WELCOME TO THE CMSA-OK ANNUAL CONFERENCE

"CONSTRUCTION OF CASE MANAGEMENT"

GENERAL SESSION

GENERAL SESSION

“SITUATIONAL AWARENESS - TRIAD SAFE SHOPPING”

Presented By:

Lieutenant Kim Lopez

Cleveland County Sheriff’s Office

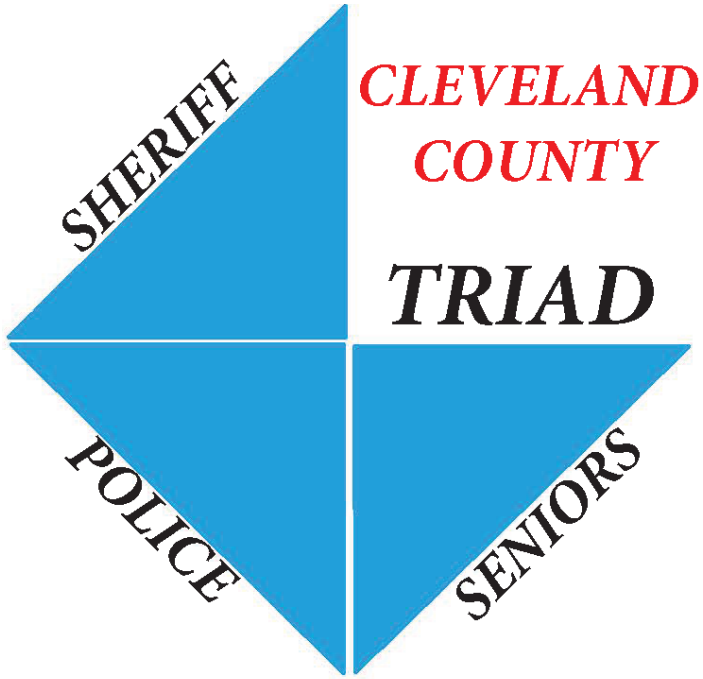
Cleveland County TRIAD

CRIME PREVENTION & PERSONAL SAFETY FOR SENIOR ADULTS

Lieutenant Kim Lopez, TRIAD Coordinator

Cleveland County Sheriff's Office

What is TRIAD?



The name TRIAD is to remind us of the 3 group/partnerships required to deploy crime prevention programs *with and for* senior citizens within Cleveland County.

WHY SENIORS ARE TARGETED?

Nest eggs!

Crooks don’t think you will defend yourselves

Crooks believe you are more trusting and will fall for anything

Most seniors do not have a plan

Or

The tools to carry out that plan.

Not having a plan is like telling yourself: “you’ll have plenty of time to put on your seatbelt before a crash”!

What exactly is your plan???

Ask yourself…Do you have a plan?

- Do you know what actions you would take if someone approached you out of nowhere and convinced you they were willing to harm you for your money or property?

- Scream?
- The most common human response… to coward and beg for your life.

TRIAD SAFE SHOPPING

- You already know your method of payment before you leave the house.

- ? How many of you ALWAYS GET A SHOPPING CART FOR ONLY ONE ITEM?

Congratulations!

- Starting today, you will have a plan!
- *A plan is only as good as the tools to carry it out.
- YOU HAVE HOMEWORK TONIGHT!

FOR YEARS GOOD INTENDING PEACE OFFICERS INSTRUCT PEOPLE TO “WALK WITH CONFIDENCE AND BE AWARE OF YOUR SURROUNDINGS”.

This is simply not enough information:

Question: How much confidence do you walk with?

Criminals know how to read your body language. You will only walk with confidence when you have training, a plan and the tools.

Step one: find a good focal point.

I hand out these stickers, but anything will work.

STEP TWO: FIND YOUR “HAPPY SPOT”

This usually requires a nice Recliner
Place your focal point behind your recliner

Ever heard the term:
“Check your six”?

As we age we atrophy in our neck, this range of motion can be re-gained, with practice.

Do this nightly

Slide to the front of your seat, feet, knees, shoulders need to be POINTED FORWARD.

TRY TO SEE THE FOCAL POINT DIRECTLY BEHIND YOU

Do this every time you turn the TV on and
every time you change the channel.

THIS WORKS!!!!

EVERY CRIMINAL UNDERSTANDS SOMETHING YOU MAY HAVE NEVER LEARNED.

- Criminals understand what is called “The Adrenaline Rush”
- Criminals use this first to startle you
- Criminals know how you will respond UNLESS YOU HAVE A PLAN!
- Criminals expect you to coward and beg for your life and offer up your valuables.
- THIS SHOULD MOTIVATE YOU TO PLAN A CHANGE! SIMPLY HAVING A RESPONSE MAY SAVE YOUR LIFE. Remember they have done this before and the most common human response is to coward and beg for your life. Your pleas mean nothing to them.

There are two most common demands from criminals who are willing to harm you to get your valuables.

THEY WANT YOUR:

KEYS AND VALUABLES

PREPARE BEFORE YOU SHOP

Did you know two (2) one dollar bills can save your life? Two one dollar bills when added to a money clip or office binder and kept in your pocket can be used as “bait money”

Bait keys are to be shown and thrown!

- This works to “BAIT” the attacker AWAY FROM YOU SO YOU CAN GET TO SAFETY.
- Adding a metal money clip adds just enough weight to throw the money.
- Keep this in your pocket, READY TO THROW.

WHY CRIMINALS may demand YOUR KEYS:

Ever heard the term: PARKING LOTS ARE DANGEROUS?

But why????

Why are parking lots so dangerous?

- When home invasions are interrupted…
- When the drug deal goes bad…
- When the fight is on…
- When police are responding…

Which parking lots are the most dangerous?

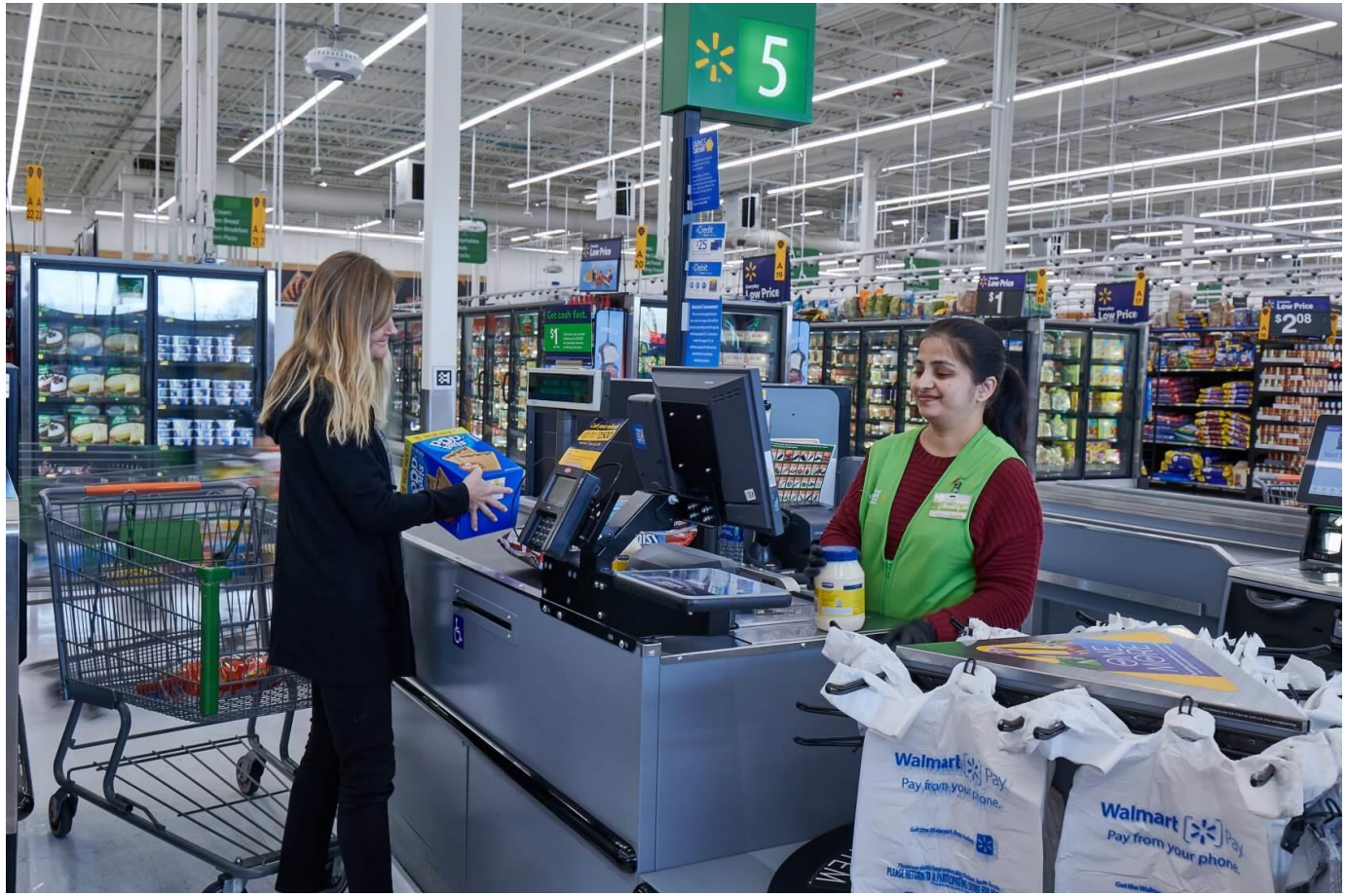
- The one you feel the most comfortable in!
    - Your church
    - Your senior center
    - Your doctor’s office

This is because your body language is far different when you feel comfortable.

All parking lots are dangerous

- Again, the parking lot you feel comfortable in.
- 24 hour parking lots are very dangerous. Its easy to dump a stolen vehicle!
- Can you name the most dangerous parking lot of all?

HOT SPOTS: PARKING LOTS AND REGISTER STALLS



ANY GOOD TRAVEL AGENT WILL TELL YOU TO CARRY A LANYARD WALLET!

Sometimes called a Travel Document Wallet

Look for one that will carry your mobile phone

When worn under your clothing, you may not be targeted

A CARABINER

Named after it’s inventor, this spring loaded gadget is an amazing crime prevention tool.

This is where planning and tools comes into play:

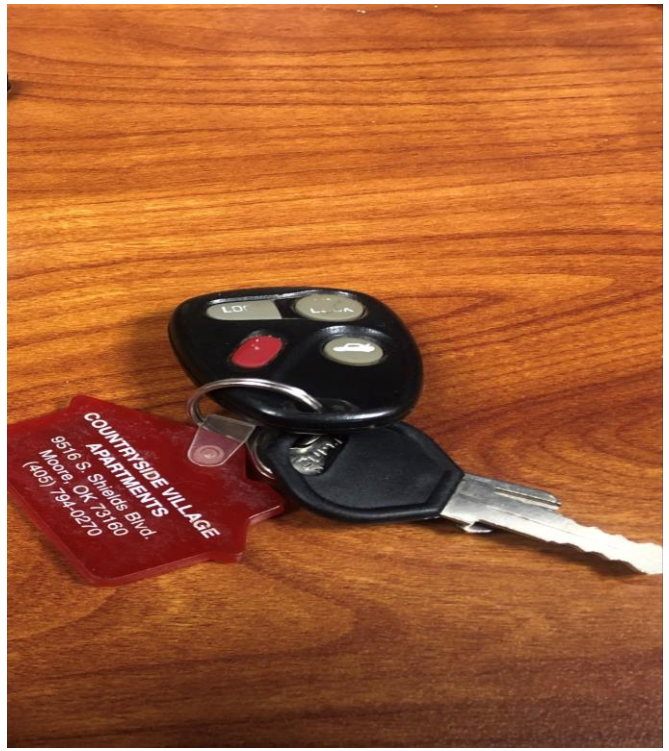
- MAKE YOUR SHOPPING LIST:
- GOOD LANYARD WALLET –FIND THESE OVER BY THE LUGGAGE
- A GOOD WHISTLE
- A WRIST LANYARD FOR YOUR GOOD KEYS
- SEVERAL OLD KEYS FOR “BAIT KEYS”

“give me your keys!”

- Be ready:
- Prepare bait keys! Add them to your key chain and separate them before entering a parking lot.
- Get a “carabiner” to connect: your good keys to your BAIT KEYS!
- ADD A “WRIST LANYARD” TO KEEP YOUR KEYS FROM DROPPING.
- DO NOT GO OUT WITHOUT A GOOD WHISTLE:

THIS IS AN INTERNATIONAL SOUND OF DISTRESS!

Be ready to “show them and throw them!”



Its simple, just find several old keys you care nothing about and make yourself some “BAIT KEYS”.

ADD AN OLD KEY FOB! THIS MAKES IT LOOK REAL!

Fanny packs are not belly bags!

- When worn in correctly, these are wonderful safety devices.

PURSE SNATCHERS PARADISE!

One strap, over the shoulder tight under your arm.

Do you get a shopping cart for 1 item?

Women are 7 times more likely to turn their back after using the baby seat belt to secure their purse. Are you in this habit?

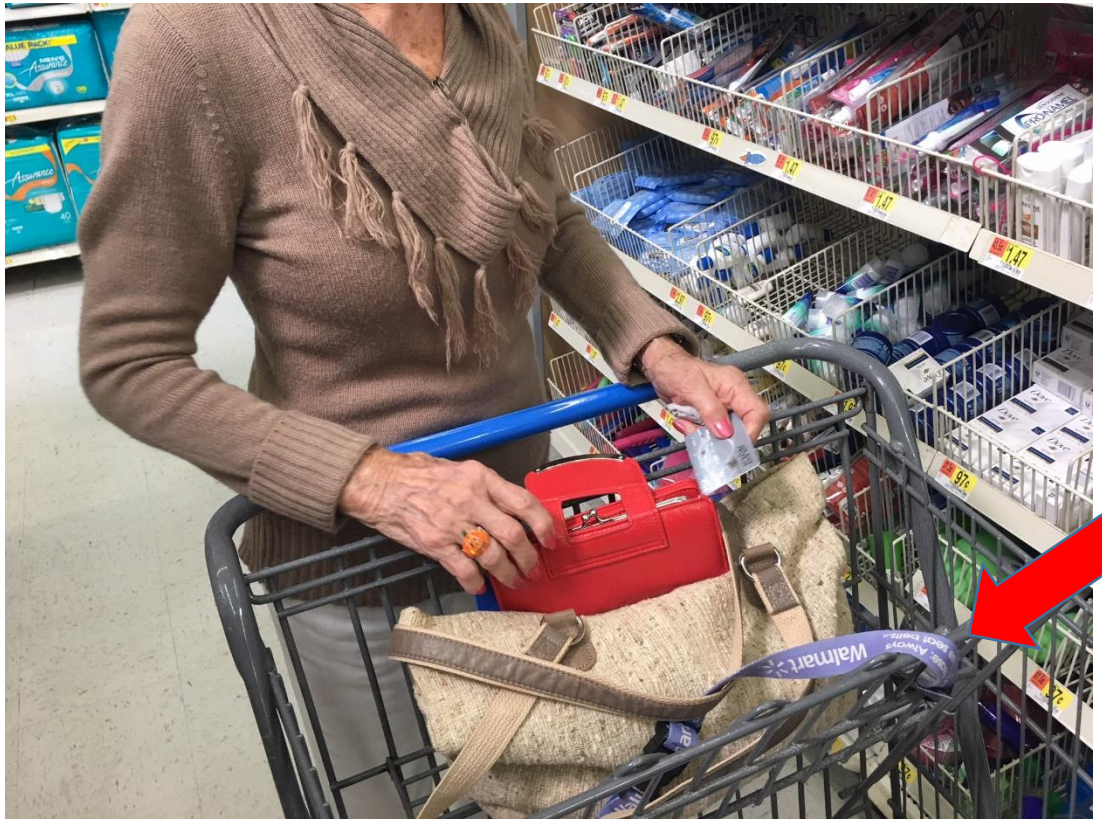
The carabiner is far more effective

Works on wallets and baby seat belts

Senior Adult men=HUGE TARGET

VS

Never ever get your method of payment out at the register!



Always get your method of payment out, by the unmentionables!

If you are still writing personal checks?????

WORST WAY TO PAY FOR ANYTHING WHILE SHOPPING.

LETS TALK ABOUT “CHECK WASHING”

BUY ONE, AND SHARE ONE WITH THE PEOPLE YOU KNOW WHO ARE STILL WRITING CHECKS AND DON’T KNOW THIS.

A $2.00 Gel pen can save you thousands!

NEVER EVER SET YOURSELF UP AS A TARGET!

- TURN YOUR RINGS AROUND
- COVER THAT EXPENSIVE WATCH
- NEVER FLASH LOADS OF CASH AT THE REGISTER

AND… NEVER EVER PUSH YOUR SHOPPING CART!
YOU PULL IT!

WATCH THIS VIDEO

- iPhone ATM PIN code hack- HOW TO PREVENT - YouTube

THAT’S THE BAD NEWS: WANNA KNOW THE GOOD NEWS?

- Simply do not touch or warm the keys
- Use your car key
- Use your gel pen
- Or: USE THREE FINGERS AND WARM ALL THE KEYS BEFORE YOU WALK OFF

THAT’S GOOD NEWS RIGHT?

- NOPE! THIS TECHNOLOGY IS ALSO USED ON DOORS

AND OUTSIDE GARAGE DOOR OPENER KEY PADS

JUST REMEMBER TO WARM ALL THE KEYS OR DEPRESS EACH ONE WITH SOMETHING ELSE

IN CLOSING

- PULL YOUR SHOPPING CART TO PROVIDE SEVERAL FEET OF SPACE BETWEEN YOU AND ANYONE WANTING YOUR FINANCIAL INFORMAITON
- REMEMBER THEY CAN VIDEO OR TAKE PICTURES WITHOUT YOU KNOWING
- READY YOUR BAIT KEYS AND BAIT MONEY
- READY YOUR GOOD KEYS, WHISTLE AND CELL PHONE

IF SOMEONE RUSHES UPON YOU…

- CALL 9-1-1 GIVE YOUR LOCATION AND START DESCRIBING THEM
- BLOW YOUR WHISTLE CALL AS MUCH ATTENTION TO THEM AS POSSIBLE
- DON’T EVER LET ANYONE GET CLOSE
    - USE YOUR OUTSIDE VOICE “STOP RIGHT THERE, I HAVE 9-1-1 ON THE PHONE”
    - WATCH YOUR 6

Remember to place a dry erase marker in your vehicle.

This allows you to write TAG NUMBERS, PHYSICAL DISCRIPTION, LOCATION/MILE MARKER on your window or rear view mirror without having to find a pin and paper.

*the ink wipes off easily with a Kleenex!

NEW INFORMATION:

IF YOU HEAR CRUNCHING WHILE BACKING OUT, DO NOT EXIT CAR WITHOUT YOUR KEYS/FOB.

Check the gas pump nozzle holder before you leave the pump.

Thieves cram bath tissue or paper towels here to prevent your purchase from being complete.

When you drive off, they pump gas on your card.

THANK YOU

I deeply appreciate this opportunity and look forward to hearing from you.
Please contact your local law enforcement agency and share my contact information.

Contact Information:

lieutenant Kim Lopez

TRIAD Coordinator

KLopez@Clevelandcountyok.com

Cleveland County Sheriff's Office

111 North Peters Ave.

Norman, OK 73069

405 701-8636

TAKE A PICTURE OF THIS SLIDE WITH YOUR PHONE.

GENERAL SESSION

"EFFECTIVE DISCHARGE PLANNING FOR THE HOMELESS PATIENT"

Presented By:

Suzanne Williams, MCJ

Oklahoma Dept. of Mental Health & Substance Abuse Services

Effective Discharge Planning For The Homeless Patient

CMSA-OK

November 15, 2023

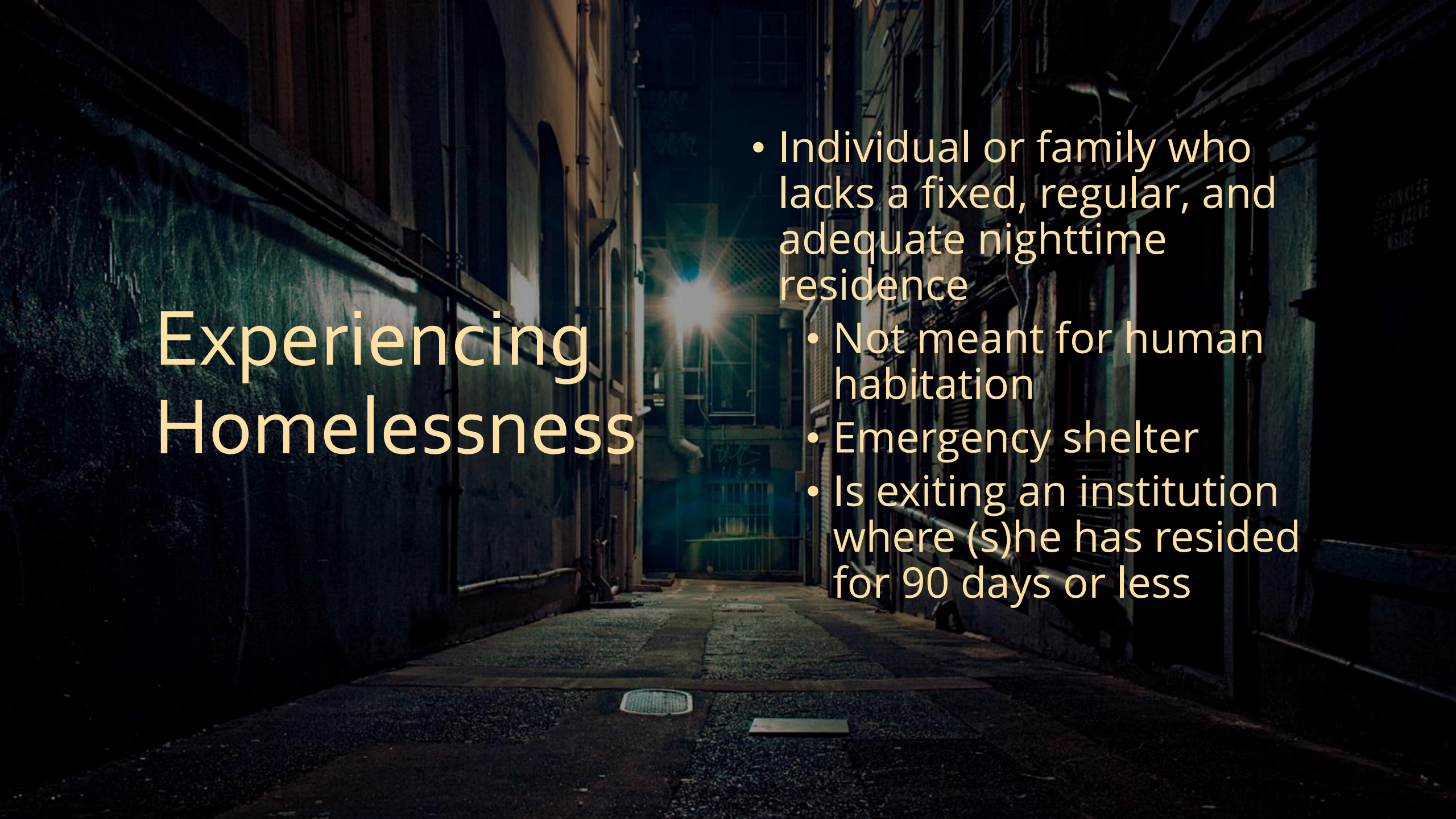
“Coming together is a beginning,
staying together is progress,
and working together is success.”
-Henry Ford

Who is Homeless?

Effective Discharge Planning for the Homeless Patient

At Risk of Being Homeless

- Eviction notice
- Not able to pay their utilities
- Needing supports for mental health and/or substance use
- Victims of domestic violence
- LGTBQ youth
- 21 or order young adults with ID/DD



Experiencing Homelessness

- Individual or family who lacks a fixed, regular, and adequate nighttime residence
  - Not meant for human habitation
  - Emergency shelter
  - Is exiting an institution where (s)he has resided for 90 days or less

Tips to Access a Homeless Patient

Effective Discharge Planning for the Homeless Patient

Do you have safe, affordable, and appropriate housing?

Housing Assessment that is reliable and informative.

Effective Discharge Plans

Effective Discharge Planning for the Homeless Patient

A warm hand off is the #1 indicator of a successful discharge.

G.O.Y.A.

Collaboration

Effective Discharge Planning for the Homeless Patient

Did you know?

- Discharge planning starts at time of admission.
- To access the HUD CoC and housing and homeless services for individuals meeting chronically, literally, imminent risk, runaway and homeless youth, and DV criteria, you can connect with the Oklahoma's HUD CoC network.
- It takes 4 months or longer to connect to safe, affordable, appropriate housing.
- All CCBHCs and CCARCs have a housing lead.

Did you know?

- Best practice is for all CCBHCs to have an entire housing team whose role is to help prevent and end homelessness for their clients to include help with challenging discharges and housing barriers.
- Discharging to an emergency shelter is discharging to homelessness.
- Emergency shelters do NOT have standards and 90% or more offer no medication management, medical care, case management, mental health and/or substance use supports.
- ODMHSAS has a care coordination. This is for individuals who have ongoing medical concerns and are not connected to a CCBHC and it will be a challenging placement.

Challenges Facing Homeless Services Providers

Effective Discharge Planning for the Homeless Patient

- No longer a state interagency council on homelessness
- No bed availability tool

Legal and Ethical Issues

Effective Discharge Planning for the Homeless Patient

Homelessness is a nationwide ethical issue. Children, seniors and everyone else chronically without shelter experience cumulative health detriments from exposure, violence, poor nutrition and limited access to hygiene opportunities and health services.

https://www.ama-assn.org/delivering-care/ethics/homeless-health-care-ending-homelessness-are-matters-justice


Questions?

GET HELP

Suzanne L. Williams

Director of Government and Public Relations

(405) 641-5200

suzanne@gethhelp.com

GENERAL SESSION

“SEXUAL HEALTH AND WELLNESS”

Presented By:

Rachelle Wilson, D.O,

Wilson Medical

SEX- NO EXPIRATION DATE

Rachelle Wilson, DO

For many health professionals, the thought that our parents and grandparents don't have sex – or didn't might be comforting….

The reality is that for a significant proportion of our older patients, sex has no use-by date. Humans are sexual beings throughout their lives, yet culture has concealed that fact.

According to **Rome**, the purpose of sex is to make children.

According to **Hollywood**, sex is only for the young, the healthy, and the beautiful.

For the **medical profession**, sex consists mainly of risks of dysfunctions.

Sexuality and intimacy are essential elements for quality of life-
with clear physical, emotional and relational benefits.

Men 70-79

-59% reported having sex in the past year

-19% reported having sex at least twice a month

18% reported masturbating at least that often

Women 70-79

-39% said they'd had sex in the past year

-6% reported having intercourse at least twice a month

-5% masturbating two times or more monthly

The male/female difference also reflects lower levels of testosterone in women.

Also, women say they value intimacy more that performance

Short-term benefits

muscle relaxation
pain relief
better sleep

Intermediate-term benefits

stress relief
less depression
HUGGING- can decrease levels of pro-inflammatory cytokines

Long-term benefits

delayed onset of dementia
substantial reduction in CV and Cerebral vascular problems in men
increase in longevity

SEXUAL DYSFUNCTION

Persistent, recurrent problems with sexual response, desire, orgasm or pain
(that distress your or strain your relationship with your partner)- are known medically as sexual dysfunction

Low Sexual Desire-

the most common female sexual dysfunctions involves a lack of sexual interest and willingness to be sexual

Sexual Arousal Disorder-

your desire for sex might be intact, but you have difficulty with arousal or are unable to become aroused or maintain arousal during sexual activity

Orgasmic disorder-

persistent or recurrent difficulty in achieving orgasm after sufficient sexual Arousal or ongoing stimulation

Sexual pain disorder- (Dyspareunia)

pain associated with sexual stimulation or vaginal contact

Factors- often interrelated- that contribute to sexual dissatisfaction or dysfunction

PHYSICAL-

any number of medical conditions including cancer, kidney failure, multiple sclerosis, Heart disease and bladder problems can lead to sexual dysfunction

Medications- including some antidepressants, blood pressure medications, anti-histamines And chemotherapy drugs can decrease your sexual desire and your body's ability to experience Orgasm

PSYCHOLOGICAL/SOCIAL

untreated anxiety or depression can cause or contribute to sexual dysfunction, as can Long-term stress and a history of sexual abuse. Worries about becoming pregnant and Demands of being a new mom may have similar effects

HORMOMAL-

lower estrogen levels after menopause may lead to changes in your genital tissues and sexual responsiveness. A decrease in estrogen leads to decreased blood flow to the pelvic region, which can result in less genital sensation, as well as needing more time to build arousal and reach orgasm

the vaginal lining also becomes thinner and less elastic, particularly if you are not sexually active. This can lead to painful intercourse

sexual desires also decreases when hormonal levels decrease

PHYSICAL/ EMOTIONAL SIDE EFFECTS OF LOW LIBIDO (MEN)

a decreased sex drive can be very unsettling for men….. Low libido can lead to a vicious cycle of physical and emotional side effects, including ED – the inability to maintain an erection long enough to have satisfactory sex.

ED may cause a man to experience anxiety around sex. This can lead to tension and conflicts between partners, which in turn may lead to fewer sexual encounters and more relationship issues.

failure to perform due to ED can trigger feelings of depression, self-esteem issues and poor body image

Physical Causes of ED

heart disease
clogged blood vessels (atherosclerosis)
high cholesterol
high blood pressure
diabetes
obesity
metabolic syndrome
peyronie's disease
treatments for prostate cancer or enlarged prostate
injuries/surgeries that affect the pelvic region or spinal cord
low testosterone

ED TREATMENTS

oral drugs (phosphodiesterase type-5 inhibitors
(Viagra/Cialis/Levitra/Stenda)
testosterone therapy
penile injection (self injections)
Intraurethral medication
vacuum erection devices
penile implant
shock wave therapy
PRP

SEX…

EVEN WHEN IT IS GOOD, IT CAN BE BETTER

PRP

PLATELET RICH PLASMA

O-Shot

100% Patient's blood

Injecting concentrated platelets
activate stem cells to the injected area and generate more functional tissue in the areas of sexual response.

can rejuvenate vaginal and clitoral function to increase sensitivity and sex drive

can also alleviate some symptoms of bladder leakage

Results will last between 6 months and 2 years

P-SHOT

(Priapus- Greek god of male regenerative power and sexual health)

Stronger/firmer erections
Easy to achieve erections
Increased penis length and girth
Improved and sometimes resolution of Peyronie's disease
Increased sensitivity
Improved sexual stamina

GAINSWave

Low-Intensity sound waves

non-invasive procedure that helps improve blood flow, releasing growth factors in
the tissue forming new blood vessels, and breaking down micro-plaque in the penis
activates the growth of new nerve tissue in the penis

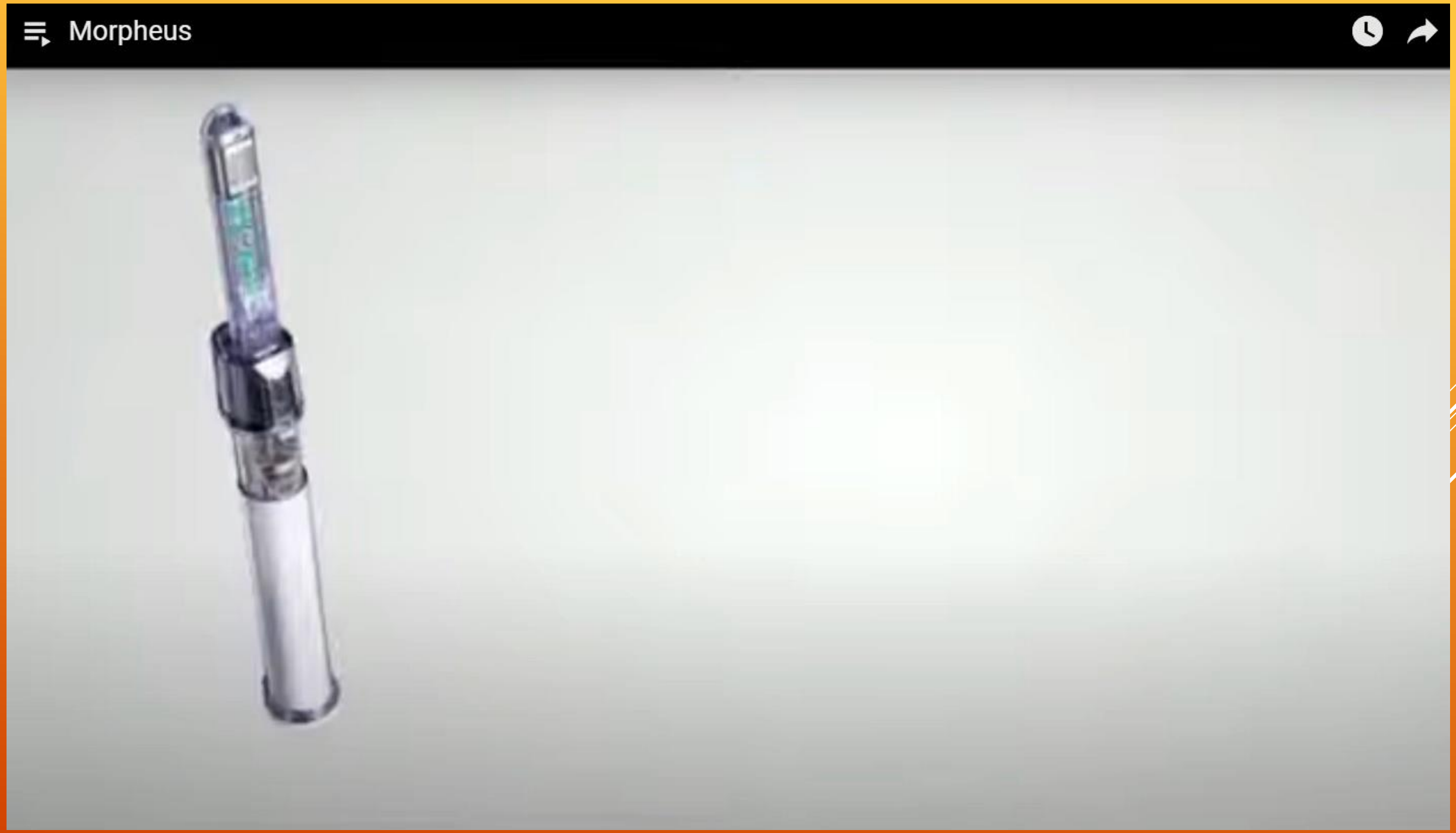
6-12 treatments each taking between 15-20 minutes

Morpheus8 V

Combination of radiofrequency and microneedling

Controlled pulses of radiofrequency energy deep into the vaginal and labial tissues that tightens the soft tissue and stimulate the production of elastin and collagen.
increased lubrication, renewed thickness, strength and tone in the vaginal walls and labia

To achieve optimal rejuvenation, usually recommend 3 treatments scheduled 6 weeks apart with maintenance 12-18 months


Morpheus

FORMA V

designed to promote women's health and can be paired with kegel exercises, which tighten the pelvic floor to increase muscle tone.

provides uniform RF heating of the internal vaginal tissue and external vulvar laxity and/or labial hypertrophy

VTone

Non-invasive treatment that helps to tone and train the muscles of the pelvic floor

Single-use stimulator, about the size of a tampon, is placed into the vaginal canal to trigger involuntary muscle contractions. These contractions tone and tighten the pelvic floor, particularly those muscle fibers weakened or overstretched during pregnancy and childbirth

Can be used for Stress, Urge or Mixed Urinary Incontinence

6-8 in office treatments over 3 months - 30 minutes

No downtime

Results are cumulative with most patients realizing optimal strengthening 1-2 weeks after final treatment


InMode V-Tone at RegenCen
TONE
by INMODE

GENERAL SESSION

"ADDRESSING INJURY CAUSATION ON WC PATIENTS"

Presented By:

Mac Moore, M.D.

Oklahoma Shoulder & Orthopedic Institute

Causation

Pearls, Pitfalls and Perspectives

CASE ILLUSTRATIONS

MAC MOORE, MD.

11/9/2023

Disclaimer

- No conflicts to to disclose

Outline

Background

What is it / Why is it important

Case Discussion

- **-Knee**
  - Mensical tear
  - ACL rupture
  - Knee arthritis
- **-Shoulders**
  - Dislocation/labral tear
  - Rotator cuff tear
  - Shoulder arthritis

Causation

- What is it?
  - "The act or process of causing"
  - "The act which produces an effect"

  - "Major Cause"
    - Identifying the most probable cause of an injury or disability
    - Demonstrating that is arose from the work/workplace
      - Physician is key here

  - 51%
    - Are the work duties or injury more likely than not

Causation

- Significant and Identifiable
  - Another path to causation
  - Presence of a pre-exisiting issue
    - Agreed upon by all involved
  - Work or injury aggravated/flared an otherwise unknown/minimal issue

- All are ways of deciphering if a **workplace event or activity is the reason for the observed clinical symptoms/pathology**

Causation

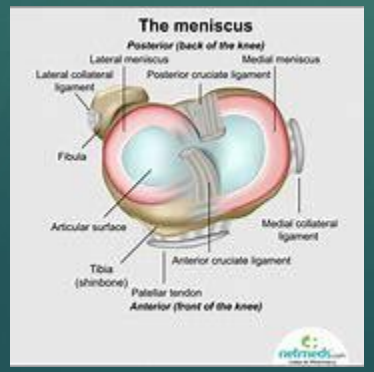
- Why it is Important for Physicians
  - Critical link in the determination
    - Medical knowledge
  - Injured party is not responsible for bill
    - Responsibility to allocate correctly
  - Expedite care

Knee – Meniscal tear

-fibrocartilage that distributes forces evenly with weight bearing
    -2 per knee

-most commonly torn with flexion, compression and/or rotation

-does degenerate and weaken with age



Knee – Meniscal tear

-43 y/o male firefighter steps up onto fire truck (18 inches) wearing bunker gear

-feels instant pop and sharp pain on inside of knee

-swells over next 24-48 hours

-no history of injuries to knee or any previous PCP visits or treatment

PE:

- effusion, TTP along medial joint line (meniscus),+ McMurray's, no ligamentous instability

Imaging:

normal xrays

MRI shows no chondromalacia, no ligament rupture, large medial meniscal tear

Knee – Meniscal tear

Causation:

No history of pre-existing knee issues

History and exam c/w meniscus tear

Imaging rules out other causes of knee pain/issues

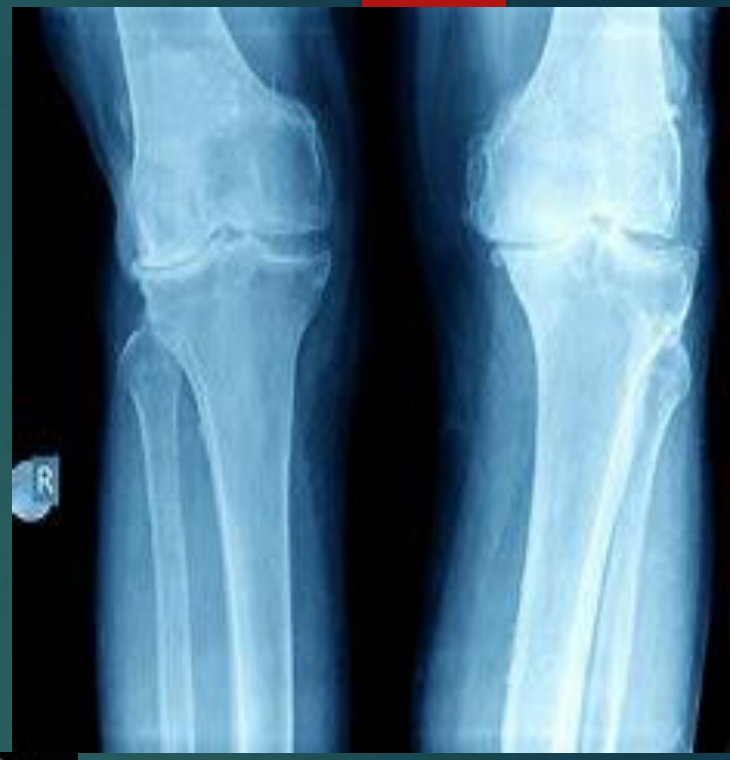
Injury **IS** the major cause of the meniscus tear

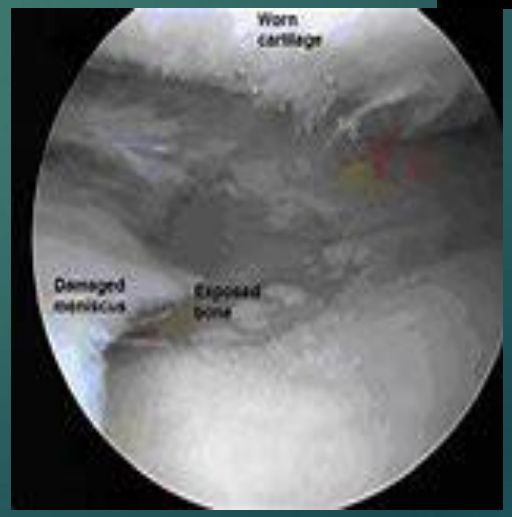
Knee – Meniscal tear

- 53 y/o male firefighter hurt his knee walking to fire truck without bunker gear (employed for 4 months)
  - No fall but may have tripped on uneven ground
  - Didn't hear or feel a pop
  - Knee scope 21 years ago and sees PCP twice per year for steroid injections

Knee – Meniscal tear

- Imaging
- Varus malalignment, bone on bone arthritis in multiple compartments
- MRI
  - Grade 4 OA, degenerative meniscal tears, no ligament tears





Knee – Meniscal tear

- Causation
  - Recent history of knee issues and treatment
  - Severe arthritis on imaging, in addition to meniscal tearing

- Meniscus tear **IS NOT** related to the injury

Knee – Meniscal tear

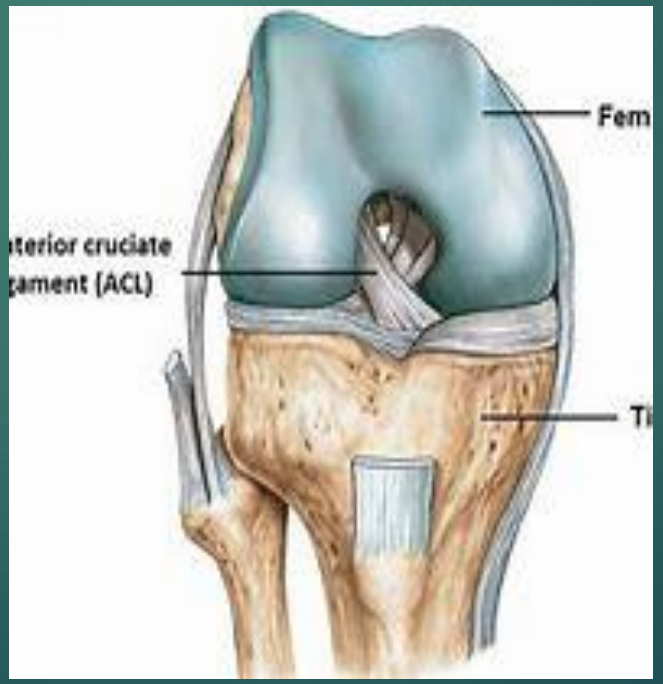
- **Alternatives:**
  - 1. Could the injury be significant and identifiable ?

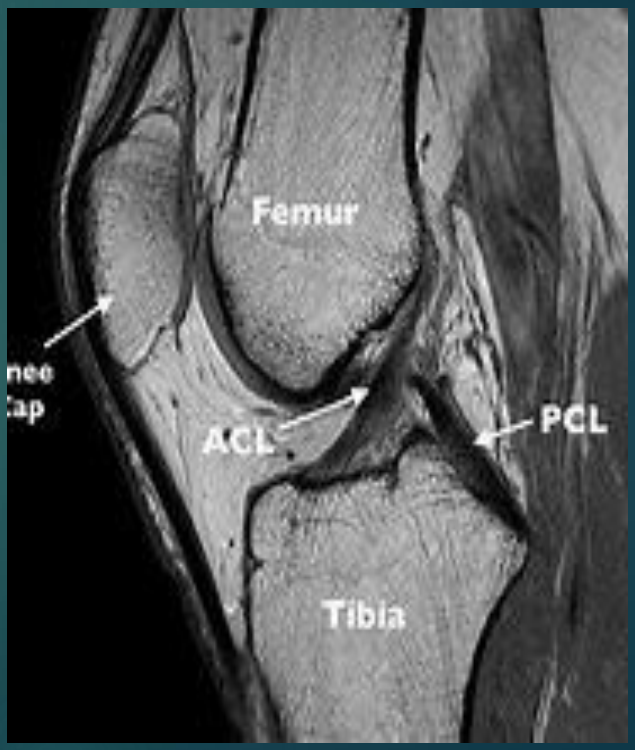
    -What if he was stepping up onto the fire truck and felt a pop

    2. Repetitive and Cumulative Mechanism

Knee – ACL rupture

- Large stabilizing ligament in knee
- Usually torn from acute pivoting event or blow to outside of knee
  - Hyperextension less likely





Knee – ACL tear

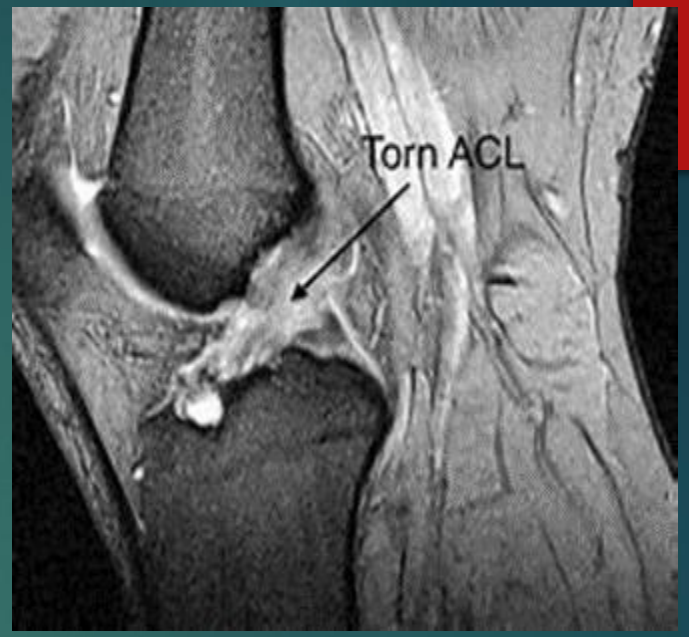
- 46 y/o teacher trying to break up fight at school
  - Student fell into knee and drives to inside causing a fall
  - Felt a pop
  - Very swollen/stiff next day
  - Hurts to walk and buckles when twisting

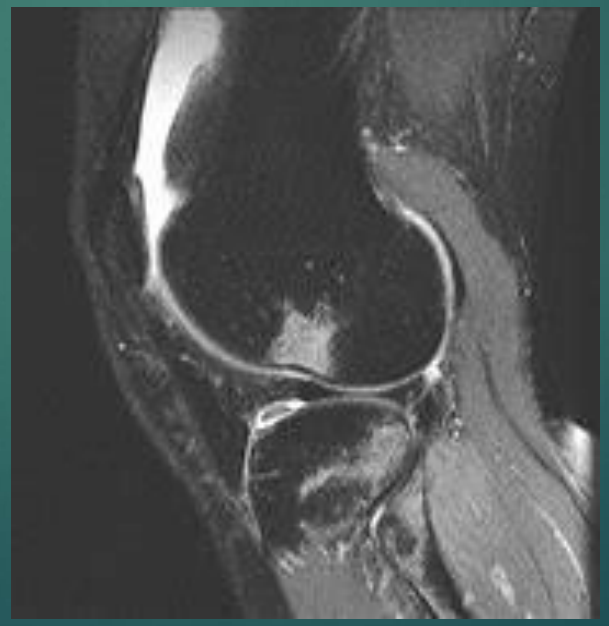
-PE:

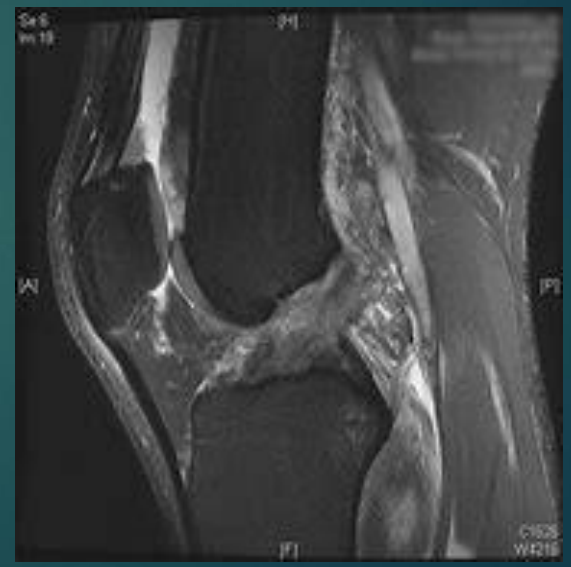
  - Large effusion, tender joint line
  - positive Lachman's and Pivot shift test

Knee – ACL tear

- Imaging
  - X-rays – normal
  - MRI
    - large effusion
    - Pivot shift bone contusions
    - Full thickness ACL tear







Knee – ACL tear

- CAUSATION
  - No history of previous knee issues/injury
  - Mechanism that's consistent
  - PE and Imaging support acute injury

- ACL tear **IS** related to the injury

Knee – ACL tear

- **Alternatives:**

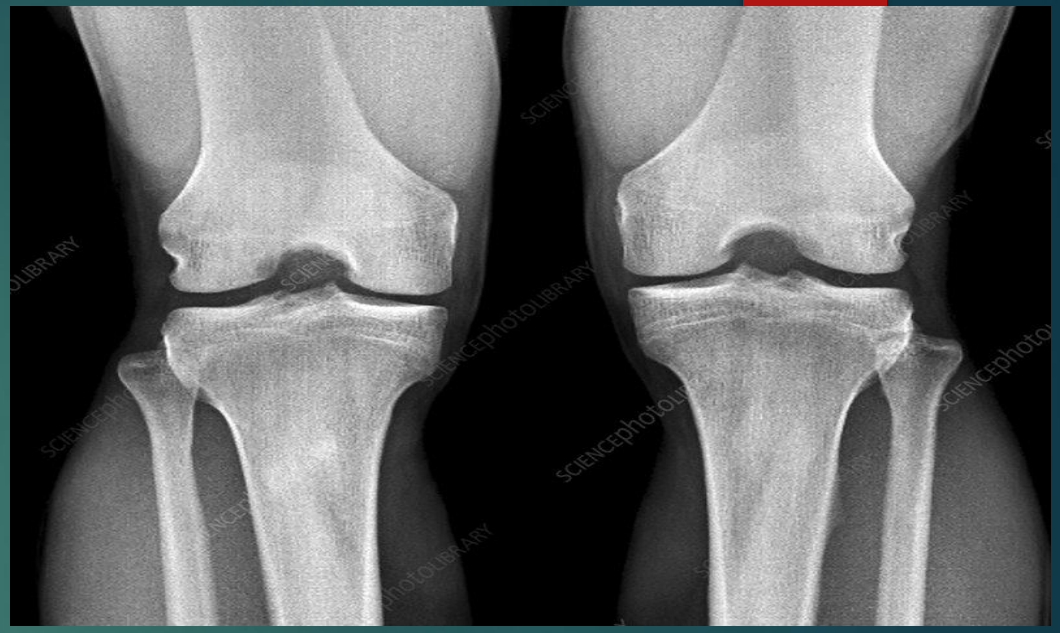
- 1. She's just walking, no impact or buckling, reports pain 2 days later

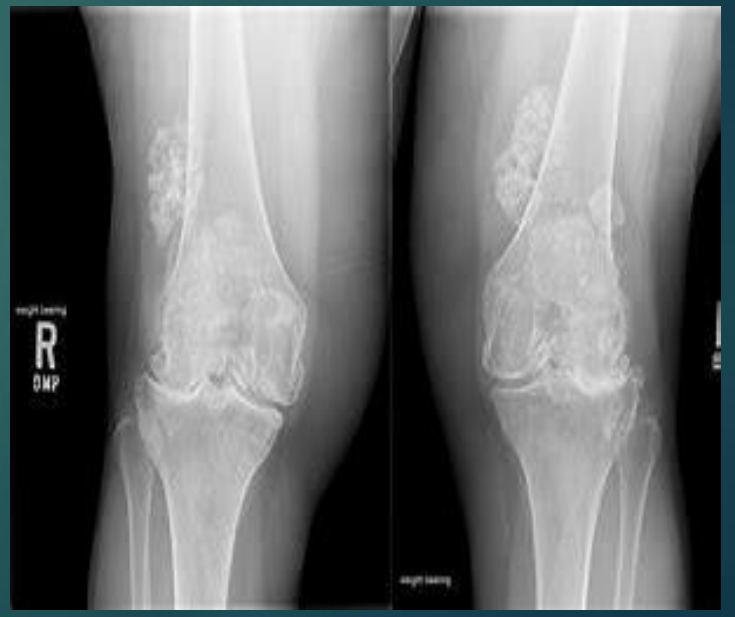
- 2. History of an injury 11 years ago in soccer,never got treated, no blow to knee or fall

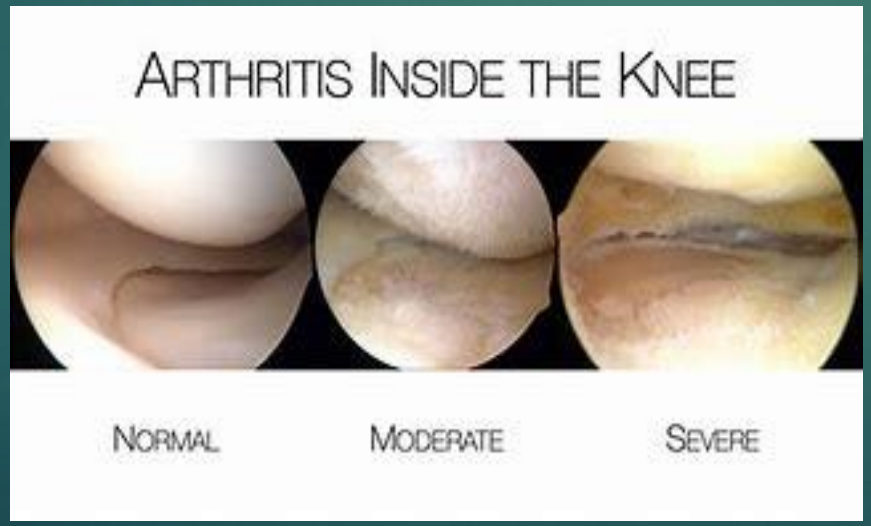
-MRI shows ACL is torn/resorbed with no pivot shift bone contusions/effusion, and moderate OA

Knee – Arthritis

- Articular cartilage
  - Smooth, firm covering of bone inside joints
  - Wears over time with activity and/or trauma
  - 4 stages of OA
    - End stage is referred to as "bone on bone"







Knee - Arthritis

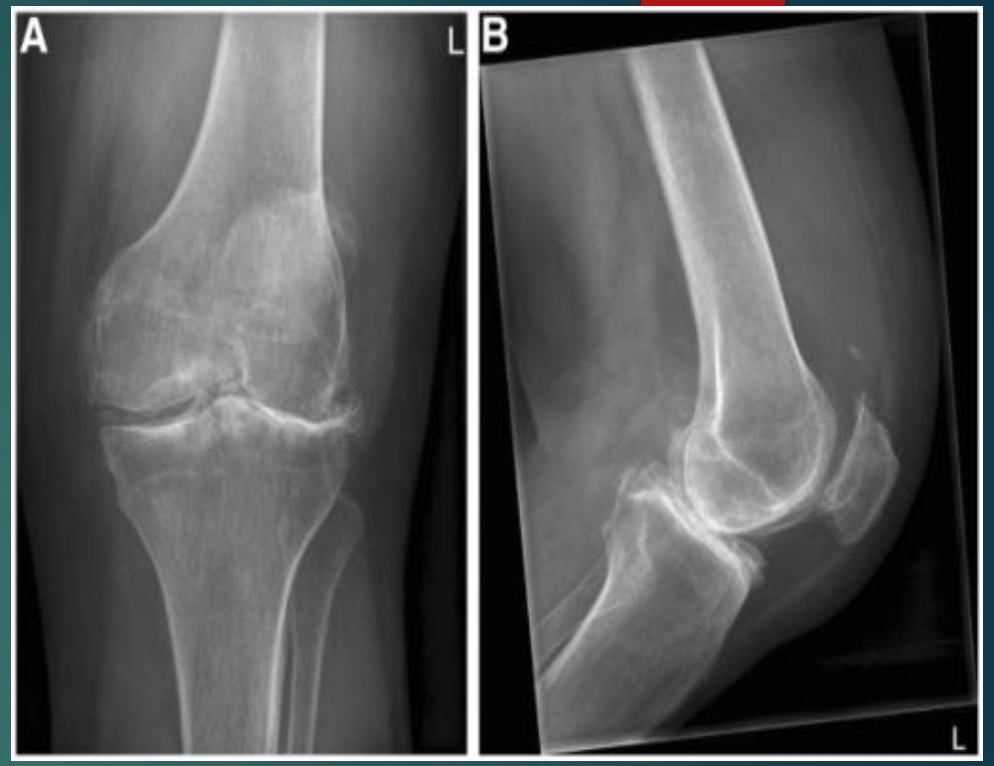
- 64 y/o executive assistant stood up at her desk and felt pain
  - Swelling over next 48 hours
  - Reported the next morning
  - No history of previous knee issues or treatment to the knee
  - No locking or buckling…just hurts all the time now

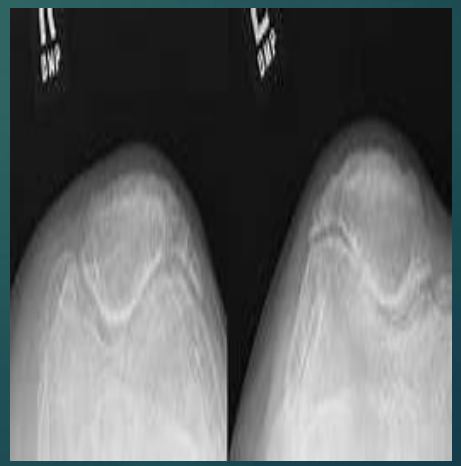
  - PE:
    - Tender along both joint lines
    - Small effusion
    - No instability

Knee - Arthritis

- Imaging
  - Bone on bone medial compartment
  - Moderate narrowing in the patellofemoral space
  - No fractures

  - MRI may not always be helpful





Knee - Arthritis

- CAUSATION
  - Minimal injury (if one at all)
  - Presence of clear end stage OA
  - Could her knee really have been asymptomatic all this time

- Injury **IS NOT** the major cause of her knee issue/arthritis

Knee - Arthritis

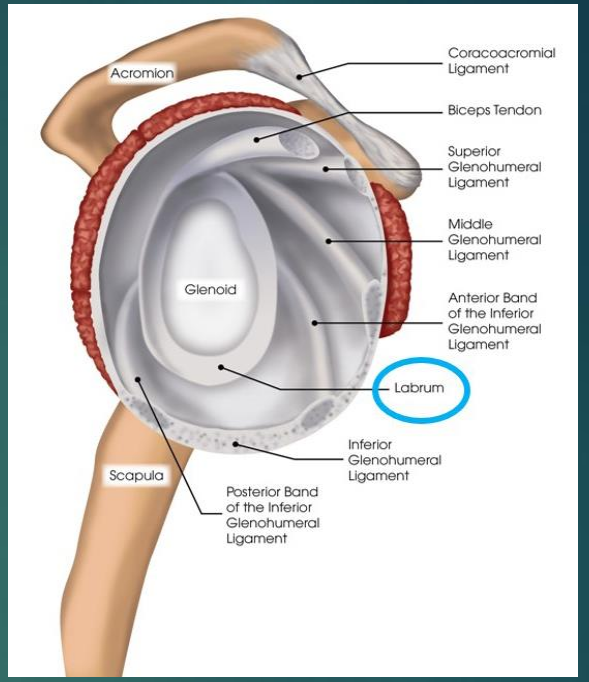
- **Alternatives:**

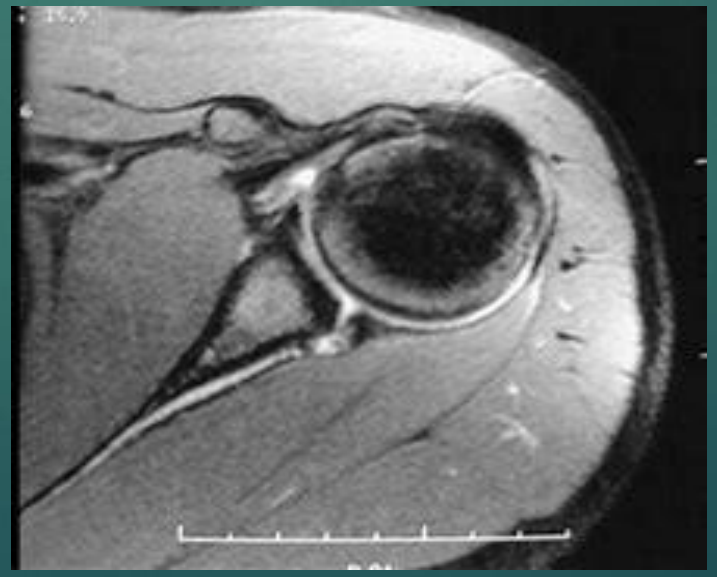
- 1. 26 year employee, walks 4-5 miles per day in large office
  - Repetiive and cumulative claim

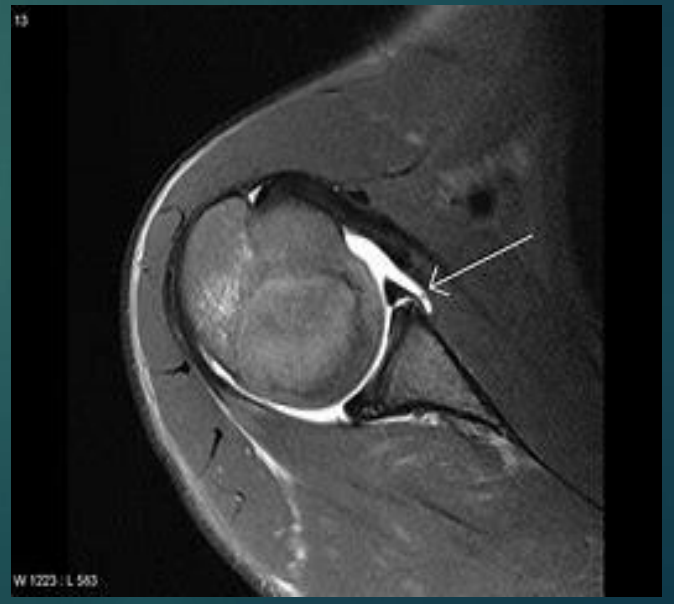
- 2. Falls 3 feet off step ladder retrieving files and impacts knee on ground
  - Large amount of swelling and bruising quickly
  - Requires ER evaluation for knee pain and instability

Shoulder – Dislocation

- Labrum
  - Acts a restraint to excessive motion
  - Can and frequently does tear in dislocations
  - Usually symptomatic





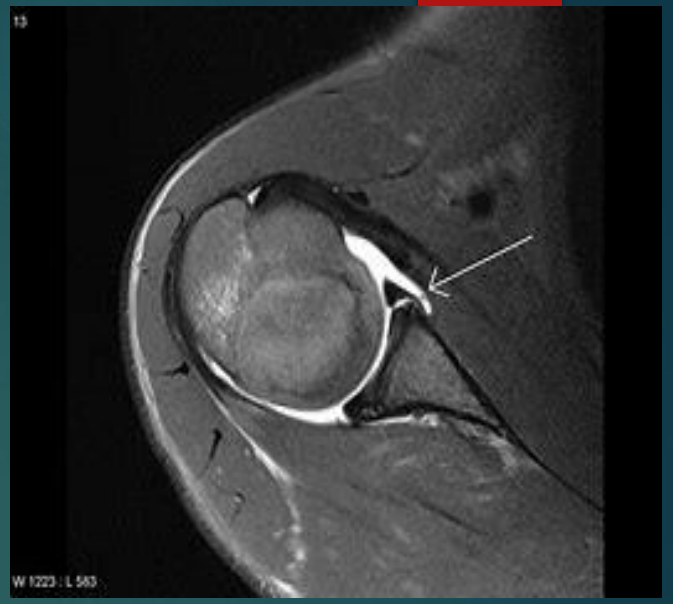


Shoulder – Dislocation

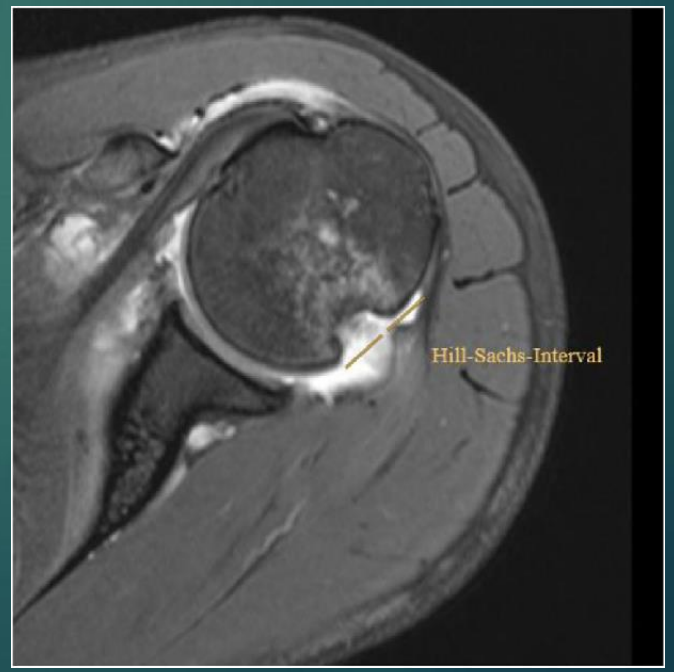
- 36 y/o truck driver fell tarping a load
  - Held onto truck bed during fall
  - Arm pulled back and up behind him
  - Felt a pop and couldn't move arm
  - Required sedation and reduction in ER
  - No previous history of issues

  - PE:
    - Pain with motion
    - Raising and rotating arm causes symptoms

Shoulder – Dislocation



- Imaging
  - Xrays normal
  - MRA shows anterior labral tear with edema in humeral head
    - No RC tear or arthritis



Shoulder – Dislocation

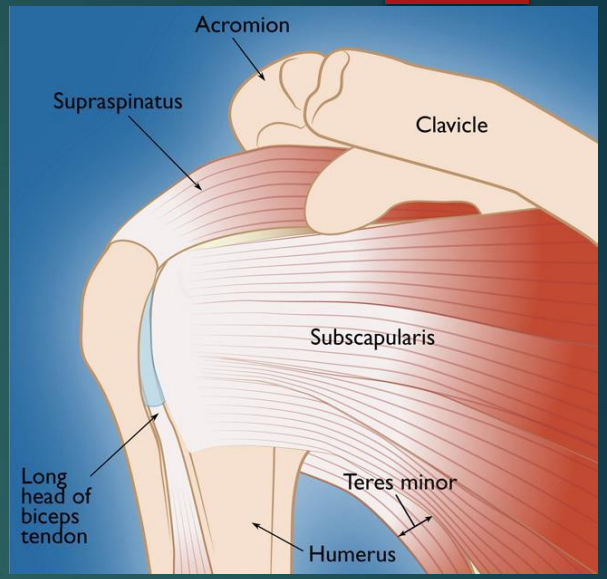
- CAUSATION
  - No previous issue
  - Documented mechanism requiring reduction
  - Imaging shows labral tear with abscense of other pathology

  - Fall **IS** the major cause of the labral tear

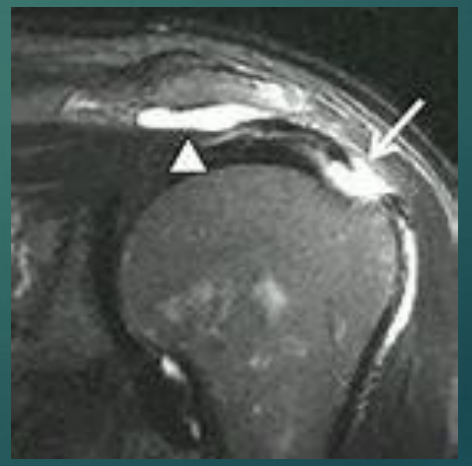
Shoulder – Dislocation

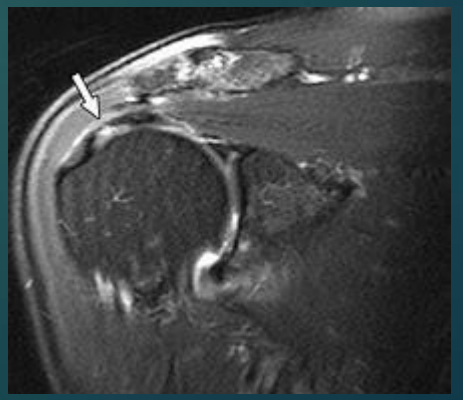
- Alternatives
- 1. Mild pain after lifting relatively small object with history of college football career and waited 2 weeks to report
- 2. Multiple document dislocations since 20 years old with same injury mechanism
- 3. Previous labral repair with long period of no symptoms with same injury mechanism

Shoulder – Rotator cuff tear



- Group of 4 tendons
  - Responsible for large amount of shoulder motion
  - Can have many sizes and shapes of tears
  - Usually produce pain and weakness
    - Night time discomfort
  - Can be an acute event or with use over time
  - Has muscle attached
    - Confers **some** ability to "age' tears
      - "Atrophy" and "fatty replacement"





Shoulder – Rotator cuff tear

- 53 y/o factory worker lifted 45 pound tire to put back on line
  - Felt immediate pain and heavy sensation
  - Worse over next 24-48 hours and at night especially
  - Pain is better but now feels weak
  - Went to urgernt care and told no fractures
  - No history of shoulder issues or surgery in the past

Shoulder – Rotator cuff tear

- PE:
  - No previous incisions
  - Pain over anterior shoulder
  - Weak on supraspinatus testing
  - No instability on exam

- Imaging:
  - X-rays normal
  - MRI shows full thickness tear of RC
  - No labral tear
  - No evidence of atrophy or fatty infiltration

Shoulder – Rotator cuff tear

- **CAUSATION**
  - No previous injury or issue
  - Credible mechanism
  - Lack of chronic changes on xray and MRI

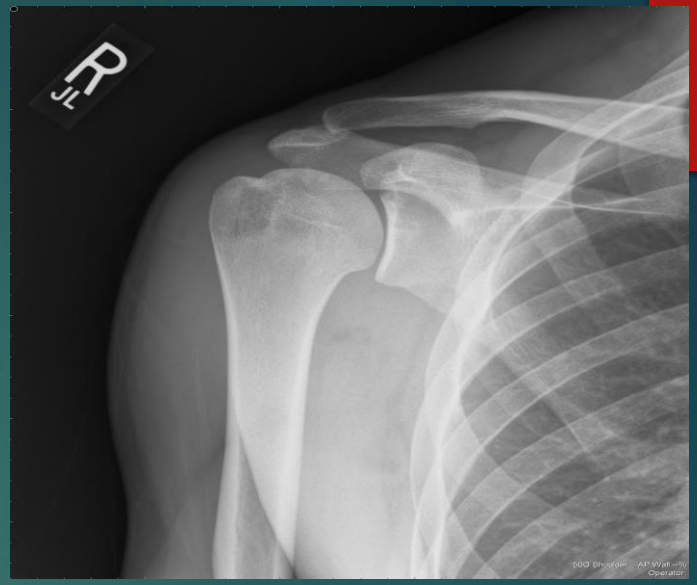
- Lifting injury **IS** the major cause of the tear

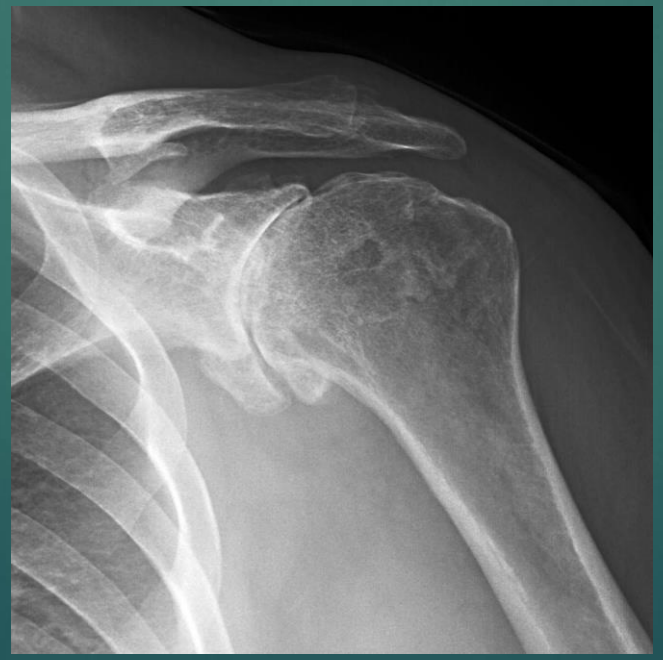
Shoulder – Rotator cuff tear

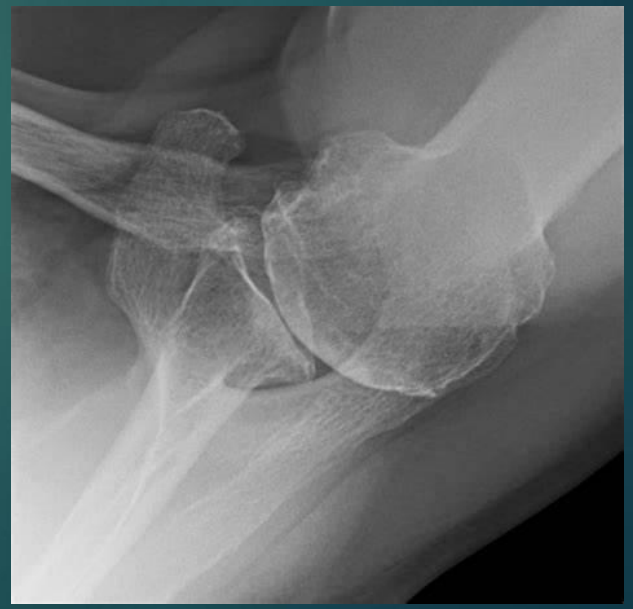
- **Alternatives:**
- 1. Reaching for small object, kept working and reported pain 2 weeks later
- 2. 90 day employee with previous rotator cuff repair 2 years ago and questionable, unwitnessed injury
- 3. Lifting telephone at work when pain began. Has seen PCP 4 times in last 18 months with shoulder pain and received injections.
- 4. 9 year employee that routinely lifts 10-15 pound objects daily and reports injury as repetitive and cumulative

Shoulder - Arthritis

- Progressive wearing of articular cartilage
  - Same process as in the knee
- Wear and tear over time and/or injuries







Shoulder - Arthritis

- 53 y/o parks department worker was turning stuck bolt on a water meter and felt shoulder pull and pain
  - History of labral repair at age 20
  - Intermittent PCP visits for shoulder pain
  - No fall onto shoulder or direct trauma
  - Pain not improving

  - PE:
    - Expected scars
    - No atrophy
    - Tender to palpation
    - Very limited shoulder ROM with pain and grinding

Shoulder - Arthritis

- Imaging:
  - X-rays show end stage bone on bone OA with large osteophytes
  - No fracture or proximal migration

  - MRI – no rotator cuff tear but profound OA and multiple loose bodies

Shoulder - Arthritis

- CAUSATION:
  - Documented previous shoulder issues c/w OA
  - Mechanism wouldn't indicate severe force across shoulder
  - Not reporting as a R/C mechanism

- Injury **IS NOT** the major cause of the shoulder arthritis

Shoulder - Arthritis

- **Alternatives:**

- 1. 24 year employee who lifts, pushes, pulls heavy objects and reports as R/C

- 2. Employer aware of the pre-existing condition of OA but worker has a MVA at highway speed with documented shoulder injury

Conclusions

- Vitally important topic – for all parties involved
- Many factors influence it
  - History
  - Mechanism of injury
  - Symptoms
  - Exam and Imaging
- Physician has essential role in assisting with this determination
  - Interpret the info
  - Use medical/surgical knowledge
  - Clearly state whether it is or isn't
- Be open to additional information

Questions

GENERAL SESSION

“BARIATRIC TREATMENT & CONSERVATIVE CARE”

Presented By:

Ashley Sale, PAC

Bariatric Partners of Oklahoma

Transformation from Obesity

Ashley Sale, PA-C

11/15/2023

Meet the presenter

Ashley Sale, PA-C, is a Physician Assistant with Surgical Partners of Oklahoma.

She completed her undergraduate studies in Zoology- Biomedical Sciences at the University of Oklahoma with distinction. Ashley then attended the University of Oklahoma School of Community Medicine in Tulsa, where she gained comprehensive medical education and training and earned her Master of Health Sciences in Physician Assistant Studies.

Ashley lives in Oklahoma City with her husband and two sons. She spends her free time with her boys and cheering on the Sooners and Thunder.

She helps patients go through the process of preparing for weight-loss surgery and follow-up post-surgery to ensure patients meet their goals. She also offers medical weight loss options.

Disclosures

Physician Assistant for Bariatric Partners of Oklahoma, a leader in providing comprehensive weight management, including bariatric surgery, in the state of Oklahoma.

OBJECTIVES

1

Define obesity and weight bias and describe the role of weight bias in current healthcare settings.

2

Explain the role of bariatric surgery in life-changing transformation.

3

Discuss ways to empower case managers in obesity management using a collaborative approach.

DEFINING OBESITY

Consensus Statement on Obesity as a Disease:

“Obesity is a highly prevalent chronic disease characterized by excessive fat accumulation or distribution that presents a risk to health and requires lifelong care. Virtually every system in the body is affected by obesity. Major chronic diseases associated with obesity include diabetes, heart disease, and cancer.”

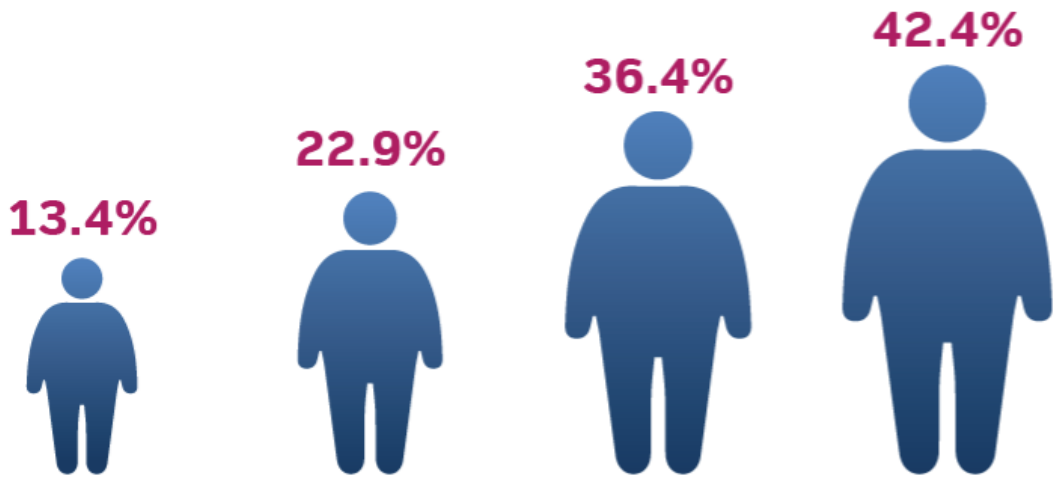
Published December 2022

Obesity is Multifactorial

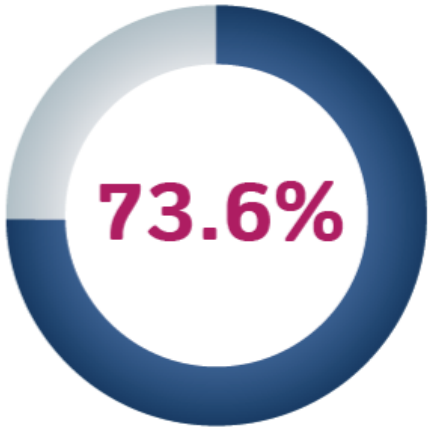
Courtesy of Northeast Business Group on Health

Majority of Americans are Overweight or Have Obesity

Percentage of American Adults with BMI>30 (Percentage of Americans Who Have Obesity)[1]

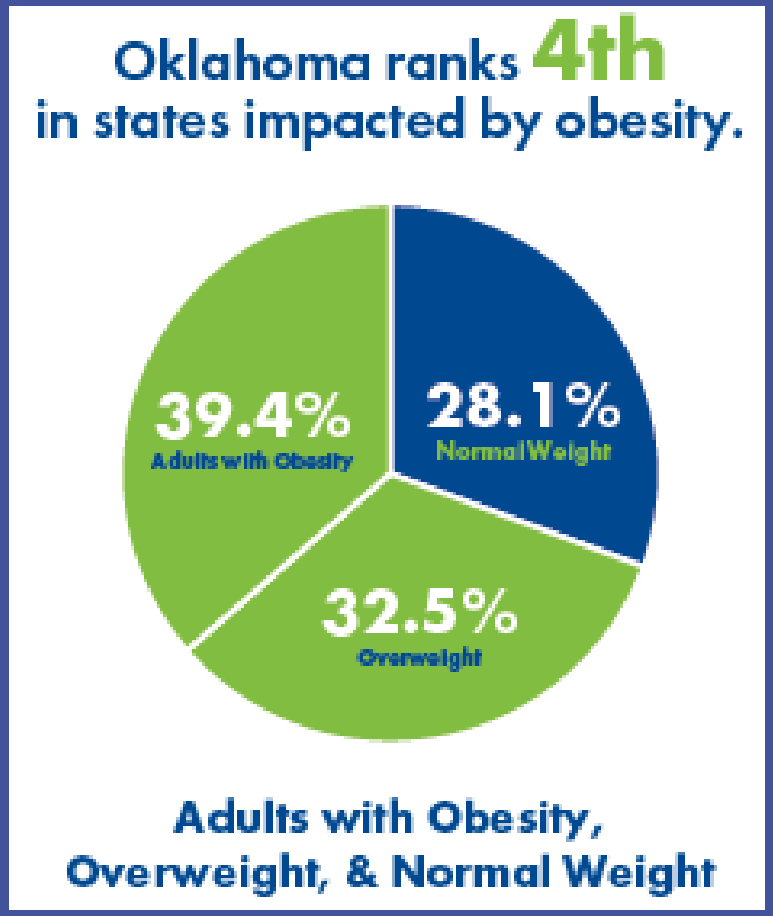


Percentage of Americans Over Age 20 Who Are Overweight or Have Obesity[2]



References: **1.** https://www.cdc.gov/nchs/about/factsheets/factsheet_nhanes.htm. **2.** https://www.cdc.gov/nchs/fastats/obesity-overweight.htm

Obesity Trends in Oklahoma



References: Trust for America's Health, Centers for Disease Control, Clinical Chemistry, Milken Institute, and Obesity Action Coalition.

Barriers for those with Obesity

- Individual struggles
  - Negative body image
  - Eating to cope with stress and depression
  - Interpersonal experiences (blaming or shaming) with friends and family
  - **Societal stigma and bias**
- **Lack of support from Health Professionals**

**To overcome these challenges, individuals living with obesity must be supported in both their physical and mental well-being, and effective obesity care must include access to this support.

What is weight bias?

Weight bias refers to the negative attitudes, beliefs, and stereotypes towards individuals based on their weight or body size.

Assumes that people living with overweight or obesity are lazy, incompetent, lacking willpower and self-discipline, and not motivated to improve their health

Weight Bias: Gap between science and society

- Body weight = calories in – calories out
- Obesity is caused by voluntary overeating
- Obesity is caused by sedentary behavior
- Obesity is a choice or a behavioral disorder
- Obesity is a condition not a disease
- BMI ≥ 35 is easily reversible with hard work

Weight Bias: Health Care

- If you lost weight, you would feel better
- Nothing can be done for your symptoms
- Treat immediate risks with medication
- Treating obesity is waste of time
- Patients are non-adherent

PREVALENCE OF WEIGHT BIAS

42% of adults living with overweight or obesity experience weight bias

Spahlholz J, Baer N, König H-H, Riedel-Heller SG, Luck-Sikorski C. Obesity and discrimination–a systematic review and meta-analysis of observational studies. Obes Rev. 2016;17(1):43-55

Is as pervasive among medical professionals as it is within the general population

Sabin JA, Marini M, Nosek BA. Implicit and explicit anti-fat bias among a large sample of medical doctors by BMI, race/ethnicity and gender. PLoS One. 2012;7(11):e48448. doi:10.1371/journal.pone.0048448

Younger healthcare providers exhibit greater weight bias toward patoents with obesity

Schwartz MB, Chambliss HO, Brownell KD, Blair SN, Billington C. Weight bias among health professionals specializing in obesity. Obes Res. 2003;11(9):1033-1039

Weight bias among health care professionals: A systematic review and meta-analysis

Blake J. Lawrence[1,2] | Deborah Kerr[1] | Christina M. Pollard[1] | Mary Theophilus[3] | Elise Alexander[1,2] | Darren Haywood[1,2] | Moira O'Connor[1,2]

Findings show that medical doctors, nurses, dietitians, psychologists, physiotherapists, occupational therapists, speech pathologists, podiatrists, and exercise physiologists hold implicit and/or explicit weight-biased attitudes toward people with obesity

CONSEQUENCES OF WEIGHT BIAS

- Weight bias associated with being overweight and obesity is a greater threat to an individual's health than increasing BMI.
- 60% increased risk of death
- Increases long-term risks of cardiometabolic health issues
- Experiences of weight bias from healthcare providers are associated with less engagement and use of health care services and consequently delaying or forgoing medical intervention. This can also contribute to early mortality in people living with overweight and obesity
- Up to 55% of women living with obesity report delaying or canceling an appointment if they anticipated needing to be weighed during the consultation

Tomiyama AJ, Carr D, Granberg EM, et al. How and why weight stigma drives the obesity 'epidemic' and harms health. BMC Med. 2018;16(1):123. doi:10.1186/s12916-018-1116-5
Sutin AR, Stephan Y, Terracciano A. Weight discrimination and risk of mortality. Psychol Sci. 2015;26(11):1803-1811.
Takizawa R, Danese A, Maughan B, Arseneault L. Bullying victimization in childhood predicts inflammation and obesity at mid-life: a five-decade birth cohort study. Psychol Med. 2015;45(13):2705-2715.
Vadiveloo M, Mattei J. Perceived weight discrimination and 10- year risk of allostatic load among US adults. Ann Behav Med. 2017;51(1):94-104
Olson CL, Schumaker HD, Yawn BP. Overweight women delay medical care. Arch Fam Med. 1994;3(10):888-892

CONSEQUENCES OF WEIGHT BIAS

- Many health care providers struggle with conversations about weight.
  - They feel frustrated, underprepared, or ineffective in helping patients with obesity
  - In response to the difficulty in communication regarding weight, some have proposed a shift to a "weight-neutral" or "weight-inclusive" approach, removing the focus on weight altogether.

- Weight stigma in the health care setting can take many forms, including:
  - Providers making assumptions about patients with obesity
  - Overattributing health problems to a patient's weight
  - Giving less health information to patients with obesity.

- Physical environment also may contribute to weight stigma if there is insufficient furniture or equipment (eg, scales, blood pressure cuffs) to accommodate patients of diverse body sizes

Kirk S.F.L., Price S.L.,Penney T.L.et al.. **Blame, shame, and lack of support: A multilevel study on obesity management.***Qual Health Res.* 2014; **24**: 790-800
Tylka T.L., Annunziato R.A., Burgard D., et al. **The weight-inclusive versus weight-normative approach to health: Evaluating the evidence for prioritizing well-being over weight loss.** *J Obes.* 2014; **2014**: 983495
Phelan S., Burgess D., Yeazel M., Hellerstedt W., Griffin J., van Ryn M. **Impact of weight bias and stigma on quality of care and outcomes for patients with obesity.** *Obes Rev.* 2015; **16**:
Merrill E., Grassley J. **Women's stories of their experiences as overweight patients.** *J Adv Nurs.* 2008; **64**: 139-146

STRATEGIES TO ADDRESS WEIGHT BIAS

Education and Awareness: Promote training programs to increase awareness of weight bias among healthcare providers

Patient-centered Care: Advocate for a personalized approach that focuses on overall health and well-being and not just weight alone

Language and Communication: Encourage the use of respectful and "people-first" language

PEOPLE-FIRST LANGUAGE FOR OBESITY

OAC
Obesity Action Coalition

Bias and discrimination can be shown in many ways, but one of the most popular ways it is shown is through the absence of people-first language. Labeling individuals as "obese" creates negative feelings toward individuals with obesity and perpetuates weight bias. It is time to recognize the importance of people-first language and the influence it has on people who are affected by obesity.

The rules of APA Style calls for language in all publications to **"put people first, not their disability"** and to **"not label people by their disability."**

Feldman and colleagues[1] found that people-first language affects attitudes and behavioral intentions toward persons with disabilities.

Referring to individuals as "obese" has been shown to influence how individuals feel about their condition and how likely they are to seek medical care.

19%
of people report that they would avoid future medical appointments if their doctor stigmatized them about their weight.[2]

21%
of people report that they would seek a new doctor if they felt a doctor has stigmatized them about weight.[2]

Example of using people-first language:

"The woman was affected by obesity." instead of **"The woman was obese."**

In Summary…

Weight Bias can look like:

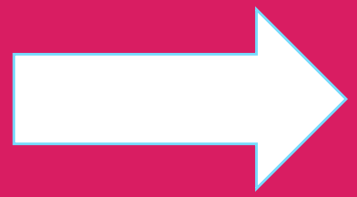
- Misdiagnosis and Delayed Diagnosis
- Limited Treatment Options
- Lack of Respect and Dignity
- Inadequate Equipment and Facilities
- Disparities in Access to Care

Weight Bias should be addressed with multi-faceted approach including:

- Healthcare Provider Training
- Promoting Patient-centered and Inclusive Care
- Ensure Healthcare facilities are equipped to accommodate diverse body sizes

TREATING OBESITY

chronic condition with multiple contributing factors



management is complex, requiring both physiological and psychological interventions

Stepped Approach to Treating Obesity

	BMI 25-26.9 kg/m²	BMI 27-29.9 kg/m²	BMI 30-34.9 kg/m²	BMI 35-39.9 kg/m²	BMI ≥40 kg/m²
 **Lifestyle Modification** Weight Loss Impact = 3% to 5%	+	+	+	+	+
 **Pharmacotherapy/ Medications & Lifestyle Modification** Weight Loss Impact = 5% to 10%		With co-morbidity	+	+	+
 **Bariatric Surgery** Weight Loss Impact = 25% to 30%				With co-morbidity	+

References: BMI, body mass index.
Volkan et al. *Obes Facts* 2015;8:402-24.

Lifestyle Modifications

- Incorporate balanced nutrition
- Increase physical activity
- Improve sleep habits
- Decrease stress

Pharmacotherapy

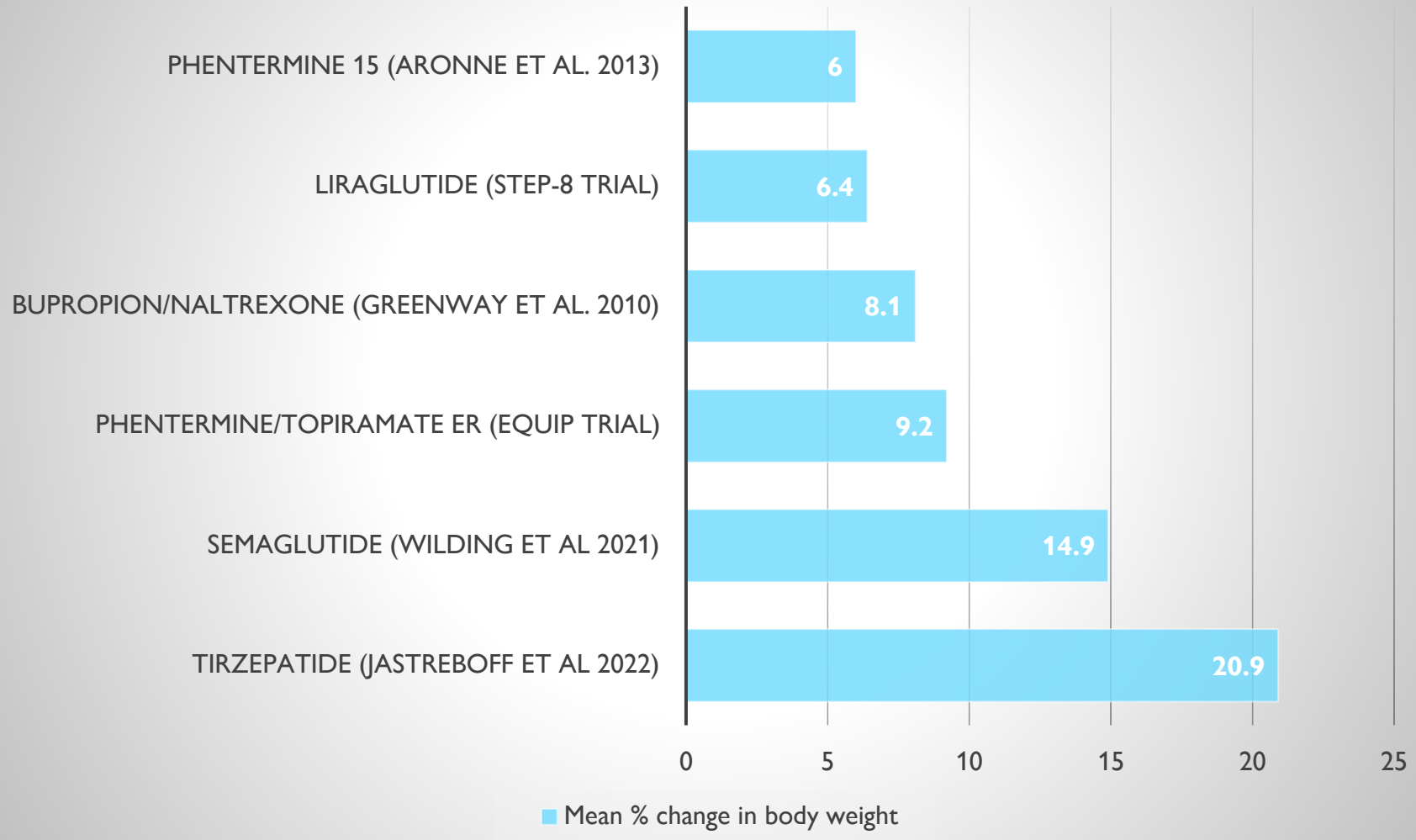
Review current medications

Evaluate effects of medication regimen in relation to body weight. Try switching medications to an option that promotes weight loss.

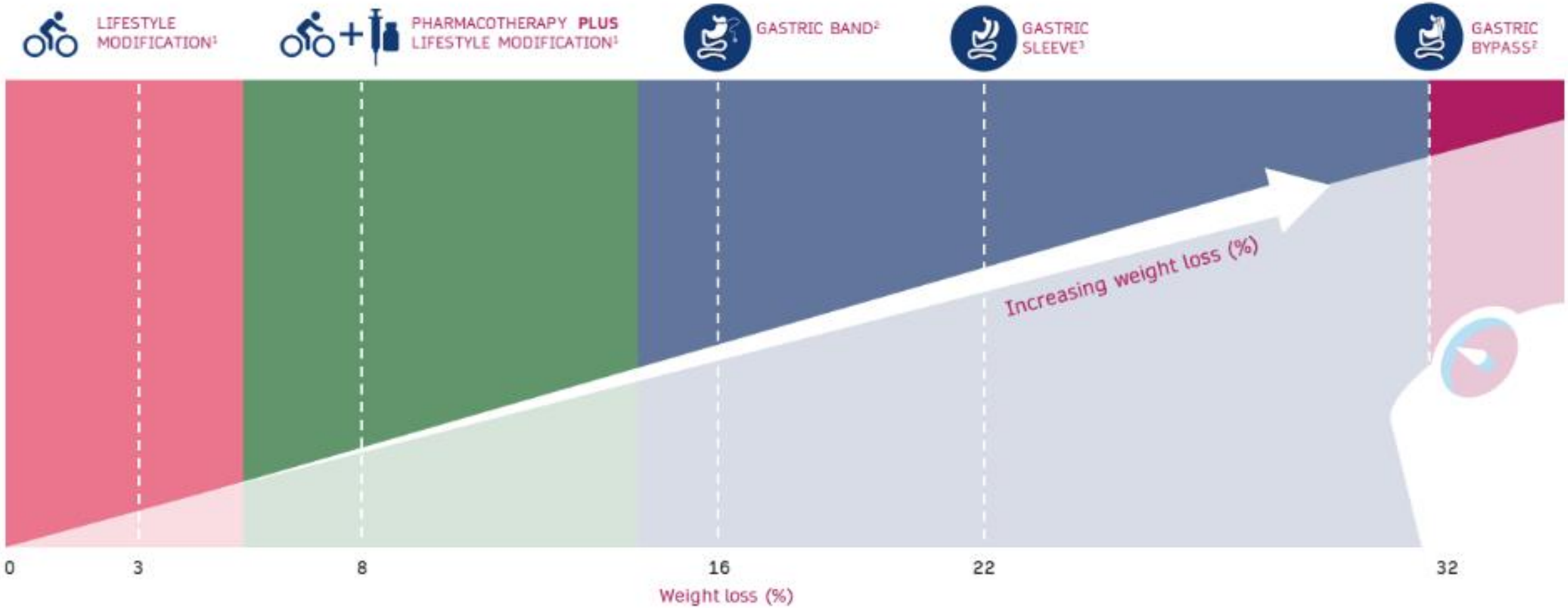
Consider Antiobesity Medications

- BMI > or = 30
- BMI > or = 27 with at least one comorbidity (HTN, DM, CHF, OSA, HLD)
- In conjunction with lifestyle modifications
    - Ideally patient is working with a dietitian

Efficacy of Pharmacotherapy

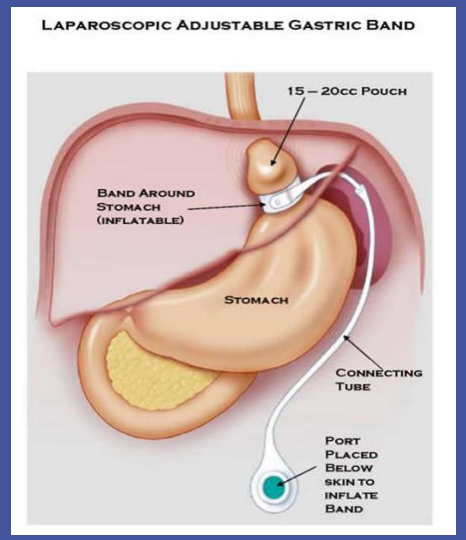


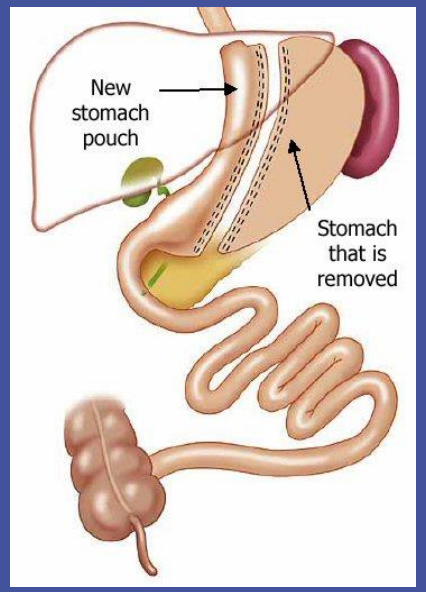
Srivastava G and Apovian CM. Nat Rev Endocrine. 2018 Jan; 14(1):12-24.
Wilding JPH, et al. N Engl J Med. 2021 Mar 18;384(11):989

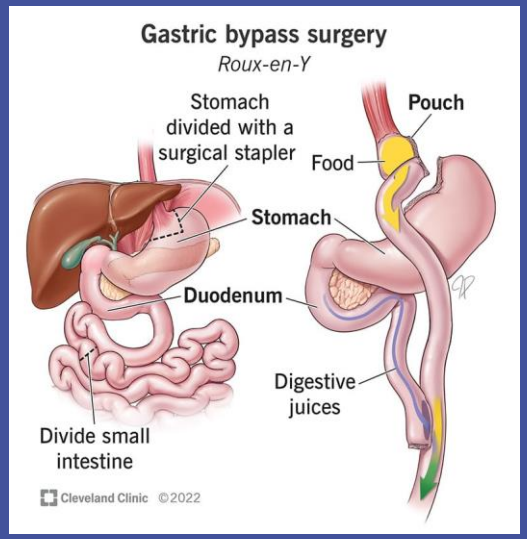


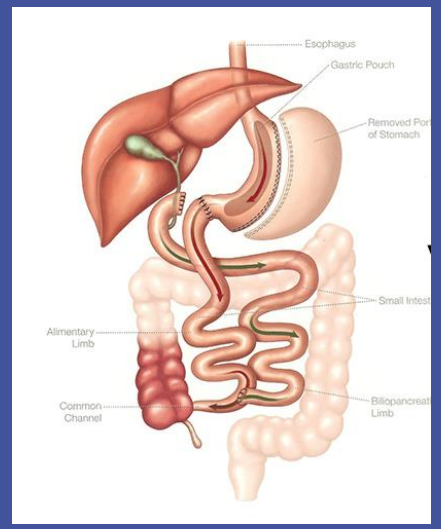
References: 1. Jensen et al. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults. J Am Coll Cardiol. 2014;63(25 Pt B):2985-3023. **2.** Courcoulas et al. Weight change and health outcomes at three years after bariatric surgery among patients with severe obesity. JAMA. 2013;310(22):2416-25. **3.** Berry et al. Sleeve gastrectomy outcomes in patients with BMI between 30 and 35-3 years of follow-up. Obes Surg. 2018;28: 649-656.

TYPES OF BARIATRIC SURGERY









Adjustable Gastric Banding

Sleeve Gastrectomy

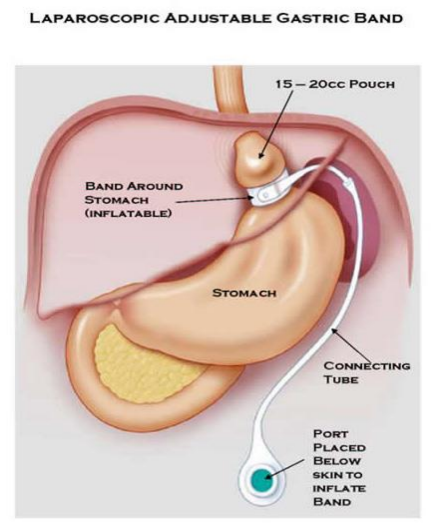
Restrictive

Gastric Bypass

Duodenal Switch

Restrictive & Malaborptive

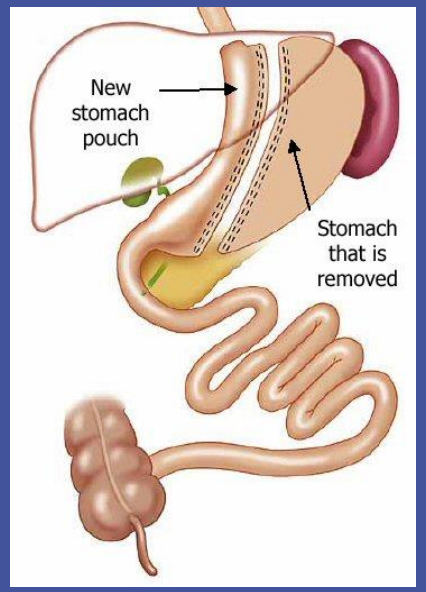
TYPES OF BARIATRIC SURGERY



Adjustable Gastric Banding

- Laparoscopic procedure that is less invasive than gastric sleeve or gastric bypass (no cutting of stomach or bowel)
- Reversible
- Adjustable, depending on desired weight loss
- Weight loss typically much less

TYPES OF BARIATRIC SURGERY

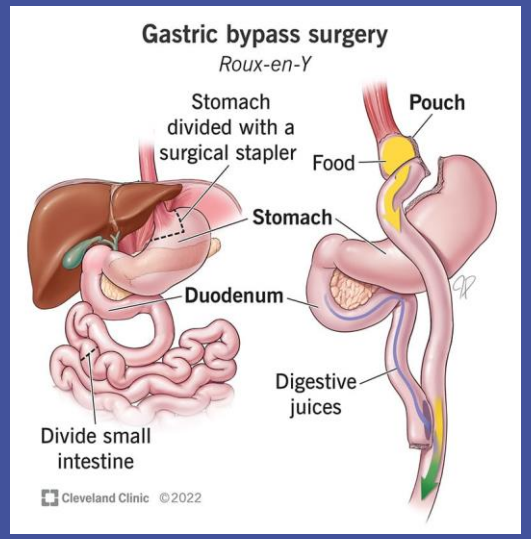


Sleeve Gastrectomy

- 50-65% excess weight loss at 2 years
- No malabsorption
- No adjustments
- Preserves the pylorus (decreases risk of dumping)
- Most common (59%) procedure in the U.S.

- Stomach may stretch over time
- Large portion of stomach is removed
- Possible heartburn after surgery

TYPES OF BARIATRIC SURGERY

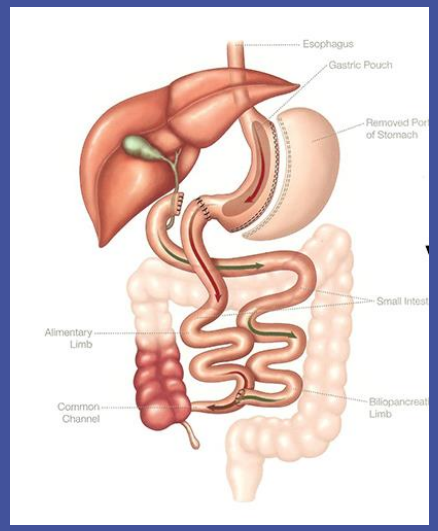


Gastric Bypass

- Proven reduction of obesity related medical problems
- Second most common (25%) operation in US with the most follow-up data
- Average 50-75% excess weight loss at 2 years

- Marginal ulcer
- Stomal stenosis
- Anemia
- Calcium deficiency
- Difficult to reverse
- Dumping syndrome
- Internal hernias

TYPES OF BARIATRIC SURGERY



Duodenal Switch

- A complex procedure that involves removing a large portion of the stomach AND rerouting the intestines
- Most malabsorptive procedure
- Many vitamin deficiencies
- Most weight loss with 80% excess weight loss at 2 years

BENEFITS OF BARIATRIC SURGERY

- Significant and sustained weight loss
- Improvement or resolution of obesity-related health conditions, such as Type 2 DM, HTN, and OSA
- Enhanced quality of life
- Increased life expectancy for individuals with severe obesity

RISKS AND CONSIDERATIONS

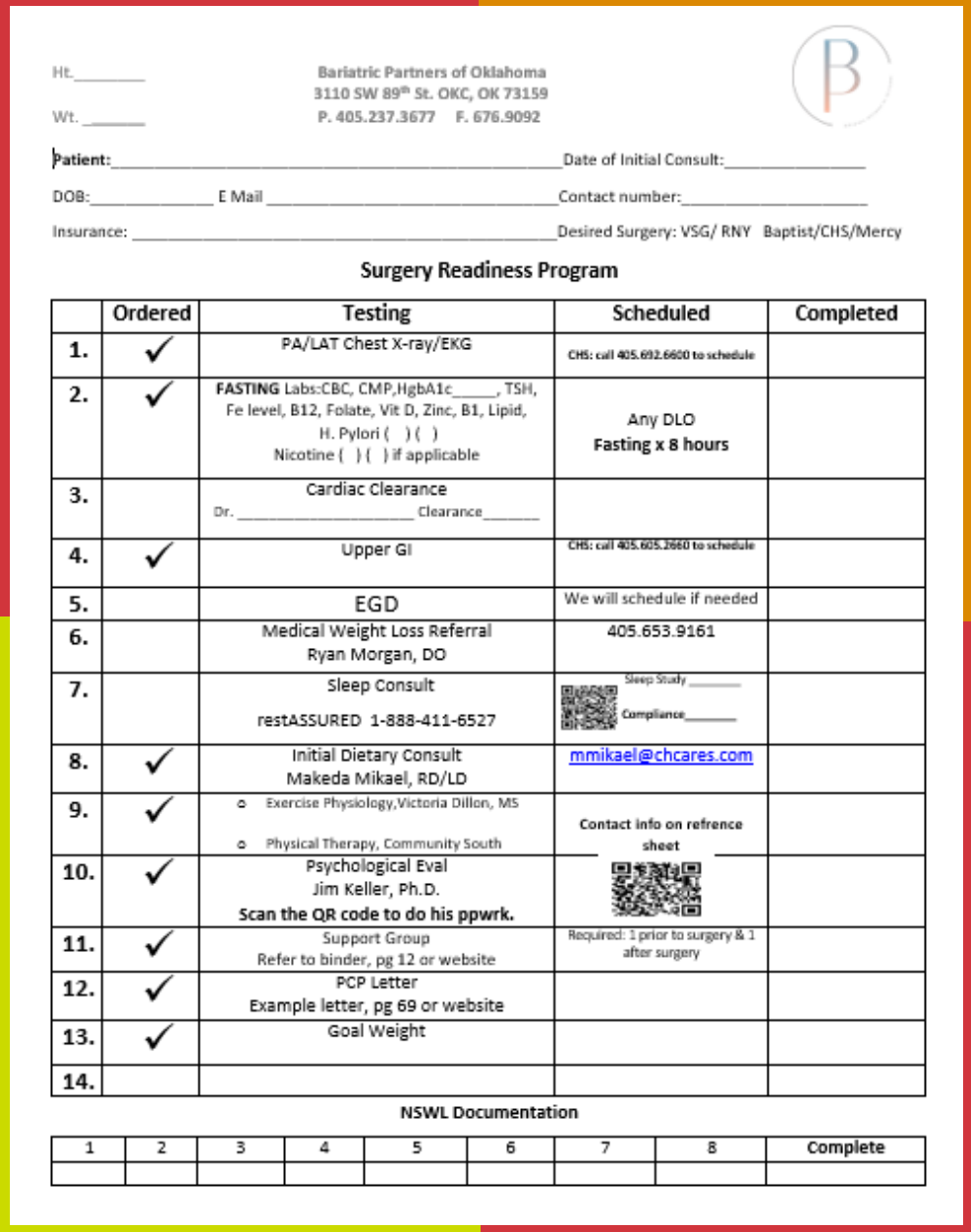
Surgical risks:

- Bleeding
- Infection
- Conversion to open procedure
- Leak of stomach fluid from the staple line: <1%
- Blood Clots (deep vein thrombosis)
- Heart attack and stroke
- Death: 0.1-0.3%

Other risks:

- Nutritional deficiencies if proper dietary guidelines and vitamin supplementation are not followed post-surgery
- Possible need for additional procedures or surgeries

MULTIDISCIPLINARY PRE-SURGICAL EVALUATION



Ht._____

Wt. _____

Bariatric Partners of Oklahoma
3110 SW 89th St. OKC, OK 73159
P. 405.237.3677 F. 676.9092

Patient:_____Date of Initial Consult:_____

DOB:_____ E Mail _____Contact number:_____

Insurance: _____Desired Surgery: VSG/ RNY Baptist/CHS/Mercy

Surgery Readiness Program

	Ordered	Testing	Scheduled	Completed
1.	✓	PA/LAT Chest X-ray/EKG	CHS: call 405.692.6600 to schedule	
2.	✓	**FASTING** Labs:CBC, CMP,HgbA1c_____, TSH, Fe level, B12, Folate, Vit D, Zinc, B1, Lipid, H. Pylori ( ) ( ) Nicotine ( ) ( ) if applicable	Any DLO **Fasting x 8 hours**	
3.		Cardiac Clearance Dr. _____ Clearance_____		
4.	✓	Upper GI	CHS: call 405.605.2660 to schedule	
5.		EGD	We will schedule if needed	
6.		Medical Weight Loss Referral Ryan Morgan, DO	405.653.9161	
7.		Sleep Consult restASSURED 1-888-411-6527	Sleep Study _____ Compliance_____	
8.	✓	Initial Dietary Consult Makeda Mikael, RD/LD	mmikael@chcares.com	
9.	✓	○ Exercise Physiology,Victoria Dillon, MS ○ Physical Therapy, Community South	**Contact info on refrence sheet**	
10.	✓	Psychological Eval Jim Keller, Ph.D. **Scan the QR code to do his ppwrk.**		
11.	✓	Support Group Refer to binder, pg 12 or website	Required: 1 prior to surgery & 1 after surgery	
12.	✓	PCP Letter Example letter, pg 69 or website		
13.	✓	Goal Weight		
14.				

NSWL Documentation

1	2	3	4	5	6	7	8	Complete

- Comprehensive laboratory testing and pre-surgical imaging
- Consult and follow-up with bariatric dietitian
- Exercise physiology evaluation
- Psychology evaluation to ensure surgical readiness
- Attendance of support group
- PCP recommendation letter

Design and evaluation of a new nurse-led case management intervention for bariatric surgery patients

Cláudia Amaro Santos[a,b,c], Manuel Carvalho[a,b], João Gregório[c,*]

[a] *Hospital Espírito Santo de Évora, EPE, Évora, Portugal*
[b] *CRI.COM – Centro Responsabilidade Integrada de Cirurgia da Obesidade e Metabólica, Evora, Portugal*
[c] *CBIOS – Universidade Lusófona's Research Center for Biosciences & Health Technologies Lisbon, Portugal*

Objectives:

Supported by DSRM, the main objective of this project is to design, implement and evaluate a new case-managing intervention for patients undergoing surgical treatment of obesity, to optimize and maintain the results of bariatric surgery.

**Ongoing study

ROLE OF CASE MANAGERS

Case managers serve as advocates, coordinators, and educators for patients.

In Obesity Medicine specifically…

- Assess patients' needs and goals
- Develop personalized care plans
- Coordinate multidisciplinary healthcare teams
- Provide ongoing support and education
- Monitor progress and adjust interventions as needed

ROLE OF PATIENTS

Set realistic performance and outcome goals

Engage in self-monitoring and track progress

Adhere to prescribed treatments and lifestyle changes

Advocate for their own health and well-being

BENEFITS OF A COLLABORATOVE APPROACH

Increased patient engagement and motivation

Enhanced communication and shared decision making

Improved treatment adherence and outcomes

Tailored care plans addressing individual needs

Support throughout the obesity management journey

STRATEGIES FOR COLLABORATION

Establish a trusting and supportive relationship

Set realistic goals and celebrate milestones

Identify and address barriers to program adherence

Encourage open and non-judgemental communication

Provide education resources for nutrition, exercise, and behavior change

Regularly review and adjust care plans

MEASURING SUCCESS

- Weight loss and BMI reduction
- Improved biomarkers (blood pressure, blood sugar, reduction of co-morbidities)
- Increased physical activity and fitness
- Enhanced quality of life and overall well-being (non-scale victories)

Patient “JR”

-229 lbs TOTAL
-71% EBW

Initial: 464 lbs

Surgery Day: 398 lbs

1 yr post-op: 235 lbs

QUESTIONS?

THANK YOU


Ashley Sale, PA-C
405.237.3677
(f) 405.676.9092
www.bariatricpartnersok.com
bariatric@bariatricpartnersok.com
3110 SW 89th St STE 200A
Oklahoma City, OK 73159
BARIATRIC PARTNERS OF OKLAHOMA