The Role of the Advanced Practice Clinician:

Nurse Practitioner

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Objectives
By the end of this program, the participant will be able to:

- Have a working definition of a Nurse Practitioner (NP)
- Be familiar with the history of the NP
- Be able to review key components of role of the NP
- Understand the concept of Scope of Practice
- Integrate team based MS care utilizing NP’s into practice
- Describe how to maximize the team approach
Historical and Current Perspective on Nursing

- “Social and cultural mandates” with focus on equity
- Nursing intercedes between powerful forces and disenfranchised groups
- Improving accessibility for quality health care services for primary and chronic illness
- Providing education, support, addressing basic health needs

Marx, et al, 2010

Before there were Nurse Practitioners

- Early 1900's
  - Community health promotion
  - Lillian Wald founded Children's Bureau
  - Mary Breckinridge founder of Frontier Nursing Service and School
  - War Nurses
Driving Forces 1960’s

- MD specialization, fewer PMD’s
- Medicare/Medicaid expansion
- Viet Nam War
- Civil rights and women’s movement
- Nurses became inactive
  - Poor working conditions, salaries, benefits
  - Lack of career ladder except administration or academia

Wilson, 1994, Pulcini & Wagner, 2002

First NP Programs

- 1965 University of Colorado
- Loretta Ford, RN and Henry Silver, MD collaborated for 1st NP training program
- Focus on health promotion, disease prevention, children and families
- 1967 Boston College Master’s program for NP’s
- Within 9 years, 65 programs in Pediatrics alone, others for women’s or family health.
- Over 1000 NP’s, midwives, nurse anesthetists.

Wilson, 1994
Challenges and Barriers

- New role met with suspicion and distrust
- Ambiguous title
- Informal training
- Lack of faculty
- Lack of credentialing
- Lack of uniformity
- Increasing sophistication of medical care
- Opposition from medicine

Wilson, 1994

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Challenges and Barriers

- Diverse nursing education for RN’s 1960’s
  - Hospital based programs-Majority
  - Associate programs 8%
  - Baccallaureate 20%
  - Push for Associate degree program to address nursing shortage
- Question: what is adequate prep for NP?
- MD support essential to development of role for faculty and practitioners
- No defined scope of practice

Wilson, 1994
Legitimizing the Role

- Legislative changes of state laws and nurse practice acts 1970’s
- Council of Primary Care Nurse Practitioners 1974
- Guidelines for FNP Curricular Planning 1980
- 1989 90% of NP programs were Masters or post-Masters degree programs.

Pulcini & Wagner, 2002

Legitimizing the role

- Standardization of education
- National Counsel of State Boards of Nursing 1986
  - Defined advanced practice
  - MSN and RN licensure minimum standard
  - Licensure for regulating profession
- National certification
- Improved role identity

National Council of State Boards of Nursing (1986)
Reimbursement

- NP’s initially paid as employees
- Managed care fee for service or per-member-per-month agreements
- Data increasingly showed cost effectiveness of NP care.
- Incremental legislative and policy changes over 30 years resulted in Medicare provider status in 1997.

O’Brien, 2003

Time Line

- 1960’s
  - 1965 First NP program at University of Colorado—Loretta Ford RN/Henry Silver MD
  - Focus on pediatric population
- 1970’s
  - Expansion of NP certificate programs multiple specialties
- 1980’s
  - Shift from post graduate certificate programs to Masters
- 1990’s
  - Increased numbers of NP’s
  - Prescriptive authority
  - 3rd party reimbursement
2000-Present

- NP programs mainstream of graduate education, accreditation process
- Legislative changes gradually leading to an increasingly independent role for NP
- Opportunities for specialization
- Globalization of NP education.
- DNP programs

Pulcini & Wagner, 2002

Today

- Era of health care change and challenge
- Still a shortage and mal-distribution of providers
- NP education needs to maintain highest quality standards.
Bibliography


Scope of Practice

- Refers to the degree of legal authority for APNs to practice
- The Nurse Practice Act legislated in each state of the U.S. specifically delineates requirements for registered nurses in advanced practice roles.
- Nurse practitioner scope of practice laws vary from state-to-state.


Scope of Practice Examples

- WA and NH: may independently diagnose, treat, prescribe, refer to physical therapy (PT) and sign handicap placard permits.
- CA: require a collaborative agreement with a physician to practice and prescribe. Can refer to PT and sign handicap placard permits.
- AL: require a collaborative agreement with a physician to practice and prescribe. Are not authorized to refer to PT or sign handicap placard permits

Scope of Practice Description in State Law

- Allows NP’s to perform at their level of education and training
- Avoid any charges of practicing medicine without a license
- Avoid imputation of liability for medical malpractice to someone other than the NP
- To place accountability for benefit as well as harm to patients squarely on the NP
- To establish that the NP is a professional entity
- To get reimbursement for services


Role of the Nurse Practitioner

- Manage acute and chronic medical conditions through comprehensive history and physical exam, diagnostic tests and treatments.
- Autonomously and in collaboration with health care professionals and other individuals, provide a full range of primary, acute and specialty health care services.

Healthcare Activities of NP Include:

- Ordering, performing and interpreting diagnostic tests such as lab work and x-rays.
- Diagnosing and treating acute and chronic conditions such as diabetes, high blood pressure, infections, and injuries.
- Prescribing medications and other treatments.
- Managing patients’ overall care.
- Provide counseling.
- Educating patients on disease prevention and positive health and lifestyle choices.


Unique Approach

- Unique emphasis on the health and well-being of the whole person.
- A focus on health promotion, disease prevention, and health education and counseling.
- Guide patients in making smarter health and lifestyle choices

Who is the MS APN (NP)

- Master’s prepared expert nurse who manages the complex medical problems and related issues faced by patients with MS and their families across the disease continuum.
- Promotes wellness, restoration of health, prevention of illness and management of disease
- Goal of instilling hope and empowering patients to participate in their own care.


Role in Multiple Sclerosis

- Administrator – staff, budget, policies, procedures and quality assurance outcomes
- Educator - teaching a variety of audiences about MS
- Collaborator – works with a variety of health professionals to ensure that patients receive appropriate care and follow-up
- Consultant – makes his/her expert knowledge available to others. Serves to identify and offer solutions for a variety of specific problems as they relate to MS.

Role in Multiple Sclerosis

- Researcher – take an active role in clinical practice research (investigator, examiner, evaluate outcomes)

- Advocate – for patients
  - Negotiating for them

- Advocate – for staff members
  - Providing support


Role in Multiple Sclerosis

Expert Clinician

- In-depth understanding pathophysiology of MS, knowledge regarding appropriate interventions (DMT’s, symptom management) and diagnostic tests to provide patient care.

- Prescriptive authority in all US states and several provinces of Canada. Responsibility to assess, diagnosis, treat and provide ongoing management for our patients.

- Make referrals as needed, promote wellness and serve as a coordinator of individualized patient care.

Unique Approach

• Emphasis on the health and well-being of the whole person.

• A focus on health promotion, disease prevention, and health education and counseling.

• Guide patients in making smarter health and lifestyle choices


Case Study

CC: 37 year old Hispanic female, diagnosed with MS in 2007. In for routine f/u but notes “I think I might need a medication for depression”.

HPI: Initial treatment with Avonex, changed to Tysabri in 2011 due breakthrough activity. MRI up to date and stable, recent JCV Abx negative. Last relapse 4 years ago prior to Tysabri.

PMHx: HTN, OSA, Vitamin D Deficiency, Hip Pain, Depression

Social Hx: Married, 2 children, one of whom has special needs. Non drinker, former tobacco smoker.
Current Medications

Tysabri 300mg IV q month
Amlodipine 10 mg po q day
Carvedilol 25 mg po q day
Norethindrone Acetate

Review of Systems

Mild fatigue, negative CP, palpitations, dyspnea or SOB. Denies GI/Urological sx’s.
Positive history of depression in the past but last treated for a short time, years ago. Admits to stress, she works full time, 24 hr in home nurses needed for care of daughter with special needs. Other daughter to have Quinceanera (time and financial investment). Husband very supportive. Pt admits to depressed mood times 6 months, crying spells and irritability. Negative for SI/HI.
Sleeping ok but some day time fatigue. When asked about CPAP, she admits that she isn't wearing it and hasn't been “for some time now”.
Exam

Vitals: 135/78, 93, 16. Ht 5ft, Wt 260 BMI:50.8

Morbidly obese, no acute distress although tearful at times. Resps regular, lungs CTA. HRRR no murmur.

Assessment

MS – Stable on current therapy. Labs an d MRI per protocol with f/u in 3 months.
OSA – Currently untreated. Pt advised about risks/side effects of not wearing CPAP (HTN, depression, fatigue) and encouraged to resume CPAP as directed. Referred back to sleep specialist for reevaluation.
Depression – Stress reduction techniques encouraged. She and family just joined YMCA, she will begin routine exercise, encouraged yoga. Offered counselor (pt declined currently). Labs are up to date to include thyroid and iron studies. Resumed Wellbutrin XL 150mg i po q am. F/u 6 weeks, sooner prn.
Vitamin D Deficiency – Resume Vit D replacement.
Obesity – Encouraged good eating habits, YMCA exercise regimen, weight loss. Motivator for wt loss = more energy, decreased BP, improved mood, long term health benefits.
HTN – Record at home readings and take with to PCP appointment.
"Teamwork is the ability to work together toward a common vision. The ability to direct individual accomplishment toward organizational objectives. It is the fuel that allows common people to attain uncommon results."

Andrew Carnegie
Why Is a Team Approach Needed in Multiple Sclerosis?

“Teamwork is central to safety in healthcare as it is often the interactions of healthcare workers that produces effective or ineffective performance.”

Given the nature of the disease course in Multiple Sclerosis, effective and efficient patient care relies on the interaction of individuals from diverse backgrounds in terms of expertise, training, and experience.


Models of Care: NPs and MDs

Many MS Centers utilize a model that has nurse practitioners and physicians.

Minimal research is available that examines an integrated or “collaborative” model of practice between Physicians and Nurse Practitioners

- Primarily look at individual outcomes such as clinical outcomes and cost savings.

Collaborative relationships between physicians and NPs have been described as addressing different needs in the management of acute illness, chronic disease management, and comprehensive care planning.
Creating an High Performing Health Care Team 1:2

- Focusing on team formation:
  - Group versus team
  - Interdependent and collaborative

- Communication is essential
  - Establishing communication structures
  - Plan for conflict (identify potential problems)
  - Working agreements

Grumbach, K. & Bodenheimer, T. Can Health Care Teams Improve Primary Care Practice? JAMA March 10, 2004 291 (3)1246-1251
Legislative: Interprofessional Collaboration: What’s Taking So Long?

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For at least two decades, healthcare leaders have described collaboration between providers as essential for efficient and effective care delivery. The Institute of Medicine (IOM) has provided considerable evidence of the positive impact that interprofessional collaboration and teamwork can have on key dimensions of organizational performance (IOM, 2000, 2003, 2004, 2009). Yet, the ability to collaborate consistently, and that ensures quality care, continues to elude us (Bensing, 2010; Martin, 2011; Polin, Bensing, & Warner, 2013). This lack of interprofessional collaboration is a significant challenge for healthcare executives, college deans, practicing nurses, physicians, and other healthcare professionals.

Rapid advances in biomedical knowledge and clinical technologies, continued pressures, consumer demands, and changes in the demographic characteristics of communities have resulted in dramatic changes in healthcare delivery in recent decades. These changes require supportive work environments to achieve positive patient outcomes. Supportive work environments require communication, mutual respect, and collaboration between the various providers, as well as between providers and patients. Collaboration among nurses, physicians, and other members of the care team can improve...
Creating an High Performing Health Care Team 2:2

- Having defined goals and objectives
  Improve patients health; 90% of Pts calling for a possible MS relapse will be seen within 2 days.

- Defining and evaluating the system (clinical & administrative)
  - Are there clear procedures and assignment of tasks

- Requires effective team members (skill, will, ability)
  - Clear expectations for each role and as a team
    - What is the most efficient way to deliver care?
    - What skill are needed? Who is the best person to do it?
    - Identify potential areas of "role overlap"
    - What are the cost implications?

Grumbach, K. & Bodenheimer, T. Can Health Care Teams Improve Primary Care Practice? JAMA March 10, 2004 291 (3) 1246-1251

Performance Outcomes

- Have collective accountability for performance and outcomes in patient-centered care

- Establish shared decision making and leadership: based upon the need for specific kinds of expertise needed at a given point in time

- Measure outcomes at regular intervals
Measuring Performance: determining success

Team Related Measures Matrix

<table>
<thead>
<tr>
<th>Contribution</th>
<th>Individual Level: An Employee’s Contribution to the Team</th>
<th>Team Level: The Team’s Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviors/Process</td>
<td>The employee: cooperates with team members, communicates ideas during meetings, participates in the team’s decision-making processes.</td>
<td>The team: runs effective meetings, communicates well as a group, allows all opinions to be heard, comes to consensus on decisions.</td>
</tr>
<tr>
<td>Results</td>
<td>The number of ideas contributed by the employee, the turn-around time for the individual’s task, productivity, the accuracy of a member’s status supplied to the team.</td>
<td>Patient satisfaction with the team product, the number of patients the team sees on a daily basis, the cycle time for the team’s entire work process. (e.g. new patient)</td>
</tr>
</tbody>
</table>

Establishing Outcome Measurements 1:2

Three Types of Measures

Use a balanced set of measures for all improvement efforts: outcomes measures, process measures, and balancing measures.

1. Outcome Measures
Are you reaching your goal?
• E.g. For access: Number of days till next available appointment

2. Process Measures
Are the parts/steps in the system performing as planned? Are we on track in our efforts to improve the system?
• E.g. For access: Who sets up an appointment? Average daily clinician hours available for appointments
Establishing Outcome Measures 2:2

3. Balancing Measures (looking at a system from different directions/dimensions)

Are changes designed to improve one part of the system causing new problems in other parts of the system?

• E.g. To have a patient see a few team players at each visit make sure clinician and patient wait time is not increasing

Case Study

• Renee, a 34 year old Caucasian woman from South Carolina, has had MS for 6 years.
• Four months ago she recently experienced a relapse, which caused her to have paralysis to her lower extremities. She was treated with high dose Solumedrol. She experienced partial recovery.
• She is distressed about her loss of functioning.
• In the past two days she has reached out to the Social Worker, the Nurse, the Neurologist, the Nurse Practitioner and the Physical therapist.
• How would a high functioning team respond?
Questions?
Thank you!

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