CONSIDERATION OF THE ADVANCED PRACTICE PROVIDER MODEL IN THE TRAUMA SETTING

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Prior to 2013, Cleveland Clinic Hillcrest Hospital was a busy level 2 trauma center on Cleveland’s Eastside with a trauma service that was managed by trauma surgeons and house officers. The majority of patients were evaluated after motor vehicle crashes and falls. The staff trauma surgeon was required to be at a patient’s bedside within 15 minutes for level 1 activations and by phone for level 2 activations. The trauma house officer was generally a retired general surgeon who would assess trauma patients in the emergency room, manage their initial work-up, provide the necessary emergent procedures and assist in their hospital admission after discussion with the trauma surgeon. After a patient’s admission, it was the responsibility of a single rounding trauma surgeon and a bedside nurse to manage the patient’s care. With the lack of provider resources, including surgical residents or fellows, there were found to be gaps in coverage for critically ill trauma patients.

The Hillcrest trauma director felt the staffing deficiencies and lack of continuity was adversely affecting patient care. Therefore, the director proposed an Advanced Practice Provider Model whereby advanced practice providers would assume the role of the trauma house officers, and build on it by taking ownership of trauma patients. The advanced practice providers would become a team of individuals who would follow patients from their ED work-up through to their discharge. The team would provide in-house 24/7 coverage on a rotating basis to meet the needs of the patients and be immediately available for emergencies. The advanced practice provider team would handle patient phone calls and follow-up appointments. This model was found to improve continuity of care, access to patient needs and increase patient satisfaction.

The Advanced Practice Provider Model was implemented in 2013 with the hiring and training of five advanced practice providers. Under the trauma director, the new hires underwent an integrative three month long training process consisting of trauma/critical care lectures, nursing floor and critical care rounding, performance of advanced procedures and completion of ATLS certification. Once completed, the advanced practice providers were well educated, confident in their abilities and thoughtfully received by the hospital community.

The Advanced Practice Provider Model also has cost-saving benefits. The salaries originally paid to the trauma house officers were more than twice that of the advance practice providers. Therefore, more money could be put into training, community outreach and clinical tools. The ED LOS was also reviewed to have dropped by 30 minutes in 2016 as compared to 2012. Patient readmissions may also have decreased given the attention spent to discharge instructions and access to follow-up care. When considering hospital LOS, there was a slight increase in the average hospital days in 2016 at 3.94 days from 3.14 days in 2012. However, this increase could be due to a higher total volume of patients in 2016 at 2236 with 111 cases (4.97%) meeting seriously injured with an ISS score >16 as opposed to 88 cases (4.51%) in 2012 with a total patient volume of 1950.

Lastly, the Advanced Practice Provider Model in the trauma setting provides tremendous job satisfaction for the advanced practice provider. This diverse position allows for autonomy, exposure to the ED, assisting in the OR, critical care management in the ICU, performance of advanced procedures and medical management on the nursing floors and outpatient setting. The Advanced Practice Provider Model in the trauma setting provides a very unique career to those passionate about helping the injured.