An APRN Super Team! The successful implementation of a shared pain and palliative care consult service led by APRNs

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Disclosures

- No conflicts of interest
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#5741
Objectives

- Review the benefits and obstacles of an APRN led Pain and Palliative Care Team.
- Identify and acquire resources to build pain and palliative inpatient consult service led by APRNs.
- Critically assess an existing Pain and Palliative Care Team.
- Describe the consult service structure and composition.
- Describe the financial model of the consult service and evaluate cost effectiveness.
- Determine if shared pain and palliative care consult services are sustainable and financially viable when staffed by APRNs vs a solely MD led group.
Palliative Care & Pain

- Palliative care has evolved over the years to provide consultation at much earlier stages in disease. Given that pain is often a chronic illness; providers may provide consultation in both specialties. And likely can provide excellent consultation in both (different practice areas). Patients with complex and refractory pain will likely benefit from the interdisciplinary model that is a mainstay in palliative care. There is a scarcity of literature on the subject of the interface between pain services and palliative care services. There is no scarcity on the topic of APRN led teams in general. APRN led team provide highly competent and safe care.
Inpatient Palliative Care programs in hospitals with 50 or more beds increased from 658 in 2000 to over 1700 in 2012 (CAPC), 67% of hospitals with 50 or more total facility beds reported a palliative care program.

90% of hospitals (>300 beds) report having palliative care teams.

[Source: American Hospital Association Annual Hospital Surveys and data from the Center to Advance Palliative Care’s (CAPC) National Palliative Care Registry™.)

American Hospital Association (AHA) Annual Surveys™ for Fiscal Years 2012 and 2013
Appropriate for palliative care?

- 32 year old woman admitted with abdominal pain and diarrhea. History of HIV.
  - High opioid requirements
  - Weight loss and occasional vomiting
  - Heroin use
Palliative care appropriate?

- 72 year old with L4 compression fracture. Opioid tolerant (daily OME>100mg) and history of depression and dementia.
  - Yes or No?
  - Prognosis?
  - Code status?
The stigma....the myth

- How *I* manage pain.
- How *you* manage pain.
The stigma = reality

WHO Definition of Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.
The Team

- There are numerous palliative care teams in the inpatient setting that are led by APRNs. They exemplify commitment to varied roles in direct consultation or in quality improvement and research.

- Fewer teams include both pain and palliative care consultation. After numerous inpatient pain consult services continued to be successful, an APRN lead team combined forces to provide pain and palliative care consultation to serve a small community.

- The question was asked: to what extent are pain specialist and palliative care specialists availing of each other’s expertise?
The history

- Our story
- Grass roots effort
- NP led
- Barriers
Hospital

- Ridges Hospital is a non-profit health system that is part of M Health (includes 6 total hospitals/medical centers).
- The hospital serves 56,479 ED visits yearly, 10,915 inpatient admissions, and has 150 licensed beds.
- The inpatient pain and palliative care consulting service sees 100’s of pain and 100’s palliative consults per year, and is staffed with 3 APRNs.
CNSs in MN

Independent - no requirement for a written collaborative agreement, no supervision, no conditions for practice.

Not Independent - a written agreement exists that specifies scope of practice and medical acts allowed with or without a general supervision requirement by a MD, DO, DDS or podiatrist; or direct supervision required in the presence of a licensed, MD, DO, DDS or podiatrist with or without a written practice agreement.

Prescriptive Authority - an APRN is authorized to prescribe pharmacologic and non-pharmacologic therapies beyond the perioperative and periprocedural periods.

Updated as of 05/2014. Permission received from NCSBN.
Findings

- Total patients seen
- Total bill out
- Salaries
- Total number of complaints
- Safety events measured
2015 metrics

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Resources

- CAPC
- IOM report
Conclusion

- The two clinical divisions (Pain and Palliative Care) are an ideal marriage. This APRN-led team has proven to provide cost effective and efficient care at a small community hospital. Hundreds of papers (and meta-analysis’s) have been written on the topic of APRN with exemplary performance and superior safety.
Questions?
References


