NURSE NAVIGATOR GERD/DYSPEPSIA GI CLINIC

COLLABORATIVE PROJECT WITH
CALGARY FOOTHILLS PRIMARY CARE NETWORK

OBJECTIVES:

-description of the nurse navigator clinic & multidisciplinary team

-outline the nursing role in the NN process

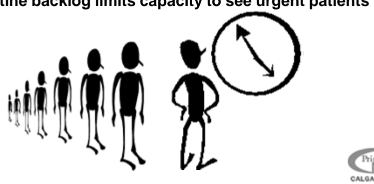
-outline the importance of teaching/education for patients

ROUTINE REFERRALS: THE PRESENT

Long wait times

Poor (or no) management while on wait list

Large Routine backlog limits capacity to see urgent patients



NOVEL PARTNERSHIP

Division of Gastroenterology & Calgary Foothills PCN & South Calgary PCN

Bridging Specialty Care with Primary Care

Increase capacity of Primary Care to manage "Routine"

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MULTIDISCIPLINARY TEAM APPROACH

Primary care physician - special interest in GI

Gastroenterologist

Dietician

Pharmacist (Foothills PCN)

Behaviour Health Consultant (access)

Nurse

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PATIENT SELECTION

The PCN patients triaged as routine/moderate GERD or dyspepsia

Exclusions:

- require a translator
- too complex (determined after phone consult)
- those who refuse this pathway

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NURSE NAVIGATOR ROLE

-Review the referral and ensure that mandatory investigations are complete as per medical algorithm

-r/o lab/DI abnormalities making patient too complex for group appt.

-Phone consultation with patient

-Education regarding their condition

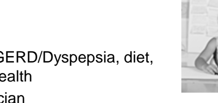
-lead the group teaching session

-Resource

GROUP MEDICAL APPT: FORMAT

Facilitated class vs didactic

"If there's no participation, there's no learning"



Initial appointment:

- Group setting overview of GERD/Dyspepsia, diet, medications, and mental health
- 1:1 appointment with physician

Follow-up:

- 1:1 with dietician, pharmacist, BHC and/or nurse as needed

GROUP MEDICAL APPT: KEY MESSAGES

Nurse:

- Normalize GERD/Dyspepsia GI pain
- Scope not always needed and why
- Mental Health affects GI pain
- Non-pharmacological interventions

Pharmacist:

- PPI's are safe, 30 min ac meals, max BID

Dietitian:

- Triggers are different in everyone
- Importance of Food Record

MEASURES

SF-12 and GOS at baseline and 6 months

Control group is regular pathway through central triage

Data demonstrates improved quality of life and decreased symptoms severity.

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CHALLENGES

Referrals from GI central triage

Patients late with lab tests

No shows and difficulty rebooking them

Not open to sharing in a group setting

Follow-up on clinical disposition(difficult if patient is well)

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TO DATE (CFPCN)

N = 327 (33 went to TSE first)

112 scopes (including 33 direct to scope)

1 Crohn’s and 2 Barrett’s (1 pre-existing)

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PATIENT SURVEY RESULTS

Recognizing others have similar symptoms
– i.e.: “not alone”
Multidisciplinary Approach
– physician, dietician and pharmacist
Empowered
– have strategies to manage symptoms on my own
Supportive Approach
-ability to access team members after clinic consultation

ROUTINE REFERRALS: THE FUTURE

Short wait times

Patients provided education & multidisciplinary team to improve management while on wait list

Increased capacity to see urgent patients

Mid 2014 – applying this model to IBS patients at PCN. IBS clinics have started at FMC already with over 70 patients having been seen.

PROFESSIONAL GROWTH

Better overview of GI clinic and some novel strategies to decrease the wait times.
In depth view of the services provided by other collaborative team members.
Independent work & utilization of critical thinking.
Development of competency in dealing with group dynamics.
Development of effective & efficient communication skills.
Development & application of adult teaching principles.
Opportunities to follow patient in PCN and Clinic streams.
More direct patient contact and impact on care.
QI experience.

SUMMARY:

The nurse has an integral role in the clinic with patient selection, education and support.

Work is done in conjunction with the physician – side by side with different roles

The nurse lead clinics have shown to improve quality of life, decrease symptom score and also decrease wait times.

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