Engaging Rural Family Practice Patients in Smoking Cessation

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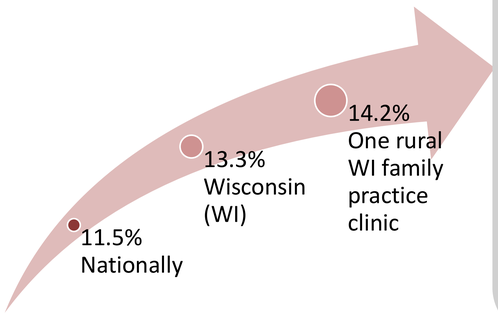
PROBLEM INTRODUCTION

Cigarette smoking is the leading cause of preventable death & disability in the United States (CDC, 2023).

Average % cigarette smokers

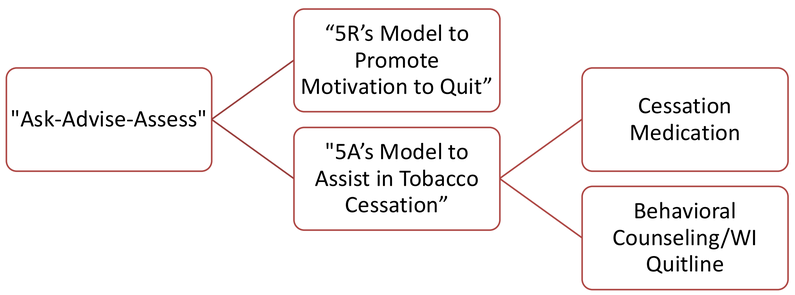


This WI clinic lacked a standardized process to ask about tobacco use & reported frequent patient resistance to smoking cessation discussions. The providers also referred few to no patients to the WI Quitline.

LITERATURE REVIEW

If all primary care providers ask about tobacco use & advise cessation, they could potentially reach over 80% of all tobacco users annually & prompt 40% of them to attempt quitting (WHO, 2014).

3–5-minute approach to cessation discussion



PROJECT METHODS

Project aims

- Standardize the rooming process to incorporate tobacco use history-taking.
- Engage all current adult, non-pregnant cigarette smokers in evidence-based smoking cessation discussion.
- Ensure evidence-based cigarette smoking cessation interventions were offered to patients to support their cessation efforts.

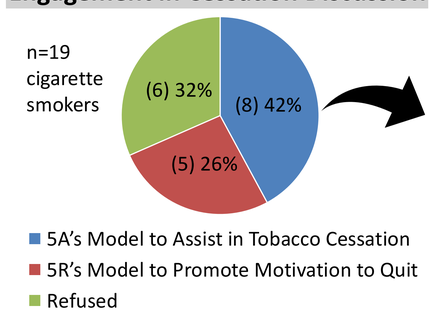
- Obtained stakeholder feedback & approval for project methods & supporting documents, followed by IRB approval.
- A standardized rooming process was agreed upon with the provider for how to screen each patient for tobacco use.
- An in-service on evidence-based smoking cessation interventions, including smoking cessation discussion models, was presented to the provider.
- Each patient room was equipped with a laminated copy of the 5 A's & 5 R's models to serve as discussion guides.
- Prefilled fax referral sheets to the WI Quitline were updated through a WI Quitline representative.

EVALUATION

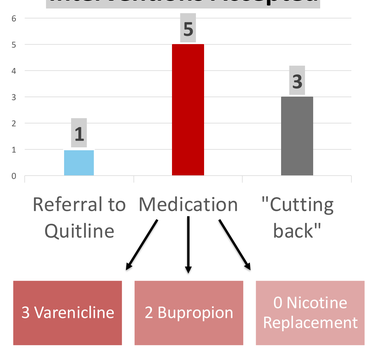
Project implementation

- The provider recorded the total number of patients & the number of cigarette smokers seen per clinic day on a calendar.
- On a table, the provider recorded each cigarette smoker's years of smoking & if the patient engaged in the 5 A's, 5 R's, or refused cessation discussion.
- For those open to cessation, the provided recorded if a referral to the WI Quitline was accepted & if smoking cessation medication was prescribed, including the medication name(s).
- A post-intervention survey was conducted.

Engagement in Cessation Discussion



Interventions Accepted



IMPACT ON PRACTICE

Immediate Impact

- The provider made monitoring, discussing, & treating cigarette smoking a routine priority.
- Patients engaged in the 5R's Model to Promote Motivation to Quit.
- Enhanced awareness of the WI Quitline & ease of referrals improved.

Long-term Impact

- Continued use of the standardized rooming process.
- Ideally, increased smoking cessation by patients.

LIMITATIONS

- Smaller than expected sample size; 7.5% of patients were cigarette smokers vs. expected 14%.
- Rooming staff unavailable during implementation.
- Short implementation period; July 2024-August 2024.

CONCLUSIONS

Smoking cessation should be a consistent priority at all patient visits.

Improved awareness of a patient's smoking status & providing evidence-based discussions & treatments can lead to more attempts & higher success rates in smoking cessation.

Further efforts should determine how to best provide smoking cessation counseling to patients from rural WI.

Leadership Wellness in Healthcare

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PROBLEM INTRODUCTION

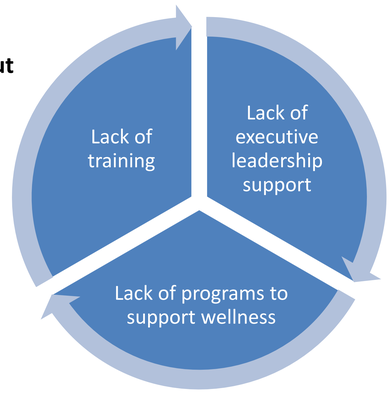
Nurse Leaders
- Especially vulnerable to burnout
- High demands of duties attributed to the position

Environmental Factors
- High-stress
- Workplace violence
- Repeated exposure to pain and death
- Staffing shortages
- Lack of leadership support

Financial Impact
- $11,000-$90,000 per nurse
- Does not factor in agency cost of fill vacancy
- Potential negative outcomes associated with higher patient/nurse ratios and leadership turnover
- Cost of training and orientation

LITERATURE REVIEW

Leader Burnout



Two Main Concepts to Support Wellness

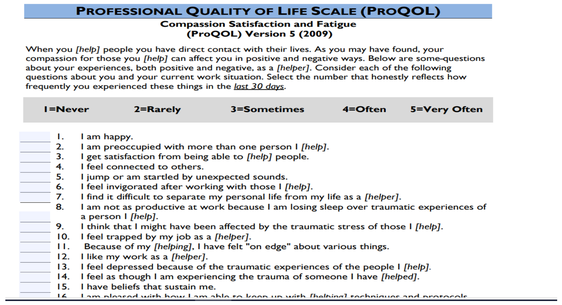
Mindfulness
- Intention to engage in mindfulness practices
- Self-efficacy related to mindfulness

Resiliency
- Adaptive strategies
- Training programs on leadership style
- Organizational strategies
- Stress reduction

PROJECT METHODS

An in-person class presentation was given to nursing leaders in a nurse manager or assistant nurse manager role by a life coach at an acute-care hospital in southern Illinois. The presentation introduced six ways a leader can learn and practice resiliency in their own professional and personal life that would contribute to being happier. The concepts included creating strong relationships, treating self-kindly, being proactive, shifting mindset, being flexible, and being grateful. Multiple interactive exercises were included in the course that allowed leaders to identify individual steps they could personally take to practice resiliency.

Participants completed a thirty-question survey Professional Quality of Life (ProQOL), survey before the class presentation began. The same survey was administered immediately after the class and allowed for attendees to complete approximately six weeks after completing the class. The ProQOL survey contains questions about compassion satisfaction and burnout.



PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)
Compassion Satisfaction and Fatigue (ProQOL) Version 5 (2009)

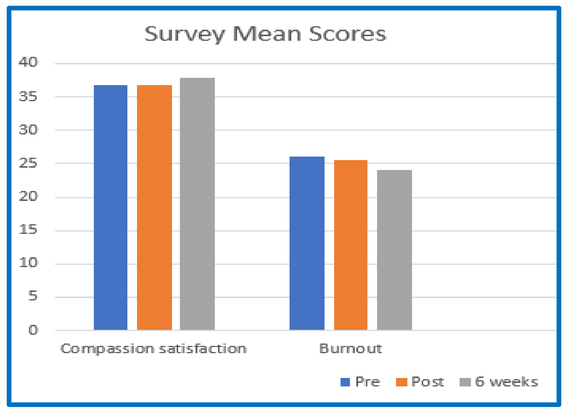
When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

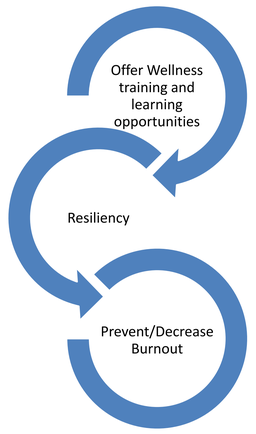
1. I am happy.
2. I am preoccupied with more than one person I *[help]*.
3. I get satisfaction from being able to *[help]* people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I *[help]*.
7. I find it difficult to separate my personal life from my life as a *[helper]*.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
9. I think that I might have been affected by the traumatic stress of those I *[help]*.
10. I feel trapped by my job as a *[helper]*.
11. Because of my *[helping]*, I have felt "on edge" about various things.
12. I like my work as a *[helper]*.
13. I feel depressed because of the traumatic experiences of the people I *[help]*.
14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols

EVALUATION

Survey results demonstrated that:
1. Mean score for compassion satisfaction remained the same at all intervals.
2. Mean score for burnout remained relatively the same at all intervals.
3. No clinical significance when comparing pre-survey, post-survey and 6-week post survey scores.



IMPACT ON PRACTICE



- Supports organizations offering wellness training and learning opportunities to leaders to reduce burnout and keep compassion satisfaction intact for those serving in the healthcare industry.
- Participants self-evaluation prior to intervention provides baseline data for self awareness and to the organization
- A single session addressing resiliency may be impactful for some leaders. Most likely, embedded and more frequent training needed to be impactful.

CONCLUSIONS

Physical and mental demands on nurse leaders subjects them to high-stress levels, mental exhaustion, and burnout.

Leadership training/development	Competing priorities	Organizational need
• Clinically strong nurse promoted into leadership • Leadership skill evaluation and development not addressed	• Physical and mental demands of position • Training another thing to do on the list	• Leadership training key component for tackling burnout issues • Support programs to promote wellness and avoid burnout

Limitations

- Small sample size that returned the six-week post-survey.
- The sample of participants was homogenous. There was a variety of male and female participants, but otherwise, the participants were all from the same organization.
- An additional limitation may have been the short length of the class. The class was only one-hour in length; therefore, it is not likely that one class would change someone's burnout. If additional sessions were provided, the impact may have been more substantial.

Establishing an Electronic Medical Record System for Global Medical Mission Trips

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PROBLEM INTRODUCTION

Approximately 6,000 organized global medical mission trips occur annually (Maarsingh et al., 2022).

A major criticism of short-term mission trips is the inability to provide sustainable care, which can lead to harm.

The previous pen-and-paper system did not allow for statistical tracking or follow-up for identified issues.

A secure system that allowed easy access and efficient documentation of the patient's medical history and treatment record was needed.

For over 14 years, one U.S. -based medical mission organization has provided healthcare to a rural community in Honduras.

Despite providing annual patient care, only rudimentary medical documentation and record-keeping existed.

In 2023, the medical team examined and treated over 1500 patients and filled 3,664 prescriptions in 4 days.

LITERATURE REVIEW

Safeguarding information

Using paper medical forms creates a threat of unsafe, ambiguous care (Dianton & Chu, 2016).

Using an electronic medical record (EMR) keeps patient records safe with password and encryption protection.

Transitioning from paper to electronic records

Globally, Caribbean and Latin American nations are struggling to digitalize patient record keeping (Borbolla et al., 2016).

Paper forms are only helpful if they are legible (Maarsingh, 2022).

Guidance for a standardized work process

Protecting private patient medical record information is an ethical obligation of providers to their patients.

United States law dictates that HIPPA applies to U. S. providers who work internationally (Alder, 2023).

Advantages of electronic medical records

Sustainability is achieved, and a coherent workflow is ensured.

Reduces the carbon footprint by being energy-efficient and space-saving (Garcia. 2024).

PROJECT METHODS

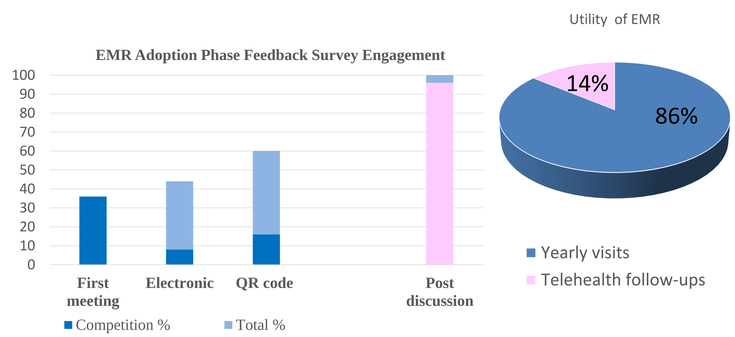
Phase I

- Met with stakeholders to discuss the EMR needs of the organization
- Created pre- and post-implementation surveys to evaluate concerns and expectations
- Administered pre-implementation surveys
- Developed custom templates for each medical team pod
- Set up training for providers, nurses, volunteers, and administrators on the medical mission team

Phase II

- Implementation of the EMR system in February 2024 on a medical trip to rural Honduras
- Conducted a post-implementation guided discussion with the global mission team and stakeholders to identify strengths and areas for improvement
- Utilized a QR code for the post-implementation survey
- Continued discussion of future modifications to improve the use of the EMR system

EVALUATION



Post-discussion: Patient areas to track

- Disease Trends 71%
- Growth and Nutrition 71%
- Prescribed Medication 57%
- Diabetic Management 43%
- Vital Statistics 29%

IMPACT ON PRACTICE

Immediate Gains

- Follow-up patients on consecutive days
- Expedite access to vital records

Evolving Implementation

- Prayer Requests
- Clean Water Ministry
- Templates for Specialists

Future Gains

- Referrals
- Telehealth visits

CONCLUSIONS

PARTICIPANTS

A Special thank you to Dr. Sobczak and Dr. Jennings

Tobacco Cessation in Patients Receiving Treatment for Opioid Use Disorder

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PROBLEM INTRODUCTION

- There are high rates of tobacco use, or nicotine dependence, and opioid co-use.
- At the Jerseyville Medication Assisted Recovery (MAR) Clinic, there are 117 patients receiving treatment for opioid use disorder (OUD), and 82.1% of those patients report using tobacco.
- While the MAR Clinic has treatment options for opioid, methamphetamine, and alcohol use, there is no program for tobacco cessation.
- The purpose of this project was to assess the patients' attitudes toward and beliefs regarding tobacco use and cessation, with the goal of ascertaining the need for a tobacco cessation program at the MAR Clinic.

LITERATURE REVIEW

Search Strategy	• CINAHL Plus with Full Text, Cochrane, PubMed, MEDLINE Complete • Years: 2018-2024 • Geography filter: "USA" • Key words: smoking or tobacco use and cessation options for patients with OUD
The Need for Tobacco Cessation in Patients with OUD	• Co-use of tobacco and illicit opioids is high (74-97%) and complicates recovery from OUD (Morris & Garver-Apgar, 2020) • New strategies should be investigated for tobacco cessation in patients with OUD because of the unique barriers this population faces (Vlad, Arnsten, & Nahvi, 2020) • People who smoke cigarettes are more likely to have OUD (Parker et al., 2023)
Evaluation of Tobacco Use in Patients Receiving Treatment for OUD	• Patients receiving treatment for OUD did not report a significant change in tobacco use from baseline (Eastwood et al., 2021; Montgomery et al., 2021) • Some patients reported using e-cigarettes to stop smoking (Baldassarri et al., 2019) • Statistically significant spontaneous reduction in cigarettes smoked per day in patients on XR-NTX for OUD (Wang et al., 2020)
Tobacco Cessation Treatment in Patients Receiving Treatment for OUD	• No statistically significant difference in the number of percentage that reported a quit attempt between IMB intervention group and Quitline control group (Cooperman et al., 2018) • Tobacco cessation treatment integration might be more feasible in later phases of OUD treatment (Felicione et al., 2022) • Some studies trialed an educational component in the form of text messages (Parker, Byers, & Villanti, 2021; Shankar et al., 2022)

PROJECT METHODS

1. Meeting with stakeholder to assess problem at clinic
2. Proposal of project to stakeholder and faculty member
3. Review of the literature
4. Development of surveys and educational brochure
5. Meeting with stakeholder to discuss implementation
6. Distribution of pre- and post-educational surveys and brochures
7. Evaluation and analysis of pre- and post-education survey results

PRE- AND POST-EDUCATION SURVEYS

- Pre-survey: qualitative questions + 14 Likert scale questions
- Post-survey: identical 14 Likert scale questions
- Data analyzed using paired two-tailed t-tests

EDUCATIONAL BROCHURE

EVALUATION

- *N* = 15 patients completed the surveys.
- The results of the data collected from the pre- and post-educational surveys were analyzed using the mean, median, and mode, followed by a paired two-tailed t-test analysis of the means.
- The difference in the means of 8 of the 14 Likert scale questions were statistically significant ($p < .05$).

LIMITATIONS

- Small sample size and non-representative patient population
- Reliance on self-reported data
- Patient participation consistency

IMPACT ON PRACTICE

- ➡ Continued distribution of brochures
- ➡ Reaching patients in primary care
- ➡ Pamphlet in exam rooms

CONCLUSIONS

- ➢ It is important to consider the implications tobacco use when treating a patient with OUD
- ➢ Potential success with the development of a tobacco cessation program at the clinic
- ➢ Future implications:
  - Longer period of implementation
  - Multiple sites
  - Diversification of participant demographics

Intimate Partner Violence Education and Identification

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PROBLEM INTRODUCTION

- The CDC reports that about 41% of women experienced sexual violence, physical violence, or stalking from an intimate partner in their lifetime (CDC, 2024).
- Research suggests that women being abused are more likely to engage with a healthcare worker than those who are not (heron & Eisma, 2020).
- Intimate partner violence (IPV) remains a persistent public health crisis with no standardized approach to screening.

LITERATURE REVIEW

Databases: CINAHL Plus „ Medline, and Google Scholar. PubMed

Search terms: Domestic Violence, Intimate Partner Violence. I then added additional terms of screening and outpatient.

Findings: There is a lack of standard screening for intimate partner violence. A large majority of survivors of intimate partner violence seek out healthcare and unfortunately are not identified by healthcare professionals. The primary intervention noted was education about intimate partner violence to the providers caring for them.

Recommendations: To develop education for those healthcare providers who are at a higher likelihood of seeing IPV survivors to empower them, then develop a screening process.

PROJECT METHODS

- Implementation Site: A women's health clinic within a moderate-sized city with a population of 115,000 people. The project was conducted with all the clinic's physicians, nurses, and Advanced Practice Providers
- Education method: A virtual education session was held and offered to all clinic healthcare providers
- There were pre-surveys conducted to identify educational needs.
- Post-surveys were collected to demonstrate the impact on practice.

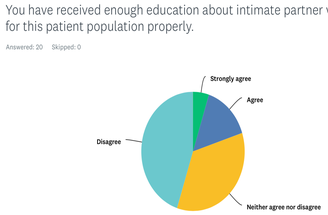
EVALUATION

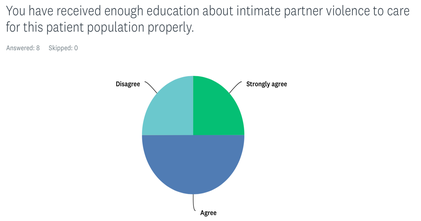
Participants:

- Pre-Survey: N=20
- Education Presentation: N= 23
- Post-Survey: N=8

Survey Design:

- Pre and Post survey design
- Quantitative Data was collected using a 5-point Likert Scale.





IMPACT ON PRACTICE

Short-term impact: Improved confidence of women's health providers

Increased knowledge of community IPV resources

Colleagues sharing information about IPV education.

Long-term impact is difficult to determine.

CONCLUSIONS

- Women's health providers want to have more education on intimate partner violence.
- You must have a good education program on intimate partner violence prior to implementing a screening tool.
- It is imperative for patient outcomes to have healthcare providers aware and knowledgeable about local IPV resources.

Acknowledgements

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