2017 FMRNA Annual Residency Nursing Workshop

Presented by the Family Medicine Residency Nurses Association
Friday, March 24 – Saturday, March 25, 2017
Location: Sheraton Kansas City Hotel at Crown Center

This continuing nursing education activity was approved by the Midwest Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Successful Completion Requirements: *Certificates verifying attendance and 6 contact hours awarded will be distributed after the event to all participants who meet the following requirements:*
1) Check-in at event.
2) Complete and submit the FMRNA evaluation.

Friday, March 24, 2017

1:30 – 2:00 p.m.: **Registration/Networking** [Benton]

2:00 – 2:15 p.m.: **Welcome Remarks** [Benton]
FMRNA President – Marcia Snook, RN, BSN

2:15 – 3:15 p.m.: **Workshop 1** [Benton]
Fostering Integration between Residency Educational Staff and Clinic Nursing to Create a Balanced Clinic Schedule
Kristen Bene, PhD; Kimberly Bell, MS

We plan to describe how we have created and fostered an integrated approach to clinic scheduling that brings together the residency educational staff and clinic nursing and scheduling. Through this collaborative effort, we have been able to equally prioritize the resident "block schedule" and the appointment and productivity needs of the family medicine clinic. Residency clinics are unique environments with many part-time providers, and many competing demands. The literature on clinic scheduling and staffing models in family medicine residencies is sparse and typically focused on PCMH models and open-access scheduling. Nothing well describes the dual purpose of the residency clinic environment and the inherent challenges created by the competing demands of education and patient care. We hope that through this workshop, we can describe our process, the logistics of making it work, and lead the audience in an evaluation of the unique challenges in clinic scheduling in a residency clinic. We plan to focus heavily on the importance of collaboration with nurse leadership and scheduling. If there is time, we may also briefly highlight how we have leveraged technology resources to template our clinics and balance appointments.

Objectives:
1. Evaluate strategies for effective communication between clinic nurses and residency educational staff in relation to clinic scheduling.
2. Design a model where clinic appointment availability is more balanced despite variations in the resident rotation schedules.
3. Leverage online and human resources for efficiency and effectiveness in clinic scheduling.

3:15 – 3:30 p.m.: Break

3:30 – 4:30 p.m.: **Workshop 2** [Benton]
Motivational Interviewing: Motivating Health Behavior Change
Tasha Marchant, RN, PhD

Motivational Interviewing is an evidence-based technique that supports individuals in changing their health behavior. The skills learned in this workshop will apply to patients, staff, and colleagues. During this workshop, we will discuss the current common practices in supporting behavior change as well as introduce motivational interviewing techniques. Participants will have an opportunity to engage while doing their own personal goal setting. We will discuss how these techniques can be applied in various patient settings.

Objectives:
1. By the end of the training learner's will be able to define motivational interviewing and its role in health behavior change.
2. By the end of the training learners will be able to identify specific tools of motivational interviewing to implement into their patient interactions.

4:30 – 4:45 p.m.: Break

4:45 – 5:45 p.m.: **Workshop 3** [Benton]
Value Added Pain Clinic Model
David Marchant, MD; Kathy Randall, LPN

Chronic pain management is an emotionally charged issue for most clinics. Five years ago, in response to resident complaints about not seeing anything but pain patients in their clinics and from patient complaints of suboptimal care, we went about exploring different options. We ended up developing a very successful multi-disciplinary pain clinic that focuses on function. We have a process that includes group education classes, yoga, massage, goal setting, and integrated behavioral health. Our physicians and patients have consistently praised the clinic because of the changes in people's lives we have seen. Our workshop will introduce you to our methods and how they can be applied in your setting. As with most residency programs, we have limited financial means and therefore have leveraged other community resources.

Objectives:
1. Verbalize benefits of team integration for the management of chronic pain management.
2. Illustrate clinical strategies for coordination of patient care in a pain clinic model.
3. Describe outcomes of patient care as they relate to care received in pain clinic.
4. Leverage resident education by introducing new methods of care delivery.

5:45 – 6:00 p.m.: **Closing Remarks** [Benton]
Marcia Snook, RN, BSN

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Saturday, March 25, 2017

8:00 – 8:15 a.m.: **Welcome Remarks** [Benton]
FMRNA President – Marcia Snook, RN, BSN

8:15 – 9:15 a.m.: **Workshop 4** [Benton]
Nurses in Family Medicine Residency Education, a Multi-disciplinary Approach
Michael Greene, MD

Practicing medicine and being a well-rounded Heath professional in the 21st century involves an interdisciplinary collaborative approach. Residency programs are adapting to this need and we at Creighton are on the cutting edge. We would like to discuss an innovative curriculum change that incorporates RN teaching into the learning curriculum.

Objectives:
1. Be able to state reasons why multi-disciplinary education for Family Medicine Residents is preferred over single Discipline education models.
2. Be able to state the benefits to RN incorporated resident education.
3. Be able to list skills and techniques nurses can teach residents.

9:15 – 9:30 a.m.: Break

9:30 – 10:30 a.m.: **Workshop 5** [Benton]
Managing the Changes in Clinical Staff Roles: How to Maximize the Scopes of Practice
Kathleen Morin, AD, RN

Never has it been more essential in outpatient practice for all clinical staff to be working at the top of their license or certification and scope of practice. Quality metrics have turned a once quick check in process into a 20-minute clinical check in-visit. Improving preventive measures, pre-visit planning, and chronic disease management are just a few clinical tasks that have been recently added to the clinical staff's duties. Telephone triage and urgent care triage are areas that not only improve appropriate and timely care, but continue to be a valuable tool for residency education. All clinical levels, registered nurse, licensed practical nurse, and medical assistant are needed in residency programs. The scope of practice needs to be used in defining their roles of each clinical staff, but often providers and or managers are not educated in the roles. Defining and, when necessary, changing the roles are needed for safe and comprehensive care to patients.

Objectives:

1. Describe the scopes of practice for registered nurse, licensed practical nurse, and medical assistant.
2. Describe the current changes and challenges in health care that are contributing to both positive and negative changes in the residency clinical structure.
3. Describe why is it necessary to employ all levels of clinical staff, including registered nurses, licensed practical nurses, and medical assistants working at the top of their license and or scope of practice, and how this team works together to assist all providers with quality metrics, timely care, safe practices, and residency education.

10:30 – 10:45 a.m.: Break

10:45 – 11:45 a.m.: **Workshop 6** [Benton]
Beating Burnout – Incorporating Mindfulness into Your Daily Practice
Theresa Salmon, LMSW

This interactive workshop will facilitate a dialogue on nursing burnout and will offer participants an introduction to mindfulness. Participants will receive resources for further learning about mindfulness and will be given the opportunity to practice mindfulness exercises.

Objectives:

1. Learners will define Mindfulness.
2. Learners will discuss how mindfulness can be incorporated into daily practice.
3. Learners will practice a structured mindfulness exercise.

11:45 a.m. – 12:00 p.m.: **Closing Remarks** [Benton]
Marcia Snook, RN, BSN

Fostering Integration between Residency Educational Staff and Clinic Nursing to Create a Balanced Clinic Schedule

Kristen L. Bene, PhD and Kimberly K. Bell, MS
PVH/Fort Collins Family Medicine Residency
Family Medicine Center
Fort Collins, Colorado

Objectives

- Evaluate strategies for effective communication between clinic nurses and residency educational staff in relation to clinic scheduling.
- Design a model where clinic appointment availability is more balanced despite variations in the resident rotation schedules.
- Leverage online and human resources for efficiency and effectiveness in clinic scheduling.

Family Medicine Center/Fort Collins FMRP

- 7-7-7 Community-based FM residency program
- Busy safety net clinic serving 37,000+ patients per year
- Predominantly Medicaid population
- NCQA Level 3 PCMH
- 9 Faculty physicians, 21 residents, 5 Nurse Practitioners
- Specialty clinics

The Issue

- Unique environment
- Importance of balance
- Little guidance from the literature

The Past

Rotation	Preceptor	FMC Clinics M	T	W	Th	F
Allergy	James-M-Brighton; Wed-Denv; Greely-Thur-Pager 229-8160	X		X		
Ambulatory Peds	Sullivan –FCYC S-T-Th 3 wks, 1 wk T-Th	X			A	X
Anesthesia	Girardi, Alessi, Rick	P	P	P	P	P
Behavioral Medicine	Carol Pfaffly	X	X	X	X	X
Cardiology	Whitsitt all day clinics				X	X
Community Med -HPDP	Kathleen Jones	X	X	X	X	X
Dermatology	Komfeld –clinic M am W-F all day	P	X			
Dermatology - Chris	Sayers or B.Baack (off on Fri all day)					X
Dermatology	Hultsch (double check)				X	X
Endocrinology	Widom	X		X		
Endo	Izon (off Tues pm)	X	P	X	X	X
ENT---Jerrie	Erickson-Surg Tor Th		X		X	
ENT-- Nancy	Loury	X		X	X	
ENT	B. Smith – off on Thurs	X			X	
GI—Sean x 203	Simmons – they do procedures M& Friday!		X	X	X	
GYN - LCHD	Rennick – 1st Wed all day staff mtg			X	X	
GYN-Chris	Englert-Closed Wed, surg Mon am	A		X		
GYN	Sparling – off on Wed			X		
Gyn-Laurie	Hayes/Stauffer- no males Fri pms off	X	X	X	X	X
GYN – Terri-x4449	Kozak-off on Friday – will take males		A	P	P	X
Hand Surgery	Tsoi (off all day T, Surg all day W)		X	X		
Hematology	Merrill	X	X	X	X	X
CCU-Pulm	3 – 1 all day, 1 half-day – 1 resident T-TH the other W-F R-2 rotation- No Monday clinics		1	2	1	2
ICU	2 Residents on at same time so that each R has alternate weeks,not same days-no more than 1 clinic together /wk	X	X		X	X
ID	Peskind-Hyperbaric -F , PVH, Th 12:30-1:30-Cobb off Wed	A	A	P		

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The Past

JANUARY, 2009
FORT COLLINS FAMILY MEDICINE RESIDENCY PROGRAM
Clinic Schedule: AM CLINIC 8:30AM-12:00PM; PM CLINIC 1:30PM-5:00PM

Revised January 6, 2008

OOT	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	
Copper - 1/25 Copper- 1/25 vac 5 vac 5	5 PGM,EJM@,DNL,IDW, DRM,BB,KDC,JB **JRW**	6 PGM,DSW,ACL-NHV,KKA, MSS,JRW,PSW,KDC,JB **BB**	7 PGM,EJM★,CG,KKA,ACL, MSS,BB,LKH,KDC,JB **PSW/JRW★** LEEP	8 PGM,ACL-A,DNL◇,DRM, AGB,LKH★,KDC,JB LEEP **BB◇/CG★** *JRW/ACL-A*	9 EJM,D KKA,PS **BB/M**
	DRM/BB★ DERM PGM,RRJ-O,KOB•,JRW, MEH,DNL@,MLL★,KDC,JB	**AGB/JRW** PGM,RRJ,ACL@,MSS,ML•, MEH,MLL,KDC	**-0-** PGM,JRW@,BB,KDC,JB	**DRM/CG** KOB,DNL,IDW,BB, LKH@,BDH,JCC,KDC,JB	**MWH(** *CG/JCC* EJM#,R BDH@,
Copper-1/25 Copper -1/25 vac 12-18 vac 12-18 vac 16-18	12 PGM@,EJM★,JRW,CG, DLS,KDC,JB **BB★** COLPO	13 PGM,ACL,KKA,MSS,PSW, LKH,KDC,JB **BB**	14 PGM,EJM,CG,KKA,ACL#, MSS★,LKH,KDC,JB **PSW/DLS★** COLPO	15 PGM,DSW-A,JRW,MSS, LKH,DLS,KDC,JB*CG/DSW-A* **BB◇/(AGB)PSW**	16 EJM★ PSW@,B **BB/CG**
	PSW◇/(JRW)MWH PGM,RRJ@,KOB◇,BB, MLL-O,MEH•,KDC,JB	**DLS/JRW★** IUD PGM,RRJ,ACL•,ML★,MLL@ , MEH,AGB,KDC	**-0-** PGM,JRW,BB,DLS@,KDC, RPB,JB	**JRW/CG** *PSW/LKH-A* KOB,DSW,KKA-NHV,BB, LKH-A,BDH,JCC,KDC@,JB	**-0- CA** EJM,RRJ BDH-NH *AGB/RR*
Copper -1/25 COPIC COPIC Copper -1/25 conf 23 ,JRW 19	19 PGM,DDM★,DRM, KDC@,JB **CG★** COLPO	20 PGM,PSW,ACL,DNL,DLS, KDC,JB **JRW**	21 PGM,EJM,JRW,DNL,ACL# LKH,MLL,KDC,DLS,JB **PSW**	22 PGM,DDM-A,ACL,DRM DNL-NH,MLL,AGB,KDC,JB **PSW** *JRW/DDM-A*	23 EJM,D LKH@,B **CG/DL**
	DRM★/(DLS)MWH PGM,RRJ-O,KOB★,MSS@ MEH-O,KDCJB DERM	**AGB/JRW** PGM,RRJ,ACL@,DNL•,MSS, ML,MEH,KDC	**-0-** PGM@,CG,JRW,KDC,JB	**DRM/JRW★** COLPO KOB,DSW★,KKA-A,BDH@,JCC, MLL-NH,DLS,KDC *PSW/KKA-A*	**CG/DL** EJM-A,R ML,LKH,
conf to 2/1	26 PGM,CG@,DRM,PSW,	27 PGM,HEH,DNL,PSW,MLL,	28 PGM,HEH,RRJ◇,DLS,	29 PGM,HEH,CG,DNL,DAM,	30 RRJ,

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Small Group Discussion

- Who is involved in resident scheduling and clinic scheduling?
- Are these the same people?
- What are the challenges?
- What works really well?

Large Group Sharing

- What did you learn from each other?
- Common people involved?
- Common challenges?
- What works well?

Our Approach

- Rotation Changes
- Process Changes
- Communication Changes

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Our Approach: Rotation Changes

- Schedule hospital rotations for entire academic year
  - Hospital rotations most rigid
- Be creative. Look for ways to make other rotations less rigid
  - Ask about flexibility
  - Persuade
  - Find new preceptors
- Move clinics to allow for max clinic productivity
- Goal is even staffing and clinics for max patient and staff satisfaction, resident productivity

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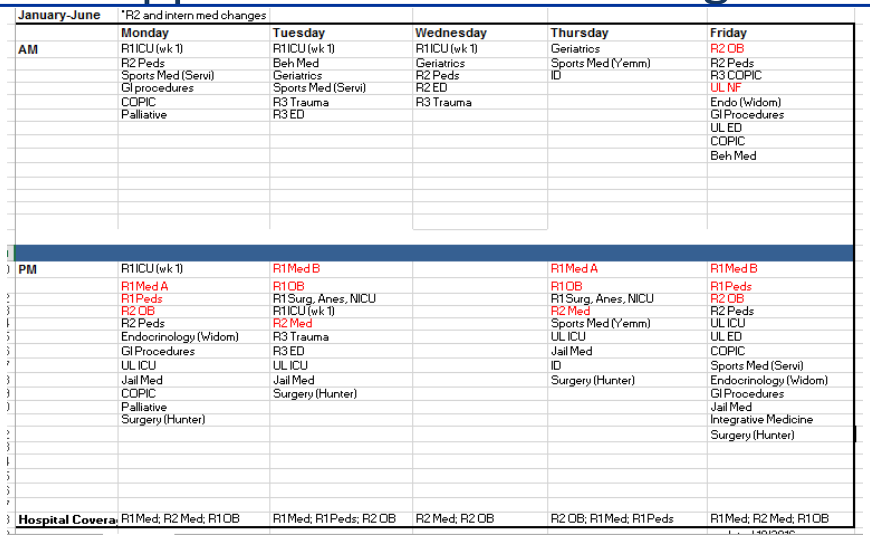
Our Approach: Rotation Changes



January-June	*R2 and intern med changes				
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
AM	R1 ICU (wk 1)	R1 ICU (wk 1)	R1 ICU (wk 1)	Geriatrics	R2 OB
	R2 Peds	Beh Med	Geriatrics	Sports Med (Yemm)	R2 Peds
	Sports Med (Servi)	Geriatrics	R2 Peds	ID	R3 COPIC
	GI procedures	Sports Med (Servi)	R2 ED		UL NF
	COPIC	R3 Trauma	R3 Trauma		Endo (Widom)
	Palliative	R3 ED			GI Procedures
					UL ED
					COPIC
					Beh Med
PM	R1 ICU (wk 1)	R1 Med B		R1 Med A	R1 Med B
	R1 Med A	R1 OB		R1 OB	R1 Peds
	R1 Peds	R1 Surg, Anes, NICU		R1 Surg, Anes, NICU	R2 OB
	R2 OB	R1 ICU (wk 1)		R2 Med	R2 Peds
	R2 Peds	R2 Med		Sports Med (Yemm)	UL ICU
	Endocrinology (Widom)	R3 Trauma		UL ICU	UL ED
	GI Procedures	R3 ED		Jail Med	COPIC
	UL ICU	UL ICU		ID	Sports Med (Servi)
	Jail Med	Jail Med		Surgery (Hunter)	Endocrinology (Widom)
	COPIC	Surgery (Hunter)			GI Procedures
	Palliative				Jail Med
	Surgery (Hunter)				Integrative Medicine
					Surgery (Hunter)
Hospital Covera	R1 Med; R2 Med; R1 OB	R1 Med; R1 Peds; R2 OB	R2 Med; R2 OB	R2 OB; R1 Med; R1 Peds	R1 Med; R2 Med; R1 OB

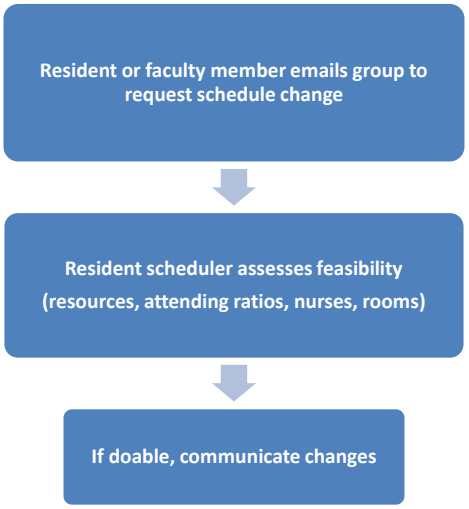
Our Approach: Process Changes

- Leadership support for change
- Education team involvement in clinic scheduling
- Automate the process
- We moved didactic conference time to Wednesday afternoon
  - No residents in clinic that afternoon. Allows for faculty and NPs to have clinic space
- Block schedule gets created first, then clinic schedule and nurse schedule
- We assign resident clinics first, then faculty clinics. No set faculty or resident clinics

Our Approach: Process Changes

- Block schedule > clinic schedule > nurse schedule
- NP set clinics > resident clinics > faculty clinics
  - No set faculty or resident clinics
  - Attending schedule created based on need and FTE

Schedule change communication process



Our Approach: Communication Changes

- Calendar Creation Committee email group
  - Limited to only those directly affected
  - Establish a process for vacations/absences
  - Ensure all change requests come through group
- Direct communication between nurse scheduler and resident scheduler prior to emailing group
- Methodically file emails
- Flex styles to include everyone

Things we haven't solved

- No "set" resident or faculty schedules
- Last minute resident/faculty clinic changes still a problem
  - With more residents in clinic, there is less wiggle room
  - Held NP schedule most days
- Continued need to flex communication styles
- Backslide in rotation rigidity
- Not enough "facetime" for scheduling team to fully build rapport
- Holiday weeks/spring break still unbalanced
- We've reached another plateau in terms of access; most solutions would involve a continued decrease in rotation time

Conclusions

- When in doubt, communicate!

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Questions?

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Motivational Interviewing: Motivating Heath Behavior Change

Tasha P. Marchant PhD, RN
Fort Collins Family Medicine Residency
University of Colorado Health
Fort Collins, CO

Outline

- State of the State (Why)
- Motivational Interviewing Concepts (What)
- Tools for putting ideas into action (How)

Prevalence of Chronic Disease

- 7 out of 10 deaths among Americans each year are from chronic diseases. Heart disease, cancer account for more than 48% of all deaths each year
- In 2012 approximately ½ of all adults,– had at least one chronic illness.
- Obesity has become a major health concern. More than1 in every 3 adults is obese and almost 1 in 5 youth between the ages of 2 and 19 is obese (BMI ≥ 95th percentile of the CDC growth chart)

Centers for Disease Control pulled from website 1/2017. Chronic Disease Prevention and Health Promotion https://www.cdc.gov/chronicdisease/overview/index.htm
.

Common Causes of Chronic Disease

- In 2011 more than half (52%) of adults aged 18 years or older did not meet recommendations for aerobic exercise or physical activity. In addition, 76% did not meet recommendations for muscle-strengthening physical activity.[9]
- In 2011, more than one-third (36%) of adolescents and 38% of adults said they ate fruit less than once a day, while 38% of adolescents and 23% of adults said they ate vegetables less than once a day..
- In 2012, More than 42 million American adults (approximately 1 in 5) reported smoking.[12]
- Excessive alcohol consumption contributes to over 88,000 deaths/year, more than half due to binge drinking.

Common Causes of Chronic Disease

Four modifiable health risk behaviors—lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption—are responsible for much of the illness, suffering, and early death related to chronic diseases.*

Centers for Disease Control pulled from website 1/2017. Chronic Disease Prevention and Health Promotion https://www.cdc.gov/chronicdisease/overview/index.htm

Chronic Disease Management

A sinking ship

-Nursing School
- lack of emphasis of motivating change

-Nursing practice
- lack of patient education time to “change diet and exercise”
- “Black Box”
- nursing attitude=token effort

The Good news…

Healthy Lifestyle also has been documented to reduce the likelihood that risk factors will turn into chronic disease

Why is it not translating?

- In the traditional medical model, we still struggle to incorporate this knowledge into healthy patient behaviors
- Less than 3-4% of individuals practice full spectrum lifestyle change that could significantly improve health and lower chronic disease risk

(Stampfer et all, N Engl J Med. 2000;343:916-22)

Why so challenging?

While there is abundant evidence that lifestyle has a significant affect on heath, the challenge is to help the populations we serve incorporate these changes in their daily life

Behavior Change is Difficult

Are we having the conversation?

Nurses Role

- Key role in supporting patient behavior change

Outline

- State of the State
- Motivational Interviewing Concepts
- Tools for putting ideas into action

Motivational Interviewing

Motivational interviewing is a client-centered, guiding method of communication and counseling style designed to elicit and strengthen motivation for change by exploring and resolving ambivalence

MI works by activating patients' own motivation for change and adherence to treatment

Points to Remember

The clinician CANNOT make change happen

People are more motivated to make change when it's based on their own decisions and choices, rather than an authority figure telling them what to do*

*(Reactance theory: Brehm & Brehm, 1981; Self-determination theory: Deci, 1980)

Common Sense

- Common sense? YES
- Common practice? NO

And…it is not new….

"People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the mind of others"

- ****Pascal 17th century *Pensees*

Why MI?

Patients exposed to MI (vs. usual treatment) are:

- More likely to enter, stay and complete treatment
- Participate in follow-up
- Adhere to glucose monitoring and improve glycemic control
- Increase exercise, fruit & vegetable intake
- Reduce stress and sodium intake
- Keep food diaries
- Reduce unprotected sex and needle sharing
- Decrease alcohol and elicit drug use
- Quit smoking
- Have fewer subsequent injuries and hospitalizations

Rollnick et al. 2008. *Motivational Interviewing in Health Care*

Spirit of MI

- Collaborative
- Compassion
- Evocative
- Honoring Patient Autonomy

Collaborative

- A conversation
- Removes power differential
- Joint decision making

Evocative

- Activate own motivation and resources

- Everyone has their own Values, Aspirations, and Dreams

Honoring Patient Autonomy

- Detachment from outcome
- Accept the individual has their own freedoms to not make change

Compassion

- the ability to actively promote the other's welfare and give priority to the other's needs.
- commitment to seek to understand others' experiences, values, and motivations without engaging in explicit or implicit judgment.
- understanding that everyone strives towards a fulfilling life and at times encounters barriers which can evoke feelings of sadness, pain, and shame

Outline

- State of the State
- Motivational Interviewing Concepts
- Tools for putting ideas into action

How?

How do we help patients make the jump?

Tools

- Use your toolbox
  - 14 Tools of MI that might help guide patient interaction.

Top 14

- #1 Style
- #2 Ask In
- #3 Agenda setting & the power of choice
- #4 Evocative Questions
- #5 Stop and listen
- #6 Understand what motivates
- **#7 Reflections**
- #8 Scaling
- #9 Roll with Resistance
- #10 Resist the righting reflex
- #11 Weighing Ambivalence
- #12 Empower
- #13 Build an action plan
- #14 Closing

#1-Style

- Dancing vs. Wrestling=collaborative
- Non-judgemental
- Empathic
- Respectful

The paradox of change: when a person feels accepted for who they are and what they do—no matter how unhealthy—it allows them the freedom to consider change rather than needing to defend against it.

What is your style?

– Your child's BMI is in the 95th percentile, what concerns, if any do you have about your child's weight?

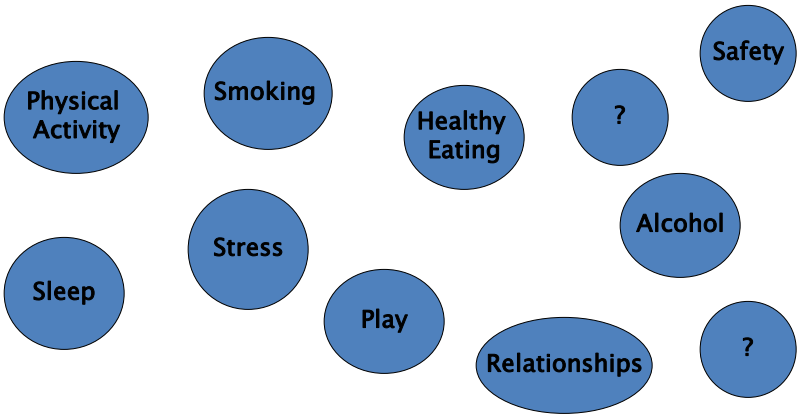
VS.

– Your child's BMI is very high and it is very important that your child gets her weight under control before it becomes a bigger problem

#2-Ask In

- I have some concerns and would like to discuss your weight with you, would that be ok?

#3-Agenda setting & the power of choice….



#4-Evocative Questions

- OPEN ENDED!
- If a miracle happened and you made all the changes to want to make, how is your life different a year from now?
- If nothing changes, what might happen, what's at stake?
- If you were going to eat better, how might you choose to do it?

#5-Sshhh…..Stop talking

- Listen to your patients with
  - Presence
  - Eyes, ears, and heart
  - Acceptance
  - Silence
  - No interruptions

#6-Understand…

- Understand what motivates your patients.
  - Concerns
  - Values
  - Motivations for change
  - ****This is what will pull them forward

Between what I think…
And what I want to say…
What I believe I am saying…
What I say…
What you want to hear…
What you hear…
What you believe you understand…
What you want to understand…
And what you understand…
There are at least 9 chances for misunderstanding

#7-Reflections

- Repeating back what the patient/parent says to build rapport and understanding.
  - Incorporate Values
    "It is important for you that your family is healthy"

Reflections

- Reflections allow for opportunity to:
  - Let the patient know you are listening
  - Allow redirection if necessary
  - Carry the conversation forward to the next level, encourages elaboration
    - So you feel…
    - It sounds like…
- Levels of Reflection
  - Simple (repeating)
  - Complex (implying meaning)

#8-Scaling

- Readiness
- Importance
- Satisfaction
- Confidence

Scaling 0-10----TELL ME MORE

0-1-2-3-4-5-6-7-8-9-10

Backwards and Forwards Questions

#9-Rolling with Resistance

Increased resistance = decreased health behavior

- Clinician should not:
  - Argue with patients
  - Impose a diagnostic label
  - Tell patients what they "must" do
  - Seek to "break down" denial by direct confrontation

Resistance is a signal to respond differently

#10-Resist!

- Resist the righting reflex

We tend to believe what we hear ourselves say. The more we hear ourselves speak the disadvantages of changing, the more reluctant we will be to change.

#11-Weighing Ambivalence

Change
vs.
No
Change

#12-Empower

- Let the patient be the expert of their own lives.

#13- Building an action plan

- Use SMART goal setting
  - Specific
  - Measureable
  - Attainable
  - Realistic
  - Time-limited
- **Plan Follow-up!**

14#-closing

- Summarize the plan
- Thank patient
- Supporting (not cheerleader) affirmation

Thank You!

Resources

- Rollnick S, Miller W, Butler C (2007). Motivational Interviewing in Health Care: Helping Patients Change Behavior. New York: Guilford Press
- Rosengren D (2009) Building Motivational Interviewing Skills: A Practioner Workbook. New York: Guildford Press
- The Motivational Interviewing Page: http://www.motivationalinterview.org

FMRNA
FAMILY MEDICINE
RESIDENCY NURSES
ASSOCIATION

Value Added Pain Clinic Model

Kathy Randall, LPN
David Marchant, MD

Agenda

Our Story

Our successes

Our struggles

Our method

Who We are

- 7-7-7 Community program
- One of two safety net clinics in county
- Providers not interested in chronic pain
- Very limited options for referral

Successes

- Smoking Cessation
- Decreased patient complaints
- Clinic Satisfaction
- Provider and PCP Satisfaction
- Other needs met by PCP
- Clinic Availability
- Socialization
- Education
- Volunteer Tree
- Mental Health
- Patient Advisory
- Community Partnerships

Key Principles

- Team Integration
- Focus on Function
- Contracts & Mandatory Monthly Appointments
- Care Management & Care Coordination
- Patient Empowerment and Education
- Surveillance (PDMP, Pharmacy)
- Medical Neighborhood

Where We Are Now….

- Appointment Types
  - Intake
  - Individual Visits
  - Group Visits

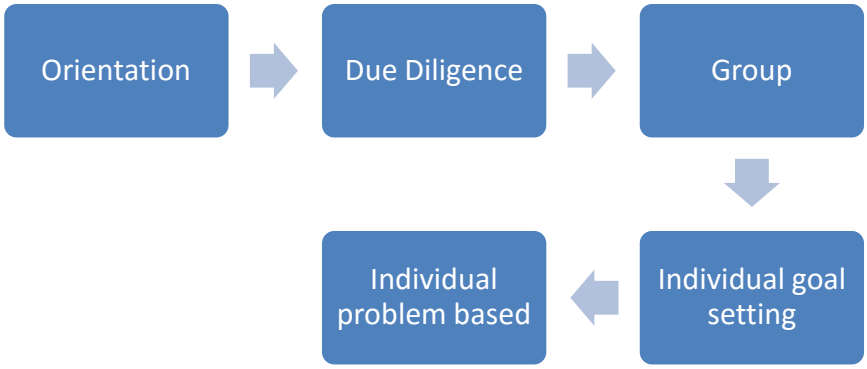
Patients

- Family Medicine Center patients
- PCP referred
- Age ranges 20-69
- Not all on narcotics
- All types of pain

Check-In

- Co-located
- Full front office service
- First floor entry
- Separate waiting
- Continuity at check-in
- Dedicated phone line

General Process



Orientation

- Review and sign contract
- Due Diligence appointment set

Intake Due Diligence

- Integrated Team visit with new patient
- Includes
  - Medical history
  - Pharmacology review
  - Substance abuse and mental health screening
  - Goal setting
  - Chart review
- Group visit (separate appt.)
  - Orientation
  - Contract talk

Group

- 12-20 patients
- Monthly topics & speakers
- Guaranteed to end on time
- Due Diligence
- Goal Setting
- Educational Handouts
- Evaluations
- Envelope
  - Prescriptions
  - Appointment card

Group Education

- Bowel Management
- Massage
- Acupuncture
- Depression
- Addiction
- Heat Therapy
- Vitamin D
- Process Group
- Gratitude
- Goal Setting
- Integrated Health
- Sleep
- Biofeedback
- Acupressure
- Reflexology
- Contracts

Individual Visits

- Semi-Annual (mandated)
- Address unique needs
- Integrated Team
- Evaluations

Growth Edges

- Resident Involvement
- Other faculty involvement
- Expansion

Team Functions

Provider

Nurse

Behavioral

Questions?

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Nurses in Family Medicine Residency Education, a multi-disciplinary approach

Michael Greene, MD

Overview, Goals and Objectives

- At the end of this presentation, the participants should be able to:
  - State the benefits of a multi-disciplinary approach to Resident education
  - Understand the contributions of the RN to resident education
  - List the ways in which RN's can be incorporated into resident education.

Why the change?

- 1. Solo-practice vs. Group practice
- 2. Uni-disciplinary vs. Multi-discplinary
- 3. RVU vs. Value based contract
- 4. Acute care consultation vs. Health maintenance
- 5. Single patient vs. Population health management

Multi-Disciplinary Team approach

- What multi-disciplinary is not: it is not more than one physician.
  - Physicians all have much in common including the training basis on diagnosis and treatment.
- It is not: a group of people working under the physician
  - Teams are made up of members, not employees
- It is not: Goal oriented to maximize revenue
  - Goal oriented to care for the patient instead

Teams

- Skill set required to work in teams:
  - Communication skills
  - Intra-personal skills
  - Presentation skills
  - Debate and argumentation skills
  - Listening and Hearing skills
- The benefits to patient care are obvious

What does the RN contribute?

- Everyone works at the top of their license.
- The RN does a job that the physician does not do.
- The scribe does a job that the physician does, but does not wish to.
- i.e., the RN is not a physician in training who does a little bit of what the physician does. He/she does a different thing
- Pediatrics story:

What does the RN contribute?

- Residents were trained in medical school to diagnose, and in residency to recognize and treat.
- There is very little (comparative) time spent on patient education.
- There is little time spent on recognizing the learning method of the patient
- There is little time spent on assessment of what the patient understands of what was just said in the 15 min medical appointment.

What are we doing?

- We have 3 nurses.
  - One is a “nurse educator” who helps run some outpatient rotations, and is in charge of some aspects of the resident education process.
  - One is a population health manager who is adept at motivational interviewing and patient outreach
  - One is in charge of IV/meds/triage and phone management of patients.

Nurse Educator

- Three rotations, many responsibilities!
  - skills verification: adequate discussion of Benefits, Risks, and Alternative?
  - able to follow up patients? return calls?
  - 360 evaluations
  - Patient prenatal education
  - Home visits

Population Health Coach

- How do we manage a panel of patients rather than the patient in front of us?
- Motivational Interviewing, back to back interviews and compare notes with same time allotted.
- Community needs assessment
- Community involvement
- Work/physician liaison

Triage nurse

- Skills, IV, Meds, etc. Afghan story
- Phone management of patients.

Next Steps

- Close the feedback loop: resident evaluations
- adding RN to CCC
- Questions?

- Michael: 402.717.0380
- Omaha, NE

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Managing the Changes in Clinical Staff Roles: How to Maximize the Scopes of Practice

KATHY MORIN, RN

OBJECTIVES

- Describe the scopes of practice for RN, LPN, MA
- Describe the current changes and challenges in healthcare that are contributing to both positive and negative changes in the residency clinical structure
- Describe why it is necessary to employ all levels of clinical staff, RN, LPN, MA, working at the top of their scopes of practice.

Scope ?

- What is the scope of practice? The term “scope of practice” is used to define the actions, procedures, etc. that are permitted by law for a specific profession. It outlines restrictions to what the law permits, based on specific experience and educational qualifications
- What may be common practice in a facility may not be always appropriate or legal
- Each facility also has regulations that are developed for the RN, LPN and MA

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RN Scope of Practice

Works under own license,
medication administration, noninvasive and invasive procedures, higher level nursing assessment , critical thinking, triage performing both assessment and recommendations, specialized care coordination and patient and family education and management.

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LPN Scope of Practice

Works under own license,
medication administration, performs clinic assessments and re-assessments, invasive and noninvasive procedures, triage with information obtaining only but can not perform high level triage or offer treatment recommendations unless explaining the providers recommendations.

MA Scope of Practice

Registered or Certified not licensed, works under a licensed physician or other licensed health care provider, scope varies from state to state but the differences revolve around:

- **use of equipment**
- **administration of medications**
- **types of invasive and noninvasive procedures**

RN VS LPN Using the Nursing Process

Evaluation:
RN-determine if the goals included in the care plan have been met
LPN: contributes results and documents them

Implementation:
RN- performs actions decided on in the Nursing Care Plan
LPN- complete tasks delegated to them by RN

Assessment:
RN-performs complete, exhaustive assessment
LPN-contributes data for assessment

Nursing Diagnosis:
RN – an educated judgment based on actual or potential complications
LPN-data collection to support

Planning:
Only RN's can complete a nursing care plan using Critical Thinking
LPN's- provide input and suggestions

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Medical Assistant

- Regulations of practice vary from state to state
- Historically there have been many facilities where their Medical Assistants are working outside of their scope of practice
- The physician is ultimately responsible but it does not remove the Medical Assistant from being accountable and can be sued for any injury to the patient under their care
- The facility who allows an MA to work outside of their scope can face serious consequences
- Patients must be made aware that they are being cared for by an MA and not a nurse.

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Medical Assistant

MA's are not allowed do the following in all states:

- Making independent health assessments, judgments, diagnose
- Triage
- Interpret diagnostic results
- Dispense medications without a prescription
- Administer medications without a doctor's order
- Administer medications directly into the vein

Medical Assistant

CRMA's in Maine are allowed to:

- Check in patients to include vitals, medication reconciliation, chief complaint etc.
- Immunizations, injections such as B 12, Depo-Provera but cannot administer any other hormone injections, allergy injections and IM Haldol and similar medications
- Nebulizer treatments, phlebotomy, pulse oximetry, CLIA waived point of care testing but cannot interpret the data
- When delegated by the team RN, they can call patients with appointments and simple instructions
- Using hospital approved refill protocols, they can call in refills

What's the Elephant in the Room?

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Why The Changes in the Types of Clinical Staff?

- **Increasing of Healthcare Costs**
- **Pay for Performance and Meaningful Use**
- **Don't forget to Click the Boxes !**
- **Administrators and Providers Need Education**

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Why The Changes in the Types of Clinical Staff?

- **Increased acuity of patients in the out-patient setting**
- **Nation wide issue with the readmission rate and the need for comprehensive out patient assessments and follow up**
- **PCMH- more services needed for patient support including education, care coordination, RN visits**
- **Population management – diabetes, hypertension etc.**

Medical Model vs Nursing Model

- **Medical Model –** Provider, MA's, Front Office Staff
- **Nursing Model –** Providers, RN's and LPN's and less MA staff
- **Medical Model-** offers lesser scope of services
- **Nursing Model –** offers greater scope of services

Staffing Ratio's

- **Medical Group Management Association Benchmarks- (MGMA)**
- **American Academy of Ambulatory Care Nursing**
- **Patient Centered Medical Home – " Our study suggests that additional staff with specific expertise and training is necessary to implement a PCMH. Further study and opportunities for funding additional staffing costs will be important for realizing the potential of the PCMH model of care."**
- **How Do You Quantify Our Responsibilities Of Educating Residents ?**

What Does A High Functioning Team Look Like?

- **All Providers can speak to the scopes of each clinical level, knows what to expect of them and does not give them any tasks that are out of that staffs scope of practice.**
- **RN Clinical Coordinator / Manager who also knows the scopes of practice and makes sure each staff works to top of their scope. The Coordinator is capable to effectively work in any clinical position.**
- **Each Team or Pod has at least one RN who is the team lead:**
  higher level of care, patient assessment needs, phone triage and acute visit triage, abnormal test results
  RN managed clinics, patient education, coordinator of care, health coaching.
  appropriately delegating to their team LPN and or MA staff.
  actively involved in residency education throughout all aspects of their roles.

What Does A High Functioning Team Look Like?

LPN:
assessments and reassessments, assist with invasive procedures, phlebotomy, administer immunizations, medications, refills using more tasks then MA's in many states, they are able to call normal test results, patient instruction with the direction of the RN and or Provider, involved in resident education during their in clinic care of the patients.

MA:
Know your state regulations! MA's in Maine are highly efficient, task oriented and valuable to the entire team. MA's are most effective with the hands on rooming of the patients, medication reconciliation, data collection, assisting with office procedures, phlebotomy. Directly involved in resident education during their in clinic care of the patients.

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Empower Your Medical Assistants to be the best they can be.

- Encourage them to learn more by taking classes:
- Become certified/registered
- Medication Safety Class through local program or online.
- Advocate with Administration to help with the tuition if finances are an issue.
- Develop Clinical Ladders for MA's
- Value them as an important member of the team!

If your state does not address clearly the MA scope of Practice, it will typically authorize delegated tasks

If a licensed practitioner is to delegate a task, here are some things to consider:

- The task must be within the providers authority.
- The task is done under appropriate supervision.
- The MA assigned the task must be competent.
- Task is safe when performed exact and does not require complex observations or critical thinking.
- If the task were done improperly, the outcome would not be life threatening or cause serious harm to the patient.

Points To Take Away

- Know each clinical staff's scope of practice

- It is just as important for RN's to be working at the top of the scope as it is for MA's not to be working outside of their scope. Everyone is accountable for their own actions. There are major consequences for facilities if they allow MA's to work outside of their scope

- The patient mix and demographics and the services you are currently doing or hope to do should help direct your staffing mix

Points To Take Away

- If your office does not employ an experienced RN, then who is supervising the clinical staff?

- It is necessary to take away duties that have been commonly performed by LPN's and or MA's to be compliant if those tasks are out of their scope

- Encourage your administration to consider using MGMA staffing benchmarks to assist with getting additional staff, including RN's

- Value all clinical staff and give them every opportunity to work at the top of their scope

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Beating Burnout – Incorporating Mindfulness Into Your Daily Practice

Theresa Salmon, LMSW
Director of Family Medicine Behavioral Health
Methodist Charlton Medical Center

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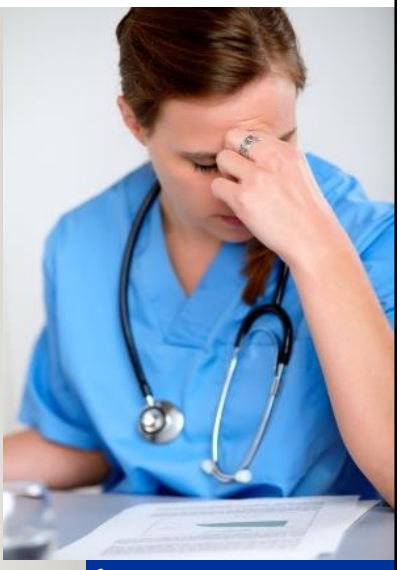
Objectives

- Define Mindfulness
- Discuss how mindfulness can be incorporated into daily practice
- Practice structured mindfulness exercises

Nursing Burnout





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Nursing Burnout

- 40% of nurses report general occupational burnout
- Stress and burnout in healthcare professionals associated with various physical problems including: fatigue, insomnia, heart disease, depression, obesity, hypertension, infection carcinogenesis, diabetes, and premature aging
- Burnout also associated with decreased patient satisfaction and “suboptimal self-reported patient care”

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www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/2017-Year-of-Healthy-Nurse

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- 2016 Culture of Safety
- Public Health Nursing
- Delirium: Prevent, Identify, Treat
- Nurse Staffing
- Nursing Quality
- Professional Standards
- ANA Call for Public Comment
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2017 Year of the Healthy Nurse

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2017 YEAR OF THE HEALTHY NURSE
BALANCE YOUR LIFE FOR A HEALTHIER YOU

Do you want to eat healthier, be more active, get better sleep, and have more joy? This is your year! ANA is declaring 2017 to be the Year of the Healthy Nurse! Join us as every month we tackle specific wellness issues that all of us can improve.

ANA defines a healthy nurse as someone who actively focuses on creating and maintaining a balance and synergy of physical, intellectual, emotional, social, spiritual, personal and professional wellbeing. We feel that nurses are ideally positioned to be the best role models, educators, and advocates of health, safety, and wellness. So come participate with us fully this year as we focus on YOU! Visit this page every month to see what is being offered as resources, events, and activities for that specific month. Join us on ANA's Facebook and Twitter pages to interact with other nurses to share recipes, success stories, challenges, and useful tips. Take our newest health survey. Engage in the Healthy Nurse, Healthy Nation™ Grand Challenge. This year, let's improve the health of the nation's 3.6 million registered nurses and in turn improve the health of the nation!

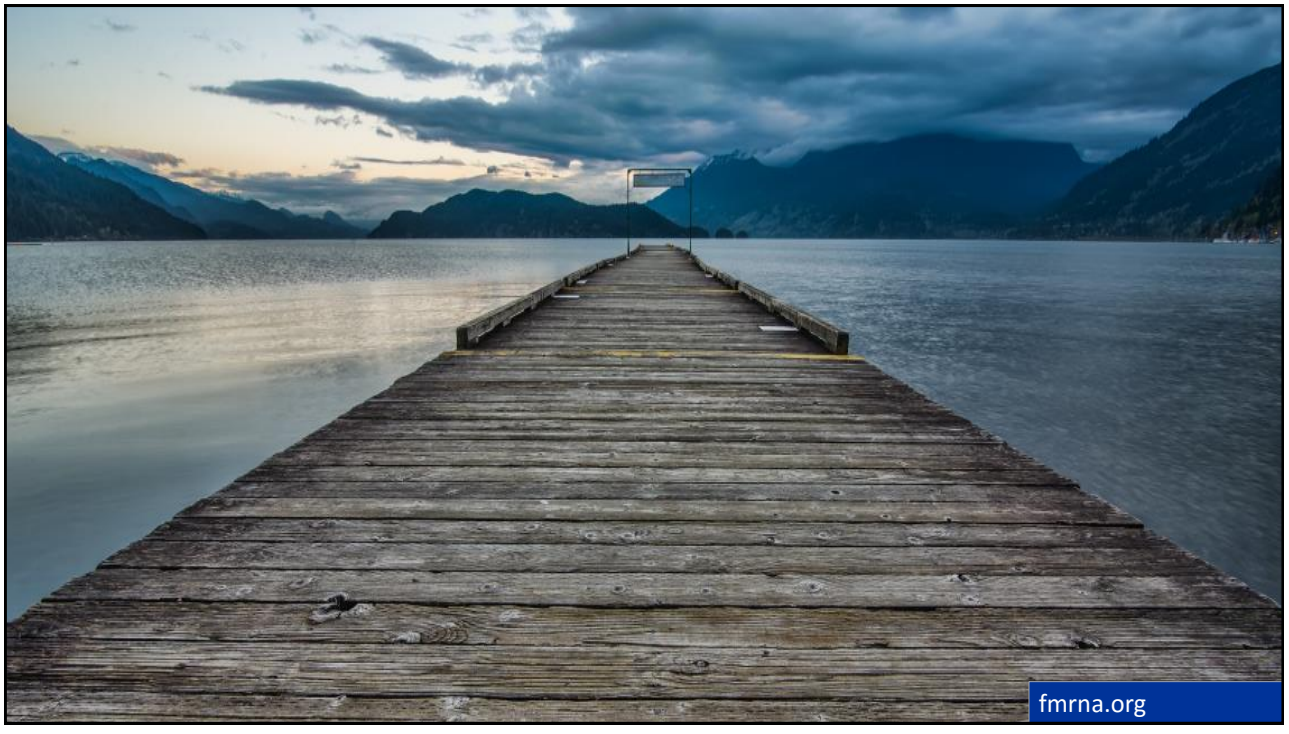
Monthly Topical Focus

Month	Topic

Mindfulness

"Paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of the experience moment by moment."

- Jon Kabat-Zinn



- https://www.youtube.com/watch?v=w6T02g5hnT4
- https://www.youtube.com/watch?v=rqoxYKtEWEc&t=3s
- https://www.youtube.com/watch?v=vzKryaN44ss&t=11s

Engaging in the Practice of Mindfulness

Requirements of Practice	Types of Practice
Capacity	**Formal practices**
Desire and commitment to practice	Breath
Time to practice	Yoga
Patience	Sitting meditation
Persistance	Walking meditation
Non-Striving – Non goal oriented	Body scan
	Mindful eating
	Informal practice
	Practice of being present in moment-to-moment experience while in daily activities i.e. washing dishes, sitting with patient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Questions?

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