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Poster Presentations
FNP & PMHNP

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Reducing Mechanical Restraints Through Trauma-Informed Care (TIC)

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INTRODUCTION & LITERATURE REVIEW

The use of restraints in healthcare systems, particularly in mental health, is a significant clinical issue. Despite awareness of restraint-related risks, inpatient mental health settings continue to rely on mechanical restraints, especially due to gaps in training on alternatives.

- Belayneh et al (2024) noticed variability in the prevalence rate of restraint use in different facilities across many countries, then concluded that restraint use is influenced more by organizational culture, staff practices, and approach to care than by patient behaviors alone.
- Ventura, Austin, Carrara, and de Brito (2021) conducted a review on nursing care in mental health concerning patient rights issues across 26 empirical studies, which identified pervasive stigma, discrimination, and restrictions on the civil, social, and political rights of individuals with mental illness.
- A systematic review of studies done on trauma-informed care (TIC) interventions in emergency medicine settings was successful and productive in reducing the use of mechanical restraint. Trauma-informed principles are transferable across settings (Brown et al., 2022).
- Findings show that multi-component interventions, particularly those combining staff education, organizational culture change, and patient-oriented strategies, offer the greatest possibility for reducing restrictive practices (Baker et al., 2021).
- Wilson et al. (2021) point out the substantial gap that exists between the theoretical endorsement of trauma-informed care and its clinical implementation in acute settings, largely due to organizational hurdles such as understaffing, limited organizational support, inadequate staff training, and high acuity.

PURPOSE & INTERVENTION

Purpose

To determine the effectiveness of a trauma-informed care (TIC) training program for nurses in reducing the use of mechanical restraints.

Clinical Question PICOT

In the adult population (P), how does the implementation of a Trauma-Informed Care training program for nurses in inpatient mental health settings (I), compared to standard nursing education (C), reduce the use of restraints on the unit by 20% (O) over a 12-week period (T)?

Intervention

A structured TIC educational program was designed and delivered to reinforce nurses' knowledge of TIC principles and associated therapeutic strategies, including therapeutic communication, grounding techniques, de-escalation methods, and appropriate use of nonverbal communication.

PROJECT METHODS

Guided by the Plan–Do–Study–Act (PDSA) framework.

- Conducted in an acute mental health setting in suburban Saint Louis County, Missouri, for a period of 12 weeks.
- Eligible participants included adult patients between 18 and 59 years of age admitted for behavioral health concerns
- TIC educational program was designed and delivered to reinforce nurses' knowledge of TIC principles
- TIC knowledge survey was completed by participating nurses during pre-intervention and post-intervention periods.

EVALUATION

Process outcome

- A pre–post design was used to evaluate the impact of the TIC intervention. A pre-and-post seven-item knowledge survey consisting of five Likert-scale items and two true/false questions was completed by a total of 13 staff members.
- Pre-intervention survey scores indicated that participating registered nurses possessed a moderate baseline understanding of TIC due to existing facility-based learning modules. However, respondents expressed a desire for enhanced competency in grounding and de-escalation strategies.
- An increase in post-intervention survey scores relative to baseline was interpreted as evidence of improved TIC knowledge and increased behavioral readiness to incorporate TIC strategies into clinical practice.

Results

Restraint use decreased from 1.48% pre-intervention to 0.94% post-intervention, representing a 36.49% reduction.

- Only 2 of 68 agitation/aggression events (2.94%) required mechanical restraint post-intervention.

	Pre implementation	Post implementation
Inpatient admission	203	212
Mechanical restraints as last resort	3 (1.48%)	2 (0.94%)

CONCLUSIONS

The implementation of the TIC training was associated with a reduction in mechanical restraint use in an inpatient acute adult mental health setting. Nurses also reported increased confidence in using de-escalation and grounding techniques.

Limitations

This quality improvement project was conducted in a single inpatient adult mental health unit with limited sample size, which restricts generalizability. The implementation phase was short and did not reflect long-term sustainability of restraint reduction outcomes. Organizational hinderances such as inadequate staffing, patient acuity fluctuations, and lack of long-term follow-up may have influenced the results.

Recommendation for further study

- This quality improvement project was designed to support feasibility, replication, and sustainability.
- Future studies should include larger sample sizes and additional settings (e.g., emergency departments, correctional facilities, and nursing homes).
- Extending the implementation period would allow for a longer data collection timeframe and better evaluation of TIC effectiveness in reducing the need for mechanical restraints.

IMPLICATION FOR PRACTICE

- The findings of this quality improvement project have significantly reinforced the role of the APRN as a clinical leader in promoting trauma-informed, least-restrictive care.
- PMHNPs are uniquely positioned to influence both pharmacologic and non-pharmacologic treatment strategies, reducing reliance on mechanical and chemical restraints while optimizing patient outcomes.
- Through leadership in interdisciplinary collaboration, policy development, and staff education, PMHNPs can drive sustainable practice change and improve safety within inpatient mental health settings.

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Universal Depression Screening in Primary Care

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INTRODUCTION/LITERATURE REVIEW

Depression is underdiagnosed in primary care due to inconsistent screening practices (National Institute of Mental Health [NIMH], 2023).PHQ-2 and PHQ-9 are validated, reliable screening tools (US Preventative Services Task Force [USPSTF], 2023).

- Universal screening improves detection and treatment (USPSTF, 2023).
- Barriers include workflow insufficiencies, stigma, bias, and knowledge gaps (Siniscalchi et al., 2020).
- Provider education + standardized workflows improve adherence (Siniscalchi et al., 2020).

PURPOSE

PICOT Question:
In adult patients presenting for routine visits at a primary care clinic, how does implementing universal depression screening using the PHQ-2 followed by the PHQ-9 for positive screens, compared to the current practice of selective or no routine screening, affect depression screening rates over two months?

Aim:
Examine current evidence regarding depression screening practices in primary care and assess the effectiveness of universal screening using the PHQ-2 and PHQ-9 tools in improving depression detection rates.

PROJECT METHODS

- QI project utilizing the PDSA framework
- Provider education + standardized workflow
- Pre/post surveys (N=15) and chart reviews (N=50)
- SIUE IRB exempt
- Chronic Care Model
- Primary care clinic in Missouri

EVALUATION

- PHQ-2 completion 36% → 52% (**+16%**)
- PHQ-9 eligibility 44.4% → 76.9 (**+32.5%**)
- PHQ-9 completion 33.3% → 80.% (**+46.7%**)
- Routine depression screening 66.7% → 93.3%
- Use of PHQ-2/PHQ-9 46.7% → 100%
- Depression screening at eligible visits 40.0% → 73.3%
- Provider support for universal screening 100%

Interpretation:

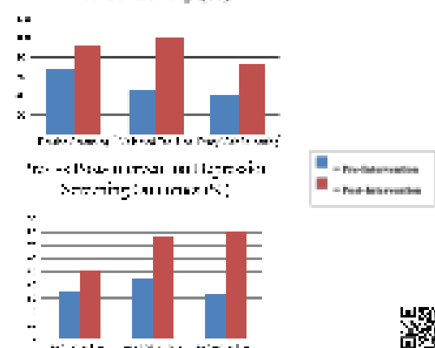
- Increased positives = **better detection, not higher disease burden**
- Indicative of improved **identification** of depression

IMPACT ON PRACTICE

- **Immediate Impact:**
  - Increased screening consistency, improved provider adherence, and better identification of depression
- **Long-Term Impact:**
  - Earlier intervention, improved patient outcomes, and reduced healthcare costs
- **Sustainability:**
  - Integrate into EHR, ongoing education, and audit + feedback

CONCLUSIONS

- Universal screening improved adherence to standard screening practice and detection rates.
- Intervention is low-cost, scalable, and sustainable.
- Recommend continued use, EHR integration, and expansion.
- Future research is needed to assess long-term impact on higher numbers of patients.



Comprehensive Discharge Planning To Reduce 30-Day Psychiatric Readmission Rates

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INTRODUCTION/BACKGROUND

Psychiatric readmissions within 30 days show a decrease in quality of care, including poor care coordination, premature discharge, and worsening conditions. Many psychiatric readmissions are often avoidable through structured discharge planning. Research shows that inadequate care transitions, medication nonadherence related to access, and social determinants of health increase readmission risks.

Fragmented discharge planning for hospitalized adults with mental health conditions contributes to increased 30-day psychiatric readmissions and emergency department use.

Multiple studies support transitional interventions, including:

- Nurse-led Medication Adherence Therapy improves adherence (Balikai et al., 2022).
- Pharmacy-driven transitions of care reducing readmissions (Tillman et al., 2020).
- Mobile health tools improving support and communication (Rohricht et al., 2021).
- Systematic reviews show that care management models reduce psychiatric readmissions (Tyler et al., 2023).

PURPOSE

Purpose: The purpose of this quality-improvement project was to reduce 30-day psychiatric readmission rates by implementing evidence-based discharge planning and transition-of-care intervention on an inpatient behavioral health unit.

Aim: The aim of this project was to design and implement an evidence-based, interprofessional, and comprehensive discharge process that integrates community resource linkages to enhance continuity of care.

PICOT:

This quality improvement project addressed the following PICOT question: In adult patients hospitalized with psychiatric mental health conditions (P), how does implementation of a comprehensive discharge planning with community resource linkage (I), compared to standard discharge practices(C), reduce psychiatric readmissions (O) within 30 days of discharge (T)?

PROJECT METHODS

Quality Improvement DNP project conducted at a local metropolitan hospital in a BH unit.

The Plan-Do-Study-Act (PDSA), interactive four stage QI model was used throughout the project in repeated cycles, building knowledge to achieve the overall implementation and evaluation.

Discharge checklist was utilized

Pre and post staff education Qualtrics surveys were used.

Guided by the Transitional Care Model (TCM) emphasizing seamless transitions, care coordination, and patient empowerment

Staff education, a structured discharge checklist, medication reconciliation, 30-day medication supply, social determinants screening, and follow-up phone calls within 24–72 hours.

RESULTS

Readmission Rates

- BHS 1000: Reduced from 17.5% to 7.1% post-implementation (10.4%)
- BHS 1000N: Remained stable (10.6%–11.4%)
- August peak followed by improvement in September
- Outcomes aligned with regional benchmarks

Staff Outcomes

- 100% improved understanding of readmission impact
- 96% agreed checklist could reduce readmissions
- 74% likely to continue checklist use

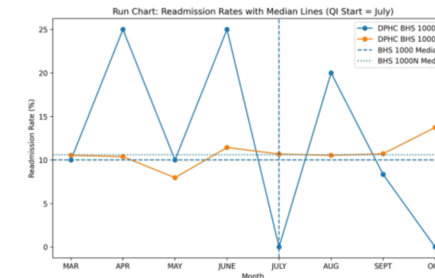
Patient Satisfaction

- 65% satisfied with care and valued follow-up outreach.
- Follow-up completed within 24–72 hours post-discharge

Overall Impact

- Interventions showed a significant reduction in readmissions, improved staff engagement, and a positive patient experience.

DATA EVALUATION



CONCLUSIONS

Structured comprehensive discharge process improves continuity of care, medication accessibility, and reduces psychiatric readmissions.

Structured discharge process intervention, including staff education, standardized checklist use, 30-day medication supply, and early post-discharge follow-up, were associated with improved staff knowledge, positive patient satisfaction, and reduced psychiatric readmissions.

These findings support the sustainability of the comprehensive discharge process as an effective quality improvement strategy in behavioral health settings.

Overall, the QI initiative was associated with a notable reduction in psychiatric readmissions, driven by significant improvement in BHS 1000, while highlighting opportunities for targeted strategies in BHS 1000N to enhance consistency across units.

IMPACT ON PRACTICE

This DNP project highlights the critical leadership role of the DNP-prepared APRN in redesigning evidence-based discharge processes through policy development, staff education, interdisciplinary collaboration, and systematic outcomes evaluation. These efforts strengthen nursing practice, improve care transitions, and contribute to a reduction in 30-day psychiatric readmission rates.

Improving Depression Identification in a Rural Primary Care Using a Standardized PHQ-9 Workflow

A Quality Improvement Project Using Score-Based Treatment Protocols

Southern Illinois University Edwardsville

Alexandria Jones, BSN, RN, DNP-FNP Student & Lauren McBride, BSN, RN, DNP-PMHNP Student

PROBLEM

Depression is underdiagnosed in primary care despite high prevalence.

- 1 in 5 adults affected
- <3% of PCPs routinely screen
- Leads to decreased quality of life, increased chronic disease burden, increased suicide risk

Gap: No standardized screening or treatment workflow

PURPOSE

To implement a standardized PHQ-9 screening workflow and score-based treatment protocol to improve:

- Depression identification
- Treatment initiation
- Provider response to positive screens

LITERATURE REVIEW

Databases: CINAHL, Cochrane
Years: 2020-2025
Focus: Depression screening in primary care
Age: 18+

- Screening improves outcomes
- Barriers include time + provider comfort
- Standardized workflows improve compliance

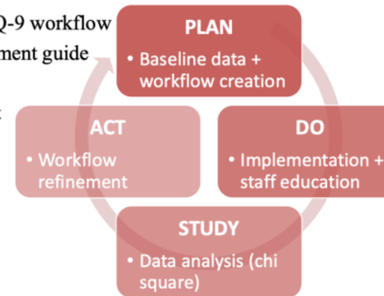
IMPLICATIONS FOR PRACTICE

- Easily scalable across primary care settings
- Minimal cost implementation
- Improves mental health outcomes at point of care

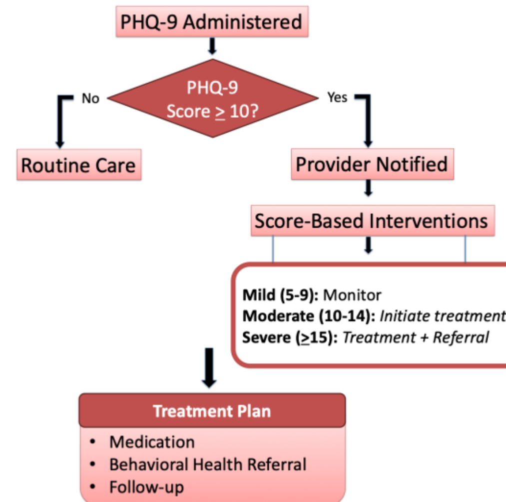
PROJECT METHODS

Design: Quality Improvement (PDSA Model)
Setting: Rural Primary Care Clinic
Sample: 266 patient encounters
Intervention:

- Standardized PHQ-9 workflow
- Score-based treatment guide
- Staff education
- Real-time support



SCORE-BASED INTERVENTIONS



Standardized scoring guided real-time clinical decision-making and improved treatment response.

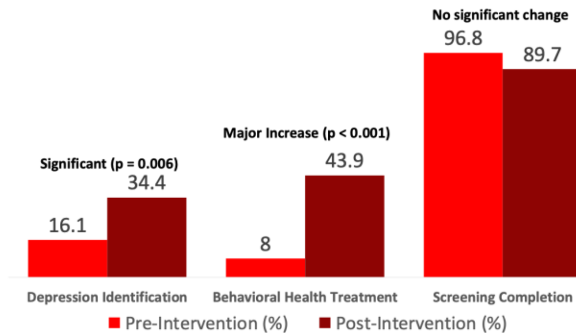
CLINICAL IMPACT

Improved early detection of depression	Increased initiation of treatment	Strengthened provider confidence	Supports sustainable workflow integration

- **2x increase in depression screening identification**
- **5x increase in treatment initiation**
- **Standardized decision-making across providers**
- **Sustainable clinic workflow implemented**

RESULTS

Pre vs Post Intervention Outcomes (n = 266)



CONCLUSION

Before: passive

After:

Implementation of a standardized PHQ-9 workflow resulted in a **statistically significant increase in depression identification and a >5-fold increase in treatment initiation.**

Recommendation:

Adopt standardized screening + score-based protocols to improve mental health outcomes.

Improving Comprehensive Diabetes Care in a Primary Care Clinic

Claire Choi, BSN, RN, DNP Student
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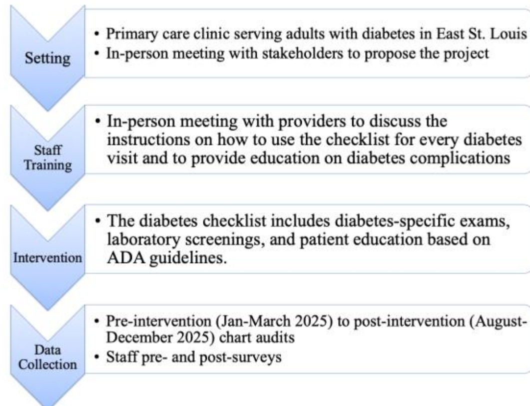
PROBLEM INTRODUCTION

- Type 2 diabetes mellitus (T2DM) disproportionately affects low-income and minoritized populations → leading to high morbidity, mortality, and healthcare costs.
- Key risk factors include smoking, obesity, lack of exercise, hypertension, hyperlipidemia, elevated A1C, and genetics.
- Chart audits revealed gaps in diabetes education, foot/eye exams, and recommended labs (i.e., A1C, lipid panels, kidney functions), limiting opportunities for early detection of complications.
- The clinic had lack of standard tools to ensure providers followed ADA diabetes care guidelines in managing patients with diabetes.

LITERATURE REVIEW

- Comprehensive diabetes care includes routine HbA1C, annual foot and eye examinations, lipid and renal screening, and ongoing patient education to reduce complications (ADA, 2024).
- Microvascular complications arise from prolonged hyperglycemia and damage to small blood vessels, leading to vision loss, kidney failure, and nerve damage (Templer et al., 2024).
- Macrovascular complications include cardiovascular disease which increases the risk of heart attacks, angina, stroke, and heart failure (Templer et al., 2024).
- Quality improvement studies show that checklists, electronic prompts, and structured education materials improve adherence to recommended screenings and support better glycemic control and complication prevention

PROJECT METHODS



EVALUATION

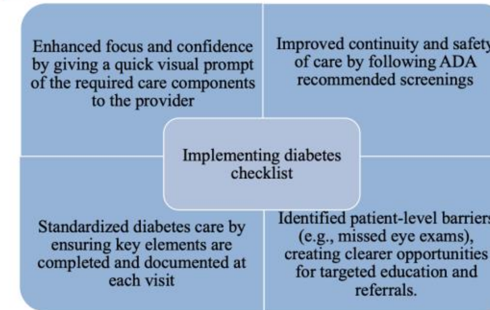
- A total of 18 pre-intervention and 29 post-intervention patients with type 2 diabetes were included.

Outcome	Pre-Intervention	Post-intervention
Diabetes Education	67%	96%
Foot Exam	0%	89%
Eye Exam	5.6%	96%
Lipid Panel	44%	69%
BUN/Cr	55%	72%
Glucose Log Provided	0%	65.5%
Follow-up visit scheduled	28%	93%

Limitations

- Small sample size
- Short intervention period to measure long-term glycemic control
- Not incorporated into the EHR system

IMPACT ON PRACTICE



CONCLUSIONS

- Improved the consistency of diabetes care, standardization of education, documentation quality, and follow-up scheduling.
- Staff feedback confirmed that the checklist was highly beneficial for ensuring that all aspects of diabetes care were addressed.

Diabetes Checklist

	Result	Action	
A1C		☐ Controlled (<6.5%), recheck 6 mo. ☐ Uncontrolled (>/=6.5), recheck 3 mo. ☐ No results available, test ordered	
Glucose		Fasting: ☐ Yes ☐ No Type: ☐ Capillary/POC ☐ Venous	Home log reviewed: ☐ Yes ☐ No ☐ Did not bring ☐ Non-compliant ☐ New log given
Does the patient have a history of atherosclerotic cardiovascular disease?		☐ Yes ☐ No Notes:	
Is the patient on any antiplatelet/anticoagulant medications		☐ Yes (Aspirin / Warfarin) ☐ No Notes:	
B/P (<130/80 mmHg)		☐ Normal, recheck 6 mo. ☐ Abnormal, recheck 2 weeks Notes:	
Lipids (LDL/HDL/Triglycerides)	☐ Normal, recheck 1 year ☐ Abnormal, recheck 6 months ☐ No results available, tests ordered Notes:		
Kidney Function (BUN/Cr)	☐ Normal, recheck 1 year ☐ Abnormal, recheck 6 month or 3 months if highly elevated ☐ No results available, tests ordered Notes:		
Foot Exam	☐ Normal, recheck 1 year ☐ Abnormal, refer to podiatry ☐ Exam Deferred Notes:		
Eye Exam	Date of last eye exam by an ophthalmologist:	Ophthalmology Referral needed? ☐ Yes, referral sent ☐ No Notes:	
Education	☐ S/S of hypoglycemia (shakiness, irritability, confusion, tachycardia, sweating, hunger) ☐ How to read food labels ☐ Healthy exercise and diet ☐ Dental hygiene ☐ Foot care ☐ Other diabetes self-management		
Medications	Any changes with medications? ☐ Yes ☐ No Notes:		Compliance checked ☐ Yes ☐ No Notes:

Completed by:

Increasing Patient Appointment Adherence at the WE CARE Clinic

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PROBLEM INTRODUCTION

- Missed appointments are common in primary care, with an average 15.2% no-show rate in the United States (Parsons et al., 2021).
- Appointment nonadherence reduces access to care, especially in communities experiencing primary care provider shortages.
- Missed visits disrupt continuity of care, delaying management of chronic illnesses and increasing emergency department use and hospitalizations.
- Healthcare systems experience financial losses when appointments are missed because scheduled provider and staff time cannot be reimbursed (Marbouh et al., 2020).
- Social determinants of health (SDOH)—including transportation barriers, low socioeconomic status, limited health literacy, and competing life responsibilities—contribute to missed appointments.
- The WE CARE Clinic in East St. Louis, Illinois, serving predominantly African American and Hispanic patients of lower socioeconomic status, experiences high rates of appointment nonadherence, highlighting the need for targeted interventions to improve access and health outcomes.

LITERATURE REVIEW

SDOH impact

- Transportation barriers
- Cost and insurance limitations
- Competing life demands

Consequences

- Missed appointments lead to:
  - Poor chronic disease management
  - Increased hospitalizations
  - Higher healthcare costs

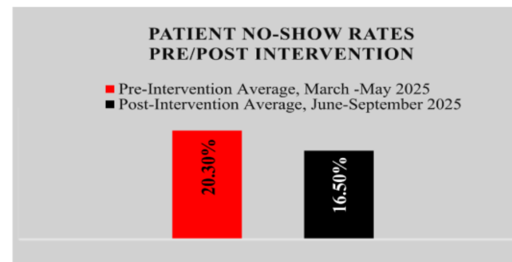
Evidence-based Intervention

- Financial incentives increase attendance rates
- Appointment reminders (text/call) reduce no-shows
- Telehealth improves access and attendance
- Flexible scheduling improves patient engagement

PROJECT METHODS

EVALUATION

- Pre-intervention no-show rate: 20.3% (n = 61)
- Post-intervention no-show rate: 16.5% (n = 66)
- Overall reduction: 3.8%; 20% relative reduction
- Most selected incentive: Grocery gift cards (50% of redemptions)



IMPACT ON PRACTICE

CONCLUSIONS

- Incentive programs can improve appointment adherence in underserved areas
- SDOH must be addressed to improve no-show rates
- Simplified, sustainable interventions are needed for long-term success
- Further research is needed on incentive-based strategies

Acknowledgments

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Implementation of a Standardized Diabetic Foot Examination Protocol in Correctional Healthcare

Courtney Hollis, BSN, RN and Kayla Marty, BSN, RN
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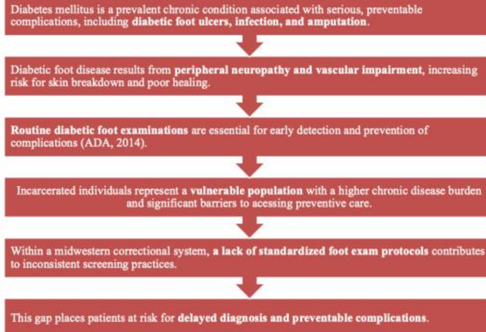
PROBLEM INTRODUCTION



LITERATURE REVIEW

- Incarcerated individuals have **higher rates of diabetes and chronic disease** than the general population (Wang, 2022; Zaitzow & Willis, 2021).
- Barriers to diabetes management include:
  - Limited preventive care access
  - Restricted diet and physical activity
  - Inconsistent care processes (Avieli & Band-Winterstein, 2024; Wang, 2022)
- The American Diabetes Association recommends **annual diabetic foot examinations** to prevent complications (ADA, 2014).
- The International Working Group on the Diabetic Foot supports **risk-based screening intervals** (Schaper et al., 2020).
- Routine foot exams enable early detection of:
  - Neuropathy
  - Vascular disease
  - Foot abnormalities (Song & Chambers, 2023)
- Evidence shows **standardized protocols and provider education** increase screening rates and improve outcomes (Praxel et al., 2011; Sylvain, 2023).
- **Limited correctional-specific research** highlights a significant gap in practice.

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PROJECT METHODS

This project used a quality improvement design to evaluate the impact of provider education and a standardized diabetic foot examination protocol on screening adherence in correctional healthcare settings.

Population: Included 23 facilities within the Midwest with 2,500 clinical staff and about 29,000 incarcerated individuals.

The project included a multifaceted approach consisting of provider education on ADA diabetic foot examination guidelines, training on proper monofilament testing technique, and instruction on conducting a comprehensive diabetic foot assessment including skin inspection, deformity evaluation, and vascular assessment.

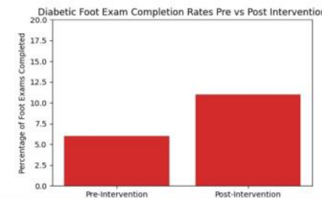
Video: How to Perform a Diabetic Foot Exam

A standardized diabetic foot examination workflow and updated clinical documentation tools were introduced to support consistent screening practices. Patient education materials were also distributed to promote daily foot care and early reporting of complications.

Pre-implementation data was collected from July to September 2025, followed by project implementation in September 2025, with post-implementation evaluation occurring from September to November 2025.

EVALUATION

- **74% relative increase** in documented diabetic foot examination completion following implementation.
- Foot exam completion improved from **6% (13/216 patients)** pre-implementation to **10% (20/191 patients)** post-implementation.
- **Provider knowledge improved** with correct responses increasing on **8 of 9 guideline-based survey questions**.
- **Provider confidence increased across all diabetic foot assessment skills**, including monofilament testing, vascular assessment, and patient education.
- Implementation of **education and standardized screening protocols** demonstrated early improvement in preventive diabetes care within correctional healthcare settings.



IMPACT ON PRACTICE

- Increased adherence to ADA diabetic foot screening guidelines
- Standardized workflow across 23 facilities
- Improved early detection of:
  - Neuropathy
  - Vascular compromise
  - Foot deformities
- Enhanced provider competency and confidence
- Strengthened preventive care infrastructure in correctional health
- Promotes health equity for a vulnerable population
- Demonstrates feasibility of system-wide QI in correctional settings

CONCLUSIONS

- Baseline diabetic foot exam rates were critically low (6%).
- Implementation resulted in:
  - 74% relative increase in exam completion
  - Significant improvement in staff knowledge
  - Substantial increase in provider confidence
- Structured education + standardized workflow = measurable clinical improvement.
- Sustained implementation and system-level support may further improve outcomes.
- DNP-led initiatives can drive meaningful preventive care improvements in correctional healthcare systems.

Limitations

- Unknown precise implementation dates
- Variable staff engagement across sites
- Short evaluation period
- Reliance on variable documentation accuracy
- Limited access to patient-level contextual data
- Dependent on external reporting for data collection

Saviorism Complex in Costa Rican & Guatemalan Global Service

Chelsea Smith, BSN, RN & Rhonda Strobel, BSN, RN
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PROBLEM INTRODUCTION

Growth of Mission Engagement
- Short-term global medical missions to Guatemala and Costa Rica continue to expand, yet structured cultural preparation remains inconsistent.

Saviorism Complex

Unexamined paternalistic attitudes may:
- Reinforce power imbalances
- Minimize local expertise
- Center volunteer narratives

Impact on Ethical & Cultural Preparedness

Without formal training:
- Emotional readiness may be limited
- Ethical boundaries may be unclear
- Sustainability efforts may be weakened

Identified Practice Gap

No standardized pre-departure training addressing:
- Cultural humility
- Ethical engagement
- Saviorism complex awareness
- Measured attitude change

LITERATURE REVIEW

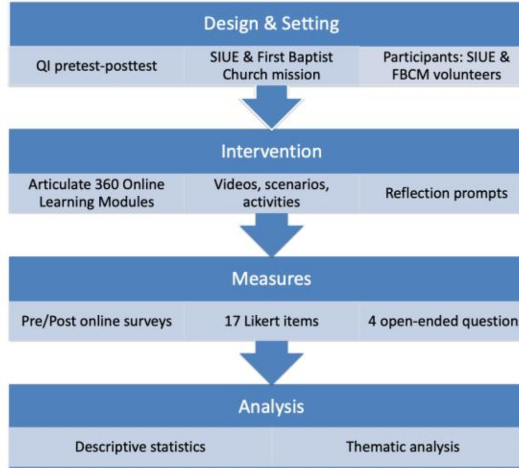
Key Findings
- White saviorism erodes cultural competence and local voice (Bandyopadhyay, 2019; Gdalman, 2020).
- Short-term, top-down projects risk dependency and clinical/ethical harm (Driese, 2022; Brodzinski-Gonzalez, 2021).
- Common problems: poor pre-departure prep, narrative commodification, unequal finances (Ulyate, 2022; Cross, 2019).
- Effective training: CFHI-style cultural humility, language prep, ongoing mentorship (Evert et al., 2019).
- Partnership models: PIH "accompaniment" and CRHP adaptations prioritize local leadership and sustainability (Rodriguez et al., 2023; Shah et al., 2022).
- SIUE recommendations: mandatory cultural humility training, formalized local governance, shared evaluation metrics (Geer, 2024).

References

Implications
- Adopt mandatory cultural humility training and formal, community-led partnerships to improve sustainability, respect, and mutual benefit.

Search Methods
- PubMed, CINAHL, Google Scholar; keywords: saviorism complex, cultural humility, ethical volunteerism, global health partnerships, short-term medical missions; inclusion: peer-reviewed, 2017–2024.

PROJECT METHODS



EVALUATION

Pre vs Post Survey Knowledge Assessment

Domain	Pre	Post
Cultural Awareness	72%	100%
Communication	56%	100%
Emotional Prep	78%	100%
Saviorism Awareness	Variable	100%

100% of participants improved across all domains

Pre-Training Themes
- Focus on helping & providing resources
- Language barriers & role uncertainty
- Superficial understanding

Post-Training Themes
- Ongoing self-reflection & lifelong learning
- Listening & local leadership
- Ethical awareness

Limitations: Small sample | Unpaired design | Self-report bias | No long-term follow-up

IMPACT ON PRACTICE

Immediate Impact
- Pre-trip orientations more focused on ethics, scope, and power.
- Volunteers using shared language (cultural humility, saviorism).
- Teams more reflective and intentional about listening to local partners.

Long-Term Impact
- Cultural humility training becomes a standard part of mission prep.
- Stronger, more trusting relationships with partners in Guatemala & Costa Rica.
- Mission teams shift from "helpers" to collaborative learners and partners.

CONCLUSIONS

What We Did
- Implemented a brief, virtual **cultural humility and saviorism** module for mission volunteers to Guatemala and Costa Rica.

What Changed
- Increased **cultural self-awareness, ethical clarity,** and **awareness of saviorism's harms**.
- Shift from "helping" mindset to **reflective, partnership-based engagement**.

What's Next
- Make training **standard** for all mission teams.
- **Refine with partner input** and add **post-trip and host-community feedback** to support long-term, ethical global practice.

Final Message
- A small, structured pre-departure training in cultural humility and saviorism can meaningfully reshape how volunteers see their role, from "helpers" to ethical partners, laying the groundwork for more respectful and sustainable global health engagement.

Effect of an Online Educational Module on Healthcare Provider and Volunteer Preparedness for Water Filter Implementation in Guatemala

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Southern Illinois University Edwardsville

PROBLEM INTRODUCTION

1. There is limited access to clean water in Guatemala.
2. Waterborne pathogens cause gastrointestinal(GI) illness.
3. GI illness can lead to health complications such as malnutrition and stunted growth.
4. Gaps between volunteer and provider knowledge decrease the effectiveness of clean-water interventions.

LITERATURE REVIEW

Water Quality
- There are links between unfiltered water and GI illness in Guatemala (Gandhi et al., 2023; Roegner et al., 2021).
- *Giardia* and *cryptosporidium* are common pathogens (Roegner et al., 2021).

Point-of-use Systems
- Point-of-use water filtration systems, including hollow-fiber and carbon-activated filters, have been shown to effectively reduce harmful bacteria and protozoa, and significantly reduce diarrheal rates in both Guatemalan and international studies (Kirby et al., 2019; Larson et al., 2017; Lindquist et al., 2014; World Health Organization, 2020).

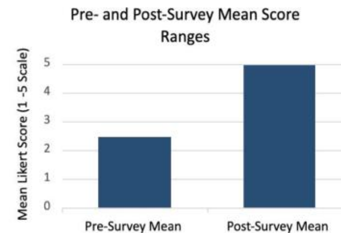
Barriers & Facilitators
- Barriers include mistrust, limited resources, poor governance (Hailemariam et al., 2019).
- Facilitators include training, funding, adaptability, and community involvement (Adams et al., 2020; Holt et al., 2022; Larson et al., 2017; Le et al., 2022).

References

PROJECT METHODS

EVALUATION

- 10 Likert-scale questions pre- and post-module, administered using Qualtrics. Assessed understanding of water quality, WASH practices, VF100 water filter use and maintenance, barriers to change, and Water4Life.
- Pre-survey knowledge means were 1.38-3.5, correlating with *strongly disagree* to *neutral*. Post-survey means were 4.88 or higher, correlating with *agree* to *strongly agree*.



IMPACT ON PRACTICE

Pre-Trip Educational Module
- Enhances preparedness.
- Strengthens collaboration with partners.
- Reduces differences in knowledge.

Project Outline/ Blueprint
- Can be used for future mission projects and health changes.
- Can be applied to global regions and health topics.
- A post-trip survey can assess the effectiveness of education on-site.

Future Studies
- Can explore clinical outcomes such as filter utilization rates, patient reported health-outcomes, reduction in waterborne disease.

LIMITATIONS

- Project implementation was set for Fall 2025; however, the trip was cancelled for unforeseen reasons.
- Trip cancellation led to limited participants (8).
- Pre- and post-survey sample size was ideally 20 or more.
- Post-trip survey originally planned to evaluate the real-world application of module education and filter implementation.

CONCLUSIONS

- A short, focused, and easily accessible educational module can be an effective teaching tool.
- It can enhance individuals' understanding of health issues in developing countries such as Guatemala.
- Improved provider and volunteer knowledge can aid in the long-term sustainability of a health change.
- Focuses include empowerment, cultural awareness, collaboration, and sustainability.

Prostate Cancer Screening for IDOC

Derek Rice, RN, BSN, DNP Student

Southern Illinois University Edwardsville

PROBLEM INTRODUCTION

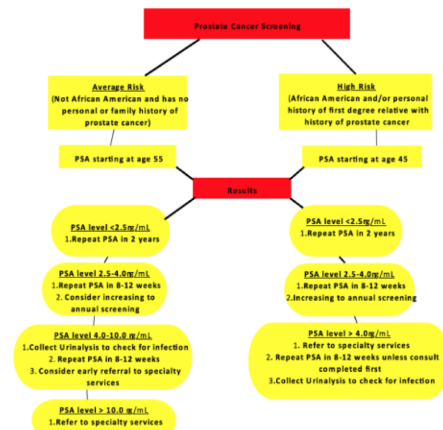
1. Cancer is the leading cause of death in United States prisons (Journal of Clinical Oncology, 2024)
2. Incarcerated individuals = Higher Risk
3. Federal lawsuit mandated overhaul of IDOC medical system including specific cancer screenings (prostate)

LITERATURE REVIEW

- There is no clearly defined national standard of care for prostate cancer screening
- IDOC mandated to follow the United States Preventative Services Task Force (USPSTF) guidelines
- USPSTF, (2018) guidelines recommend men ages 55-69 years old be allowed to make an informed decision on screening process
- Prostate specific antigen (PSA) is the most widely used test for prostate cancer screening (Jain et al., 2023)
- Prostate cancer screening that involves the sole use of PSA levels was associated with fewer prostate cancer-specific deaths and an overall reduction in metastatic disease in randomized trials (Jain et al., 2023)
- Digital Rectal Exams (DRE's) are no longer recommended for prostate cancer screening as a stand-alone test or in conjunction with PSA's as they do not improve the detection of cancer. (Kirby et al., 2024)
- According to last court monitor report , Raba (2024) IDOC is still not meeting mandated standards for prostate cancer screening and outdated screening tests such as a DRE over PSA are still the standard screening method.

PROJECT METHODS

- Modified Likert scale questionnaire surveys (KAP)
- Educational presentation to providers on site
- Evidence-based prostate screening algorithm introduced for providers
- Tally sheet to collect non identifiable numerical value of PSAs' ordered by providers with algorithm tool



EVALUATION

- Pre-Surveys: 1
- Post-Survers: 1
- Post-survey score was higher
- Facility had 53 total serum PSA tests ordered in 2 years.
- 3-month intervention with algorithm resulted in 15 tests ordered during this time.
- = Estimated increased rate of 60 tests annually to be completed

Limitations

- Limited provider accessibility
- Changing of health care vendor mid project
- Electronic restrictions at facility (prisons)
- Policy dictates practice currently

IMPACT ON PRACTICE

- Help IDOC set a standard for evidence-based prostate cancer screening
- Increase prostate cancer screening efforts in vulnerable populations
- Reduce delayed diagnosis, improved patient outcomes
- Discontinuation of DRE as standard screening method

CONCLUSIONS

- Utilization of evidence-based screening algorithms potentially can increase cancer screenings for incarcerated individuals
- More studies with larger base of providers needed to evaluate overall benefit
- Review of current screening methods needed agency wide

Implementation of Validated Mental Health Screenings in a Rural Primary Care Clinic in Guatemala

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PROBLEM INTRODUCTION

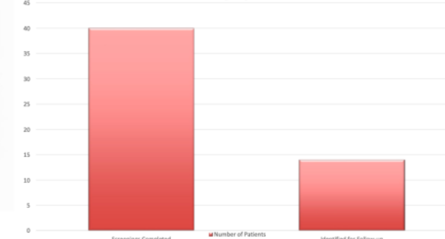
- Anxiety and depression are leading causes of disability worldwide (WHO, 2023)
  - >75% of individuals in LMICs receive no treatment (WHO, 2023)
  - Guatemala allocates <1% of health budget to mental health (Baker-Henningham et al., 2022)
  - Severe shortage of mental health providers limits access (Bruckner et al., 2011)
  - Providers lack standardized tools to identify mental health conditions
  - Missed diagnoses → delayed care → worsening outcomes

LITERATURE REVIEW

- Validated tools (PHQ-9, GAD-7) improve detection of depression/anxiety (Ali et al., 2016)
- Early screening improves outcomes and reduces disease burden (Rosenberg et al., 2020)
- Cultural adaptation improves accuracy in LMIC populations (Manea et al., 2015)
- Verbal administration supports low-literacy populations (Ali et al., 2016)
- Provider education increases confidence and screening utilization (Lund et al., 2020)
- Integration into primary care supports task-shifting models (Patel et al., 2018)

PROJECT METHODS

- A quasi-experimental pre- and post-test design was used during a fourteen-day global health initiative.
- A telehealth-based educational session was delivered to volunteer providers prior to clinic implementation. Training included bilingual instruction on administering and interpreting the PHQ-9 and GAD-7, with an emphasis on verbal proctoring for patients with low literacy. Providers implemented screenings over four clinic days, using interpreters and bilingual team members to ensure cultural and linguistic accessibility.
- Provider-level data were collected anonymously via Qualtrics before and after the intervention.



EVALUATION

- Pre/post surveys assessed knowledge, confidence, readiness
- MAKS + ARCC-informed tools used
- Screening utilization tracked during clinic
- 40 screenings completed over 4 days
- 14 patients identified for mental health support
- Increased provider confidence in screening use
- Improved knowledge of screening tools
- Increased readiness to implement evidence-based practice

IMPACT ON PRACTICE

- Standardized screening is feasible in low-resource primary care
- Improved identification of previously unrecognized mental health needs
- Supports early intervention and referral
- Enables non-specialists to participate in mental health care
- Verbal screening overcomes literacy barriers
- Model is scalable to similar LMIC and rural settings

CONCLUSIONS

- Successfully implemented validated mental health screening in a rural LMIC clinic
  - Demonstrated improved provider knowledge, confidence, and practice readiness
  - Identified patients who would otherwise have gone untreated
  - Confirmed the feasibility of integrating screening into short-term clinic workflows
  - Reinforced the importance of culturally adapted and accessible tools
- Expand implementation across additional clinics and regions
  - Increase sample size and duration
  - Strengthen long-term follow-up and referral pathways
  - Continue provider education and support
  - Evaluate sustained impact on patient outcomes

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Establishing Effective Mentor-Mentee Relationships in the DNP Mentorship Program

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PROBLEM INTRODUCTION

Transition from DNP education to advanced practice can be stressful and challenging for Family Nurse Practitioner (FNP) students. While mentorship is widely recommended, many graduate nursing programs lack a structured, formalized mentorship model.

This project implemented and evaluated a structured mentorship program within a DNP-FNP program at a mid-sized university in Southern Illinois to enhance student preparedness, professional identity formation, and leadership development.

LITERATURE REVIEW

National nursing organizations, including the American Nurses Association, American Association of Nurse Practitioners, National Organization of Nurse Practitioner Faculties, and American Association of Colleges of Nursing, identify mentorship as essential for:

- Improving readiness for advanced practice
- Enhancing clinical reasoning and confidence
- Reducing transition-related stress
- Increasing job satisfaction and retention
- Supporting leadership and lifelong learning

Common best practices include:

- Structured goal setting
- Scheduled mentor–mentee communication
- Use of mentoring toolkits
- Ongoing program evaluation

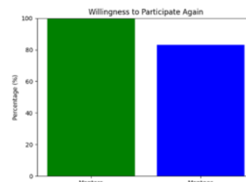
Evidence strongly supports integrating structured mentorship into graduate NP education.

PROJECT METHODS

Design: Quality improvement project
Setting: DNP-FNP program, Fall 2025
Participants: 28 total (students and alumni NP mentors)
Intervention Components:

- Mentor–mentee pairing using the DNP/FNP Mentorship Matchmaker Tool
- Matching criteria:
  - Personality type
  - Specialty interest
  - Demographics
  - Geographic location
  - Structural Timeline
- Week 1: Match notification + AACN Mentorship Toolkit
- Weeks 4 & 8: Guided communication prompts, professional development resources, AACN webinar suggestions
- Week 12: Closing guidance + Qualtrics satisfaction survey

EVALUATION



Response Rate

- 5 mentors (35.7%)
- 6 mentees (42.9%)
- Overall: 39.3%

Mentors (n=5) :

- 100% reported clarity and strong support
- 80% satisfied with match
- 100% willing to mentor again

Mentees (n=6) :

- 100% reported clear expectations
- 83% felt well matched
- 66.7% met learning goals
- Reported increased confidence and reduced stress

Primary barrier: inconsistent communication due to competing schedules.

IMPACT ON PRACTICE

This structured mentorship model:

- Improved perceived readiness for advanced practice
- Supported professional identity formation
- Reduced student stress
- Strengthened mentor leadership and teaching skills
- Fostered professional connectedness

The intervention is:

- Low cost
- Scalable
- Sustainable within DNP programs

LESSONS LEARNED

- Structured communication improves engagement
- Clear expectations enhance satisfaction
- Communication frequency must be explicitly defined
- Baseline and longitudinal measures are needed
- Larger sample sizes would strengthen outcome data

LIMITATIONS

- Small sample size
- Low response rate
- Single implementation cycle
- Self-reported data
- No baseline confidence measure
- No long-term outcome tracking

CONCLUSIONS

A structured mentorship program is a feasible and valuable addition to DNP-FNP education.

Findings demonstrate positive influence on:

- Professional development
- Leadership engagement
- Perceived readiness for advanced practice
- Overall program satisfaction

Enhancing Fall Risk Screening and Education: A Quality Improvement Initiative for At-Risk Populations

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PROBLEM INTRODUCTION

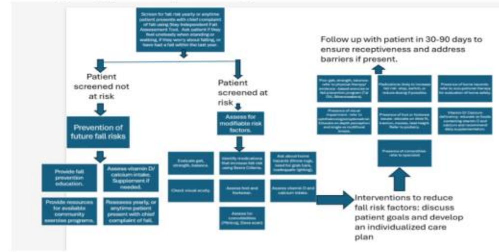
- Falls are a significant cause of mortality and morbidity in adults aged 65 years and older and a common chief complaint in emergency departments (Davenport et al., 2020).
- Typical education provided to patients at primary care appointments includes removing trip hazards, adding grab bars and handrails, and ensuring adequate home lighting to prevent falls. Although this type of education is commonly shared with patients who are at risk, statistics show that deaths and serious injuries related to falls are worsening (Healthy People 2030, n.d.).
- Fall prevention recognition and education is a helpful instrument that is inexpensive, involves little activity, and prevents harm to the patients involved (Ong et al., 2021). It is of high importance that the patient's knowledge deficit be identified during the screening of the fall risk process so that a more individualized and appropriate learning method can be portrayed to enhance a positive health outcome (Ong et al., 2021).

LITERATURE REVIEW

- Maintaining the safety of patients is a core value of advanced practice (Mark, 2024).
- A higher incidence of comorbidities leads this higher fall-risk population to an increased frequency of visits with their healthcare providers.
- Creating and adapting a fall treatment algorithm in practice can be beneficial in guiding advanced practice providers when forming a patient-specific fall prevention plan in the office with notable current time constraints.
- Routine use of this algorithm when completing fall risk assessments at each visit will benefit clinicians and patients as the use can help prevent future significant morbidity and mortality due to falls.

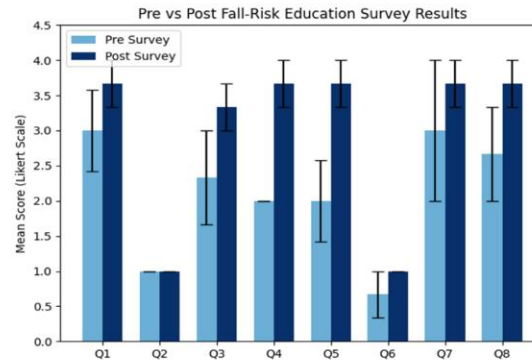
PROJECT METHODS

The project assessed providers' knowledge, attitudes, and practices related to identifying, and managing patients at high risk for falls. Providers first completed an anonymous eight-question pre-survey. They then received education on fall-risk screening, prevention strategies, and use of the CDC's validated Stay Independent tool and treatment algorithm. During implementation (late June- early September 2025), providers screened eligible patients and recorded de-identified data on screening use and high-risk interventions. After implementation, the same survey was emailed as a post-survey. Changes in provider knowledge and comfort levels were evaluated by comparing pre- and post-survey results.



EVALUATION

Comparison of Pre- and Post- Survey Average Scores- Fall Risk Knowledge and Competence



IMPACT ON PRACTICE

Spearman's correlation showed a strong positive relationship between pre- and post-intervention scores ($\rho = 0.707$), but it wasn't statistically significant ($p = 0.116$), likely due to the very small sample size ($n = 6$). Despite this, descriptive data show clear practical improvements, indicating the intervention boosted staff preparedness for managing fall-risk patients.

KEY RECCOMENDATIONS:

- **Increase sample size** to improve statistical power.
- **Use follow-up surveys** to measure long-term retention.
- **Target weak areas**, such as defining fall risk assessments.
- **Reinforce tools in practice** through ongoing training and competencies.

CONCLUSIONS

This project aimed to improve provider knowledge in identifying and managing high-fall-risk patients. All survey items showed improvement, and providers reported greater confidence and consistent use of the fall-risk algorithm during patient care.

The algorithm is expected to have lasting impact as it becomes part of routine workflow, strengthening patient safety. Because the facility is part of a larger system, the protocol can be scaled to other sites for broader standardization.

Next steps include formalizing the protocol, integrating it into the electronic health record, and offering ongoing training to ensure consistent, long-term use.

References

Increasing Access to Medication-Assisted Treatment at a Rural Health Clinic: Implementation of a Standardized Substance Use Screening Tool

Daniel Murphy, BS, BSN, RN, PMHNP Doctoral Candidate

PROBLEM INTRODUCTION

- Over 60% of rural county residents reside in an opioid treatment shortage area yet experience twice the rate of hospitalizations for opioid overdoses compared to urban areas (Cole et al., 2019).
- Barriers to accessing medication-assisted treatment (MAT) in rural communities include stigmas, inadequate provider education, and geographic distance to care.
- The shortage of MAT educated providers in rural communities leads to delayed treatment initiation and lower overall MAT utilization.
- The only substance use screening currently completed at the rural health clinic (RHC) is for tobacco and alcohol use.

LITERATURE REVIEW

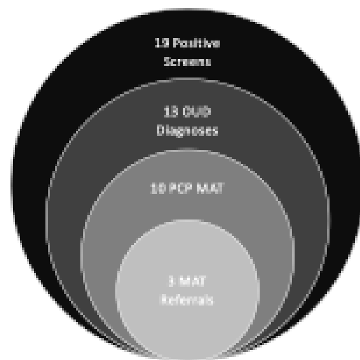
- MAT is a "whole-patient" approach for opioid use disorder (OUD) that combines FDA-approved medications and behavioral therapy.
- PCPs can act as an access point in rural communities by identifying and treating OUD.
- Implementing PCP-provided MAT increases MAT utilization and treatment retention, as well as decreases overall opiate use, opiate-related overdoses, intravenously contracted diseases, and utilization of emergency services (Boudreau et al., 2020; Incze et al., 2023).
- Evidence-based substance use screening is the first step to increasing access to MAT.
- The National Institute on Drug Abuse (NIDA) recommends the Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) screening tool for the primary care setting (2023).

PROJECT METHODS

- A pre–post evaluation design was employed to assess the impact of an educational intervention on clinic staff knowledge, attitudes, and beliefs regarding MAT.
- Descriptive statistics were calculated, and comparative analyses were conducted to assess shifts in response distributions following MAT education.
- Implemented an evidence-based substance use screening tool in the RHC, the TAPS assessment, from October 2025 to December 2025.
- De-identified data were compiled and analyzed to obtain objective clinical metrics.

EVALUATION

- Analysis of the five knowledge-based survey items demonstrated substantial improvement in self-reported staff knowledge following the intervention.
- Findings from the five attitude and belief survey items also reflected meaningful shifts, suggesting a reduction in stigma and misconceptions related to addiction and MAT.
- 539 patients completed the TAPS assessment.
- 19 patients (3.5%) screened positive for opioid misuse, exceeding the national average of 2.7%.



IMPACT ON PRACTICE

- The implementation of the TAPS tool facilitated earlier identification of patients with OUD and improved integration of MAT into routine primary care services.
- The predicted long-term impact includes sustained increases in MAT utilization and treatment retention, and reduced opioid-related morbidity and mortality.
- Expanding MAT within the primary care setting is expected to enhance accessibility, reduce treatment delays, and promote continuity of care.

CONCLUSIONS

- Targeted staff education combined with implementation of a standardized substance use screening tool improves both provider readiness and clinical identification of OUD within an RHC.
- Integrating MAT into primary care settings is a feasible and effective strategy for addressing treatment gaps in rural communities.
- Future efforts should focus on expanding MAT services across additional clinical sites, increasing sample sizes to strengthen generalizability and further assess long-term outcomes.
- Continued emphasis on education, screening, and integrated care models will be essential in addressing the ongoing opioid crisis and improving outcomes for individuals with OUD.

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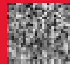
References



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