Doctor of Nursing Practice
Scholarly Project Project Symposium

July 28, 2016

Signe Skott Cooper Hall
701 Highland Avenue
Madison, Wisconsin
It is my pleasure to welcome you to the Summer 2016 Doctor of Nursing Practice (DNP) Scholarly Project Symposium. Thank you for joining us as we celebrate the accomplishments of our graduating students.

The AACN Position Statement on the Practice Doctorate in Nursing (AACN, 2004) recommended that advanced nursing practice education be moved to the doctoral level. A decade later, the Doctor of Nursing Practice (DNP) is widely recognized as one of the discipline’s two terminal degrees, and is the preferred path for those seeking preparation at the highest level of nursing practice. One important role of the DNP is to translate evidence (research) into improved clinical practice through quality improvement initiatives, policy development, and advanced leadership.

The scholarly project is a culmination of the DNP student’s graduate education. Scholarship is the mechanism by which new knowledge is generated within a discipline. The DNP student is not prepared to conduct formal generalizable research, but is instead educated to appraise research findings, apply new science to practice, and evaluate the outcomes of this process. This kind of scholarship will naturally inform our own work; and when shared, stands to further improve outcomes and care quality in settings beyond our own. Thus, DNP graduates generate new knowledge through their practice to guide improvements and outcomes of care (DePalma & McGuire, 2005). "The impact of DNP scholarship is gauged, not by its contribution to generalizable knowledge, but by its contribution to improved outcomes (Rolfe & Davies, 2009).

New recommendations from the 2015 American Association of Colleges of Nursing (AACN) Task Force on the Implementation of the DNP echo these perspectives. The focus and design of our 2016 DNP candidates’ final scholarly projects were shaped by an emphasis on applied evidence, improved outcomes, and
innovative practice. Our students have worked hard to master these skills, and it is our proud pleasure to have you join us as they share their scholarly projects.

Many thanks for your ongoing support of our program and our August 2016 DNP graduates.

Warmest Regards,

Pamela Ann McGranahan DNP, APHN-BC
DNP Interim Program Director
Clinical Assistant Professor

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1:00pm  Promoting Psychosocial Assessment & Implementation of Evidence-Based Clinical Support Tools in a Federally Qualified Pediatric Primary Care Setting
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1:30pm  Evaluating and Improving Referrals to a Pediatric Specialty Dyslipidemia Clinic
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2:30pm  Music Intervention: Impact on Anxiety in Cardiac Catheterization Patients
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3:00pm  Shared Medical Appointments: Impact in Behavioral Health
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9:00am  Welcome and Introductions

Session 1

9:20am  Guiding and Informing Comprehensive Care of Women Veterans: An In-depth Approach
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Session 2

1:00pm  Design and Development of an Evidence-Based Mobile App to Support Informal Caregivers of Older Adults: Spotlight on the Creation of a Driving Safety Module
Paula Brady

1:30pm  Identification of Barriers to Primary Care and Behavioral Health Integration
Jonathan Williams

2:00pm  Effects of Standardized Patient Simulation on Nursing Students in the First Year of Clinical Nursing Practice
Stacey Boehm

2:30pm  Implementing Group Medical Visits to Improve Complex Patient Outcomes in an Integrative Medicine Clinic
Carissa Dolens

3:00pm  Routine Body Mass Index Screening and Referral to Improve Care Integration in a Community Mental Health Clinic
Melissa Fuhrmann
Increasing Senior Participation in FoodShare through Policy Change Developing a Policy Recommendation for Public Health Madison & Dane County
Nicole Mendolla, BSN, RN, OCN

**Background:** Over 9 million seniors in the United States experience food insecurity, negatively impacting health outcomes and creating subsequent financial burden to individuals and families. Food insecure seniors are more likely to experience diabetes and heart problems. The Supplemental Nutrition Assistance Program (SNAP) is the largest federal food assistance program for food insecure households. Senior participation in SNAP is low. SNAP is called FoodShare in Wisconsin. Less than half of eligible seniors in Wisconsin participate in FoodShare. The literature recommends addressing the following barriers to increase senior participation in SNAP: confusion about eligibility, burdensome application process, low benefits, mobility and transportation issues, and stigma.

**Design:** A gap analysis was conducted on best practice for increasing senior participation in SNAP and current practice in Wisconsin. Findings supported a policy recommendation for administrative and legislative changes at the local and state levels to support increased senior participation in FoodShare.

**Methods:** Interviews were conducted with multiple senior nutrition assistance stakeholders at the local, state, and national levels. Data on outreach projects targeting seniors were also collected at the local, state, and national levels.

**Conclusion:** Senior participation in FoodShare can be increased through outreach, simplifying the application process, maximizing benefits, and expanding FoodShare retailers. Following the recommendations proposed as a result of this project should improve FoodShare participation by food insecure seniors in Dane county and could be adapted for use at the state and national levels.
Biographical Sketch: Nicole Mendolla, BSN, RN, OCN is a post baccalaureate Doctor of Nursing Practice student. She earned her Bachelors of Science in Nursing from the University of Wisconsin Madison in 2010. She has worked as a Registered Nurse at UW Hospital and Clinics for six years with the hematology, oncology, bone marrow transplant and palliative care populations. Upon graduation she will become a board certified Adult-Gerontology Primary Care Nurse Practitioner. She looks forward to starting a career in primary care with an interest in health promotion and disease prevention.

Scholarly Project Professor: Julia Vance, DNP, MS, CNM

Clinical Project Partner: Nick Heckman, Food Security Policy Analyst at Public Health Madison & Dane County
Additional credit to Elizabeth Rice PhD, PMHNP-BC
Interdisciplinary Teamwork within Primary Care: A Qualitative Approach to Best Practice Recommendations
Becca Weld Hall

Abstract: Primary care serves as the principal health care entry point for insured patients into the healthcare system in the United States. Teamwork has been identified as a critical mechanism for achieving optimal primary care by improving efficiency, coordination, and patient satisfaction. Within primary care, a basic team most often consists of a prescribing provider and a medical assistant (MA). Little practice guidance exists to facilitate effective teams of providers and MAs.

This project identified preliminary practice recommendations for optimal teamwork in primary care by combining an analysis of well-functioning MA and provider teams in a single practice with available literature. The overall intended impact of these recommendations are to guide team structures and processes to improve the primary care practice environment.

Several themes emerged from the analysis as possible “best practices” for MA and provider teamwork: shared goals between provider and MA to provide patient-centered care; ability of MA to build relationships with patients and families while acting as liaison between provider and patient; mix of communication methods to best fit the situation; and provider openness to MA providing important “heads-up” information. Several recommendations were formed to guide primary care processes: encouraging an open communication environment, consistent, long-lasting working relationships between providers and MAs, and encouraging a shared connection with patients throughout the team. Additionally, areas for future quality improvement and research inquiry were identified.
**Biographical Sketch:** Becca Weld Hall, BSN, RN is a post-baccalaureate Doctor of Nursing Practice student. With graduation, she will become a board certified Adult Gerontology Primary Care Nurse Practitioner. She has clinical interests in systems issues and improvements. As a registered nurse, she has worked in geriatrics, internal medicine, and sub-specialty medicine. After graduation, she is interested in advancing in clinical practice in one of those areas.

**Scholarly Project Professor:** Linsey Steege, PhD
Additional credit to Pam McGranahan, DNP, APHN-BC

**Clinical Project Partner:** Tosha Wetterneck, MD, University of Wisconsin School of Medicine and Public Health and University of Wisconsin Center for Quality and Productivity Improvement
Implementation of the Healthcare Equality Index
Trenell “Tré” Darby, BSN, RN

Abstract: Background. Lesbian, gay, bisexual, and transgender (LGBT) individuals and families have a long history of facing societal stigma and discrimination. Such discrimination has permeated many facets of society, including the health care system. LGBT individuals often face barriers to accessing needed health services resulting in health disparities that can lead to poor health outcomes such as more chronic conditions and higher prevalence of disabilities. Health care organizations can begin addressing barriers to health care access by assuring that policies are inclusive of the LGBT patients, families, and employees and creating an environment that is open and welcoming to sexual and gender minorities. Methods. Using the Healthcare Equality Index developed by the Human Rights Campaign Foundation, a policy implementation project was developed to address and enhance patient-centered care for LGBT patients who seek care or wish to seek care at a large, Midwestern community hospital. The goal of the project was to obtain the designation of “Leader in LGBT Healthcare Equality” by implementing organizational non-discrimination policies inclusive of LGBT patients, families and visitors and provide education to hospital leadership and staff on culturally competent care. Results. The project was successful in revising organizational policies inclusive of the LGBT community and increasing awareness of issues unique to LGBT health. Eleven policies were revised to include additional non-discrimination language and online training was provided to five senior-level leaders within the organization. Discussion. Health care organizations can improve the patient-centered care by implementing policy level changes that affect the environment of care and highlight its commitment to equity and inclusion.
Biographical Sketch: Trenell “Tré” Darby, BSN, RN is a post-baccalaureate DNP student in the adult/gerontology primary care nurse practitioner track. He earned his Bachelor’s degree in Nursing from the University of Wisconsin-Madison in 2010. Since graduation, he has worked as an inpatient nurse on a plastics/ENT/medicine unit and an assistant nurse manager on a pulmonary/medicine unit at Froedtert Hospital in Milwaukee. He currently works as the clinic supervisor for the After Hours Clinic at UnityPoint Health – Meriter in Madison, Wisconsin. Upon graduation, Tré plans to enter clinical practice working in primary care with adults and older adults. His interests include health promotion, disease prevention, population health, health policy and leadership. He hopes to use his doctoral training from the University of Wisconsin-Madison to pursue a career that will have lasting impacts on the health care system for all.

Scholarly Project Professor: Julia Vance, DNP, MS, CNM

Clinical Project Partner: Mary Forrestal Jones, Director of Human Resources, UnityPoint Health – Meriter
Abstract: Type 1 diabetes mellitus (T1DM) is one of the most common chronic diseases in childhood. Parents have a large role in the complex tasks of caring for a child with T1DM and as a result experience relatively high levels of stress. The effects of stress can impact both the health of the child and the parent. The purpose of this quality improvement project was to evaluate the effectiveness of a monthly support group at Children’s Hospital of Wisconsin- Fox Valley Diabetes Clinic (CHFVDC) in addressing the needs of parents and its impact on their stress levels as it relates to caring for a child with T1DM. The Pediatric Inventory of Parents (PIP) was used to assess changes in stress in parents of children with T1DM who attended four separate 1.5-hour support groups. Parents interestingly had higher mean PIP stress scores following participation in the support group, but overall, the majority of participants responded positively to the sessions, indicating that talking with others who personally understand T1D was helpful. Although this project had a limited number of participants and was only conducted for 4-months, the support group was a promising social support intervention for parents raising children with T1DM. Results further support the need for diabetes care teams to consider the psychosocial needs of parents as an integral component of pediatric diabetes care management. Diabetes care teams should consider creating support groups as a means to influence health outcomes and to better serve families of children with T1DM.

Biographical Sketch: Crystal Bales, BSN, RN, CLC is a Post-Baccalaureate DNP student who also completed the Nurse Educator certificate during her time in the program. She is a pediatric nurse and certified lactation consultant for Children’s Hospital of Wisconsin-Fox Valley. She also previously taught as a Senior Teaching Assistant for the UW-Madison School of Nursing. Her scholarly project focused on improving support for parents of children with Type 1 Diabetes. Upon graduation, she will become a board certified Pediatric Nurse Practitioner. Crystal hopes to pursue a career as a PNP in an ambulatory setting, as well as a career in nursing education.
**Scholarly Project Professors:** Linsey Steege, PhD
Barb Pinekenstein, DNP, RN-BC, CPHIMS

**Clinical Project Partner:** Shari Liesch, APNP, RN, CDE,
Children’s Hospital of Wisconsin-Fox Valley Diabetes & Endocrine Clinic
Abstract: Almost every person in the United States will be infected with human papillomavirus (HPV) at some point in their lives. Most HPV infections are cleared by the immune system; however, in some individuals HPV is not cleared, and instead proliferates and can cause cancer. The HPV vaccine is a safe and effective strategy to decrease HPV rates and yet, this vaccine is underutilized. HPV vaccination rates at Beloit Community Health Center (BCHC) are below national and state averages. The objectives of this project were to increase HPV immunization rates at BCHC and increase clinician knowledge of HPV and the HPV vaccine. Implementation consisted of provider education and a reminder component. A pre- and post-test design was utilized to evaluate knowledge change. Clinicians’ vaccine knowledge and confidence in discussing HPV vaccine with patients increased significantly on the post-test. A text message reminder from an outside vendor for the next dose of HPV vaccine was offered to parents of 11-18 year old patients seen at BCHC during the 12 week project implementation period. Overall, HPV immunization rates among patients at BCHC increased one percent for the first dose and two percent for the third dose of HPV vaccine. Seventy percent of adolescent patients seen at BCHC during the 12 week data collection period who were eligible for a dose of HPV received one. Clinician education and text message reminders do increase HPV vaccination rates and should be expanded to initiatives beyond HPV vaccination.
Biographical Sketch: Maria Standiford, BSN, RN is a post-baccalaureate Doctor of Nursing Practice student in pediatrics. Her career as a registered nurse has been in pediatric hematology and oncology, adolescent medicine and bleeding disorders. She plans to continue her career in adolescent medicine with a clinical focus on menstrual management.

Scholarly Project Professor: Linsey Steege, PhD

Clinical Project Partner: Ruth Amenda, Director of Operations and Thad Regenold, RN, Beloit Community Health Center. Additional credit to Tracy Saladar, DNP, CPNP, RN
Promoting Psychosocial Assessment & Implementation of Evidence-Based Clinical Support Tools in a Federally Qualified Pediatric Primary Care Setting
Anne K. Palmer

**Background:** Emerging research highlights the fundamental importance of patients’ social, emotional, and physical well-being throughout the life course. Without sound assessment and intervention to support the psychosocial health of children and families, the incidence of chronic disease increases dramatically. Several barriers to screening and assessment in the primary care setting exist including a lack of provider training and comfort with this type of assessment, a lack of knowledge of effective community resources, and limited economic incentive to conduct standardized assessment. Addressing this gap in provider knowledge regarding evidence based means of addressing psychosocial needs of families in the outpatient setting was the focus of this project.

**Methods:** This quality improvement project utilized a pre-post intervention design to assess the effects on health care professionals’ knowledge, attitudes and confidence surrounding addressing the psychosocial needs of patients and families. This project included the development and distribution of an Adverse Childhood Experiences Surveillance Questionnaire, the development of a provider training curriculum, the delivery of two-provider education sessions, and the creation of updated community resource manuals for utilization within the clinic.

**Results:** Improved knowledge of the long-term physiologic consequences of childhood adversity was evident in the intervention group. This project also noted an improvement in providers’ interest in and support for an increased scope and frequency of psychosocial screening in their clinic. Participants also agreed, in accordance with prior research, that increased referral rates for at-risk children and families to trusted community resources would be an important protective mechanism for families. Increased provider confidence regarding his or her effectiveness in addressing psychosocial issues was observed and a clinical recommendation to begin utilizing a researched psychosocial assessment tool was made.
Conclusions: This project confirmed that improvements in attitudes, knowledge, and confidence in pediatric providers regarding psychosocial assessment and screening, can be made by addressing clinical barriers and disseminating the results of research addressing childhood adversity. Familiarity with community resources also increases confidence in providers’ ability to refer patients to these resources. Supporting clinician understanding of the long-term implications of adverse childhood experiences, how to access trusted clinical resources, and how to utilize comprehensive psychosocial assessment tools can help health care delivery systems overcome these clinical barriers.

Implications for Nursing: Gaps in provider knowledge regarding the Adverse Childhood Experiences study and confidence in addressing psychosocial screening addressed by the provider education sessions are an opportunity for didactic clinical learning opportunities. Open-source clinical resources for addressing childhood adversity and assessing provider understanding of psychosocial health in primary care setting should continue to be researched.

Biographical Sketch: Anne Palmer, BSN, RN, is a DNP student with a background in pediatric critical care nursing. Her interests include the integration of social determinants of health into health assessment and opportunities to support sound interdisciplinary care to pediatric patients. Her scholarly project addresses clinical supports for ensuring evidence-based pediatric psychosocial assessment and community referral processes are in place and reliable. Anne plans to work as a Pediatric Nurse Practitioner at Seattle Children’s Hospital on the Medically Complex Child team starting in the Fall of 2016.

Scholarly Project Professor: Pam McGranahan, DNP, APHN-BC

Leadership Practicum Preceptor: Tracy Saladar, DNP, CPNP, RN, Beloit Area Community Health Center
Evaluating and Improving Referrals to a Pediatric Specialty Dyslipidemia Clinic
Cassandra M. Lovato, BSN, RN, RNC-NIC

Abstract: Cardiovascular disease has become an epidemic within the United States; research has shown that clinical changes begin in early childhood. Universal pediatric lipid screening guidelines were created to identify and treat children who are at most risk for cardiovascular disease in adulthood. As universal screening became routine for health care providers, a large pediatric population was identified with having pediatric dyslipidemia. At the same time, pediatric cardiology providers created the Pediatric Preventative Cardiology Clinic (PPCC) to diagnose and treat pediatric dyslipidemias. Many patients referred to PPCC were identified as having mild to moderate dyslipidemia, which do not require the specialized care of PPCC providers. The purpose of this project was to evaluate the referrals to PPCC and develop a decision support algorithm to assist pediatric primary care providers in managing care of mild to moderate dyslipidemias as well as clarify the PPCC referral guidelines for patients who require lipid specialists. Data of patients seen in PPCC during 2011-2015 were examined and results showed that over one third of patients referred to PPCC did not meet clinic guidelines for referrals. The clinic’s original provider handout was modified to include lifestyle modifications as well as provide a decision tree to create the decision algorithm for providers. Implications for practice includes education for primary care providers in treating mild to moderate dyslipidemia and clarification on lipid panels that require referrals with the use of the decision support algorithm. Next steps include evaluation of cardiac risk factors that prompt referrals and evaluation of the decision support algorithm in patient referrals at PPCC.
**Biographical Sketch:** Cassandra Lovato is a post-baccalaureate Doctor of Nursing Practice student. Upon graduation she will become a board certified pediatric nurse practitioner. She earned her nursing degree from the University of Arizona and has practiced as a certified neonatal nurse in both Arizona and Wisconsin. Her clinical interests include caregiver support and prevention of depression during NICU admissions and the treatment and prevention of pediatric obesity.

**Scholarly Project Professor:** Barbara Pinekenstein DNP, RN-BC, CPHIMS

**Clinical Project Partners:** Ann M. Dodge, APNP, and Amy Peterson, MD, University of Wisconsin Hospital and Clinics
Abstract: Concussion among pediatric patients has become a significant public health concern because the effects can be severe and life changing. Diagnosis of pediatric concussion frequently occurs in Emergency Departments (ED) since they commonly provide initial evaluation post-injury. However, there is substantial variability among post-concussion discharge practices in the ED. Consistent evidence-based discharge education is critical as patients are at risk for secondary catastrophic injury, increased symptom severity, and delayed recovery. The purpose of this quality improvement project was to improve outcomes among pediatric patients discharged from a regional Level 1 trauma center ED through improvement of the nursing discharge education process. A pre-project survey of ED nursing staff found that only 12% of the 25 respondents identified themselves as very knowledgeable and just 20% identified themselves as very comfortable when caring for pediatric patients with concussion. This project invited nurses from the ED to attend a 60-minute education session accompanied by implementation of an evidence-based pediatric concussion discharge education handout and electronic health record (EHR) documentation review. Following the session, 43% of nurses perceived themselves as very knowledgeable and 64% of nurses perceived themselves as very comfortable. Additionally, 60% of patient charts included documentation of concussion education compared to 37% before the intervention. Findings demonstrated that nurse knowledge and comfort are important when caring for pediatric patients with concussion. However, combining education with an evidence-based education handout and EHR documentation review, brought greater improvement and sustainability to the concussion discharge education process.
Biographical Sketch: Melissa Mellum, BSN, RN is a Post-Baccalaureate DNP student. She earned her Bachelor’s degree in nursing from University of Wisconsin-Madison in 2008 and has worked for the past eight years on the pediatric inpatient medical-surgical unit at American Family Children’s Hospital (AFCH). Her scholarly project work focused on improving the nursing discharge education process for pediatric patients diagnosed with concussion in the AFCH Emergency Department. Her clinical interests include health promotion and disease prevention in primary care through close partnerships with patients and families. Upon graduation, she looks forward to transitioning into the DNP role either in a pediatric primary care or specialty clinic setting.

Scholarly Project Professor: Linsey Steege, PhD

Clinical Project Partners:
Traci Snedden PhD, RN, APRN-PNP, CNE
Postdoctoral Fellow

Mary Jean Erschen-Cooke, RN, MS, BSN, CPEN
Pediatric Emergency Care Coordinator
Music Intervention: Impact on Anxiety in Cardiac Catheterization Patients
Anne Fischer

Abstract: Ischemic heart disease, also called coronary artery disease (CAD), remains the single leading cause of morbidity and mortality in the U.S. and particularly among Veterans who use the VA healthcare system (Department of Veterans Affairs, Veterans Health Administration [VHA], 2013). With more than 500,000 VA patients diagnosed with CAD, it is also one of the most frequent indications for hospitalization within the VHA healthcare system (Maddox et al., 2014). Cardiac catheterization, or coronary angiography, is an invasive procedure requiring a catheter to be placed through a peripheral artery to the heart. The procedure is indicated for diagnosis and/or intervention in coronary artery disease. In preparation for the cardiac catheterization, the patient must lie still on a small fluoroscopy table and is draped with a sterile cloth. The patient is usually awake during the procedure with minimal sedation. Procedural sedation involves the use of short-acting analgesic and anxiolytic medications. It can be assumed that some level of stress or anxiety is natural when preparing for cardiac catheterization. Patients undergoing cardiac catheterization are subject to multiple environmental and psychosocial factors that contribute to anxiety, with up to 35% experiencing severe anxiety (Astin, Jones, & Thompson, 2005). Unfamiliar environments, loss of control, and perceived or actual physical risk are factors affecting anxiety associated with cardiac catheterization, especially if the presenting diagnosis is a new or life threatening condition (Hamel, 2001). Specifically, patients identified lack of control, pain/discomfort, possible medical complications, exposure of body parts, an unknown physician performing the procedure, and unknown future health risks as fears related to impending cardiac catheterization procedures (Caldwell, Arthur, Natarajan, & Anand, 2007). The North American Nursing Diagnosis Association (NANDA) defines anxiety as “A vague, uneasy feeling of discomfort or dread accompanied by an autonomic response, with the source often nonspecific or unknown to the individual; a feeling of apprehension caused by anticipation of danger” and one intervention suggested by NANDA is patient's
choice of music ("Anxiety", 2014, para 1). Speilberger (2004) differentiates situational or state anxiety from trait anxiety, which is a personality trait. His widely accepted State-Trait Anxiety Inventory (STAI) describes state anxiety as "a psychobiological state or condition consisting of subjective feelings of tension, apprehension, nervousness, and worry, associated with activation of the autonomic nervous system" (p.71). Studies show there is a strong association between patient anxiety and invasive medical procedures suggesting that music may have a beneficial effect (Bradt, Delio, & Pontif, 2013; Gillen, Biley, & Allen, 2008; Vanderboom, 2007). The "Guidelines for Complementary Care Interventions" published by the Association of Perioperative Registered Nurses (AORN) states, “The perioperative team can implement music interventions. The collective body of evidence strongly supports the use of music to relieve anxiety during surgical and other invasive procedures.” (Burlingame et al., 2015, Recommendation I, para. 1), rating a level 1 strength of evidence. Clinical practice guidelines for nurse-administered procedural sedation and analgesia in the cardiac catheterization laboratory published in the Journal of Advanced Nursing (pp. 1040-1052) also recommend offering music for intra-procedural patient comfort, relaxation, and reduced anxiety (Conway, Rolley, Page, & Fulbrook, 2014).

Biographical Sketch: Anne Fischer RN, MEd, is a Post-Baccalaureate DNP student in the adult/gerontology nurse practitioner track. She served 28 years in the military as an Air Force flight nurse and nurse administrator, retiring in October 2013. She earned her Master of Education degree in Curriculum and Instruction from Concordia University in 2014. She spent most of her career in critical care and trauma nursing. She is currently working the Cardiac Catheterization/Electrophysiology Lab at the William S. Middleton VA Medical Center. She plans to continue working with this population after graduation.

Scholarly Project Professor: Barbara Pinekeinstein DNP, RN-BC, CPHIMS

Clinical Project Partner: Laura Ziegler, CNMT, Cardiology Manager, Wm S. Middleton VA Medical Center
Abstract: Improving access to health care while maintaining patient satisfaction is a growing challenge. Legislation and policies, such as the Mental Health Parity and Addiction Equity Act of 2008 and the Patient Protection and Affordable Care Act of 2010, increased insurance coverage for behavioral health services and provide significant opportunities to redesign care delivery. Access, however, continues to be limited due to an inadequate number of psychiatric providers, large out-of-pocket expenses, and long wait times. As a result, organizations are exploring innovative scheduling and redesign options to better meet patient needs. Shared medical appointments (SMA) are defined as outpatient appointments that include three or more patients with differing diagnoses, treatments, and demographics attended by one or more providers, intended to enhance the overall wellbeing of individuals, as well as improve access to care. This innovative appointment style, successfully used in chronic disease management, was recently implemented in a behavioral health outpatient clinic.

The purpose of this project was to conduct a semi-structured program evaluation to review the impact of SMA on access, workflow, and patient and provider satisfaction. Evaluation of three groups showed overall satisfaction with the SMA. The patients reported satisfaction with wait time to schedule an appointment and would recommend this type of appointment to family and friends. Almost all patients who attended the mental health follow up SMA rescheduled into another SMA. Persons who attended SMA after acute hospitalization were less likely to be readmitted or to be seen in an emergency room in the months following hospitalization. The SMA can be an effective strategy to increase access, decrease wait times, and improve patient satisfaction.
**Biographical Sketch:** Susan Sample, RN is a post Baccalaureate DNP student. She earned her BSN from Indiana University in 1983. She has worked as a Registered Nurse and Nursing Supervisor for over 30 years at various hospitals and clinics. She is currently working on the inpatient unit of St. Elizabeth’s Hospital in Appleton, Wisconsin. She will begin her job as a PMHNP at Aurora Health Care in September of this year in Oshkosh, Wisconsin at an outpatient psychiatric clinic.

**Scholarly Project Professor:** Barbara Pinekenstein, DNP, RN-BC, CPHIMS

**Clinical Project Partner:** Nadine Duncan, Clinic Manager, Affinity Behavioral Health Clinic
Guiding and Informing Comprehensive Care of Women Veterans: An In-depth Approach
Jessica A. Thieme

Abstract: With the rapid growth of the women Veteran population the Veterans Health Administration (VHA) has made it a priority to research, improve, and develop innovations in gender-sensitive care of women Veterans. Recently, the VHA has mandated women receive care from designated women’s health providers (DWHPs) using designated approaches to segregating care. The purpose of the quality improvement (QI) project was to better understand women Veterans’ health care experiences and preferences in order to guide and inform accessible gender-sensitive comprehensive care within a new women’s health clinic at a Midwestern VHA. The vision-analysis-team-aim-map-measure-change-sustain (VA-TAMMCS) quality improvement framework guided the project. Qualitative methods were utilized to gather information from women Veterans by conducting facilitated focus groups with a semi-structured guide. Multi-step narrative analysis of textual data revealed five themes related to participants experiences of VHA health care: ‘staff interactions’, ‘health care system experience’, ‘care environments’, ‘Veteran culture’, and ‘women Veteran’s preferences’. Participants reported overall negative health care experiences within the VHA and identified areas for improvement. Each of the identified themes was utilized to develop and implement a comprehensive practice change bundle within a new model of care. Care of women Veterans can be improved by the implementation of QI projects and advanced practice nurses are in an ideal position to lead. Recommendations were set forth in this project that once completed, have the potential to improve health outcomes of women Veterans including patient satisfaction, preventative screenings, and overall health status.
**Biographical Sketch:** Jessica Thieme BSN, RN, is a post baccalaureate DNP student. She has spent most of her nursing career caring for critically ill medical, surgical, and trauma patients. Her scholarly project work focused on improving accessible, gender-sensitive comprehensive care delivery for women Veterans at the William S. Middleton Memorial Hospital. Upon graduation from the DNP program she will become board certified as an adult/gerontology primary care nurse practitioner (AGPCNP-BC). Jessica has accepted a position as a nurse practitioner in the Medicine-Pulmonary Department at UW Health. She will have a dual focus of Cystic Fibrosis & Interventional Pulmonology and provide comprehensive care to both well and ill patients primarily in the outpatient setting.

**Scholarly Project Professor:** Tonya J. Roberts PhD, RN

**Clinical Project Partner:** Sandra R. Schumacher PhD, WHNP, BC, CNM, RN, Women’s Veteran Program Manager, William S. Middleton Memorial Hospital
CAUTI Prevention in the Acute Care Setting: A Focus on Bladder Irrigation
Connie Endvick, BSN, DNP(c), RN

Abstract: Catheter-associated urinary tract infection (CAUTI) is an important quality measure in healthcare. Among the most common healthcare-associated infections, CAUTI can increase the length of hospital stay and healthcare costs, cause discomfort, and contribute to increased mortality (AHRQ, 2015). The CAUTI rates at Aspirus Wausau Hospital (AWH) were consistently higher than the national benchmark (AWH, 2015). Root-cause analyses revealed a potential link to bladder irrigation and suggested opportunities for improvement at many levels within the organization. The overarching goal of this quality improvement (QI) project was to standardize practice and reduce CAUTI by utilizing a translational practice model to develop a system-wide evidence-based practice protocol; and select a bladder irrigation kit that would drive best practice at the bedside and improve patient outcomes through appropriate use of bladder irrigation and proper bladder irrigation technique. A secondary goal was to improve documentation of bladder irrigation in the electronic medical record (EMR) to align with the newly developed protocol. This project enhanced the multifocal CAUTI prevention initiative at AWH. Staff education was released July 18, 2016 and the protocol with algorithm and SmartPhrase will be implemented on August 21, 2016. CAUTI prevention initiatives to date have shown signs of success. AWH went from more than double the national benchmark with a SIR rating of 2.368 in calendar year 2014, to better than the national benchmark at 0.710 as of first quarter in calendar year 2016. The sustainability of this initiative will hinge on continued stakeholder engagement, ongoing staff education, execution of best practice recommendations, and evaluation of outcomes as manifested by decreased CAUTI rates.
Biographical Sketch: Connie Endvick BSN, DNP(c), RN is a Post-Baccalaureate DNP student. She earned her Bachelor of Science in Nursing degree from Viterbo University in 2011 and Associate of Science in Nursing degree from Northcentral Technical College in 2006. Upon graduation she will become a board certified Adult-Gerontology Acute Care Nurse Practitioner and will be joining the Aspirus Pulmonary and Critical Care team. Clinical interests include transitions of care in primary, secondary, and tertiary prevention. Her career as a registered nurse has been with Aspirus Wausau Hospital, a Level II trauma center located in central Wisconsin. From 2006 to 2011 she worked in the Post-Surgical Care Unit and from 2011 to the present has worked in the Post-Anesthesia Care Unit.

Scholarly Project Professor: Pamela McGranahan, DNP, APHN-BC

Clinical Project Partner: The Performance Acceleration Team for CAUTI prevention at Aspirus Wausau Hospital. Jeannine Nosko, CNO; Amber Sopata, CNL; Shirley Wiesman, CNS; Anna Marciniak, MT (ASCP) Infection Control Coordinator; Dr. William Wessels, CMO
A Participatory Approach to Quality Improvement in Long-term Care
Megan McGrath

**Background:** Behavioral and psychological symptoms of dementia (BPSD) are often challenging for residents and caregivers alike. Antipsychotic medication became a popular tool by which to manage these symptoms. Increased awareness of the adverse health and safety, as well as the quality of life outcomes related to antipsychotic use in this population, is driving efforts to reduce reliance on these unsafe medications. The purpose of this quality improvement project was to investigate how training in nonpharmacological intervention can mitigate the use of antipsychotic medication for treatment of BPSD.

**Methods:** This project was a non-experimental, correlational design inquiry, quality-improvement project conducted in one long-term care facility. Training on effective communication strategies when caring for patients with dementia was provided to direct care staff in training sessions and small group participation formats. The intervention was designed to be tailored to the wishes and needs of the long-term care facility at any point during the study. Participatory Action Research (PAR) methods were utilized to empower the direct care staff and ensure the content covered was useful in their setting.

**Conclusion:** The participatory approach shows promise in addressing many of the barriers to implementing quality improvement in long-term care facilities.
Biographical Sketch: Megan McGrath B.S., R.N. is a post Baccalaureate Doctor of Nursing Practice Student. Upon graduation she will become a board certified Psychiatric Mental Health Nurse Practitioner. Her clinical interests include resiliency and military mental health. She will begin her career as a Psychiatric Mental Health Nurse Practitioner by providing psychiatric and mental health care to Airmen and their families as a member of the United States Air Force.

Scholarly Project Professor: Pamela McGranahan DNP, APHN-BC
Recognizing and Addressing Depression in Palliative Cancer Care
Rachael Booth BS-N, RN, OCN

Abstract:
The risk of developing depression is high after a diagnosis of cancer for those adults with advanced disease or high symptom burden. Regular screening for depression in this population is lacking, within the urban setting of the University of Wisconsin Carbone Cancer Clinic (UWCCC) there is no standardized screening.

The purpose of this quality improvement project was to enhance recognition and follow-up of depression by implementing and evaluating systematic usage of a standardized, specific screening tool for depression in a palliative cancer care clinic.

The first intervention, Translating Initiatives for Depression into Effective Solutions (TIDES)-based educational modules, was completed by medical assistant and provider staff to increase awareness of depression, introduce the workflow change and review relevant guidelines. The second intervention was a change of workflow for medical assistants and providers to integrate the Patient Health Questionnaire (PHQ) tools and subsequent treatment, into usual care. Feedback from process measures involving staff and patients were incorporated back into the project. Outcome measurements were used to analyze appropriate screening tool administration and ensure positive screens were recognized and addressed.

Process measures goals were all met with the majority of patients and clinical staff satisfied with changes to workflow as well as how depression was addressed. 54% of the 53 eligible patients were screened with the PHQ-2 and 86% of those positive completed the full PHQ-9. Of those with a positive PHQ-9, 50% had depression clearly documented and clear follow-up plan documentation reached 100%.

Routine screening practices and planned follow-up can be successfully integrated into standard cancer care to improve care of the whole patient. Reducing the assumptions associated
with psychosocial needs should be a focus of further quality improvement projects.

**Biographical Sketch:** Rachael B. Booth, BS-N, RN, OCN is a post-Baccalaureate Doctor of Nursing Practice student. Her career as a registered nurse has been focused on oncology and hospice populations. Upon graduation, Rachael will practice as an Adult/Gerontology Primary Care Nurse Practitioner. Her special interests include symptom management and end of life care. She aspires to continue her work in palliative care as a nurse practitioner within the geriatric population.

**Scholarly Project Professor:** Dr. Tonya Roberts PhD, RN

**Clinical Project Partner:** Dr. Toby Campbell, MD, Chief of UW Health Palliative Care program and director of the palliative care fellowship training program, at the Carbone Cancer
Abstract: *Clostridium difficile* is the leading cause of health care associated diarrhea in the United States. At the University of Wisconsin Hospital (UWHC), the rates of *Clostridium difficile* infections consistently rise above national benchmarks. Internal chart reviews revealed a pattern of inappropriate testing for *C. difficile* infections. Inappropriate testing of patients who do not meet the clinical criteria for active *C. difficile* infection increases the risk of false positives and unnecessary treatment for these individuals. Therefore, a computerized clinical decision support (CDS) tool embedded in the electronic health record (EHR) was developed and implemented by the *C. difficile* infection (CDI) workgroup at UWHC to facilitate appropriate testing of adult inpatients, change the ordering behavior of providers and nurses, and decrease overall rates of *C. difficile*. Results of pilot implementation indicated the CDS tool was over-firing for adult inpatients related to incomplete stool documentation affecting the tool. This created a potential lack of credibility and specificity of the tool to influence end-user action. Facilitators and barriers to stool documentation were then explored and analyzed via survey. Stool documentation compliance monitoring, additional stool documentation rows within the EHR, and audit of the Bristol Stool Chart access were initiated following survey feedback. Continued monitoring of stool documentation compliance and improvement in documentation will ensure that upon full implementation of the CDS tool, it will be accurate and efficacious in guiding clinicians to test appropriately for *C. difficile* at UWHC.
**Biological Sketch:** Ann Titzkowski, DNP-c, BSN, RN is a post-baccalaureate Doctor of Nursing Practice student. In her career as a registered nurse, she has worked in critical care and perioperative areas. She hopes to continue her practice in the acute care setting with a particular interest in internal medicine and palliative care. Upon graduation, she intends to become board certified as an Adult/Gerontology Acute Care Nurse Practitioner.

**Scholarly Project Professor:** Tonya Roberts PhD, RN

**Clinical Project Partner:** Linda Stevens, DNP, RN-BC, CPHQ, CSPHP
Design and Development of an Evidence-Based Mobile App to Support Informal Caregivers of Older Adults: Spotlight on the Creation of a Driving Safety Module
Paula Anne Brady, BSN, RN

Background: Motor vehicle injuries are a leading cause of injury-related death among older adults. Age-related changes in vision, physical ability, and cognitive functioning impair older adults’ driving fitness. Input from informal caregivers (i.e., spouse, adult children) positively influences driving behavior of older adults; however, conversations about driving safety are often avoided until crises occur. Informal caregivers require assistance initiating proactive conversations and decisions about driving to help reduce motor vehicle related deaths among older adults and ensure safe community mobility for all.

Purpose/Objectives: To design, develop, and pilot an evidence-based mobile caregiver support app (eCARE) in collaboration with the University of Wisconsin-Madison School of Nursing’s Center for Aging Research and Education (CARE). This project spotlights the creation of the driving safety module within the larger eCARE suite of topics. The purpose of the driving safety module is to help caregivers explore options, anticipate needs, prepare for future decisions, and initiate conversations about driving with older adults.

Methods: App content was informed by caregiver input, published research, and expert sources. App design was accomplished through a participatory design approach by means of evolutionary prototyping. The Mobile App Rating Scale (MARS) criteria were used to ensure high-quality app design and provide a framework for evaluation. Evaluation was conducted with a community advisory group and representative informal caregivers using MARS dimensions.

Conclusions: This project demonstrates a systematic approach to developing a caregiver-oriented mobile support app to promote older driver safety. App content, development, and evaluation was grounded in theory, guided by evidence, and balanced with end-user feedback using MARS dimensions to maximize impact on caregiver satisfaction. Through an iterative process, end-user preferences and feedback was incorporated.
into the app prototype that met users’ needs, wishes, and preferences.

**Biographical Sketch:** Paula Brady, BSN, RN is a post-baccalaureate Doctor of Nursing Practice (DNP) student. Her education includes Bachelor of Science degrees in Rehabilitation Psychology and Nursing from the University of Wisconsin—Madison. Upon graduation from the DNP program, she will become an Adult-Gerontology Primary Care Nurse Practitioner. Her career as a registered nurse in General Medicine and Geriatrics has solidified her calling to serve the healthcare needs of older adults, especially those residing in rural communities at home and abroad. After graduation, she plans to work locum tenens assignments across the United States to diversify her experience and better understand the challenges and opportunities that exist to improve health among rural dwelling adults. She will also continue her yearly volunteer mission in Haiti serving the dental health needs of a rural community.

**Scholarly Project Professor:** Tonya J. Roberts PhD, RN

**Clinical Project Partners:** Barbara Bowers, PhD, RN, FAAN, Diane Farsetta, PhD, Kimberly Nolet, MS, Nicole Crain, BS, Michael Funk, BA, Valerie Stevens, MS, and Zhiyuan Yu
Identification of Barriers to Primary Care and Behavioral Health Integration
Jonathan Williams BSN, RN, CCRN

**Background:** Limited access to behavioral health services is a known barrier to the recognition and treatment of mental illness. In order to provide the most comprehensive care, it is a priority for health systems to integrate mental health practitioners with primary care and utilize a mental health consultative model.

**Objectives:** The goal of this project was to identify barriers to care coordination between primary care and behavioral health in two northeastern Wisconsin clinics. Once the barriers were identified, specific recommendations for improved integration were provided.

**Methods:** A needs assessment project based on the Agency of Healthcare Research and Quality (AHRQ) Framework/Guidelines for Behavioral Health Integration.

**Analysis/Evaluation:** A needs assessment was completed which focused on primary care providers at the identified clinics using the AHRQ Site Self-Assessment Evaluation Tool. The survey results were evaluated to identify the three main barriers to behavioral health integration. Information gathered from the survey was the basis for developing evidence-based recommendations, which were then presented to the health system.

**Results:** Three most pertinent barriers identified were 1) Patient care team for implementing integrated care, 2) Treatment plans for primary care and behavioral/mental health care, and 3) Co-location of treatment for primary care and behavioral/mental health care. Utilizing the AHRQ Framework/Guidelines for Behavioral Health Integration, three solution categories focusing on interventions involving 1) Staff education 2) Utilization of EBP screening tools and planning tools, and 3) Grouping of services were derived. Interventions were disseminated and presented to the administration of the two northeastern Wisconsin clinics, and synopsis was provided by email to administration and providers.
**Biographical Sketch:** Jonathan Williams, BSN, RN, CCRN is a post baccalaureate Doctor of Nursing Practice Student. His education includes a bachelor’s degree in Biology and Natural Sciences. Upon graduation he will become a Psychiatric Mental Health Nurse Practitioner. His career as a registered nurse started in corrections at the Dane County Jail where he developed an interest in psychiatric nursing. His career then took him to the Neuro/Surgical/Spinal and Rehabilitation unit, then finally to the Surgical Specialty Intensive Care Unit. His clinical interests include improving access to those seeking behavioral health care, and improving the integration between behavioral health and primary care. He is interested in clinical practice, and will be serving northern Wisconsin as a Psychiatric Mental Health Nurse Practitioner early this fall.

**Scholarly Project Professor:** Julia Vance, DNP, MS, CNM

**Clinical Project Partners:** Credit to Elizabeth Rice PhD, PMHNP-BC for project initiation assistance
Effects of Standardized Patient Simulation on Nursing Students in the First Year of Clinical Nursing Practice
Stacey Boehm

Abstract: Suicide is a serious public health problem in the United States whose rates have increased from 10.9 to 12.93 per 100,000 individuals over the last ten years. Prevention strategies include early identification and screening, assessment, treatment, and referral for care. Registered nurses, as the first professional often encountered by patients in health care settings, are positioned to impact the identification of suicidal patients, leading to timely intervention and preventative treatment. However, research indicates that nurses consistently report a lack of knowledge or skills in performing an accurate suicide assessment. In an attempt to bridge this gap, some nursing programs have implemented standardized patient simulation, which has been shown to increase a student’s abilities and confidence in performing suicide assessment.

Standardized patient simulation (SPS) is an educational tool that has been shown to integrate suicide assessment skills and improve student confidence, but the retention rate of that information into the first year of practice is unknown. The objectives of this project were to determine if the initial expressed increase in confidence of senior nursing students who participated in a SPS suicide assessment pilot program in 2015 continued into their first year of practice. Based on the survey results of the SPS pilot and alumnus survey, recommendations for the use of simulation as a continuing education opportunity were developed for nursing educators and a partnering health care organization. Project findings supported the use of SPS in nursing programs to increase students’ skill and confidence in performing suicide assessments. Survey results indicated that alumni experienced a waning of skill and confidence during the first year of nursing practice. This quality improvement project concluded that nursing programs have utilized SPS to teach suicide assessment
skills and improve self-confidence; SPS could also be implemented in clinical practice as an annual continuing education offering to increase practicing nurses’ confidence and consistency in performing a suicide assessment

**Biographical Sketch:** Stacey Boehm, MS, RN is a Post Baccalaureate DNP student. She earned her Master’s in Nursing Education from Winona State University in 2002 and has taught Mental Health Nursing for the past eleven years at Western Technical College as well as Viterbo University in La Crosse, Wisconsin. Upon graduation she will become Mental Health Nurse Practitioner board certified. She plans to practice as a Psychiatric-Mental Health Nurse Practitioner in Montana in an acute care setting.

**Scholarly Project Professor:** Julia Vance, DNP, MS, CNM

**Clinical Project Partner:** Mary Lu Gerke, PhD, RN Interim Dean of the College of Nursing and Human Behavior and Kimberly Nelson, RN, MSN, Viterbo University

Additional credit to Elizabeth Rice, PhD, PMHNP-BC
Implementing Group Medical Visits to Improve Complex Patient Outcomes in an Integrative Medicine Clinic
Carissa M. Dolens

Abstract: In the United States, chronic diseases have become prevalent, costly, and increasingly complex. It is recommended that individuals with chronic disease receive regular medical care, self-management education, and ongoing support to achieve effective disease management. Many clinic practices have been faced with mounting pressure to report quality benchmark data while increasing patient panel numbers and maintaining 15-minute clinic visits. For these reasons, patients often struggle with scheduling a routine medical visit in a timely fashion. To address these challenges, the use of evidenced-based disease self-management programs has been shown to help improve quality of life and reduce the number of healthcare visits needed to maintain good health for people with, or at high risk for, chronic conditions. A quality improvement project was implemented using a group medical visit model in an integrative medicine clinic. The project addressed current barriers concerned with patient-centered communication and health education toward the diagnostics and self-management of chronic autoimmune and gastrointestinal conditions. The objectives of this project were to improve patient satisfaction, symptoms, and self-management as well as provider time utilization, satisfaction, and cost-effectiveness. The project objectives were measured using clinic and provider data along with questionnaires at all implemented group medical visits, which were then compared to those of a prior cohort who received online-only patient education. The evaluation measures indicated that group medical visits worked to improve all objectives except provider time utilization. These results positively influenced the clinic’s decision to further utilize the group medical visit model for future patient groups.
Biographical Sketch: Carissa Dolens, BSN, RN, OCN is a post-baccalaureate Doctor of Nursing Practice student. Her Bachelor of Science in Nursing degree was earned from Edgewood College in 2007. Since then, she has been practicing as a registered nurse on an inpatient hematology, oncology, bone marrow transplant, and palliative care unit at UW-Health. Upon graduation from the UW-Madison DNP program she will become a board certified Adult-Gerontology Primary Care Nurse Practitioner. Her intentions are to continue working with the oncology population in a nurse practitioner role, where she can further aid in improving patient care and outcomes through clinical practice and quality improvement initiatives.

Scholarly Project Professor: Pamela McGranahan, DNP, APHN-BC

Clinical Project Partner: Patrice Streicher, MS, RN, FNP-BC, Nurse Practitioner with the Sheryl Spitzer-Resnick, MD, LLC: Women’s Health and Integrative Medicine Clinic at Wildwood Family Clinic in Cottage Grove, WI.
Abstract: Persons with severe mental illness die an average of 25 years earlier than the rest of the population, primarily from physical health conditions. Care integration is supported by research as well as public policy to address this major health disparity. Care integration is defined as mental health and general medical care providers working together to address both physical and mental health needs of patients. The purpose of this project was to improve care integration processes and physical health outcomes in persons with mental illness. A provider-focused training program including components to improve screening for a high Body Mass Index (BMI), documentation in the electronic health record (EHR), and referral of patients to treatment, was developed and implemented in a rural mental health center. Components of the program were developed based on the Centers for Medicare and Medicaid Services (CMS) quality metrics to promote better integration of care for persons with mental illness. The Reach Effectiveness Adoption Implementation Maintenance (RE-AIM) model was used to guide the translation of the guideline into practice. Following the intervention, 75% of participants were able to demonstrate competency by documenting to standard in the EHR. In addition, 64% of all patients had BMI documented in the EHR, and 61.6% of qualifying patients had appropriate referral documentation. Care integration addresses major health disparities for persons with serious mental illness. This project was a first step in care integration at the mental health center. Despite barriers in modifying the EHR, there was an increase in patients receiving appropriate referrals for their BMI.
Biographical Sketch: Melissa Fuhrmann, BS, RN is a post-baccalaureate DNP student in the adult-geriatric primary care tract. Melissa earned her Bachelor’s degree in Business Administration from Augustana University in 2002 and Bachelor’s degree in Nursing in 2006 from South Dakota State University. She was an RN at St. Mary’s Hospital for 9 years, working on a cardiac surgical step down unit. In 2015, she started working as a nurse care coordinator with the Integrated Health Home at Northeast Iowa Behavioral Health. Upon graduation she plans to work in primary care. She would also like to continue working with persons with severe mental illness, improving the physical health care they receive and their health outcomes.

Scholarly Project Professor: Linsey M. Steege, PhD

Clinical Project Partner: Marcia Oltrogge, MA, Executive Director, Northeast Iowa Behavioral Health Center
Evidenced Based Strategies to Improve Heart, Vascular, Thoracic Patient-Centered Care
Mary Francois

Overview: A 2001 Institute of Medicine (IOM) report, entitled *Crossing the Quality Chasm*, identifies patient-centered care as one of the six fundamental aims of the United States healthcare systems (IOM, 2001). The IOM (2001), defines care to be patient centered if it is “respectful of and responsive to individual patient preferences, needs, and values and ensures that patient values guide all clinical decisions”. The IOM further defines patient and family centered care as: Health care that establishes a partnership among practitioners, patients, and their families to ensure that decisions respect patient’s wants, needs, and preferences. In addition, patients have the education and support they need to make decisions and participate in their own care. (p.12) The IOM (2001) separates patient-centered care into eight areas: respect for patient preferences, information, medication communication, coordination of care, emotional support, physical comfort, involvement of the family, continuity, transition, and access to care.

Methods: There were three goals parts to this project:
1. Seeking to increase quantity and quality of patient input to improve patient-centered care response rates. Improve the volume of quantitative patient satisfaction data and integrating into practice.
2. To initiate a PFAC to elicit site specific contextual feedback for patients and families. Qualitative data is a method that is pragmatic, interpretive, and grounded in the lived experiences of people. It allows for diverse perspectives including ideological, social justice, philosophical stances, and systematic procedural guidelines.
3. Integrate the findings into practice to assure high level patient satisfaction for those patients and families who receive care from the HVT service line. A foundational strategy to meet these goals was engagement of other leading healthcare organizations.

Conclusion: Integrating Patient and Family Advisory Councils (PFACs) within the hospital setting is an excellent approach to gain insight and have involvement from patients while increasing the quality of care delivered in a hospital. Despite the strong policy agenda to increase patient involvement in quality improvement functions, further assessments of patient centeredness should examine its effectiveness in terms of the type of patients performing the functions, the criteria used for their selection, the
training they received to perform their functions, and the contributions they make to quality improvement. While genuine intentions to engage patients and use their input to improve satisfaction and quality care, many questions still remain about the best strategies to elicited feedback. The success of patient involvement however, may depend largely on being able to recruit patients with an ability to express their views constructively. Despite the evidence that considerable consensus exists regarding the necessity of patient-centered care by CMS, literature review, UW Health leadership, implementation and obtaining achieving true patient centered care is daunting. While there are many promising examples of organizations achieving excellence in patient-centered care, these innovators are not yet the norm. The challenge lies in elevating the norm through strategies at both the organization and the system level that can leverage the experience of these innovators to motivate large-scale changes. Not being able to compare data results to Qlikview results due to lag time of results reported. Changing the mind-set of employees from a ‘provider-focus’ to a ‘patient-focus’ is a challenge. Changing the culture of an organization can take three to five years according.

Biographical Sketch: Mary Francois, MSN, RN, CNS, CCTC is a Post-Master's DNP student. She earned her Master's degree from Edgewood College. She earned her CNS degree from the University of Wisconsin. She has worked at UW Health for 30 years-the last year as a Program Director for the Heart, Vascular and Thoracic Service Line. She is currently the President –Elect for a National Organization in Transplant. Her current career goal is to become a Clinical Operations Director.

Scholarly Project Professor: Dr. Pam McGranahan DNP, APHN-BC

Clinical Project Partner: Linda Procci – Was the Vice President Service Line Operations at Cedars Sinai Medical Center in Los Angeles. In addition to the Deans Advisory board, Linda currently serves on the University of Wisconsin Foundation Board and the Board of Visitors for the UW-Madison School of Nursing.
Childhood Obesity Prevention: Evaluation & Dissemination of Sustainable Practice-Based Evidence
Erika Bourdeaux, BSN, RN, DNP (c)

Abstract: In the United States, childhood obesity continues to become a growing epidemic. Prior recommendations of nutrition and fitness education alone has shown minimal sustainability or translation into practice in the home. Evidence-based clinical guidelines for childhood obesity prevention fails to recognize successful and sustainable practice-based evidence that adopt a multi-factorial and contextual approach. Practice-based evidence can help provide a clearer understanding of effective interventions. Currently, there is a lack of consistent or systematic program evaluation and dissemination of credible practice-based evidence regarding childhood obesity prevention. The overall purpose of this quality improvement (QI) project was to demonstrate the value of incorporating practice-based evidence into a community-based pediatric wellness program to improve sustainable healthy behaviors that translate into the home.

An 8-week pilot was conducted based on practice-based evidence with the intent to evaluate the effectiveness of current program framework and disseminate findings. The short timeline of this project did not allow for statistically significant changes in weight or Body Mass Index. Audio field notes along with pre-, mid-and post- participation surveys with variable response rates did depict multiple qualitative themes centered on behavior and attitude changes. The themes were useful for evaluation and modification of an existing program while identifying a familial desire to achieve overall health and wellness. Additional evidence is needed to demonstrate the long-term benefits and sustainability of childhood obesity prevention programs utilizing practice-based evidence. This QI project concluded that practice-based evidence offers a realistic compromise between research and appropriate practice.
Biographical Sketch: Erika Bourdeaux is a Post-Baccalaureate DNP student. She also completed the nurse educator courses during her time in the program. In 2015, she assumed an adjunct faculty and pediatric clinical instructor role at Edgewood College School of Nursing in their accelerated Post Bachelorette Nursing program for one academic term. Her quality improvement scholarly project focused primarily on childhood obesity prevention and the role of sustainable practice-based evidence. Her clinical interests include pediatric wellness and family engagement along with incorporating her nursing background in Asthma/Allergy and Urgent Care. Upon graduation she will become a board certified Pediatric Primary Care Nurse Practitioner. She has secured a part time position with MercyRockford Health System in a clinic setting to begin Fall of 2016. She also hopes to obtain her Nurse Educator Certification and continue teaching in both Undergraduate and community settings.

Scholarly Project Professor: Pam McGranahan, DNP, APHN-BC

Clinical Project Partner: Laurel Runte, APNP, CPNP, Fort HealthCare, Lake Mills Clinic; Special thanks to Alyssa Villareal, MS, OTR, Fort HealthCare