# FMRNA Annual Residency Nursing Workshop

*March 23-24, 2018*

*Sheraton Kansas City Hotel at Crown Center*

*Kansas City, MO*

## Agenda

### Friday

- 1:30 – 2:00 p.m.: Registration/Networking
- 2:00 – 2:15 p.m.: Welcome Remarks
- 2:15 – 3:15 p.m.: Workshop 1
  - Leveraging the Role of Nursing Leadership in the Residency
  - Marcia Snook, RN, BSN; Kay Anderson, RN
- 3:15 – 3:30 p.m.: Break
- 3:30 – 4:30 p.m.: Workshop 2
  - Work Place Transformation: Making Changes to Improve Team Communication, Education and Patient Care
  - Kathleen Morin, AD, RN
- 4:30 – 4:45 p.m.: Break
- 4:45 – 5:45 p.m.: Workshop 3
  - Teaching and Living Resiliency Before, After, and During Difficult Challenging Patient Encounters
  - Theresa Salmon, LMSW
- 5:45 – 6:00 p.m.: Closing Remarks
- 6:00 – 7:00 p.m.: Networking Hour

### Saturday

- 8:00 – 8:15 a.m.: Welcome Remarks
- 8:15 – 9:15 a.m.: Workshop 4
  - Opioid Epidemic- What's a Nurse to do….
  - Alice Brown, RN; Terri Magee, RN
- 9:15 – 9:30 a.m.: Break
- 9:30 – 10:30 a.m.: Workshop 5
  - Crucial Conversations
  - Mary Beth McLellan, RN, BSN
- 10:30 – 10:45 a.m.: Break
- 10:45 – 11:45 a.m.: Workshop 6
  - Panel Discussion
  - Mary Beth McLellan, RN, BSN; Kathleen Morin, AD, RN; Marcia Snook, RN, BSN; Kay Anderson, RN
- 11:45 a.m. – 12:00 p.m.: Closing Remarks

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# Leveraging the Role of Nursing Leadership in the Residency

Kay Anderson, RN-Methodist Charlton Family Medicine Residency Program, Dallas, TX
Marcia Snook, RN, BSN-Fort Collins Family Medicine Residency Program, Fort Collins, CO

## DISCLOSURE - ABSENCE OF CONFLICT OF INTEREST

Leveraging the Role of Nursing Leadership in the Residency

The nurse planner, presenters and faculty involved in the planning, creation and presentation of these materials have no actual, potential or perceived conflicts of interest – relationships with any commercial interest – that have the ability to control or influence the content of this educational activity.

## OBJECTIVES

Compare and contrast the differences between leadership and management characteristics.

Verbalize methods to leverage the impact that nursing leaders and staff have on the overall goal of residency education

Identify and discuss potential challenges for nursing leadership in the residency setting.



## Leadership

Which way did they go? How many were there? How fast were they going? I must find them; I am their Leader!

## Leadership

What is your leadership style?

Whatever it is-let your staff know!



## Leadership

The best leader is the one who has the sense to pick good people to do what he/she wants done, and self-restraint enough to keep from meddling with them while they do it.-Theodore Roosevelt

A beaver is very skilled at its craft. It knows exactly what to do to fix a dam. The last thing it needs is someone on the bank shouting out dam instructions

## Leadership

What's important as a leader is not necessarily what happens when you are there. It's what happens when you're NOT there.

Clinic should function as well when you're not there as when you're there.

Support decisions made by whoever is left in charge while you're not there. If necessary discuss and learn from them later.

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## Leadership vs. Management

### Leadership

Doing right things
Transformational
People enhancers
Vision, inspiration, influence, motivation
What & why?
Horizon focus
Effectiveness focus
Challenge the status quo
Develop & Encourage
Produce change and movement
Emphasis on influence
Have followers
Pull

### Management

Doing things right
Transactional
Process enhancers
Planning, organizing, controlling, coordinating, directing
How and when?
Bottom-line focus
Efficiency focus
Enforce the status quo
Implement & Execute
Insure consistency and order
Emphasis on authority
Have subordinates
Push

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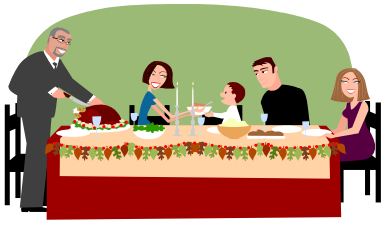
## Leadership



Remember–you will be at your employees house for dinner at least once a week!



## Leadership

Nobody in your clinic will be able to sustain a level of motivation higher than you have as their leader

## Working with Staff

- Know your audience
- Help them see their role as bigger than just answering the appointment line or rooming patients.
- Help them feel that they are an integral part of training a physician.
- Help them see the bigger picture
- HR issues-ongoing



## Working with Staff

**Staff Role in Residency Education**

Realize they are a teacher

Realize they are a learner

## How to measure value

In Winter 2005,the American Academy of Ambulatory Care Nursing conducted a survey in an attempt to define the value of ambulatory care nursing.

248 members responded to 3 open-ended questions



## Working with Staff

1. Describe the value that you provide to your employer/workplace
2. Is your workplace collecting data regarding performance improvement indicators to evaluate the effectiveness of the registered nurse in the ambulatory care setting
3. If so, what performance indicators are being used.

## Working with Staff

1. Describe the value that you provide to your employer/workplace

- Patient and Family Education
- Accurate Telephone and Clinic Triage
- Leadership and management
- Collaboration with medical staff
- Patient advocacy
- Financial gains to institution by avoidable hospital days and avoiding inappropriate use of the emergency department.



## Working with Staff

Other responses

- Staff education
- Quality initiatives
- Compliance with regulatory agencies
- Continuity of care
- 'feeling responses'
  - Critical thinking
  - Bridging the gap for patients
  - Provide all levels of care
  - Oil in the machine
  - 'whole picture thinking'

## Working with Staff

2. Is your workplace collecting data regarding performance improvement indicators to evaluate the effectiveness of the registered nurse in the ambulatory care setting?

- >50% NO
- Of those who answered yes, 28% cited patient satisfaction scores
  Other responses included: JCAHO Safety Goals, chart review, peer review, number of calls, wait times, QI projects



## Working with Staff

Article Summary

- It is clear that nurses recognize their value in the ambulatory setting.
- It is not clear why nurses have not been able to articulate their value to patients, employers, payors, legislators…

## Working with Staff

Staff impact the capability of programs to meet residency goals and objectives

All residencies should have some form of goals and objectives.

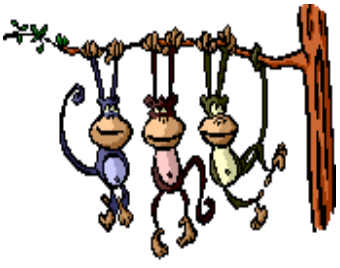
Find yours and see how you can translate this to the bigger picture for your employees



## Working with Staff

Example of transitioning Residency Goals and Objectives

Goal/Objective:
To train residents in a family orientated approach to primary care medicine



## Working with Staff

### Helping Accomplish the Goal/Objective

Front Office Staff
Keeping all family members with one physician
Creative scheduling with mom and 2-3 kids

Back Office Staff
Knowing when to room family members together/separate
Briefing new resident PCP on family dynamics/history



## Working with Staff

### Example of transitioning Residency Goals and Objectives

Goal/Objective:
To provide experience in a problematic approach to healthcare through problem oriented records and patient management

## Helping Accomplish the Goal/Objective

Front Office Staff
Obtaining accurate chief complaint over the phone

Back Office Staff
One problem may become 10—so help the physician by helping the patient prioritize and focus to understand only one or two problems may be addressed at this visit

Patient Management

Follow up on issues or abnormal labs to help curb recurring phone calls about the same problems.





## End Goal

Employees understand the impact of their everyday job in the bigger picture of resident education.

## Working with Residents

Deal with them directly

Deal with them as equals

Generational differences

Understand where they are in their knowledge base

Understanding the demands of the residents schedule-inpatient, outside rotations, work hours/call schedule

Countless Repetitions and Explanations

Patience-Kindness-Respect



## Misc.

Orientation
Staff roster
Top 10 laminated things for new first years
Rotations with staff
Re-orientation for 2nd and 3rd years
Residency Handbook for new employees
Meetings/Communication
Interdisciplinary committee involvement
Don't feel like you always have to know the answer
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## Alphabet Soup

| Abbreviation or Term | Explanation |
|---|---|
| AAFP | American Academy of Family Physicians. www.aafp.org |
| ACGME | American Council for Graduate Medical Education. This is a peer reviewed accreditation body for post M.D. training programs. www.acgme.org |
| AMA | American Medical Association. www.ama.org |
| AOA | American Osteopathic Association. This is the AMA equivalent for D.O.s. www.aoa.org |
| Attending | Most often used to indicate the supervising physician in the hospital or clinic. In Family Medicine, this term is most often used to designate the faculty physician who has responsibility for the hospital team or residents who are seeing patients in clinic. |
| COMLEX | Comprehensive Osteopathic Medical Licensing Examinations. Often used as a word pronounced com-lex. There are 4 parts to this exam. See http://www.nbome.org/ . |
| Competencies | In 1997, the ACGME identified 6 competencies that residents needed to master in order to graduate. The competencies are a part of residency training for all specialties. See www. acgme.org for further information. |
| CV | Curriculum Vitae. A document similar to a resume except that a CV includes presentations, research and publications as well as other academic honors. |
| Didactic | A lecture or presentation. |
| DIO | Designated Institutional Official. The ACGME requires that an official for each residency be the DIO. |
| DME | Director of Medical Education |
| DO | Doctor of Osteopathic Medicine |
| Duty Hours | The number hours that a resident is on duty. This is usually calculated weekly and should not exceed 80 hours per week. |



## Alphabet soup

| | |
|---|---|
| Extern | This term usually refers to a 4th year medical student who is completing a rotation. |
| ERAS | The Electronic Residency Application Service. Medical students use this service to apply for residency. See http://www.aamc.org/audienceeras.htm for more information. |
| Evidence based medicine | Practicing medicine by uniformly applying the best research to each disease or problem. |
| Fellow | Sometimes residents go on to complete additional training past their residency training. This training is usually referred to as a fellowship and the physician as a fellow. Common fellowships in Family Medicine are Sports Medicine; Geriatrics; Obstetrics; and Rural Medicine. |
| Fifth Pathway | Medical students from a foreign medical school are sometimes referred to as a fifth pathway. These medical students complete 4 years of medical school in another country, often Mexico and then commit to an extra year of training. See www.ama-assn.org. |
| FMG | Foreign Medical Graduate. An old term used to designate someone who graduated from medical school outside the U.S. The term currently more frequently used is IMG. |
| IME/DME | Payments made to institutions that support residency education. For more information see: http://www.aarp.org/research/medicare/financing/aresearch-import-692-FYI.html |
| IMG | International Medical Graduate. Anyone who graduates medical school in any country other than the U.S. |
| Intern | A 1st year resident. This distinction is important because a resident who completes an internship is often eligible to apply for a license to practice medicine. In some states, IMGs must complete the entire residency program before applying for a license. |
| longitudinal | Used to indicate that the resident is expected to learn the concept/skill or philosophy over the course of training rather than during a time limited rotation. |

## Alphabet Soup

| | |
|---|---|
| M and M | Morbidity and Mortality Conference. |
| Match | This term refers to the culmination of the recruitment process. After interviewing medical students for residency, each program enters a list of acceptable candidates with the #1 slot being the top choice. Each medical student enters a list of acceptable residencies with #1 being the top choice. The residency and student are "matched" by a computer. A computerized list is generated to notify the student and residency. |
| MCAT | Medical College Admission Test. College or post college students take this test in order to be considered for placement in medical school. www.aamc.org |
| MD | Doctor of medicine. |
| NAPCRG | North American Primary Care Research Group. Often referred to as napcraig. www.napcrg.org. |
| NRMP | National Residency Matching Program. www.nrmp.org |
| PCMH | Patient Centered Medical Home |
| PCP | Primary Care Physician. |
| PGY | Post Graduate Year. |
| Preceptor | A supervising physician. |
| Procedure Log | In order to obtain privileges to perform procedures (suturing, chest tubes, and circumcision) after graduation, a resident must prove proficiency in both ability to perform the procedure as well as experience in performing the procedure. A procedure log is either a paper or electronic record of all procedures that the resident performed during residency. |
| Rank List | The list of acceptable student candidates that is turned into NRMP for the match. See www.nrmp.org |



## Alphabet Soup

| | |
|---|---|
| Rank List | The list of acceptable student candidates that is turned into NRMP for the match. See www.nrmp.org |
| Resident | M.D. or D.O. who has graduated medical school and is in the process of continued training on the way to practicing independently. As residents progress, they are given more autonomy and responsibility to prepare them for practice. Referred to as post graduate training. See PGY. |
| Rotation | A designated amount of time that a resident spends in any one specialty or on any particular service. Rotations are commonly ½ month, 1 month or 4 weeks. |
| RRC | Residency Review Committee. The RRC mandated by ACGME to review each program. the committee that reviews each program |
| **Abbreviation or Term** | **Explanation** |
| Scramble | Occasionally, a residency will not match or fill all of the open positions for the next intern class. When this occurs, most residencies attempt to fill the positions during a 2 day period referred to as the scramble. It is now called SOAP (see below) |
| SOAP | Supplemental Offer and Acceptance Program-Used to be called the scramble, this is where residents try to get into unfilled positions using this procedure through ERAS |
| STFM | Society for Teachers of Family Medicine. stfm.org |
| Stipend | This term is often used to refer to a resident's or fellow's salary. |
| USMLE | United States Medical Licensing Exam. There are 4 parts to the exam. Three parts (Step 1, Step 2 CK, Step 2 CS) are taken during medical school and the final part, step 3 is taken during the 2nd year of residency. www.usmle.org. |
| Volunteer Faculty | Community physicians who donate time to instruct and mentor family medicine residents. These physicians are often in other specialties (surgery, OB/Gyn, pediatrics, psychiatry) |

References

"The essence of management is accomplishing optimal outcomes with constrained or scarce resources. Management is always challenged to get great outcomes, often with less staff, less materials, less equipment, etc., than we might ideally need. Great management teams have that unique ability to get great things done despite not always having as much to work with as they might like. If resources were plentiful, more people could probably be successful managers."

Stephen L. Mansfield, Ph.D., FACHE
President and CEO
Methodist Health System

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# Work Place Transformation: Making Changes to Improve Team Communication, Education and Patient Care

Kathy Morin, RN

## Objectives

- List and discuss trends in work place structure and transformation in primary care practices
- Implement physical changes that will allow providers and staff to sit together during clinic time
- Implement team processes that will improve communication, patient care and residency education



## Current Practice Structure

- History of Residency Programs
  - Clinic Structure
  - Triage
  - Team communication
  - Impact on patients, staff and providers



## Influence of Patient Centered Medical Care

Continuity

- Team Development
- Communication
- Efficient Office Processes
- Modeling Care/ Residency Education

## Recent Trends in Primary Care

Expanding Roles of Clinical Staff

- Pre-visit Planning
- Team Quality Projects/Standardization
- Population Health Management
- Team-let or Co-location
- Improvement of Emotional and Physical Health of Staff and Providers



## Our Journey to Team Co-location

The Vision

- Buy-In
- Communication-What went wrong
- Breaking down walls!
- Relationships-Mending and making

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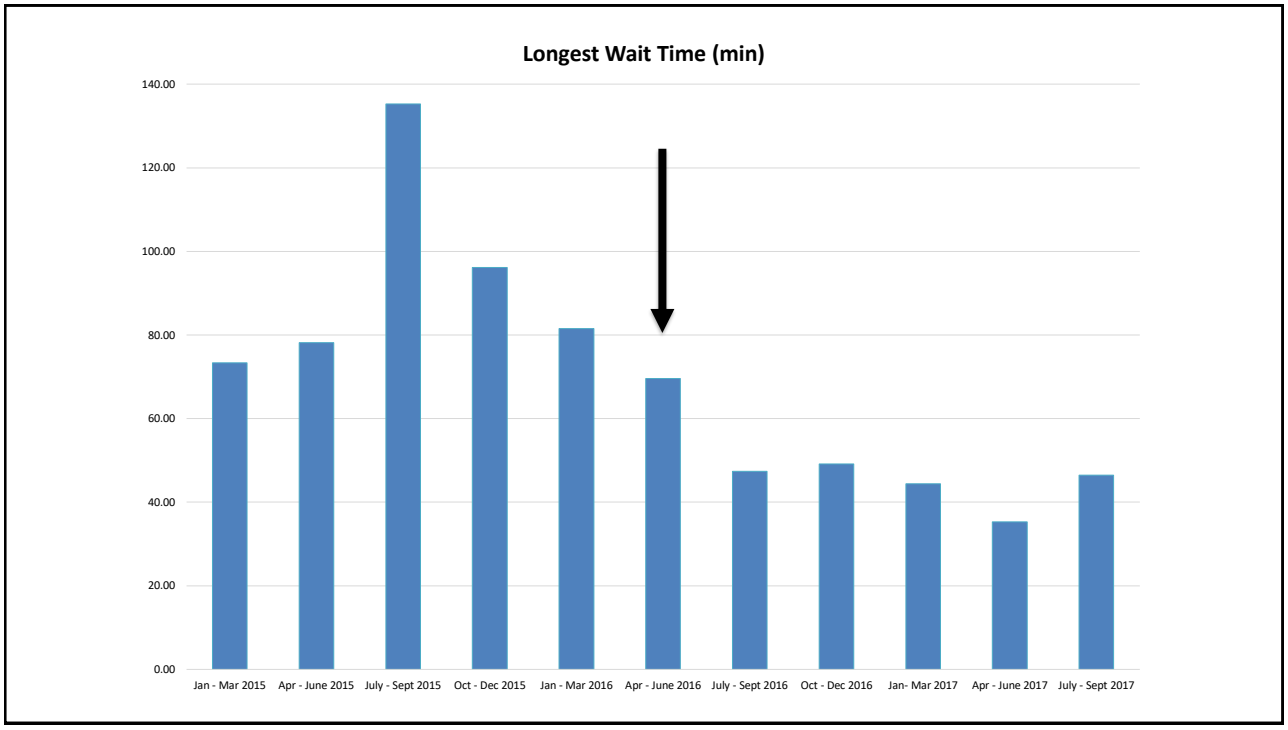
## What has happened in the last 21 months!

Communication

- Provider/MA Huddles
- Triage
- Efficiency in Clinic
- Team Projects to Improve Processes
- Relationships and Feedback
- Improved Patient Care!
- Better Education for Everyone!
- Less Burnout- More Fun!


Longest Wait Time (min)
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Jan - Mar 2015
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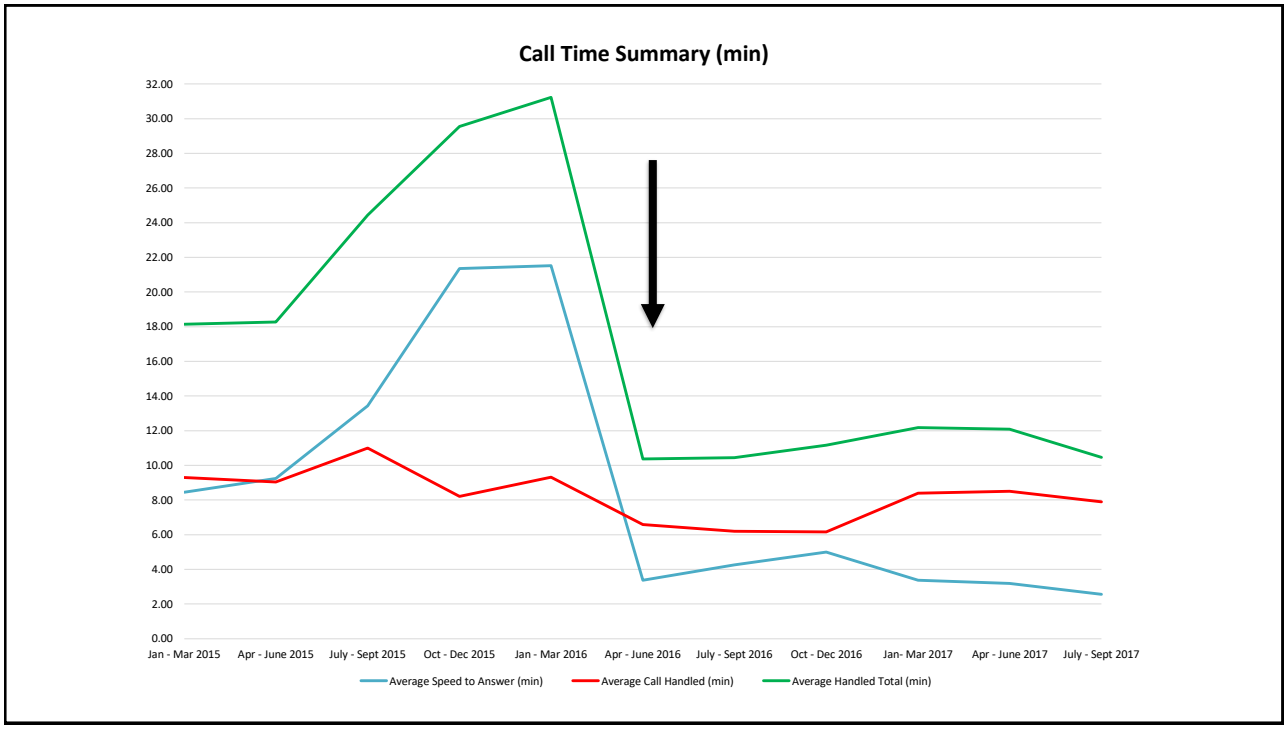
Call Time Summary (min)
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Oct - Dec 2015
Jan - Mar 2016
Apr - June 2016
July - Sept 2016
Oct - Dec 2016
Jan- Mar 2017
Apr - June 2017
July - Sept 2017
Average Speed to Answer (min)
Average Call Handled (min)
Average Handled Total (min)

## Resident Video



## Take Aways!

- Residencies should be the innovators of transformation!
- Vision and change involves all voices
- Communication can always be improved
- Physically sitting together as teams has improved all clinic processes and improved patient care.
- Clinic time has been more fun and morale has improved!!

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# Teaching and Living Resiliency Before, After and During Difficult Patient Encounters

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

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## Disclosure – Absence of Conflict of Interest

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## Objectives

- Learners will discuss the factors that contribute to a patient being defined as “difficult”
- Learners will recognize and differentiate when to appropriately use various behavioral approaches with challenging patients
- Learners will practice a structured mindfulness-compassion exercise to enhance communication before, after and during a challenging patient encounter

# 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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## Heart Sink

*"There are patients in every practice who give the doctor and staff a feeling of 'heartsink' ….*

*They evoke an overwhelming mixture of exasperation, defeat and sometimes plain dislike that causes the heart to sink."*

Dr. Tom O'Dowd

British Medical Journal, 1988

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## Patient Characteristics

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## Healthcare Worker Characteristics

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# Dependent Clinger

**Characteristics:**
- Insecure
- Desperate
- Worried about abandonment

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# Dependent Clinger

**Approach:**
- Maintain a professional demeanor
- Establish boundaries early and consistently maintain them
- Involve the patient in decision making
- Assure the patient that you will not abandon him or her
- Schedule regular follow-up appointments

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# Entitled Demander

**Characteristics:**

- Often angry
- Does not want to go through necessary steps of assessment or treatment
- May be reacting to loss and fear



# Entitled Demander

**Approach:**

- Suspend judgement, and examine your own feelings
- Recognize that the patient's hostility may be his or her way of maintaining self-integrity during a devastating illness or other trauma
- If a specific emotion is evident, address it with the patient; do not react defensively when the patient expresses concerns
- Reinforce that the patient is entitled to good medical care, but that anger should not be misdirected at those trying to help

# Manipulative help-rejecter

**Characteristics:**
- Wants attention
- Has been rejected previously and has difficulty with trust

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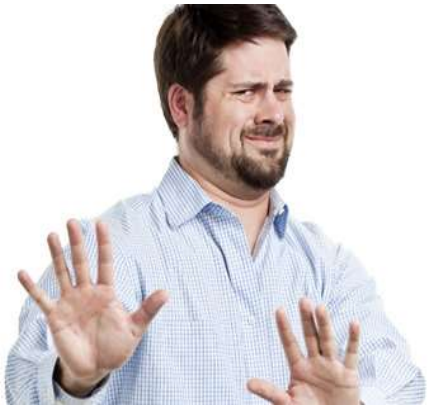
# Manipulative help-rejecter



**Approach:**
- Recognize that the patient wants to stay connected to the physician
- Engage the patient by sharing frustrations over poor outcomes
- Reformulate the health plan with the patient to focus on alleviating symptoms

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# Self-Destructive Denier

**Characteristics:**

- Feels hopeless about changing the situation
- Unable to help himself or herself
- Fears failure
- May have untreated anxiety or depression

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# Self-Destructive Denier

**Characteristics:**

- Set realistic expectations
- Redirect patient's behavior to identify causes of non adherence (e.g., money time, access to medical care or appropriate treatment)
- Celebrate each small success with the patient
- Offer/arrange for psychological support

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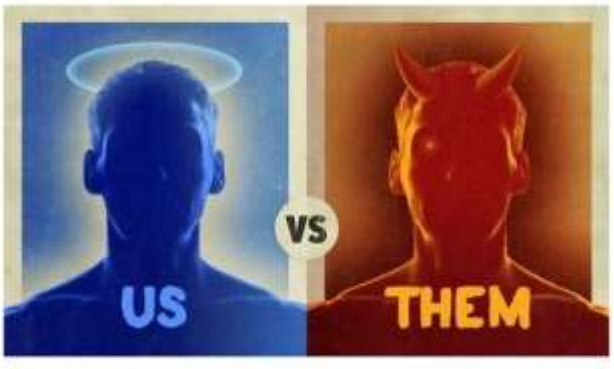
## Communication Strategies to Redirect an Emotionally Charged Clinical Encounter

- Active listening
- Validate the emotion and empathize with the patient
- Explore alternative solutions
- Provide closure



## Explicit vs. Implicit Bias

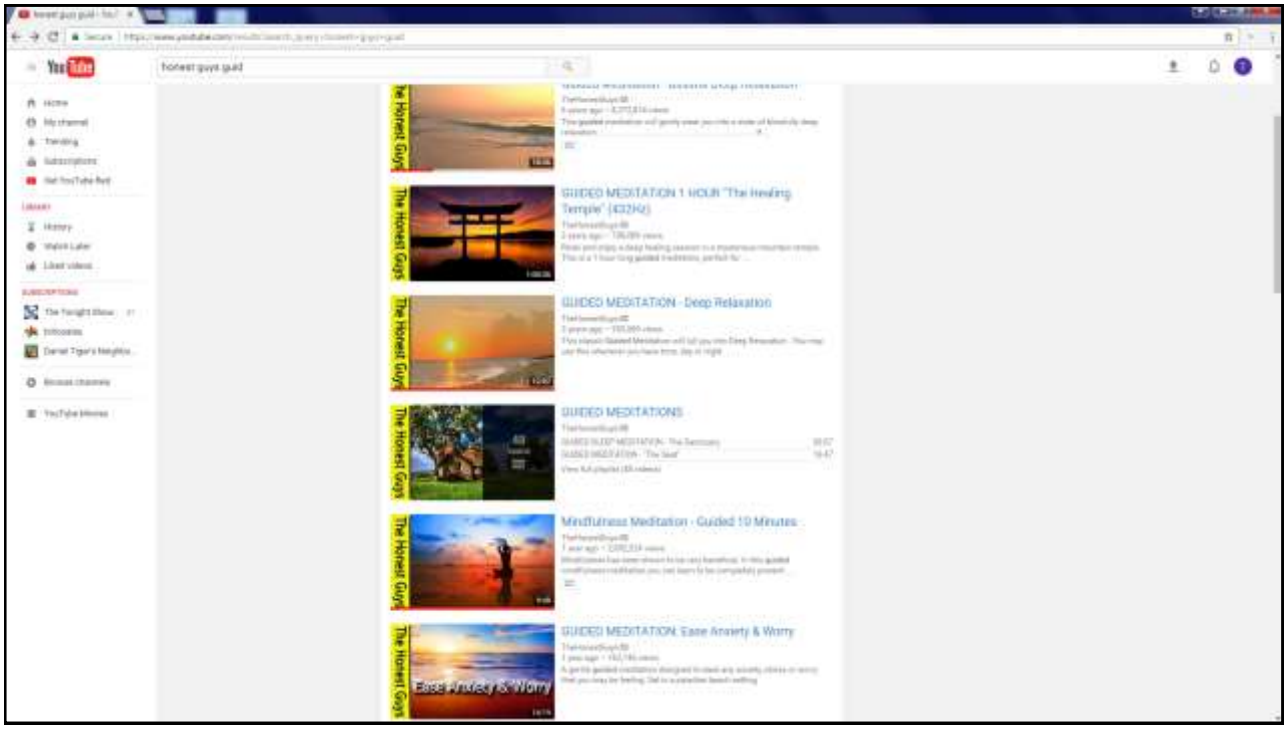
In-group / Out-group Bias




## Mindfulness

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

- Jon Kabat-Zinn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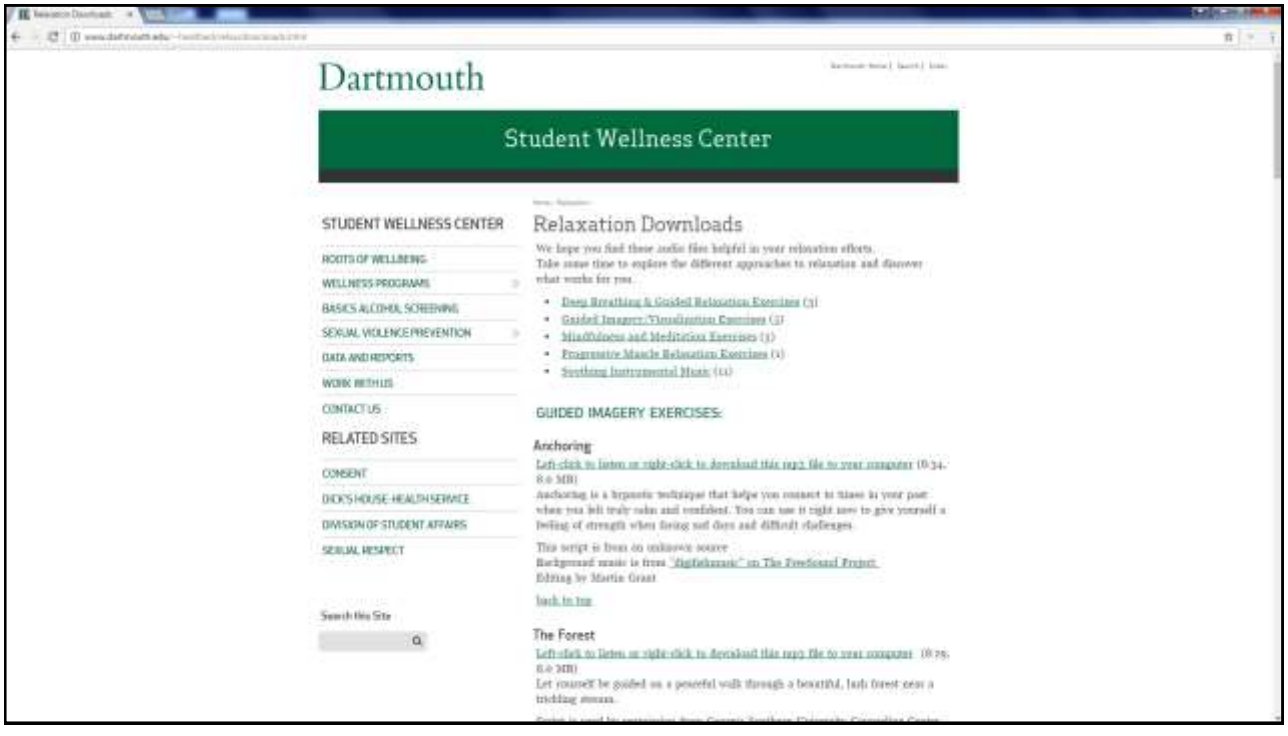
GUIDED MEDITATION 1 HOUR "The Healing Temple" (432Hz)
GUIDED MEDITATION - Deep Relaxation
GUIDED MEDITATIONS
Mindfulness Meditation - Guided 10 Minutes
GUIDED MEDITATION: Ease Anxiety & Worry


Dartmouth
Student Wellness Center
STUDENT WELLNESS CENTER
ROOTS OF WELLBEING
WELLNESS PROGRAMS
BASICS ALCOHOL SCREENING
SEXUAL VIOLENCE PREVENTION
DATA AND REPORTS
WORK WITH US
CONTACT US
RELATED SITES
CONSENT
DICK'S HOUSE HEALTH SERVICE
DIVISION OF STUDENT AFFAIRS
SEXUAL RESPECT
Search this Site
Relaxation Downloads
We hope you find these audio files helpful in your relaxation efforts.
Take some time to explore the different approaches to relaxation and discover what works for you.
Deep Breathing & Guided Relaxation Exercises (3)
Guided Imagery (Visualization Exercises (3)
Mindfulness and Meditation Exercises (1)
Progressive Muscle Relaxation Exercises (1)
Soothing Instrumental Music (11)
GUIDED IMAGERY EXERCISES:
Anchoring
Left-click to listen or right-click to download this mp3 file to your computer (0.34-8.6 MB)
Anchoring is a hypnotic technique that helps you connect to times in your past when you felt truly calm and confident. You can use it right now to give yourself a feeling of strength when facing sad days and difficult challenges.
This script is from an unknown source
Background music is from "Highlebrook" on The FreeSound Project
Editing by Martin Grant
back to top
The Forest
Left-click to listen or right-click to download this mp3 file to your computer (0.29-8.6 MB)
Let yourself be guided on a peaceful walk through a beautiful, lush forest near a trickling stream.

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# Questions?

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- 4:30 – 4:45 p.m.: Break
- 4:45 – 5:45 p.m.: Workshop 3
  - Teaching and Living Resiliency Before, After, and During Difficult Challenging Patient Encounters
  - Theresa Salmon, LMSW
- 5:45 – 6:00 p.m.: Closing Remarks
- 6:00 – 7:00 p.m.: Networking Hour

**Saturday**

- 8:00 – 8:15 a.m.: Welcome Remarks
- 8:15 – 9:15 a.m.: Workshop 4
  - Opioid Epidemic- What's a Nurse to do….
  - Alice Brown, RN; Terri Magee, RN
- 9:15 – 9:30 a.m.: Break
- 9:30 – 10:30 a.m.: Workshop 5
  - Crucial Conversations
  - Mary Beth McLellan, RN, BSN
- 10:30 – 10:45 a.m.: Break
- 10:45 – 11:45 a.m.: Workshop 6
  - Panel Discussion
  - Mary Beth McLellan, RN, BSN; Kathleen Morin, AD, RN; Marcia Snook, RN, BSN; Kay Anderson, RN
- 11:45 a.m. – 12:00 p.m.: Closing Remarks

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# Opioid Epidemic - What's a Nurse to do...

Alice Brown, RN

Terri Magee, RN

## Patient Video



## What is Pain?

In 1996, The International Association for the Study of Pain (IASP) defined pain as:

*An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.*

## History of Pain Management

- Pain is a global affliction and the oldest medical problem. Until recently there has been little understanding in the physiology of pain.
- Attempts of pain management are well documented throughout history.
  - Stone tablets
  - Chinese Yellow Book
  - Edwin Smith Papyrus



## Introduction of Opium

- European physicians relieved pain through the use of opium.
- After 1680, laudanum (mixture of opium in sherry) was introduced by Thomas Sydenham.
- In the 19th and 20th century, physicians/scientists discovered that opium, morphine, codeine, and cocaine could be used to treat pain.

## Types of Pain

- Nociceptive Pain:
  - Normal pain, resulting from trauma or injury
  - Usually fades once injury heals or painful stimulus goes away
- Neuropathic Pain:
  - Results from damage or dysfunction of nerves
  - Doesn't go away when patient heals or stimulus taken away
- Depression is the most frequent reaction to chronic pain and anxiety for acute pain.



## Cultural and Gender Differences

- Clinical studies report ethnic differences in pain perception and response
- Minorities (AA, Latino, Asian, etc.) remain at risk for inadequate pain control
- Men and women respond differently to opioid medications
- Women are more likely than men to experience depression, have more physical conditions, and comorbidities

## Perception of Pain

Factors that can affect the perception of pain:

- Emotional and psychological well being
- Physical well being
- Memories of pain
- Upbringing
- Expectations of and attitudes towards pain
- Beliefs and values
- Age / Sex
- Social and cultural influences



## How Did We Get Here?

- In 2001, the Joint Commission presented its Pain Management Standards. This standard required healthcare providers to ask every patient about their pain due to the perception that pain was being undertreated.

## How Did We Get Here? (cont.)

- Since that time, the U.S. has experienced an huge increase in opioid prescriptions, and subsequently, an increase in overdoses and deaths tied to these medications.
- NIH 2012 survey revealed 126.1 million adults reported some pain in the previous 3 months.

Chronic pain is largely undertreated in society, leading to a negative impact on quality of life.



## Controversy Over Opioid Therapy

- Use of opioids as treatment for non-malignant chronic pain remains a subject of debate
- Opioids were reserved for use only in treatment of acute pain and cancer pain syndromes
- Non-malignant chronic pain was considered to be unresponsive to opioids, or use of opioids was associated with too many risks
- Recent studies of physicians specializing in pain and those who do not, have shown that prescription of long term opioids is increasingly common

## Pain Management Trends

- Pain management deemed a human right
- Some patients believe they're entitled to opioids
- Clinicians feel pressured to prescribe and continue prescribing


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## The Epidemic

- According to the Centers for Disease Control and Prevention, the amount of pain medications sold in the U.S. has nearly quadrupled since 1999.
- The CDC estimates that on average, roughly 115 Americans die each day as a result of an opioid overdose; 46 daily involving prescription opioids.
- Drug overdoses are now the leading cause of injury death in the U.S. - outnumbering traffic crashes and gun-related deaths.

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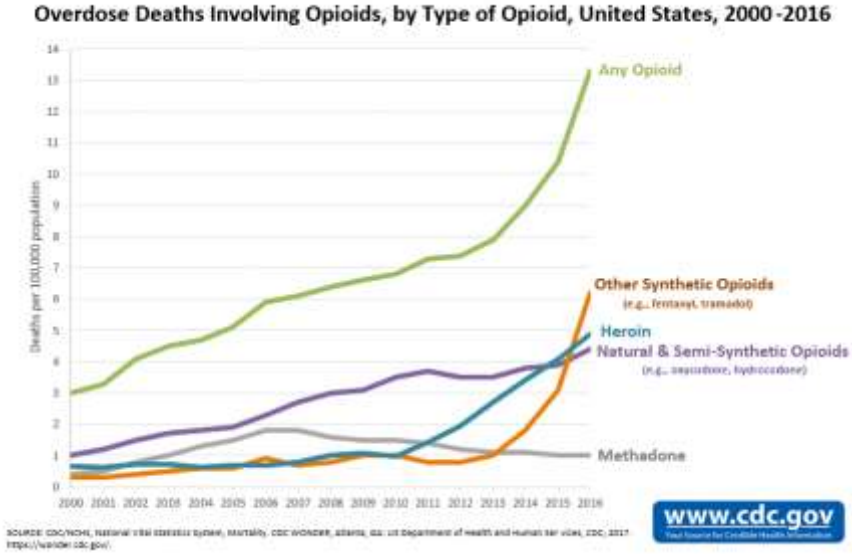


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In 2016, more than 11.5 million Americans, aged 12 or older, reported misuse of prescription opioids in the last year.

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# High Profile Deaths

Heath Ledger (28)

Philip Seymour Hoffman (46)

Prince (57)

Anna Nicole Smith (39)

Tom Petty (66)

Chris Farley (33)

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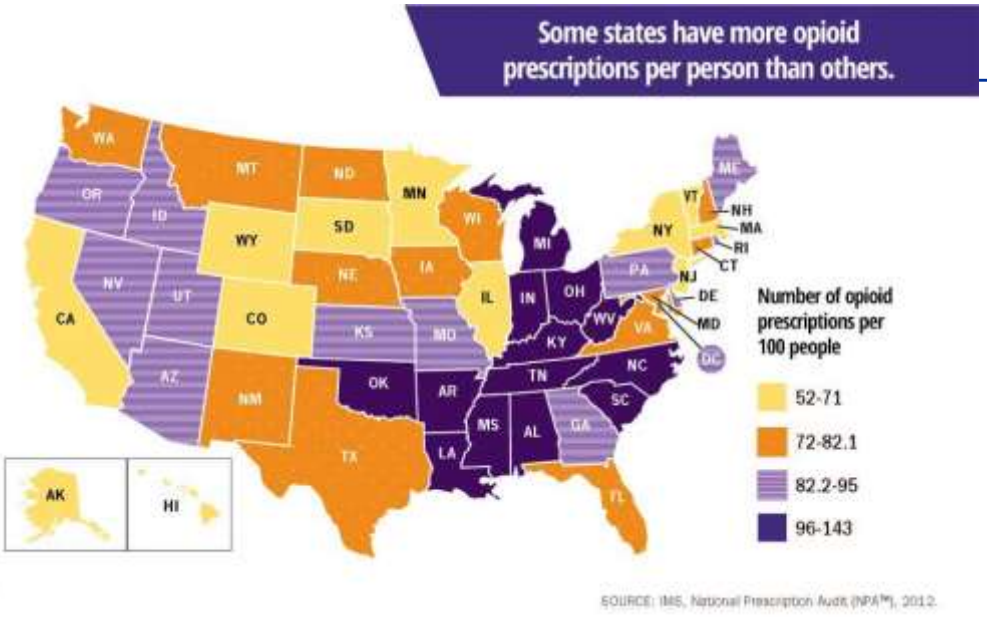


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## Education - Institute of Medicine Report (2011)

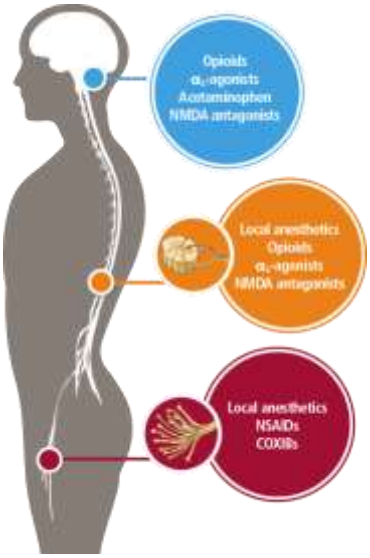
- Education for chronic pain patients should NOT be a one-time effort
- Deemed pain management as a moral imperative
- Outline value of comprehensive treatment
- Stress need for interdisciplinary approaches
- Recognize conundrum of opioid use
- Acknowledge collaborative roles for patients and clinicians



## Education of the Pain Patient

- Learn the cause of the pain
- Methods of pain assessment
- Set goals and realistic expectations
- Treatment options
- Rationale for therapy
- Flare-up preparation
- Using coping skills
- Assess what works

# Medical Management of Pain




Pain can be addressed at either the site (local), the spinal cord, or the brain.

- Pain used to be treated locally, now it's treated systemically
- Studies strongly conclude that opioids result in small improvement with pain severity and function compared to placebo.

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# Psychological and Physical Rehabilitation Approaches

- Cognitive Behavioral Therapy (CBT)
- Acceptance & Commitment Therapy (ACT)
- Mindfulness

The modest reductions in pain severity witnessed with psychological interventions were similar to those noted with medication management, pain interventions, and physical and rehabilitative approaches

- Evidence suggests that exercise can effectively decrease pain and improve function, but no conclusions can be made about exercise type

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## Patient Provider Relationship

Essential elements of a healthy relationship include:

- compassion
- clear expectations or established boundaries
- provider giving adequate explanations
- patient encouraged to be active participant
- patient part of decision making



## Communication

There are 5 essential components to effective communication:

1. Really listen
2. Express empathy
3. Be concise
4. Ask questions and reflect
5. Watch your body language

# Improving Communication

Communication can be improved by:

- Investing in the beginning
  - Create rapport, let the patient tell their story
- Elicit patient's perspective
  - Ask for ideas, requests, and how it impacts their life
- Demonstrate empathy
  - Be aware of your own reactions and be open to patient emotions
- Invest in the end
  - Share medical decisions, patient education, and provide diagnosis



# "Difficult" Patients

"There are no difficult patients, just patients with difficulties"

## Movements for Change

- Identified by CDC as “public health epidemic”
- CDC released guidelines on March 18, 2016
  - determining when to initiate or continue opioids for chronic pain
  - opioid selection, dosage, and duration, follow-up, and discontinuation
  - assessing risk and addressing harm of opioid use
- In October 2017, President Trump declares opioid crisis a nationwide public health emergency
- Narcan (naloxone) available over the counter in 46 states

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## Promote and Monitor Compliance

- Pain management agreements
- Chronic pain protocols
- Prescription monitoring systems
- Frequent follow-up appointments
- Urine toxicology
  - should be apart of
  - obtain at baseline
  - periodically while patient receiving opioids

# Chronic Pain Protocol

- Pre-visit pain packet:
  - Includes patient information, medical questionnaire, pain inventory, release of information forms, SOAPP assessment, PHQ-9, CAGE-AID
- Chronic pain appointments:
  - Initial visit: collect history, obtain records, review previsit packet & KTracs, score assessment tools, collect Aegis drug screen
  - Second visit: update any new history, complete physical exam, address mental health issues if warranted
  - Third visit: diagnosis, education, expectations, comprehensive treatment plan
  - Follow Up



# Misc. Regarding Chronic Pain Protocol

## Aegis drug screen

- initiation / random UDS policy

## Medication informed consent

- I _____ , understand that I have pain that keeps me from doing things I would normally be able to do.
- I understand that my medicine is to help me improve my function and is not likely to make the pain go away completely. I understand that my provider is not obligated to give me this pain medicine and can stop or change the prescription at any time, especially if it is decided the medicine is harming me or that there is a better option for managing my pain or improving my function.

## Nurses Role

- Advocate for the patient
- Advocate for your provider
- Document
- Be aware of RED flags
- Communicate effectively



## Patient Video

# References




# Crucial Conversations

Mary Beth McLellan, RN, BSN
Regional Health Rapid City Hospital
Family Medicine Residency

## Objectives: Crucial Conversations

- Learners will define crucial conversations, and compare to typical conversations.
- Learners will review and describe the 7 principles and skills for mastering crucial conversations, practicing certain techniques to effectively conduct such conversations.



## *Crucial Conversations: Tools for Talking When Stakes Are High*

- Patterson et al. (2012) found that the key skills of effective parents, teammates, leaders, and loved ones is the ability to successfully address emotional and politically risky issues.
- When we fail a crucial conversation, every aspect of our lives can be affected – our careers, our communities, our relationships, and our personal health.

## Contrast Typical and Crucial Conversations?

**Typical:**

- ✓Social
- ✓Work related
- ✓Family
- ✓Business
- ✓Not-threatening subject
- ✓Pleasant

**Crucial:**

- ✓Opposing opinions
- ✓Strong emotions
- ✓High stakes



## Crucial Conversations:

- How do we typically handle these conversations?
  - ✓We can avoid them
  - ✓We can face them, and handle them poorly
  - ✓We can face them, and handle them well

## Crucial Conversations:

- Why don't these conversations tend to go well?
  - ✓Emotions tend to rule
  - ✓Your body physically reacts
  - ✓We are under pressure from multiple areas
  - ✓We act in self defeating ways



## Crucial Conversations:

- Examples:
  - ✓Asking for a raise or promotion
  - ✓Addressing inappropriate behavior
  - ✓Work related conflicts
  - ✓Evaluating a peer or subordinate
  - ✓Confronting an abusive person
  - ✓Family matters
  - ✓Financial issues
  - ✓Ending a relationship

## Crucial Conversations:

- Benefits of positive conversations:
  - ✓Improved professional and personal life.
  - ✓Improved physical health.
  - ✓Improved mental health.
  - ✓Greater satisfaction.
  - ✓Positive outcomes.



## 7 Principles of Crucial Conversations:

- Start with heart.
- Learn to look.
- Make it safe.
- Master my stories.
- State my path.
- Explore others' paths.
- Move to action.

## Start with the heart

- What is the desired result from this conversation?
- What exactly is at stake?



## Learn to Look

- Observe behaviors
- Identify potential for adverse behaviors
- Address your stress

## Make it Safe

- Respect
- Be observant
- Non-threatening
- Personal space
- Tone, rate, cadence of voice
- Setting



## Master My Story

- Base your conversations on facts
- Identify your role
- Try to see both sides of the situation
- Think about what you want to say
- Be reasonable

## State My Path

- **STATE:**
  - ✓**S**hare your facts
  - ✓**T**ell your story
  - ✓**A**sk for others' paths (what)
  - ✓**T**alk tentatively
  - ✓**E**ncourage testing (how)

  Remember to be "persuasive" and not "abrasive"



## Explore Others' Paths

- Consider other views
- Other solutions
- Compromise

## Move to Action

- Don’t keep rehashing issues
- Make a plan
- Stay positive an get results
- Document and follow up



## Role Play

Time to Practice:

- Start with heart.
- Learn to look.
- Make it safe.
- Master my stories.
- State my path.
- Explore others’ paths.
- Move to action.

## Crucial Conversations in Health Care:

- Grenny study from 2009 found
  - ✓77% of nurses and clinical care providers experience disrespectful or abusive conversations.
  - ✓Only 7% confronted the person.
  - ✓It is more difficult to confront when the conversation is related to incompetence or poor teamwork.



## Crucial Conversations in Health Care:

- Silence Kills Study
  - ✓Disrespectful behavior in the health care setting is associated with poor patient outcomes.
  - ✓The Silence Kills study found countless examples of caregivers who delayed action, withheld feedback, or went along with erroneous diagnoses.
  - ✓The Joint Commission has now included Disruptive Behavior in their standards.

## Crucial Conversations in Health Care:

- Grenny and Maxfield (2011) discuss the relationship of crucial conversations and workplace safety:
  1. Get it done. Unsafe practices that are justified by tight timelines.
  2. Undiscussable incompetence. Unsafe practices that stem from skill deficits that can't be discussed.
  3. Just this once. Unsafe practices that are justified as exceptions to the rule.
  4. This is overboard. Unsafe practices that bypass precautions that are considered excessive.
  5. Are you a team player? Unsafe practices that are justified for the good of the group.



# Discussion / Comments

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# FMRNA Panel Discussion

*Kay Anderson, RN*
*Mary Beth McLellan, RN, BSN*
*Kathy Morin, AD, RN*
*Marcia Snook, RN, BSN*

## Topics for Discussion

- Nurse Led Group Visits
- How to locate clinical top of licensure for my home state
- Oral Health for Pediatric and Obstetric Patients
- Open Discussion

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# Nurse Led Groups

*Kay Anderson, RN*
*Mary Beth McLellan, RN, BSN*

## Nurse Led Groups

- Population Management- patient with common diagnosis
- Patient self management teaching
- Improves patient to patient and patient to provider interactions and relationships
- If nurse has specialty certification these may be able to be billed to insurances- diabetes educators, tobacco cessation counseling
- Residents can join group to learn teaching skills

## Shared Group Visits

- Combined group visit with nurse, provider, pharmacist
- Nurses often asked to led the educational groups while provider is seeing patients individually
- Decreases ED visits, admissions and cost of care
- Improved preventative care, screening, patient satisfaction
- Certified Diabetic Educator and bill for services
- Residents can join group to learn teaching skills

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## Licensure

*Kathy Morin, AD, RN*

## Verifying Clinical Licensure and Scopes of Practice

- 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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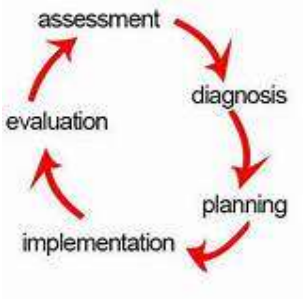
## RN VS LPN Using the Nursing Process

**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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## How to locate clinical licensure

- RN/LVN licensure and scopes of practice in your state
- Boards of Nursing in your state /territory
  www.ncsbon.org/contactbon.htm
- Great site that will connect you to your states Board of Nursing



## How to Locate Medical Assistant Scopes of Practice

- American Association of Medical Assistants
- http://www.aama-ntl.org/employers/state-scope-of-practice-laws
- Site for employers to verify MA's Certification and state specific scope of practice
- Each state shows their definition of "delegable duty". Task specific like venipunctures, injections, medications
- Missouri defines triage-independent clinical judgement or to make clinical assessments and evaluations
- Missouri defines non-triage- provider approved protocols and verbatim conveying of information

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# Cavity-Free at Three

*Marcia Snook, RN, BSN*
*Practice Administrator*
*Fort Collins Family Medicine Residency Program*

## Why?

- Why would you want to provide dental care in a medical office?
  - We have a captive audience while the children get their WCC's in our office.
  - Providers are already performing oral assessment.
  - It's the right thing to do.
  - It's reimbursable.

# The Pain and Cost of Poor Dental Health

How many of you are performing pre-op physicals for dental procedures under anesthesia?

- In 2012, 3,113 children visited the operating room at Children's Hospital for restorative needs under general anesthesia costing as much as $15,000 per operation



# We Are Behind the 8 Ball

- It was found in Colorado in 2016, through the Basic Screening Survey, that 35.8% of kindergartners and 48.3% of 3rd graders have dental decay. (trending down since 2012
- In 2016, only 11% of children less than a year, and 37.6% of children under 3 years of age saw a dentist
- Most common childhood disease
- 5 X more common than asthma

## We Can Help

Through prevention-

Fluoride varnish can help prevent about 37% of tooth decay in baby teeth.

Through education-

Start brushing at first sign of teeth with fluoride toothpaste



## Cavity Free at Three-Mission

- Focuses on children under 3 years old
- Performs a caries risk assessment for infants and toddlers
- Get the child connected with a dental home by age 1, 3 at the latest
- Caries risk assessment is best practice but not required by Medicaid for ages 5 and older in order to get reimbursed by MCD for varnish

# Reimbursement

- Dental codes must be paired with Well Child Check codes.
- Reimbursable through MCD 2 X/year for all children and up to 4 X/year for high risk children.
- Commercial insurances will not cover dental codes-check your charges and share with the parent before performing varnish



# Billing and Reimbursement

- **Ages 0-2**
- D0145 Oral evaluation, counseling with primary caregiver child < 3 (MCD reimbursement 30.44)
- D1206 Topical Fluoride Varnish (MCD reimbursement 16.02)
- ¨ Pair with Well Child Visit, document that formal Caries Risk Assessment was performed
- ¨ Reimbursable twice per year, two additional per year for high risk children.
- ¨ ICD 10—Diagnosis codes: Z00.129 (well child exam <28 days) Z13.84 (screening for dental disorders)
- 
- **Ages 3-4**
- D0190 Dental Screening (MCD reimbursement 15.91)
- D1206 Topical Fluoride Varnish (MCD reimbursement 16.02)
- **¨ Pair with Well Child Visit, document that formal Caries Risk Assessment was performed**
- ¨ Reimbursable twice per year, two additional per year for high risk children.
- ¨ ICD 10 Diagnosis codes: Z00.129 (well child exam <28 days) and Z13.84 (screening for dental disorders)
- 
- **Ages 5 +**
- D0190 Dental Screening (MCD reimbursement 16.02)
- D1206 Topical Fluoride Varnish (MCD reimbursement 10.90)
- ¨ Reimbursable a maximum three times, regardless of risk.
- ¨ Not required to pair with well child
- ¨ ICD 10 Diagnosis codes: Z01.20 (dental exam) or Z13.84 (screening for dental disorders)

## Training

- Free 2 hour training followed by hands on experience:
  - Incorporate children's preventive oral health services into your practice
  - Prevent dental disease
  - Assess caries risk
  - Deliver anticipatory guidance and patient education
  - Provide oral health evaluations



## Supplies

- The kit costs $7 through Bayaud Enterprises
  - 1 unit dose fluoride varnish
  - Gauze
  - Infant toothbrush
  - Caregiver toothbrush
  - Child toothpaste
  - Patient education

## Documentation

- Dot Phrase:

*"I have completed a dental caries risk assessment using the Cavity Free at Three Screening form and found the caries risk to be <high/low>. Fluoride varnish was applied by a trained <provider/RN/MA>, parents received oral health advice, and were referred to a dental home.*



## In Summary

- **Look in the mouth** and get a sense of what kind of urgency this child has for dental care (our providers are not expected to be dentists!)
- **Paint fluoride varnish on their teeth** as a preventive tool (37% reduction in decayed, missing and filled tooth structures on primary teeth)
- **Refer to a dental home** (It's important you see a dentist!)
- **Want to get started?** support@cavityfreeatthree.freshdesk.com

# THANK YOU for attending the 2018 FMRNA Annual Residency Nursing Workshop

- Certificates verifying attendance and 6 contact hours awarded will be emailed after the event to participants who meet the following requirements:
  1. Sign in at event.
  2. Complete the FMRNA evaluation

**Click here if viewing the PDF:**

*Please complete the FMRNA Evaluation to evaluate each FMRNA workshop **AND** the FMRNA event as a whole. All are included in one evaluation survey.*

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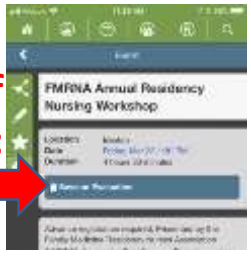


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