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Trauma Models: Surgery PAs and NPs Increasingly Embedded in Care Teams

By Bonnie Darves

Advanced practice clinicians looking for fast-paced, clinically challenging and gratifying work, and a practice environment that typically offers ample opportunities for professional growth are likely to find both at a Level I trauma center. Physician assistants and nurse practitioners who've made their way onto trauma-care teams—or devoted their careers specifically to trauma practice—report that the subspecialty is a good fit for APCs who want to be where the action is and have the energy to manage what can be a demanding workday.

Physician assistants (PAs) have been a mainstay in orthopedic surgery for decades, and both nurse practitioners (NPs) and PAs have a well-established presence in hospital emergency departments. APCs are relatively new on the trauma-care scene, but both their numbers and their clinical responsibilities are growing, according to Jon Van Horn, MPAS, PA-C, immediate past president of the American Association of Surgical PAs (AASPA).

"Trauma programs with PAs and NPs are getting larger because a lot of facilities that do exclusively trauma, to ensure a good outcome in resuscitative surgeries, now have to have a team that's been in the OR frequently," said Mr. Van Horn, who practices trauma and critical care at Legacy Emanuel Medical Center in Portland, Ore. "We're now seeing models with embedded PAs and NPs as the backbone of the service and, frequently, working collaboratively with physician residents if there's a training program."

At the other end of the trauma-program spectrum, PAs and NPs might have far more limited roles, serving primarily as rounders on the floor and also working in the post-discharge clinic setting. The potential problem with those programs is that there's not really a defined career path for PA development, for APCs who want to pursue expanded roles, Mr. Van Horn noted. "You won't likely see the really complex patients or deal with the resuscitative stress, but it's still a great job for those who prefer 7 a.m. to 3 p.m. shiftwork and want to practice in a hospitalist model," he said.

In Mr. Van Horn's program, the trauma-care model is definitely full spectrum. APCs are in the ER, the OR, the ICU and on the floors. That's the comprehensive model that many programs around the country are moving toward, if incrementally, he points out, when no barriers exist in practice-scope limitations, hospital bylaws or surgery training-program needs. Embedded APC teams are even becoming more common at academic medical centers, which continue to struggle with the 80-hour work week and shift-length limitations imposed on physician training programs, as they accommodate ever-growing patient volumes.

To get a sense of how PAs and NPs are functioning on trauma-care teams these days, Surgery PA Market Watch obtained a snapshot of several programs throughout the country by speaking with APCs about their programs and their work. We also asked sources to offer tips for new grads and others interested in pursuing trauma practice.

Richard Winters, D.H.Sc., PA-C

Lead Advanced Practice Provider,
Medical City Plano
Plano, Texas

At Medical City Plano, part of Envision Healthcare, PAs and NPs are integrated in every trauma care-delivery setting. ACPs work in the ER and as first assist in the OR, they follow and manage patients who end up in the

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Trauma Models

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ICU, and also participate in discharge planning and seeing patients in the follow-up clinic. "We're involved in every aspect of trauma patients' care here," said Mr. Winters, who is also director of clinical services for Envision Surgical Services. "Our model is to engage PAs and NPs in all facets of care, and to enable us to practice at the top of our license."

That means that PAs and NPs have numerous opportunities to work in the ER and the OR, Mr. Winters explained, "unlike in some hospitals and large academic centers." He previously worked in trauma practice in an academic center in Alabama where the PA role was extremely limited clinically. In addition, Texas has a decidedly unrestrictive regulatory environment for PAs, he added, which allows the program leeway to train PAs to broaden their procedure skills.

TIPS

- *If you're considering a move, ask about and understand the state laws governing what PAs and APCs are permitted to do in that state. Also ask at the hospital level if there are restrictions on practice in the OR or in terms of procedures you would be allowed to do.*
- *It's also important to understand the employment model—whether it's hospital or physician group employment. If it's a hospital, roles for PAs tend to be more well defined and specific vs. a physician group, where PAs are more like righthand clinicians to surgeons and have a broader clinical role.*

Jonathan Messing, NP

Advanced Practitioner Trauma Surgery Lead,
The George Washington University Hospital
Washington, D.C.

The trauma program at The George Washington University is unusual in many respects. It's a relatively small urban medical center (350 beds), in the middle of the nation's capital and therefore geographically constrained. "We're somewhat unique in that few trauma centers in the middle of urban areas have advanced practitioners who practice at top of license like we do," Mr. Messing explains. "Part of that is because we are six blocks from White House and a few blocks from State Department, so don't get the volume some urban centers get, but we do get a good variety and high-acuity patients."

APCs are encouraged by the trauma center's director, Babak Sarani, MD, to function as close to fellow status as possible—and Dr. Sarani provides the requisite training. "He sees us as the continuity in the service, and as educators. From a clinical standpoint, we just go where we're most needed on any given day," said Mr. Messing, who also co-directs the hospital's advanced practitioner residency program.

On a typical day, the three APCs first assist in OR, do trauma activation and consults, perform numerous procedures, see patients in the ICU, and work collaboratively with the physician residents. "We can run the service as needed, which sends a positive message to the PA and NP students who rotate on our service," he said. "It's a fast-paced field, and because we care for a very vulnerable population, it requires a lot of discipline and dedication. And it's gratifying—anything you do for these patients will help, and there's so much opportunity to grow as a clinician."

TIPS

- *If you want to go into trauma, a fellowship isn't needed, but some surgical experience is always desired. If you don't have that, general surgery and critical care are great fields to get some experience and set you up for moving into trauma practice later on.*
- *Many trauma physician societies openly welcome APCs, and if you want to find a surgeon to mentor you, you'll have no difficulty doing so. There's just a great community culture in trauma.*

Aaron Pugh, PA-C

Trauma Center Physician Assistant,
Intermountain Medical Center
Murray, Utah

As team lead for resuscitation of all trauma patients at a high-volume center with high-acuity patients and a 24/7 service staffed by seven surgeons, Mr. Pugh and his nine APC colleagues function at a breakneck pace in a highly collaborative environment. They do all the bedside procedures except open thoracotomy, and they're involved at every juncture of care from the OR to the ICU and the floors, through discharge. They also train emergency medicine residents in certain procedures.

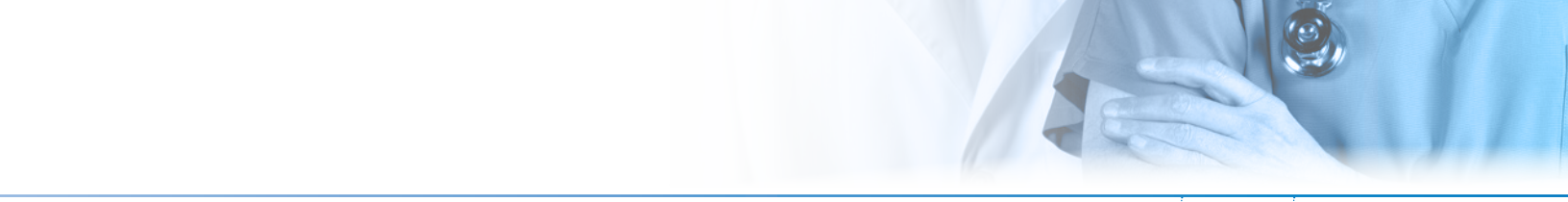
"It's a very busy practice, and because trauma service has been growing at 2.5% annually over past decade, our daily census during our busiest time of year runs between 30 and 50 patients," Mr. Pugh said. "Basically, I don't ask my attending if I can do something; I ask for help if I need it."

The practice has evolved substantially in recent years to continually broaden APCs' roles, thanks to a visionary surgeon, Mark Stevens, MD. "He had the idea that if you give PAs and NPs access to the 'fun stuff,' they'll stay," said Mr. Pugh, who frequently speaks on PA career paths and leadership, and trauma APC program development. "And it has worked. We have a very APC-friendly environment, and people rarely leave unless it's because of a life change." The Utah laws recently changed so that PAs now have a more collaborative practice with surgeons, not a strictly supervised one—and surgeons can now oversee six PAs.

The medical center also operates a thriving trauma APC fellowship program, which Mr. Pugh helped to develop and implement, and whose graduates have gone on to several high-profile programs throughout the country.

TIPS

- *If you're looking at opportunities, ask a lot of questions. You want to know exactly how the service is run, and all the details*



of what PAs or NPs are permitted to do. It's important to find out what kind of career growth opportunities are available.

- *Ideally, you're looking for a program where the surgeons have the concept of working collaboratively with APCs in their DNA."*

Marialice Gulledge, ACNP
Tyler Cook, PA

Carolinas Medical Center–Atrium Health
Charlotte, North Carolina

At Carolinas Medical Center, the region's only Level I trauma center, to say that the ACP service is busy is an understatement. The 16 ACPs—currently a 50/50 mix of PAs and NPs—assist with 5,100 trauma code activations annually and handle more than 4,700 adult admissions—qualifying the center, with 29 trauma beds, as the country's sixth largest. "Most people don't realize how busy this place is until they get here—it just doesn't stop!" said Ms. Gulledge, the lead NP and chief of the service.

The APCs' scope is defined by their privileges, per state laws, and for some procedures ACPs must be proctored. Overall, however, the team's practice is fairly broad and the pace is fast, because of the high patient volumes and the fact that they support 13 surgeons. "We're primarily working on the floors and in the ICU, and only occasionally in the OR, and all but two of our ACPs are cross trained to work in the ICU," said Ms. Gulledge, a former flight nurse who also once served in an Army MASH hospital.

One interesting design component of the Carolinas program is its approach to scheduling, which has evolved over time to reflect, as Ms. Gulledge puts it, "what really happens." ACPs working in the trauma ICU do 13.5-hour shifts to allow for sufficient overlap when transferring care.

Mr. Cook, who came to trauma practice at Carolinas via a stint in a busy emergency department, says he found his niche in his current position because of the clinical diversity. "This is a true multidisciplinary service, so we also see a lot of brain and spinal-cord injuries. We're involved in a lot of success stories, so it's very gratifying," he said. The medical center also serves as a tele-trauma support service for outlying Level II and III trauma centers, adding further service complexity.

As it has expanded, the Carolinas program—which has become a model for other programs—has sought candidates with surgery or emergency medicine experience, or NPs and PAs who've completed a fellowship. The interview process is a daylong affair that includes an interview with all attendings and the entire ACP team. "I think it's important for NPs and PAs interested in trauma to do rotations at places like ours, or shadow colleagues, so that they can see what it's really like on a daily basis," Ms. Gulledge said.

TIP

- *During the interview, ask specifically how emergencies are handled and ACPs' roles in those situations, because you want to be able to practice at the top of your license. If you don't sense that there's good physician support for the PAs and NPs, walk away.*

Jacob Privitera, PA-C

***Trauma and Acute Care Surgery PA,* Strong Memorial Hospital**
Rochester, New York

At Strong Memorial Hospital, part of the University of Rochester, the five APCs primarily manage acute care surgery and trauma patients admitted to the hospital floor, working in a nearly one-to-one ratio with the facility's six trauma surgeons. They respond to trauma alerts in the ED and serve as OR first and second assists one to two days a week. APCs also provide care in the outpatient setting by seeing patients in follow-up clinic.

It's the diversity of both the clinical practice and the patients that drew Mr. Privitera to academic PA trauma practice two years ago. "I enjoyed the idea of an unknown work day," he said. "As a trauma APC, it could be an ordinary work day and then three traumas roll in, and we have to be prepared to act fast and efficiently."

He appreciates the challenge that an academic center provides to treat complex patients who have multiple medical comorbidities who became injured, and the opportunity to work closely with several different types of physicians. "The gratitude and appreciation we receive from our patients is the best feeling an APC could ask for," he said. "I enjoy working with multiple specialists to help save lives and change lives, daily."

At Strong Memorial, APCs also play a key role in educating residents—and the trauma division specifically looks for versatile APCs who can be interchangeable with surgical residents and who have a strong procedural and surgical foundation. "It's vital that our APCs are able to identify a patient who is crashing and initiate resuscitative efforts," Mr. Privitera said.

TIPS

- *A new PA looking at trauma should ask several key questions: What service model does your trauma center use (service based vs. physician based)? What is the APC's role in the trauma bay during activations? What does a typical day look like? Will there be opportunities to assist in the OR? Will the APC be in charge of treatment plans and disposition planning?*
- *Red flags to be aware of are a high rate of APC turnover, poorly defined orientation goals and schedule, an undefined service model or a lack of policy protocols—for chest tube protocol or trauma admission criteria, for example.*

Ms. Darves is an independent healthcare writer based in the Seattle area and editor of Surgery PA Market Watch.

PERSPECTIVES

Pursuing Optimal Team Practice: Q&A with AAPA's Gail Curtis, MPAS, PA-C

In its efforts to promote greater flexibility nationally in how physician assistants (PAs) practice to better reflect the realities of the current health services delivery environment, the American Association of Physician Assistants is promoting a new model called Optimal Team Practice (OTP). AAPA President L. Gail Curtis, MPAS, PA-C, who chairs the Department of PA Studies at Wake Forest University School of Medicine, talks about the rationale for OTP and what it might mean for surgical PAs.

What is OTP and why is AAPA pursuing it?

Optimal Team Practice is a new policy adopted by AAPA in 2017 that calls for laws and regulations that emphasize PAs' commitment to team practice; and authorize PAs to practice without an agreement with a specific physician—enabling practice-level decisions about collaboration. OTP regulations would enable creation of separate majority-PA boards to regulate PAs or give that authority to healing arts or medical boards that have as members both PAs and physicians who practice with PAs. The policy also calls for laws authorizing PAs to be directly reimbursed by all public and private insurers.

The PA profession celebrated its 50th anniversary last year. But since its inception, healthcare has continued to evolve. AAPA is pursuing these changes because many of the oversight provisions included in early PA state laws to assure quality are antiquated and unnecessary. OTP aims to enable PAs to practice at the top of their experience and education, which is what's best for patients and their physician colleagues.

For example, as more physicians and PAs are practicing in groups, the requirement for PAs to have an agreement with a specific physician is increasingly difficult to manage. It also puts all providers involved at risk of disciplinary action for administrative infractions that are unrelated to patient care or outcomes.

The pursuit of OTP does not mean PAs want independent practice. PAs value a sustained partnership with physicians, have great respect for the depth of physician training, and rely on the PA-physician team in clinical practice. This is especially true in surgery, where the role of the surgeon and others involved in caring for patients, like PAs, are well-defined and profession-specific.

What's happened to date with this initiative, and what are the next steps?

State laws determine PA practice, so each state PA chapter will decide how and when to advocate OTP. Since the policy was adopted, more than 20 states have become active on OTP in some way. For some, that means they've formed task forces, surveyed members, reached out to stakeholders, educated members, or published articles about the new policy. Half of these 20 states are planning to pursue elements of OTP in legislation in 2019.

If OTP moves forward nationally, what might it mean for practicing PAs—and surgical PAs in particular?

We anticipate that the role of PAs—and specifically the role of PAs in surgical practices—will remain unchanged. However, there are a few ways that all PAs—including surgical PAs—might benefit from more modernized PA-practice laws.

First, it will help level the playing field with nurse practitioners. In a 2017 survey, 45% of PAs said they have personally experienced NPs being hired over PAs due to the administrative

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SURGICAL PA JOBS

Farmington, NM: *Hospital Employed-General Surgery*
Reno, NV: *Private Practice-Neurosurgery*
Pinehurst, NC: *Hospital Employed: Neurosurgery*
San Antonio, TX: *Academic-Neuro-ICU*
Long Island, NY: *Private Practice-Neurosurgery*
Raleigh, NC: *Academic-Neurosurgery*
Trenton, NJ: *Hospital Employed-Lead PA/ NP Job for Neuro-ICU*
Greenville, NC: *Hospital Employed: Cardiothoracic Surgery*
Reno, NV: *Private Practice-PM&R position*
Greenville, NC: *Hospital Employed: Orthopedic Trauma Surgery*
Fresno, CA: *Priva-demic-Neurosurgery*
Greenville, NC: *Hospital Employed-Functional Neurosurgery*
Las Vegas, NV: *Private Practice-Neurosurgery*
Salina, KS: *Hospital Employed-Orthopedic Surgery*
Greenville, NC: *Hospital Employed: Trauma Surgery*
Macon, GA: *Private Practice-Neurosurgery*
Farmington, NM: *Hospital Employed-Neurosurgery*

Communicating After the First Interview: Timeliness, Professionalism Key

By Katie Cole

You've narrowed down your options and identified a position that fits what you're looking for, and you've met the team at the practice. Regardless of whether you have interest in moving forward with this practice opportunity, what is your next step?

If this interview is a serious contender for your new job opportunity, communication is key in moving things forward. An emailed thank you letter is the ideal way to show you appreciate the time the practice took to meet with you. It is sufficient to write the email to the main contact person you worked with who initiated the interview, but you might also choose to include the others you met during the site visit as well.

A single email usually suffices, as opposed to writing separate emails to everyone you met. One exception might be if there was a surgeon you had a particularly good exchange with and that surgeon is the person you would ultimately be working for if you took the job. That merits an individualized thank-you email.

The practice will almost always require references from you, either the names of three surgeons or other advanced practice clinicians (APCs) you have personally worked with, or alternatively, letters of reference from current or past employers. It is good to have these on hand before you go to the interview. If the topic came up during your visit, you might consider sending those reference letters along with your thank-you email if you didn't provide them then.

If the hospital or practice provided any paperwork that you need to complete, fill this in and return it quickly. Sometimes a hospital requires pre-screening paperwork to be completed prior to generating an offer letter.

If you haven't received feedback from the recruiter or practice within a week of your interview, checking in would be appropriate. You don't want to pressure them, but at the same time, it's also important to reinforce your interest in the opportunity. It can be a fine line determining how often to get in touch, but you should have a better idea of what's appropriate if they respond to your first follow-up inquiry.

More often than not, there are other interviews scheduled, and usually, multiple individuals in both administration and surgery will work together to make the ultimate hiring decision. This process can take time. Checking in weekly if you haven't received any developments, or after the date they mentioned that interviews would conclude, would be suitable depending on the timeline for filling the position. One good way to check in if you haven't heard anything for more than a week is to simply ask when the practice needs to fill the position and if they have concluded other interviews.

If, after you leave the interview, you feel the practice wouldn't be a good fit for you, it is still important to send a thank-you email and to maintain a professional relationship with individuals you met. There are many positions for surgery PAs, of course, but keep in mind that healthcare environment is still a small world—you never know when you might encounter or even work with someone you met on that interview. Being professional, courteous, and receptive will help ensure that you find the ideal position while also laying the groundwork for making connections for future opportunities.

Ms. Cole is a Denver resident and publisher of Surgery PA Market Watch and Neurosurgery Market Watch.

Perspectives

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burdens imposed on employers and physicians requiring that PAs have an agreement with a specific physician. As OTP starts to take hold in states, this will be less of a challenge for PAs.

Second, it will strengthen healthcare teams by reducing administrative burdens and allowing them to practice more efficiently. State laws should not dictate to physicians how many PAs they may collaborate with or which charts must be co-signed. Those decisions should be made at the practice level where the care is being provided.

Third, PAs will have more meaningful input into the regulation of their profession. PAs want what physicians and nurses already have: regulatory boards that have current knowledge of their profession. Whether that requires a separate PA board—or just the addition of PAs and physicians who work with PAs as members of a medical or healing arts board—this should be determined on a state-by-state basis. Some states already have PA boards, but in most states, PAs are regulated by the medical boards.

At its core, OTP is about improving patient access and removing barriers so that PAs can provide high-quality care as members of medical and surgical teams.

LEGAL CORNER

Liability Risks for PAs: Oversight, Identification and Charting Are Key Areas

By Bonnie Darves

Michael Sacopulos, JD

In this new column, Surgery PA Market Watch speaks with health lawyers about legal issues affecting physician assistants and other advanced practice clinicians (APCs). This article, the first in a two-part series, features Michael Sacopulos, JD, a partner in the Terre Haute, Ind., law firm Sacopulos, Johnson & Sacopulos who specializes in physician and provider medical malpractice liability and associated legal issues. He discusses basic issues that PAs starting out or contemplating a move should understand about the liability environment.

As physician assistants (PAs) start exploring practice opportunities or accept a new position, what are the chief issues they should keep in mind to mitigate potential malpractice and related risks?

Oversight. Physician oversight requirements and arrangements is a big one. You should thoroughly review and understand the regulations in the state where you'll practice in terms of not only the ratio of physician to PA but also what constitutes adequate oversight. There's considerable variation among states, and even though there's movement toward making oversight regulations less restrictive generally, PAs need to familiarize themselves with the current laws of the state where they practice.

For example, what does the definition of "oversight" actually mean? Must the overseeing physician be physically present in the facility? How available must the physician be to answer clinical questions or address concerns that a PA might have about a patient's care? Once you understand this, make sure that any facility where you're considering practicing adheres to current regulations and is willing to provide a detailed explanation of how oversight is handled in the clinical setting.

> **"PAs should ensure that everything they do in the chart is under their name, not someone else's, and that there's no possibility that anyone's work will be misconstrued as theirs."**

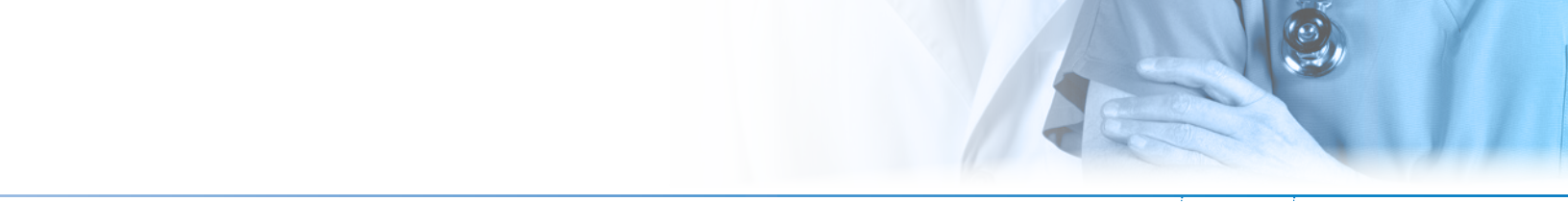
Identification. This might sound basic—that PAs should always make their position and role clear to patients and their families—but it doesn't always happen. The risk is that PAs might be misidentified, through no fault of their own, as physicians, and later be targeted as having misrepresented himself (even if that's not the case) or potentially blamed for a faulty care plan or a complication of care.

The way to mitigate this risk in the hospital setting is pretty simple: wear a badge that clearly identifies who you are. Take the time to introduce yourself as the physician assistant who works with Dr. X or X surgical group. Studies have found that hospitalized patients are not good at knowing or remembering who their healthcare providers are, so PAs can help reduce confusion about roles and responsibilities by identifying themselves and their role within the care team.

Charting. This is another area where risks can arise for PAs. If information gets entered into a patient's chart and there's any ambiguity about who entered what or who ordered what, trouble may follow. There are situations, for example, when a patient's chart is open and the physician in a hurry might ask a PA, "Can you just finish up for me?" Even in the interest of saving time, PAs should never enter information in a chart under anyone else's password to comply with a request or avoid the hassle of logging out and logging back in again.

At a minimum, PAs should ensure that everything they do in the chart is under their password, not someone else's, and that there's no possibility that anyone else's work will be misconstrued as theirs. EHR systems produce an audit trail by date, time, and password. These trails can be pulled and audited anytime by risk managers or, potentially, by plaintiff's attorneys, so the last thing you want is to be deemed responsible for someone else's work.

Cyber-security coverage. With ransomware and other cyber-attacks on the rise in healthcare—such events have increased dramatically in just the last year—PAs should ensure that there's coverage in place to protect them or consider purchasing it themselves. This is a serious emerging risk area for all healthcare providers and clinicians, should patients' information be released after a system is hacked. What we're seeing is that the majority of organizations do not have sufficient coverage for that.



FEATURED OPPORTUNITY

Neurosurgery Physician Assistant or Nurse Practitioner Job in Texas

A department of neurosurgery in San Antonio is seeking a neurosurgery physician assistant or nurse practitioner to join its department. The incoming advanced practice clinician will provide consultation and advice to patients and support staff. The department will consider both PAs and NPs, and prefers at least one year of experience.

Neurosurgery residents take call, so there will be no OR or in-house call for the incoming APC. The hours will be general office hours with no night or call obligations. The incoming APC will have a clinic-focused practice, and there is limited OR time, likely just once a week.

Working in an academic center, the incoming PA or NP will be exposed to all types of neurosurgery cases, including spine, cranial, functional and neuro-oncology. The department's neurosurgery PAs/NPs typically practice primarily in clinics and on the floor. The neurosurgery department has 17-plus neurosurgery residents, so the incoming APC will be mostly clinically based.

Knowledge and experience in neurosurgery and/or neuro-critical care is preferred, as well as knowledge of health education focused in neuroscience. The department will provide a competitive compensation package including salary, a benefit package second to none, PTO, relocation and retirement.

SURGERY PA EVENTS

23rd Annual Challenges in Critical Care
❏ August 24
Hershey, Pennsylvania

2018 UCHealth Trauma, Critical Care and EMS Symposium
❏ August 24-25
Colorado Springs, Colorado

Emergency and Trauma Outreach Symposium
❏ September 5-6
Scottsbluff, Nebraska

Arthroplasty for the Modern Surgeon: Hip, Knee and Health Innovation Technology 2018
❏ September 6-7
Sonoma, California

Skin, Bones, Hearts, & Private Parts
❏ September 11-14
Orlando, Florida

Advanced Practice Providers Oncology Summit
❏ September 14-15
Greenwood Village, Colorado

2018: Restoring Neurological Function
❏ September 28
Cleveland, Ohio

Association of Neurosurgical Physician Assistants
❏ October 7
Houston, Texas

2018 Fundamental Critical Care Support
❏ October 11-12
Lake Buena Vista, Florida

2018 AASPA CME Meeting & Surgical Update
❏ October 11-14
Orlando, Florida

AASPA Winter Weekend 2019
❏ January 19, 2019
Orlando, Florida

APACVS 38th Annual Meeting
❏ April 4-7, 2019
Miami, Florida

AAPA 2019
❏ May 18-22, 2019
Denver, Colorado

CONTRIBUTIONS WELCOMED!

Help shape Surgery PA Market Watch by contributing opinion articles that address issues affecting surgical APC practice or that provide guidance on career matters. We also seek ideas for articles on topics of potential interest to our readers.

To discuss an idea or to propose a coverage topic, please contact Surgery PA Market Watch editor Bonnie Darves at **425-822-7409** or **bonnie@darves.net** or publisher Katie Cole at **303-832-1866** or **katie.cole@harlequinna.com**.