PRACTICE REFLECTION

The Advance Practice Nurse: A valuable resource to increase timely access to palliative care for those in need

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It is well established that palliative care plays a pivotal role in meeting patients’ medical, psychosocial, and spiritual needs and improving their quality of life (World Health Organization, [WHO], 2020). Many hospitals have palliative care specialists who provide pain and symptom management for patients with malignant and non-malignant disease at various stages in their disease trajectory. These specialists address patients’ and their families’ goals of care, facilitate decision making, and assist with discharge planning. Additionally, they consult on patients at end of life who can often have complex care needs and an inherently short timeframe for intervention.

The Canadian population is aging and approximately 60% of Canadians currently die in acute care settings (Ontario Palliative Care Network [OPCN], 2020) and Health Quality Ontario [HQO], 2019). Growth in demand for specialized palliative care services has outpaced the capacity of the current healthcare system to train and supply specialized palliative care specialists. Additionally, increasing volumes, decreasing healthcare budgets, palliative care program resource constraints—including Ministry restrictions on the number of funded physicians for the program—and decreasing nursing support have created quality gaps in the delivery of timely access to high-quality palliative care. A recent environmental scan completed revealed that 40% of Ontarians die without having received palliative care services during their final 12 months of life (OPCN, 2020; HQO, 2019).

Most hospital palliative care teams face growing clinical demands and “there has been an unprecedented rise in the demand for inpatient and outpatient clinical services coming from both clinicians and administrators. The downside is that most teams...are struggling, overwhelmed by the workload demands” (Weissman, 2015, p. 204).

The composition of hospital palliative care teams is characteristically interprofessional and may include a physician(s), a nurse(s), a social worker, and a chaplain. Some teams have also adopted the inclusion of an advance practice nurse (APN). An APN is a nurse who holds a master or doctoral degree in nursing and has expertise in patients with complex care needs. Specifically, an APN brings forth specialized knowledge, skills, and leadership to the clinical setting to enhance patient and family care and the decision-making process, and impacting healthcare system outcomes and cost (Canadian Nurses Association [CNA], 2019). APNs have been described as instrumental in the care of high-volume patient populations (Parker & Hill, 2017).

Our inpatient Palliative Care Consult Service, serving a large tertiary care facility, has also seen our clinical volumes increase significantly. Our new patient referrals have increased by 12%, and follow-up referrals have increased 10% annually over the last four years. Our palliative care consult team has had an APN as an integral part of the team since its inception, and considers the APN role to be in a unique position to be optimized in addressing quality gaps in the timeliness to accessing palliative care. The team, as a whole, reviews referral volumes quarterly and yearly. Having a full appreciation of each team member’s workload, as our volumes increase, is imperative to ensure the delivery of timely quality care.

This paper will describe our institution’s perspective of the clinical model in which the APN functions in collaboration with the physician, as well as the contribution the APN has made on the in-patient palliative care consult team.

The latter is made evident through the use of our team’s internal database, which captures patient demographic data, consult-specific information, reason for referral, referring service, malignant versus non-malignant disease, date of initial consult, death information, and disposition (Stilos et al., 2015). The database was expanded in 2019 to include the APN’s unique contribution to clinical care similar to the physicians. The data highlighted will support that this role is uniquely positioned in our team-based approach to care and can address the aforementioned quality gaps faced by Ontario’s growing demand for palliative care expertise.
OUR CLINICAL MODEL

The clinical model within which the APN works in our institution is team-based. It is well established that teamwork has become a collective covenant in healthcare, as it improves patient care and outcomes, increases employees’ job satisfaction, and maximizes organizational efficiency (Stahlke & Dahlke, 2020). Our APN is responsible for assessing patients referred to our consult service; collecting relevant demographic and clinical information; and, creating an individualized assessment and plan for interventions and evaluation of outcomes. The plan is then reviewed with the physician to finalize the care plan. This team-based practice approach can make it difficult to decipher the specific contribution of the APN, as the plan that is subsequently documented in the patient’s chart is produced by this symbiotic dyad. The positive, though mutually exclusive, relationship between the physician and APN poses a unique challenge in that the specific impact of the APN role on patient care is seldom evident due to the blurring of roles between the APN and the physician (Salamanca-Balen et al., 2018).

The APN role is further challenged in showcasing its distinctive contribution to cost effectiveness, patient care, and patient outcomes as the number of referrals seen by the APN is always supported directly or indirectly by a physician. This can make their distinct contribution somewhat invisible. The APN’s contribution to a palliative care service is not reflected in physician billings, nor are APN volumes submitted separately. On a systems level, this impedes the ability of the Ontario Ministry of Health and Long-Term Care in obtaining a true appreciation of the integral role of the APN in teams when the Ministry is evaluating cost and models of healthcare delivery. This, perhaps in part, has contributed to a reduction in APN funding and support for teams such as ours in recent years. At our institution, since our team’s inception, the APN funding support in the program has decreased.

REVIEW OF THE APN ROLE

We conducted our first review of the APN role on the palliative care team in 2015 to clearly define the role and its contribution to patient care. The five-year retrospective database review revealed that the APN’s primary clinical role was working predominantly with an elderly population referred with serious, complex and life-limiting conditions, and likely to die in acute care (Stilos et al., 2015). The findings supported the role of the APN in spearheading a hospital-wide program called the “Quality Living and Dying Initiative,” which addressed several domains of end-of-life care. Through this initiative the APN has been instrumental in improving the end-of-life care experience for imminently dying patients across the acute care setting (Stilos et al., 2016).

Furthermore, to help delineate the APN patient encounters, in 2019, the APN expanded the items included in the workload tracking to reflect parallel activities to those of the physician’s billing. This allowed the APN’s clinical encounters to be tracked in a similar fashion to those of the physician. The items allow us to track whether the patient was seen independently or with a physician and the length of the encounter.

Review of the workload data showed that the APN spent 93% of the time responding to patient consults independently with the review process taking place over the phone with the physician. The remaining 7% of the patients were seen in conjunction with the physician. New consults took approximately 50 minutes and the average follow-up encounter (patient known to our service) with a patient/family member/next of kin was 28 minutes. A notable finding from this review was that the APN was responsible for the highest number of end-of-life care encounters for patients referred to the Palliative Care Consult team, higher than the physician group. Overall, these workload data indicate the APN plays a vital role in providing primary palliative care expertise to acute care patients.

IMPLICATIONS

Health Quality Ontario (2020) and the Ontario Palliative Care Network (2019) outline key quality standards that hospitals, primary care organizations, LHIN home and community care services, and long-term care homes can use in their Quality Improvement Strategies. This includes an evaluation of their individual programs. Organizations are encouraged to prioritize the required quality issues and indicators and to actively engage in quality improvement measures to improve performance. Review of these two documents inspired us to review our own clinical data to evaluate the quality of palliative care we provide.

Our data validates how the existing APN role can contribute to Health Quality Ontario’s (2020) Quality statement #2, which is “timely access to palliative care supports.” Their definition states, “palliative care support consists of health advice, resources, treatment, and other assistance provided by the healthcare team to meet a person’s palliative care needs. Support should be culturally relevant and it can come in many forms including a telephone call with a registered nurse; a number to call when pain or other symptoms are not well managed; or a home visit from a primary care or palliative care provider (Health Quality Ontario, 2020).”

The APN was able to assess a large volume of patients independently while utilizing the physician in a joint visit for complex encounters. Our data support the notion that programs and organizations must look at how all team members contribute and function within one interprofessional team.

The demand for palliative care expertise is on an upward trajectory. The spirit of continuous quality improvement in palliative care calls for a thorough understanding and optimization of its consult team membership and its team processes to maximize both team efficiency and attainment of quality standards. In addition to maximizing the utilization of non-physician providers in the design of sustainable models of high-quality palliative care delivery, implementation of an APN role in a palliative care consult service fosters communication, problem-solving, shared goals and mutual respect, thus creating a professional
environment conducive to team collaboration (Schroeder & Lorenz, 2018). This has been documented in the literature (Schroeder & Lorenz, 2018) and is consistent with the experience we have had on our inpatient palliative care consult team.

Systemic growth of the APN role remains limited due to the wide variation in implementation of the role and limited research concerning the role within and across organizations. Hence, ongoing appraisal of the APN role is of critical and timely importance, to validate the value the role brings to a team and to the program and organization it serves. We recommend that other palliative care teams consider adopting a model of care embedding an APN to improve timely access to palliative care, especially when there is limited physician manpower.

Access to palliative care is a fundamental right for all Canadians and the APN is well positioned to address the shortfall of palliative care expertise now and in the coming years. It is time the role of the APN is brought out of the shadows and be perceived, accepted, and acknowledged as a valuable interprofessional member of a palliative care program and the healthcare system.

REFERENCES