Curbside Consultation for the Nurse Practitioner: Qualitative Inquiry for Education, Policy, and Practice

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INTRODUCTION

Lack of coordination in health care engenders great costs. Nurse practitioners (NPs) as stakeholders for quality health care are leaders within interprofessional teams and medical homes. Accessible information resources utilized at the point-of-care by clinicians faced with complex decision-making drive quality health care. Curbside consultations (CCs) are the most frequently utilized source of information in clinical decision-making for healthcare providers.

CC are defined as a bidirectional communication process in which one health care provider seeks advice from another in the management of a patient without formal consultation, or consultant-directed patient evaluation and primary data collection.

PURPOSE

CC is a cornerstone for interprofessional collaboration in health care because it provides the opportunity for individual providers to share their expertise. NPs utilize the expertise of other primary care providers and specialists as part of their decision-making processes however this interprofessional process of collaboration among NPs has not been assessed extensively.

A systematic review of CC by Papermaster & Champion (2017) found that only physician samples met inclusion criteria and focused primarily on their perspective. The majority of results exemplified naturally occurring interprofessional CC including NPs and physicians or other healthcare professionals. The CC was primarily with a physician (63%) rather than NP (26%).

The purpose of this study was to describe aspects of CC processes among NPs to provide insight concerning this critical aspect of interprofessional collaboration and decision-making.

INTERPROFESSIONAL EDUCATION

Interprofessional collaboration, a World Health Organization priority and core competency of the collective healthcare professional, improves patient outcomes and team function.

CC, as one such form of this collaboration, is a natural, valued practice amongst healthcare professionals and allows opportunities to learn new skills and resources from the wisdom of others, disrupting stagnant channels of thinking.

CC fosters effective interprofessional communication and evidence based practice stimulating the necessary integrated coordination of care.

Formal training on the practice of CC for all healthcare professionals as well as institutional promotion of collaborative networks and communication is warranted.

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METHODS

Qualitative descriptive methodology, seen as a less interpretive and theoretically based approach, was utilized to deploy in-depth, semi-structured interviews. Drawing from naturalistic inquiry for descriptions of phenomenon, this approach provides a means for consensus among investigators through analyses and interpretations of the meaning ascribed to phenomena.

We obtained institutional review board approval. Eligibility included board-certified NPs currently practicing in either primary or specialty care settings in a metropolitan area of the southwestern United States, aged 18 years and over and English-speaking.

Participants were recruited by purposive sampling and approached by either face-to-face or via email through various employer (i.e. hospital or healthcare practice) or NP networks in order to meet the maximum representation of the NP voice in the given study location.

A recruitment email was sent to NPs practicing in the health care facility. Seven NPs responded to the email and five met inclusion criteria and agreed to study participation. The remaining fifteen participants were recruited by word of mouth in the health care facility.

Two researchers including a senior qualitative researcher with over 30 years experience, conducted the analysis independently and then conjointly to confirm findings.

We reviewed the interviews transcribed verbatim through GMR Transcription© service in their entirety. Transcribed data and audio recordings were compared and amended for accuracy. Inductive content analysis, an investigative process to identify meaning, was selected given the dearth of studies in this matter.

Trustworthiness was achieved through the integrity, criticality, authenticity, and credibility. Integrity was reached through written field notes allowing the researcher to reflect on setting, nonverbal communication, ideas and biases through the process. Further criticality was attained through detailed notes on decision justification. Authenticity ensured the participants perspectives were represented through free discussion and credibility was completed with content validation with the dissertation chair to support coding.

Member checking was also on-going during the interview, expanding or clarifying statements and confirming key points. Participants were given the opportunity to reflect on the findings. Data saturation was achieved with thorough and comprehensive analysis. Preliminary analysis was ongoing during data collection, and ceased with saturation of themes answering the research questions.

We used Atlas.ti© data analysis program to organize data. Reading word-by-word, codes created by highlighting exact words, captured key thoughts or concepts. We sorted and grouped codes and examined these for more specific similarities and dissimilar content into the overarching themes in the abstraction process. We were careful to label the data based on the interview question to view the data across participants as well as identify emergent themes.

SOCIODEMOGRAPHICS

We achieved thematic saturation after completion of 20 interviews.

Participants were female (75%), between 30-50 years (70%) and non-Hispanic White (85%). Half of all participants identified as primary care providers in family practice (FP), internal medicine (IM), or pediatric settings while 50% identified as specialty care NPs in diverse settings.

Majority identified urban (80%) or suburban (15%) practice settings with no one practicing in rural settings. Relationships with supervising physicians ranged from independent and meeting only as mandated by state laws (10%) to practicing alongside supervising physician (40%).

Highest education reported by the majority (55%) was MSN.

One participant practiced solo while 2 participants had 10+ clinicians in their current practice. Average years in NP practice was 9.325 (SD 8.61) with 80% practicing since 2001

FINDINGS

Theme - **Information seeking in decision-making**
When confronted with an information need, NPs made a decision to use either CC, formal consultation or alternate resources ranging from software applications, websites, textbooks or other resource combinations. Formal consultation was chosen based on specific clinical situations, “If life threatening, I’m gonna err on the side of punt” (Outpatient, Family NP, 34-years).

Formal consultation was indicated when either NPs deemed a situation was beyond the scope of practice or questions were unanswered. Formal consultation was requested when specialty procedures were necessary for patient management. Some NPs explicitly stated formal consultation was used for documentation purposes. “That provider made that recommendation on paper, formally saw the patient, laid hands, smelled the patient, touched the patient, saw the patient, I know for a fact” (Inpatient, Family NP, 3-years).

Theme - **How to: Curbside consultation approach**
When NPs decided to proceed with CC, the approaches used were synchronous or asynchronous modes of communications. Synchronous communication included in-person or the telephone and asynchronous communication included email or text. Health Insurance Portability and Accountability Act (HIPAA) considerations were prioritized when using either mode.

Decisions to use either mode involved the timeliness and urgency, or presence or absence of a relationship. For instance, NPs considered “How much time I have to do this?” or “How urgent is this?” This context factored in decision making regarding the communication mode. For example, if a case was more complex, factoring in the need for a longer conversation was key as opposed to a quick and easy question.

Emails and texts were considered more impersonal, whereas a telephone call or in-person discussion could be relationship building and preferable when the seeker did not know the expert personally. When the seeker had a relationship with the expert, they were more comfortable texting. There were broad variations in descriptions of communication modes with some solo provider NPs stating they only phoned or texted while others in larger practices only used in-person CC. Some NPs used group conversations for CC in-person or texting. Synchronous communication resulted in the exchange of additional information.

When CC exchanges occurred on phones or face-to-face, nonverbal communication cues, e.g. voice fluctuation or tone distinction impacted the information flow. For CC, “... we offer on-the-fly thing (phone) … most people choose email (Outpatient, Orthopedic Family NP, 5-years).

Theme - **Information received. Now what?**

NPs desired to make sound and appropriate medical decisions emphasizing quality. CC typically impacted decision-making positively. “It is why you are consulting someone. You want it to affect your decision-making” (Outpatient, Women’s Health, Family NP, 19-years). NPs were still the decision-makers and followed instincts, erred on the side of caution and continually considered safety. "It's additional information to consider on top of your own experience, what you read, what you think, what you research, what you know" (Outpatient, Family NP, 34-years).

Advice Validation

NPs may or may not explicitly substantiate the advice received. Some reported they do alternative research prior to asking and won’t carelessly ask for advice without researching beforehand. Some NPs gauged their decision to validate the advice received. For example, NPs may ask for advice on a certain medication and then confirm dosage or other features of the medication.

NPs were careful to evaluate CC advice that did not resonate with them. This occurred when NPs thought the advice was excessive or out of character with what was normally done or inconsistent with the original plan leading them to question the soundness of the information obtained. If the expert seemed hesitant, or “pretty sure”, the NPs were hesitant to implement this advice without some other form of confirmation. NPs validated advice by seeking out someone else or researching via another resource.

FINDINGS

(Dis)agree with the advice

“(It is) about balance … to decide how much weight you put on any one consultation ...” (Outpatient, Pediatric Primary Care NP, 11-years). When NPs agreed with advice, the decision was made to accept and apply the advice. NPs may consider the advice further and decide whether it confirmed their plan or informed choices prior to fully implementing the advice. NPs may change their plan based on advice received. Some NPs reported they used a combination of plans or chose the expert’s plan if perceived as equally guideline based.

Basis of the advice

NPs had varied opinions concerning evidence or experience-based advice. Some NPs stated the advice was evidence-based and they could reliably find similar information in an evidence-based resource. Other NPs perceived the advice was experience-based and occurred more often in cases where there is scant research available. Advice given in these situations was based on experience of the expert or even institutional culture or protocols.

Many times, the expert was applying their experience to the options available in the research literature. Some situations warranted more logistical or geographical considerations as opposed to straight-forward application of the research literature, such as the knowledge surrounding institutional radiologic procedure scheduling, insurance, or transportation. NPs rarely found experience-based advice contradicted the research literature.

Theme - Learning from Curbside Consultation

CC was a way to learn, extend NP education, and expand what could not be found in other resources. NPs were exposed to a wide range of cases and appreciated learning other’s opinions and advice. Mutually beneficial experts also learned via CC processes. Many NPs enjoyed educating, giving back to the nursing profession, and being able to expand upon their own knowledge with unique questions they had to find themselves.

It strengthens our community. And then, it helps me think, too. And sometimes people ask me really good questions. And that I have to be like, “Oh. I haven’t thought about that for a really long time. That’s a really good point.” And, occasionally I’m asked questions which are really good questions and I really do have to stop and go back and be like, “You know what? That’s a great question. Let’s look at the guidelines together.” And then it gets my own gears going. And then we both have a learning experience. It’s fantastic (Outpatient, Gastroenterology/Endocrinology Family NP, 12 years).

CONCLUSIONS

CC is a vital, organic component of NP practice

NPs informed their practice through multiple “ways of knowing” including communicating with other health care professionals as part of an interprofessional CC to inform and reinforce their decisions and improve the lives of their patients.

NPs expanded personal knowledge via interprofessional CC. When information seeking did occur, seeking a colleague was perceived as a more useful and accessible source of information than any research-based method. Additionally, it was seen as more specific and pertinent, time efficient, and removed the need to judiciously evaluate.

Synchronous or asynchronous communication for decision-making was based on factors such as relationship, timeliness, and urgency. This exemplifies the multidimensional function of decision-making with personal and environmental factors that weigh into a particular circumstance.

CC is a vital, organic component of NP practice. It is one component of the overall decision-making process and provides NPs an opportunity for interprofessional collaboration.

These study findings represent an initial understanding of CC as a component of the decision-making for NPs. Study findings have implications for education, policy and practice expounding upon this frequently used process to promote optimal interprofessional communication, collaboration, and application of health information for quality patient care outcomes.