Recognizing Barriers in the Elderly Population and Increasing Access to Case Management Services

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PROBLEM INTRODUCTION

- According to Glans et al. (2020), patients aged 65 or older accounted for 56% of early readmissions, while 27% of readmissions can be prevented within 30 days of post-hospital discharge.
- Several barriers lead to a patient’s hospitalization, including socioeconomic status, education level, housing situation, the severity of their chronic conditions, and access to primary care.
- Providing a multicomponent intervention involving primary care appointments, patient satisfaction, patient accountability, and self-care may reduce the number of patients needing emergency room care (Pugh et al., 2021).

LITERATURE REVIEW

- Lack of transportation could lead to missed appointments, preventative care, and health maintenance (Henning-Smith et al., 2017).
- Access to resources such as community services, recreation centers, and public transportation.
- Lack of access to primary care associated with increased mortality and decreased quality of life (Zaben & Khalil, 2019 & Fraze et al., 2019).
- Access to primary care allows for monitoring of chronic conditions and appropriate referrals for further treatment as indicated (Elliott et al., 2018).
- Case management can provide resources to help lower the cost of medications, set up transportation to a doctor’s visits, and help with finances (Kripalani et al., 2014).

PROJECT METHODS

- A questionnaire was given to patients to examine the different aspects of social disparities among the ages of 65 and above.
- Implementation of the project from June 2022 through August 2022.
- Data compiled from the questionnaire was entered into an Excel spreadsheet.
- Referral to case management placed based on patients’ social needs and/or their chronic medical conditions.
- Resources will be provided to patients from the social worker if necessary.

IMPACT ON PRACTICE

- Social disparities and complexity of chronic medical conditions can affect how care is provided.
- Case management can provide additional resources.
- Long term impact:
  - Screening patients and ordering case management if appropriate based on social needs.
  - Creating more awareness and accountability to seek help.
  - Improving quality of life and decreasing unwanted hospitalizations.

LIMITATIONS

- Number of participants during the time data was collected.
- Length of the project.
- Using one primary care clinic.
- Type of patients seen.

CONCLUSIONS

- By using case management, resources are provided to help address social needs but also provide a way to connect with a provider if they are experiencing worsening symptoms of their condition and need to be assessed.
- Help to address disparities that are seen in the elderly population which can improve the quality of care of our patients and increase adherence to their treatment.
Understanding COVID-19 Vaccine Hesitancy in Underserved Populations
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PROBLEM INTRODUCTION

• Vaccination remains one of the most effective ways to limit the spread of infectious disease and reduce mortality and morbidity in the United States, especially in underserved populations.

• African Americans and Latinos are eight times more likely to die than White Non-Hispanic populations of COVID-19-related complications (CDC, 2020).

• Although vaccines are currently offered and approved to anyone over five years of age, there continues to be vaccine hesitancy in underserved populations.

• Compared to other ethnicities, African Americans and Hispanics have higher death and hospitalization rates.

LITERATURE REVIEW

• Vaccine hesitancy is the delay in acceptance or refusal of vaccination despite the availability of vaccination services (Butler, 2016).

• The decision to accept, delay or refuse vaccination can be complex and depend upon factors such as availability, cultural concepts, and even stigma.

• According to Sharp Healthcare (2021), before COVID-19 vaccines became available in the U.S. only 42% of Black Americans said they planned to get one.

• Currently, 49% of Black people in the U.S. are unvaccinated, yet the prevalence and complications associated with COVID-19 impact Black people at alarming rates.

PROJECT METHODS

• Questionnaire to identify barriers to vaccination hesitancy and education to address any misconceptions and vaccine information.

• Nurse practitioner assessed every patient’s registration form to identify vaccination status if the vaccine was offered and identify barriers to vaccination hesitancy.

EVALUATION DATA

• 565 surveys collected during free COVID-19 testing.

• Due to incompletion of surveys, 506 surveys used.

• 283 females (56%) and 223 males (44%).

• 96% of surveys collected from African American and Hispanic patients.

IMPACT ON PRACTICE

• Follow up calls, education, and the offering of COVID-19 vaccines resulted in a 30% increase in vaccination rate.

• Increase in vaccine accessibility

• Extending clinic hours & addressing misconceptions of COVID-19

• Continuation of vaccination boosters and vaccines being given

CONCLUSIONS

• Providers play a vital role in building rapport, providing resources and making the COVID-19 vaccine accessible.

• Accessibility, affordability, and community engagement can help reach underserved populations in vaccine hesitancy.

• Education, follow up calls, and building trust should be priority.
Implementing an EMR System in a Small Psychiatric Practice
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PROBLEM INTRODUCTION
- Mental health settings have adopted EMRs more slowly than other specialty practices. Barriers in mental health settings include cost burden, physician reluctance, computer literacy, and concerns with the privacy of psych notes.
- Overcoming barriers alone does not lead to the successful implementation of EMRs. Successful EMR implementation within organizations depends on EMR acceptance.
- Strategies for the successful implementation of EMRs are limited in mental health settings.

PURPOSE STATEMENT
- This quality improvement project aims to develop an implementation and training plan to successfully transition from paper charts to an electronic medical record (EMR) in a private psychiatry clinic.

LITERATURE REVIEW
- Electronic medical records are digital versions of paper charts containing clinical notes and additional health information collected for diagnosis and treatment (ONC, 2019).
- The adoption of EMRs is influenced by perceptions of the potential clinical benefits offered by EMR technology (Cellucci et al., 2015). The most common barrier categories found are cost, technology, and user attitude toward EMR technology. EMR implementation will fail without the acceptance and support of clinicians (Singh et al., 2020).
- The success of EMR implementation in mental health requires a proper implementation plan (Kpobi et al., 2018). Perspectives of physicians and users, organizational factors, and technical factors have impacted EMR adoption in mental health settings (Zurynski et al., 2021).
- Negative provider perceptions of workflow disruptions and lack of appropriateness have led to the slow adoption in mental health (Zurynski et al., 2021). Customizable EMRs to individualized practice needs are more practical for mental health settings (Kruse, Kofman, et al., 2016).
- Adequate planning, preparation, staff training, and support promote successful EMR implementation (Aguirre et al., 2019).

LIMITATIONS
- Small sample size.
- Staff changes during the study.

EVALUATION
- Five participants completed the SUS surveys for each of the three roll-out phases were completed during this three-month period.
- Phase 1 post-implementation SUS results ranged between 70.0 points to 80.0 points. The range of phase 2 SUS results was 72.5 points to 82.5. Phase 3 SUS results ranged between 75.0 points to 87.5.
- All three phases of the post-implementation results had mean scores associated with a B grade and good ratings.

SYSTEMS Usability SCALE

<table>
<thead>
<tr>
<th>Phase</th>
<th>Range of Score</th>
<th>Mean Score</th>
<th>Grade</th>
<th>Adjective</th>
<th>SUS Score</th>
<th>Grade</th>
<th>Adjective Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Scheduling</td>
<td>70-80</td>
<td>74</td>
<td>B</td>
<td>Good</td>
<td>88.3</td>
<td>A</td>
<td>Excellent</td>
</tr>
<tr>
<td>2 - Charting</td>
<td>72.5-82.5</td>
<td>77.5</td>
<td>B</td>
<td>Good</td>
<td>80.5</td>
<td>B</td>
<td>Good</td>
</tr>
<tr>
<td>3 - Billing</td>
<td>70-87.5</td>
<td>80.5</td>
<td>B</td>
<td>Good</td>
<td>77.5</td>
<td>B</td>
<td>Good</td>
</tr>
</tbody>
</table>

PROJECT METHODS
- Conducted an assessment on staff perceptions of EMRs and user skills assessment.
- Developed EMR implementation plan and identified two-clinic super users. Rollout followed Lewin’s theory of change: unfreeze, move, and freeze.
- Customized EMR screens and templates based on identified workflow needs.
- Post-implementation feedback was collected at 2 weeks post-implementation for each phase to identify user satisfaction, revisions needed, and training needs.
- The primary outcome measurement was John Brooke’s (1996) System Usability Scale (SUS) administered at 2 weeks post-implementation following each phase.

IMPACT ON PRACTICE
- User satisfaction & acceptance has increased through each rollout phase.
- Customization of the EMR has improved accessibility of patient information and improved efficiency of workflow.
- Acceptance of the EMR has improved the organization of patient records.
- Scheduling of follow-up appointments and tracking no-shows has improved.

CONCLUSIONS
- This process could be used in other outpatient clinics.
- Implementation is an important step to consider.
- An appropriate rollout strategy can promote user buy-in, minimize workflow disruptions, and facilitate successful rollout.
- Understanding the organizational needs is detrimental when planning each rollout phase.
- SUS survey is appropriate to assess user perceptions of usability.
- User satisfaction can be increased when training needs are met and workflow revisions are made.
**PROBLEM INTRODUCTION**

- Corneal abrasions are the most common ophthalmic injuries that occur in the perioperative period. (Grixti, Sandi, & Watts, 2013).
- Result of physical trauma, exposure, or reduced tear production (Grixti, et al., 2013).
- Many risk factors, both physiologic and mechanical, contribute to corneal abrasions.
- Create a guideline and continuing education program highlighting the best practice for corneal abrasion prevention for faculty and staff CRNAs.
- A structured educational program is crucial in lowering corneal abrasions (Martin, et al., 2009).

**LITERATURE REVIEW**

- Pubmed, CINAHL, Cochrane Database
- Corneal abrasion, anesthesia anesthesia complications
- 2009 to present

**PROJECT METHODS**

- Proposed to educate CRNA staff at a large academic medical center.
- The presentation focused on risk factors associated with increased corneal abrasion in the perioperative period.
- Procedural risk factors, prevention techniques, litigation costs, and long-term risks of untreated corneal abrasions.

**EVALUATION**

**Percentage Correct**

<table>
<thead>
<tr>
<th>Cornea Function</th>
<th>Pre-Test</th>
<th>Post-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors that increase corneal abrasion</td>
<td>50%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Risk Factors associated with corneal abrasion</td>
<td>0%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Prevention Methods</td>
<td>8.3%</td>
<td>80%</td>
</tr>
<tr>
<td>Litigation Costs of corneal abrasion</td>
<td>20.8%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Long-term Risks of corneal abrasion</td>
<td>33.3%</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

**IMPACT ON PRACTICE**

- Creation and annual education focused on risk factors and preventative measures may help reduce corneal abrasions in a large academic medical center in Southeastern Pennsylvania.
- The goal is to reduce the corneal abrasion rate from 0.48% to documented standard levels.

**CONCLUSIONS**

Providing an extensive educational presentation focused on corneal abrasion risks and prevention practices improved the knowledge base among a group of CRNAs at a large academic hospital.

**LIMITATIONS**

- Only 15 total participants
  - Provide another educational session to increase staff participation
  - Provide education for CRNAs that work in other parts of the health system.
  - Lack of time for completion of Post-test
Amniotic Fluid Embolism (AFE) Diagnosis & Treatment Pathway
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PROBLEM INTRODUCTION
- AFE is a rare occurring medical emergency in obstetric patients
- Rural hospital staff lack experience with AFE as well as knowledge needed to identify hallmark symptoms and treatment options
- Project aimed to provide annual education for all staff nurses to assist them with recognizing signs and symptoms of AFE as well as understanding treatment and monitoring options

LITERATURE REVIEW
- AFE is a potentially fatal obstetric emergency that defies definitive diagnostic technology (Sundin & Mazsac, 2017).
- AFE results in a cascade of events culminating in loss of vascular tone, disseminated intravascular coagulation (DIC), cardiopulmonary collapse, and often death (Stanford et al., 2020).
- Clark and colleagues define AFE based on four criteria:
  - Quick onset of cardiopulmonary arrest
  - Sudden onset of DIC not caused by blood loss
  - Clinical symptoms over either during labor or within 30 minutes after placental delivery
  - Patient remains apyrexial during labor (Fitzpatrick et al., 2019)
- Treatment:
  - Supportive effects to mitigate cardiac, pulmonary, and hematologic symptoms
  - Atropine, ondansetron, ketorolac, tranexamic acid (AOK+T protocol)

PROJECT METHODS
- Goal of project was to assess for knowledge deficits of AFE, followed by an educational teaching session that addressed the areas of deficits
- Target population identified as staff on the obstetrics unit at a small rural birthing center in central California
- Pre-test of 13 questions given to staff during staff meeting
- In person education session conducting utilizing a powerpoint presentation
- Post test of 13 questions given to staff

EVALUATION
- Pre-test survey identified that respondents had some prior knowledge and understanding about AFE
- Prior to the education, however, a lack of knowledge was identified around AFE treatment as well as risk factors associated with AFE
- Post-test analysis identified a statistically significant increase in respondents that correctly identified risk factors and medications used to treat AFE
- Score improvements: Pre-test Median 75 (68.8-87.5) and Post-test Median 100 (87.5-100) resulting in a p-value of 0.002

IMPACT ON PRACTICE
- Implementing a crisis management blueprint for AFE positively impacted medical staff, anesthesia staff and nursing personnel as well as the potential benefits to patients who experience AFE
- Due to the Rare disease occurrence and lack of staff hands-on experience with AFE, an annual refresher educational module was added to required competencies
- ID badge checklist for AFE diagnosis, risk factors, and treatment can be utilized during any suspected AFE event

CONCLUSIONS
- Goals of project, increase awareness of risk factors, diagnostic methodologies, and treatment for AFE
- Project can be sustained by adding AFE education to annual competencies and offering ID badge checklist to new staff
**Problem Introduction**

Perioperative Aspiration
- Gastric contents, liquid or solid, rise from stomach and enter into trachea and lungs
- Occurs perioperatively due to
  - Depressed reflexes related to induction of unconsciousness and direct impairment by anesthetics
  - Improper NPO status or inadequate gastric emptying with proper NPO

Aspiration pneumonia - can lead to prolonged mechanical ventilation
- Mortality rate up to 5%
- 9% of all anesthetic-related deaths

Conditions that Promote Gastropareis
- Obesity
- GERD
- Chronic kidney disease (CKD)
- Diabetes mellitus
- GI tract abnormalities (e.g., Hiatal hernia, ileus, bowel obstruction)
- Hepatic impairment
- Neuromuscular diseases (e.g., Parkinsons or Multiple sclerosis)
- Stress/trauma
- Chronic opioid use
- Pregnancy

**Literature Review**

Reasons to Use Gastric POCUS:
- Simple: Findings are easily recognizable & scanning technique can be quickly learned and performed
- Fast: Takes less than 5 minutes
- Non-invasive
- Accurate & Reliable: Provides diagnostic data (qualitative and quantitative), high specificity and sensitivity
- Point-Of-Care: Performed at bedside, Focused/Limited in scope
- Real-time

Quantitative Assessment
- Grade 0 = antrum empty in both positions and indicates no gastric contents
- Grade 1 = antrum appears empty in supine and clear liquid in RLD position (consistent with baseline gastric secretions)
- Grade 0 and 1 are common findings in healthy patients

**Project Methods**

The anesthesiology staff at Gibson Area Hospital (GAH) were provided with structured educational content and guided practical experience regarding the use and relevant application of gastric point of care ultrasound (POCUS).
- Consent to participate
- Pre-test and Initial Survey
- Healthstream lecture slideshow presenting the key background information, instructional POCUS process, and decision-making guidelines
- Practicum session was scheduled with each participant
- Participants were encouraged to scan as many patients as possible
- Training post-test and follow-up survey

**Evaluation**

Overall test scores improved from pre-test to post-test (see Table 1). The pre-test score average increased from 50% to post-test score average of 87%. Ten providers took the pre-test and only the five providers that completed training took the post-test.

<table>
<thead>
<tr>
<th>Average Student Score</th>
<th>Number of Participants</th>
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<tbody>
<tr>
<td>Pre-Test 50%</td>
<td>10 (All providers)</td>
</tr>
<tr>
<td>Pre-Test 53%</td>
<td>5 (Providers that completed training)</td>
</tr>
<tr>
<td>Post-Test Initial Score 61%</td>
<td>5</td>
</tr>
<tr>
<td>Post-Test Best Score 87%</td>
<td>5</td>
</tr>
</tbody>
</table>

**Limitations:**
- Low case volume
- Anesthesia provider schedules limited exposure to training
- Limited time available during workday with cases
- Limited trainer availability to confirm scan results
- Variable motivation to perform elective scans
- Short training period to perform sufficient number of scans to achieve proficiency

**Impact on Practice**

- GAH providers overall displayed a desire and willingness to learn this new skill despite some skepticism in their ability to make clinical decisions from it. Since implementation, providers have continued to use gastric POCUS in situations to confirm or deny a lack of adequate NPO status. Implementation of gastric POCUS to risk stratify patients with high-risk comorbidities does not appear to have increased.
- Although the training occurred over a short period of time, providers were encouraged to continue scanning patients regularly, despite not having a clinical need on a case-by-case basis. Improving the ability to identify an empty stomach is key to successful use of the gastric POCUS. The anesthesiology providers did not achieve the number of scans that literature has identified as necessary to achieve competency. Therefore, with continued scans beyond this project, providers can achieve competency.

**Conclusions**

Through continued practice, the anesthesiology providers at GAH can continue to gain confidence in Gastric POCUS at little to no cost. This skillset and appropriate decision-making will provide improved safety for surgical patients by minimizing potential aspirations and improving patient outcomes. Overall, participants increased their likelihood to use gastric POCUS, confidence in using gastric POCUS, and desire to incorporate gastric POCUS in the future.
Foley Catheter Algorithm
Chary Mathew MBA, MSN, FNP-C
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PROBLEM INTRODUCTION

• Urinary catheterization is a common procedure performed in various healthcare settings with unspecified instructions on size and indication

• Though simple and straightforward in most case it can become a challenging procedure in absence of a standardized protocol for difficult catheterization

• This project aimed to develop a standardized Foley catheter algorithm/flow chart available in the institution's intranet and laminated charts placed in nursing stations and procedure rooms listing Foley catheter indications, types, sizes, pertinent patient history, and indications to consult with urology team.

• Providing a catheter algorithm will help practitioners prevent complications that are costly and possibly fatal.

PROJECT METHODS

• The project targeted knowledge improvement interventions by examining the level of understanding of evidence-based best practices for Foley catheter insertion

• The targeted staff and stakeholders for the project were nurses, advanced practice providers, resident and attending physicians working in the ED

• Data collection was done through pretest questionnaire with 10 questions followed by a 20 to 25 minutes PowerPoint presentation on the topic and a 13-question post test

• Sample size was 29

EVALUATION

• The ER staff had some knowledge on genitourinary conditions and Foley catheter placement however the need for more knowledge regarding complications, indications and sizes were noted

• Wilcoxon signed rank test showed that a 20-25 minutes presentation on Foley catheter elicited a statistically significant change in knowledge of participants on catheter type for hematuria with blood clots (Z = -3.742, p = 0.000)

• 65-year-old male with Benign Prostatic Hyperplasia and Acute Urinary Retention (Z = -2.972, p = 0.003), and type of catheter used for mid-urethra resistance with a 16-inch Foley (Z = -5.292, p = 0.000)

• Most significant knowledge deficit areas noted was on a question which was choosing the correct size of catheter on a 28-year-old male patient with 500 ML of urine in the bladder, unable to urinate after feeling a 16 French Foley catheter which was the next appropriate catheter to use almost all the participants answer the question incorrectly in pre-test and were able to correct and acknowledge the benefit of the PowerPoint presentation.

IMPACT ON PRACTICE

• A Foley catheter algorithm was developed with Foley catheter indications, type, size, pertinent patient history scenarios, and when to consult a urology team

• All the participants agreed that having the Foley catheter algorithm easily available will benefit all the employees for catheter related decision making

LIMITATIONS

• Small sample size due to decreased accessibility to emergency room staff because of various working shifts

• Difficulty scheduling meetings with hospital administration prohibited the algorithm from getting uploaded in intranet at this time

CONCLUSION

• Despite the educational skills and quality assurance programs, Foley catheter related issues remain a challenge for most Frontline healthcare workers who make prompt decisions

• Easy access to the algorithm will be of great help with urological Foley catheter related decision making
Standardization of Perioperative Management of the Breastfeeding Women
Amrutha Panakkal, MSN CRNA
Southern Illinois University Edwardsville

PROBLEM INTRODUCTION

- NPO status
- Archaic practice of "pump and dump"
- Decreased Breast Milk Supply
- Anxiety

Develop and implement a best practice guideline at a large urban academic medical center in Pennsylvania to optimize perioperative practices and educate anesthesia providers on best practices for breastfeeding mothers presenting for surgery.

LITERATURE REVIEW

The lack of research on vulnerable populations, such as breastfeeding mothers and newborns, by pharmaceutical companies (Smather et al., 2016).

Most medications used in the perioperative setting are short-acting and are safe for lactating patients.

Diazepam, codeine, tramadol, droperidol, oxycodone, and hydrocodone should be avoided for lactating patients (Dalal et al., 2013).

Caution in using hydromorphone due to its long half-life, and more studies are needed to assess ketamine's safety (Mitchell et al., 2020).

PROJECT METHODS

- Target Population
  - Breastfeeding Patients

- Target Stakeholders
  - Anesthesia providers

- Education
  - An evidence-based best-practice guideline incorporating categories and stoplight color-coding chart was used to group medications according to their safety.

- Data Collection
  - Pre and post education surveys completed by the attendees electronically.

IMPACT ON PRACTICE

- Guidance needed in the host facility for anesthesia providers caring for breastfeeding patients.

- Sustainable: Increased accessibility, direct link to hospital lactation policy, and low cost of maintenance.

- Short-term: A quick reference tool for providers to assess the safety of common perioperative medications.


EVALUATION

- Significance of Post-survey questions correct responses
  - How soon mothers can resume breastfeeding after surgery (p<.01) and unnecessary practice of discarding breast milk (p<.01).

- Data Collection
  - Pre and post survey scores increased from 68% to 88%, and the standard deviation decreased by about 10%.

- Education
  - The respondents supports having a resource in the organization’s intranet.

LIMITATIONS

- The RCT studies were over five years old.

- The usefulness of the "stoplight" color chart for providers that are color-blind.

- Sampling bias – primarily CRNA participants pre-survey (96.3%) and post-survey (98.11%).

- Statistical analysis - Item nonresponse error.

CONCLUSION

This evidence-based project can aid in streamlining practices to provide optimal care for breastfeeding patients and minimize interruption of breastfeeding.

The effectiveness of this guideline will be evaluated through repeated assessments of staff knowledge and improvement in patient satisfaction.
Establishing a Diabetes Self-Management Resource for the Self-Pay Client in a Rural Clinic
Emily Birkhead, BSN, RN-BC
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**PROBLEM INTRODUCTION**
- Of the 1,065 DSME programs available to nonmetropolitan (rural) counties, 62% of nonmetropolitan counties across the United States did not have a DSME program (Rutledge et al., 2017). The 1,065 programs that were available were spread out amongst only 38% of nonmetropolitan counties in the United States.
- Diabetes prevalence is 17% higher in rural areas than it is in urban areas; therefore, the DSME programs are not reaching the most critical areas of the country (Bolin & Ferdinand, 2018). Even if insurance is adequate, clients also have difficulty traveling long distances due to schedule interruptions and costs of travel (Balamurugan et al., 2006).
- Clients pay out of pocket for visits, medications, and testing. They have no access to DSME programs. The clinic offers financial assistance, but it only applies to those with legal identification. Most underinsured clients in this office are undocumented Hispanic residents.

**LITERATURE REVIEW**
- Self-management for type 2 diabetes mellitus includes the acts and behaviors a person exhibits day-to-day to manage their diabetes mellitus and obtain control of their condition (CDC, 2018). These behaviors include: diet, exercise, glucose monitoring, medication adherence, and coping with the condition.
- Diabetes self-management education (DSME) programs are multidisciplinary programs formed to provide education and support to those with type 2 diabetes mellitus. DSME programs have shown to improve glycemic control, improve A1C levels, and increase self-confidence and self-management amongst clients with type 2 diabetes mellitus (Chrvala et al., 2016).
- Throughout research, DSME programs, whether taught by a single provider or a group of specialists, are shown to decrease A1C levels amongst patients with type 2 diabetes mellitus (Chrvala et al., 2016). The evidence of DSME programs effectiveness also reported to benefit everyone regardless of baseline A1C status (Chrvala et al., 2016). A review of studies, including 42 randomized control trials, also confirmed that diabetes education, whether in a formal program or not, show significant reductions in A1C scores, microvascular complications and diabetes mellitus related mortality (He et al., 2017).

**PROJECT METHODS**
- Researched the local area for free diabetes resources, medication programs, and affordable diabetic supplies.
- Met with Stakeholder to discuss barriers towards DSME.
- Proposed project idea and objectives to stakeholder to supply a brochure of DSME to clients in the office.
- Reviewed Literature and Evidence-based practice regarding DSME programs and the included domains.
- Developed the DSME brochure to include education from literature review and local resources found. Brochure professionally translated to Spanish.
- Implementation through Plan, Do, Study, Act (PDSA) model.

**IMPACT ON PRACTICE**
- All patients with type 2 diabetes mellitus, regardless of insurance status, will receive free DSME brochures. Spanish brochures also available.
- All staff, including ancillary staff, has increased knowledge on DSME and type 2 diabetes mellitus.
- Ancillary staff can more effectively delegate questions and concerns to the provider.

**EVALUATION**
- **Staff Education**
  - DSME, Brochure procedure, and target population education prior to implementation.
  - Education provided during staff meeting and included one provider and ancillary staff.
  - Reinforcement of education and revision of Brochure process between Cycle 1 and Cycle 2.
- **PDSA Cycle**
  - Cycle 1 focused on type 2 diabetic clients without insurance, but it became difficult and lengthy to single these patients out. Unintended consequences of target population not being available during implementation summer months.
  - Cycle 2 included all patients with type 2 diabetes mellitus.
- **Staff Surveys**
  - Reported confusion in cycle 1 regarding brochure process and target population.
  - Assessed surveys regarding confidence with the DSME brochure procedure and discussing type 2 diabetes mellitus. Staff reported increased confidence after the 2nd educational session prior to Cycle 2.

**CONCLUSION**
- Important to understand lifestyle factors and culture of the target population in order to understand needs and limitations.
- Assess clinical staff knowledge to ensure information provided to clients is accurate and effective.
- Increased knowledge and education amongst staff members increases confidence in providing information to clients.

**LIMITATIONS**
- Target population unexpectedly unavailable during time of implementation.
- Target population unavailable during implementation confused initial implementation cycle.