INCORPORATING AN ADVANCED PROVIDER INTO YOUR UROLOGY PRACTICE:

From our Urologic Oncology Team
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Urology Family Pride
What are we doing?

- Managing acute issues
- Performing UDS
- Cystoscopies
- TRUS biopsies
- Inpatients/outpatients or both
- Dedicated to one MD
- Manage own patient panel
- New patients or revisits
- General uro. or subspecialty
In 2008 the AUA formed a committee looking at how to address the workforce shortages, one of its recommendations was to increase usage of NPs and PAs.
Number of urologists peaked in 2008 at 9,852 and is declining.

American population growing, number of urologists per capita is declining.

Almost half of urologists are over 55.

Federal funding for urology residency programs stopped 1997, less medical students able to get into residency programs.
Urological Allied Health Professionals
The American Urological Association (AUA) and the Urology Care Foundation recognize that in some areas, allied health personnel contribute to the care of the patient with genitourinary disease and, therefore, encourages the proper utilization of allied health personnel.
Allied health personnel should be considered as para-professionals and should work in a closely and formally defined alliance with a physician.
Where the major duties of allied health personnel are those of diagnosis, treatment, or management of [patients with] urological disease or problems, the designated supervising physician should be a urologist certified by the American Board of Urology (ABU).
The AUA recognizes that the role and privileges of allied health personnel vary according to individual state regulations and that the restrictions and/or controls established in any state should be honored.
APs and the future - how urologists’ use of non-physician providers will change in 5 years

- 57% increase
- 40% stay the same
- 3% decrease

Source: Urology Times 2012 State of the Specialty Survey
AP’s Future in Urology

Life is good.
American Academy of Nurse Practitioners estimates the number of NPs in urology has grown 1.1% annually since 2003.

AUA 2008 reported appx. 1,300 APs based on info. from APA and AANP

No accurate number of urology specific NPs

As of 2011- 143 NPs certified by CBUNA – Certification Board of Urologic Nurses and Associates
Membership in American Urologic Association (AUA) and Urologic Association of Physician Assistants (UAPA) has risen

UAPA estimates 3,000-4,000 PA’s working in urology
In 2011 AUA surveyed 678 affiliate members – NP, PA, nurse, clinical nurse specialist and surgical techs.

- 205 respondents – 51% NP
- 37% PA

In 2012 SUNA reported survey done out of University of Pennsylvania, Philadelphia.

- 527 urologists responded – 255 had at least one AP
“C” is for Concord Urology
Urology Practice Sub-specialties

- 9 Physicians with sub-specialties:
  - Oncologic robotic surgeons
  - ED/infertility specialist
  - Men’s health/laser surgery
  - Female sexual dysfunction/pelvic medicine/incontinence specialists
  - Stone management
Practice Goals

- Availability to see acute visits to decrease ER visits and provide comprehensive assessment and treatment of sickest patients.
- Relieve MD schedule of patients that are on surveillance or routine visits to allow MD to see new patients, surgical patients.
BPH
UTI
Med f.u.
H&P’s
Acute visits
ADT starts

BCG visits

Trimix self-injection teaching

Acute visits every c.c.

Man 2 Man

NP c.c. hematuria

Hospital rounds

Cancer registry reporting
AP support in each subspecialty

- Oncology
- Pelvic medicine
- Stone management
Awesome APs
Preparing for Prostatectomy

ONCOLOGY NP

- H&P
- Review expected post-op pathway with emphasis on incontinence
- Expectations for sexual functioning
- Outline surveillance protocol per NCCN

RN

- Review surgical sites and drains
- Show + tell Foley catheter
- SHIM score
- Schedule 2 days p.o. phone call
- Distress Thermometer
Robotic prostatectomy pre-op education and assessment

- Foley catheter shown to patient and explained. Catheter care sheet reviewed.
- Catheter thigh strap and cath-secure provided to patient. Patient reminded to bring this to the hospital day of surgery.
- JP drain reviewed. Explained usual location in the RLQ and likely removal on the day of discharge.
- General incision care reviewed, usual location of incisions (3 across top of belly, umbilical and RLQ) explained.
- Post-op care sheet reviewed with patient
- Patient reminded to be sure all jewelry INCLUDING WEDDING BAND removed prior to surgery.
- Explained likely discharge post-op day #1, if all is well.

Notes

Prev Form (Ctrl+PgUp)  Next Form (Ctrl+PgDn)
Distress thermometer

- Developed and validated in 1998 for evaluation of distress in cancer.
- It was adopted into recommendations by NCCN.
- Screening tool to help identify patients experiencing significant psychological, emotional, financial distress.
- RN reviews with patient at pre-op visit and repeats at 6 week post-op visit.
- We use a score of 5 or > as a trigger to offer social services referral.
Distress Thermometer

At the Center for Urologic Care, we are concerned about your overall social and emotional health as well as your physical health. This brief assessment will allow us to help you with concerns you may have. Please be sure to fill out both sections.

1. Circle the number from 0 to 10 on the thermometer that best describes how much distress you have felt in the past week, including today:

2. Please check any of the following that has been a cause of distress for you in the past week, including today:

   **Practical Concerns**
   - Housing
   - Insurance
   - Work/School
   - Transport
   - Child Care
   - Finances

   **Physical Problems**
   - Pain
   - Fatigue
   - Sleep
   - Eating
   - Sexual Concerns
   - Changes in urination
   - Bowel Concerns
   - Mobility

   **Emotional Problems**
   - Worry
   - Sadness
   - Depression
   - Nervousness
   - Anxiety
   - Spiritual or Religious Concerns
   - Loss of interest in usual activities

   **Other Concerns:**
   
   **Family Concerns**
   - Relationship with partner
   - Relationship with children
   - Coping with elderly relatives and/or dependants
Our Robotic Da Vinci’s
Post Prostatectomy Algorithm

7-10 days post-op
- Foley removed
- Surgical pathology reviewed
- Refer to PT for pelvic floor rehab

2 weeks post-op
- Review of activities, coping, plans for work
- Assess incontinence, begin discussion “penile rehab”
- Much emotional support

6 weeks post-op
- First post-op PSA
- Assessment of incontinence, psychosocial issues
- #2 distress thermometer
Prostatectomy surveillance

- Follow NCCN guidelines with OV every 3 months first one year, 6 months for 1-2 years, then yearly.
- For duration of their surveillance the patient alternates visits with MD and APRN.
Androgen Deprivation

Pca

MD

Rheum.

NP

Rad.Onc
Follow NCCN guidelines for prostate cancer treated with EBRT and brachytherapy

RCC surveillance per NCCN guidelines as well.
Non-invasive bladder cancer BCG intravesical therapy.

- NP visit treatment #1
  - Review treatment protocol, potential SE, reassurance and support, this should not interfere significantly with life!

- NP visit treatment #4
  - Review symptoms, encouragement. Plans for post-treatment cystoscopy and potential surveillance thereafter.
Urology MA Support
Median wait time from transurethral bladder resection to cystectomy was 50 days. Unadjusted and adjusted analyses demonstrated that prolonged wait times were significantly associated with a lower overall survival rate. The relative hazard of death with increasing wait times appeared greater for low stage vs high stage cancers. The cubic splines regression analysis revealed that the risk of death began to increase after 40 days.

Treatment delay between transurethral bladder tumor resection and radical cystectomy resulted in worse overall survival. The effect of wait time was greatest in lower stage lesions. The suggested maximum wait time from transurethral bladder tumor resection to cystectomy was 40 days. Further studies assessing disease-free survival are required to corroborate these findings.
MD Visit
(Diagnosis of Muscle Invasive Disease, Introduction to RN²)

Staging Studies
?Second Opinion
?Hold Surgical Date

Phone call once a week for update

Tumor Board Presentation

Possible additional MD visit after Staging Studies

Oncology Consult
Pulmonary Consult
Cardiology Consult

Phone call once a week for update

Follow up and/or pre-op visit with MD
RN² Visit w/Distress Thermometer and Pre-op teaching

Phone call once a week for update

Ostomy RN Visit pre-op for marking w/RN² at hospital
Pre-op Testing

Phone call once a week for update

SURGERY
(Inpatient for 7-10 days, RN² post-op visit while inpatient)

Phone call once a week for update

Post-op visit w/MD 2-3 weeks post-op
Ostomy RN visit for initial appliance fitting w/RN² in office

Phone call once a week for update

Post-op visit w/MD 6-7 weeks post-op
Ostomy RN visit for final appliance fitting w/RN²
Prostate and Urologic Cancer Program: Non-physician players

- APRN/PA
- Resource nurses/bladder cancer navigator
- Enterostomal therapy nurse
- Cancer specific social workers
- Cancer specific dietician
- Man 2 Man support group
- Tumor Board
- Physical therapist