Peer Support Specialist Incorporation into Collaborative Patient Centered Care

Mathew Blount, BSN and Jamie Wagner, BSN, FNP Students
Southern Illinois University Edwardsville

PROBLEM INTRODUCTION

Peer support specialists (PSS) can deliver recovery care to those suffering with mental health and substance abuse issues.

Peer support workers have lived through mental health or substance abuse challenges of their own, which is crucial in personalizing care to patients’ needs and preferences.

The purpose of the project was to improve the referral process and increase the number of referrals to the in-house PSS at a health clinic that focuses on Veteran’s Affairs.

LITERATURE REVIEW

Roles of PSS

- Lead wellness groups
- Case manage
- Recommend housing
- Recommend jobs
- Health coach
- Accompany patients to appointments
- Serve as emotional support

(Burnet, Weis, & Gordon, 2017)

Utilization of PSS:
- Bridge the gap between mental health providers and patients with pragmatic familiarity and understanding of the recovery process at its rudimentary level
- Ultimately complementing the work of mental health professionals

(Avondo et al., 2020)

Mental health recovery orientation with peer support services can:
- Fostered empowerment
- Encourage confidence
- Afford the patient a higher level of functioning

(Reznick & Rosenheck, 2018)

Health teams with PSS experienced:
- Improved outcomes for patients with substance abuse
- Reduced relapse rates
- Increased treatment retention and adherence
- Enhanced motivation

(Pouyanoff et al., 2018)

PROJECT METHODS

Design

- Quality improvement project to improve referral process to the PSS
- Setting: Midwest Department of Veteran’s Affairs clinic
- Aim: To increase the number of patients who see the PSS through education provided by the clinic staff

Implementation

- A PSS receives referral from the provider or nursing staff
- An educational handout created for staff about the PSS’s role
- Educational sessions provided to assist clinic staff in identifying patients eligible for PSS services
- If patient qualified for services and was agreeable, the provider was notified and gave a warm handoff to the PSS

Evaluation

- Data from May and June 2021 to determine the number of referrals pre implementation
- Project Implementation: July and August 2021.
- Data number of referrals two-months post intervention
- A meeting with clinic staff, providers and the PSS was held to allow qualitative feedback

EVALUATION

Pre and Post Implementation Pre and Post Support Educational Handout and Associated Total Patient Appointments

Impact on Practice

- Clinical staff at this Veteran’s Affairs clinic have a better understanding of the services that the PSS provides

- This project can help to identify the role of the PSS and clarify the confusion on when to refer to the PSS or a PCMHI
- Clarification between the two roles will help to establish a better referral system and ensure the correct and most appropriate referral is placed

Conclusions

PSS continue to act as an additional mental health resource for the primary care provider

In the setting of the VA, defining the role of the PSS and other mental health specialist (PCMHI) to ensure the correct referral is placed and the proper expertise is used

Long term impact could involve an increase of referrals and the use of PSS over all disciplines of health care

Better recognition and diagnosing tools for mental health disorders; as well as enhanced methods of treatment and the incorporation of collaborative care with other mental health professionals

Acknowledgements

Data number of referrals to PSS:
PROBLEM INTRODUCTION

- Nationwide, the volume of emergency department (ED) visits has steadily increased over the last several decades (Joshi et al., 2019).
- This increase in volume frequently causes ED crowding and delays in patient evaluation and treatment, which is associated with poor patient outcomes (Rademacher et al., 2019).
- In an effort to decrease door-to-provider (DTP) wait times, an ED in central Illinois initiated a tele-triage process utilizing on-call nurse practitioners and physician assistants.
- Prior to this implementation, no guidelines existed regarding the activation and use of tele-triage medical screening exams at the ED for patients in the waiting room.
- A protocol was developed to guide the tele-triage process and to train ED staff on how to implement tele-triage protocol.

LITERATURE REVIEW

- Tele-triage in the ED decreases DTP times and reduces the number of patients who leave without being seen (LWBS) (Izzy et al., 2018; Rademacher et al., 2019).
- Overcrowding of EDs linked to decreased quality of care, negative patient experiences, and exceedingly long door-to-provider times, it also leads to long wait times resulting in patients who leave without being seen (LWBS) (Rademacher et al., 2019; Joshi et al., 2019).
- A study by Rademacher et al. (2019) evaluated tele-screening of patients versus their previous in-person screening and LWBS patient numbers decreased from 25.1% to 4.5%.
- Implementing tele-triage will decrease door-to-provider wait times and decrease the providers and patients’ risk to exposure as well as decrease the number of patients who leave without being seen.

IMPACT ON PRACTICE

- Increased use of tele-triage protocol = faster patient evaluation by a medical provider
- Expansion: implementing the tele-triage protocol in other EDs and giving tele-triage providers the ability to not only assess but discharge when appropriate

EVALUATION

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<thead>
<tr>
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<th>Prior to Project Implementation</th>
<th>During Implementation</th>
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</thead>
<tbody>
<tr>
<td>Average Door to Provider Time</td>
<td>20 minutes</td>
<td>17.37 minutes</td>
</tr>
<tr>
<td>Average Overall Length of Stay</td>
<td>178 minutes</td>
<td>146.95 minutes</td>
</tr>
<tr>
<td>Percentage of Patients Who Left without Being Seen</td>
<td>3%</td>
<td>2.96%</td>
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CONCLUSIONS

- Overall successful implementation of the tele-triage protocol
- Decrease in DTP for patients, overall length of stay and percentage of patients who LWBS
- A limitation faced during implementation was staffing shortages which resulted in inability to activate the protocol on several occasions
- Recommendation from ED staff was to move the tele-triage process to private room with one nurse technician assisting in tele-triage protocol

Acknowledgements

We would like to thank Dr. Sobczak and Dr. Schmidt for their guidance throughout the project. We would also like to thank all at Envision and St. John’s Hospital Emergency Department.
Establishing A Neonatal PICC Line Team
Rebecca L. Hunt, APRN-CNP, ACCNS-Neonatal, DNP Candidate
Southern Illinois University Edwardsville

PROBLEM INTRODUCTION

Infants admitted to the NICU have a plethora of diagnoses. The nature of these disease processes usually precludes enteral feedings. Providing the infant with appropriate nutrition and hydration is a priority; this usually requires central venous access. Peripherally Inserted Central Catheters (PICCs) allow for a reliable route of administration for total parenteral nutrition and medications.

Due to various factors, a proposal was made to begin a nurse-led neonatal PICC line team to allow for timelier placement of PICC lines and, ultimately, better care for the neonatal population at the hospital.

LITERATURE REVIEW

The placement of PICC lines in neonates has been found to be safe, with significantly fewer complications and infections than with surgically placed central venous catheters (CVS).

McDiarmid et al. (2017) found that when a member of the nurse-led team places a PICC, the patient receives all the advantages of a PICC line with a very low risk of complications.

Krein et al. (2015) suggested that the increasing utilization of PICC lines in the NICU can be attributed to nurses' ability to safely and cost-effectively insert PICC lines after receiving additional training. Thus, PICC teams have become an extremely vital part of the health care team.

PROJECT METHODS

Selection of the PICC Line Team
Team members divided evenly between day shift & night shift to provide 24-hour coverage year-round
Initial qualifications included 4+ years of level III NICU experience, expert peripheral IV skills, and excellent communication and organizational skills

Defining the Structure of the Team
Neonatal PICC line team oversight committee led by a chairperson
Make decisions on how to manage ongoing PICC team education, guideline updates, and quality improvement projects

Training of the PICC Team Members
Didactic work - online education, proper procedures, dressing change techniques, and recognizing/managing potential complications
Clinical work - successful insertion of five PICC lines proctored by the experienced NPs

Evaluation of Outcomes
Length of time between PICC line consultation to successful PICC line placement
Average number of umbilical line days
Number of peripheral IV attempts that take place between PICC line consultation to successful PICC line placement

EVALUATION

Project variables were chosen for collection and review based upon a comprehensive literature review of relevant research and performance improvement projects in conjunction with the institution's specific goals.

One year of retrospective data analysis of patient medical records was completed before the establishment of a neonatal nurse-led PICC line team
One year of retrospective data analysis of patient medical records was completed following the establishment of a neonatal nurse-led PICC line team

IMPACT ON PRACTICE

Improved care to the neonatal (NICU) population
Decreased the average number of umbilical line days
Decreased the length of time between PICC line consultation to successful PICC line placement
Decreased the number of peripheral IV attempts that took place between PICC line consultation to successful PICC line placement

CONCLUSIONS

Nurse-Led PICC Line Team
Improved patient care due to timely placement of PICC line
High success rate of PICC line insertion with minimal complications
Decreased CLABSI rates (impacts length of stay and overall healthcare costs)
Team members become powerful advocates for standardizing how PICCs are inserted and maintenance
Improving Healthcare Team Communication with Limited English Proficiency Families in the NICU
Ivonne Mandell, MSN, NNP-BC
Southern Illinois University Edwardsville

**PROBLEM INTRODUCTION**

Language barriers in healthcare settings create dissonance in care between individuals with limited English proficiency (LEP) and those with English proficiency.

For LEP families in the NICU, the inability to communicate with healthcare providers can isolate parents and result in adverse outcomes at higher rates of adverse events, worse post-op pain management, decreased treatment adherence, increased length of hospital stay, and increased rates of readmission.

Despite the acknowledged advantages of using professional interpreters, even when they are readily available, they are frequently underutilized.

The setting for this project was a 65-bed, university-affiliated, level IV NICU in a medium-sized Midwestern city.

**LITERATURE REVIEW**

**Databases:** Academic Scholar Complete, Cumulative Index to Nursing and Allied Health Literature Plus with Full Text (CINAHL), MEDLINE Complete, Google Scholar

**Keywords:** language barriers, limited English proficiency, safety risks, healthcare, interpreters, video, modalities, NICU, family centered care, education, best practice, practice guidelines, evidence-based practice

Sources published from 2000-2021

1. Professional medical interpreters have been shown to greatly improve parent/staff communication, increase parent satisfaction, and improve quality of care
2. Solid parent-provider communication can result in better health outcomes by increasing parental empowerment and participation in their child's care (Walker-Vischer et al., 2015)
3. Despite the acknowledged advantages of using professional interpreters, even when they are readily available, they are frequently under-utilized
4. Use of ad hoc interpreters should be avoided

Post-education surveys revealed that staff found the PowerPoint clear, easy to understand and applicable to the care of NICU patients.

5 LEP families identified
- All language preferences and interpreter needs documented in EMR
- Families with 2 LEP parents updated with interpreters most frequently (every 1-2 days)
- Care conferences scheduled for 2 long-term stays
- Video was most frequently used modality

**PROJECT METHODS**

The purpose of this project was to improve communication between the healthcare team and limited English proficiency families in the NICU using professional interpreters.

IRB approval not required as this was a QI project

Literature review and evaluation of available interpreter modalities

Staff education and practice guidelines developed and implemented

Evaluation of project using anonymous surveys

**IMPACT ON PRACTICE**

**EVALUATION**

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**CONCLUSIONS**

- Educational module and clear postcare guidelines helped NICU staff understand the importance of identifying LEP families and using professional interpreters
- Staff felt empowered to use available modalities, improving routine communication with LEP families
- Video remote interpreter service was by far the most popular for its convenience and “personal” factor

Daily communication using interpreters became part of routine care

Future implications for potential projects:
- Review of available translated materials
- Certification of staff members as interpreters

**PROJECT COMPONENTS**

**Staff Education**
- Importance of professional interpreter use
- Strategies for communicating effectively through an interpreter
- Instructions on all three available interpretation modalities (in-person, video, and telephone)

**Practice Guidelines**
- Identification of LEP families and documentation of language preference and assistance needs in the electronic medical record (EMR)
- Routine communication between LEP families and the medical team using an interpreter
  - "Orientation" to the NICU at the time of admission
  - Communication during daily bedside rounds
  - Routine multi-disciplinary care conferences
Anticipatory Guidance for Caregivers of Pediatric Patients Ages 0-12 Months

PROBLEM INTRODUCTION
- The greatest causes of infant death include sudden unexpected death in infancy (SUDI), suffocation, transportation-related injuries, drowning, burns, poisoning, and falls (Borse et al., 2008).
- Anticipatory guidance is defined as proactive counseling for caregivers regarding various aspects of childcare and development (Weber-Gasparoni & Rayes, 2019).
- The purpose of anticipatory guidance is to promote health in the developing child while working to prevent unintentional injury or harm.
- Common topics include but are not limited to nutrition, sleep, safety, immunizations, and developmental milestones.
- This project sought to improve the process and delivery of anticipatory guidance for infants aged 0-12 months at one rural pediatric primary care clinic.

LITERATURE REVIEW
- Anticipatory guidance has multiple benefits: improved parenting and child safety practices, increased child development and decreased maternal stress (Hsu et al., 2018).
- There are various methods of providing anticipatory guidance education to caregivers of children aged 0-12 months, some of which include videos/other electronic materials, written materials, and verbal discussion.
- Various studies have demonstrated benefits in the provision of anticipatory guidance education through the combination of videos, written materials, and verbal discussion (Franz et al., 2018; Hsu et al., 2018; Panza et al., 2020; Paradis et al., 2011).

PROJECT METHODS
- Updated written educational materials with most recent recommendations
- Revised design of written educational materials to optimize caregiver engagement
- Created anticipatory guidance educational videos
- Presented videos on clinic tablet to caregivers during each well child visit prior to the provider entering the examination room
- Through these interventions, caregiver education regarding most recent evidence-based anticipatory guidance recommendations was optimized and tailored to the caregiver’s current understanding of recommendations

IMPACT ON PRACTICE
- Provider perspectives were collected using anonymous, voluntary surveys, utilizing open-ended questions
- A focus group was also held with clinic staff to discuss provider/staff perspectives on the project
- Provider perspectives were similarly positive

EVALUATION
- Data regarding written and video educational materials were collected from caregivers through the administration of anonymous, voluntary paper surveys with Likert scales
- 32 caregiver surveys were collected - RESULTS:
  - 96.9% Educational materials were easy/very easy to understand
  - 96.9% Materials were visually appealing/very visually appealing
  - 96.9% Educational materials were helpful/very helpful
  - 96.9% Overall satisfaction with education was somewhat/very satisfying

CONCLUSIONS
- Anticipatory guidance is best received when given in multiple formats
- Caregivers received more individualized education during appointments
- Need for funding for rural clinic website updates identified
- Provided new, updated means of caregiver education
- Updated hand-out forms for caregivers to take home and utilize later
- Opportunity for further development for how anticipatory guidance is provided in the office
Establishing Care with a Primary Care Provider
Ashley Whitlatch, MSN, APRN, FNP-BC
Southern Illinois University Edwardsville

PROBLEM INTRODUCTION
Approximately one out of every four Americans do not have a regular primary care provider (Brody, 2020).

Not being established with a primary care provider can lead to issues for patients, healthcare providers, and the healthcare system. Being established with a primary care provider (PCP) increases preventative measures, increases access to other needed healthcare services and decreases the emergency health care system (Bataineh, 2019).

Delaying or not establishing care with a primary care provider may also deteriorate the patient’s quality of life (Faridi et al., 2016).

An increase in patient care errors, increased patient mortality, increased waiting times, and increased instances of harm to the patient leading to increased financial troubles can all take place the healthcare system is under stress (Salway, Valenzuela, Shoenberger, Mallon, and Viccellio, 2017).

The systematic review revealed a 10% reduction in patients being evaluated in the emergency room when they have access to primary care (Morley, Unwin, Peterson, Stankovich, and Kinsman, 2018).

Brody (2020) suggests that when a patient has an established primary care provider, not only do they have increased continuity of care, but they also have a decreased chance of dying prematurely.

PROJECT METHODS
Clinic Employee Education
Primary Care Provider Information
Clinic Employees Training
Follow-up Appointments for Non-established Patients
Tracking and Charting Information
Feedback from Staff Using Likert Scale and Survey

IMPACT ON PRACTICE
An assessment is completed during every rooming process to see if a patient is currently established with a primary care provider. This assessment ensures that every patient who utilizes the clinic’s services has an opportunity to be provided access to a primary care provider. The impact of this process will assist with decreasing the unnecessary usage of urgent and emergent care services.

LITERATURE REVIEW
Reducing unnecessary usage of urgent/emergent care resources
Effects on the quality of life when established with a primary care provider
Stress on the urgent/emergent healthcare system
Process/Policy change to establish a primary care provider
Continuity of care and improved patient outcomes

EVALUATION
PowerPoint Presentation
Live Demonstration
Clinic/Technical Education
Pre-Assessment and Post-Assessment
Completed by Clinical Staff
EPIC Resource Personnel
Technical Education
Questions

CONCLUSIONS
There were a total amount of 44 patients who had an appointment scheduled to establish care with a primary care provider.

Twenty-three of all the patients were compliant.

Seven percent of patient could not follow up due to be cancelled by the provider.

Thirty-eight percent of the patients were non-compliant.
ERAS protocols for General Abdominal and Orthopedic Surgery: Preoperative Hydration and Multimodal Management

Kristin Wolff, BSN, SRNA & Sadie Turner, BSN, SRNA
Southern Illinois University Edwardsville

PROBLEM INTRODUCTION

Introduction to ERAS:
- Evidence-based, patient-centered, interdisciplinary team-developed protocol (AANA, 2017)
- Utilized to decrease the patient’s stress response to surgery, maintain preoperative physiological function, and expedite recovery (AANA, 2017).
- Conventional ERAS protocols were the first ERAS protocols developed (late 1990s), and today medical centers are currently developing and implementing more ERAS protocols for specific patient services, such as general abdominal and orthopedic cases (Heathcote et al., 2019).

ERAS Evidence:
- Current evidence demonstrates that ERAS protocols lead to better patient outcomes, decrease postoperative complications, facilitate recovery, and allow for earlier discharge (AANA, 2017).
- Studies show that one must employ the preoperative, intraoperative, and postoperative components of the ERAS protocols to achieve maximum benefits (Heathcote et al., 2019).

Project Problem:
- A rural hospital in eastern Illinois, Paris Community Hospital (PCH), utilizes some components of the ERAS protocols, mainly the intraoperative portions, but lacks the full utilization.
- The purpose is to identify evidence-based ERAS protocols for general abdominal and orthopedic surgery, with emphasis on preoperative hydration, preoperative multimodal management, and postoperative multimodal pain management.

LITERATURE REVIEW

Preoperative Hydration
- Preoperative fasting guidelines are consistent for nearly all surgical procedures, allowing patients to drink clear liquids (including carbohydrate drinks) until 2 hours before anesthesia induction and eat a light meal until 6 hours before surgery. (Thiele et al., 2016; Gustafsson et al., 2019)
- The ERAS protocols for orthopedic and abdominal general surgical cases include consuming a carbohydrate drink 2-3 hours prior to surgery. (Gustafsson et al., 2019)
- Maintaining a zero-fluid balance is the goal, as fluid excesses and deficits are associated with increased postoperative complications and prolonged hospital stay. (Gustafsson et al., 2019)

Multimodal Analgesia
- The American Society of Enhanced Recovery states that multimodal analgesic strategies should include a minimum of two nonopioid analgesics and an epidural or regional nerve block as appropriate. (Marcotte et al, 2020)
- Utilizing a multimodal approach, including NSAIDs, acetaminophen, gabapentinoids, corticosteroids, lidocaine, NMDA antagonists, and dexmedetomidine, can significantly reduce the opioid requirements of the patient. (Kaye et al., 2019)
- Utilizing multimodal medications optimizes pain control for the patient, reduces the reliance on opioids, and reduces the length of stay. (Frassanito et al., 2020; Feldheiser et al., 2015)

PROJECT METHODS

Aim
- Educate the healthcare providers in the knowledge deficit areas: perioperative goal-directed fluid management, preoperative and postoperative multimodal analgesic management, and the contraindications to the medications utilized in ERAS protocols.

Implementation
- Educational voiceover PowerPoint and protocol regarding the management of hydration status and multimodal analgesia for general abdominal and orthopedic surgeries.
- In-person presentation at the monthly surgical meeting, giving providers another opportunity to receive the material and ask questions.

UPDATING HYDRATION PROTOCOL

<table>
<thead>
<tr>
<th>Protocol</th>
<th>General Abdominal Surgery</th>
<th>Orthopedic Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluids</td>
<td>Light meal until 6 hours before anesthesia induction, carbohydrate drinks until 2 hours before anesthesia induction</td>
<td>No fluid restriction until surgery, light meal before induction, clear liquids before induction</td>
</tr>
<tr>
<td>Interventions</td>
<td>Postoperative:</td>
<td>Postoperative:</td>
</tr>
<tr>
<td>Mortality</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Infection</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Wound dehiscence</td>
<td>0%</td>
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<tr>
<td>Hospital stay</td>
<td>3 days</td>
<td>3 days</td>
</tr>
<tr>
<td>Mortality</td>
<td>0%</td>
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<td>Hospital stay</td>
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<td>3 days</td>
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EVALUATION

Evaluation: post-presentation anonymous survey completed by three anesthesia providers, two surgeons, and two other surgical healthcare workers.

Six out of seven participants stated the knowledge gained from the presentation would affect their practice.

IMPACT ON PRACTICE

The number of general abdominal and orthopedic procedures continues to grow. ERAS protocols improve patient satisfaction, decrease surgical complications and decrease costs and hospital length of stay.

Proper preoperative hydration improves patient satisfaction along with being economical and clinical benefits.

Multimodal analgesia management decreases stress response to surgery and opioid use. With the current opioid epidemic and the multiple adverse effects of opioids, limiting their use has numerous benefits for the patient.

CONCLUSIONS

The project can be sustained by continued use of the protocols and the providers’ ability to update the protocol as evidence continues to evolve.

Continued Research
- Changing the research methods of this project at facilities across the country would lead to increased utilization of ERAS protocols.

Limitations
- A limitation of this project was the small number of participants.
- Another limitation of this project was using a convenience sample of participants.

References
- Marcotte et al. (2020)
- Heathcote et al. (2019)
- Thiele et al. (2016)
- Gustafsson et al. (2019)
- Frassanito et al. (2020)
- Feldheiser et al. (2015)