Making the Management of Acute Otitis Media a SNAP

Cassandra Newell MSN, CPNP
Children’s Mercy Kansas City
Division of Emergency Medicine
March 26, 2020

Learning Objectives
• Identify opportunities and methods to promote Watchful Waiting (WW) or Safety Net Antibiotic Prescription (SNAP) for non-severe AOM in an Emergency Department (ED) or outpatient setting

Background
• Acute otitis media (AOM) is the leading condition for which antibiotics are prescribed for children
• 2013 American Academy of Pediatrics (AAP) guidelines recommend providers offer a WW or SNAP for non-severe cases
• Over prescribing of antibiotics, antibiotic stewardship

Children’s Mercy Kansas City
Adele Hall Campus

Disclosures
No disclosures

Background
• 228 randomly selected records of patients diagnosed with AOM by ED Advanced Practice Providers (APPs) at Children’s Mercy Adele Hall between August 2017 and April 2018 were reviewed
• All patients received immediate antibiotic prescriptions
• Sixty-seven (29.4%) patients would have qualified for WW/SNAP

Aim

- To increase WW/SNAP in children > 6 months old diagnosed with AOM by APPs in the ED from 0% to 15% by May 2020
- Outcome measures: percent WW/SNAP and parental acceptance of SNAP when offered
- Balancing measures: return to the ED within 14 days and/or tympanic membrane (TM) perforations

Methods

- **June 2018**: a pre-intervention survey related to the AAP guidelines was completed by 13 (52%) ED APPs
- **PDSA #1: August 2018**: Pre-intervention survey data was shared with the ED APPs. An algorithm summarizing the guidelines was placed in highly visible areas in the ED APP work room
- **PDSA #2: December 2018**: Standardized documentation for the electronic medical record to facilitate documentation of parent education was developed and shared with ED APPs
- **May 2019**: a post-intervention survey was sent to the same cohort of ED APPs with 7 (28%) responses

Results of the Pre-intervention and Post-intervention survey

- **Pre-intervention survey**:
  - 85% reported awareness of the AOM guidelines
  - 92% recognized WW/SNAP eligibility of a 2-year-old with bilateral non-severe AOM, only 31% recognized eligibility for a 10-month-old with unilateral non-severe AOM
  - 31% of the ED APPs acknowledged never discussing the option of WW/SNAP
- **Post-intervention survey**:
  - 100% reported awareness of the AOM guidelines
  - 100% recognized WW/SNAP eligibility of a 2-year-old with bilateral non-severe AOM, 57% recognized eligibility for a 10-month-old with unilateral non-severe AOM
  - 71% of the ED APPs reported discussing WW/SNAP “all the time” and 29% “sometimes”

Parental acceptance: 60% of offered WW/SNAP prescriptions were accepted

Conclusion

- Simple interventions can increase offering and parental acceptance of WW/SNAP prescriptions for non-severe AOM
- This model can easily be recreated in a tertiary ED or primary care clinic
Acknowledgements

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• Brian Lee MPH, PhD
• Rana El Feghaly MD, MSCI

The End!

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Opioid Reduction in Unplanned Orthopaedic Admissions: A Quality Improvement Project

Jennifer Weiner, DNP, APRN-CNP, CPNP-AC/PC
March 26, 2020

Learning Objectives
• Understand the importance of multi-modal pain management for children

Why This Project
• Prescription opioid overdoses in Ohio have been climbing1-3
• Opioid crisis in Ohio has led to restrictions on opioid prescribing4-6
• Need to develop creative pain management strategies for patients admitted to the orthopaedic service

Project Title: Opioid Reduction for Ortho Trauma Patients

Aim
• Decrease number of opioid pain medications prescribed on admission to orthopaedic service with unplanned admissions from 5 to 2 per patient for 6 months

Key Drivers
• Reasonable, Shared Expectations
• Effective Patient/Family Education

Interventions
• Use of Non-Pharma Interventions
• Global Goal: Reduce risk of opioid misuse by patients and families
Project Title: Decreasing Opioid Use in Orthopedic Unplanned Admissions  
Project Leader: Jenny Weiner

**Aim**

**Effective Patient/ Family Education**

- Provide routine consults for ancillary services
- Consider anxiety screen for improved well-being assessment
- Review & update pain management policies

**Global Goal:** Reduce risk for opioid misuse by patients and families

**Use of Non-Pharma Interventions**

- Use HCAHPS consistent language
- Share literature supporting NCH practices regarding pain management
- Consider alternate pain scales for improved assessment accuracy
- Update Epic flowsheet so coping plans follow pt
- Make coping plans shareable and accessible
- Consistent communication with all regarding pain management expectations
- Discuss planning for scheduled meds vs pre-medicating

**Effective Patient/ Family Education**

- Provide handouts about opioid use on admission

**Use of Non-Pharma Interventions**

- Share literature supporting NCH practices regarding pain management

**Outcomes**

Mean = 5.1

Routine Child Life consult initiated: APN, Ped Surg, and ED education session regarding pain and medication policies

Feedback shared with Ortho teams

Mean = 3.7

Mean = 2.4

Mean = 1.7

**Balancing Measure**

Routine Child Life consult initiated

Outcomes feedback shared with Ortho teams
Next Steps

• Working on handout for patients and families
• Expanding to ED
• Changing EPIC consult
• Dissemination of results

References


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Developing nurse practitioner student skills and cultural competence through international missions

Lisa Merritt, DNP, APRN, CPNP-PC/AC, PMHS
Clinical Assistant Professor
University of Tennessee-Knoxville, College of Nursing

Learning Objectives

- Discuss the importance of providing international mission opportunities during nurse practitioner training
- Identify resources available for nursing faculty interested in leading international missions
- Describe the benefits of international missions for nurse practitioner students and faculty

Why is this important?

- Students need exposure to medically underserved and different cultures
- Experiential learning (Kolb, 1984)
- Supplement clinical practicum hours
- Lack of literature NP student international missions

Guatemala January 2019

- Primary care nurse-led clinics in El Quimal La Joya and Alotenango
- 10 NP Students
- FNP, AGNP, PNP, PMHNP
- Rubric measuring practice competencies
- Post-evaluation survey measuring confidence in skills and cultural competency

Disclosures

No conflicts of interest to disclose in regards to this presentation
“We’ve been taught about social determinants of health throughout our NP program, but it really never made sense until now”
-NP Student

References

• Nursing Heart International – Nurse-led Organization
  www.nursingheart.org
• World Strides | International Studies Abroad – Faculty Led Programs
  www.worldstrides.com or www.studiesabroad.com
Learning Objectives

- Describe the value of student engagement in service learning in a local setting.
- Discuss an example of student engagement with a pediatric refugee population.
- Discuss challenges and future foci.

Student Engagement at Emory University Nell Hodgson Woodruff School of Nursing

Our Values

- Excellence: We achieve outcomes that are significant and distinctive with persistent commitment to high quality.
- Collaboration: We embrace community partnerships, mentoring, and diverse perspectives.
- Social Responsibility: We treat all with respect and dignity. We engage with others to positively influence health and social justice.
- Innovation: We create, use, evaluate, and disseminate cutting-edge approaches to advance our mission and vision.
- Leadership: We shape nursing, health care, and the NHWSN through vision, courage, and optimism.

Our Primary Strategic Initiatives

- Improve the student experience
- Build capacity for complex data analytics
- Streamline curricular pathways between degrees
- Lead in health promotion and wellness initiatives
- Advance health policy and advocacy activities
- Expand global health and community engagement activities

Challenges and Current/Future Foci

Challenges

- Meeting Refugee Student Needs
  - Families’ Perceptions of Well Care
  - Families’ Perceptions of Mental Health
  - High PTSD Screening Scores
  - Elevated BPs With/Without Overweight/Obesity Profiles
- Meeting NP Students Needs
  - General Refugee Care
  - Clearance for Sports Physicals
  - Mental Health
  - Orthopedic Injuries

Current/Future Foci

- Refugee Student School Follow-Up Plan
- Resiliency Training
- Community Needs Assessment
- Debrief Opportunity for NP Students
- Development of Refugee Care Module
- Rework Mental Health/Ortho Content
Healthcare Hotspotting in the Pediatric Push Towards the Triple Aim
Alexa McWhinnie, BSN, BS, RN, PNP/s

Learning Objectives
• Describe key concepts of healthcare hotspotting
• Explore current implications of healthcare hotspotting techniques in the realm of pediatric care
• Identify indications for pediatric healthcare hotspotting in relation to the Triple Aim of Healthcare Improvement

What is Healthcare Hotspotting?
Lightning Edition

Reallocation of Resources to High-Need, High-Cost Patients
• Top 5% of patients account for 50% of all healthcare costs (~$50,000 per person annually)
• Top 1% of patients account for 22% of all healthcare costs (~$110,000 per person annually)

How does this apply to Pediatrics?
• Children ≤19 make up approximately 1/4 of the US population and account for 10% of healthcare spending
• Children of Medical Complexity (CMC) are estimated to account for 0.4%-6% of all children and 1/3 of all pediatric healthcare spending
• CMC therefore are only 0.01%-1.44% of total population, but account for 3% of healthcare spending in the U.S. at approximately 108 billion dollars

Disclosures
Alexa McWhinnie has no relevant financial or nonfinancial relationship(s) within the services described, reviewed, evaluated, or compared in this presentation.
Current Hotspotting-Type Framework Initiatives in Pediatrics

Hospital-Based Complex Care Programs
- **Pros:** Improves coordination of care, decreased risks of costly hospital error
- **Cons:** Isolated to hospital settings, primarily addresses medical complexity, underemphasizes community-based settings for CMC care, geographic access

Neighborhood Approaches to Population Health
- **Pros:** Addresses Social Determinants of Health, can be implemented distant to hospital centers, improved outcomes for all not just CMC families
- **Cons:** Barriers of funding and bringing to scale

Tele-Health and Project ECHO
- **Pros:** Opportunity for widespread access, improves community-based capacity
- **Cons:** Potential for decreased provider awareness of specific community support systems and resources, perceived depersonalization of care

Application to The Triple Aim of Healthcare Improvement
- **Improved Coordination of Care** (primary care, specialty care, therapies, home care, etc.)
- **Increased Access to Resources** (durable medical equipment, transportation, community supports)
- **Better Short & Long-Term Outcomes** (school attendance, societal integration, familial financial well-being, caregiver savings, retirement, and elder care planning)

Prevention of unnecessary hospitalizations, readmissions, and duplicated care
- **Improved Family Health & Wellness** (caregiver burden & stress reduction, familial supports)
- **Increased Productivity & Involvement** (caregiver ability to work, DALY’s, quality of life measures)
- **Better Short & Long-Term Outcomes** (school attendance, independence, financial well-being during transition to adulthood)

References


Return to Learn Guideline in Pediatric Concussion

Jennette Firlein, MSN, CPNP-PC
Nemours/A.I. duPont Hospital for Children, Concussion Program

Learning Objectives

- Understand the need for Return to Learn program addressing home, social, and everyday activities, mirroring return to school
- Describe return to learn program
- Understand how tool is utilized in healthcare setting

Background

- Primary recommendation for pediatric concussion management includes a brief, defined period of rest, with gradual transition to activities
- Guidelines for school and return to play are readily available in the literature. However, there is much less evidence surrounding the protocol for return to learn.
- Identified need: gaps in early care regarding rest and graduated return to learn process
- Limited tools with concrete age-appropriate recommendations
- Caregivers often receive limited and conflicting information from health care providers

Objective

- Devise an easy to use, age-appropriate return to learn guideline that addresses home activities in conjunction with the return to school

Implementation

- Information distributed at first point of contact with concussion clinic triage nurse
- Instruction on initial patient zone/target and how to progress as symptoms improve
- Encouraged families to utilize guidelines as a reference at follow up visits
- Distributed guidelines throughout Nemours Pediatrics Primary Care Clinics, AIDHC Emergency Department, and inpatient units with instructions for utilization in practice or upon discharge

- Organized by color-coded zones and age groups as a concise pathway families can easily follow
- Listed activities to avoid and appropriate activities during specific stages of recovery
- Provide generalized time frame for return to school and coordinate home based leisure and social activities in each zone
- Instruct on how/when to progress and when to contact your provider
- Produce on tear sheets for ease of use and distribution
- Integrate into inpatient EMR and a template letter for outpatient use
Outcomes, Implications, and Future Recommendation

Outcomes

• Positive qualitative feedback from health care providers.
• Positive insight from families with injury distribution.
• Families demonstrate utilization of the guideline through spontaneous reference during follow up visits and phone calls.
• Families report clarity when determining which activities are safe for their children.
• The clinic receives fewer inquiries from families concerning types and levels of approved home activities.

Implications

• Shorter recovery from concussion and quiker transition to school
• Decreased sequelae related to concussion
• Streamlined clinic visits

Future Plans

• Maintain up-to-date recommendations based on current literature

References


USE OF REST PROTOCOL IN PATIENTS WITH DISORDERS OF CONSCIOUSNESS DURING ACUTE REHABILITATION
CHILDREN SPECIALIZED HOSPITAL
Evelyn David MSN APRN

Learning Objectives
• Learn the main disorders of consciousness
• Learn the strategies to promote brain recovery
• What is REST PROTOCOL
• Learn the use of Coma Recovery Scale Revised (CRS-R)

DISORDERS OF CONSCIOUSNESS (DOC) CONCEPTS
• DOC: impaired consciousness
• Leading Causes: Severe TBI, hypoxic ischemic, poisoning, hemorrhagic, encephalitis
• Accurate diagnosis that is evidenced-based should guide treatment strategies and predict outcome.
• Effort should be made to increase arousal prior to establishing final diagnosis (pharmacological/non-pharmacological)
• Misdiagnosis can lead to grave consequences, especially in end-of-life decision-making
• To reduce diagnostic error with prolonged DOC after brain injury, serial standardized neurobehavioral assessment to identify trends in the trajectory of recovery.
• Coma Recovery Scale-Revised (CRS-R) have shown to have good reliability and validity to detect subtle behavior signs of consciousness. (auditory, visual, verbal, arousal, motor, communication)

MAIN DISORDERS
• Coma- unconscious, no awareness, reflexive responses to painful stimuli, Diffuse brain injury, may last 2-5 weeks, Ranchos Los Amigos (RLAS) (1)
• Vegetative state- UWS- (can appear to be awake, but unable to purposefully interact), Cortical and thalamic injuries, Sleep awake cycles preserved, Eye movements, Reflexive action (oral/swallowing/yawning), Autonomous & brainstem functions preserved (minimal but definite awareness) RLAS (2), chronic VS >3 mos non-traumatic and >12 mos TBI
• Minimally conscious -Inconsistent signs of self and environment, may be able to communicate, interact, may show verbalizations or command following, show emotional behaviors, Visual tracking present/visual pursuit *If receiving rehabilitation during the first six months may improve. RLAS (3)
• Emergence from MCS (EMCS) recognize and use 2 familiar objects

Disclosures

SPEAKER DISCLOSURE
EVELYN DAVID

Relevant Financial Relationship
• Works as a Pediatric Nurse Practitioner, Brain Injury, conversion and Chronic Pain Programs of Children Specialized Hospital in New Jersey (CSH)
• receives a salary at CSH

USE OF REST PROTOCOL IN PATIENTS WITH DISORDERED OF CONSCIOUSNESS DURING ACUTE REHABILITATION
• Injury to the frontal lobe and subcortical systems results in loss of function
• White matter shearing and diffuse axonal injuries may result in interruption and inefficiencies in processing information, disruption in connectivity, along with slower mental speed and stamina
• Damage to ganglia > dysfunction of the motor and premotor cortical areas so that voluntary movements cannot be performed smoothly

https://radiopaedia.org/cases/normal-midline-brain-mri-1
STRATEGIES TO PROMOTE BRAIN RECOVERY

- **BRAIN DAMAGE** - creates maladaptive pathways that interfere with “normal” processing of information. Brain healing is a natural process with or without therapy.

- **STIMULATION** - Brain's neuroplasticity - lifelong capacity of the brain to change and **REWIRE** itself in response to the **STIMULATION** of learning and experience.

- **REST** - is crucial to allow the brain time to process the new information being presented. Brain also requires ample **REST** to rebuild or **CREATE NEW** neuronal connections.

- **Oversaturation** - often causes the brain to be confused, and limiting ability to respond to the environment.

**REST PROTOCOL** - R: restful recovery, E: education, S: sensory stimulation, T: therapeutic activities

- Multi-disciplinary approach: medical, nursing, skilled therapists, support staff

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**ENROLLED WHO MET CRITERIA**

- (25) patients with disordered of consciousness, in an acute rehabilitation hospital from 2016-2018
- (11) patients with severe traumatic injury, (5) patients with anoxic event, and (9) patients with non-traumatic brain injury
- REST protocol was discontinued on (4) patients due to non-progression of neurological status, (1) because of family request and the rest due to patients transitioning to the emerging minimally conscious state.

**OUTCOME** - There were (52) patients who progressed from vegetative state to minimally conscious state.

- There were eleven (11) who remained in vegetative state and there were two (2) patients in minimally conscious state emerging.

- However, more research is needed if this protocol helped the recovery of patients with severe traumatic and non-traumatic brain injuries.


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**REFERENCES**


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**THANK YOU!!!**
The Use of a Portable Stool as a Means for Improving Patient Satisfaction

Barbra Murante, MS, RN-C, PNP
Pediatric Nurse Practitioner
Golisano Children’s Hospital/University of Rochester

Disclosures
I have no conflicts, however, I must admit that I prefer sitting to standing

Learning Objectives
Describe how sitting with a patient can improve patient satisfaction
Understand the advantages and ease of carrying a portable stool for patient rounding

Grab a Seat! Nudging Providers to Sit Improves the Patient Experience in the Emergency Department.

Connecting With Patients

Effect of sitting vs. standing on perception of provider time at bedside: A pilot study

120 post-operative spine surgery patients
Surgeons visited for post-operative check
Randomized to sitting vs standing
Length of visit recorded
Patients asked:
Length of visit
Quality of visit
60 surgeons randomized to sit, 60 to stand
Patients’ perception of time spent

Fig. 3. Actual time and patient perceived time of provider at bedside.
Ask permission:

“Do you mind if I sit and talk with you?”

Why Use A Portable Stool in Patient Care

- Patients like when clinicians sit with them
- Eye level with patient/parents
- Easy to use, light weight and readily accessible
- Can fit easily in crowded patient rooms
- Inexpensive
- Anyone can use them