

# Improving Depression Screening in Primary Care

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## PROBLEM INTRODUCTION

- Major depressive disorder (MDD) is a common mental health concern affecting approximately 21 million adults in the United States with only 66% seeking treatment (NIMH, 2022).
- US Preventive Services Task Force (USPSTF) recommends (GRADE B) routine depression screening for adults 18 years of age and older (USPSTF, 2023).
- A primary care practice was identified to have no routine depression screening protocol in place despite feedback revealing that patients with depressive concerns were frequently encountered.
- Without proper depression screening, the effects of untreated depression can negatively impact patients' mental and physical health.

## LITERATURE REVIEW

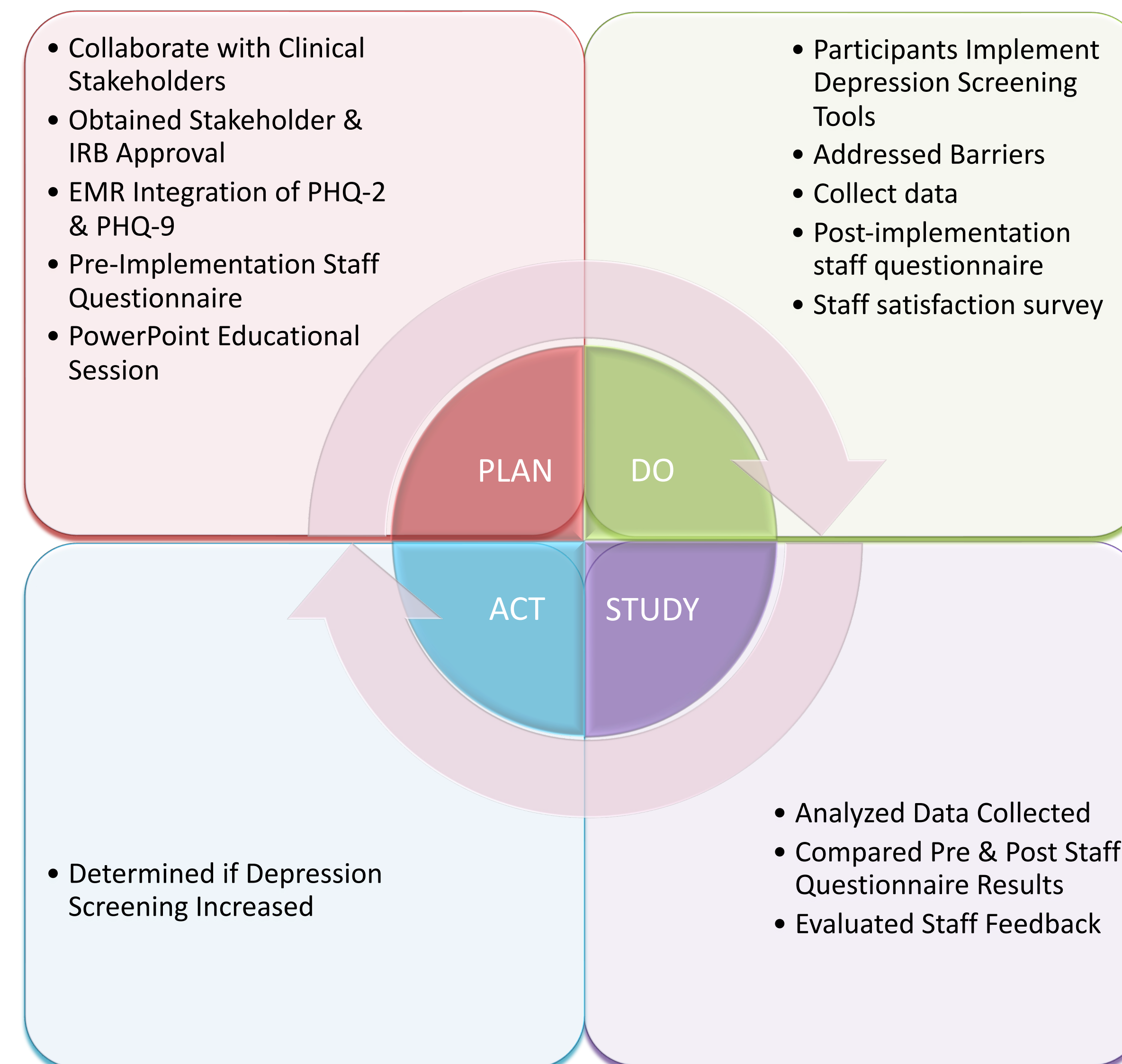
An estimate of only 50% of primary care providers reported using a depression screening tool (Owens-Gary et al., 2019; Siniscalchi et al., 2020).

Patient Health Questionnaire (PHQ)-2 and PHQ-9 are based on the DSM-5 criteria and are commonly used in primary care settings to screen for depression (APA, 2020; Siniscalchi et al., 2020).

Implementing routine depression screening resulted in 17.3% of 25,000 adult patients screening positive for depression using the PHQ-2, with 56.1% diagnosed MDD after further evaluation using the PHQ-9 (Jha et al., 2019).

Implementing depression screening tools may increase early identification to enhance the management of depressive symptoms leading to improved patient outcomes (Jha et al., 2019; Owens-Gary et al., 2019).

## PROJECT METHODS



## IMPACT ON PRACTICE

- EMR Integration of PHQ-2 & PHQ-9
- Standardized Use of Depression Screening Tools
- Identification of Depressive Concerns (n = 10%)
- Overall Improvement of Depression Screening

## CONCLUSIONS

- Results showed depression screening improved from 0% to 43% with 10% scoring positive.
- Depressive concerns were identified in 42% of PHQ-2-positive patients.
- Overall improvement in personnel comfort, knowledge, and frequency of screening.
- Use of depression screening tools was considered valuable to assess for depressive concerns.

## EVALUATION

### PHQ-2

- A total of 433 patients were seen in practice during the 4-week implementation phase
- 187 (43%) patients were screened using the PHQ-2
- 19 (10%) patients had a positive score of >2

### PHQ-9

- All PHQ-2-positive patients were further screened using the PHQ-9
- 8 (42%) patients had a score >4 score on the PHQ-9

### Staff Pre vs Post Questionnaire

- Feedback from personnel showed an improvement in:
  - Depression screening tool use
  - Comfort in asking depression-related questions
  - Knowledge interpreting PHQ-2 & PHQ-9 results

### Staff Post Satisfaction Survey

- Feedback from the personnel was unified:
  - Depression screening tools were considered a valuable aspect of assessing depressive concerns
  - A common concern was time constraints related to personnel shortages
  - No changes were recommended

TABLE 1. Depression Screening Results

|       | Total<br>(n = 433) | Positive Score | Gender            |                     |
|-------|--------------------|----------------|-------------------|---------------------|
|       |                    |                | Male<br>(n = 224) | Female<br>(n = 209) |
| PHQ-2 | 187 (43.18%)       | 19 (10.16%)    | 100 (53.47%)      | 87 (46.52%)         |
| PHQ-9 | 19 (4.39%)         | 8 (42.10%)     | 11 (57.89%)       | 8 (42.10%)          |

## Staff Pre & Post Questionnaire

Table 2. Staff Pre & Post Questionnaire

|  | Pre,<br>median<br>(min, max) | Post,<br>median<br>(min, max) |
|--|------------------------------|-------------------------------|
| 1. I use a standardized depression screening tool to identify depression concerns in adult patients of the practice. <sup>a</sup>                    | 1 (1, 1)                     | 4 (4, 4)                      |
| 2. I encounter patients with depressive concerns in practice. <sup>a</sup>   | 4 (4, 4)                     | 4 (4, 4)                      |
| 3. I feel comfortable asking adult patients of the practice depression-related questions. <sup>b</sup>   | 4 (3, 5)                     | 5 (5, 5)                      |
| 4. It is beneficial to utilize depression screening tools with primary care patients to improve the early identification of depression. <sup>b</sup> | 5 (5, 5)                     | 5 (5, 5)                      |
| 5. I have the knowledge and skills needed to interpret results of the PHQ-2 and PHQ-9 screening tools. <sup>b</sup>                                  | 5 (3, 5)                     | 5 (5, 5)                      |

### Response scale:

a 1 = Never 2 = Occasionally 3 = Sometimes 4 = Frequently 5 = Always

b 1 = Strongly Disagree 2 = Disagree 3 = Neither 4 = Agree 5 = Strongly Agree



# Evaluating Nurse Comfort Levels Assessing for Depression in an Urban Hospital Setting

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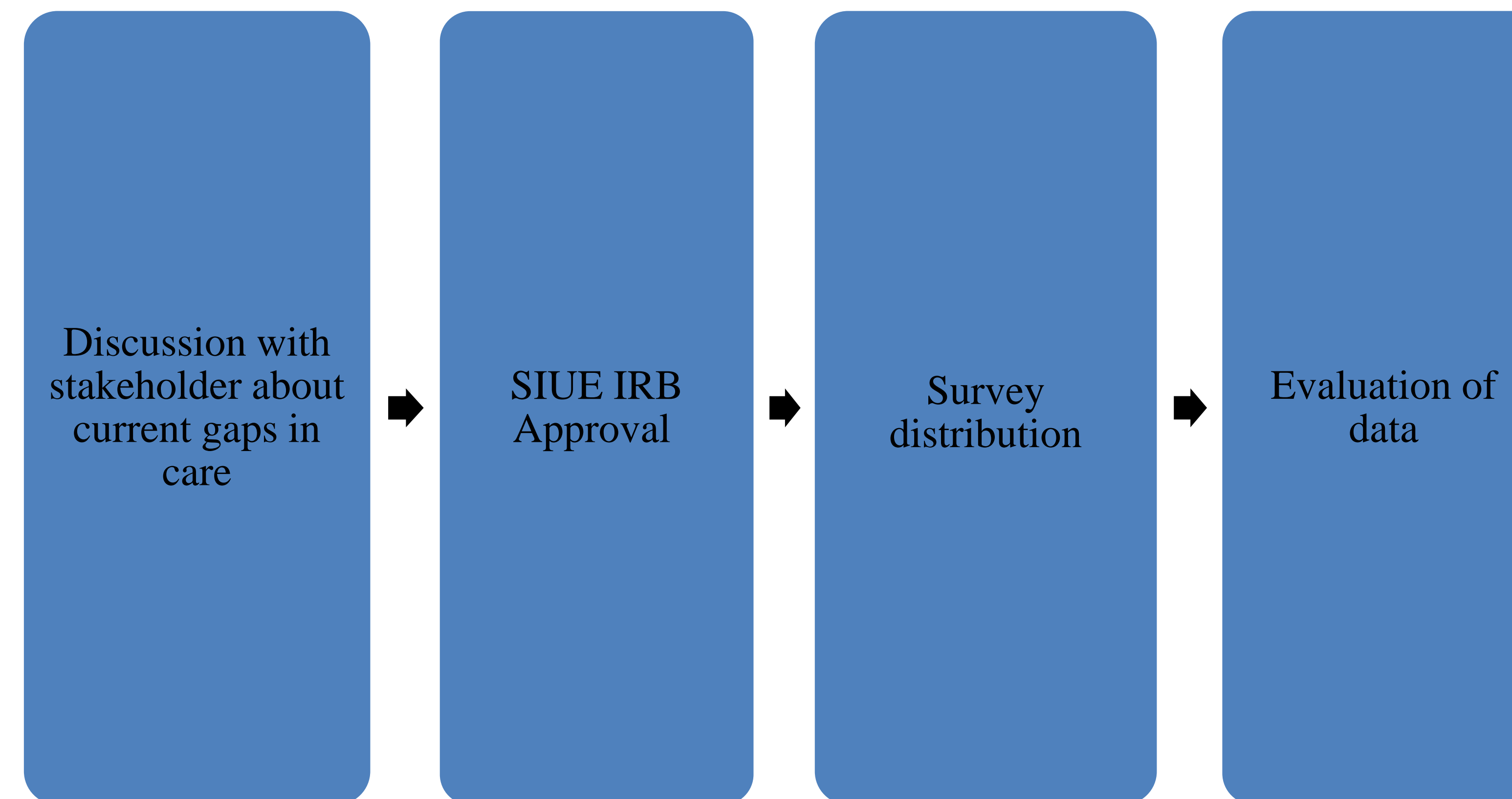
## PROBLEM INTRODUCTION

- Approximately 300 million people worldwide suffer from depression (World Health Organization, 2017).
- Depression is one of the most common mental disorders and can cause tremendous challenges for individuals and families. It also carries a large economic cost. The economic burden of major depressive disorder among U.S. adults was an estimated \$236 billion in 2018, an increase of more than 35% since 2010 (year 2020 values), according to research published in early May in the journal *Pharmacoeconomics*.
- Blackstone et al. (2022) reported that 3% of adults in a medical practice were not screened for depression despite not having a diagnosis of depression.
- According to the stakeholder, at an urban hospital in Missouri, nurse comfort levels need to be evaluated to detect discrepancies in screening for and recognizing depression in patients.
- The stakeholder is concerned about lack of screening and awareness of depression in patients on this medical unit.

## LITERATURE REVIEW

- Upon delivery of the depression attitude questionnaire (R-DAQ) Camacho-Leon et al., reported that 70% of the healthcare professionals surveyed believe that psychological illness is more uncomfortable to assess than physical illness.
- Ohtsuki et al. (2012) surveyed 367 physicians and discovered that all of the non-psychiatric physicians (n=187) believed that depression care is beyond their scope of practice and are uncomfortable addressing needs of depressed patients.
- Mulvaney-Day et al. (2017) reported that rates of screening in physician practices for mental health conditions, such as depression, are low. Administering surveys to clinicians can lead to increased awareness about the importance of evaluating patients for depression.

## PROJECT METHODS



## EVALUATION

Seventy-three participants completed the survey.

42% agreed and 29% strongly agreed that they feel comfortable in asking a patient and/or patients about their mental health.

10% disagreed and 3% strongly disagreed with feeling comfortable in asking a patient and/or patients about their mental health.

62% agreed and 18% strongly agreed that they feel confident in identifying non-verbal cues for a patient and/or patients who are depressed.

30% of the participants reported sometimes asking about mood and 21% rarely asking about mood.

Only 47% of the participants knew what depression screening tools were available for assessment.

## IMPACT ON PRACTICE

- Implementing EBP Surveys surrounding the assessment of nurse comfort levels provides awareness of depression screening.
- These surveys enhance the importance of being comfortable and/or confident upon assessing patients for depression.
- Amplified prevalence of these surveys could trigger an increase in healthcare institutions providing more educational interventions that could improve comfortability among nurses assessing patients for depression.

## Limitations

- Survey was limited to internet users and to participants who accessed their email during the evaluation window.
- An intervention was not developed for this project due to a stakeholder change before implementation and time constraints.

## CONCLUSIONS

- Upon discussion of the survey results with the stakeholder, it was determined there are still gaps that exist in assessing patients for depression.
- More measurable data would likely be gained with implementation of an education/intervention to analyze an increase or decrease in comfort levels among nurses evaluating patients for depression.



# Blanket Forts and Psych Reports: Weighted Blankets Implementation Inpatient Psychiatry

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## PROBLEM INTRODUCTION

- ❑ Patients frequently complained their PRN medication for sleep and anxiety was insufficient. Nurses in this thirteen-bed acute inpatient psychiatric unit had few options for patients.
- ❑ Patients consistently voiced concern about their discharge medication for anxiety and sleep despite developing coping skills such as meditation and breathing exercises.
- ❑ Weighted blankets offer another tool to patients. Lying down under a blanket is as simple as it sounds.

## LITERATURE REVIEW

- ❑ Weighted blankets improve the patient's perceived mood and distress levels (Dickson, 2012; Ekholm et al., 2020).
- ❑ The use of weighted blankets improves patients' sleep experience and improves daytime symptoms of sleep deprivation (Ekholm et al., 2020; Hjort Telhede et al., 2020).
- ❑ The use of weighted blankets does not significantly alter patients' health status, with no significant change in blood pressure, blood serum levels of oxygen or carbon dioxide (Bolic Baric et al., 2021; Ekholm et al., 2020; Hjort Telhede et al., 2021).

## PROJECT METHODS

- ❑ Development of a proposal to integrate weighted blankets and weighted lap pads into patient care items.
- ❑ Educating staff and implementing the use of weighted blankets and lap pads.
- ❑ A series of anonymous surveys using the Likert Scale were conducted to understand how staff perceived patient benefit, safety, impact on milieu, and feasibility.

## EVALUATION

- ❑ Across the six-week study, staff reported ten potential safety issues, with no immediate threats posed to anyone; example blankets being given to others and blankets left unattended in communal areas.
- ❑ 65% of nurses agreed or strongly agreed that weighted modalities positively impacted the milieu.
- ❑ The final survey showed that 75% of nurses agreed or strongly agreed that weighted modalities were safe for patients and staff, with less than 10% disagreeing or strongly disagreeing.

## LIMITATIONS

- ❑ Limited by the subjectiveness of the outcomes. No patient feedback or data is a limiting factor as well.
- ❑ Due to the short duration of the study and the small sample size of nurses, it is possible that unique phenomena failed to occur.
- ❑ The study was conducted at a recently renovated ligature resistant unit, with cameras in the patient room and common areas.

## CONCLUSIONS

- ❑ Nurses see the benefit of using weighted blankets and lap pads.
- ❑ Offering weighted blankets increases nurses' workload, but staff agreed that it is manageable to continue use of them.
- ❑ Weighted blankets can be safely used in inpatient psychiatric units.

## IMPACT ON PRACTICE

- ❑ The facility will continue to offer weighted blankets to help patients. Other units are investigating the use of weighted blankets.
- ❑ Staff have a new awareness to reinforce education about non-pharmacological sleep management practices and coping skills.



# Implementing the Edinburgh Postnatal Depression Scale in Emergency Department and Family Care Settings

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## PROBLEM INTRODUCTION

Postpartum Depression (PPD) is a prevalent issue and affects the lives of 10-20% of new mothers each year and often goes largely unnoticed.

- Mood disorder or depression following the birth of a baby
- Suicide is the leading cause of death among new mothers

Postpartum Psychosis (PPP) is much less common and is related to untreated postpartum depression and the results of this disorder can be catastrophic.

- Severe mental illness and is a medical emergency
- Affects .1-.2% of new mothers
- 5% of these commit suicide, and 4% commit infanticide

There are a lack of comprehensive screening processes to fully identify at risk patients.

- Only OB and Pediatrics screen for these disorders. Currently, Emergency departments and Family Care clinics, although caring for patients in the postpartum time frame, do not screen for PPD/PPP.

Symptoms of these disorders wax and wane and OB/Pediatric visits might be infrequent, limiting the opportunity for screening to a very narrow window.

- The purpose of this project is to increase the sites of screening to the ED and Family Care Clinic settings to increase identification of at-risk patients.

## PROJECT METHODS



The design of this project included implementing the EPDS & EMR changes within a family care clinic and emergency department of a mid-size level 3 rural hospital system in east central Illinois.



Meeting with stakeholders to identify problem and propose project.  
Meeting with host hospital's IRB board to propose solution to problem identified. Granted approval April 2023.



Edinburgh Postnatal Depression Scale (EPDS) was implemented in the clinic and ED for all postnatal patients having given birth or been pregnant within the prior year.



Formulation/Creation of instructional pathways for both the ED and the clinic settings (see bottom right graphics).



Meeting with providers and staff at both facilities to provide education on disorders and instruction on how/when to use tool.

## IMPACT ON PRACTICE

Positively affects the amount of at-risk patients identified.

Allows interventions to be given if a patient is identified as having a post-partum disorder.



Interventions can prevent negative outcomes.

Helps spread awareness of this disorder through staff and patient education.

## CONCLUSIONS



Screening for PPD/PPP in the ED and Family Care settings can increase recognition of at-risk patients and allows for early interventions, which can mitigate negative outcomes.



The EPDS is an effective screening tool and means of increasing identification of patients who are at risk for these disorders.



Staff confirmed the importance of screening for PPD/PPP but acknowledge the time constraints in the ED setting as a limitation.

## LITERATURE REVIEW



## EVALUATION

### ED RESULTS

- 30 ED patients met post-partum criteria, ranging in age from 18-34. 10 of these patients were given the EPDS screener to complete.
- 20% (n=2) of ED patients who completed screener had positive scores, indicating PPD.
- 10% (n=1) of ED patients with who completed screener received medication, counseling, and hospitalization interventions (patient had suicidal ideations, necessitating all three interventions).
- All ten patients who completed the screener received education on PPD/PPP, which included monitoring signs and symptoms and emergency contact information.

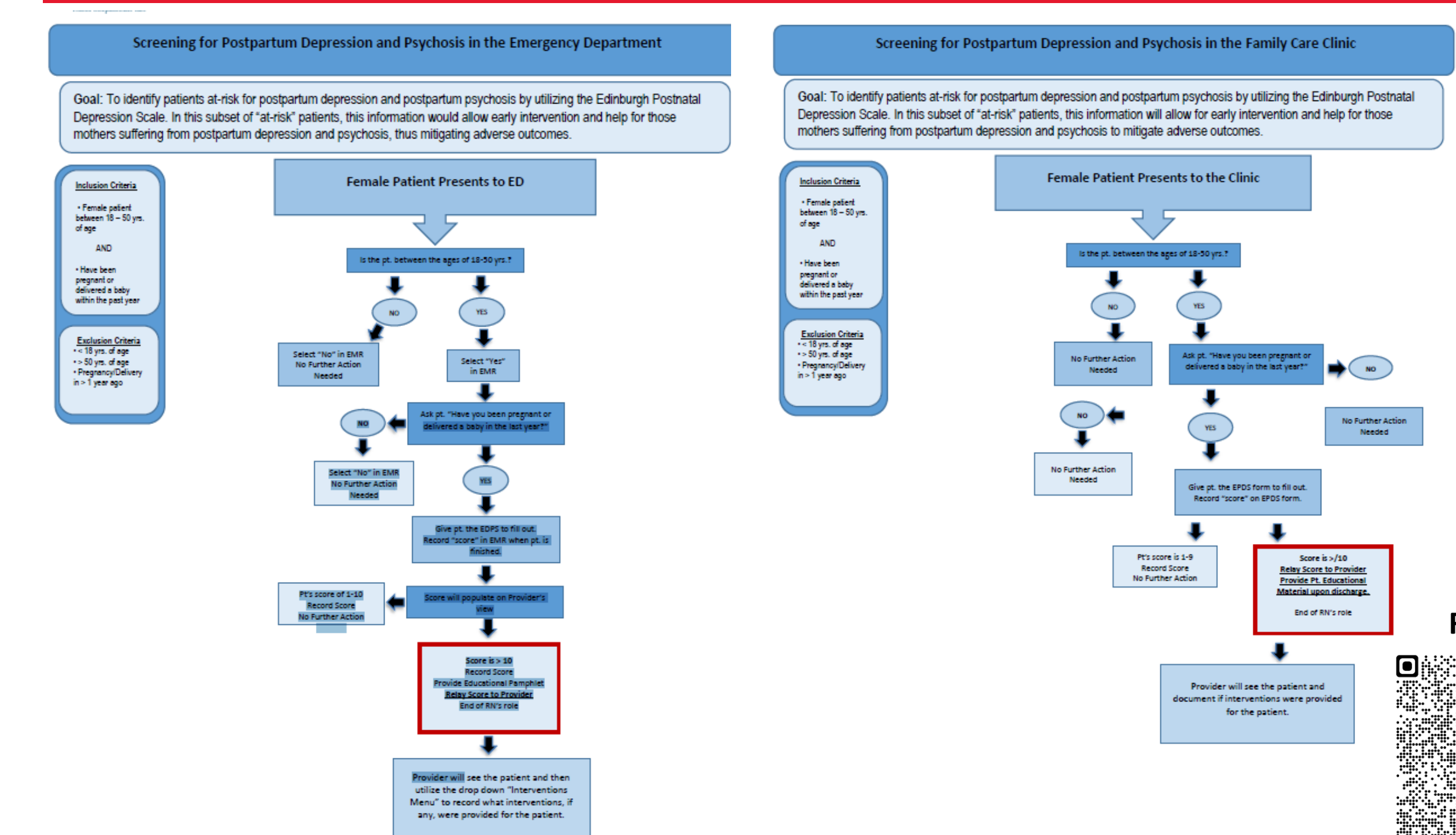
### FAMILY CARE CLINIC RESULTS

- Two Patients qualified for the screening and completed the EPDS form.
- 50% (n=1) clinic patient had a positive score.
- Patient with a positive score was diagnosed with post-partum anxiety.
- Patient received interventions of medication and education.
- At her 1-month follow-up, the patient reports an improvement in symptoms.

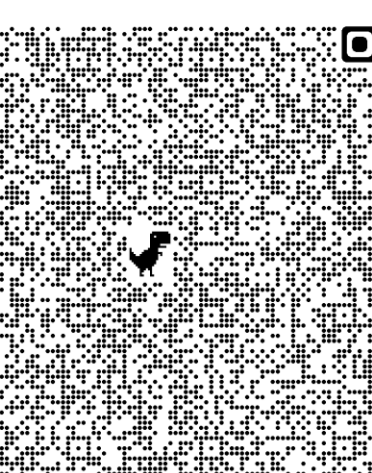
### SURVEY RESULTS

- 16 responses from the ED and 3 responses from the family care clinic
- 67% of the ED and 100% of the clinic felt that screenings in these settings were important.
- 87.5% of the ED and 100% of the FC clinic felt that screening for these conditions positively impacts patient care/outcomes.
- Self-professed knowledge about these two conditions was only "fair" at 56.25% for the ED and "strong" at 100% for the FC clinic.

## PATHWAYS



### REFERENCES





# Improving Lung Cancer Screening in a Primary Care Clinic

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## PROBLEM INTRODUCTION

Lung cancer is a leading cause of cancer mortality in U.S. (American Lung Association, 2022a).

Working conditions in coal mines lead to an increased risk of lung cancer (Jenkins et al., 2013).

Current screening guidelines focus on cigarette smoking as main cause of lung cancer (American Lung Association, 2023).

Recommended lung cancer screenings are not routinely done in primary care clinics.

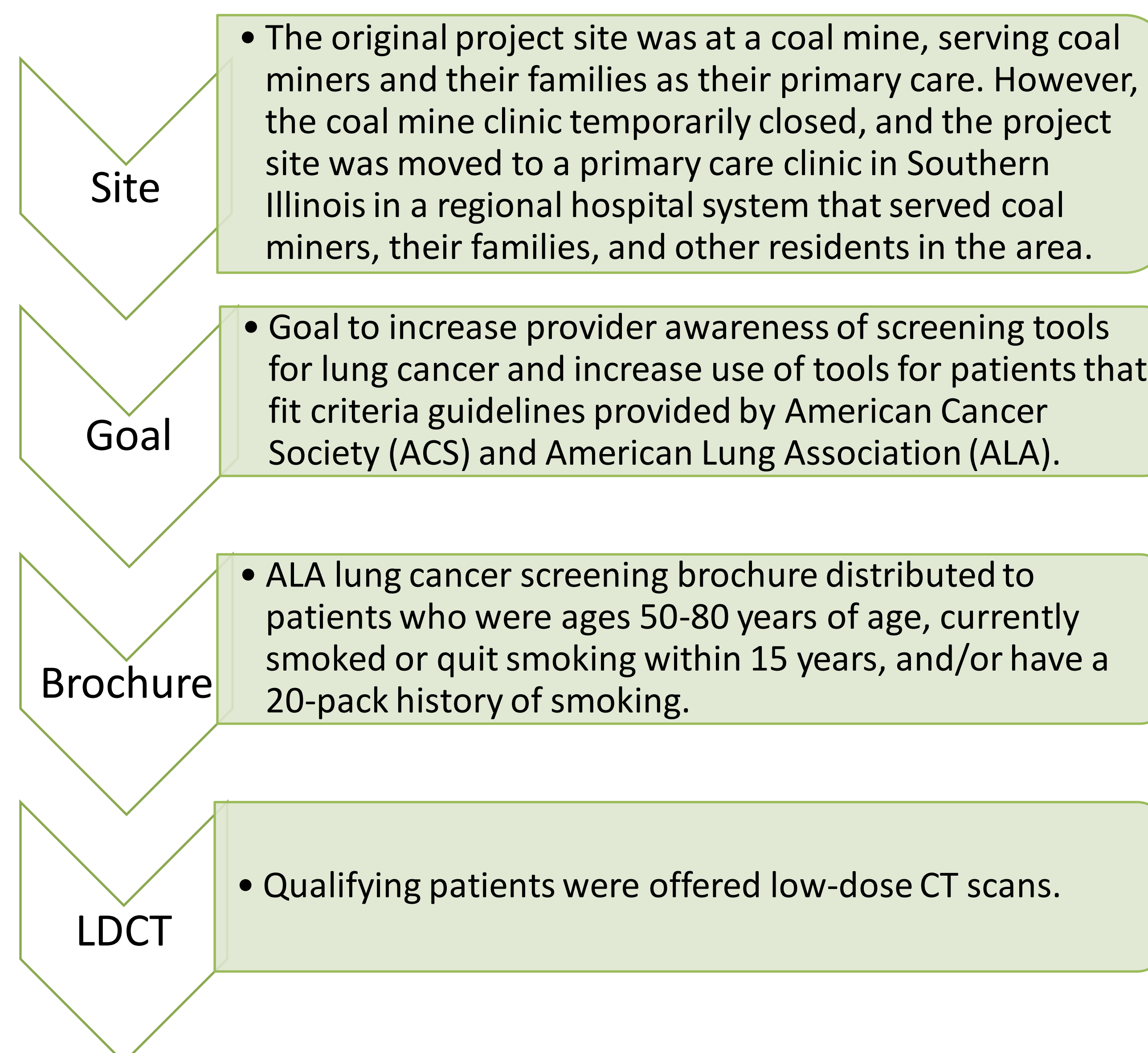
A primary care clinic at a coal mine in southern Illinois did not have a method in place to screen and evaluate patients at risk for lung cancer.

## LITERATURE REVIEW

\*Coal miners of 15+ years have higher lung cancer rates. (Jenkins et al, 2013).

- Bituminous coal found in Illinois leads to higher rates of cancer (Barone-Adesi, 2012; American Geosciences Institute, 2021).
- The American Cancer Society recommends low-dose CT scans for patients aged 50-80 years who currently smoke or have quit in the last 15 years and have a 20-pack-year history (2023b).
- Low-dose CT scans are linked to a 20% reduction in lung cancer deaths vs. chest x-rays, but only 6% of patients receive CT scans despite indications (Cui et al, 2015; Doubeni et al., 2020).

## PROJECT METHODS



## EVALUATION

|  |                                 |                             |
|--|---------------------------------|-----------------------------|
| Number of patients seen in clinic each day | Age of each patient seen        | If patient was a coal miner |
| Smoking status                             | Smoking history                 | Duration of smoking history |
| Patient eligibility for LDCT screening     | LDCT scan results if applicable | Reason for LDCT refusal     |

- 20 patients were screened.
- 6 patients were eligible.
- All 6 of the eligible patients were current or former smokers.
- 0 of the 6 patients were coal miners.
- 0 of the 6 patients received LDCT.

## IMPACT ON PRACTICE

### Short-Term

- Improved provider awareness of lung cancer screening guidelines.
- Increased adherence to recommending patients be screened according to guidelines

### Long-Term

- Providers will use the current lung cancer screening tool for all patients that meet criteria and recommend low-dose CT scans as appropriate.
- Eligible patients will be screened with LDCT to help detect early lung cancer.

## CONCLUSIONS

- ACS and ALA guidelines for lung cancer screening are a valuable tool for providers to use in evaluating patients at risk for lung cancer.
- Patients are reluctant to pursue further lung cancer screening, but providers are more aware of how to initiate the conversation with patients who would benefit from screening (Hamann et al., 2018).

## LIMITATIONS

- Site and stakeholder change midway through project.
- Limited time frame.
- Population not limited to coal miners.
- Patient reluctance to participate.



# Hepatitis C Management for Individuals in Custody

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## PROBLEM INTRODUCTION

- Hepatitis C virus (HCV) is the pathogen that causes hepatitis C disease, a liver infection.
- HCV is:
  - Transmitted by contact with infected people's blood
  - The most common chronic liver disease linked to hepatocellular carcinoma (half of all cases)
  - The most common reason for liver transplantation in the United States (Centers for Disease Control and Prevention, 2020)
- The correctional system is a valuable but frequently missed opportunity to detect HCV-infected individuals
  - Over ten million Americans enter and exit correctional facilities each year
  - HCV infection is about 10x more common in the incarcerated population than in the general community (Morris et al., 2017; Varan et.al 2014).

## LITERATURE REVIEW

Prisons in the United States keep people convicted of a crime and serving a sentence of a year or longer. Inmates in jails are either awaiting trial or committed to shorter periods

In 1998 and 2003, the CDC issued guidelines for HCV testing and to prevent and control viral hepatitis in correctional facilities

2014 witnessed significant screening policies with opt-out testing policies.

WHO launched a global effort in 2016 to eliminate hepatitis C virus (HCV) infection as a severe public health issue by 2030.

Both injecting and non-injecting risk exposures expose individuals in custody to HCV infection

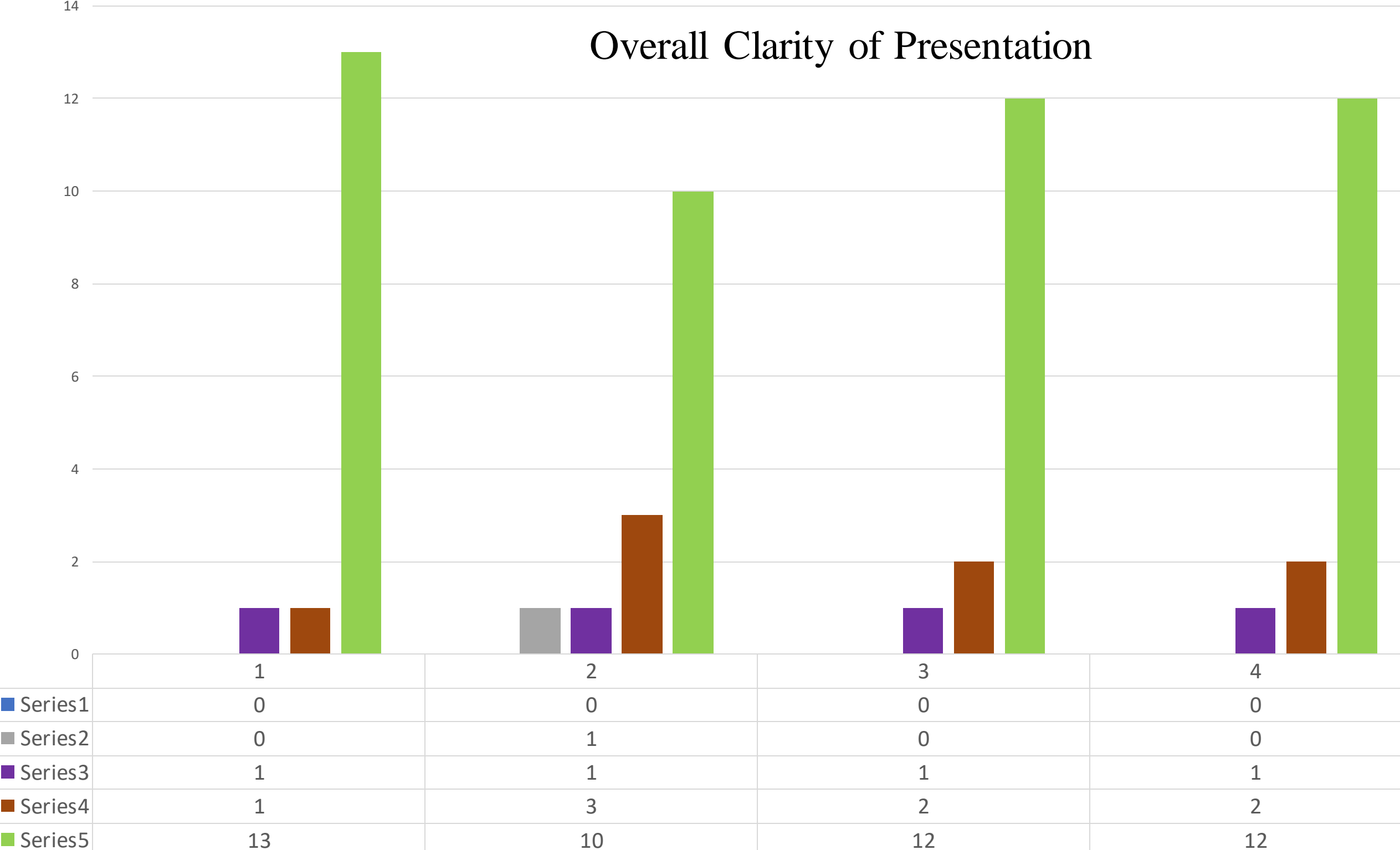
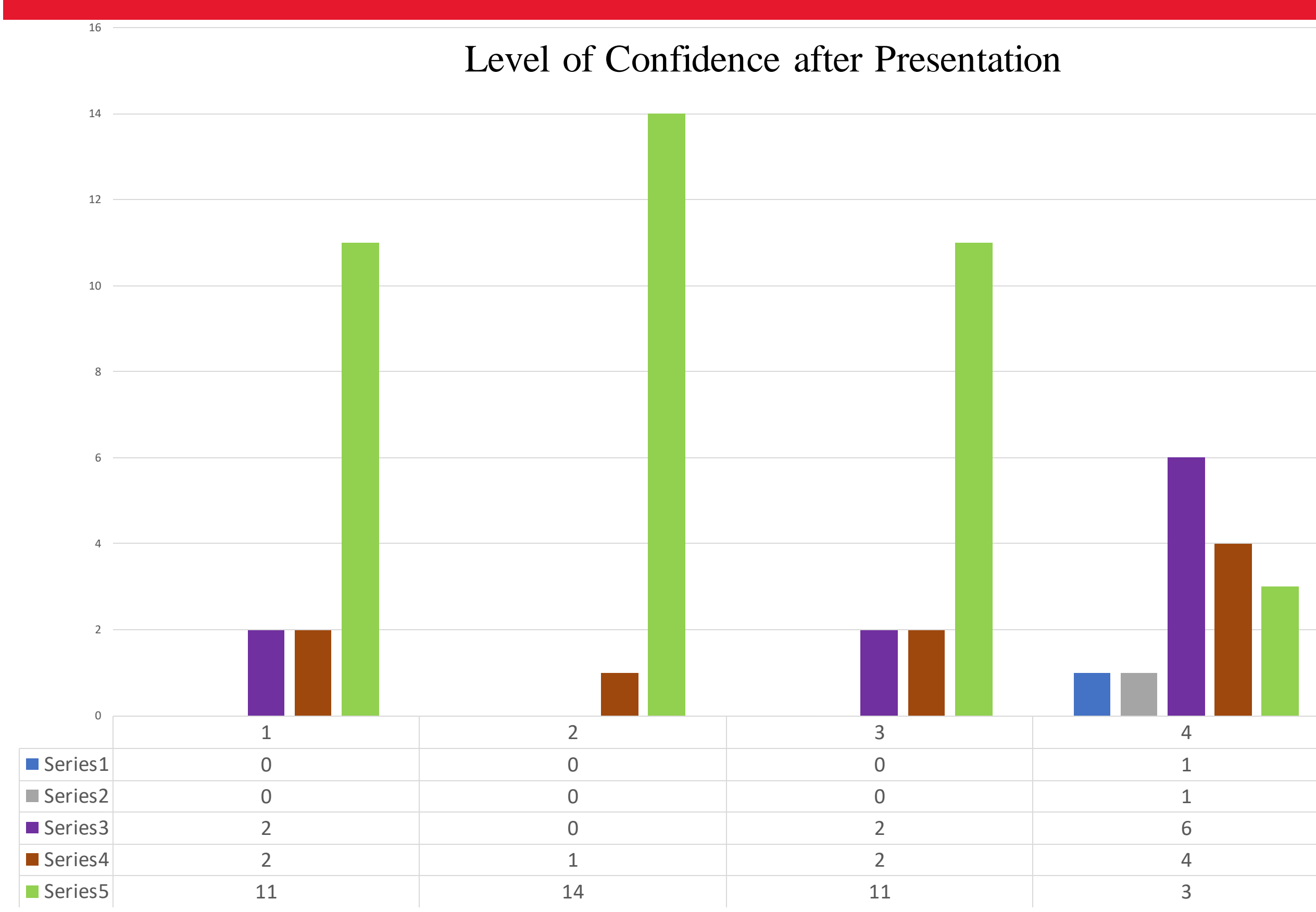
Non-injecting risk factors include tattooing, bloody fist fights, unprotected sex, and sharing contaminated personal items

## PROJECT METHODS

- Contacted California DOC for a sample of an HCV algorithm for individuals in custody
- HCV toolkit developed including educational infographic for inmates & PowerPoint for staff
- Evaluated post-survey responses



## EVALUATION



## IMPACT ON PRACTICE

Heightened awareness of HCV treatment refusal

Improved nurses' knowledge on handling HCV treatment refusals

Increased HCV treatment

Process to administer the infographic flyer about HCV treatment at admission

Improved public health outcomes beyond the correctional facility

Table 1. Post-Survey Responses

|   | Strongly disagree  | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree |
|---|--|-------------------|----------------------------|----------------|----------------|
| The presentation provided a clear understanding of:   |  |                   |                            |                |                |
| Risks associated with incarceration and HCV, including the impact of untreated Hepatitis C  | 0.0% (n=0)   | 0.0% (n=0)        | 6.6% (n=1)                 | 6.6% (n=1)     | 86.6% (n=13)   |
| Reasons for avoiding or delaying treatment  | 0.0% (n=0)   | 6.6% (n=1)        | 20.0% (n=3)                | 66.6% (n=10)   |                |
| Factors that enhance treatment adherence and ways to handle treatment refusals  | 0.0% (n=0)   | 0.0% (n=0)        | 6.6% (n=1)                 | 13.0% (n=2)    | 80.0% (n=12)   |
| Hepatitis C treatment for individuals in custody.   | 0.0% (n=0)   | 0.0% (n=0)        | 6.6% (n=1)                 | 13.0% (n=2)    | 80.0% (n=12)   |
| Please rate your agreement with the following statements:   |  |                   |                            |                |                |
| After viewing the presentation, I feel confident in my knowledge of strategies to address hepatitis C treatment refusals among individuals in custody | 0.0% (n=0)   | 0.0% (n=0)        | 13.3% (n=2)                | 13.3% (n=2)    | 73.3% (n=11)   |
| The information presented is relevant to my role as a healthcare provider working with individuals in custody.  | 0.0% (n=0)   | 0.0% (n=0)        | 0.0% (n=0)                 | 6.6% (n=1)     | 93.3% (n=14)   |
| The interactive elements in the presentation (examples & discussions) were helpful in engaging with the material                                      | 0.0% (n=0)   | 0.0% (n=0)        | 13.3% (n=2)                | 13.3% (n=2)    | 73.3% (n=11)   |
| I will make changes to my current practices as a result of the presentation   | 6.6% (n=1)   | 6.6% (n=1)        | 40.0% (n=6)                | 26.6% (n=4)    | 20.0% (n=3)    |
| If you answered that you would consider making changes to your practice, what changes might you implement?  | <ul style="list-style-type: none"> <li>Exercise greater vigilance in monitoring and addressing symptoms of medication side effects and comprehending laboratory values for follow-up.</li> <li>Motivated to improve the education that I offer</li> <li>Need for follow-up on lab work, insufficient sentence length to complete the full length of treatment, backlog in treatment, and the identification of lab testing upon entry/admission to correctional facilities.</li> </ul> |                   |                            |                |                |
| Are there any barriers or challenges you foresee in implementing these practices into your care? Please explain.                                      |  |                   |                            |                |                |
| How many years of experience do you have in this facility (or in a comparable role/facility)?   | Minimum 20   | Maximum 1         | Mean 8.0                   | Median 8       | Mode 10        |

## CONCLUSIONS

Stakeholder interviews revealed an ongoing issue with inmates refusing HCV treatment.

Prevalence of HCV in prisons is alarmingly high

Methods such as educational toolkits may be effective to increase knowledge on HCV treatment and risks of refusals.

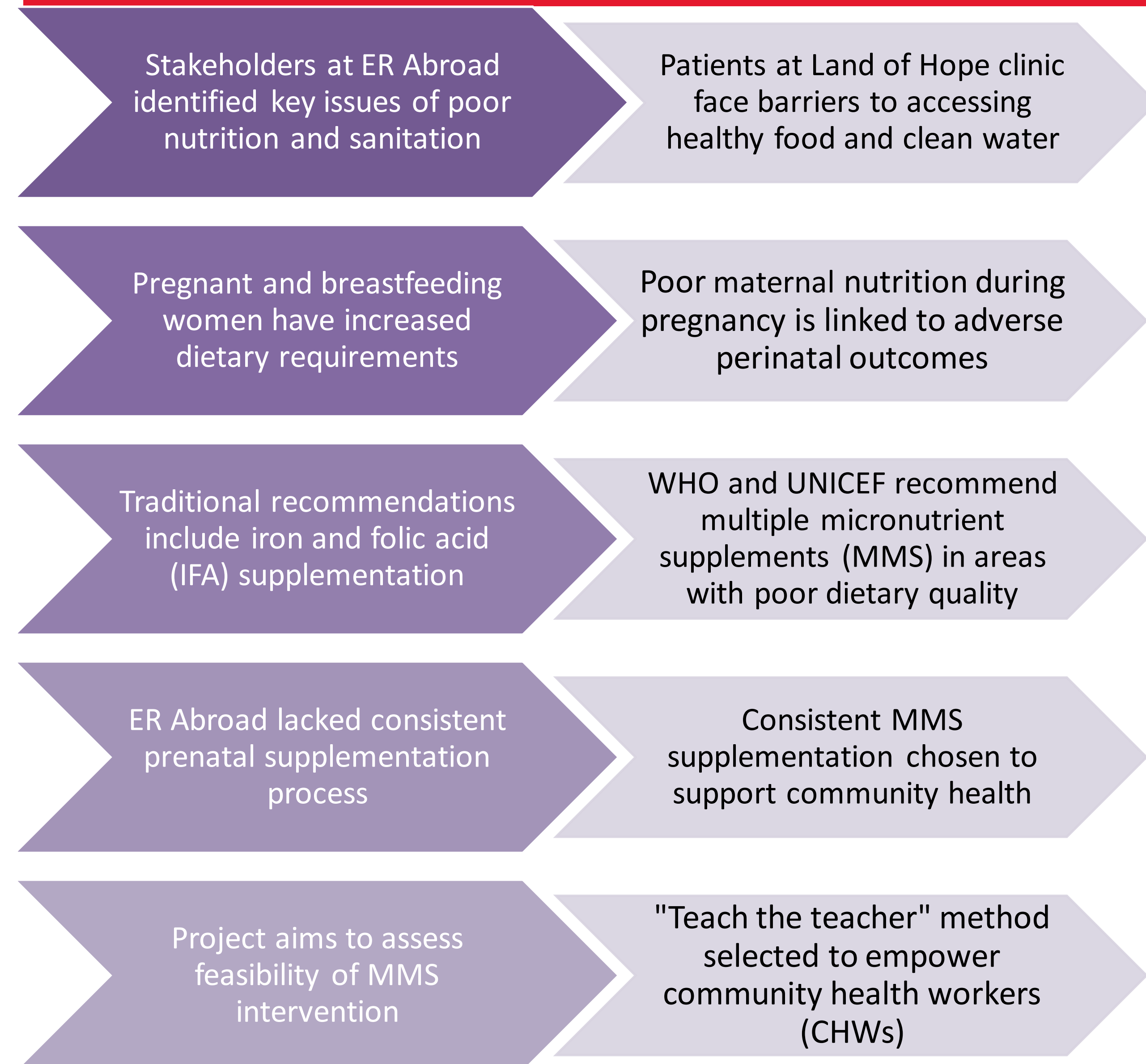
Correctional facility staff can anticipate an increase in treatment rates



# Establishing Routine Multiple Micronutrient Supplementation During Pregnancy in an Impoverished Guatemalan Community

Marissa Schuette BSN, RN & Erin Robke BSN, RN  
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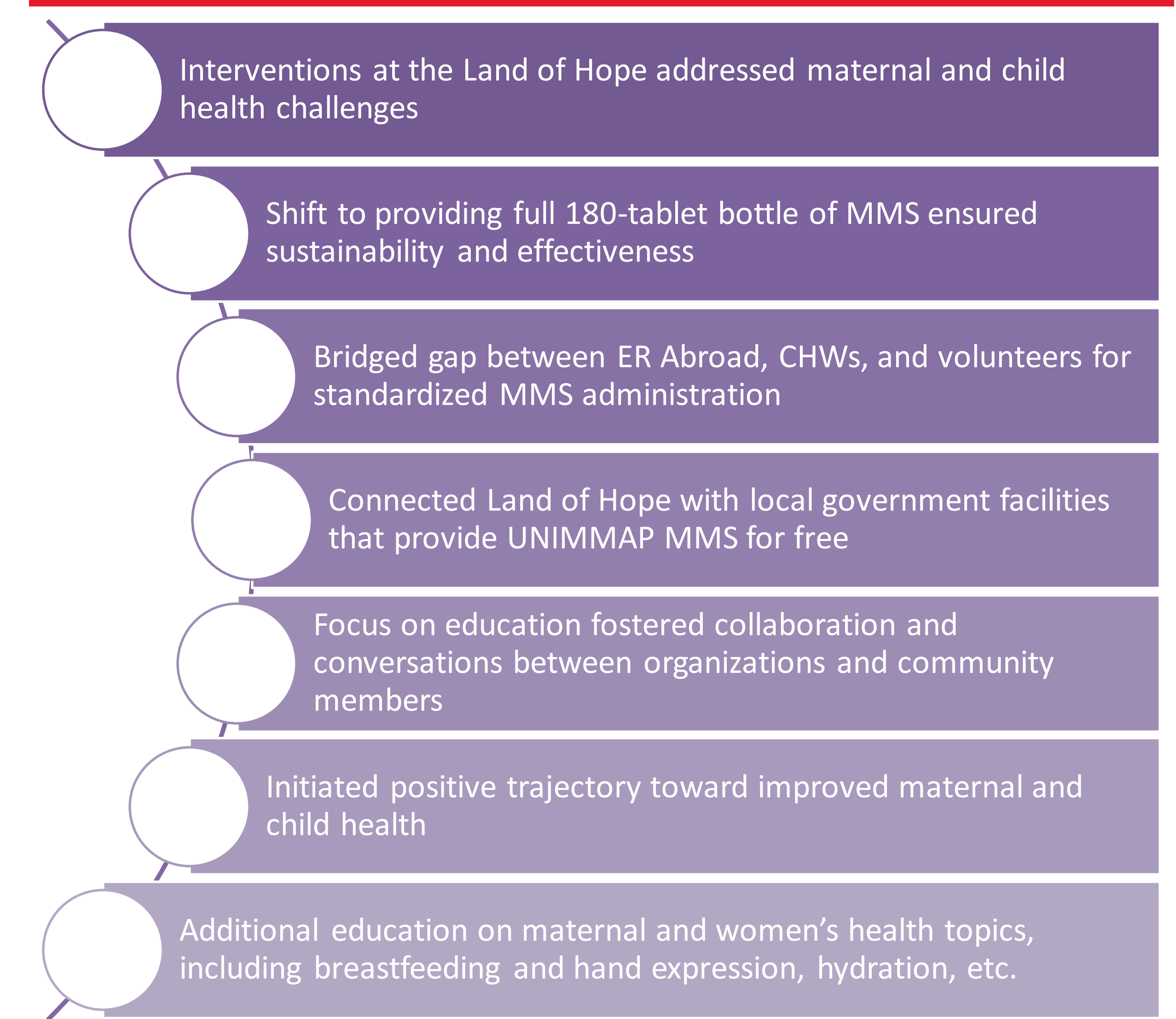
## PROBLEM INTRODUCTION



## PROJECT METHODS

- Worked with ER Abroad stakeholders to identify needs
- Proposed project intervention and objectives to stakeholders
- Reviewed literature about prenatal supplementation in low- and middle-income countries
- Connected with Earth's Splendor at CPC to obtain MMS
- Awarded RGRDS grant from SIUE for funding
- Developed MMS distribution algorithm and perinatal educational materials
- Visited site at the Land of Hope in Escuintla, Guatemala for 7 days
- Educated community health workers (CHWs) and distributed MMS
- Evaluated CHWs perception of overall intervention, barriers and facilitators to MMS adherence, and general feedback

## IMPACT ON PRACTICE



## LITERATURE REVIEW

- **Databases:** CINAHL, Cochrane Database of Systematic Reviews, and Medline Complete
- **Keywords:** "Pregnant women," "multiple micronutrient supplements," and "pregnancy outcomes."

### Evidence for Multiple Micronutrient Supplementation (MMS)

| Benefits of MMS  | Intervention Modifiers  |
|--|---|
| <ul style="list-style-type: none"> <li>• Reduces:                             <ul style="list-style-type: none"> <li>• Preterm/very preterm delivery</li> <li>• Preterm rupture of membranes</li> <li>• Low/very low birth weight</li> <li>• Perinatal mortality</li> <li>• Maternal anemia</li> </ul> </li> <li>• Increases:                             <ul style="list-style-type: none"> <li>• Gestational weight gain</li> <li>• Childhood intellectual development, procedural memory, and IQ</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Barriers:                             <ul style="list-style-type: none"> <li>• Side effects (nausea, constipation)</li> <li>• Forgetting doses</li> <li>• Difficulty swallowing pills</li> </ul> </li> <li>• Facilitators:                             <ul style="list-style-type: none"> <li>• Using at least 180 days of MMS supplementation</li> <li>• Initial one-time administration of full 180-tablet supply</li> <li>• Providing free MMS</li> <li>• Increased provider and patient education</li> </ul> </li> </ul> |

## EVALUATION

### MMS

- 84 bottles of MMS supplied by project team, 58 administered during implementation
- MMS algorithm provided to determine recipients and reinforce MMS teaching
- Organizational change led to lack of awareness of current MMS supply
- Supplement was being provided in quantities of 30 tablets instead of evidence-supported 180-tablet bottles
- No side effects reported by on-site CHWs; positive reception of MMS reported overall

### Education

- On-site interviews included broader maternal and infant health topics
- Provided reusable water bottles to promote hydration and lactation beads for educational purposes
- CHWs demonstrated strong pre-existing knowledge about prenatal teaching points

### Application

- Identified additional needs and educational barriers for future projects
- Model can be replicated in other impoverished communities

## CONCLUSIONS

Successfully administered 58 MMS bottles despite challenges like travel safety hazards

Positive reception and lack of reported side effects by on-site CHWs demonstrated feasibility of intervention

Identified poor nutrition and sanitation as critical issues in Escuintla, Guatemala

### Future Implications for Practice:

- Identified additional needs such as breastfeeding pumps, continued perinatal teaching, and maternal education topics
- Algorithm created is a valuable tool for future interventions
- Project's success can be replicated in other impoverished communities.
- Exemplifies potential for transformative healthcare initiatives through collaboration and education

## REFERENCES





# Improvement in Patient Compliance for Gynecological Care

Tracee Williams-Hubbard, BSN

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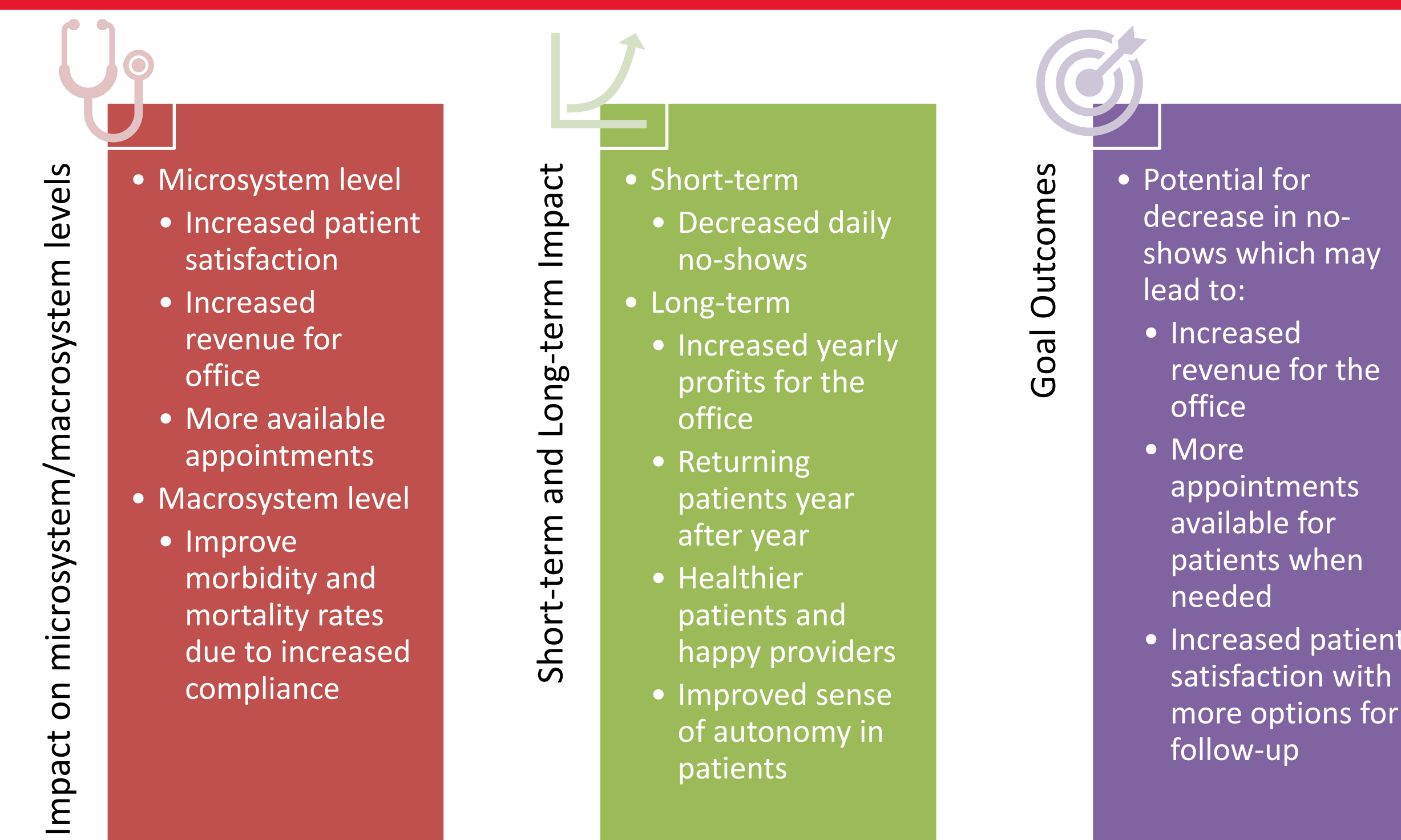
## PROBLEM INTRODUCTION



## PROJECT METHODS

- Proposal to stakeholder regarding PIFU being implemented to decrease no-show rates
- Development of Pre-implementation Patient Satisfaction Survey
- Pre-implementation patient satisfaction survey conducted via phone call
- Meeting with providers and staff to review results of the survey and educate on the use of PIFU
- Creation of criteria for patients to be offered PIFU vs. office scheduling
- PIFU utilized for a period of three months
- Evaluation of project via post-implementation patient surveys

## POTENTIAL IMPACT ON PRACTICE

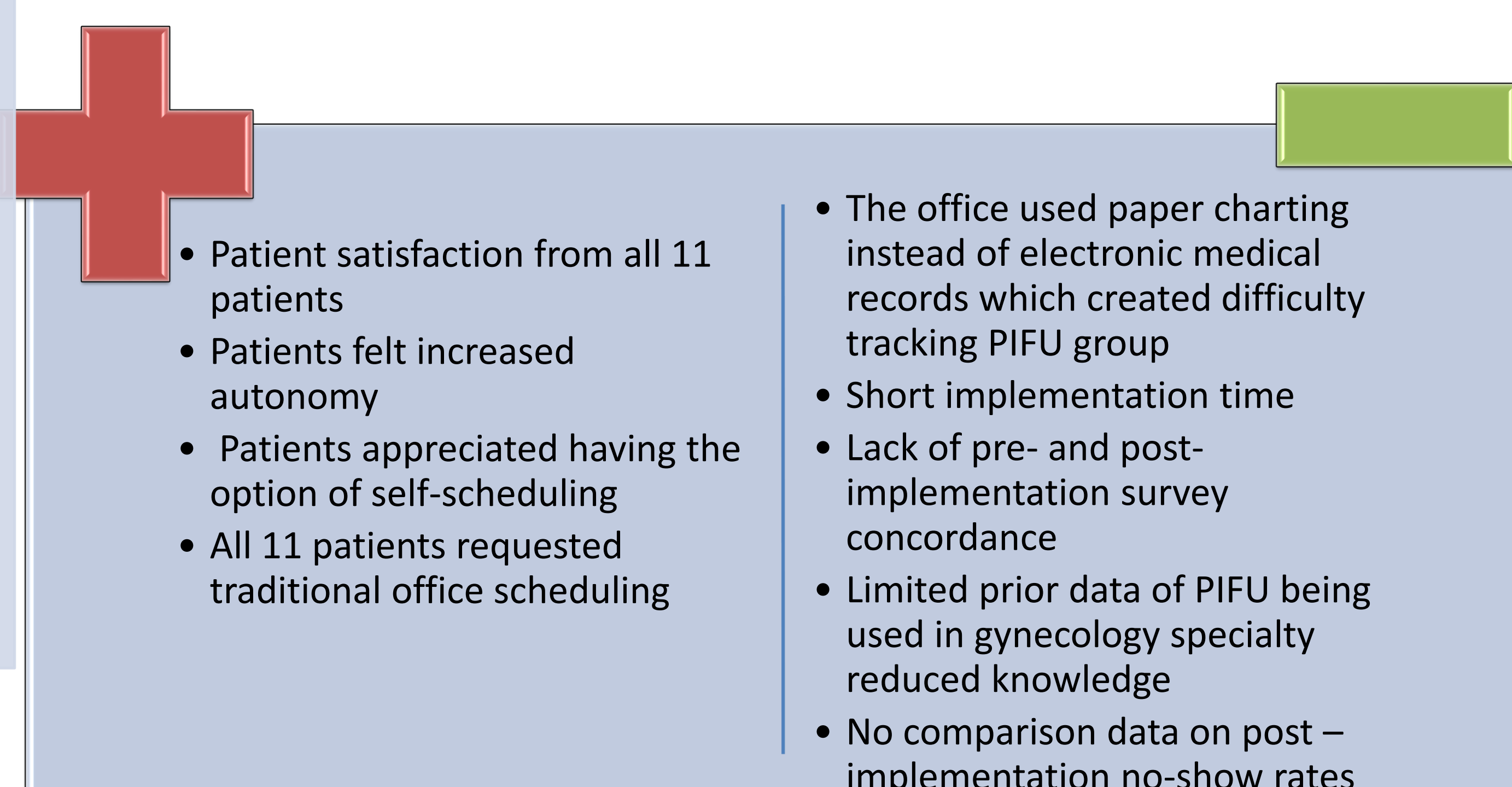


## LITERATURE REVIEW

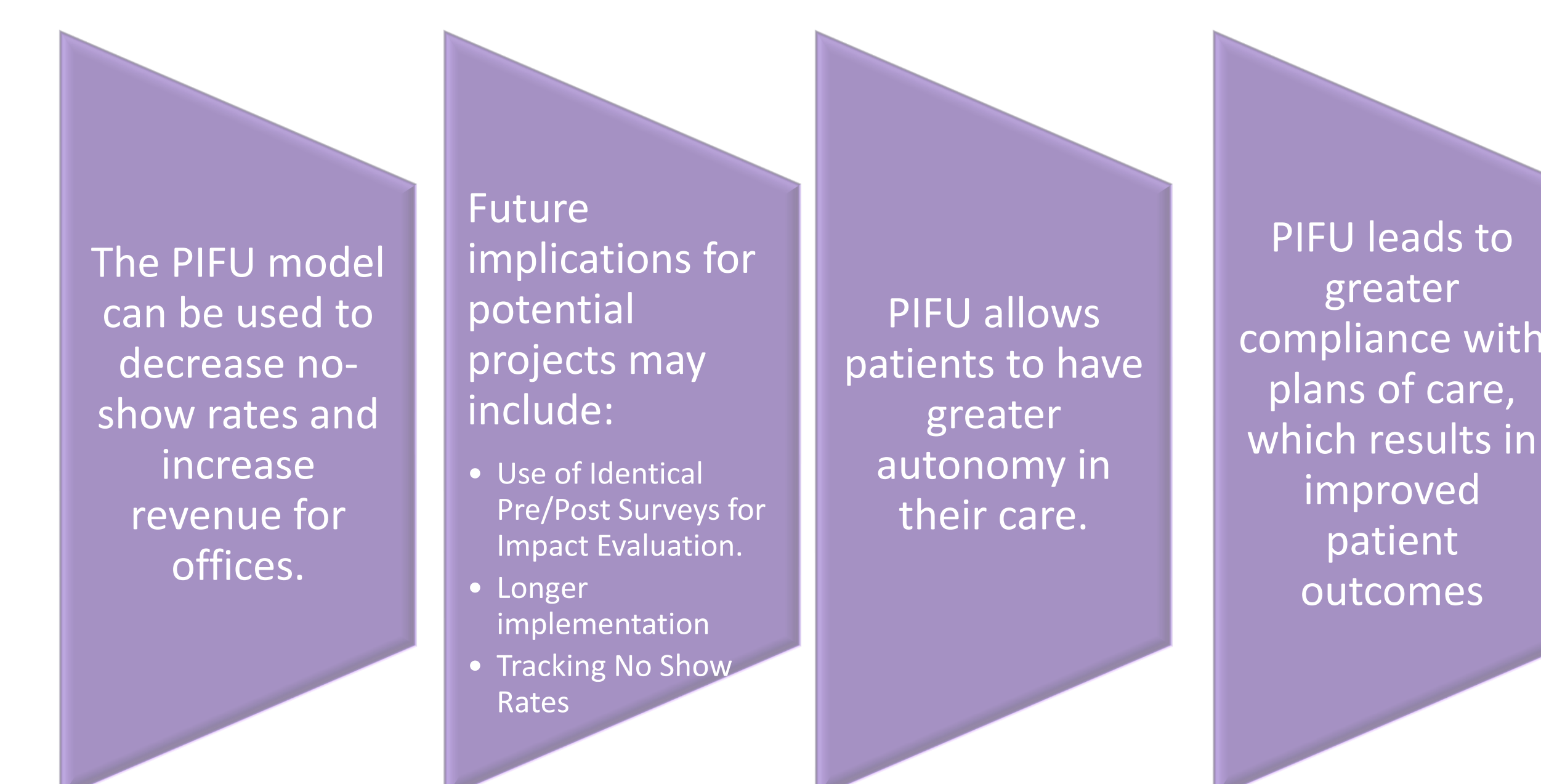
| The Search  | The Review   | The PIFU Model   |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Database used was CINAHL</li> <li>• Keywords used were:                             <ul style="list-style-type: none"> <li>• "no-show" appointments or missed appointments</li> <li>• Gynecology</li> <li>• Improve or increase or enhance or promote</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Missed appointments and "no-shows" are prevalent, especially in minorities and low socioeconomic status patients.</li> <li>• Multiple barriers correlate with no-show appointments including unmet social needs and low health literacy</li> <li>• Technology as means of reminders have been shown to improve attendance to appointments.</li> </ul> | <ul style="list-style-type: none"> <li>• Patient-initiated follow-up (PIFU) is a method used in a variety of primary care areas.</li> <li>• It allows patients to have autonomy with their care.</li> <li>• It allows patients to schedule their appointments based on their needs and availability.</li> <li>• It has shown to have higher rates of patient satisfaction and reduction in no-show rates.</li> </ul> |

## EVALUATION

- 11 out of 36 patients had follow-up appointments during the implementation period of the three months
- The following respondents completed post-implementation surveys: a nurse practitioner, a medical assistant, and a receptionist
- Evaluation of the project was limited by:



## CONCLUSIONS



## PRE-SURVEY RESULTS

| Question/Prompt   | Strongly Agree | Agree     | Uncertain | Disagree  | Strongly Disagree |
|---|----------------|-----------|-----------|-----------|-------------------|
| I usually kept waiting for a long time when I am at the doctor's office.                                | n=0 (0%)       | n=1 (4%)  | n=2 (8%)  | n=4 (16%) | n=18 (72%)        |
| Sometimes it is a problem to cover my share of the cost for a medical care visit                        | n=3 (12%)      | n=3 (12%) | n=4 (16%) | n=2 (8%)  | n=13 (52%)        |
| I feel satisfied with the care I receive and feel like I play an active role in my care decision making | n=21 (84%)     | n=2 (8%)  | n=1 (4%)  | n=1 (4%)  | n=0 (0%)          |
| I have to pay for more of my medical care than I can afford   | n=3 (12%)      | n=1 (4%)  | n=5 (20%) | n=4 (16%) | n=12 (48%)        |
| I call to cancel and reschedule when I can not make it to my gynecology visits                          | n=17 (68%)     | n=6 (24%) | n=0 (0%)  | n=2 (8%)  | n=0 (0%)          |
| I find it hard to get an appointment for gynecology care right away                                     | n=1 (4%)       | n=2 (8%)  | n=4 (16%) | n=3 (12%) | n=15 (60%)        |
| The gynecology clinic is very conveniently located  | n=20 (80%)     | n=3 (12%) | n=1 (4%)  | n=0 (0%)  | n=1 (4%)          |
| I have to miss appointments due to lack of childcare or adult care                                      | n=3 (12%)      | n=0 (2%)  | n=2 (8%)  | n=2 (8%)  | n=17 (71%)        |