FMRNA SPECIAL PROGRAMMING
Annual Residency Nursing Workshop

Presented by the Family Medicine Residency Nurses Association
Friday, April 1, 2016
The Westin Kansas City Hotel at Crown Center

8:00 – 8:30 a.m. **Registration/Networking** [Pershing North Foyer]

8:30 – 8:45 a.m. **Welcome Remarks** [Pershing North]
FMRNA President – Marcia Snook, RN, BSN

8:45 – 9:45 a.m. **Workshop 1**[Pershing North]
Managing the Changes in Clinical Roles: How to Maximize the Scopes of Practice
Kathleen Morin, ADRN; Alice Brown, 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.

9:45 – 10:00 a.m. Break

10:00 – 11:00 a.m. **Workshop 2** [Pershing North]
Lights, Camera, Action!
Melodie Reich, BSN, RN; Alice Brown, RN
Successful encounters improve patient outcomes as well as improve overall satisfaction. A successful encounter involves educating the patient to empower them in decision making and goal setting. If the patient feels empowered to take an active role in their own health, it can produce improved outcomes and increase provider and patient satisfaction. However, with time-pressured appointments, it becomes harder for providers to accomplish everything, especially teaching. In order to close the education gap and empower patients, our clinic has developed a course of action to implement custom bilingual educational videos using audio-visual technology. Creating educational videos for patients can lead to higher rates of retention, increased compliance, and increased involvement in health care decisions, while allowing them to learn at their own pace. The videos will not only help provide education to patients, but help improve communication among

medical staff. Communication skills are of the utmost importance between all involved in a successful patient visit. The obvious communication skill needed is between the patient and the provider, but the other side of this is the collaboration between the provider and supporting staff (nurses, medical assistants, etc). With pre-visit planning, we can increase the communication between the provider and medical staff.

Objectives:
1. Describe the importance of using audio-visual educational tools for increased patient education retention.
2. Identify benefits of using educational videos as a method of improved collaboration among providers and nursing staff.
3. Understand an approach to empower patients in advocating for their health.

11:00 a.m. – 12:00 p.m. **Workshop 3** [Pershing North]
Team Based Care in a PCMH Family Medicine Residency Program
Randee Fleming, RN
FMC Residency directly engages all staff elevating their practice to the top of their licensure, while surrounding the patient with care and resources to optimize their well-being. Using the Lean Six Sigma model and Change Agents, FMC has paired simple electronic medical records (EMR) reports with streamlined processes to empower staff and deliver unique and personalized patient care. We will examine the work FMC Residency has put into elevating safe quality care for our patients over the last three years. Attendees will benefit from the shared pieces of our care model, including ED/inpatient follow-up, previsit planning, preventative care, disease state management, care of the high-risk population, efficient and comprehensive patient care during the office visit, acknowledging the necessity for follow-up, and avoiding gaps in care. During this growth and ongoing learning experience, we have realized that it is vital to involve all persons affected with a process change or implementation, and we will share what each team member contributes to the team-based model of care. We will share encouraging data, our successes and our failures, providing a well-rounded picture of our continual journey to provide the quality care patients deserve.

Objectives:
1. Respond to the ideation of patient-centered care and its benefits to health care in its entirety.
2. Foster processes that provide optimal and efficient patient care in an ambulatory setting.
3. Evaluate new ideas to introduce to their ambulatory health care clinic.

12:00 – 1:15 p.m. **Lunch** [Place or On Your Own]

1:15 – 2:15 p.m. **Workshop 4** [Pershing North]
The Path to Meaningful Use
Rebecca Higdon, MPH; Lisa Stephens, RN; Lucky Morton, LPN; Julie Jeter, MD
Address issues and workflow to achieve meaningful use measures through nursing, physician input, and electronic medical record optimization.\

Objectives:
1. Understand the requirements of stage 2 of meaningful use (MU).
2. Develop an implementation plan.
3. Evaluate and assess achievements.

2:15– 3:15 p.m. **Workshop 5** [Pershing North]
Immunize Your Clinic from Burnout! Implement Clinic Case Conference
Charlotte Navarre, RN-BC; Jennifer Hill, PhD
Domestic violence, addiction, suicide, and uncontrolled chronic disease are some of the challenges faced in the patient-centered medical home (PCMH). Any of these can produce powerful emotional reactions, impair empathy, and contribute to

burnout. Clinic case conference was initiated as a protected space to offer support and guidance to all clinic staff and to empower our care teams with specific skills and knowledge to improve the delivery of care in complex and challenging situations. Clinic case conference is replicable in any clinic able to prioritize the time for all team members. This presentation explores the structure and content of clinic case conference, explaining how we have implemented this high-value training opportunity and its impact on burnout, empathy, teamwork, and willingness to learn. It can help residency programs meet milestones, provide a forum for direct observation and evaluation of core PCMH competencies, and be a component of a structured physician and staff wellness program.

Objectives:

1. Describe the characteristics of an effective clinic case conference.
2. Explain how to incorporate clinic case conference into the patient-centered medical home (PCMH) curriculum and link to the milestones and core competencies.
3. Discuss the benefits of measuring adaptive reserve and burnout when incorporating new interventions into the PCMH.

3:15-3:30 p.m. Break

3:30-4:30 p.m. **Workshop 6** [Pershing North]

Safely Home – Transitions of Care in the Residency Out Patient Practice

Kathleen Morin, ADRN

NCQA is monitoring all of our quality measures and the readmission rate has been hard to change over the past years. But reducing the readmission rate is only one part of why this transitional care is so important. Gone are the days when we could spend as much time as we wanted making sure the patient's discharge planning was set before they left. Most hospitals are staffed with hospitalists who do not know the patients like when primary care providers used to admit and discharge their own. Patients are going home with little knowledge of what their medications are and they are being asked to follow up with their primary doctor who may or may not have gotten the discharge note. Transition of care is an important health care responsibility of everyone involved who care for the patient. A "Safely Home Visit" is one model of transition of care.

Objectives:

1. Describe the many areas of care that are needed for a complete transition of care out- patient model.
2. Learn how transition of care can reduce the readmission rate by reviewing developed visit called Safely Home.
3. How can transition of care be used as a competency training tool in the Family Medicine Residency Program.

4:30 – 4:45 p.m. **Closing Remarks** [Pershing North]

Marcia Snook, RN, BSN