

University of Groningen

Assessing Advanced Practice Provider Value

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Published in:
Critical Care Medicine

DOI:
[10.1097/CCM.0000000000004254](https://doi.org/10.1097/CCM.0000000000004254)

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Document Version
Publisher's PDF, also known as Version of record

Publication date:
2020

[Link to publication in University of Groningen/UMCG research database](#)

Citation for published version (APA):

Kreeftenberg, H. G., & van der Voort, P. H. J. (2020). Assessing Advanced Practice Provider Value: Beyond a Single Healthcare System reply. *Critical Care Medicine*, 48(4), E336-E336.
<https://doi.org/10.1097/CCM.0000000000004254>

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DOI: 10.1097/CCM.0000000000004199

The authors reply:

With interest we have read the letter of Gigli and Martsolf (1), concerning two recently published articles (2, 3) in *Critical Care Medicine* regarding the benefits of replacing “incident-to” billing with billing traceable to advanced practice providers (APPs). We fully agree with the authors that this would create another level of clarity regarding the tasks APPs perform. The spin-off of this intervention could possibly be surprising. For instance, we retrospectively collected data from the Critical Care Outreach Team (CCOT) calls for a period of 2 years and evaluated their performance (unpublished data). APPs apparently handled twice as many calls as medical residents (MRs). The MRs said that they had enough to manage in the relatively new critical care environment and the CCOT call distracted them from their task. Furthermore, they had an uncertain attitude toward handling severely ill patients during a CCOT action. In contrast, the more experienced APPs saw a challenge in diagnosing and treating these patients. In published studies, the effect of the experienced APP in relation to other professions has not been completely elucidated. Studies are often not designed to evaluate the performance of just APPs alone. For example, an eloquent study evaluated the effect of adding an APP to an existing team (4). This showed a reduction in time for transfer to the ICU of critically ill patients but evaluation of the mechanisms and effort of APPs was not described to its full extent.

In The Netherlands, the initiative to implement APPs in all areas of medicine has been enthusiastically embraced by the government because it is undoubtedly a quality impulse and it can be a better alternative than a physician. However, it is also the overture to a reduced reimbursement by the health insurance companies. In the Netherlands, this brings hospitals into an uncertain financial position. An intervention billed by an APP is considered to be cheaper than an intervention billed by a physician. The disadvantage of this method is, that the effort of team work and quality improvement receives less attention. If the intensive care could be approached as a whole in which billing covers the costs of the entire intensivist led team of nurses, MRs and APPs, this would acknowledge all participants for their efforts in critical care.

Dr. Kreeftenberg received funding from the Catharina Hospital (Clinical Teacher for Advanced Practice Providers on the Intensive Care). Dr. van der Voort disclosed that he does not have any potential conflicts of interest.

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DOI: 10.1097/CCM.0000000000004254

Ultrasound for Pulmonary Gangrene: All That Glitters May Not Be Gold

To the Editor:

We read with great interest the article published in a recent issue of *Critical Care Medicine* by Echivard et al (1). The authors have done a great job of providing subjective description of ultrasonic imaging in suspected pulmonary gangrene. We would like to make few points that may be of interest to authors and readers of this case report.

Echivard et al (1) describe picture as fluid effusion below the fractal lines with its boundaries shredded, they called a “quagmire sign.” Other conditions that may give similar picture include encysted pleural effusion formed on consolidated lung with metastasis with damaged, inflamed, and sloughed malignant tissue or local spread of tumor with hemorrhage or necrosis that may take a shape of area with irregular boundaries;