Building a Comprehensive, Multi-Disciplinary Pelvic Medicine Program: An Integrated and Coordinated Multidisciplinary Approach to Patient Care

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*Disclosures: NONE*
Overview

• Elements of Multidisciplinary Approach to Pelvic Medicine
• Identify nursing interventions to assist the pelvic medicine patient in navigating the program
• Patient Benefits of a Multi-disciplinary Approach
  — Case Presentations
Basic Principle

A team approach and collaboration between all healthcare professionals is required to facilitate good quality holistic care
WHY DO I HAVE TO GO FIRST?

THERE'S NO I IN TEAM DAVE
Basic Principle

Recognition of the talent and creativity of all members of the multidisciplinary team will increase the chance of success in establishment of the concept
The “Anti-Silo” Movement

• Multidisciplinary approach focuses directly on equal collaboration with all disciplines working within a single unit

• Move away from the idea of specialty, move towards the idea of hybrid-specialty
Introduction

• The concept of multidisciplinary care is a well-established paradigm in medicine

• Numerous diagnoses are best cared for in a multidisciplinary fashion with nursing playing an integral role
  – Diabetes
  – Breast Care
  – Cancer
  – Wound Care
Benefits of Multidisciplinary Care

- Comprehensive assessment through their individual expertise and in consultation with one another
- The team approach promotes:
  - coordination and communication
  - offers the patient a one stop effort as opposed to many separate evaluations, interpretations and plans.
Benefits of Multidisciplinary Care

- Patient centered
- Facilitate care delivery with a nursing coordinator
  - Care pathways/Algorythms
- Limit redundancy
  - One stop “shopping”
- Curb costs
- Built in consultation
- Enhance professional knowledge
BIG PICTURE

A Multidisciplinary Approach to Pelvic Floor Disorders

- Urology
- Urogynecology
- Colorectal Surgery
- Physical Therapy
BIGGER PICTURE

"BRIDGING THE GAPS"

NURSING

PATIENT

URO

GYN

PT

BEHAVIORAL

COLORECTAL

NUTRITION

ACCUPUNCTURE
Multidisciplinary Approach to Care: Nursing Model

- Nursing has long espoused the plan of developing, maintaining and evaluating a plan for the care of patients.
- Ideally, the plans of all members of the healthcare team come together to form an integrated multidisciplinary approach to care.

Pathway Concept

- Traditional nursing care plans have evolved to pathways
- These are defined as *interdisciplinary* tools that identify expected outcomes, key interventions, and evaluation of a patient’s progress

Pathways as the tool for Integration

• Pathways were developed in the 1950s by industry to decrease the steps in production.
• Common reasons for developing pathways in the healthcare setting have been to reduce costs, enhance quality, standardize and ensure best practices, and connect the plan of care among all disciplines.

Components of the pathway include:
- the level of care required
- key diagnoses
- measurable outcomes

Pathways are now commonly used in many healthcare institutions as the *interdisciplinary* tool to document
- care required
- outcomes desired
- patient’s response to the plan of care.

Multidisciplinary Integrated and Coordinated Pelvic Medicine Program

• Approach to is similar to creating a care pathway
  – Level of care
  – Diagnoses
  – Outcomes

• NURSE COORDINATOR
Pelvic Floor Dysfunction (PFD)

- Common, but often goes undiagnosed and untreated
- 11% of women will require surgery for PFD in their lifetime,
  - 30% of these require re-operation
- >$20 billion spent in US in 2005 for treatment
- Aging population and increase in obesity
Projected female population in future decades (U.S. Census Bureau)
Female pelvic floor disorders in US

Consults/year

- By 2030, population of women older than 50 will increase by 72%
- Approximately 45% increase in patients that will seek treatment for pelvic disorders, primarily in the outpatient setting
- Increase in demand for specialized care centers

UrologyTimes, Oct 2009
PFD

- Pelvic Organ Prolapse
- Bladder Dysfunction
- Bowel Dysfunction
- Pelvic pain
- Female Sexual Dysfunction
Where I would like to take you:

- **Away from these:**
  - Endometriosis
  - Ovarian Cysts
  - Pelvic Adhesions
  - PID
  - Pelvic Congestion
  - Severe dysmenorrhea

- **Towards these:**
  - Gynecologic triggers
  - Urinary Bladder Pain Syndromes
  - Irritable Bowel Pain
  - Hypertonic Pelvic Floor Dysfunction
  - Neuropathic Pain
Typical complex of pelvic painful problems are often associated with various combinations of these symptoms:

- Urinary frequency & urgency
- Lower back and/or lower abdominal pains
- Sexual pain (entrance, during, and/or after)
- Vulvar pain, burning, or itching
- Irritable bowel issues
- Lower abdominal bloating and pressure
- Vaginal itching, burning, and sensitivity
What does that mean?

The proportion of women requiring treatment for a PFD will increase at least 2 to 3-fold in the next 1 or 2 decades.
Premise

• Pelvic Medicine needs are unmet in our community
• Hybrid specialty that lends itself to combined approach to care
• Delivery of specialty care should be performed in a coordinated, complimentary and multidisciplinary fashion
Premise

• Such strategies could substantially influence a more effective approach to women's health care
  – result in improved treatment outcomes
  – liberate women from
    • embarrassment
    • social and sexual isolation
    • restriction to employment and leisure opportunities
    • potential loss of independence
Impact of Pelvic Dysfunction Quality of Life

- **Physical**
  - Limitations or cessation of physical activities

- **Sexual**
  - Avoidance of sexual contact and intimacy

- **Occupational**
  - Absence from work
  - Decreased productivity

- **Domestic**
  - Requirements for specialized underwear, bedding
  - Special precautions with clothing

- **Psychological**
  - Guilt/depression
  - Loss of self-respect and dignity
  - Fear of:
    - being a burden
    - lack of bladder control
    - urine odor
  - Apathy/denial

- **Social**
  - Reduction in social interaction
  - Alteration of travel plans
  - Increased risk of institutionalization of frail older persons
Program Identity

- The program exists as a hybrid subspecialty
- The individual providers are participants in an integrated Pelvic Medicine Program
- Our primary focus is to advance the treatment and care of women with pelvic disorders by cooperating in the management and treatment of these patients
Goals

• To meet heightened demand for pelvic specialty care
• To create a coordinated integrated multidisciplinary program for the treatment of female pelvic disorders
Goals

• To assemble a team of care givers with an interest and expertise in pelvic medicine
• To centralize and coordinate care while being mindful of available resources and limiting redundancy in care
• To Create a Center of Excellence
Visions

- Community/Region
- Education
- Research
- Quality Measures
- Role Model for Collaborative Specialty Care
“The Team”

• PRIMARY PROVIDERS
  – Urologist(s)
  – Gynecologist(s)
  – Midlevels (NP, PA)
  – Nurse specialist(s)
  – Physical Therapist(s)
  – Behavioral Therapist(s)
  – Pain Specialist

• OR STAFF
  – Dedicated assisting

• NURSING STAFF
  – Manager/Program Coordinator
  – Nurse Triage
    • Medical Assistant

• ADJUNCT SPECIALTIES
  – Colorectal Surgeon
  – Dermatologist
  – Gastroenterologist
  – Nutritionist

• ALTERNATIVE MEDICINE
  – Accupuncture
  – Naturopath
  – Chiropractic
Current Providers
Our Experience

• Began March 2010 as one combo clinic day a month
  — Currently, weekly
• Experience to date:
  — >700 patients seen
  — >100 joint surgical cases
  — onsite consult between the diverse providers delivered during one visit
  — Monthly joint rounds
  — DMS student elective in Pelvic Medicine
Pelvic Medicine Clinic

• Currently takes place weekly
• Concord Hospital center for Urologic Care
  – 246 Pleasant St, Suite G2, Concord NH 03301
  – TEL. 603-230-1940
• One GYN, 2 FPMRS - URO, PT, NP on site
• Dedicated scheduler
• Dedicated Medical Assistants
• Dedicated Nurse Specialists (UDS, Interstim, triage)
Nurses play a key role

- Outpatient
- Inpatient
Outpatient Nursing
Office Nursing Roles

- Nursing Program Coordinator
- Nursing Clinical Leader
- Nursing Triage
- Education
- Pre-procedure Preparation
- Procedures (Urodynamics, Interstim programming, pessary maintenance, catheter management etc)
- Postop Management
Program coordinator

• Managing provider office schedules
• Decrease redundancy of visits
• Oversight of surgical scheduling
• Outcomes measurement
• Treatment Pathway creation and implementation
Nursing Triage - Navigation

• Urinary frequency
• Urgency /dysuria
• Incontinence
• vulvar /vaginal pain, burning, itching
• prolapse of uterus, bladder, rectum
• vaginal pain/pressure
• Sexual pain (entrance, during or after)
• poor libido
• pelvic / abdominal pain
• Combo of all / some of these problems
Pre-op Education

Pelvic surgery pre-op education
Planned surgery: - c/dups/robotic sacrocolpopexy Surgery date: 09/23/2013

Pelvic surgery checklist given to patient.
Reviewed Four Phases of Recovery with patient, specifically:
1. Postop activity and lifting restrictions reviewed.
2. Medication and diet regimen reviewed.
3. Postop bowel habits reviewed, Colace and Miralax discussed. Medication handouts given.
4. Reviewed when to call MD/office.

Foley catheter shown to patient and explained. Catheter care sheet reviewed.
Patient reminded to be sure all jewelry, including wedding band, removed prior to surgery.

Reviewed bowel prep with patient.

Comments / addenda Patient aware to call 9/13 for phone call appointment with MD to discuss surgery. ........Susanne Evans RN September 9, 2013 2:29 PM
Inpatient Nursing
Inpatient Nursing

- Intraoperative
- Postoperative
Contact us
If you have any questions or concerns, please call our office Monday through Friday, 8:30 am - 5 p.m. (A physician can also be reached after hours and on weekends.)

Concord Hospital Center for Urologic Care  
(603) 224-3388

Pelvic Medicine, Continence and Sexual Health Program (located in Center for Urologic Care)  
(603) 230-1940

Concord Hospital Medical Group  
Concord Obstetrics and Gynecology  
(603) 228-1111

Name

Surgeon

Date of Surgery

Your Path to Recovery
Pelvic Surgery Checklist

Notes: ____________________________________________________________

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Welcome

Welcome to Concord Hospital. Our team takes pride in providing exceptional patient care and your comfort, safety and satisfaction are our top priorities.

PHASE 1: After surgery

After your surgery, you will wake up in the Post Anesthesia Care Unit (PACU) where you will be closely monitored for one to two hours. You will then be brought to a patient care unit where the nurses are specially trained to care for you.

As you wake up, you may notice some of the following:

- **Abdominal Binder** – An elastic binder that wraps around your abdomen for added support and comfort.
- **Anti-embolism Stockings and Sequential Compression Devices (SCDs)** – Sleeves to help prevent blood clots in your legs.
- **Foley Catheter** – A urinary catheter to drain your bladder.
- **IV Intravenous Line** – To help replace fluids lost from surgery and to avoid dehydration prior to surgery. Your IV may also be used to give you medications.
- **Patient Controlled Analgesia (PCA) Machine** – If medication given to you by mouth does not adequately control your pain, the surgeon may order this machine to allow you to safely medicate yourself, as needed.
- **Vaginal Packing** – Sterile gauze placed in your vagina to decrease bleeding.

Please make sure you understand your discharge instructions before you leave the hospital.

PHASE 2: Recovery begins

The nurses will assess your overall condition, including monitoring your vital signs and giving you medications.

They will assist with:

- **Deep-breathing exercises** – Using an incentive spirometer to help keep your lungs clear.
- **Getting out of bed and taking short walks** – To improve your bowel function, circulation and breathing. You will be able to sit in a chair for short periods of time.
- **Diet** – You should be able to sip liquids. As your appetite and bowel function return, your diet will slowly be increased to solid food.
- **Pain Control** – It is important to request pain medication, as needed, to maintain a level where you are comfortably able to move. You will be asked to "rate your pain" on a 0-10 scale, where 0 means "no pain" and 10 means the "worst pain you can imagine."
- **Nursing** – Your nurse can give you medication to help with nausea, as needed.

PHASE 3: Getting ready to go home

Once you have met the following goals and your provider has determined you are ready to go home, it may take a few hours for your paperwork to be processed.

Before being discharged, you will need to be able to:

- Eat and drink without nausea or vomiting.
- Control your pain with medication taken by mouth.
- Change positions and walk short distances by yourself.
- Understand postoperative education and instructions.

PHASE 4: Recovering at home

What to expect:

- Your recovery will continue for six to 10 weeks after surgery.
- Abdominal and vaginal discomfort that will last for the first few weeks.
- Light lower abdominal pain may be the most uncomfortable area.
- Continue to use the abdominal binder as long as it provides comfort.
- You may have urinary incontinence during the first few months.
- Vaginal bleeding will gradually decrease over the first two weeks.
- If you go home with a urinary catheter, a nurse will teach you how to care for it.

To help you recover as fully and quickly as possible, follow the following instructions:

**Activity:**

- Do not lift anything greater than 10 pounds; do not strain, bend, squat or do any strenuous activity for six to eight weeks.
- Do not swim or soak in hot tubs or baths for six to eight weeks.
- No sexual activity and nothing in your vagina for six to eight weeks.
- Do not drive while you are taking narcotic pain medications or until your urinary catheter has been removed.
- Plan to return to work, as previously discussed with your provider.

**Bowel habits:**

- It may take up to a week for your bowel habits to return to normal.
- Avoid straining to have a bowel movement.
- You may use Miralax® and/or Colace® as needed.

**Diet:**

- For a more comfortable recovery, increase your intake of fiber, fruits, vegetables and water.

**Medications:**

- Take regular and newly-prescribed medications as directed unless otherwise instructed by your provider.
- You will be given prescriptions for pain medications and five days of antibiotics at discharge.

**Follow-up appointments:**

- If you go home with a urinary catheter, you will have an appointment at the doctor's office two to three days after surgery to have your catheter removed.
- You may have a postoperative appointment two weeks after surgery with a nurse practitioner or physician assistant.
- You may have a postoperative appointment to see the surgeon(s) eight weeks after surgery.

**Call your provider's office if:**

- Your pain is not controlled or is getting worse.
- It is difficult to empty your bladder or if your incontinence is getting worse.
- You notice blood in your urine.
- Your vaginal bleeding increases.
- You have fever over 101 F or if you have shaking chills.
- You notice redness, increased tenderness, yellow/green drainage from your incisions.
- Your catheter is not draining (if you were discharged with a catheter).
- You experience shortness of breath, chest pain, leg or calf pain.
Surgeries

- Robot Hysterectomy
- Robot Sacrocolpopexy
- Sling
- Vaginal Hysterectomy & Reconstruction
- Cystoscopy and laparoscopy combination
Post Op Floor Care

• Understanding of Procedure
• Implementing Post operative care pathway
  – Pain PCA/No PCA
  – RLQ port is non robotic, largest and most painful
  – POD 1 regular diet
  – POD 1 discharge for most pts, by urology service low threshold to keep until POD 2
  – Antibiotics
• Post op appts coordinated through the PMP
• Post op Rx: pain, stool softener, antibiotics
  – Activity restriction
  – Nothing per vagina
  – estrogen
Case presentations
Case #1

- 32 y/o G0P0 female with a 8 yr history of pelvic pain and urgency and frequency with associated dyspareunia and vaginal pain
- Seen by multiple specialists, fragmented care
- Underwent numerous procedures
  - Cystoscopies
  - Laparoscopy
  - Intravesical instalations
  - Multiple medications
• Seen in PMC
  – Interstitial Cystitis
  – Endometriosis
  – Vulvodynia (hormonal and musculoskeletal)
  – IBS
• Management
  – PT
  – Cognitive behavioral therapy
  – Accupuncture
  – Anticholinergics
  – Topicals
  – Neuromodulating Medications
  – Anti-inflamatories
  – Diet
Case #2

• 49 y/o who presented to her PCP with complaints of vaginal bleeding
• ER visit for severe vaginal bleeding, found to have a “pelvic mass” and be in urinary retention
• Imaging revealed 18week uterus
• Started on ISC in anticipation of intervention
• Seen at Pelvic Medicine Clinic
• Evaluation included urodynamics and cystoscopy as well at uterine biopsy.
• Evidence of CLPP of 89cmH2O with retention secondary to extreme uterine enlargement
• Stage 3 cystocele, +CST on pelvic exam
• Underwent RASCH, RASCP, DUPS.
• EBL 100cc
• Uneventful hospital course
Case 3

- 56 yo G1P1 with h/o MUI/POP treated with pessary desiring surgery
- **PMHx:** Breast Ca Er positive - L mastectomy and reconstruction, Hodgkins lymphoma stage III - staging laparotomy, transposition of ovaries and radiation, premature menopause @ 26, HRT x 20 yrs. with BTB, BTL, cholecystectomy, GERD, hypothyroidism, anorgasmia, chronic low back pain, SVD x 1
- **Evaluation & Tx:** Urodynamics/Dynamic MRI - SUI, POP Stage 3, fibroid uterus, nl ovaries
Op course:
dense adhesions involving bowel, omentum, and left adnexa encased in sigmoid enterolysis with Harmonic Ace and successful Robot assisted Hyst/BSO/SCP followed by DUPS/cysto and rectocele repair

Path: simple endometrial hyperplasia w/o atypia
right ovary granulosa cell tumor 0.8 cm
Case #4

- 46 yo female presented with periclitoral pain s/p VH, endometriosis, POP, complex cyst
- HRT c/o LLQ pain
- Exam under anesthesia: ?periclitoral abscess, priapism
- treated with injection of phenylephrine
Case#5

- 36 y/o female G2P2 high forceps delivery with persistent left vaginal dyspareunia
- Exam revealed left pubococygeal spasm
- Referred to PT for treatment
- Unable to tolerate myofascial release
- Injected once weekly with kenalog/bupivacaine and lidocaine cocktail
- Resumed PT with resolution of her dyspareunia
Case #6

• 45 y/o female with a 25 year history of pelvic pain, overactive bladder
  – Vaginal pain, vulvodynia
  – Abdominal and pelvic pain
  – Not sexually active
  – Unable to sit secondary to pain in perineum
• Diagnosed with Interstitial cystitis
• Interstim placed 10 years ago
• Some improvement of OAB symptoms
• Ongoing refractory vaginal pain
• Seen at PMC
• Diagnosed with vulvodynia, treatment initiated
• Pain Specialist – pudendal nerve block, central neuromodulator therapy, weaned off.
• Behavioral Therapist
  – Breakthrough, history of abuse
• Accupuncturist
Summary

• Pelvic floor dysfunction affects women of all ages and is associated with functional problems of the pelvic floor

• Pelvic dysfunction describes a wide range of clinical problems that rarely occur in isolation
Summary

• Inherent in achieving and promoting better health care services for women is the need for better collaborative approaches to care.
Conclusion

• There is a need to identify and develop comprehensive interdisciplinary, multi-professional strategies that improve the assessment and treatment of pelvic dysfunction

• If this area of women's health care is to be improved nurses, whether community- or hospital-based, must play a front-line role in challenging and changing current practices.
Thank-you