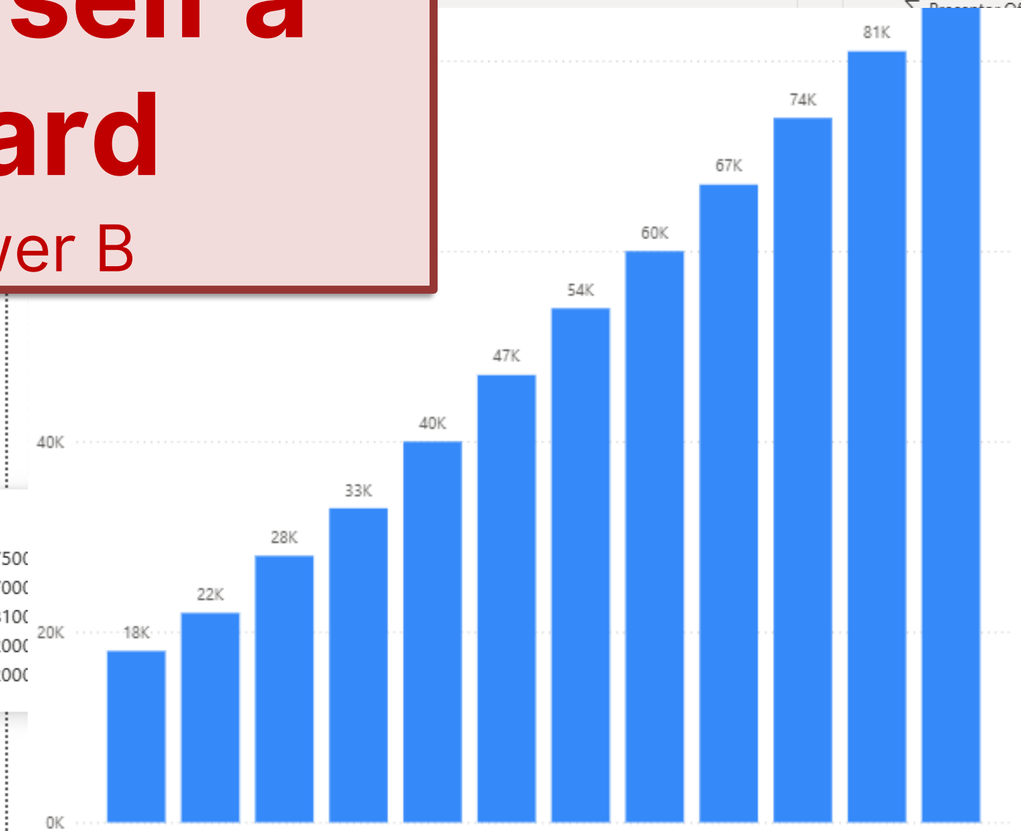
Microsoft Power B

Cohort Month	Cohort month number	Calendar Month	Fellow RVU	Fellow Revenue	Fellow Collection	Preceptor Offset	Cost Avoidance Locum	Cost Avoidance Vacancy	Program Cost	Retention Rate	Weeks to Independent Practice
Month 1 (Oct)	1	Oct	120	18000	15000	10000	40000	25000	20000	0.9	20
Month 2 (Nov)	2	Nov	150	22000	18000	11000	45000	30000	20000	0.9	19
Month 3 (Dec)	3	Dec	190	28000	24000	12000	50000	35000	20000	0.9	18
Month 4 (Jan)	4	Jan	220	33000	28000	13000	55000	40000	20000	0.9	17
Month 5 (Feb)	5	Feb	260	40000	34000	14000	60000	45000	20000	0.91	16
Month 6 (Mar)	6	Mar	300	47000	40000	15000	65000	50000	20000	0.91	15
Month 7 (Apr)	7	Apr	340	54000	46000	16000	70000	55000	20000	0.92	14
Month 8 (May)	8	May	380	60000	52000	17000	75000	60000	20000	0.92	14
Month 9 (Jun)	9	Jun	420	67000	58000	18000	80000	65000	20000	0.92	13
				74000	64000	19000	85000	70000	20000	0.93	13
				81000	70000	20000	90000	75000	20000	0.93	12
										0.93	12

Cost avoidance = money you did NOT have to spend







Data

Search

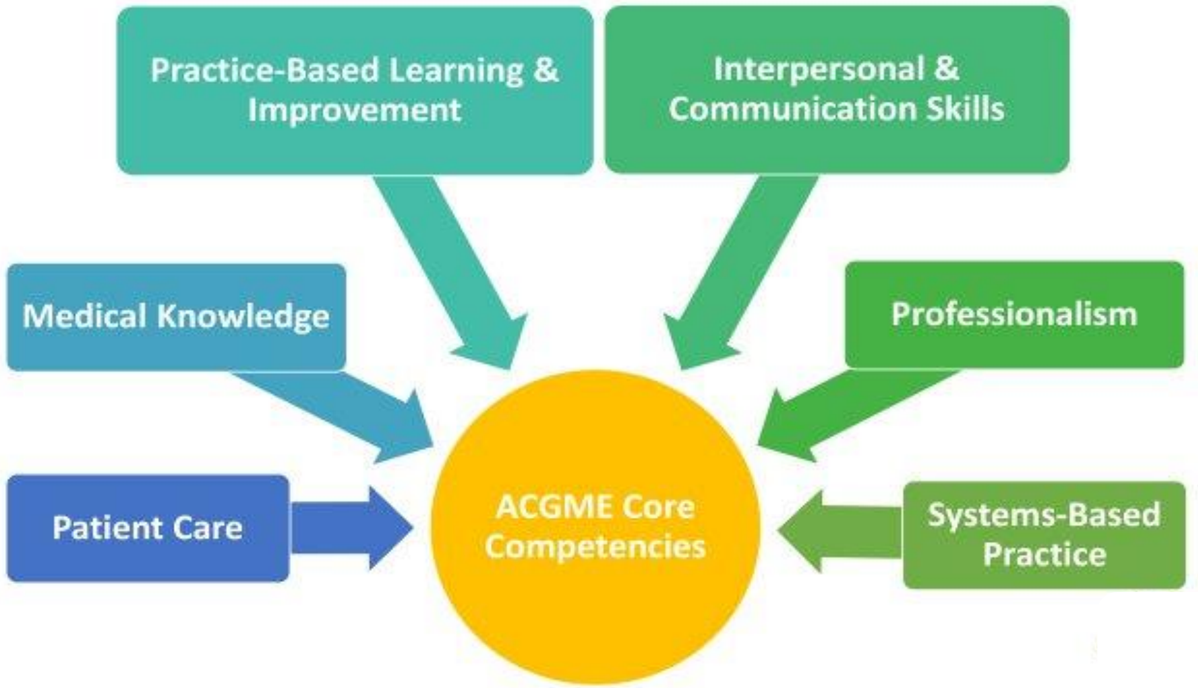
Financial ROI DataSet
Query1
Table
Calendar Month
Cohort Month
Cohort month number
Cost Avoidance Locum
Cost Avoidance Vacancy
Fellow Collection
Fellow Revenue
Fellow RVU

Quick measure

How do you know the fellow is ready for independent practice?

“We don't guess. We use a structured, milestone-based evaluation framework adapted from the ACGME competency model.”

Competencies and Evaluations



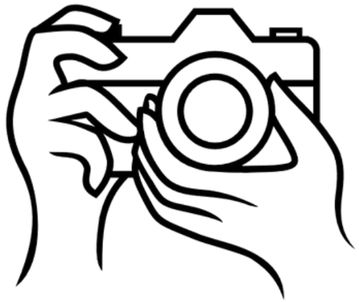
Competency Domain	Milestone	Level 1 (Beginning)	Level 2 (Developing)	Level 3 (Competent)	Level 4 (Ready for Independent Practice)
Patient Care	Conducts focused and thorough GI evaluations	Requires direct supervision; misses key elements	Completes basic H&P with some prompting	Independently performs comprehensive GI consults	Confidently manages complex cases; integrates multidisciplinary input
	Clinical decision-making in GI	Relies heavily on preceptor guidance	Beginning to identify common GI issues	Synthesizes data and formulates safe plans	Independently prioritizes and adjusts care plans
Medical Knowledge	Applies GI pathophysiology to patient care	Recalls basic concepts	Applies knowledge to common conditions	Demonstrates knowledge across GI subspecialties	Teaches peers; manages rare/complex disorders
Practice-Based Learning & Improvement	Seeks and applies feedback	Needs prompting to reflect	Accepts feedback and makes efforts to improve	Consistently integrates feedback into practice	Proactively seeks coaching; shows clear progression
	Engages in quality improvement	Passive participant	Participates in QI project	Contributes meaningfully to QI outcomes	Leads or presents QI project
Interpersonal & Communication Skills	Communicates with patients/families	Basic communication; may need redirection	Builds rapport; communicates clearly	Explains complex GI issues in lay terms	Demonstrates empathy, clarity, and cultural sensitivity
	Team communication	Inconsistent documentation or sign-out	Communicates clearly with staff	Anticipates team needs; practices closed-loop communication	Functions as a team leader or liaison
Professionalism	Accountability and reliability	Needs reminders; inconsistent follow-through	Generally reliable with supervision	Consistently dependable; manages time well	Highly reliable, proactive, models professionalism
	Response to feedback and ethics	Defensive or passive	Receives feedback with variable insight	Consistently receptive and reflective	Accepts responsibility; upholds ethical standards
Systems-Based Practice	Navigates care systems (EMR, referrals)	Needs frequent help	Uses systems with minimal supervision	Efficiently manages transitions and referrals	Streamlines care and improves clinic/ward flow
	Resource utilization and cost-awareness	Orders excessive or unnecessary tests	Developing awareness of value-based care	Orders judiciously with guidance	Champions high-value care practices

Milestone Evaluation Grid

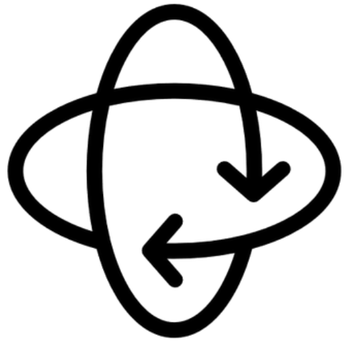
Evaluation Tools

Defensible Proof of Readiness

Mini-CEX
The Mini-CEX is a 15 minute direct observation assessment or "snapshot" of a trainee/patient interaction that focuses on the core skills that trainees demonstrate in patient encounters.



360 Evaluation
Combines feedback from supervisors, peers, and self for broader insights.



Confidence Survey
Measures learner perception of growth and alignment with objectives.

Key Takeaways

1. Fellowships are an investment, not an expense — the line item pays for itself through retention and faster productivity.

2. Onboarding with fellowship: ~11 weeks to independence ($66-80K) vs. without: ~25 weeks ($361K per APP).

3. Cost avoidance is real ROI — money you don't spend on locums ($150-250+/hr), lost revenue from vacancies ($300-500K+/yr).

4. Fellows reach 100% productivity at 12 months vs. 18-24 months for traditional hires.

5. Structured evaluation tools (milestones, competency grids) provide defensible proof of readiness and protect your investment.