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The Nurse-Practitioner Therapist and the Internist-Psychiatrist: A Novel Co-located Psycho-Oncologic Care Delivery Model

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Background

Psychiatric consultation services were initially offered as part of a pilot at the Stanford Cancer Center (SCC) through the efforts of a nurse practitioner and a psychosomatic medicine physician in the winter of 2015. At that time psychiatric services were not routinely available on-site for distressed patients with cancer. System wide initiatives by the SCC were then created to refer patients for supportive care services to comply with the requirements of the National Cancer Institute designation. Substantial evidence demonstrates patients with cancer have significant psychosocial needs for which there is evidence based treatment. Yet without the use of validated screening tools and effective referral processes, the integration of psychiatric and psychosocial care services is limited and also impacted by resource allocation.⁴

At SCC, over the course of the last 15 months, significant efforts by psychiatry and oncology social work have taken place to develop effective screening and referral methods, to create a collaborative care model of psychosocial care, and to enhance outreach to cancer center service lines.

While the collaborative care model has demonstrated strong evidence, there are numerous care delivery models, secondary to institutional variability and the vast scope of expertise and practice of psychosocial care providers. We present a novel care delivery model delivered by a dually trained internist-psychiatrist (SL) and a nurse practitioner (NB) also licensed as a psychotherapist (LMFT). We demonstrate the breadth and depth of psychosocial needs that are both explored and managed effectively to highlight the importance of attending to the developmental stages of individuals with cancers, caregiver distress, and indications for psychopharmacology.

Findings

Demographics		<ul style="list-style-type: none">Increased diagnostic precision of psychiatric symptoms and diagnosesMore comprehensive formulation: neurocognitive impairment, including dementia and delirium, metabolic disorders, sexual health issues, substance use disordersIncreased patient readiness to endorse disclose parent – child distress or spousal distress impacting careNew opportunity to meet with spouse and/or caregiver
Gender	Males: 7 Females: 3	
Age	23-80	
Race/Ethnicity	Caucasian: 80% Hispanic: 10% South Asian: 10%	
<ul style="list-style-type: none">-High alliance scores with mean of 106 (93%) for degree of alliance with high level of accordance with provider satisfaction rating-GAD-7 mean: 12, PHQ-9 mean: 13Improvement in compliance with therapy and medication plan-Qualitative near-complete consensus on efficiency and acceptability of care model for patients and family		

- Improved provider satisfaction related to:
 - increased confidence in care plan through offering interdisciplinary services
 - stress reduction related to partnership with internal consultant
 - effective utilization of the shared skillset and expertise of providers
 - implementation of scope of practice for each provider
 - improved morale, decreased isolation, peer support
 - increased time with patients over multiple visits

Conclusions

Emerging Themes:

- *Trust in all treatment recommendations due to shared expertise
- *Less stigma disclosing sexuality/sexual health concerns
- *More comprehensive psychiatric symptom inventory and assessment of medical conditions causing psychiatric symptoms
- *Greater acceptance of psychoactive or psychotropic medication(s) for treatment of many symptoms at once (e.g., anxiety + nausea + insomnia)
- *Participant-Observer dyad facilitated case formulation and peer feedback
- Patients value different kinds of experts for different aspects of “self”
- *Working with an aligned team resulted in a high level of patient satisfaction, demonstrated a higher level of therapeutic alliance, significant acceptance of psychopharmacological and therapeutic recommendations, improvements in screening measurement scores, and adherence to plan of care
- *Patients readily recognized different but complementary skill sets: noting more advanced management of psychiatric disorders related to medical etiologies as well as family and couples care

Methods

Over the course of our assessment and care, we identified a cohort of patients presenting with complex needs that required a collaborative approach using the shared expertise of two psycho-oncology providers (SL and NB). Contrasted with more traditional upward or external referral, we jointly provided a model of care comprising same day and co –located visits with oncology services at the SCC. During a period of 3 visits we promoted our respective colleague’s skillset, using patient education, motivational interviewing, CBT, as well as family therapy approaches; then we arranged face-to-face introduction, joint visits, a warm handoff and collaborative appointment scheduling for follow-up.

We conducted regular case-conferences and supported the care plan going forward for individual and joint care. In various cases this involved marital counseling, parent–adult child family counseling, inpatient management of complex psychiatric presentations, and medication adjustments around acute and complicated situations. We used the following measures: GAD-7 and PHQ-9 assessment at intake and periodically during care, cognitive testing as indicated, and therapeutic alliance scale (HAQ-II)⁵ with primary provider. We solicited feedback was on the joint model of care specifically with a standardized, qualitative questioning format. Verbal consent was obtained from all participants.

Patient Testimonials

I did see other therapists during my treatment and found my contacts with Dr. L beneficial, specifically concerning sleep...The Psycho Oncology program was essential for my recovery and I found each member of the team enhanced the treatment. Thank you!

We [patient and spouse] really appreciated seeing both on the same day as we came from far away and are so happy to have both involved in my care.

I needed to think about this out loud and talk because I was going in the wrong direction. It helped to meet with you both at different times.

I never thought I would do something like this, let alone enjoy it. It’s helped me meeting with a MD, and I feel the time I spend with my therapist is valuable.

The MD was amazing, at times [the patient] might not even remember [referring to period of inpatient episode delirium]. It made me feel better she was there because she understood what was going on with him when no one else did. She is more there for him than she should, but seeing [the therapist] also means someone can also be there for me and for us as a couple.

I feel the best today about the conversation as I have in a long time. Each of you help me with a different part of what I am going through.

Really appreciated seeing both on same day and having input from both providers.

Summary

Our shared model allows patients to utilize different areas of expertise and leverage their transference for optimal care. Patients’ trust and alignment with role/title allows fosters affiliation with providers with varying training and certification. Internal consultation and shared visits were demonstrated to be feasible and preferred by patients. They enabled escalation of care bypassing stigma of external referral processes, facilitating a higher level of care, and improving access to a range of provider specialization.

While the NP/LMFT is unique in this model, this can be extended to standard models of traditional care delivery using a MD + advanced practice provider or licensed clinical social worker with couples or family-focused training or including a LMFT or LMFT intern as part of the care team. Our model demonstrates the benefits of an interdisciplinary approach using warm hand offs to build trust and assure adherence, collaborative psycho-oncological care planning, family centered care, and peer-peer education and support in a shared setting.

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