Transcript Details
This is a transcript of an educational program accessible on the ReachMD network. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/crohns-colitis-foundation-perspectives/2020-crohns-colitis-congress-key-takeaways-for-apps-rns/11260/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

2020 Crohn's & Colitis Congress: Key Takeaways for APPs & RNs

Announcer:
You're listening to ReachMD. The following episode was produced in collaboration with the Crohn's & Colitis Foundation & the American Gastroenterological Association.

Here's your host, Dr. Matt Birnholz.

Dr. Birnholz:
Coming to you from the 3rd Annual Crohn's and Colitis Congress in Austin, Texas, this is ReachMD. I'm Dr. Matt Birnholz. Joining me to discuss advanced practice provider takeaways from the sessions presented at this year's Congress is Kimberly Kearns, Nurse Practitioner Extraordinaire at DuPage Medical Group. Ms. Kearns, welcome to you.

Ms. Kearns:
Thank you so much for having me. I so appreciate that.

Dr. Birnholz:
Yeah, great to have you with us. So, to start off, maybe we'll just start with the high-level view first and get a sense of some of the most eye opening or maybe jaw dropping updates that you've seen, thus far, from the vantage point of an APP at this conference.

Ms. Kearns:
That's a great question. Thanks for starting with that one, by the way. I think our whole APP workshop that we had yesterday afternoon was wonderful, and I think it really was due to the diversity of our panel. We had such a multidisciplinary panel of experts, and I think that that just lead to a really unique perspective for all the audience members. We opened up with Michele Kissous-Hunt really giving an overview of IBD, and she really talked about how there's been some change in the overall management of IBD, specifically looking at target-to-treat, not only for induction but for maintenance, and also looking at mucosal healing as being really a part of one of our goals in treating IBD, which is kind of a newer thing for us, in, I guess for APPs. Another part that I really thought was a little bit more "jaw dropping," to quote you, for example, was our great discussion on emerging topics in IBD. We had an amazing panel discussion opening up with discussing the microbiome. In the microbiome, I think, understanding its multidisciplinary kind of interaction that's having, and specifically with our IBD population. I think there's a ton of emerging data that's coming up about that. We had Allison Egeland, who is a naturopathic doctor who provided multiple resources about the microbiome and how specifically it's related to IBD, factors that affected the microbiome, and even then led into discussions from Heidi Drescher about even the utilization of some of the positive nutrients in the microbiome, the short-chain fatty acids, which then led to a great discussion by some of our dieticians about the utilization of diet in the microbiome. We were even able to discuss some of the most emerging data in some of our biologics how it's influencing the microbiome as well with IBD.

Dr. Birnholz:
And what I love about the conversations that are happening within those sessions is that there is always an eye kept towards what is going to be actionable, and I think that's no more important than in the NP & PA universe where you're right in the frontlines with these patients who are looking at you and saying, "What are you gonna do for me right now?" And there is sometimes a disconnect at conferences across the world between the latest updates that are intriguing, that have great promise, and the latest updates that are truly actionable. And I'd love to learn more about some of the updates that came across in these multispecialty groups and sessions that you thought "I gotta jump on that! Like, we can actually change our approach based on what I've just heard."

Ms. Kearns:
Yeah, that's such a great topic and I think, too, when I go to these meetings, I get a plethora of information. And you're like, what can I take back and implement into practice versus what is kind of coming down the pipeline, and I think for advanced practice providers and nurses, the first thing you need to do is prioritize. What can I instantly implement? And you're right, versus the other items that maybe are coming through the pipeline or will need some additional work or time in order to implement that into practice. So, the first thing I always say is, prioritize. What can I implement right away? And some of the things, I think, from the APP conference was first and foremost, having open dialogue with your patients. Discussing health maintenance issues and psychology issues, which was a huge discussion point, which I know I think we'll get to a little bit later as well, but psychology issues and making your patient feel comfortable during their evaluation, from day one, because we recognize the psychosocial components of our IBD patients really aren't recognized so well but instantly has an APP or even the clinical staff of the nurse, taking that back but that's something you can bring back instantly. Also, healthcare maintenance. You know, those things in itself are something that you can apply instantly into practice.

Dr. Birnholz:
Well, let's jump into those in turn. So, let's take psychosocial measures. There's a question that often comes up as who's holding the hot potato on that one? Whose role is it? And where do they need to refer, are there any kind of turf wars that occur? But for NPs and PAs who are there, they have to take a pretty proactive measure on the psychosocial factors from your vantage point, where do we stand on psychosocial issues and where does the buck stop?

Ms. Kearns:
Sure. That was a really great discussion point that we had yesterday. Heidi Drescher had some wonderful psychosocial tools that as a staff member myself, I'm gonna bring this back for our patients. But you're right, there is kind of this overlap. Where do we fit in in the specialty of GI versus where do we use our psychology counterparts or even our psychiatric nurse practitioners or nurses, but I really feel that the buck really needs to stop with us. These patients come in to see us and they need assistance from us and we either need to initiate that referral to a specialist in psychology but it really should stop with us and nowhere else. And I believe, not necessarily is there a turf war, I think all of us have the patient's best interest in mind. So, when we have that in mind, I think that sending them down the pathway of seeing a psychologist, seeing a psychiatrist, really starts with us, and it was very interesting, Tina, one of our patient panelists, really went into really deep detail about her kind of role with her IBD disease and how she really had some hard times describing the psychosocial component. And it wasn't until someone actually asked her, and having that comfort level and asking your provider specifically about psychosocial issues, how they're feeling about depression, how they're feeling about their body image because of their IBD – but creating that comfortable space was really up to us in GI. And I think that that's where APPs are stellar. We really can communicate with the patient, sit down with them and provide that comfortable atmosphere.

Dr. Birnholz:
And what you're saying really resonates with many of our colleagues we've talked to from the psychological expertise wing, who say patients are waiting for you to ask them about the psychosocial measures. And only about 30% or so of patients are actually asked about this, and you are at the perfect position in the APP universe to be able to change the tide on that one. Why don't we switch over to health maintenance because you talked about that. That is a hot-button topic right now within the APP world. What was discussed at the sessions regarding that subject?

Ms. Kearns:
You know, Nana Bernasko did a great job presenting healthcare maintenance and IBD, and I think one of the biggest take-home points for us that were in the audience is that recognizing that our IBD population does not receive preventative care as like our general population does; it's actually much less. So, again, it goes back to the buck stopping with us that we really need to make sure that preventative care is a part of their individualized IBD care and that taking care of their IBD and their healthcare maintenance all goes together and it's just as important. So, even one of those take-home message was discussing healthcare maintenance should be at every single visit. Even if they're there because they're having a flare, addressing healthcare maintenance needs to be a part of that every time visit.

Dr. Birnholz:
What about if we continue on this track, pain management for patients. Many patients are experiencing pain whether they presented with it during flares or not, they're experiencing it even during remission, and I'm sure you and your colleagues are put in the position often times of how to best manage pain for these patients at various intervals of their care continuum. What are some thoughts in terms of how APPs can intervene and play a really important role in the management of pain for these patients?

Ms. Kearns:
Yeah, so part of our emerging topics discussion that we had with our panel is that we recognize even as APPs the opioid epidemic has

affected all of us. And for our patients with IBD, they do experience real acute pain, so how do we in this current state that we're in of the opioid epidemic and managing our patients who have chronic pain who need acute pain management and then also try to figure out how do we blend that with making sure that we don't have an opioid issue. So, Heidi Drescher provided a wonderful resource um from the *New England Journal of Medicine*, which had a lot of non-opiate pain management suggestions. But a part of like also recognized, it was looking at some alternative therapies recommending acupuncture, talking about massage therapy, utilizing yoga, and even just looking a little bit outside of our box. But, again, a lot of it was also talking with even our patient panelists who gave us some great recommendations about not using opiates for her chronic pain, but also recognizing as a patient when she's in pain, that we need to manage their pain and not be afraid to use opiates as well. So, I think that opening up that discussion really opened up some doors for some of our audience members that were there.

Dr. Birnholz:
Right, and you're bringing up an avenue that is sadly underrepresented the patient population themselves, being able to talk about the trial and error best practices, what has worked for them, the struggles that they've had, why they're diagnosis was delayed – a number of things that can actually lead to improvements in their care. So, I really appreciate you bringing that population into the sessions as well. For my final area of inquiry – hopefully not inquisition – I'd like to ask you about patient triage. Now there are a number of questions that come up with that, but how can APPs better manage this triage process for IBD patients, and I'm interested in some of the recommendations that you might have here, which I understand also came up during the sessions.

Ms. Kearns:
Yes. So, Erica Heagy from the Oregon Clinic gave a great presentation on Terrific Triage, which I think she did a great job in summarizing it into basically four points. So, one, assess your patient. Is this urgent? Does this need to get to a provider instantly? Number two, is this acute or chronic? Because that makes a difference when we're managing our IBD patients. The third thing that I think really is where we need to partner with our clinical staff is acquiring detailed information that will give us a picture of what's going on with our patient, but enough so that we're not asking for more information to delay the patient's care and some of the questions that Heidi included in our nurse triage, she gave a 10-step questionnaire which was wonderful, which is listed on the APP site to actually get looked at again. 10 questions that she had on there was, first of all, you know, is this acute? Also, checking out bowel activity – what is their baseline versus what are they having now? What current medicines are they on? What was their last dose? When was their last prednisone use? You know, simple questions such as that that really help tailor down what is happening to this patient. Is it acute? Is it something that's chronic? And then, how do we get to manage that quickly? And I think a lot of that was disseminating that back to our clinical staff and even our nursing team as to how to get that to the provider faster, so then again, we can provide optimal IBD outcomes. And then the fourth part of that, which number four was putting that all into three sentences. So, she used a great acronym called Old Carts, which again is listed as a reference. A lot of us use it as providers, which really helps summarize all that information, and then that was one of those great tools to bring back, and I think that in itself will really provide better IBD outcomes for our patients, to get to that terrific triage!

Dr. Birnholz:
Well, it sounds like a perfect way to close our interview. I really want to thank you for your time. We've been speaking with Kimberly Kearns, Nurse Practitioner Extraordinaire from DuPage Medical Group about the Advanced Practice Provider insights over the sessions of the Congress. Thanks so much for your time.

Ms. Kearns:
Thank you so much for having me.

Announcer:
This program was brought to you in collaboration with the Crohn's & Colitis Foundation & the American Gastroenterological Association. If you missed any part of this discussion, or to find others in this series, visit ReachMD.com/foundation, where you can be part of the knowledge.